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Streamlining the Performance/Talkback Model Using Media and Alternative Action (MAAct): An Intervention

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Streamlining the Performance/Talkback Model Using Media and Alternative Action

(MAAct): An Intervention

Capstone Thesis

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Drama Therapy

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Abstract

This capstone project ventures to develop a drama therapy method that may increase empathy, social skills, and communication skills in populations with substance use disorders. Particular attention has been paid to the efficacy of performance/talkback methods in increasing these factors. An attempt has been made to streamline the performance/talkback method for greater accessibility to such methods in clinical spaces. The literature shows a particular need in populations with substance use disorders for social skills, communication skills, and empathy training. There have been published drama therapy studies that aim to intervene in these areas, though few with this particular population. This method was tested in a clinical partial hospitalization program that treats adults with substance abuse disorders. The participants were white women between the ages of 21-61. Through this inquiry, I have learned that it may be possible to replicate many of the studied effects of performance/talkback models using pre-recorded media instead of live performance. I believe this method can be applied to many populations to spark discourse, encourage perspective-taking, provide social rehearsal, break down communication patterns, and increase topic-related empathy. I also believe this model can increase access to performance-based interventions by eliminating many of the logistics of staging a live performance.

Keywords: substance use disorders, performance-based, empathy, social skills, drama therapy
Author Identity Statement: The author identifies as a US-born, US residing, white male.

Introduction

Theatre has been used to spread and question ideas since time immemorial.

Contemporary drama therapists use theatre of the oppressed, theatre for change, and other

models to spread awareness of power, privilege, and oppression within the United States

(McAdam & Davis, 2019). An intervention or method for conversation that has seen frequent use

after live theater events is the "talkback," an opportunity for audiences to engage the cast,

directors, and producers of a production (Bailey, 2009). In my experience, the

performance/talkback model has efficacy in creating a shared experience, increasing empathy,

and sparking energetic and sometimes transformative conversations.

My passion for this model started while I was pursuing my undergraduate degree, a BFA

in musical theatre. The university would have talkbacks after performances, which provided a

beautiful opportunity for the community to come together and process shared experiences. My

passion for the performance/talkback model peaked when I was fortunate enough to see the

powerful work done by NYU's therapeutic theatre series (NYU, 2021). These productions

brought together specific populations for a particular therapeutic purpose, and they changed my

perspective on what "drama" could be. In fact, the effect NYU's therapeutic theatre series had on

me is one of the reasons I decided to become a drama therapist.

I have an affinity for performance-based art and intervention. Therefore, I have an

inherent bias toward them. I was fortunate enough to have been exposed to the theatre from a

young age and have always loved it. I realize that not everyone shares my feelings around

performance-based art and intervention and may have an aversion to it. I also recognize my

privilege as having grown up a straight, white male in a middle-class family, a family who could

provide me with the opportunities to explore my artistic-self and the support to fall and get back

up. Another reason I became a drama therapist: I do not believe performance-based art and intervention should be reserved for those privileged and supported enough to have grown up in the theatre. Bringing theatre to the client inside the treatment space is the spirit of my method.

However, the performance/talkback model also has its drawbacks. The actors can often be turned into objects for the audience's consumption, creating a problematic or harmful environment. Talkbacks can resemble a physical embodiment of a YouTube comment section at their worst. A study by Wood and Mowers (2019) has shown that a co-active model in which the spectators are given an active, participatory role in response to the performance may create more positive and productive engagement. Another drawback is the logistical feat of putting together a live performance. A therapeutic performance may have all the logistics of any other staged performance (venue, ticket sales, rehearsal, scheduling, etc.) on top of the additional logistical feats of dealing with hospitals, clinics, shelters, and insurance. Overall, the institutional support needed to stage a full production can be in short supply.

I have seen throughout my life the ability of the theatre, the pieces themselves, and the shared experience, to create valuable and empathetic discussion (Rathje et al., 2021). After working with clients with substance use disorders (SUDs) in an intensive outpatient program (IOP) and a partial hospitalization program (PHP), I have seen a particular need within this community for creative interventions to widen perspective and increase empathy and communication skills. As I sat in PHP and IOP, I wished there was a way to use performance-based drama therapy interventions to improve social skills and empathy with the group. Yet, the institutional backing simply was not there.

The performance/talkback model is an effective intervention with reach and potential for transformation and empathetic growth, especially when using a co-active model (Wood &

Mowers, 2019). I have long pondered how the performance/talkback model could be more accessible. In addition, I wanted to bring this model to clients in the spaces they already meet for therapy. Therefore, I devised a model to curate media clips for group consumption, transformation, performance, and processing. After learning about the specific needs of the SUD population, the research question I decided to investigate was, "Can changes in empathy and social skills be observed for people with SUDs who participate in a modified version of the performance/talkback model?".

I reviewed the literature on the needs of people with SUDs and the ability of existing drama therapy methods to aid in their healing and skill-building. I reviewed research on therapeutic performance and how drama therapists have used performance/talkback models in their work. I investigated the literature that touched on theatre's ability to forge and reforge connection, increase empathy, and increase social skills. My inquiries also led to research detailing the needs of the SUD population for these types of interventions.

Literature Review

I have experienced the ability of theatre to increase confidence, social skills, and empathy during my lifelong engagement with the art form. My desire to be a drama therapist blossomed from the desire to share these gifts with others who may not have had the opportunity to engage in theatre. Rich research has been done to measure the effects of engaging in and watching live performances. Often, the result can be an increase in empathy and social skills, just as I have found in my personal life (Rathje et al., 2021).

My method is a stitchwork of methods that came before. To start, I combed the literature to find peer-reviewed articles for the various elements I am laboring to combine into a cohesive approachable method. I read about the ability of drama therapy to have a positive impact on

empathy, social and communication skills, the strengths and weaknesses of performance/talkback methods, and how all of this applies to the SUD population with which the method was tested.

Empathy, Social, and Communication Skills

I started my research by looking for drama therapy interventions with therapeutic goals reflective of those I had for my group, increasing social and communication skills and empathy. Much of the research I found on this subject was conducted using younger populations. Karatas (2011), for example, worked with 77 high school students split between control, placebo, and experimental groups. The students in the experimental group experienced 10 psychodrama sessions over the semester with conflict resolution training. The placebo group experienced the same number of interactive groups as the experimental group sans the conflict resolution training, and the control group experienced no interactive groups and simply took the pre and post-tests. Results were measured using The Scale of Determining Conflict Resolution Behavior. In the post-test, statistically significant decreases in aggression ($p<.05$) and increases in problem-solving behaviors ($p<.05$) were shown in the experimental group. While this research shows increases in the aforementioned areas, the methods are primarily non-descript psychodrama sessions making it difficult to repeat the process. However, the data provided by Karatas' work shows an important precedent for measurable outcomes in social and communication skills, an element related to my research.

Another example is Amatruda's (2006) research, in which it is hypothesized that psychodramatic interventions may increase communication and social skills in children 10-13 years old in a special education setting. Amatruda reported one psychodrama session in which she had the students embody their favorite character from a book they were reading in class. On

this particular day, she noted that students were able to be more curious and empathetic with their classmates while in character. This anecdote gives valuable information, as role-taking after consuming media is integral to my developing method. Based on Amatruda's experience, it could be hypothesized that a group might show increased levels of empathy and communication if given the distance of enrollment. Furthermore, it could be hypothesized that exposing clients to stories and characters they can relate to may lead a facilitator to essential discoveries regarding clients' empathetic and social skills.

Wiener's (2015) exploration into staging dramatic enactments to resolve conflicts in couples was the work I found that most closely reflected my method and goals as a unit. Much of the work Wiener has done in this study is based on well-precedented couple's therapy techniques that have been documented by authors such as Datillio (2014). Wiener (2015) takes these tried-and-true techniques and adds the nuanced lens of a drama therapist. Psychodramatic methods are described in couples and family therapy texts without citing their origin.

A significant difference between Wiener's (2015) work and mine is that he worked with relationship systems that are intimate and firmly established, using excerpts from real-life conflictual exchanges between couples, while I am working with fictional scenes from a tv show in a group therapy setting. Another way of looking at it, Wiener's research leans toward the psychodramatic (enacting scenarios inspired by one's real-life experience) while mine leans toward the drama therapeutic (using role and fictional narrative). While Wiener's work "…extends the use of psychodramatic techniques to a drama therapy format that permits the therapist to titrate better the degree of aesthetic distance" (p. 9), my work relies on the embodiment of fictional roles to achieve a level of distance that would be appropriate for an

IOP/PHP group with SUDs. As Amatruda (2006) found, Wiener postulates that embodying a role, or interacting with someone embodying a role, may increase one's empathy.

A scriptwriting portion of Wiener's (2015) intervention highlights the parallel narratives that couples may have during a conflict. Dekkers et al. (2020) conducted focus groups consisting of people in recovery from SUDs and found that, similarly to Wiener's findings with couples, people in recovery and those they are in relationship with also experience parallel narratives: "parallel recovery processes take place in individuals in recovery, family members, social networks and communities. However, these recovery processes proceed at different speeds, which results in mismatching expectations and views" (Dekkers et al., 2020, p. 532). If a person lacks the humility and perspective to validate others' perspectives and perceptions, relationships can be challenging to navigate. Empathy, social skills, and communication skills are necessary to navigate mismatched expectations and views.

Ozturkcu et al. (2018) employed a method combining psychodrama and cognitive behavioral therapy (CBT) in hospital settings to see if a decrease in burnout could be measured. The implementation of this study included participants bringing in scripted scenarios they wrote themselves inspired by at-work or at-home conflicts. The scenes were dissected using the previously learned CBT skills in group sessions, namely, identifying and questioning one's automatic thoughts. The PHP/IOP groups I tested my method with often engage in CBT skills training, as the participants in this study did, but do not have many opportunities to put theory into practice. Ozturkcu's et al. article provided a solid precedent for the breaking-down of a scene as implementation and training of communication skills.

D'Amico et al. (2015) investigated drama therapy's ability to teach communication skills to adolescents with autism. 75-minute therapeutic sessions took place once a week for 21 weeks.

Participants engaged in activities such as emotional expression and projection exercises. The researchers used the Social Skills Improvement System-Rating Scales. Statistically significant differences between parent pre-tests and post-tests result data was shown ($M = 0.55$, $SD = 0.52$), $t(5) = 2.57$, $p = 0.05$) regarding the social skills of their child with autism. However, statistically insignificant data was shown between the pre and post-tests given to the adolescents themselves ($M = 1.10$, $SD = 1.80$), $t(5) = 1.50$, $p = 0.19$.) This project demonstrated that drama therapy can effectively enhance children's ability to engage others socially, according to their parents' perceptions.

Bornmann and Crossman (2011) used playback interventions with students (24 in 5th grade and 23 in 8th grade) to measure its effects on their empathy using the Index of Empathy for Children and Adolescents. The groups (randomized age and sex) watched a video detailing a criminal justice hearing involving a violent incident at a school and engaged in a playback response afterward (a model resembling my own). This study did not produce statistically significant results regarding an increase in empathy ($p > .32$). It should be noted that the students in the Bornmann and Crossman study were not considered an at-risk population and showed a high propensity for empathy in the pre-test results. Due to this, the results of the intervention could have been a ceiling effect.

Wilmer-Barbrook (2013) inquired into drama therapy's efficacy in improving social and communications skills for eight young people with Asperger's syndrome (what would now be called autism spectrum disorder or ASD). The author met with this group for an hour a week for the whole school year (36 weeks). The group played theatre games to warm up, then the main intervention, which took many forms, served as social rehearsal. Changes were measured using an investigator-developed evaluation. The averaged results showed that participants perceived a

22% positive change in themselves, the tutors of the participants perceived a 38% positive change, and the parents of the participants perceived a 12% positive change. These three studies (Bornmann & Crossman, 2011; D'Amico et al., 2015; Wilmer-Barbrook) follow a trend of measuring changes in people that have not yet reached adulthood or people that are on the autism spectrum, both factors that are not shared with the population with which my method was tested. However, they do show statistical evidence that drama therapy interventions, such as the one I am developing, can be effective at increasing empathy and social skills.

Performance Response

While my method might not be considered performance-based, I was inspired by and borrowed heavily from the structure of performance-based interventions. Wood and Mower's (2019) "co-active experience for the audience" (p. 230) inspired in me an idea to enroll clients as the audience. Like the population my method was tested with, the participants are people in recovery enrolled in an IOP, though it was an IOP for eating disorders, not SUDs. Wood and Mower's model is thorough and precise, detailing a process that takes up to three months and requires a set group. This method would not be possible within an IOP/PHP with rolling enrollment such as the one I had access to. In a way, I have inverted Wood and Mower's design by taking a performance that already exists, with themes relevant to the IOP/PHP, and enrolled the clients as the audience. When describing the audience response portion of her manualized method, Wood and Mower (2019) wrote,

> Another distinguishing feature of CoATT includes an element of audience participation that differentiates from talkback… or psychodramatic sharing… In fact, the CoATT model is adamantly against the post-show talkback format, as we believe that it often creates a breeding ground for voyeuristic behavior that further creates a divide of power

and privilege between audience and performer, recasting the participant back into the role of the 'sick one.' Instead, using an image, theme, line or activity from the play, the cast creates a co-active experience from audience members to be led by them at the conclusion of the production. (p. 230)

Using media clips significantly reduces, if not eliminates, the possibility for talkback to cause harm to performers. Wood and Mower's perspective on the vulnerability of clients/performers during talkback-centered interventions was invaluable to the formation of my method. I did not wish the participants in my test group to be judgmental voyeurs into a fictional person's life but to think critically and personally invest in the intervention. I did not want the group to distance themselves from the characters but to find themselves within them.

A study by Rathje et al. (2021) has shown that the simple act of attending a theatrical performance may work to increase empathy in the audience. Rathje's et al. study showed increased topic-related empathy ($p<0.001$), show-related attitudes ($p<0.001$), and interest in charity ($p<0.001$) from the audience as measured by investigator-developed surveys handed to audiences before and after live theatre performances. This study influenced my media selection process because the study shows an increase in "show-related attitudes" (p.7). Therefore, I wanted to be sure to pick a show that had an informed and hope-oriented attitude toward SUDs. Though this research pertains to stage performance and not a tv show, my method employs a portion of script reading with group members serving as performers and audience, making the findings relevant to my work.

I was struck by the measure of "topic-related empathy" (p. 3) in Rathje's et al. (2021) work. The PHP/IOP I work with uses the disease model of addiction. A part of this model is growing empathy around the disease of addiction so that self-forgiveness can eventually occur.

Stephens-Hernandez et al. (2007) did research looking at the ability of a theatrical production to educate a community and advocate for involvement around SUDs. Education on the disease is vital for people with SUDs to communicate their needs and boundaries effectively. For this reason, I made sure to pick a show relevant to the recovery journey that put forth real effort to represent the disease and what recovery looks like accurately. When re-scripting a conflict having to do with SUDs, clients may increase topic-specific education and empathy that will aid them in improving their communication skills moving forward.

Kewley's (2019) article has valuable information on the needs of people with SUDs to acquire recovery capital (behaviors relevant and beneficial to recovery) and engage in prosocial behavior. The article details a group of people who achieved this by forming a community theatre. Though these aims differ from those of my method, the parallels drawn between theatre engagement and prosocial behavior have implications for my research. Kewley states part of the function of this theatre group: "Using drama and theatre techniques, facilitators work with participants, usually in groups, to help practice skills to prevent further reoffending, explore difficult emotions or behaviours, or build strategies to cope with problems in life" (p.85). Kewley's research indicated that the theatre group showed a lower rate than the average person with an SUD of reoffending. People with SUDs need space to practice and rehearse social and communication skills in environments with other people in recovery, and this article shows how drama therapy might fill that need.

Population Specific Research

This method is being developed for use with people with SUDs. Therefore, I carefully considered the specific communication and empathetic needs of people with SUDs. In the

Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM5), a few criteria for

Alcohol Use Disorder are these:

> 3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or
>
> recover from its effects… 5. Recurrent alcohol use resulting in a failure to fulfil major
>
> role obligations at work, school or home 6. Continued alcohol use despite having
>
> persistent or recurrent social or interpersonal problems caused or exacerbated by the
>
> effects of alcohol. 7.3 Important social, occupational or recreational activities are given
>
> up or reduced because of alcohol use. (APA, 2013, p. 490)

A notable criterion for alcohol intoxication (a condition all people with alcohol use

disorders have experienced) is this: "2. Clinically significant problematic behavior or

psychological changes (e.g., inappropriate sexual or aggressive behavior, mood liability,

impaired judgment) that occurred during or shortly after alcohol ingestion" (APA, 2013, p. 497).

When a person with an SUD enters into recovery, the situations listed in the above criteria

involve extensive and intricate repair with family, friends, and the workplace. Consequently, I

have seen the need for people with SUDs to increase empathy to see the effect their SUD has had

on the people around them and the need for communication and social skills to process and

repair the damages that may have occurred while they were in active use.

People with SUDs may be more susceptible to social anxiety and social avoidance

(Aurora & Coifman, 2021). As Ólafsdóttir et al. (2020) writes, they may also be predisposed to

tumultuous home-lives and familial relationships:

> Studies have shown that the family members of individuals afflicted by SUD or other
>
> mental illnesses are important as a source of social support and often find themselves

acting as a caregiver for their relatives… Family members in these situations must often

cope with difficult feelings of stress, anxiety, worry, shame, anger and guilt. (p. 136)

Because family members of people with SUDs are predisposed to the conditions

mentioned in the above quote, I chose a scene between a mother and an adult child with a SUD.

Firstly, a person with a SUD may better understand what their family is experiencing and

communicate more effectively after an intervention aimed to increase their empathetic abilities.

Secondly, social and communication skills training may equip people with SUDs to lean on their

social supports without burning them out.

Selbekk et al. (2015), in a critical review of SUD treatment theories, expressed that

clinicians need to highlight the importance of intervening in relationships as well as with

individuals in SUD treatment. The Matrix Model (Wagener, 2021), which is used at my

internship site, has a curriculum meant to include families throughout the treatment process,

though, in my experience, family members may not come for a variety of reasons. My method

provides an opportunity to put social and communication skills into practice, regardless of the

active participation of the client's family. These skills may then be brought home and used with

family members and key social supports.

Drama Therapy and Substance Use Disorders

Newman (2017) wrote an article detailing her role-work with recovering addicts.

Newman writes that upon the removal of the addict role, the roles that are left may often be

'liar,' 'failure,' and 'the depressed.' While the focus of Newman's work was on the shifting

identity of the recovering addict, exploring the role of 'liar' had direct implications for my

method. Some in the substance use population may have a need for social and communication

skills training, as well as empathy and perspective-taking, in part because of the deceit and

interpersonal rupture that can occur when a person is in active use. Making reparations and amends for the actions taken while enrolled as the 'liar' takes interpersonal navigation skills people with SUDs may not have without intervention.

Jaaniste (2008) used role play, role reversal, and improvisation in a drama therapy group for participants with co-occurring mental illness and SUDs. There were five participants total, four with schizophrenia and one with bipolar affective disorder. Two of the three clients I worked with during the method test had co-occurring mental illnesses as well, and this article provided guidance in navigating that. The details Jaaniste gave about the role-play and its intended effects mirrored some of the results I hoped to see from my method test, namely, creating a shared experience that allows for deeper communication and disclosure. My method is more structured, as the narrative of the scene is established beforehand, but it was valuable to learn what might be observed from a more improvisational approach.

Cheung et al. (2021) completed a pilot study utilizing performance-based drama therapy techniques and measured the use of theatre in promoting mental health recovery, reducing psychiatric symptoms, and reducing substance use cravings. Four different measurement methods were used in this study; the Theatre Impact Scale, Brief Psychiatric Rating Scale (BPRS), Visual Analog Scale, and an investigator-developed Attitudes, Knowledge, and Beliefs Related to Substance Use questionnaire. The authors describe the group as being quite small, though no exact number is given. The group met once a week for six 1.5-hour rehearsals, a public performance with a talkback, and two wrap-up sessions. The performance was devised by participants and included various art modalities. The BPRS results showed modest yet statistically insignificant reductions in psychiatric symptoms (42 ± 9.9 vs. 37 ± 12.8, $p = 0.068$; mean $\pm$ SD, pre- versus post-program). No significant change was seen in cravings or in

participants' attitudes, knowledge, or beliefs related to substance use. As a pilot study, this intervention had many inherent limitations. This being the case, it was still a solid foundation on which to base my expectations for the sorts of observations that may be seen during my intervention.

Conclusion

In my research leading up to the development of my method, I strove to weave together four main threads: population research on people experiencing SUDs and their needs, established performance and talkback-based methods and their efficacy and effects, drama therapy interventions that have been developed to measure differences in communication skills, social skills, and empathy, and, finally, the established use of drama therapy methods with the SUD population. I have labored to weave these threads into a chord that informs the establishment of a method that streamlines a performance-based drama therapy method aimed at observing changes in social skills, communication skills, and empathy in a population with SUDs.

I have identified a few needs in the literature through this review. There is a lack of literature measuring the ability of drama therapy to effect change in empathy, social skills, and communication skills in adult populations. There also is a need for more drama therapy research into the SUD population, specifically US populations and populations without comorbidities. I aim for this capstone project to serve as both a literature review and an applicable method for drama therapists working with this population.

Methods

I developed this method using a patchwork of methods cited in the literature review. I wanted to find out if similar observations surrounding increases in empathy, social skills, and communication skills could be made using a streamlined version of a performance/talkback

intervention utilizing media and alternative action, specifically within the SUD population. As a practicum student at a SUD clinic in the western United States, I had access to an SUD PHP. I determined the need for such an intervention within this population, so I moved forward with testing with the PHP. Three participants were present on the days I tested the method, all white-identifying females ages 21-61. In addition, a white female therapist observed the method, chiming in seldomly. The method took place over two one-hour sessions, two days apart.

Materials

First, I found relevant media for the clients to respond to. After reviewing a few different shows, I decided to take excerpts from *Single Drunk Female* (Headland, 2021). I decided on this show because I perceived it to have a realistic and optimistic take on recovery and sobriety, whereas other shows I reviewed may have glorified alcohol and drug use. I found four scenes that showcased a variety of conflicts or confrontations within various types of relationships.

Parent Pt. 1 (Ep. 1, minute 17)

Parent: Oh, hello

Addict: I know you're upset

Parent: Sit down

Addict: Yeah, I'm covered in like 50 kinds of urine and every STD right now.

Parent: Ok, don't sit

Addict: I know you are probably mad.

Parent: I'm not mad. I'm done.

Addict: Yeah, no, I know. And I'm sorry, but if you could just let me explain to you what happened.

Parent: It has been 24 hours since you left rehab. You've already been arrested for drunk driving after totaling my car, so no.

Addict: I'm sitting at the bar, right? Dead sober. Swear to God I could drive a school bus.

Parent: Let's not

Addict: Brit walks in, and she's wearing a veil on her head because it's her bachelorette party. And she's marrying Joel.

Parent: I know. I am going to their wedding.

Addict: Are you kidding me?

Parent: No. I've known Brit since she was little.

Addict: Yes, mother because she was my friend.

Parent: This isn't about Brit. This is about you growing up. So, number 1: You're going to start paying me rent or find another place to live.

Addict: I just got out of rehab!

Parent: Yeah, and I spent a lot of money for you to go to that place. Money that I was saving for my neck lift, which now I can't have because of you.

Addict: Where would you like me to go? I don't have any money.

Parent: That is what my book group calls "not my problem." So, you are going to get a job and, with that job, you are going to pay me rent… I'm trying that setting boundaries thing; I think I am quite good at it.

       I chose this scene, Parent Pt. 1, because it portrays some classic behaviors and situations that I wanted to play with during the method test. I have observed that people with SUDs, especially those in early recovery, may go to great lengths to justify their using behaviors. The addict in this scene has drunkenly crashed her mother's car and her first instinct is to make excuses. In family sessions, we have seen parents and spouses trying to navigate around boundary setting. These conversations can be full of tension, as a grown person, understandably, does not want to be required to ask permission to have access to a car, submit to a breathalyzer when arriving home, or any other number of boundaries that may be set in these situations. Giving the clients a chance to step into the shoes of the one having to set boundaries may give

them a chance to empathize with those that may have been put in similar situations by their using behaviors.

<p style="text-align: center;">*Parent Pt. 2 (Ep.1, minute 24)*</p>

Parent: So Giovanni's?

Addict: Yep

Parent: I'm proud of you. Definitely did not think you could do it.

Addict: I'm really sorry for crashing your car.

Parent: Don't be dramatic. It was 12 years old.

Addict: What are you doing?

Parent: What? I thought you could have one glass of wine.

Addict: Nope. No, I can't. Unfortunately, that's not how it works.

Parent: I can do this, though, right? That's ok?

Addict: Yup. Yeah, you can do whatever you want.

Parent: Whew! Not that it's a big deal or anything…

Addict: It turns out I can't. Apparently, alcoholism is a disease, and boy, do I have it.

Parent: Did you just say you have a disease? You don't have a disease. I know what a disease looks like. Leukemia, for one.

Addict: I'm sorry I wasn't trying to bring up dad.

Parent: A disease is when you can't walk from your bed to the bathroom.

Addict: Right. I hear you. I was just trying to say that like it's recognized as a disease. You can look it up. That's all.

Parent: If you want to call yourself sick, call yourself sick, but don't judge me for having some wine at night because everybody wants to have some wine at night. It's hard to be a person.

Addict: Just doing the best that I can.

Parent: I'm sure you are. And welcome! The rest of us have been doing the best we can the whole time you've been drinking.

One reason behind including families in treatment may be to educate them on the disease of addiction. People can feel distressed by the behaviors of family members with SUDs and are often lost as to how to be supportive without becoming enablers. The parent in the above scene (Parent Pt. 2*)* seems to have little clue how to support a person with an SUD, as evidenced by the belittling speech as well as offering a glass of wine. Engaging with this scene may help clients think ahead about how to effectively respond to a family member or loved one who may not be supporting a person with an SUD in the way they need.

<div align="center">

Friend (Ep. 3, minute 13:40)

</div>

Addict: You can't just leave me here.

Friend: Oh, like you left my kid? You know what? People told me this, and I just didn't want to believe it.

Addict: Told you what?

Friend: That you just see me as your drinking buddy.

Addict: Ok. No… But I mean, it's a little true, right? Cuz like the only place we've ever hung out was at the bar.

Friend: Because it was your suggestion, Ok? I'm a full-time mom and a full-time employee; I've got real-life shit on my mind. So when you name a place, I've gotta get a sitter, I've gotta move a bunch of shit around, but I do that because it's you.

Addict: And I appreciate that, ok? Why don't we go inside and talk?

Friend: You know, I would just love to sit on the couch and watch some mindless TV with you; that would be so wonderful. There's like seven seasons of Summerhouse we could binge. But no, you don't want to do that because you don't know how to be an actual friend.

Early recovery can be an isolating experience for many people, especially those that have built their social lives around substance use. I chose this scene (Friend) because it touches on the topic of recalibrating one's social life in recovery. This scene depicts a friend who is more than

willing to do something that doesn't involve substance use (which is not always the case), but the addict has not yet started to think of them outside the realm of substance use. Engaging with the scene may assist clients in looking critically at their friendships through the lens of recovery and how to have difficult conversations with the friends they have decided to keep.

Sponsor (Ep. 1, minute 20)

Sponsor: Hi

Addict: Hi. I have three days. I want all the booze and all the sex and all the drugs all at the same time.

Sponsor: You want to come in for a cup of tea? It's not blow, but it's all I have.

Addict: Oh, that's alright; I only do coke to help me drink more.

(Skip)

Addict: Wow, I can't believe you're an alcoholic.

Sponsor: Anyone can be an alcoholic. It's a disease.

Addict: Yeah… I just meant like… this is a lot of stuff to get while drinking

Sponsor: I didn't get them while I was drinking; I've been sober for 10 years. But the cash and prizes don't all come at once, so… don't call me next week asking me where your mortgage is.

Addict: I won't… I don't even have a job.

Sponsor: Um… My sponsee Mindy, she manages Giovanni's Market… I know she's looking for a cashier.

Addict: Wow. Ok. Got it. Ok: Cashier, and then Peabody, and then sick house, and then awesome paint colors.

Sponsor: Let's just worry about getting the job first and let your higher power handle the rest.

Addict: I knew it was a cult.

Sponsorship is a key tenant for those who engage in a 12-step program. It bookends the recovery journey, as one of the first things a person in a 12-step program does is find someone to

sponsor them, and one of the last is to sponsor someone else. I picked this scene (Sponsor) because it gives clients a chance to explore the role of the sponsor. I have seen many of my clients show hesitation in finding a sponsor, and I have seen many jump from sponsor to sponsor. Enrolling as a sponsor may help clients have a deeper understanding of why they may be hesitant to find a sponsor and what they may be needing from their sponsor that they aren't getting.

Procedure

The scenes were printed out to be handed to the group. For clarity and ease of reference, I named the scenes and included the episode, minute, and second of the scene's start. I used broad descriptors for characters (e.g., parent, child, friend, addict, etc.) as the character's presentation may conflict with the client's cultural or gender identity. Due to this possible conflict, it is important to bring to clients' awareness that they are making this character their own and do not need to conform to the way the character presents. The intervention took place in two sessions: for an hour on a Monday and another hour on the following Wednesday. In the first session, we focused only on Addict/Parent scenes (Parent pt. 1 & 2). On the second day, we worked with the Addict/Friend and Addict/Sponsor scenes (Friend & Sponsor).

The first day, the group took place in a room with sunken couches and furniture that generally encourages unalert body language, so we brought in structured chairs. I told the group that this was an intervention I had considered and researched carefully. I also explained that I would be incorporating the process of these sessions into my graduate thesis while also assuring them that I would protect their identities completely and only incorporate anecdotal information into the paper. I had facilitated many drama therapy groups with this PHP, so the members had warmed up to me already and were generally warm to the interventions I do. This group, in

particular, would often show anticipation for groups I facilitated and a general affinity for me and our time together.

I gave a brief overview of how the intervention would go, explaining we would be watching a clip, editing the script, and everyone would have an opportunity to perform the revised scene with myself playing the addict. I also explained that everyone would be playing the counter-role to the addict because it avoids casting them in a role they are working to move away from and gives them a chance to step into others' shoes. Next, we did a sound and movement to check-in, then everyone sat back down, and I handed out the scripts.

Participants used a pen and a hard surface to edit the scripts. I used a computer and an HDMI cord to put the video on a TV mounted in the group therapy room so all could see clearly. I logged into my Hulu account and streamed the clip but ideally would have had the episodes downloaded to eliminate the variable of WIFI connectivity. After watching a clip, group members had a short time to process what we had just watched. One purpose of this short processing time was to allow a period for the group to react and to avoid stifling any impulses that came from sharing the experience of watching a narrative together. We talked about parts that made them laugh and why they were funny. Next, the group discussed whether or not they had had similar interactions. The group also shared their initial reactions. I asked questions such as: "How did you feel about the characters? How do you think the interaction went?" and, to usher the group into the next portion of the session, "Is there anything you would have done differently?".

Due to the small size of the group and the difference in writing ability within it, I did not put a time limit on the script-editing portion of the session, thinking it would be counterproductive. After all the members had finished editing their scripts, I invited them to

perform, and all three did so. The edited scripts were, by nature, incoherent to some degree as the participants only edited the dialogue of one character. For example, the parent says, "I thought you could have a glass of wine," in Parent pt. 2, and many clients edited this line out. The response "Nope. No, I can't" (Headland, 2021) no longer makes sense in this scenario. Therefore, I took pictures of their edited scripts so I could improvise responses that kept the scenes flowing. To close, we kept something and left something (a closure the clients had familiarity with). This something can be emotional, metaphorical, a piece of the intervention, or something else.

The procedure of day two mirrored day one in all respects, with two exceptions: Firstly, we used the Friend and Sponsor scenes. Secondly, there were some unexpected disruptions that will be detailed further in the results section. Timing was adjusted for this day's procedure. Offers were made for alternative participation, such as reading the unedited script and identifying a single line that felt significant.

Record Keeping

The most valuable assets for reflection and reference after the interventions were the clients' edited scripts. These scripts told a story of the client's reactions, biases, past experiences, and relationships. Supplementally, I also kept a small notebook in which I would jot down notes on reactions and points of conversation and my feelings and thoughts about the session. This notebook was especially necessary on the second day when one client chose not to participate. Without the notebook, I would not have had a record of that client's experience, as she did not edit a script for me to keep as a catalog of her experience. I wrote down observations on clients' embodied and verbal responses, as well as noting the feedback they had for me on their feelings surrounding the method's application and efficacy.

Results

Day One

After describing the method to the group, they seemed anticipatory about trying something new. They were energetic in their sound and movement check-ins and attentive when watching the clip. They agreed that they liked what they had seen and felt it was an appropriate depiction of an interaction between a person with an SUD and their parent. They all expressed that they could relate to the addict character in some way. After processing, we moved into the editing portion. They asked some clarifying questions at the beginning about the editing process, mostly seeking reassurance before putting pen to paper. It took 10-15 minutes for everyone to finish the editing-portion—those who finished early colored or journaled while waiting for everyone to finish. Everyone then accepted my invitation to perform the edited scene. Without prompting, clients stuck to the core narrative of the scene, choosing only to change how ideas and feelings were communicated rather than the nature of feelings and ideas that were expressed. The inability to edit the scene-partners dialogue may have created a narrative anchor.

After performing the scene, we began to process the changes that were made by the various members of the group. Two of the group members were mothers themselves, which gave them a multilayered perspective on the dynamics, as they could see both characters' perspectives. One of the group members, a mother, went in a more aggressive and reactive direction than the parent in the script. The other mother in the group used a gentler, communication-based approach than the parent in the script. This response opened the floor for a conversation about the different choices made during the editing process. The client with the more reactive edits said that she made changes to reflect how she thought the conversation would go between her and her dad (I was grateful at this moment I did not gender the characters in the

scripts). She began sharing how her dad was stern and overbearing. She shared how nothing she did was good enough for him, so she ultimately stopped trying. When asked, hypothetically, if she would take this same approach with her children, she said she would. The group challenged her for this. They pointed out that she had expressed these tactics did not work with her and asked her, "why would this work with your kids?" These questions led to a rich conversation about generational patterns and how isolating and defining them is the first step to making significant changes and transformations. This conversation led to a client becoming very emotional as she shared her estrangement from her children due to her addiction. The group offered their support and affirmed that she was doing all she could do to get better, which was all that mattered. This client's reaction also opened a brief conversation around the triggers that can come from media and how we might mindfully navigate those triggers.

When asked about her choices, the clients who based their edits on relationship-building and support said they made edits to reflect how they would like to be treated and talked to if they were the addict in this situation. We talked about some of the difficulties that families of people with SUDs have to deal with, referencing the parent spending a large amount of money on rehab (Parent pt. 1). The group and I discussed how the family of people in recovery might be experiencing emotional strain comparable to the person in recovery, but, likely, they were not receiving the same level of treatment and support. The therapist who was observing made a point that the Matrix Model (the curriculum used by the clinic) includes family treatment for this very reason; families are going through a recovery of their own.

At this point, there were about 25 minutes left before the session ended. The observing therapist had already queued the next clip (Parent pt. 2) using the time stamp on the script. After viewing clip two (Parent pt. 2), there was another moment of processing. The conversation

mainly revolved around the moment when the parent pours the addict a glass of wine. We discussed how we know that this moment was problematic but could simply be a lack of education on the parent's part. Once more, I highlighted the importance of family involvement in treatment and how this interaction might have been different if the parent had taken the initiative to educate herself on the nature of the diagnosis of the addict. We also discussed a few other awkward situations and conversations that can occur with friends and family at the beginning of recovery. After five minutes of discussion, we moved into the second editing portion.

The editing portion took about five minutes for two of the clients and 10 minutes for the other client, similar to the first editing portion. This client is sensitive to feeling behind, so I did not move on until she finished. Once they finished editing the second clip, all three clients again agreed to perform the scene with me. Clients had all chosen to rewrite the interaction making the parent less defensive, humbler, and more curious. In the three scenes edited by the group, the parent asked more questions and was significantly more affirming. After everyone had performed, I asked the clients if they thought they would benefit from their friends and family being more curious and affirming when talking to them about their addiction and recovery. They agreed that it would be helpful, which led to a conversation about how to advocate in these areas and ask for what is needed from friends and family. Finally, we closed with "take something, leave something." Clients kept the support of the group, communication, and curiosity; they left defensiveness, being reactive, and pride.

Day Two

Day two of the method utilized the same space at the same time and intervened with the same clients as day one. The group came in presenting as tired and agitated. We checked in and warmed up with a sound and a movement. The group offered long exhalations and downward

movements. I passed out the scenes we would be working with on that day (Friend & Sponsor). One client said, "This again?" upon being handed her script. I felt disappointed at the reaction, as I had perceived this client benefitted from the previous session. I played it off and tried to keep the energy up. I explained the general themes of the two scenes and played the first (Friend). After the clip, I opened the floor for discussion. I asked if anyone had had to make shifts in their relationships, like the shift shown in the scene. One said that she had to cut off contact with friends because they were too triggering and wished some of them had been willing to do more recovery-friendly activities with her. The conversation was shorter than it was during the first session.

When I made the invitation to begin editing the scripts, the same client that expressed disengagement said they had done the same activity that morning and was feeling overwhelmed by having to do it again. I was surprised by this. After further inquiry, I discovered that the therapist that had observed on day one (also present on this day) had made copies of the scripts (Parent pt. 1 & 2) and repeated the method without my knowledge or presence in the morning IOP/PHP, which included the three clients present for the two days of my method test. I was affected and took a breath to recenter myself. I tried to take a position of curiosity, asking how it went. The observing therapist explained that it was family day in the IOP, and she thought this method would be a good way to facilitate a conversation on family support and disarming techniques. This group had to do the first portion of the method twice and now were expected to participate in the second portion on the same day as the repeated first portion. The IOP has about 10 people at any given time, so it stands to reason the method (in whatever form it took in my absence) took around two hours. If I had it to do again, I would have shifted the group into a

different activity and continued the method test the next week. However, at the moment, with the clip cued, the scripts passed out, and the other therapist to observe, I chose to continue.

After editing the script (Friend), two of the three agreed to perform them. These scripts repeated the pattern of being less reactive, clearer, and more concise when communicating feelings. One client mentioned she thought she made the scene boring with her edits. This response led to a conversation about how media might shift our perceptions of how relationships and communication should look and sound. A client mentioned that she felt that a relationship without passion and high levels of emotion might be sterile and uninteresting. The group challenged this and discussed the differences between passion and volatility, some concluding that staying mindful of one's feelings during conflict can be an act of love. I offered the client who chose not to participate the alternatives of performing the unedited script or sharing a line she resonated with in particular. She turned down both offers, claiming that she gave all the energy she had had for this activity in the morning.

We moved on to the final clip (Sponsor). I had hopes that I could engage the client who was choosing not to participate in this scene, as she had expressed many times in the past her desire to one day become a sponsor with Alcoholics Anonymous (AA). Unfortunately, she declined to participate. I did manage to engage her briefly in a conversation following the clip about her goals to become a sponsor and asked her thoughts on the sponsor from the clip. This scene had the least number of edits out of the four. A part of this could have been the burnout the group was experiencing. The group thought the sponsor effectively supported, challenged, affirmed, and communicated, so they could not think of ways to improve upon the sponsor's dialogue. The one exception was that clients with an aversion to the idea of a higher power made edits to that end. Improving upon the dialogue was not a directive I gave them, but it seemed it

was an inference the group made at some point. We ended, once again, with "take something, leave something." The group kept support, communication, and relationships and left exhaustion, self-pity, and sadness. Finally, we had a moment of reflection to look back on the two days of the method test, what we learned, and if any transformations had been made. This session was 15 minutes shorter due to one client's low level of participation.

Overall Observations

I carefully observed the clients during all portions of the sessions and conducted a closing moment of reflection. The atmosphere was that of friends watching TV together during the clip-watching section. I observed this to be a disarming experience for the clients, as the activity was fun and familiar. On the first day of the method test, the clients were alert and interested. On the second, they appeared tired and frustrated for reasons stated previously. Clients were engaged in their work and the work of the others in the group. I saw them listening carefully and paying close attention to the differences between the changes made in their scripts as compared to others and the rationales behind them. Clients were willing and excited to participate in the performance portion of the method. One client expressed a degree of nervousness beforehand and a sense of accomplishment afterward.

In our moment of reflection at the end of day 2, we discussed the effect this activity may have had on their individual social skills and their levels of empathy for the people walking with them through recovery. They expressed that they felt this was a good way to raise awareness and effectiveness in these areas. One client shared that this activity provided a framework for her to think about the way she formulates her responses. They were grateful that they did not have to play the addict.

Clients were asked in a PHP group prior to the method if they thought an intervention focusing on social and communication skills would be something from which they would benefit, and clients responded affirmingly. All three women felt that the activity was generally helpful in increasing social and communication skills. They also felt that the activity was generally helpful in understanding what people in their lives may be experiencing and increasing empathy. These findings align with the reviewed instances of drama therapy interventions with similar attributes strengthened (Amatruda, 2006; Karatas, 2011; Ozturkcu et al., 2018; Wiener, 2015).

One client expressed a preference only to do one clip at a time if we were ever to do this again. Also, I learned sometime later from my supervisor that this client had complained about having to do the activity for so many hours on the second day when the observing therapist co-opted the method for the morning group. As a result of this complaint, my supervisor informed me that she had announced during treatment team that therapists untrained in expressive arts therapies (EAT) should not attempt EAT interventions.

Discussion

Reflections

This thesis intended to explore how the performance/talkback model can be condensed and used to address some specific needs of people with SUDs, namely, an increase in empathy, social skills, and communication skills. My approach was to enroll the clients as an active, participatory audience of media relevant to the life experience of a person with a SUD. The reports of the clients that engaged in the intervention reflected the reports of much of the literature reviewed in this thesis: Topic-related empathy may have increased (Rathje et al., 2021), clients seemed not to feel exposed or objectified (Wood & Mowers, 2019), engaging in live

performance with peers appeared to increase group closeness, and recovery capital (Kewley, 2019), social skills, and communication skills may have been learned and strengthened (Amatruda, 2006; Ozturkcu et al., 2018; Wiener, 2015). Further study would be needed to measure the therapeutic effects of this method as compared to a live performance/talkback model. Yet, I can say with some confidence that the model I have tested here may be able to be used to a similar effect as live performance while abandoning the heavy logistical lift.

An interesting, unforeseen result was that the clients continued to watch *Single Drunk Female* (Headland, 2021) after the method test was over. They wanted to watch the full episode I took the clip from, which led to them keeping up with the show weekly. I heard them talking about it in morning groups I shadowed weeks after. I kept up with the show as well, and this gave us a point of conversation that was social and colloquial, as well as relevant to recovery. We talked about the relationships, dating, sex, cravings, relapses, struggles, and other situations and behaviors the characters were dealing with that week. Clients expressed empathy, not only for the characters struggling with addiction but for their friends and families as well, mirroring the findings of Rathje et al. (2021). For weeks to come, talking about that week's episode gave clients a way to bring up and process recovery-related experiences. These observations align with Kewley's (2019) findings on community and theatre as recovery capital and Stephens-Hernandez et al. (2007) findings around the efficacy of narrative SUD education. The Matrix Model (Wagener, 2021) only uses DVDs containing lectures. I wonder how much more effective and engaging it would be for therapy groups to watch a narrative depiction of a person in relapse rather than watching a PowerPoint about what relapse means and entails? During these psychoeducation days, when watching these DVDs, I have observed people fidgeting and nodding off. However, when watching clips from *Single Drunk Female* (Headland, 2022),

everyone seemed alert and engaged. Using narrative media as psychoeducation in SUD IOP/PHP would be a fascinating area for further study.

While considering what show to pull media from, I had also considered making a short film myself. While requiring more logistics than pulling from existing media, a film could be used with clients in perpetuity after being created. I fully believe drama therapists can conceptualize and dramatize truthfully and respectfully all manner of social issues among a diverse variety of people. I would be fascinated to see the effect of this intervention using a short film created by a drama therapist for a specific population.

The method is not without its shortcomings. The most glaring shortcoming of the method test was that parts of the method relied heavily on reading and writing ability. This is a shortcoming in its difficulty of use with disabled people, illiterate people, and people who do not speak the same language as the therapist (though perhaps there is potential here with translated subtitles). Even with populations not aforementioned, dependency on writing ability, as was observed in the method test, can also be a shortcoming considering the spectrum of time people may need to respond. I observed clients feeling pressured or inferior when noticing them taking longer to finish a written intervention than those around them.

A shortcoming separate from, albeit related to, writing ability is the method's mental demand. As was found out by happenstance of miscommunication, this method may be mentally fatiguing when conducted for too long of a time or in too quick succession. Further development of this method is necessary to discover variations that are less mentally taxing and reliant on reading/writing ability and to discover if an hour is an ideal amount of time for this intervention. Lastly, a variable shortcoming dependent on the state of COVID-19: I conducted this method in person. In a world of surging and receding disease, an online variation of this method could be

an important development. With screen-sharing and other tools included in video chat software such as Zoom; an online variant of this method may not be difficult to achieve.

Conclusion

The main finding of this thesis was that a condensed performance/response model could indeed be used to a similar effect as more established live performance/talkback models. By engaging with this method, clients reported increased topic-related empathy and more confidence in their social and communication skills. While this method may not replace rehearsing and performing for an audience, it allows therapists and clients to reap similar benefits without the organizational puzzle. Going forward, perhaps drama therapists without the resources and support to stage performance-based interventions will still feel they have access to some benefits of performance-based interventions.

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THESIS APPROVAL FORM

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Student's Name: _____ Daniel David Brown

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Streamlining the Performance/Talkback Model Using Media and Alternative Action

(MAAct): An Intervention

Date of Graduation: _____ May 21st, 2022 _____

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor:_____ _____

Angelle V. Cook, PhD, RDT/BCT E-Signature 5/2/2021 1:56 pm EST