Therapeutic Theatre Program Design for Kidney-Transplant Recipients in Transition

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Abstract

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This paper outlines an intervention design for a therapeutic theatre program designed to meet the complex needs of adolescent kidney transplant recipients. For young people with chronic illness, the transition from pediatric to adult health care can come at a difficult time. The interaction of developmental, psychological and social aspects of adolescence often impact upon medical follow-up, which in turn presents serious short and long-term consequences for young kidney transplant recipients. In response to these concerns, transition programs are being implemented at children's hospitals to help bridge the gap. These programs seek to address these complex needs, though most programs are designed from a psychoeducational perspective and do not address deeper psychological, social and developmental issues. The proposed therapeutic theatre program seeks to take this work a step further through a group therapy process that encourages participants to share and make meaning of their experiences. The process will culminate in a performance, thereby fostering a sense of empowerment and mastery in the group members.

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Chapter 1

Researchers in a number of fields have begun to investigate the exceptionally complex psychological, emotional, spiritual and social aspects of kidney transplantation. Compared to the wealth of research studies performed on the medical aspects of transplantation, there is relatively little research on the psychosocial experience of transplantation, particularly from a qualitative perspective (Amerena & Wallace, 2009; Decker, Lehmann, Fangmann, Brosig, & Winter, 2008; Lindqvist, Carlsson, & Sjodén, 2004; Richards, 2008; Roberts, 1999). While there is a need for further study, researchers in the field propose that psychological health has an influence on the recovery of the transplant recipient (Amerena & Wallace, 2009; Decker et al., 2008; Ghetti, 2011; Hutchinson, 2005). The lack of research regarding the patient's experience is reflective of a larger issue, the need for increased attention to mental health issues in transplant recipients. As research has revealed difficulties with depression and anxiety amongst transplant recipients, a number of researchers recommend that psychotherapy services be made available to meet the psychosocial needs of this population (Decker et al., 2008).

This paper will outline an intervention design intended to meet the needs of a group of adolescent kidney transplant recipients, between thirteen and seventeen years of age, preparing for transfer to adult care. The clinical program will involve a group therapy process, culminating in the development and performance of a piece of therapeutic theatre.

Chapter 2

Kidney Function and Renal Disease

The kidneys are two fist-sized organs found in the back of the abdomen. They are responsible for the regulation of water in the body, the removal of waste from the blood and the production of certain hormones (The Kidney Foundation of Canada (TKFC), 2006). These hormones stimulate the production of red blood cells, regulate blood pressure and help to maintain calcium for healthy bones (US Department of Health and Human Services (USDHHS), 2009).

Kidney disease refers to a number of conditions that impair kidney function. Usually these conditions affect their ability to regulate the body's water and filter waste from the blood. The severity of the impairment is classified according to five stages. In the early stages, kidney failure can go unnoticed by the individual, as function may gradually decrease without showing any symptoms (TKFC, 2006; National Institute of Diabetes and Digestive and Kidney Diseases (NIDDKD), 2012).

As renal function decreases, the body begins to retain water, since the kidneys are no longer able to properly filter it from the blood. The skin becomes increasingly itchy as toxins build up in the bloodstream, which the kidneys are not able to filter. By stage five, (also known as *end stage renal disease*), the kidneys are functioning at under 15% and the individual is likely having difficulty sleeping, is vomiting frequently and is experiencing trouble breathing (TKFC, 2006).

Treatment

An individual struggling with kidney disease may alter their diet to minimize the stress on the kidneys, thereby decreasing the presence of toxins in the blood and alleviating

symptoms. A special diet high in protein and low in potassium, sodium and phosphorus is recommended, while some people may need to limit their fluid consumption as well (TKFC, 2006).

Though a strict diet may help in alleviating some discomfort, it is not enough to compensate for the failing kidneys. At stage five, either dialysis or a kidney transplant is required to sustain life (TKFC, 2006). Both are considered a treatment, not a cure, as the kidneys are not revitalized with either treatment.

Dialysis is a process during which the blood is filtered to remove waste. This procedure is required either for the duration of the life of the individual or until a transplant is possible. There are two types of dialysis: hemodialysis and peritoneal dialysis. With hemodialysis, the blood is filtered through a machine that acts as an artificial kidney. The filtered blood is then returned to the body. This process takes four to five hours and is required several times a week. Hemodialysis is usually done at a hospital, however home treatments are possible as well. With peritoneal dialysis, the abdominal cavity (called the peritoneum) is filled with a dialysis fluid, through which the blood is filtered. Peritoneal dialysis can be conducted from home, however treatments are required on a daily basis (TKFC, 2006). While both forms of dialysis have advantages and disadvantages, both can be experienced as invasive, time-consuming and disruptive to the life of the individual.

Transplantation is now considered to be the best treatment for End-Stage Renal Disease, as it generally results in a better quality of life than people tend to experience on dialysis (Goldstein, Gerson, Goldman, & Furth, as cited in Meade, Tornichio, & Mahan, 2009). It is not, however, without its challenges. Immune-suppressant medications must be

taken for the rest of the individual's life, and are associated with a number of side effects. A rejection episode can occur at anytime, which may be treated by drug therapy, but could result in a return to dialysis treatments and another transplant (Meade et al., 2009; TKFC, 2006).

Common Illness Trajectories

The most common causes of kidney disease in adults are high blood pressure and diabetes (NIDDKD, 2012; Meade et al., 2009). Over time, these diseases can cause damage to the *nephrons,* which facilitate the filtering processes of the kidneys (TKFC, 2006).

In young children, kidney disease is usually caused my congenital and urologic abnormalities Ardissino et al., 2004). As the age of onset of kidney disease increases, these congenital and urologic abnormalities are less common, while diseases associated with genetic and environmental triggers become more so (NIDDKD, 2012).

Depending on the child's age at the onset of kidney disease, growth and developmental processes can be significantly affected by improper kidney function (Bawden, 2004). Children in mid to late stages of kidney disease may be required to follow special diets, which may prevent normal caloric intake, thereby preventing normal growth (Meade et al., 2009). Chronic kidney disease can impact cognitive and intellectual development, as well as academic performance (Meade et al., 2009). Of course, this is not helped by frequent absences from school due to medical appointments and illness (Gerson et al., as cited in Meade et al., 2009).

Chapter 3

Psychosocial Experience of Transplantation

Research reveals the important role that psychosocial factors play in the recovery of transplant recipients (Amerena & Wallace, 2009) and the many aspects of adaptation for the recipient (Decker et al., 2008). These studies reveal that recipients often experience negative affect pre- and/or post- transplant (Amerena & Wallace, 2009), high levels of anxiety, pain and nausea (Madson & Silverman, 2010), express particular concern regarding the possibility of rejection (Amarena & Wallace, 2009; Lindqvist et al., 2004), and an incongruent sense of self in relation to their new organ (Amarena & Wallace, 2009; Decker et al., 2008). These psychological experiences are often at odds with the individual's feelings of gratitude at having been offered a "second chance" by a known or unknown donor (Richards, 2008). This creates a paradox for the recipient (Amarena & Wallace, 2009), who is striving to negotiate these conflicting psychological reactions, all the while trying to balance the physical complexities of the new organ, the side effects of immunosuppressant medications and physical recovery from the procedure.

Mental Health of Pediatric Transplant Recipients

Researchers have begun to examine the complexity of the illness trajectory for individuals who were transplanted as children. While focus has long been placed on the physical needs of these individuals, there is increased recognition of the complex reciprocal relationship between these special health care needs, mental health, and academic and social aspects of school life (Annunziato, Jerson, Seidel & Glenwick, 2012).

In children, adjustment is further complicated by normal developmental processes, namely pressures related to academic achievement, social inclusion, bullying and the gradual process of self-management associated with maturation. Amongst children with chronic illness, anxiety and depression are common, as are academic, social and behavioural problems in school (Annunziato et al., 2012).

For kidney transplant recipients, fear of a rejection episode can cause both anxiety and depression (Meade et al., 2009). For adolescents with chronic kidney disease, depressive symptoms are usually observed in the form of depressed affect, social isolation, withdrawal from activities and negative thinking. These adolescents are aware that they could experience a rejection at any time, which may result in a deterioration of their health and lifestyle, perhaps resulting in a return to dialysis treatments, and the need for another organ transplant (Meade et al., 2009).

A recently published study conducted in Finland sought to identify risk factors in long-term quality of life and psychosocial adjustment amongst pediatric transplant patients. This study revealed relationships between psychosocial adjustment in pediatric transplant recipients and neurological comorbidity, family structure and poor parental self-reported quality of life (Haavisto et al., 2013), with pre-adolescent transplant recipients reporting a poorer quality of life than adolescents. A number of factors related to the illness trajectory of this age group may explain these differences, however there is a need for more research into the psychosocial challenges of children this age (Annunziato et al., 2012; Haavisto et al., 2013). Furthermore, this study found that parents and teachers reported more internalizing symptoms (such as anxiety and depression) than did the children (Haavisto et al., 2013).

Similarly, an American study found that parents reported significantly more and children significantly fewer internalizing symptoms compared to control groups (Wu, Aylward, Steele, Maikranz, & Dreyer, 2008). In this study, American researchers hypothesized that parents' over-reporting of internalizing symptoms may reflect a heightened sensitivity to abnormalities in their child following transplantation, while children may underreport their symptoms as a coping mechanism, or to increase social desirability (Wu et al., 2008). This theory is consistent with the use of avoidance and denial as defenses, often observed amongst adolescents with chronic illness (Liakopoulou, 1999). Both avoidance and denial are illustrated by non-compliance with health regimens; avoidance is observed in the form of missed appointments, while denial is seen in a refusal to acknowledge the limitations of their bodies. These defenses may keep an adolescent reliant on his parents, impede the separation processes that should be underway (Liakopoulou, 1999) and become particularly evident following transfer to adult care.

A study which examined issues of long-term quality of life found that adults who received kidney transplants as children were less likely than their peers to be living independent of their parents, to have obtained qualifications requiring schooling or to be employed. There were, however, no significant differences in the degree of psychosocial stresses reported by adults transplanted as children or the control group (Reynolds, Morton, Garralda, Postlethwaite, & Goh, 1993).

Group Therapy with Transplant Recipients

A study conducted by Bauer and Orbe (2001) into transplant recipient communication revealed a number of themes. Participants of this study described a sense

of community amongst transplant recipients, who value mentoring potential recipients, a natural commitment to education and increasing awareness of transplantation procedures. Equally important were different sources of support, from friends and family, to other transplant recipients and medical personnel. Bauer and Orbe (2001) indicate the importance of experiential support to the participants of their study. A growing body of research exists on the role of social comparison amongst cancer support group participants, which the researchers believe warrants examination in the transplant community (Bauer & Orbe, 2001). Social comparisons for kidney transplant recipients would involve exchanges that provide a type of experiential support amongst a group of transplanted individuals. This may involve discussions regarding aspects of the transplant experience that other transplant recipients would easily understand and could relate to, but that other people may not appreciate in the same way.

Chapter 4

Therapeutic Approach for the Proposed Program Design

Therapy and theatre. Theatre has a rich history of healing. Aristotle believed that the purpose of theatre was to bring about catharsis, allowing audience members to vicariously experience the feelings of the characters onstage, thereby purging the spectators of these emotions (Jones, 2007). There was a time when theatre was inescapably religious, when it affected the spectator by bringing about a " renewed awareness of (his) personal truth, " (Grotowski, 2002, p. 22) by liberating "the spiritual energy of the congregation or tribe by incorporating myth and profaning or rather transcending it," (Grotowski, 2002, p. 22). In more recent history, theatre has made a

gradual appearance in psychiatric hospitals, beginning with aristocratic institutions in the seventeenth and eighteenth century and becoming more widespread following the development of Moreno's psychodrama (Jones, 2007).

It is the immediacy of theatre that sets it apart from other arts. Theatre occurs in the present moment. The act of creation occurs before an audience, who witness the actor's creative process. The "here and now" of theatre "can make it more real than the normal stream of consciousness," (Brook, 1972, p. 111), allowing forces at work in people's lives to be extracted and examined on stage (Brook).

For the "creative actor" (Brook, 1972, p. 129), the theatre is an exploration of the self through performance, one that pushes him beyond his limits, allowing him to experience the infinite possibilities of who he is. Through exploration in rehearsal, the actor works at removing the psychological barriers that prevent him from accessing deeper impulses and impede the flow of his performance. According to Winnicott (1971), "It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self," (p. 110).

In this way, the rehearsal process mirrors a psychoanalytic process. In theatre, the director learns to read his actors and knows that the process cannot be rushed. The director must sense the actor's resistance, and wait for the right moment to address it (Brook, 1972). According to Brook, the "director enables an actor to reveal his own performance, that he might otherwise have clouded for himself," (Brook, p. 122). The process culminates in a performance, in which the actor sacrifices himself to the audience, after having worked to eliminate his resistance to his internal processes

(Grotowski, 2002). A true sacrifice before an audience is made only by the "holy actor" (Grotowski, p. 34) and through performance, the actor is reborn (Grotowski, 2002), though he is aware that his self-exploration is not complete (Brook, 1972). Nonetheless, he takes to the stage knowing that the exploration continues in performance, before an audience (Brook, 1972). Though the performance ends, the process has changed the actor forever (Brook, 1972).

Similar to the director, the psychoanalyst identifies areas of resistance in his client and when appropriate, encourages him to face them. This process allows the client's repressed memories and emotions to surface (Freud, 1914/2004). Through his relationship with his therapist, the client has the opportunity to explore and analyze his changing-self. In the later stages of analysis, the client uses his time with the therapist as a transitional space, existing outside of day-to-day life. Just as the actor's work is incomplete when performance begins, so too is the client's work when he goes out into the world after each session. In session, the client revisits issues in his life that challenge the person that he is working to become (Freud, 1914/2004). In performance, the actor repeatedly revisits the same moment, and is repeatedly challenged by it.

For Freud, repetition in the psychoanalytic process represented the replaying of past behaviours in a defensive reaction to the therapist and the process (Freud, 1914/2004). This repetition opens the door for the analyst's first interpretations of their relationship. It is interesting that the French use the same word, *repetition* to mean rehearsal in the theatre (Brook, 1972). The actor enters the rehearsal process weighed down by tension (Brook, 1972), and through repetition of the piece, the actor and director

work together to eliminate the actor's resistance (Grotowski, 2002), which is raised by his relationship to the character he is striving to embody.

Therapeutic theatre. Therapeutic theatre, as defined by Snow, D'Amico and Tanguay (2003), is a process through which a play is developed on the basis of therapeutic intentions. The process is facilitated by a therapist, who possesses the skills and expertise necessary to mount a performance for members of the community. Though the process culminates in a performance, it is important that post-production reflection be integrated into the program, so that group members have the opportunity to process any issues that are raised in performance.

Emunah and Johnson (1983) emphasize the importance of the group process in therapeutic theatre, both in regards to the development of the play and the evolution of the relationships in the group. Emunah and Johnson assert that over time, individual members are challenged by their relationship to the group for many, the internal processes that underlie these relationships (Brook, 1972; Emunah & Johnson, 1983) will come to be recognized as resistance (Freud, 1914/2004) within the client actor.

While drama therapy encompasses a number of different approaches, therapeutic theatre is distinct in that its process culminates in a performance for a public audience. This encounter with the audience has been part of the group's plan since the beginning, and represents a sort of coming out for the performers, an affirmation of their development over the course of the therapy process (Emunah & Johnson, 1983). Though the work of the "creative actor" (Brook, 1972, p. 129) and the "holy actor " (Grotowski, 2002, p. 34) goes beyond that which the average person in a therapeutic theatre process

seeks to achieve, there is no reason that one cannot strive for this degree of transformation (Grotowski, 2002).

The words spoken by the performer are spoken from the margins (Miller & Taylor, 2006). For the performer, the sharing of personal, social or cultural truths pushes him towards wholeness (Emunah, 1994), which can have emancipatory effects (Mienczakowski, 2001). Speaking of a related method known as staged personal narrative, Miller and Taylor (2006) call attention to the desire of many performers who speak about a particular aspect of identity, to "move from the position of misrepresented and passive subject to a more powerful position of creative agency, through the shaping of lived experience into performance" (p. 177).

The process of creating a performance works with the common experience of the group members, which is further heightened by sharing in the experience of performing the story that they have collectively created (Bailey, 2009; Emunah & Johnson, 1983; Miller & Taylor, 2006).

Richards (2008) speaks to the need for attention to the experience of individuals who have been transplanted, saying;

> Very few … works go beyond the bigger life-and-death issues to the impact on the individual, or stray far into life after the transplant once the most immediate medical crises are over. This is because most of them are not concerned with people as people, but rather with what they represent or with medical processes and what these involve. These works are not about individuals. That is not their purpose. But lives are lived by individuals, just as facts precede theories. (p. 1719)

The opportunity to be witnessed as a whole person, not simply as a patient or as a sick person has the possibility of being a transformative experience for the performer and for his family, peers and medical professionals in the audience.

In performance, the stakes are high. There is anxiety amongst the cast members, but also a sense that success onstage may compensate for past failures. In the final stages of rehearsal, cast members find that they are able to reach within themselves, to their fellow cast members and their therapist to reinforce the trust that has been carefully cultivated throughout the rehearsal process (Emunah & Johnson, 1983). The process of building the performance fosters a sense of mastery (Nash, 1996; Snow, 2000). In this way, the group members prepare themselves for a successful performance, one with the potential to be tremendously powerful (Emunah & Johnson, 1983). The group members themselves developed the performance, about themselves and it is thus the self that is applauded by the audience as the curtain falls (Emunah & Johnson, 1983). In this way, the sense of mastery carefully nurtured in rehearsal, is reaffirmed by the audience (Snow, 2000).

In their work mounting therapeutic theatre productions with psychiatric patients, Emunah and Johnson (1983) found that the intensity of the performance for the actors varied depending on four factors; the audience's awareness of the actor's patient status, the relationship between the script and the real experiences of the group members; the processing of the relationships amongst group members; and the processing of the relationships between individual members and their roles.

This method has been applied to work with individuals suffering from mental illness, adults with developmental disabilities, prison inmates, veterans, at-risk youth and

the elderly (Snow, 2000; Snow et al., 2003). According to a study conducted by Snow et al., (2003), the application of a therapeutic theatre program with adults with developmental disabilities showed improvements in the areas of self-image, confidence, socialization, communication, and freedom of expression.

Performance. Performance is memorable and engages sensorial, emotional and intellectual attention (Weber & Mitchell, 2007), making it accessible and relevant as a tool for therapy and education.

The script for this production will evolve out of storytelling, improvisation and discussions with the group of kidney transplant recipients. Therefore, the content of the resulting script and the performance itself will be managed by the participants. In this way, the group members truly own their experiences (Mienczakowski, 2001) and the performance may be particularly powerful as the actors are also the playwrights, and it is their bodies that lived the stories that are shared onstage (Emunah, 1994). Mienczakowski (2001) explains that through the authorship of the piece, power is given over to the participants, who, as patients, often experience an unequal distribution of power (Miller & Taylor, 2006).

In the context of a transition program for kidney transplant recipients, therapeutic theatre will provide the opportunity for group members to engage with their bodies and their life experiences from a non-medical standpoint. The process will also seek to normalize some of the developmental struggles of adolescence, addressing issues such as the marginalization of youth.

Storytelling and group therapy. Research conducted by Hsieh (2004), who examined the storytelling and group dynamics in the context of a transplant support

group, raised questions regarding how strategic narratives shape individual and group identity, and empower transplant recipients in their daily lives. Participants had the opportunity to share their experiences with illness and subsequently refine these stories through interaction with other group members. Stories provide a "shelter of shared meaning" (Roberts, 1999, p. 11), which allow families and social groups to be held together, and provide "the fabric of our relationships and the basis for community" (Roberts, p. 12). The development of a sense of group identity through the process of group therapy may be particularly appropriate to transplant recipients, in light of the research conducted by Bauer and Orbe (2011) regarding communication in the transplant community.

A growing body of research exists in the field of illness narration, which has suggested that patients use stories to understand their experiences, to create a coherent sense of self (Hsieh, 2004; Richards, 2008) and to empower themselves (Hsieh, 2004). Stories are the means by which we make our experiences meaningful (Roberts, 1999). In fact, Frank (2000) contends that illness narratives are told in order for people to experience themselves as separate from their illnesses, and discover who they are apart from their afflictions. This provides an opportunity for people, marginalized by illness, to take ownership of their stories and align themselves with others who have lived similar experiences. For Frank, illness narratives are limited by the aloneness of the storyteller. From his perspective, stories are constructed in relation to others, thus narratives should be viewed as a dialogue between the storyteller and the many voices that contribute to and influence their story. This dialogue urges the storyteller to acknowledge the influence of others without assimilating them, thereby recognizing the illness as the

"disruptive", "destabilizing" force that it is (Frank, 2000, pg. 139). Through the process of organizing and understanding the experience and sensations of the illness (Frank, 2000), the story can empower the individual in owning his story (Richards, 2008).

In the context of group therapy, drama therapist Alida Gersie (1997) encourages "a habit of involvement in each other's stories" (p. 147), through a method known as therapeutic storytelling. Each group member responds to the storyteller, which offers him or her different perspectives and insight. Through this process, the group develops a shared memory for the stories that have been told, and themes can be extracted and examined together. The insight gained through the feedback of others encourages the storytellers to work in collaboration with the therapist to examine, deconstruct and reconstruct their stories (Dunne, 2000).

The proposed program will incorporate elements of therapeutic storytelling in the development of a piece of therapeutic theatre, thereby encouraging participants to engage in social comparisons and support each other in making meaning of their experiences.

Use of narratives in health care. According to Hydén (1997), since the 1980s, there has been increased attention to the perspective of the patient regarding the illness experience, particularly amongst medical sociologists and anthropologists. Captured from the patient's point of view, these narratives allow those who do not share the culture of the illness to appreciate how a person's life and sense of self are affected by chronic illness (Hydén, 1997). Hydén asserts that this shift in focus from the illness itself to the suffering of the individual fostered interest in the patient's, rather than the doctor's, narrative. The acknowledgement of the experience of the patient also recognizes, in a

way, the fallibility of medical professionals and consequently, the field of medicine (Hydén, 1997).

A study conducted in Ireland (Kierans & Maynooth, 2001) examined narratives collected from individuals with end-stage renal failure. An analysis of these narratives revealed a number of themes connected to the liminal nature of the illness. An individual's unusual experience of temporality, in which the present exists as a moment on hold, creates a pause in the narrative. The presence of the illness in between extremes, following transplantation, for example, the individual is neither well nor unwell but somewhere on a continuum between the two. The fistula, a permanent passageway made for dialysis treatments, maintains a connection with the world of sickness, and a disconnection from normal life. The sensations of the illness, what we often call symptoms, such as the rationing of fluid intake and difficulty in urinating alter the individual's normal life-sustaining habits and bodily functions. The individual is aware of a disconnection between the body, the "medicalized other" and the "suffering self" (Kierans & Maynooth, p. 240). Importance should be placed on the experience of the "suffering self", as its experience is sensorial, embodied and connected, in sharp contrast to the distant, somewhat inaccessible experience of the "medicalized other".

The disconnection (Kierans & Maynooth, 2001) and altered sense of self (Hydén, 1997) experienced by individuals with chronic illness make the unification and exploration of their narratives particularly appropriate (Frank, 2000; Richards, 2008). Narratives are the means by which individuals make experiences meaningful (Roberts, 1999) and organize life events (Smith, 2000). From the perspective of narrative therapy,

the reconstruction and reorganization of an individual's life story following a destabilizing experience will contribute to improved mental health (Hydén, 1997).

Narrative therapy. Narrative therapy evolved from the philosophical work of Foucault and other poststructuralist thinkers and is reflective of a move within philosophy and the social sciences towards an examination of language. This approach holds that language is related not only to our sense of identity and of self, but also plays a key role in how we interact with and understand the world (Besley, 2002).

Narrative therapy maintains the individual as the expert on his own story and views problems as external to the person himself (Weingarten, 1998). In the context of the proposed program, this would entail encouraging the individual to see the illness as separate from who they are. The process of narrative therapy is a collaboration between the therapist and the person, who work together to find meaning and make sense of the person's life story (Weingarten, 1998). The therapist accompanies the individual in making sense of their stories, which they are constantly performing and changing (White, 1989). Stories are deconstructed in an effort to extract the dominant themes for further exploration (McCoy, Stinson, Bermudez, & Gladney, 2013). This deconstruction leads to the externalization of the problem, wherein the individual is invited to use distancing, objective language in discussing the issue, which consequently encourages him to see the problem as separate from himself.

Externalization is also a key concept in drama therapy, and is valued as a means through which the internal experience of the client can be externalized through the use of any dramatic medium, such as the body, masks or puppets (Dunne, 2000). Through externalization, the individual is granted more distance, allowing him to examine the

issue from all sides and gain awareness of possible solutions to the problem. It also provides the therapist the opportunity to draw attention to exceptions within the problem-saturated story, thereby strengthening the individual to face their difficulties (McCoy et al., 2013). The externalized experience is processed with the help of the therapist, and, in the case of therapeutic theatre, is presented to an audience who are able to connect to the "common human truth" (Grotowski, 2002, p. 23) within the actor's unique story.

Chapter 5

Considerations in Adolescent Psychosocial Development

Adolescent development. Adolescence is recognized as a particularly turbulent time in a person's life. Adolescence brings with it physiological changes, which upset the psychological balance of the individual and bring about an internal struggle, as the inner world strives to reorganize (Frankel, 1998; Liakopoulou, 1999; Loughran, 2004). It is a period during which the adolescent redefines his values (Liakopoulou, 1999; Loughran, 2004). This internal conflict is expressed in the paradoxical behaviour of the adolescent, who wants to grow up, and wants to remain a child; who is both dependent on and independent from his parents. Adolescence is therefore, a contradictory stage of life, a period characterized by both regression and growth (Liakopoulou, 1999; Loughran, 2004).

The developmental tasks of this stage involve the process of individuation (Liakopoulou, 1999; Loughran, 2004) and the achievement of sexual maturity (Liakopoulou, 1999; Ryckman, 2004). These related tasks culminate in the preparation for the adolescent to take his parent's place as a parent himself. This is after all, what it

means to grow up (Winnicott, 1971). The adolescent challenges his parents to support him through this growing up, to survive his aggression and his destruction (Winnicott, 1971). It is through this rebellion that the adolescent finds himself; the support of the family through this crucial period is paramount to his successful individuation (Brage & Meredith, 2001; Sheeber, Hops, & Davis, 2001; Winnicott, 1971).

Feelings of loneliness have been associated with the process of individuation (Brage & Meredith, 2001), which involves the redefinition of family roles (Sheeber et al., 2001) in relation to the development of the adolescent. Research has shown loneliness to be a common experience in adolescence (Brage & Meredith; Koenig, Isaacs, & Schwartz, 1994). This is perhaps a reflection of the efforts of the adolescent to understand himself in relation to his internal and external worlds (Ashbach & Schermer, 1987), a process which is by definition, solitary in nature. While loneliness and depression are not necessarily related experiences, there has been found to be a strong correlation between them (Ashbach & Schermer, 1987).

Depression in adolescence. Adolescence has long been regarded as an emotionally difficult stage of life. The emotional turmoil during these years has been normalized to such an extent that until recently, depressed mood in adolescence was accepted as part of the experience of growing up (Petersen et al., 1993; Sheeber et al., 2001). In fact, research has shown that the majority of adolescents pass through their teen years without any major psychological or emotional disorder (Petersen et al., 1993). However, the normalization of emotional turbulence in this stage of life has resulted in a certain dismissiveness in regards to the difficulties faced by those who experience depressed mood or depressive symptoms (Petersen et al., 1993; Sheeber et al., 2001).

Rates of depression amongst adolescents are on the rise, with 20% experiencing a depressive episode before the age of eighteen (Sheeber et al., 2001).

Research has shown that depressive episodes can have a negative impact on future emotional, social and occupational performance (Sheeber et al., 2001). Depression has been shown to be highly comorbid with anxiety, conduct and personality disorders, drug use, substance abuse and eating disorders (Petersen et al., 1993). In addition, depression is also a strong predictor of suicidal ideation (Petersen et al., 1993).

According to recent research, an adolescent's risk for depression is greatly influenced by the family environment (Sheeber et al., 2001). During this developmentally complex period in which adolescents begin to separate from their families, they continue to benefit from supportive family environments (Brage & Meredith, 2001; Loughran, 2004; Sheeber et al., 2001; Winnicott, 1971). Adolescent depression has been linked to inadequate communication with parental figures and low levels of parental support (Brage & Meredith; Sheeber et al., 2001). Family relationships were shown to have more influence than peer relationships on an adolescent's risk for depression (Sheeber et al., 2001), and high levels of conflict in the family unit has been associated with unfavorable developmental outcomes (Sheeber, Hops, Alpert, Davis, & Andrews, 1997; Sheeber et al., 2001). Parental support was also shown to impact upon impressions of self-efficacy, autonomy and responsibility; all of which were linked to self-esteem, and thereby indirectly and negatively associated with risk of depression (Sheeber et al., 2001).

Chapter 6

Challenges Facing Adolescent Transplant Recipients

Separation-individuation. Chronic illness presents a unique set of challenges for the normal developmental stage of adolescence, particularly in regards to the process of separation-individuation, which should be a major focus of therapy with these adolescents (Liakopoulou, 1999). For any parent, the balance to be struck between supporting and encouraging independence is a delicate one. For adolescents with chronic illness, this is a particularly sensitive balance since the impact of teenage rebellion may have more serious and certain consequences. According to Liakopoulou (1999), this difficulty in separation-individuation is illustrated by the difficulty many adolescents experience in transferring to adult care hospitals.

Medication and side effects. The most common reason for non-compliance to medication is unpleasant side effects, with those related to physical appearance being the least desirable for adolescent transplant recipients (Schweitzer and Hobbs, 1995). These side effects, which include acne, increased hair growth, weight gain and a cushingoid appearance (also known as "moon face") have an impact on body image and consequently may result in low self-esteem, self-consciousness, anxiety and unhappiness (Meade et al., 2009). These factors may also contribute to difficulties around sexuality and sexual relationships (Siegel et al., as cited in Meade et al., 2009), which present challenges to normal developmental processes at this stage in life.

Transition from pediatric to adult care. Preliminary research shows a need for more study into the impact of major transitions in the lives of patients with renal failure (Hutchinson, 2005). As previously outlined, many recent studies have acknowledged the

challenges faced by children with chronic illness, as they mature in their adolescent years and eventually transfer to adult care (Bell et al., 2008; Crowley, Wolfe, Lock, & McKee, 2011; McDonagh, 2005). This transition can be very difficult for patients who are not adequately prepared to self-advocate in health care situations or manage their own health. Self-advocacy in health care includes having an understanding of the illness, being involved in health-related decisions, asking questions, knowing how to access health care services and adhering to medication (McDonagh, 2005).

For transplant recipients, adherence to medication is paramount, without which an individual may face organ rejection, graft loss or death (Bell et al., 2008). Kidney transplant recipients are at greatest risk for these complications during adolescence and young adulthood (Bell et al., 2008). Delays in intellectual functioning and psychosocial aspects of development, including autonomy, have been associated with chronic organ failure in children, which may result in a slower rate of maturation in juvenile transplant recipients (Bell et al., 2008).

Research conducted by a children's hospital in Australia found that amongst a cohort of eleven transferred patients, the health of two patients deteriorated following transfer to adult care. A third patient refused to be treated at the adult care facility and continued being treated by the pediatric nephrologist in an unofficial capacity (Charturvedi, Jones, Walker, & Sawyer, 2009). The study also noted an increase in the number of inpatient days and a decrease in attendance at scheduled appointments following transfer to adult care. The researchers found that participants did not feel involved in the transition process and that there was overall a lack of preparation for the move to adult care (Chartuvedi et al., 2009).

While a number of studies have raised concerns regarding the impact of the transition from pediatric to adult care for young adult transplant recipients, a Dutch study found a decrease in acute rejection following transfer of care (van den Heuval et al., 2010).

Transition care is a relatively new concept, owing to advances in the health sciences which have allowed an increasing number of children with chronic illness to survive into their adult years (Bell et al., 2008; Blum, et al., 1993) and more research is needed to understand the complex reciprocal relationship between psychosocial considerations and physical health. The obstacles faced by young transplant recipients are numerous and transition programs which take all of these factors into consideration are being established to help bridge the gap in services.

Pediatric to adult care transition in Canada. In recent years, a handful of transition programs have been undertaken by hospitals across Canada in an effort to meet the unique needs of adolescents transitioning to adult care. Grant and Pan (2011) conducted a comparison of five such programs, four of which were developed by either a pediatric or adult care hospital and one which was conceived of as a community-based, peer-led program.

Though the specific objectives of the programs differ from one to the next, most of them designate a health professional to oversee the individual's transition and aim to promote autonomy, enhance collaboration with medical professionals, provide community resources and teach negotiation skills (Grant & Pan, 2011).

Two of the hospitals have a particularly strong focus on psychoeducation and developmentally-appropriate responsibility and care. A third program caters to the needs

of young adults with rheumatic diseases and aims to provide a continuity of services during transition. The clinic maintains a number of partnerships with other organizations, which allow their clients to benefit from referrals to psychologists, physiotherapists, education programs, and a number of alternative health therapies. A fourth program works closely in collaboration with community resources to assist in the transition of young adults with diabetes. This program also provides peer support, which encourages socialization, and provides guidance and emotional support during the transition. Lastly, the community-based program is led by individuals with chronic illness (non-health care professionals), who have received special training. A series of psychoeducational workshops, developed by a interdisciplinary team of psychologists, nurses and trainers, is offered by the leaders. Though the program does not offer therapy as such, youth in transition benefit from the support of their peers (Grant & Pan, 2011).

These programs were carefully designed to meet many of the challenges facing youth in transition, though none of them offer mental health services as part of their program. While peer support provides invaluable reinforcement for young people, ideally they would also have access to professional mental health services for more complex psychological needs.

According to a recent report, there are no studies concerning the information and support needs of kidney transplant recipients (Tong, Morton, Howard, McTaggart, & Craig, 2011). In addition, there is a demand for increased research and consideration for the transition challenges unique to transplant recipients. While other chronic illnesses have been investigating the transition experience for some time, recognition of these issues has been slower in the transplant community (Bell et al., 2008).

Developing a therapeutic theatre transition program at the Montreal Children's Hospital. In order to address the challenges of transition in their hospitals, the McGill University Health Centres have formed a Transition Research team, comprised of pediatric nephrologists and clinical epidemiologists, as well as professors in Psychology, Social Work and Education. This research team hopes to develop a transition program to meet the complex needs of this population.

In an effort to meet the needs of this population at the Montreal Children's Hospital, a plan has been outlined in the following pages for a therapeutic theatre program applied in the context of the ongoing process of transition. The proposed intervention design was planned with this research team in mind, in the hopes that sometime in the future, the resources will be in place to offer this program to adolescent kidney transplant recipients.

The participants of this group, all kidney transplant recipients, will range from thirteen to seventeen years of age. For these young people, the process of transitioning to adult care is already underway. They should be in the process of taking on more responsibility and participating more actively in discussions with health care professionals. The therapy group will provide an opportunity for psychosocial concerns to be addressed, which have likely been overshadowed by medical issues.

Chapter 7

Focus of Proposed Program

In response to concerns that the transition of youth with chronic illness to adult care hospitals occurs at a developmentally complex time for young adults, the Canadian

Pediatric Society has released a position paper regarding the importance of adapting programs to meet the needs of these young people (Kaufman & Pinzon, 2007). Unfortunately, only a handful of hospitals in Canada have established developmentally appropriate transition programs to guide young adults in their transition and many young people continue to be transferred to adult care without proper preparation for the changes and challenges ahead.

Therapeutic Needs of the Population

Adolescent kidney transplant recipients have complex health care needs. A number of psychological, social, medical and developmental concerns interact to affect the overall quality of life of these young people, and impact their lives in both the short and long term. The illness extends beyond the body, becoming a lens through which the individual sees the world. The illness comes to occupy not only the physical sphere, but the social and psychological as well (Kierans & Maynooth, 2001), thereby affecting every aspect of life.

Psychological needs. Given the relationship between psychological difficulties in adolescence and psychopathology in adulthood (Petersen et al, 1993), treatment of depression in young transplant recipients is not to be overlooked. The likelihood of internalizing symptoms amongst adolescent transplant recipients is increased when kidney disease causes functional impairment and when family functioning is upset (Soliday, Kool, & Lande, 2001). In fact, any adolescent, regardless of whether or not they have received a transplant, is at greater risk for depression if his family environment is unsettled (Sheeber et al., 2001; Sheeber et al., 1997). The unique stresses and challenges confronted by families coping with a chronically ill member make the negociation of

adolescent development within the family context an even greater undertaking (Meade et al., 2009). Depression has been shown to be highly comorbid with other psychological disorders, namely anxiety, conduct and personality disorders, drug use, substance abuse and eating disorders (Petersen et al., 1993). Of course, each of these disorders would pose unique challenges in the context of an individual with a kidney transplant. Substance abuse and drug use being particularly dangerous for a person with a compromised immune system, on a number of medications.

Developmental needs. As the adolescent evolves from early to middle and late adolescence, his needs change. By his mid-teens, good relationships with peers are increasingly a source of support and are helpful in off-setting stressful life events (Petersen et al.,1993). Adolescents with chronic illness may have limited social circles, which may affect their psychosocial development (Liakopoulou, 1999), heighten feelings of isolation (Brage & Meredith, 2001) and slow the process of separation and individuation (Liakopoulou, 1999).

The process of separation and individuation has been outlined as the primary developmental task of this stage of life. For youth in transition, this is further complicated by the medical needs for which they must be gradually taking more responsibility if they are to be well-prepared for transfer to adult care. Research has shown that the acquisition and development of life skills is associated with parental support, without which depression becomes increasing likely (Sheeber et al., 2001). Amongst adolescents with chronic illness, parental support is particularly important in the improvement of lifestyle behaviours (Bell et al., 2008). If independence comes too quickly, the adolescent may experience feelings of neglect (Liakopoulou, 1999), and may fail to gain the knowledge

and skills necessary for a successful transition.

Psychoeducational needs. Much of the literature regarding transfer to adult care for transplant recipients addresses the issue of adherence to medications (Meade et al., 2009). While this is a critical issue in transplant care, it is equally important to consider the reasons for non-adherence. Given the illness trajectory of young transplant recipients, cognitive delays due to organ failure, absence from school and academic difficulties, the experience of being different from their peers, limited peer relationships, unpleasant side effects of medication and normal adolescent developmental processes, it is essential that we look beyond the issue of non-adherence to the factors that influence this behaviour.

The Proposed Program Design

The proposed therapeutic theatre program is designed within the context of a therapy group, which will seek to develop social supports for group members and develop interpersonal skills. In building this drama therapy program, the therapeutic needs of the population and the power of group therapy have been taken into consideration, as have the current trend of illness narratives in health research, the theoretical foundations of narrative therapy and the benefits of performance. These elements have been drawn together to develop a framework from which a piece of therapeutic theatre will be built by the members of the group.

Group therapy. Group therapy can facilitate the development of social supports, while reinforcing social and problem solving skills, in the context of a supportive environment (Brage & Meredith, 2001). Group therapy was originally conceived of by Jacob Moreno, who organized one of the first support groups in 1912 (Blatner & Blatner, 1988). Moreno's interest in group dynamics guided the development of psychodrama,

which has become the most practiced form of active psychotherapy today (Blatner & Blatner, 1988). In working with groups, Moreno gained an appreciation for the power of group therapy and the potential for each member to act as a therapeutic agent within the group (Garcia & Buchanan, 2000). Moreno's theories and the widespread acceptance of psychodrama have opened up many possibilities for the field of drama therapy. Though psychodrama is only one approach within the wider field of drama therapy, many of Moreno's theories in terms of the power of group process and the value of spontaneity can be applied to drama therapy as a whole.

For a number of reasons, group therapy is an appropriate context for the proposed program design. Given the challenges presented by the adolescent years, some researchers believe that preventative therapy should be made accessible to as many people as possible and that additional support should be made available to those at high risk for depression (Petersen et al.,1993). Unfortunately, it is believed that the majority of adolescents may have insufficent access to mental health services (Petersen et al., 1993). With adolescents transplant recipients, medical issues may be the focus of interventions, to the detriment of the individual's mental health. These young adults could benefit from the opportunity to participate in a group that encourages self-reflection, practices interpersonal problem solving, and aspires to relieve participants from feelings of loneliness, helping them to find meaning in their lives. In fact, from a psychoanalytic perspective, some argue that the group may be viewed as a transitional object, thereby facilitating the process of individuation (Ashbach & Schermer, 1987; Levin, 1982), which presents great challenges to adolescents with chronic illness.

Chapter 8

Stages of the Proposed Program

Earley's stages of group processes (1999) highlight the evolution of therapy groups over time, as well as some of the therapeutic benefits of participation in such a group. The most relevant of these in terms of the therapeutic needs of adolescents include the sense of trust that evolves out of experiencing acceptance by the group after disclosing personal stories, and the negotiation of interpersonal relationships. When considered alongside Yalom's therapeutic factors (1995), the enormous potential of the therapy group to meet the needs of adolescents with depression is apparent. The therapist works to foster a sense of hope, universality, altruism, interpersonal learning and group cohesion (Yalom, 1995), which create a supportive environment for the group members.

Framework for the Group Process

Stage 1: Getting comfortable (Sessions 1-3).

Group process. In the early stages of the group, the therapist will focus on fostering a playful atmosphere that encourages interaction between participants, physical engagement, trust, emotional expression, observation and focus (Emunah, 1994). In the beginning of the rehearsal process, emphasis is on group building and sessions are structured in such a way as to encourage playfulness and minimize any pressure to perform. In this early stage, participants learn that in this context, there is no right and wrong (Emunah, 1994). This freedom to play is the base upon which the rest of the therapeutic theatre process will rest. The exercises selected will help shape the culture of the group and will allow the group members to get to know each other (Earley, 1999). At

this stage, members have yet to commit to the group; they are deciding if it is a good fit for them (Earley, 1999).

Therapeutic goals. The therapist will aim to instill a sense of hope (Yalom, 1995) in the group, by expressing a belief in the potential of the group to facilitate healing of its members. The hope for a positive outcome will encourage members to continue their participation in the group. Secondly, a fostered sense of universality amongst group members will facilitate the establishment of a safe environment for sharing in later sessions. The realization that they share common experiences with other members will help to create a sense of cohesion (Earley, 1999) and will challenge members to look outside themselves (Yalom, 1995).

Lastly, the therapist plans to address psychoeducational issues throughout the program, as concerns arise. In the early stages of the group, this will include discussion with the participants regarding the challenges of the transition process and how these difficulties may impact different aspects of their lives. This will provide structure and context for the participants (Yalom, 1995), who may wonder why they are talking about transition to adult care years before it happens. According to Yalom, providing clarification is in itself therapeutic, as an understanding of "the phenomenon is the first step towards its control," (Yalom, 1995, p. 10).

Drama therapy exercises:

- Introduce Yourself as Another (Emunah, 1994)
- Magical Ball (Emunah, 1994)
- Upside Down Fruit Basket (Pura, 2008)
- Liar's Club ((Fancy, 2003)

- Categorical Groupings (Emunah, 1994)

Stage 2: Exploration Through Therapeutic Storytelling (Sessions 4-12).

Group process. As the process carries on, the group becomes more cohesive and individual members are challenged to explore new aspects of themselves through different characters (Emunah & Johnson, 1983), building on the foundation of trust established in the early sessions. This stage aims to promote collaboration (Earley, 1999; Emunah, 1994), expression and communication amongst participants (Emunah, 1994). Group members will be encouraged to share their experiences (Earley, 1999; Emunah, 1994), and will be challenged to commit to their involvement with the group (Earley, 1999).

This gradual formation of the group coincides with the ongoing creation of the performance piece, which begins to reflect the collective identity of the group (Emunah & Johnson, 1983) and contribute to the group's sense of ownership over the piece (S. Snow, personal communication, July 14, 2013). The increased intimacy in these relationships challenges individual members to examine their role in relation to the group (Emunah & Johnson, 1983), which can lead the group to what Earley refers to as the *conflict stage*.

Therapeutic goals. During this second juncture of the group's process, instillation of hope and imparting of information (Yalom, 1995) will continue to play important roles. As therapy is likely to be new to many of the participants, it is likely that some will look to the therapist to guide their interactions with other group members. For Yalom, this imitative behaviour has therapeutic potential, as it allows the participants to "try on" different qualities, which provides an opportunity for them to explore who they

are and who they are not (Yalom, 1995). This may be particularly appropriate with adolescents, who are constantly re-inventing themselves. For many adolescents, the trying-on of different identities is done in relation to their peers and different social circles. For adolescents with a limited social circle, the group may provide a safe context in which to experiment with who they are.

Self-disclosure marks this stage, as the established sense of trust deepens between group members and they begin to realize that the therapy group is unlike other social situations in their lives (Earley, 1999). The group's acceptance of these disclosures is key to the healing of its members. The members learn that they will be accepted with their imperfections and respected for having shared with the group.

Drama therapy exercises:

- Social Atom (Moreno, 1947)
- Therapeutic Storytelling (Gersie, 1997)
- Dramatic Projection (Jones, 2007)

Stage 3: Collective Script Development (Sessions 13-20).

Group process. Tensions may rise as intimate relationships between group members have now been established, and group members are challenged to find ways of compromising for the benefit of the performance (Emunah & Johnson, 1983). This stage of the group process has the potential to be cathartic (Earley, 1999), as group members challenge each other to deal with interpersonal issues. The feedback provided by the group allows individual members to practice social skills. By working through conflict and hearing others' perspectives, empathy fosters an appreciation for the experience of others (Yalom, 1995).

In this third stage, group members will work together to develop a script for the performance. The therapist will have taken notes of the scenes, images, and discussions which have emerged since the beginning of the process. The therapist will apply narrative analysis in facilitating the development of the script.

Group members engage in discussion regarding what has emerged and the group begins to build scenes reflecting these themes. Some of these scenes may be similar to what has emerged; others may be inspired by the group's material, according to the comfort level of the group.

Therapeutic goals. Like a family, therapy groups are rife with strong feelings, the sharing of personal stories, a sense of intimacy and negative feelings (Yalom, 1995). It is through early experiences with family members that people learn to deal with difficult situations and learn to adhere to the norms of their own families in confrontations. In learning to resolve conflict and express differences of opinion, group members are challenged to deal with disagreements according to group norms, which may differ from their usual way of resolving conflict and provide alternate solutions to problems.

Drama therapy exercises:

- Dramatic Improvisation (Nash, 1996)
- Living Sculptures (Emunah, 1994)
- Dramatic Projection (Jones, 2007)
- Revisiting of previously explored material through narrative analysis

Narrative analysis. At this stage of the rehearsal process, narrative analysis will be applied in order to highlight and recognize common and related experiences amongst group members. The strength of this approach lies in the involvement of participants in

the process of interpretation and dissemination (Murray & Sargeant, 2012), which is consistent with the collective creation of a therapeutic theatre piece. While the proposed intervention design is not in itself research-oriented, the principles of narrative analysis can easily be applied to the group work in an effort to create a collective group narrative.

Narrative analysis derives from the philosophical tradition of hermeneutic phenomenology (Murray & Sargeant, 2012). This method of analysis contends that people organize the interpretations of their lives into narratives (Murray & Sargeant, 2012) and that these narratives are not created in a vacuum, but are influenced by external factors such as, political, social, and cultural considerations (Warren & Karner, 2010; Webster & Mertova, 2007). Events in the life of an individual are not significant on their own; importance is placed on the relationship between this event and the rest of their narrative (Ezzy, 2002; Murray, 2003; Murray & Sargeant; Smith, 2000). By studying an individual's narrative, it is possible to gain insight (Smith, 2000) into the stories that a person tells, both to themselves and to others (Murray & Sargeant, 2012).

Narrative analysis reflects the objectives of the proposed performance, to study the lived experience of a people by placing emphasis on the examination of the subjective reality of the group members (Tesch, 1990). The value of this method of analysis lies in the depth of understanding possible from the extensive accounts of the group members (Smith, 2000) and the potential to challenge society to come to a deeper understanding of itself (Tesch, 1990).

Narrative analysis in script building. In discussing the material brought forth by the group members, the therapist will guide the group in the collective examination of two levels of narrative analysis. Carried out as a group, this analysis will facilitate the

development of the final performance, as the group engages in a collaborative process of analysis, discovering how their stories and experiences are relate to each other's experiences, and to other facets of their lives. This will help to create a through line for the performance, and consequently, a stronger, more cohesive piece.

The structured approach of Labov (Murray, 2003; Murray & Sargeant, 2012) will be applied on an ongoing basis, to familiarize group members with the basic components of the story. Labov's approach involves identifying specific aspects within the narrative, including *orientation* (or setting), *complicating action* (the central details), *evaluation* (the significance to or attitude of storyteller), *resolution* (what happened at the end of the story), and *coda* (how the story connects to today) (Butler-Kisber, 2010; Murray, 2003; Murray & Sargeant, 2012).

Next, the second stage of analysis will involve the identification of critical events, defined as events that in hindsight reveal a change of understanding or worldview for the storyteller (Webster & Mertova, 2007). Typically, these events can be said to have an impact on a person's professional life; contain a traumatic component; reveal a public or media interest; or personal exposure to risk (Weber & Mitchell, 2007). The group members will also identify *like events* and *other events* related to the critical events. *Like events* mirror the critical event of an informant's narrative, but happened to another person, while *other events* reveal the same issues, but are anecdotal in nature (Webster & Mertova, 2007).

Stage 4: Rehearsals (Sessions 20 – 32).

Group process. By this point in the group process, members have worked at relating to one another and group norms have been established. This is a time for

individual exploration (Earley, 1999), the opening up to deeper, more connected impulses (Brook, 1972) and the elimination of resistance (Grotowski, 2002).

As the performance draws closer, fear of failure before an audience may increase anxiety. Despite the fact that group members are likely aware of their individual growth since the beginning of the process, they may be concerned about facing the world outside the group in performance (Emunah & Johnson, 1983). The fears of the group members may trigger different defensive reactions or "acting-out" behaviours, making the presence and support of the therapist vital at this stage (Emunah & Johnson, 1983). Anxiety may be particularly high at the end of rehearsals, as the group realizes that there is no time left for exploring, and their full efforts are necessary to make the show a success (Emunah & Johnson, 1983).

Drama therapy exercises:

- Rehearsal
- Relaxation exercises

Stage 5: Performance (Sessions 33-34).

Group process. The group has been working together for a long time and a deeper level of intimacy is achieved (Earley, 1999) as they bond together to prepare for the performance. In response to mounting anxiety around the performance, the cohesiveness of the group is emphasized at this point, as the group realizes that they have prepared for this "planned crisis" (Emunah & Johnson, 1983, p. 236) and hold the skills necessary to get through it. They find that the trust that has developed in themselves, for group members, and in their therapist encourages and challenges them to prepare for a positive outcome (Emunah & Johnson, 1983).

Therapeutic goals. Participation in a performance has transformative potential (Grotowski, 2002; Miller & Taylor, 2006). Stories are the means by which we make our experiences meaningful (Roberts, 1999) and collaboration on a process-oriented drama is powerful in itself, (Emunah & Johnson, 1983) as the intimacy of being witnessed by an audience heightens the experience of the performer (Emunah, 1994). This is particularly true when the performance has been developed by the people performing it; in this case, it is not only the performance that is applauded by the audience, but the individuals themselves, as creators of the piece (Emunah & Johnson, 1983).

Stage 6: Post-Performance (Session 35).

Group process. Post-performance processing is an important part of the therapeutic theatre process (Snow et al., 2003). As any actor knows, the ephemeral nature of theatre can leave a sense of emptiness once the curtain has fallen, the set has been struck, the costumes put away (Emunah & Johnson, 1983). In therapeutic theatre, group members have been changed through the process of self-exploration and group work. A new process has begun; the integration of the "new self" into daily life (Emunah & Johnson, 1983).

It is not unusual for the end of the performance and the closing of the group to bring about negative feelings (Emunah & Johnson, 1983). This possibility will be addressed in the final session, as the group says goodbye to one another. Mementos from the show will be shared in this session, to serve as reminders of the group's successful performance (Emunah & Johnson, 1983).

Therapeutic goals. This final session will serve to emphasize the growth and development of group members, as well as honouring the work that was done in performance.

Drama therapy exercises:

- Show on fast-forward
- Sharing of small mementos
- Magic Box (Emunah, 1994)

Chapter 8

Evaluation of Program

In order to evaluate the efficacy of the program in meeting the needs of adolescent kidney transplant recipients, group members will be asked to complete questionnaires. These questionnaires will be administered at three different points in the process; the first after the exploration through therapeutic storytelling; the second following the process of script building; the third during the last session, after the performance.

Each questionnaire will be concerned with the participants' experience of the process, at a particular stage and will be designed to evaluate the efficacy of the program in addressing the psychological, social and psychoeducation needs of the participants. These surveys will be anonymous, encouraging participants to respond freely so adjustments can be made to the program according to the needs of the population.

Relevance to Drama Therapy Clinical Practice

The proposed therapeutic theatre program design considers how therapeutic storytelling and therapeutic theatre can be used as a means to explore the embodied,

emotional and psychological experience of the transplant process. Through drama therapy, the individual himself will engage in an exploration of his body, one that has been invaded by illness and medical procedures. This has the potential to be a powerful experience for the participants, who have directed a great deal of attention towards the management of their physical health from a medical perspective. In this way, it addresses a need that has been expressed by the Canadian Pediatric Society; that services catered to the needs of adolescents be made available to those with chronic illness (Kaufman & Pinzon, 2007).

The proposed program design recognizes the recent interest of the health sciences regarding illness narratives (Miller & Taylor, 2006) and builds upon it through an embodied exploration of transplantation. The performative nature of this research project encourages the sense of advocacy described by some members of the transplant community (Bauer & Orbe, 2001) in educating and raising awareness about transplant procedures. This research has the potential to foster interest and awareness of drama therapy amongst health organizations and the medical community, while increasing awareness of patient experiences.

There is no precedent for therapeutic theatre with this population, though autoethnographic performance research is currently underway, focusing on the experience of renal failure (L. Lewis, personal communication, 2013). A second study has recently examined the efficacy of conducting drama therapy sessions during dialysis treatments (Davis, 2013).

Conclusion

This program aims to support adolescent transplant recipients in preparing for an important step in their lives. By taking into consideration the many factors that have influenced their lives thus far, participants will be encouraged to examine how the choices they make in the coming years will influence their transition to adult care services. Group members will benefit from the opportunity to share their experiences with others and will be challenged to relate to others on a more intimate level through the collaborative process of therapeutic theatre. Through performance, they will have the chance to be seen by an audience of family, friend and medical professionals, thereby empowering the performers and instilling them with a sense of mastery (Nash, 1996; Snow, 2000).

Though the focus of the proposed program is on providing support for young transplant recipients, it may have benefits beyond the small group of participants. Within the partner health care establishments, the performance may inform the transition practices of the institutions.

For the medical professionals, it may encourage medical professionals to consider the lived experiences of the patients with whom they work (Mienczakowski, 1997) and draw attention to the need for medical staff to look beyond the physical health and consider the psychological, social and emotional health of their patients (Roberts, 1999), which would be of benefit to many patients in these hospitals.

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