Theatrical bodies and madness: a case study of a theatre playground in a South African forensic psychiatric hospital.

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Declaration

I declare that this thesis is my own work in both concept and execution.

Signed by candidate

Alexandra Sutherland

Abstract

This study analyses, over a three-year period, a theatre programme with forensic psychiatric patients and staff at Fort England psychiatric hospital in Grahamstown/Makhanda, South Africa. Framed as a 'theatrical playground', programme sessions were structured around theatre games, improvisation and devised theatre processes that culminated in playmaking at the end of each session. Participation in the group was voluntary and constructed to allow involvement in theatrical play on its own terms, set apart from the therapeutic and rehabilitation agendas that govern the institution.

By means of a conceptually-driven critical analysis of the empirical practice, the study explores the ethical tensions and possibilities of locating all participants as political actors with agency to develop the stories, characters, and images they choose for themselves. It juxtaposes the democratic principles of the theatre space with the oppression and control of psychiatry when viewed as a Total Institution. I draw on the work of Michel Foucault and Erving Goffman in order to conceptualise the history and critique of psychiatry, and to contextualise how colonial psychiatry developed in South Africa. I compare manifestations of power and control that are part of forensic psychiatric practices with the political possibilities of different resistant theatre spaces, such as the work of the Olimpias artist collective and the Madness Hotel (Brazil). I show how these examples, and the theatre project researched here, approach all participants as authors and makers of and on the world. I deploy a Vygotskian lens to discern how participants collectively create a Zone of Proximal Development, which explains the profound shifts in learning and skills observed in participants considered as low functioning or beyond treatment or rehabilitation.

The study analyses three aspects of the practice: video documentation of selected workshops and performances; interviews with patient and staff participants; and my reflective practitioner field notes - in order to build the case for the radically humanising effect of the theatre playground. My analysis of key moments in the theatre practice highlights the ways in which patient-participants perform 'a head taller' than clinical staff's expectations, when offered opportunities to experiment with relationships by means of embodied practices in a creative process set apart from the therapeutic gaze.

Reflective and critical analysis of the practice reveals three types of experience in particular: first, hope as an overall affect that aligns with a recovery approach to mental health; secondly, how participation is experienced as humanising by disrupting and playing with institutionalised roles and bodies; and finally, how permission to play with the roles, narratives, and the power structures of psychiatry as an institution, reoriented participants as political actors in relation to the forensic hospital and the wider world. These experiences challenge the stigma and positioning of forensic psychiatric patients as incapable, outside of culture and humanity, and reposition them as legitimate knowers and creators.

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1 Theatre in a psychiatric hospital: political and personal contexts

Why this study

This thesis emerges out of a body of practice spanning twelve years involving theatre workshops with men in forensic settings: a twelve-year project in a medium security prison (2005-2017), and a five-year project in a forensic psychiatric hospital (2012-2017). The latter forms the case on which this study is based and is referred to throughout as the FEH Project, a shorthand for 'Fort England Hospital Theatre Project'.

Through years of practice, I have observed that inviting people to collectively improvise, devise performances, and witness each other in engaging in these activities, creates shifts within individuals as well as at a group level over time. These incremental shifts in how people see who they can become in the world by relationally playing with other people, stories, and identities, impacts a wider repertoire of roles that people feel more confident that they can play in diverse contexts. Within prison environments, when people experience their performances as contributing to meaningful encounters with others - by sharing stories that mean something to an audience, or making people laugh, or performing many diverse roles that are collectively witnessed - people who have been socially and institutionally labelled as deviant and/or incapable are able to assert an alternative to this social script on their own terms. The collective embodied nature of theatrical play is the distinctive site of change.

This is not a new observation in the field of applied theatre practice. However, there is something particular about the implementation of theatre and improvisation within a mental health setting that is also a prison that is not attempting to achieve a specific change (be it rehabilitative or therapeutic) as a desired outcome. The desired outcome is that we create a space that is playful and builds on and from each person's contributions (the building blocks of improvisation), as we would in any other setting. The change that is achieved is due to an approach that trusts every person's ability and right to create and perform stories that matter to them, and to collectively support each other's ways of doing so.

In 2012, in addition to my work with men at the Grahamstown Correctional Facility, I was invited by a psychologist colleague, Lauren Creese,[1] to run a drama/theatre group at Fort England Psychiatric Hospital, also in Grahamstown South Africa.[2] I rapidly experienced how the regimes of power operating in the hospital, as a paradoxical site of both confinement and health care, offered challenges and opportunities for theatre as a site of play, unpredictability and agency, within the extremities of an institution confining people labelled mad and bad. Forensic psychiatry is an area of psychiatric specialisation that involves the assessment and treatment of those who are diagnosed as mentally ill and who present a significant risk to the public (Sukeri et al. 2016). A forensic psychiatric hospital is therefore hybrid in that it functions as both hospital and prison, in which health care professionals are responsible for health care as well as the social control of people who have committed criminal acts for which they are not held responsible due to mental illness. Jacob and Foth (2013, p.179) argue that forensic psychiatry plays out the tension between care and custody, health care and protection, in which the medicalised body of a patient needs to be understood as a 'politicized entity' that is 'always caught up in a matrix of power relations that seek to shape and reshape its being'.

This study is thus an interrogative dialogue between my experience of the rigid relations of power within forensic psychiatry and a theatre project that operated within that institution as a small, weekly aperture, where we played with who we might become beyond the roles scripted by the institution. For the patients the latter roles are mostly confined to being sick or deviant persons. Relationships between staff and patients are prescribed by diagnosis and treatment regimes. The study explores what happens when patient-participants are not defined by their illness or criminality but as fellow theatre players and a pathologising gaze is interrupted, and, for staff-participants, it traces the impact of stepping out of a therapeutic

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[1] Pseudonyms are used for all participants in the theatre practice except for Lauren Creese who co -founded the project, and Luvuyo Yanta, my co-facilitator. I use first names of all participants throughout as this less formal reference aligns with the intimate nature of the practice and relationships built through the practice.

[2] I use the terms drama or theatre interchangeably when referring to the FEH Project. This is because both words were used interchangeably by the institution and participants. For example, the word 'drama' was a more understandable and used term by patient-participants, yet the group was officially called 'The Fort England Hospital Theatre Group' by the hospital. The flexible use of both words highlights the process-based nature of the performance work as well as the theatre-making component that concluded each session.

relationship with patients.[3] Documentation on (mainly visual) arts projects in cognate contexts consistently show that participants engaging in arts projects in psychiatric institutions value a creative activity that is not focused on their illness, providing a welcome distraction from illness-centred activities or interventions that dominate these institutions (Meeson 2012; Stickley & Hui 2012; Spandler et al. 2007). As the participants in the FEH project are in forensic wards and will remain there for a minimum of two years before they can move through the system towards release, this becomes particularly pertinent. For patients in closed wards (wards that restrict the mobility of patients who need to be accompanied by a security guard) most of their day-to-day life is either in the ward, or in a therapeutic activity. It becomes difficult to escape the illness positioning: one of the key themes that I will discuss in the study, concerns the identification of how participating in the theatre group makes participants 'feel human'. This also becomes crucial for staff who participate, all of whom reflected on how significant their release from their therapy role becomes in the theatre space.

Applied theatre and this study

The field of research falls broadly under applied theatre, a term which denotes the intentional use of theatre processes towards personal, social and political change. Applied theatre has its roots in the political left, and historical trajectories emerge from political, worker, community based, and workshop theatre practices around the world. In South Africa and most Commonwealth countries, applied theatre practices have roots in the liberatory and experiential approaches to pedagogy emerging from the Drama-in-Education movement in the UK, the influence of Paulo Freire's *Pedagogy of the Oppressed* and the spread of Augusto Boal's Theatre of the Oppressed techniques around the world (Nicholson 2005; Balme 2008). Change within applied theatre discourses is therefore conceived as political and social, rather than individual, and theatre practitioners are '…concerned with social transformation rather than individual pathologies and rehabilitation' (Prentki & Preston 2012,

[3] In this study I use the term patient-participant and staff-participant to identify the types of participants in the theatre group. The official term Mental Health Care User is given to people using the mental health system (as established by the Mental Health Care Act of 2002). I resist using this terminology as patients in the hospital refer to themselves as patients, and all patients are required to wear a hospital uniform that boldly labels them as 'Fort England Patient'. I discuss discourses and naming in psychiatry in chapter three.

p.12). This resistance to discourses around pathology, therapeutic intention and rehabilitation is pertinent to the how I use theatre within a psychiatric hospital. For many applied theatre practitioners, the term therapy is regarded with suspicion as they 'view change as political rather than therapeutic' (Landy & Montgomery 2012, p.171). This is a view that I take and will argue for in this study. This is not to undermine the benefits that various therapies have for many people, but rather to situate a theory of change in this study as an ethical imperative to provide alternatives to the gaze of pathologisation that dominates the fields of psychology and psychiatry. An implicit assumption underlying theatre practices in forensic settings is that the overarching motivation is rehabilitation.[4] My experiences and observations across the prison and the hospital suggests that a theatre process, which does not have an intention to 'fix' or heal, nonetheless has a particular developmental quality that this study seeks to understand. Such a theatre process contradicts a major part of the prevailing institutional agenda because the embodied, collaborative, creative activity of these processes with people labelled 'criminal' and 'mad' is politically purposive. It subscribes to a human rights-based agenda, which posits that all people have the right to self-representation and creative expression. As such, the theatre space holds political possibilities within what Erving Goffman (1961) defines as a Total Institution. In my practice in both institutions, theatre games and improvisation exercises were used as a play-based methodology that believes in the developmental possibilities of theatrical play in and of itself. The weekly workshops are structured to encourage making and remaking stories, relationships, modes of expression, characters, and different performances together. Our premise each week for meeting was as people who wished to explore our creativity and theatrical expression with each other. This was an attempt to move away from a deficit model which starts from a participant's illness, deviance or weakness, an approach that has been critiqued in some applied theatre (Murray 2015; Prentki 2012) and disability arts projects (Ignagni & Church 2008). To start the creative process based on a marginalised identity and perceived deficit that needs fixing (such as healing mental illness, rehabilitating the prisoner, empowering the disabled) would be to fall into a paternalistic power relationship.

[4]Some programmes make this rehabilitation agenda explicit – see Buell (2011) and Baim, Brookes & Mountford (2002). In my own practice I have never described what I am doing as rehabilitation, yet this has been ascribed to my practice by journalists, academics, and health care professionals.

The site of this study is a forensic psychiatric hospital in the Eastern Cape province, the poorest province in South Africa, in a small city called Grahamstown (founded by a violent British colonial army officer Colonel Graham) and renamed Makhanda in 2019, after the Xhosa prophet and leader who rallied local opposition to fight British occupation of Xhosa land in and around Grahamstown. The site and participants (researcher, facilitators, staff and patients) in the study are deeply embedded in the complexities of race, class and gender within the South African political terrain.

The Political context of the study

The South African state twenty-seven years after the first democratic elections in 1994 is a failure of the original promise of freedom for the oppressed. Although South Africa's constitution is widely lauded as one of the most progressive in the world, ensuring equality for all irrespective of race, class, gender, ability, ethnicity or sexuality, access to these freedoms remains only for those who are able to litigate to ensure these freedoms when the State or citizens fail to do what they are constitutionally obliged to. South Africa continues to be ranked as the most unequal country in the world and this inequality has remained a persistent feature since the country's transition to democracy (Statistics SA 2019). A stark example is the unemployment rate in South Africa which rose to 29 percent in 2019 (Statistics SA 2019). The Eastern Cape province, where FEH is situated, has recorded the highest employment rates by province since 2017, steadily increasing to 37 percent in 2019 (Matingara 2019). Race and gender continue to determine access to the type of housing, labour, healthcare, and education one receives. Oxfam South Africa's inequality report states that

> the structure of South African wealth and income inequality looks more like a caste system, where one's social status is determined at birth and is based on race, class and gender than a system of free association among people of equal value (Oxfam SA 2020, p.12).

It is beyond the scope of this thesis to detail reasons for persistent widening inequalities. However, while the legacies of South Africa's 350-year history of colonial conquest and dispossession remain a persistent factor, this combined with the increasing neo-liberal economic choices made by the ruling party during South Africa's transition to democracy, in

my opinion, account for many of the reasons for the current government's failure to transform the legacies of apartheid (see Bond 2005; McKinley 2017; van Niekerk & Padayachee 2019). This has contributed to rampant corruption resulting in the entrenchment of poverty and even further widening of inequality. Political Studies Professor Steven Friedman (2020) shows how corruption has been a central feature of South African politics since the first white settlers in the seventeenth century: it is not unique to the post-apartheid state.

The effects of inequality on mental health

Research shows a direct correlation between psycho-social stress and inequality that has chronic detrimental effects on mental health: the more unequal a country, the greater the levels of mental illness (Pickett & Wilkinson 2009). Haas et al. (2019) report that in 2017 mental illness was the leading cause of the disease burden in Africa.

On paper, South Africa appears to make a break from its apartheid and colonial past through a slew of laws and policies that are progressive. However, in practice, the implementation of many policies and laws are a failure for a variety of reasons, which include aspects such as a lack of funding to support implementation, a lack of political will, or not enough human or infrastructural resources to ensure adherence. A relevant example is South Africa's *Mental Health Care Act, No. 17 of 2002* (2004) which is internationally regarded as one of the most progressive in the world due to its basis within a human rights-based model (Burns 2011). However, there is a chronic gap between the rights guaranteed in the Act and the day-to-day realities within the sector, such as lack of access to adequate care and support, meaning that in practice 'mentally disabled people generally remain isolated, stigmatised and in many cases disenfranchised' (Burns 2011, p.99). A recent study shows that expenditure for public mental health represented just 5 percent of the national health budget and that 'mental health human resource availability infrastructure and medication supply are significant constraints to the realization of the country's progressive mental health legislation' (Docrat et

al. 2019, p.707)[5]. However, studies show that one in three adults are affected by a mental illness in their lifetime in South Africa (Haas et al .2020). Stigma for people with mental health issues in South Africa is exceptionally high, resulting in a lack of visibility and minimal activism and advocacy around disability issues and rights, although this situation is gradually changing (Kakuma et al. 2010).

In South Africa, mental illness is classified as a disability. This has a distinct social and economic implication as a person can apply for a disability grant, which is a means tested state grant that is the only source of income for millions of citizens, and often supports an extended family beyond the individual who receives it (Wright 2015). At the time of writing, a person on a disability grant received R1800 per month (approx. $100 per month), and approximately 1.2 million people currently receive the grant.

Gender based violence in South Africa

While mental illness represents a significant burden on the health system, so does gender-based violence. South Africa has one of the highest rates of gender-based violence in the world. Patriarchal gender norms are entrenched across society and the appalling rape and femicide statistics and resultant lack of justice for victims due to low conviction rates speaks to a structural misogyny that legitimates patriarchy. I am influenced by black feminist scholars like hooks (2015) and Gqola (2015) who insist we understand how patriarchy is damaging to all genders. The normalisation of violence under apartheid and the material legacies of the system are key to understanding why violent masculinities prevail in South Africa (Morell 2002; Suttner 2009). Gqola (2015, p.156) argues that when men make claims to a traditional African masculinity this claim should not always be interpreted as patriarchal within the context of colonial and racial domination. 'Under apartheid, such declarations are assertions of adult agency, which is defiant in the face of an infantilising regime' and are therefore claims to freedom (Gqola 2015 p.156). Black masculinity in South Africa is therefore complex and deeply implicated in its violent history.

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[5] In comparison, Britain's NHS dedicated 11% of its total budget to mental health service over the same period of the South African study, which is still considered woefully inadequate given that mental illness is calculated at 23% of the burden of disease (https://fullfact.org/health/mental-health-spending-england/).

In the FEH project, although the overwhelming majority of the participants were men (reflecting the demographic of the hospital), women were always present as participants. For the first year, four to six women from the female forensic ward participated. Two of these women had assertive, strong personalities that set a 'no nonsense' tone for how they were engaged with as gender minorities in the space. There were four staff-participants who participated throughout the period of study: one white female psychologist, one black male Occupational Therapist [OT], and two female OTs: one black and one white. There were brief periods where mostly black female nurses-in-training would attend for a couple of weeks during their internship at the hospital. The gender dynamic remained healthy and respectful.

In my own theatre work with men who have committed violence, often against women, men in prisons have over time, started to play with gender norms through theatre-making processes that extend their performances of masculinity beyond violence (Sutherland 2013; 2015). At FEH, this gender play was far less predominant. Rather, traditional gender roles associated with cultural practices were chosen, or types such as fathers, brothers, street traders, taxi drivers. In relation to Gqola's argument, the choice of traditional roles associated with manhood can be seen as an assertion of an adult identity, a claim to a freedom in a system that treats patients like children. Masculinity and gender play emerged as a theme in my prison theatre scholarship but is not given emphasis in this study. This is because emphasising masculinity with men considered dangerous, when it did not appear as a central theme in their theatre making, runs the risk of diverting the focus of the research to themes that are a preoccupation of the institution and these participants' therapeutic processes.

The social and political context of Fort England Hospital

As an institution FEH is both unique as housing South Africa's only National Maximum Secure Unit (abbreviated to MSU) for the assessment of dangerous offenders from around the country, and mundane as a typical reflection of South African society along the fault-lines of race, gender and class. The demographic profile of patients show that the vast majority are black, from low socio-economic backgrounds (Nagdee et al. 2015). On the other end of the hierarchy of the hospital, at the time of this study there was one psychiatrist of colour out of seven posts, and two psychologists of colour out of eleven permanent posts. This means that

the majority of people treating patients, psychologically, do not speak the patient's home language and come from vastly different social positions to the patients they treat. During the whole period of the theatre project at the hospital there were ongoing tensions between black unionised nursing staff and the white British CEO, whose management style was disliked by many (including some senior clinical staff members who verbally reported this to me). There were regular strikes by the nursing union calling for his dismissal, three of which resulted in burning and destruction of hospital property in 2016 (Dayimani 2018a). An investigation exonerated the CEO from any wrongdoing and dismissed the union's claims of mismanagement and he was eventually redeployed elsewhere by the Department of Health in 2017. He has since unsuccessfully tried to sue the Department of Health to regain his original job. During the final write up of this study (2021) the hospital has no psychiatrists after a series of resignations, leaving the hospital and patients in a dangerous and precarious position (Carlisle 2021). The racial composition of the psychologist team has also shifted towards an equal number of black isiXhosa speaking psychologists and those who do not speak isiXhosa.

There are ongoing racial tensions between staff. In September 2018, the *Daily Dispatch* reported that

> a group of 30 white health and administration staff at the province's premier psychiatric hospital, Fort England in Grahamstown, have claimed they are victims of racial discrimination, abuse and hate speech. They claim the hate speech comes from black unionist colleagues who want to rid the institution of white managers (Dayimani 2018b, n.p.)

In South Africa, race and class continue to align. This incident is not only about race: it is also a conflict between black working-class union members and white middle-class employees. These ongoing tensions, accusations and resignations of senior staff, point to an unhealthy work context in which the vulnerabilities of race and racial relationships, and the incompetency of the provincial Departments of Health to address deep seated issues are problems that occur nationally and are playing out in this and other hospital environments. At FEH the patients come from predominantly poor and working-class backgrounds. In the forensic wards they are committed involuntarily as custodians of the State (a State patient). They are rendered powerless and need to surrender to instructions of doctors and therapists

if they are to have any hope of leaving. The indeterminant nature of a patient's confinement, and his release – all determined by senior medical staff - reinforces his subordinate position. Völlm, Bartlett and McDonald (2016) highlight how studies around the world show that long-stay forensic psychiatric patients can stay longer in the institution than the sentence they might have received in prison for the same offence, posing ethical and human rights issues.

Fort England Hospital within the context of South African Psychiatry

Fort England Psychiatric Hospital occupies a space suspended between the East and West in the city of Grahamstown/Makhanda: a small city of around 140 000 people, dominated by and known for Rhodes University where I worked as a lecturer from 2001 - 2017 and the home of three of South Africa's top private schools. The West demarcates the predominantly white and middle-class side of town, with its many colonial-era homes and historic buildings and the East is the poor area, where the majority of residents, who are black, live in township-built, sub-economic housing in degrees of poverty arising from 70 percent unemployment; while the whole town suffers the profound shortcomings of a corrupt municipality that is regularly placed under administration. Fort England exists in a buffer zone between the two and the first structures were built by the British military to bolster the frontier line of defense against the indigenous amaXhosa people in the early nineteenth century. The Fort served as military base from 1815 to 1870, and in 1875 the Fort England Lunatic Asylum became the first dedicated mental health hospital in South Africa. This is in keeping with a feature of the British Empire which had very few custom-built asylums – most were converted prisons or military bases (Swartz 2015). Harpin's study of the cultural history of psychiatric asylums in the United Kingdom examines the association of asylums with danger, an association that is exacerbated by the architecture of the fort or prison. She asks,

> how did these Victorian monuments of care become visual metonyms for danger… the scarred history of psychiatry and cultural portraits of asylums have collectively authored and sustained the image of the haunted house populated by damaged souls in the lay imagination (Harpin 2013, p.335).

Fort England Hospital, in name and meaning, is no different. The hospital is set on large grounds with multiple buildings that are a mix of Victorian architecture and the modernist, functionally mundane rectangular blocks of the wards, interspersed with fields and large

green areas. The high barbed wire fence, the signing in and out at a security boom, the further layers of signing, checking, metal detection, surveillance cameras and security personnel, continue to provide a frontier defence, a protection between contested binaries of normal and abnormal, known and unknown, inside and outside, mad and sane, mind and body, ill and healthy, visible and invisible. Fort England continues to be a fort in the minds of people in Grahamstown, an untouchable, strange space where mad people go. Like my own position in the hospital as an outsider who gets to experience snapshots of life inside the institution, FEH is characterised spatially by its proximity to everyday life in Grahamstown, and distance – a space in town which is cut off from the world too.

FEH occupies a unique place within the history of psychiatry in South Africa, being the first dedicated mental health hospital (Jones 2012; Nagdee et al. 2015). Swartz (2015, p.30) notes how, in response to a growing settler population,

> [T]he Cape Colony was the only one of Britain's possessions in Africa to have anything resembling a substantial asylum network by 1900, and histories of African psychiatry demonstrate that, in the early twentieth century, South Africa continued to provide mental institution space in quantities significantly at variance with her neighbours to the north.

Most mental health institutions in the Cape province in the late nineteenth century were converted military barracks and prisons and '[t]he first facility was the Grahamstown Lunatic Asylum established within the Fort England barracks' (Sukeri, Alonso-Betancourt & Emsley 2014, p.36). Mental health provision in South Africa and the Eastern Cape province is deeply entwined with colonial history, apartheid and the development of Bantustans in the province (Sukeri, Alonso-Betancourt & Emsley 2014).[6]

The Grahamstown Asylum (as Fort England Hospital was first called) initially admitted people of all races, although there were differences in treatment and accommodation of people

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[6] The Bantustans – or 'homelands' as they were euphemistically called – were a major administrative mechanism for the removal of Black Africans from the South African political system under the many laws and policies created by Apartheid (www.SAhistory.org.za). The creation of Bantustans were the means by which Black people were denied South African citizenship and lost their right of access to the opportunities and resources of the cities, which, henceforward, they were only permitted to enter temporarily as migrant labourers. A central feature of the Eastern Cape province, which is mainly rural in nature, is the legacy of under-development in the former Bantustan regions of the Transkei and Ciskei.

according to their “race”. Colonial government policy was aligned with racist implementation leading to inferior accommodation and therapeutic interventions for black patients (Sukeri, Alonso-Betancourt & Emsley 2014). The asylum became a whites-only facility in 1908. In 1952, a ward for ‘non-whites’ was created in line with the segregation policies of the new apartheid state.

In the early 2000s a decision was made to change the emphasis of the hospital from a long-term facility to one specialising in acute and specialist forensic psychiatric provision. The hospital was the only one in the country to be awarded a National Maximum Security Unit status, possibly because no such forensic facility existed in the province, and because of the under-resourcing and funding of psychiatric services in the province (Creese, personal communication, September 2019). Because it is the only provider of forensic psychiatric services in the Eastern Cape, and the only hospital in the country with a National Maximum Security Unit, it is relatively well funded and resourced. However, there remains significant pressure on bed space and specialist services (Sukeri et al. 2016). Today, Fort England Hospital is the fourth largest forensic psychiatric hospital in the country and provides space for 189 male forensic psychiatric patients (Sukeri et al. 2016). Female forensic psychiatric patients are accommodated in the generic female ward as there is a low incidence of high-risk patients in the female mentally ill population. Van Wyk et al. (2012) document the serious challenges faced by the Eastern Cape in providing adequate mental health care services, due to inadequate resources. They report that in mid-2012, the Eastern Cape province (population 6.83 million) had eleven private and fifteen government employed psychiatrists. ‘Only three (11.5%) have isiXhosa as their mother tongue, although 83.7% are isiXhosa speaking’ (van Wyk et al. 2012, p.119). The psychiatrist to patient ratio is therefore approximately 1 to 28,000. Dr Mo Nagdee, clinical head at FEH, is cited in a Prof. Malegapuru Makgoba’s Health Ombud report, articulating a breakdown of trust between psychiatrists and the Eastern Cape Department of Health (ECDOH):

> The vast majority of specialist psychiatrists in the EC have lost confidence in, and frankly respect for, the DSS (Department of Social Services) and the ECDOH Head Office as a result of years of ineptitude, broken promises, inaction, indifference and hostility we have experienced in various settings, hospitals and regions. Most of us have little doubt that matters have deteriorated and that, far from making progress,

> we have in fact regressed in the ECDOH over the past few years (email to EC Department of Health cited in Makgoba 2018, p.76).

Following the tragedy of the Life Esidimeni hospital transfer case in 2015/16 in the Gauteng province there has been a spate of exposés of human rights abuses of patients under psychiatric care. The Health Ombud's report on Life Esidimeni concluded in 2017 (Makgoba 2017) and established that up to ninety-four psychiatric patients had died following transfer from a provincial institution (Life Esidimeni) to unregistered and unqualified NGOs that could not care for them. Subsequent to this report it has been established that the final figure is one hundred and forty-four deaths. These patients died primarily from starvation and neglect (such as hypothermia and dehydration). The transfers did not follow Department of Health protocols (such as notifying family members or assessing the suitability of places of care) and it was concluded that the decision was an unethical cost-cutting measure resulting in tragic and unnecessary deaths amounting to gross human rights abuses (Makgoba 2017).

In 2018, Tower Hospital in Fort Beaufort, a psychiatric hospital for chronic patients ninety kilometres from Fort England Hospital - where several men from the FEH Theatre Project were transferred - was in the news when a psychiatrist resigned citing the 'degrading and inhumane' treatment of patients (Venter 2018).[7] This report was followed by a report on Fort England Hospital, where a patient's family had laid a complaint of assault against nursing and security staff at the hospital, following what they claim were years of assault (Cleary 2018). As indicated, most forensic psychiatric patients come from poor backgrounds. This exacerbates the power hierarchies of a forensic psychiatric hospital where patients are expected to be grateful and compliant. A patient is constructed as the least knowledgeable about their condition and healing, and often considered helpless and entirely dependent on medical diagnosis, treatment and therapeutic care. If they are also from socially marginalised positions, the possibility of standing up to abuses in authority is further diminished.

[7] This case was thoroughly investigated by the Health Ombud, who found no evidence of 'institutionalised, systematic or deliberate violations of Human Rights by staff at Tower Psychiatric Hospital' but did conclude that their investigation revealed multiple failures 'representative of a broader systemic and prolonged poor-quality service delivery for Mental Health Care Users (MHCUs) in the EC (Eastern Cape)' (Makgoba 2018,p.9).

Fernando (1998) discusses how, internationally, forensic psychiatry is the exception to the rule when it comes to the de-institutionalisation movement of the 1950s and the concomitant devolution of psychiatric power that is spread over varying expertise and services in multi-disciplinary teams. If anything, ‘the power of the psychiatrist – usually the “forensic” psychiatrist – is as evident today as it has ever been in the history of psychiatry’ and ‘forensic psychiatry as a medical influence exerts to a large extent the power that was evident in psychiatry as a whole until the middle of the twentieth century’ (Fernando 1998, p.2-3).

Considering my applied theatre praxis

This thesis emerged out of a praxis and history of choosing to work in outsider or border positions. I was invited into a variety of institutional spaces to implement theatre practices that led to and from the project discussed in this study. Canadian academic and activist Julie Salverson (2001) reflects on how people who work in community arts contexts do not often talk about themselves. She critiques the assumption that we are not part of the work we do with vulnerable communities, that we somehow stand separate. This is the first of a few moments in this study in which I situate myself and certain significant co-workers firmly within the practices I evoke.

I first encountered the merging of performance, politics, psychology, and pedagogy at university in South Africa in the early 1990s when South Africa was in the process of a messy and violent transition towards democracy. I studied drama-in-education which led to running workshops in township schools in Pietermaritzburg (Kwa-Zulu Natal province) during the Apartheid state-orchestrated civil war between the Inkatha Freedom Party (IFP) and the African National Congress (ANC), which was playing out a mere five kilometres from the privileged space of the university. My memories are of helicopters circling overhead, and young white conscripts lining the township streets with automatic weapons as we drove in, followed by the embodied play processes involved in using drama to teach English literature to youngsters.

In 1996 I worked as a volunteer in a disability arts organization in Vienna Austria, which provided a cultural space for young adults and adults with physical, mental, and learning

disabilities to learn dance/drama/art and to showcase their work. This organization was run by a radical, passionate Hungarian who had escaped the Hungarian dictatorship in the 1950s and was marked by her difference in her inability to speak perfect German and her relentless quest to give people with disabilities aesthetic experiences which were visible within wider Viennese society: a society (like many others) that expected people with disabilities to remain unseen in public life. This was my first experience of working with a range of people with quite severe physical and cognitive impairments, where I was forced to confront my prejudices and interrogate what diversity and inclusivity means in relation to who are visible and valued as cultural actors, meaning makers, and performers.

Later, when I was employed as a junior lecturer at Rhodes University (2001), I was invited to run drama workshops in a street children's shelter, resulting in a long running theatre project called the *Art of the Street* which created street theatre commissioned for Grahamstown's National Arts Festival from 2003-2009 and a tour to the United Kingdom (2006).[8] From this point I mainly worked with young men as the shelter was dedicated to boys. In 2003 I was invited by a youth development NGO to run an HIV/AIDS drama workshop in the juvenile section of the local prison, and so started a long commitment to running theatre workshops with men at the Grahamstown Correctional Centre.[9] I continued to run this theatre project until 2017 when I left for a new city and a new job in the social justice sector, whilst the project has continued under the leadership of my colleague, Luvuyo Yanta.

A key success of the Grahamstown Correctional Centre project is the dynamic facilitation relationship that developed between myself (as a white middle-aged female) and Luvuyo (a black, younger, isiXhosa speaking male). I have known Luvuyo since 2001 and we have worked together on an array of theatre processes. I have directed him in theatre education projects, he worked as a theatre-making tutor for a first-year course I co-ordinated for five years, and I have commissioned him to devise plays with communities in rural areas around issues that affect them. As a gifted performer, director, actor and facilitator, Luvuyo brings a

[8] We were the first group from Africa selected to participate in the Contacting the World Festival at Contact Theatre, Manchester.

[9] The Grahamstown Correctional Facility is a male facility. The nearest female facility is 170km away in East London.

level of playful support to our sessions and is a role model for the men that became integral to how we worked together as co-facilitators for nine years. As friends and colleagues, we have developed a complementary facilitation style. Luvuyo often invokes the clown, playfully inviting participants into the world of improvisation. He is skilful in helping less confident participants enter into each activity and, as a gifted improviser, he readily gives examples of exercises and scenarios and can translate instructions effectively so that every participant understands what is asked of them. While Luvuyo tends to work in the moment, my role is to think ahead about the shape and form of each workshop, changing exercises or sequences based on how I read the group to be responding. Luvuyo worked with me as a co-facilitator in both the prison and the FEH projects. We developed a working relationship that is integral to the success of both projects. Walsh's (2017, p.13) article posits that our prison theatre project is an example of a long-term intervention that models a facilitation approach reflective of a wider politics: '[b]y collaborating, [they] offer the prisoners a model of cooperation, mutuality and respect between the white and English-speaking facilitator and the black and Xhosa-speaking male'. Luvuyo's voice is notably muted in this study. Although he is integral to the success of each workshop, he understood his role in the process through my lead. Luvuyo was sensitive to the fact that patient-participants were not well – and he expressed a fear of doing something that might trigger an episode for a patient (Luvuyo interview 2017). While he could readily plan and run a workshop in our prison project without me, he felt a lack of confidence to do the same at the hospital. When I relocated from Grahamstown and he was asked by Lauren (the psychologist who initiated the FEH theatre project) to continue to run the group with her, he declined. For him, the time at Fort England was a project that was mine, not his, and he was a vital mediator for the work that we did. When the project at Fort England ended in 2017 I conducted a concluding interview with him to understand how he understood the experience. I have chosen not to analyse this in the same way as the other interviews as this interview was quite distinctly between theatre colleagues in which he reflects on our working relationship, methods used, and our journey together. I include some of his insights from this interview elsewhere in the study.

Currently a senior psychologist at FEH, Lauren Creese was studying drama and psychology at Rhodes University in 2001 when I first started lecturing. We discovered a common interest in the synergies between drama and psychology, and many times she expressed her desire to

explore the potential of a drama group with mental health patients. In 2012 Lauren contacted me to invite me to start a drama group at FEH. Over subsequent years of working together and experimenting with what might be possible with patients, we developed a collegial relationship, at all times centred in what might best serve the participants. Lauren became not only a fellow player but also a co-researcher. In numerous conversations we discussed the workings of the hospital, the progress of participants and she assisted me with all the research procedures such as ethics forms and consent processes: generally ensuring that the research progressed with integrity: balancing the technical need for forms and procedures with care for patient-participants who needed to understand these processes. It is fortunate that, after my departure from FEH (and Grahamstown), Lauren has continued the theatre project at FEH with the assistance of a colleague. Lauren's voice is prominent within this thesis as she was the most experienced staff member who participated and my primary sounding board as I was navigating my way through the institution and theatre practice.

Although the forensic nature of FEH means that it is a prison, I experienced the two institutions very differently. For example, in the Grahamstown Correctional Centre, there was a level of homogeneity in the group, in that participants had similar levels of energy, motivation to be in the drama group, verbal and physical expressive ability. In the hospital, although the patient population appears to share many commonalities, such as gender, class and race, the group is highly diverse: participants exhibit a range of abilities (be they creative, physical, verbal, intellectual), impairments (physical, intellectual, mental), energy levels due to the side effects of psychiatric drugs, and in some cases, levels of psychosis. This makes this theatre space unique within my body of practice. Firstly, the high level of diversity as discussed above. Secondly, the restricted nature of the hospital meant that who got to witness or be audience to the creative processes was limited; and thirdly, there were the pressures and an assumption by clinical staff that any activity within the hospital needed to have a therapeutic and rehabilitative agenda in order to be considered useful, valuable, or beneficial.

In summary, three bodies of work, all with young men, have been a core constituent of my practice since 2002: young men in the street children's shelter, men who participated in the prison theatre programme at Grahamstown Correctional Centre, and men who were

incarcerated psychiatric patients at FEH. The participants in each site are united by their role as social outsiders within institutions established to help improve them: whether these be psycho-social behavioural issues arising out of extreme poverty; criminal behaviour; or mental illness that caused criminal behaviour. Each institution has a broader aim of reintegrating inmates back into society. In each project, our work moved from an initial storying of victimhood and a close relationship with the group's identity as victims towards a diverse range of characters and stories as the project consciously established our participation as fellow theatre makers and not only people with a marginalised identity as a street child, a prisoner or a mad person. In my experience, a group whom society considers to be on the margins will always start with the story that they think defines them as a victim. As a theatre practitioner, my approach has been to offer any group exposure to a variety of characters and playmaking possibilities that shift their storying of the world to multiple stories, characters and relationships. While it is important for prisoners to perform a story of crime and remorse if they so choose, I advocate that if this is the only story they tell or the institution permits them to tell, the radical possibilities of play and performance are diverted to maintaining people as dependent, continually asking for pity or forgiveness.

Due to the smallness of Grahamstown as a place, these practices and people have converged in eerie ways. For example, I worked with a core group of six young men from the street shelter for seven years, before they moved or got involved in other art projects or work. One day one turned up in the prison drama group, serving two sentences for robbery and aggravated assault. He became a committed, creative, central figure in the prison theatre group for several years until his parole in 2019. Another spent a brief period in the prison after an assault; two gained employment in the security industry, one of the only possibilities for young men with minimal education. One day, I bumped into one of them, a man who had been a leader in the *Art of the Street* project, having travelled to the UK three times to represent the group. He was on duty as a security guard outside a bank. He revealed to me how he had done a few months' shift at FEH, in the one ward where several of the theatre group's men came from. He had heard that I was running the group, but his schedule did not permit him to accompany the men to the session. It was as if the *Art of the Street* work had come full circle and this man now performs his role as a security guard, ensuring the safety of those in his allocated ward. He becomes part of the disciplinary logic of the hospital,

connecting with patient-participants around their love of drama and his history with myself as facilitator, but remains stuck on the ward as part of the security apparatus. These encounters have forced me to question the meaning of theatre and performance, and the limits of what it can do. This is one reason I embarked on a doctoral study. In all three contexts, men and boys are compelled to submit to the regimes of a Total Institution that controls and surveys their behaviour. A theatre group and the making of theatre in each of these contexts became a means to story the world beyond these institutions and institutionalised identities. In each case, a core committed group formed who clearly found meaning in the activity as they returned week after week and worked hard towards final performance with no promise of monetary gain or employment. The value of the work held meaning socially, politically and personally. Yet the material circumstances of these men do not change. They are still subject to their penal sentence and to systemic oppressions associated with poverty, race, and class.

Liebling (1999, p.152) notes how research in prison contexts requires us to confront the fact that such research 'indicates[s] as much about us as well as about prison: confinement, authority, power, control, injustice, violence, relationship, hope, pain and sadness'. As a feminist, I am continually reflecting on my role as a white privileged female working within these contexts. What does my identity location as 'other' to these men, who are also 'other' to me, bring to the work? Part of my continual reflection as a practitioner is how to balance a commitment to treating every participant as a creative human being as the starting point for the work, while not ignoring or denying the reality of the reasons for them being in the institution: reasons that are a complex mixture of suffering and violence. This includes the structural violence of inequality that impacts on mental health and access to services, and the violence that some of the participants have committed on others, and the suffering and stigma this brings. It also includes epistemic violence, a term rooted in postcolonial studies that refers to groups in society who are excluded as knowers and creators of knowledge, contributing to their invisibility and silencing (Liegghio 2013). But these deliberations do not comprise substantive research: as a researcher I need to bring together evidence to build my case in a systematic and rigorous way.

Research Intentions

Hughes and Nicholson (2016, p.4) note how 'applied theatre has often been preoccupied with a central tension between understanding itself as a force for imaginative resistance and as problematically entwined with networks of power and exploitation'. This study emerges out of this tension as I wished to understand what the meanings and possibilities are of a maverick theatrical playground situated within a context where the networks of power are particularly fixed and legitimised. What happens when the theatre process exists to 'pause' the institution rather than reinforce what the institution is trying to do? Why is it ephemeral drama and theatre processes which prompt changes of being? How can I account for the development, or changes, that I have observed in participants (be they staff or patients) when they are released from their institutional identities or associations, and invited to play with the possibilities of becoming story generators, and *makers* of the world, as opposed to passive recipients of a world made for them?

The method for doing this was to approach the structuring of each workshop as a theatre playground that offered a diversity of creative experiences and relationships. In so doing, I wished to trust the agency of patient-participants to explore self-representation and the storying of the/their world, on their own terms. This approach, after Vygotsky, was based on philosopher Fred Newman's argument that in order for theatre to have any personal, political, social, or educational meaning or effect, theatre should be conceived of as a playground and not a classroom or therapeutic space (in Holzman 1999). Friedman (2010; 2013), a theatre scholar who worked closely with Newman, argues that theatrical performance allows us to be simultaneously who we are and who we are not, which provides a unique platform for theatre to be a developmental activity rather than an end result: a proposal for a theatre as development, rather than a theatre for development. The instrumentalism inherent in applying theatre for social, personal or political ends, he argues, fundamentally limits the developmental potential of any theatre. The research therefore seeks to explicate how an intervention, which playfully recruits the performing arts, not for the purposes of therapy or rehabilitation within a forensic psychiatric context but as artistic practices in their own right, may lead to development; and how theatrical play is understood and experienced by participants labelled mentally ill and the clinicians who treat them. I

define developmental as progressions in capabilities in which participants become makers and creators in the creative space. Following the propositions of Lev Vygotsky (1978) I posit that when participants are related to as active creators and meaning makers, further capabilities emerge. These include improvements in communication and listening, story-creation, understanding and contributing to group processes, creativity, relationships with other participants, an ability to step into and out of the 'as if' frame of the expressive arts, and overall, demonstrating positive abilities that are often not observed elsewhere within the institution. As a researcher-practitioner and activist I am ultimately interested in the political possibilities of a theatre space that approaches all participants as authors and makers of and on the world.

How the study proceeds

Chapter two introduces the key components of the study: the hospital, the participants, the practice and myself in relation to all of these. Chapters three and four provide the conceptual framework for the study.

I draw on four groups of theoretical orientations to support a political reading that frames the empirical part of the study. All are broadly part of a critical or emancipatory research lens in that they challenge established orthodoxies. In chapter three I establish the field of psychiatry as contested within a critical tradition that locates psychiatry as an institution within relations of power. I examine how madness is a cultural and political concept that changes with time and context. The chapter examines the political implications of adopting a scientific approach to mental suffering.

Michel Foucault's writings on the history of madness and Erving Goffman's in-depth ethnographic study of an asylum are placed in dialogue. I explore Foucault's discussion of moral therapy in the early twentieth century in relation to its application in asylums in South Africa, and in the Grahamstown Lunatic Asylum (that became Fort England Hospital). Foucault conceptualises the regimes of power that have evolved regarding how mad people have been treated, and Goffman empirically demonstrates how these regimes of power operate to legitimise the control of patients in what he calls the Total Institution. Both theorists complement each other by helping this study situate institutional power and the

impact of institutions on people. Chapter three concludes by theorising the theatrical playground as an enabling space, using Lev Vygotsky's theory of Zones of Proximal Development to situate theatrically playing together as a site of change.

The group of theories that I discuss at the start of chapter four, concern issues and debates within Disability Studies Mad Activism and radical psychiatry. Both Mad and Disability Studies share a political critique of 'normal' and the ways in which a medical model locates the problem and disability within an individual. Radical psychiatry refers to psychiatric theories and practices that resist mainstream psychiatry, often, but not always against a medical model. All of these approaches which are broadly post-structural in their analyses of discourses and power, argue for a reframing of madness and disability away from seeing people as tragic, dependent and incapable. They argue for reinstating the social, cultural, historical and political contexts that give rise to how disability and madness have been perceived and treated. In many ways, these fields develop from the work of scholars such as Foucault and Goffman. These approaches argue for people with disabilities to self-determine and to fight for self-representation on their own terms and in their own way.[10] I also discuss the recovery movement that emerges from the psychiatric survivor movement as a patient-centred holistic approach to living with madness, as it centres on choice and hope as key internal conditions associated with recovery. The theatre space I analyse is structured to ensure it is a space of choice, agency and respect for how participants wish to perform the stories that matter to them.

The final group of concepts I examine in chapter four concerns how theatre and performance can be used to feed stigma and stereotypes around madness, or creatively subvert a pathologizing gaze. I focus on two performance practices and practitioners (Vitor Pordeus in Brazil and Petra Kuppers in the US/Europe) whose approach to performance with people who experience madness aligns with (and at times challenges) many of the ethical and political

[10] The oft-quoted phrase 'not about us without us', is used to remind researchers that extractive research and writing practices, which exclude marginalised people's voices and lived experiences, is exploitative, was first coined by Michael Oliver in his pioneering work on disability published in *The Politics of Disablement* (1990).

principles of my own practice. These two practices influence and dialogue with my own and embody a praxis that resists the hegemony of psychiatry.

In chapter five, I navigate the reader through the complex ethics procedures and decisions that were required for this study. I discuss how I processed the three types of data (field notes, interviews, and videography) using reflective practitioner and performance analysis methods, and highlight the limitations of the research design.

The empirical part of the study is explored in chapters six, seven and eight. Chapter six highlights the patient-participants' reflections on their experience of the theatre group. I extract key themes from the interviews conducted to highlight how patients articulated their sense of future, capability and hope, through their experiences of being part of the group (and how this links to a recovery approach).

In chapter seven, I provide an analysis of the practice. I foreground three participants, who have been institutionalised for several years and who exemplify change and development throughout the process which builds a case for a Vygotskian understanding of the power of collectively creating together. I analyse phases of the theatrical playground (the warm-up, partner work, improvisation exercises, and theatre making), to show how participants played with the activities and emerged as people who, given the opportunity, challenged and played with the Total Institution and created stories about choices, their past lives and a future beyond the institution. I highlight how treating people as creative actors in and on the world, through the theatre process, positions them as political actors capable of making imaginative and ethical choices within the aesthetic framing. The sense of agency and responsibility participants demonstrated through their playmaking defies the association of forensic psychiatric patients with a lack of capability to create knowledge and culture and to make moral choices.

The concluding chapter explores the core paradoxes that permeate this study and suggests the contributions that this research makes for arts practitioner-facilitators structuring theatre-as-development spaces in rigid institutions. I argue that the theatre playground is a space where risk and uncertainty can be explored creatively and collectively and is therefore a space of hope that is essential for restoring the humanity of all participants.

2 Introducing the participants, space, and place of the theatre group

Establishing the Fort England Hospital Theatre Project

Psychologist Lauren Creese had initially contacted me as she thought role play could be integrated into a group therapy process to act out different future scenarios but there had been resistance within the hospital to interfering with an established, therapeutic process. One day she phoned to confirm that we were starting at 'the MSU'. I subsequently discovered that this translated into the National Maximum Secure Unit where men are sent from all over the country by the courts or from other hospitals due to their high-risk profile, to be observed and assessed as to whether they are fit to stand trial or understood their actions at the time of the crime. Once a patient has been assessed as mentally ill, he either stays at FEH or is sent to a forensic unit nearer to his home.

We were only allowed to work with a maximum of six patients at a time in the MSU and there always had to be one security guard present for every patient. The space we used was an empty room in a new wing, next to the unit that has never been opened because the government had run out of money. Lauren casually wondered if the room had a panic button and whether the mandatory security guards should watch the drama work from inside or outside the room. Due to the level of surveillance and therapy-sized stipulation of the group, I was concerned as to how to create a non-judgemental space outside of the gaze of therapy. Years later we laugh at how all this rolled off Lauren's tongue, how habituated she had become to the regimes of security, surveillance and potential danger. And so it was I found myself creating a playful creative space in a highly secure ward of the hospital, where men diagnosed with a mental illness and considered extremely dangerous were confined, lacking autonomy, involuntarily on psychiatric drugs, and subject to a strict behaviour modification system and the continual threat of demotion. In this prison unit, people's lives are eternally suspended as they never know how long they will spend there in the mundane routine of the unit. Apart from their attending medical or therapeutic consultations, their other activities included snooker, television and the endless scraping together of money for tobacco. I

regarded being in the MSU as similar to being stuck in a Beckett play of never-ending waiting, where a person is required to surrender to the controls and continual surveillance in the space. How would it be possible to work with the future-ness of performance, in such a space of stuckness? The group was successful within these constraints as we managed to adapt theatre games and improvisation exercises to suit the varying abilities and needs of the participants. It was also a challenging experience, as participants were in the first phase of their treatment and experienced side effects from drugs such as shaking or lethargy or participants could be quite ill, and we had to adapt how we managed the space to accommodate a small number of men with varying energy levels and behaviours. This group in the MSU ran for two years (2012-2013). Due to the perceived enjoyment by patients who requested that it continue, we decided, and Lauren secured permission for us, to extend the Drama project to other wards beyond the MSU.

The ethical clearance for this study commences from mid-2014 after the second phase started in March, and was open to any patient from any of the other forensic wards as the group did not have to be restricted to a small number of participants.

Once a patient had been assessed in the MSU, he either is deemed fit to stand trial and be responsible for his actions at the time of his alleged crime and is moved back into the criminal justice system; or he moves to the closed wards (secure wards) from there to the more open wards, eventually towards release. The process of moving through the hospital system takes a minimum of two years, and there were several men in our group who had been at the hospital for over a decade and would in all likelihood become long-term terminal patients. At the MSU some patients from outside the Eastern Cape often stayed far longer than was intended, due to delays in securing transport by the DOH to cross a provincial border to get a patient to a hospital closer to where he lives.

The group in this second phase was larger (around twenty participants at a time), and more diverse, as men and women came from different wards and different stages in their institutionalisation. The MSU is for men only. The few female forensic patients are observed and treated in the one female ward at the hospital that mixes forensic as well as regular psychiatric patients, and women were invited to be part of the group. The group was held in

a hall a distance away from the wards and therapeutic spaces. In this space the institution could be paused somewhat, and we could create a space that was less influenced by associations of illness, therapy, and strict power relations.

A typical afternoon of setting up the session looks like this: when I get to the old Victorian hall where the group takes place, a few members are already waiting – socialising, sharing tobacco, dashing to the tuck shop before the group starts. At least two staff members are there too: Lauren, a psychologist, and Bulelani, an occupational therapist. One of them will have phoned each of the four forensic wards in the morning to remind the nurse on duty that the group is happening that afternoon, although in the later months patients self-organise to remind the staff and take themselves there. Luvuyo and I open the hall and a few members help us to set up the chairs in a circle: a ritual that starts every session. There were months when the hall was being renovated and we spent the first ten minutes sweeping or clearing. Everyone helps to establish our space: facilitators, staff-participants, patient-participants.

The hall is part of the original Victorian architecture of the Fort and we chose it because it is a space associated with ritual and recreation. It is used for large staff meetings (such as union meetings to organise around grievances with hospital management), church and memorial services, recreational activities organised by the OT department such as the annual Valentine's Day dance, and performances by visiting groups. It has a stage with fraying velvet curtains, a large floor space with wooden floors and a high, pressed ceiling. It borders a soccer field where every Wednesday the hospital soccer team plays another team based in Grahamstown. This sporting event is very popular and represents one of the few activities where patients interact with the world outside the hospital as normal citizens.

The distance of the hall from wards and other therapeutic spaces such as the OT department is important, as the walk from these spaces to the hall, and the wait outside, meeting up with other participants, sharing cigarettes, jokes and helping set up the space, all form part of the transition from institutional life to something other than this.

Patient profile and ward structure at FEH

The majority of wards in the hospital are forensic (five out of eight wards), which also means that patient-participants are long term, staying a minimum of two years as they are State Patients. Marais and Subramaney (2015, p.86) describe a State Patient as follows:

> State patients are individuals who have been charged with offences involving serious violence and who have been declared unfit to stand trial and/or who are not criminally responsible because of their mental illness or defect. They are referred by the courts for treatment, rehabilitation and indefinite detention at a forensic psychiatric facility.

To attend the theatre group, patients must be in level A of the Behaviour Modification Programme (BMP), a system of reward and punishment that is the organising principle of how patients move through the hospital system. On level A, they have been promoted to the top rung which includes privileges such as a 'ground pass'. This means that a patient has permission to leave their ward to attend sporting and therapeutic activities such as those offered in the OT unit. If a patient is demoted for any reason, they are not permitted to leave the ward, and therefore these participants do not attend the theatre project until they have been promoted to level A again (usually a two-month period). The politics and debates around BMP systems internationally, and within Fort England, are critiqued later in this study.[11]

The profile of men and women within the forensic psychiatric sections provides a picture of who participates in the theatre project. At the hospital 96 percent of forensic patients are male; the majority (75 percent) are between the ages of eighteen and forty and 61 percent of charges against them relate to violent crimes such as murder and sexual assault. There is a high (70 percent) unemployment rate prior to conviction of patients, concomitant with low socio-economic status (75 percent) and poor education levels (60 percent). Most forensic psychiatric patients speak isiXhosa and English and isiXhosa were used interchangeably in the theatre group (Nagdee & Erlacher 2012; Nagdee et al. 2015). The diagnostic profile indicates that the majority are diagnosed with disorders within the psychotic spectrum.

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[11] Note that the designation, 'A level' should not be confused with wards that are also alphabetical. Wards A, B and C house the non-forensic psychiatric patients.

Each forensic ward is allocated to patients at a particular stage in their progress through the hospital and state patient system. I outline these briefly here to provide an overall understanding of the hospital. Ward D is the only female ward, which accommodates both forensic and non-forensic female patients. In 2014, the first year of the project, there were on average four women who were regular participants throughout the year. There was initial hesitation expressed from hospital staff as to whether mixing men and women would work, as there had been issues (in the art group for example), where women did not wish to participate with men as they felt uncomfortable. However, this was never an issue in the theatre group.

Wards G and H are closed wards. This means that there is heightened security and that men who leave the ward are usually accompanied by a security guard. Generally, a male patient will first go to the Maximum Secure Unit (MSU) to be observed, and either stay there once he has been declared a state patient, or move to Ward G or H. Over the last two years of the project, the majority of participants came from ward H. Ward G is reserved for patients whose cases are considered complicated due to their level of mental illness (and who are possibly a danger to themselves or others), or whose rehabilitation progress is slow or deemed impossible. Wards G and H are in the same part of the hospital as the MSU and far removed from the main campus of the hospital. This means that men must walk a longer distance to get to the theatre group. Extremes in weather can inhibit their attendance as excessive heat or cold can cause side effects with certain medications.

Ward E is a pre-release ward, and, with ward F, is close to the main hub of the hospital, such as the Occupational Therapy building, a small gym, the sports field and the hall. Once a patient is transferred to ward E, they know that they will be granted leave to visit home, and perhaps be released permanently. Sometimes when a participant who has been a regular member of the drama group is then transferred to ward E, their participation becomes intermittent as they start to imagine a world outside of the hospital. However, some men who go on an extended Leave of Absence (LOA), which then requires them to return to the hospital for a week for a check-up, will attend the group for that one week. Patients in ward E are granted much more autonomy and have a certain status for having reached ward E. They can move in and out of the ward as they please without a security guard and are not required

to wear hospital uniform, although several continue to do so as their low socio-economic status means that they do not have civilian clothes at the hospital. On average, this ward attracts the least number of participants to the group, mainly due to the transient nature of the patient profile.

Ward F is adjacent to ward E. It is not a closed ward, but is not a pre-release ward either, as patients who are deemed unready or unable to return to home or community life are transferred here. These are patients who are considered a-potential: who will not recover or be able to manage their mental illness in a family context and are unable to be rehabilitated.[12] These men will either get transferred to Tower Hospital, a chronic mental health care facility in Fort Beaufort (or another equivalent if closer to their home) or stay in ward F for an extended period of time (sometimes several years depending on bed availability).

The other wards, A, B and C, are in-patient, non-forensic wards. They are psychiatric wards for different categories and stages of mental illness, but the patients are not State Patients. This is a far more transient group of patients, and from time to time a few have joined the group but usually only for a few weeks.

Over the three years of running the project for the forensic wards, the group number has averaged between fifteen and twenty consistent patient attendees. Numbers are slightly lower during the cold winter months of June and July. A side effect of some medication includes bodily stiffness which is exacerbated in the colder weather.

As regards staff participation, Lauren has consistently participated since 2012 when the project was initiated in MSU. Between 2014 and 2017 when the project moved to the forensic wards, three occupational therapists have participated. We also regularly incorporate student nurses, who arrive throughout the year at Fort England for three-week practical placements from nursing colleges throughout the Eastern Cape. They range in

[12] A-potential refers to patients who stay long term in a psychiatric hospital because they do not demonstrate potential for recovery or rehabilitation. I discuss this term in more detail in chapter seven.

number from three to ten, often increasing over the three weeks as word gets around about the group and the kind of relationships that are encouraged within it.

There have been a few occasions where a security guard has joined in, but usually if they have accompanied groups of patients from the closed wards, they sit and watch – often actively enjoying observing the group activity. Any new person who wishes to observe, rather than participate, is invited to take part in the warm-up first. This is an attempt to avoid passive observation and to request people to move a little out of their comfort zones with us. Most of the people who agree end up actively participating for the whole session.

Patients are told about the group in ward round or by other patients or via a suggestion from a therapist. The theatre group is open to anyone – staff or patient – who wishes to participate on a completely voluntary basis. The voluntary nature of the group needs to be emphasised to patients, as this is certainly not part of the normal modes of participation in the hospital. A participant may attend or leave the group when they wish: there is no obligation to commit to a certain number of sessions, or to commit at all. A participant may also choose to leave in the middle of a session, although this seldom occurs, unless a participant is feeling unwell. One of the OT staff-participants positions the voluntary aspect of the group as an invitation:

> *I think patients are forced into so many things within this hospital and this is the one thing where you are invited. You don't have to come, but we would love to have you. And it gives patients a lot to think about and consider and make a choice* (Thandiwe 2015).

There have been times where nursing staff have assumed that the theatre project operates like other projects and have demoted participants who did not attend on a particular day. The presumption that a patient who does not feel like attending the group must be punished speaks to the distinctiveness of the group's voluntary aspect within the hospital. The demotion is usually reversed during the weekly ward round when a patient's case is discussed by the multi-disciplinary team, led by the psychiatrist assigned to that ward, nursing staff, a social worker, a psychologist, and an occupational therapist. However, this demonstrates how easily the theatre group could be co-opted into the behaviour

modification programme and subsumed into the institutional logic of control and punishment.

Over time, certain patient-participants have become responsible for reminding others in their wards and initiating the walk to the hall. This initiative speaks to a sense of ownership and identification with the group, since it is not something that is enforced by the institution but chosen by patients, who then take responsibility for remembering, arriving on time, and recruiting other patients in their wards.

The consistent attendance of the majority of participants speaks to the meaning the theatre workshop has for members. My records indicate that approximately five participants out of approximately forty-three over the period of ethics approval have dropped out voluntarily after a few sessions. All others were either transferred out of the hospital or sent on Leave of Absence (LOA) or knew that their LOA was coming up and decided to end their participation close to that time. A few patients were demoted, and never returned to the group. A total of forty-two patient-participants gave consent to be part of the research, and two declined. It was explained that the right to withdraw from the research, or decline to be part of it, did not prevent people from continuing to be part of the theatre group.

Structure of the theatre workshops

Each session lasts between sixty and seventy-five minutes, depending on the energy levels and size of the group. For the first year (2014) the session was in the morning, and in subsequent years (2015-2017) it was after lunch, from about 14:15 – 15:30. Participants choose to either sit on a chair in the circle before we begin, or to socialise outside the hall. Sometimes a participant will spontaneously start a song or a game while we wait, but usually we wait until the majority are there.

The structure of our sessions involves an ice breaker to physically warm our bodies and change the nature of our interactions and the space we are in into a collaborative play space, a deliberative space where spontaneity and creativity can be explored. This is usually followed by pair work and less active, non-verbal exercises to encourage trust and partner-work. This is mostly followed by improvisation or story-telling activities that lead to the last

group work phase in which small groups craft and rehearse a short scene to perform for the whole group. This last playmaking section forms half of the workshop time, and includes showing, watching, and briefly reflecting on what each group has made.[13]

I am not advocating a unique method for the encouraging of theatre games and dramatic scenarios. Over many years of teaching, practising, and learning from others, I have developed a 'basket' of approaches and exercises, which I am drawn to, and which I have learned do work in the various contexts that constitute my body of practice. The games I will describe in the analysis chapters are recognisable: from Augusto Boal's *Games for Actors and Non-Actors* (2002) and the many variations of Keith Johnstone's theatre games as outlined in his classic text *Impro: Improvisation and the Theatre* (1987). Practitioners such as these are recycled over and over in many manifestations and variations: from different people I have worked with, or been introduced to by students, or at conferences and workshops. Participants also introduce their own games, deriving from childhood or adaptations of well-known call and response games that are re-imagined, using the vernacular. All of these games and exercises form the scaffolding that enables the playmaking to take place. The Rhodes University Drama Department curriculum is heavily orientated towards physical theatre and the centrality of the whole body to convey meaning through different performance forms. This elevation of the performing body, derived from practitioners such as Jacques le Coq as well as Poor Theatre workshop techniques that were central to dissident theatre-making practices under apartheid, aligns with the performative embodiment of many South African cultural and expressive modes. Song, dance and performance poetry are central to religious, political, and recreational life in many South African communities, particularly in the vicinity of Grahamstown. In the prison and the hospital, inviting participants to use their bodies in creative, spontaneous ways became central to the practice as a means of overcoming the docile, institutionalised bodies that are required within these institutions.

[13] Appendix B contains the seven workshop plans documented in video recordings and gives an indication of the structure and type of games and tasks.

If there is an original element to my workshops, it lies in how Luvuyo and I lead the workshops and structure the exercises to incorporate a range of physical and relational activities that focus on participants becoming both performers and spectators - audience to performance - throughout the process. Relationality is central to my practice: building and rebuilding how we relate to others by focusing on the performer-audience relationship. Participants engage in a variety of processes that involve storytelling, story creating, and story responding; an interchange between watching and listening, doing and creating. In so doing, participants experience diverse ways of seeing the world and being in the world. The activity of collectively creating new performances and stories becomes a Zone of Proximal Development (Vygotsky 1978) – which I will thoroughly discuss in chapter three - in which participants with diverse abilities support each other to perform beyond their perceived level of ability or development. This study argues that structuring the group as a playground for experimentation, away from the gaze of diagnosis, therapy or rehabilitation, shifted participants' sense of themselves beyond institutionalised roles towards experiencing hope and feeling more fully human in the world.

Researcher-facilitator as insider- outsider

Leading the theatre project at FEH on a weekly basis between 2012 and 2017 afforded me an everyday lived experience of the hospital. The institution became so accustomed to the project, Luvuyo and myself, that I sometimes wondered if that didn't render us invisible – and by implication – without significance. But there were other times when I did become visible and in turn was able to observe some workings of the hospital. For example, at the start of the second phase of the theatre group in the forensic wards in 2014, Lauren invited me to speak to the multi-disciplinary team before a ward round for each of the wards that would be involved. This was an opportunity to explain what the group was about to the psychiatrist, psychologist, ward manager, social worker, head nurse and occupational therapist team for each ward. The team could then recommend or suggest to a patient that they might like to join the group if they wished to. I found this an intimidating process. I felt like an intruder sitting in the room with the psychiatrist at one end – in each case removed physically from everyone else with his files for each patient that he would be seeing that afternoon – and the other staff sat around the room with an isolated chair for the patient. I had to find a way to

pitch a theatre group to medical professionals so that they could see potential value for their patients. In one of these ward rounds, the psychiatrist forgot that I was to do my brief pitch before they started to see the patients for that day, and I sat through a consultation with a patient who was in great distress. It felt unethical for me to be present given the high level of protection and anonymity that is required in terms of hospital procedures. Yet there was no way to leave discreetly and so I was trapped.

Another interaction with FEH staff was during two morning briefings, which occurred at eight each morning in the clubhouse for all daytime clinical staff. At these meetings there was a handover where any incidents (to do with patients) were reported and any relevant administrative business dealt with. Once a month staff hold a journal club in the morning briefing slot, which is a space for sharing research. I was invited by Lauren to present twice: the first in March 2014 on the distinctions between art therapy and applied theatre and our work in the MSU; and then in August 2016 I presented on my own research on the theatre project and its potential links with the characteristics of the recovery model to mental health. Waiting for my chance to present I was privy to the morning briefing. At these two presentations it was evident that there were a handful of the audience (of around fifty clinical staff) who were interested and engaged in the presentations. These morning meetings and journal club are mandatory and particularly in 2016 with contestations around the management at the hospital, staff morale was low. It was a period of extreme conflict between the nursing union and management, resulting in daily pickets and in some cases, destruction of property (Dayimani 2018a). Staff who did engage with the presentations expressed support for the theatre project within the hospital. This included two senior psychiatrists and the CEO. However, this support from senior management did not extend in any significant way practically. Although the theatre group was included in presentations at conferences (Nagdee et al. 2014) and for the Department of Health - as an example of the unique activities offered at the hospital and an example of a recovery model in place - this did not translate into any sense that the group was important, or even recognised as a legitimate part of the treatment regime, in any way.

Some of the instances in which we were all but ignored follow. We were often prevented from using the hall without notice despite the hall being booked for the theatre project for

the year. In addition, other ward activities such as meetings with patients, would be scheduled at the same time as the theatre project without any communication or consideration for those patients who regularly attended the project. For the whole of 2014 the hall was under major renovation and we would start each session sweeping, clearing space, and picking up broken glass. Or we would open the hall only to find hundreds of chairs set out following an event or meeting that week and would spend the first ten minutes of the session stacking chairs to clear space for our activities. A week before our first showing of our work in 2014, four performers were demoted, which meant they were not permitted to leave their ward for at least two months and hence could not participate in the performance. Their demotion was non-negotiable. My field notes at the time describe a flurry of panic and replacing of roles during the final rehearsal to try to ensure that we could do the performance (6 December 2014). Throughout our time there, there was only one ward manager out of six who would remember which day of the week the theatre group was on and ensure that participants were reminded. Every other ward manager forgot, or did not diarise, even though we would visit at the start of each year to notify the day and time, put posters up to recruit new members, and phone in the morning to remind staff. It was only when some participants self-organised to round up participants that we had regular and prompt attendance. I began to understand the different nature of each ward through these visits, which included putting up posters at the start of each year and at the year's end to advertise the annual showing, and they afforded me insights into the nature of each ward. These brief visits led me to understand what patients meant when they said they had nothing to do. Each ward was characterised by men either sitting and watching TV or sleeping in the yard or smoking outside. The impression was of an overwhelming sense of stasis and passivity. Patients are forbidden to be in bedrooms during the day. In the locked wards there is no privacy – patients are under continual surveillance, compelled to behave under constant visibility.

The four staff who participated in the theatre group over the years became vital in helping me navigate the institution and its layers of contradictions. The conversations with these staff members, before, during and after each session, informed me about the institution and what was or was not possible for our group. Through these conversations, and participation in the journal club and ward rounds, I experienced fractured human relations. Nursing staff pitted

against senior management, occupational therapists who felt that their skills and approach was not taken seriously, and patients who were not spoken about as fully human. Several studies point to the ethical and paradoxical challenges of care and control through punishment for staff in forensic psychiatry (Holmes 2005; Holmes & Murray; Hörberg & Dahlberg 2016; Jacob 2012; Jacob & Foth 2013; Völlm, Bartlett & McDonald 2016). Psychiatrists, doctors, and psychologists' code of practice is to place the interests of a patient first, yet when these professions act as witnesses in criminal procedures they become accountable to the court, which is not what might necessarily be in the best interests of the patient (Völlm, Bartlett & McDonald 2016). Holmes (2005) describes the political aspect of nursing in forensic psychiatry when staff are required to be both agents of care and disciplinarians. He describes how psychiatric nurses are both subjects of power in terms of their surveillance and punishment roles, and their place in the caring hierarchy also makes them objects of power as they too are watched and judged.

Within the restructuring of FEH by the Department of Health the hospital security services, which desirably should be specialists in psychiatric care, as well as the cleaning and catering, were outsourced to private profit-making companies. This resulted in a continual changeover of security personnel depending upon which company had won the contract each year. When staff responsible for these services have a dispute with their employer and strike, nursing staff are left in highly vulnerable situations with unpredictable patients who require routine. Mclennan (2020) reports of chaos at the MSU after security personnel went on strike after repeated late or reduced payment of salaries.

> Confined to their cells for two days and two nights, dozens of patients screamed through barred windows and banged on doors to be let out as terrified staff mopped up urine streaming into the passageways at Fort England Psychiatric Hospital's Maximum Security Unit (MSU) last Thursday.

As I observed and experienced it, the hospital is an unhappy place for many people caught within the paradoxical mandate of care and social control. Staff-participant Maya expresses this in a journal entry she sent me from 2016 when, as a new staff member, she was questioning some of the practices of the behaviour modification programme:

> It seems to me that so much of what is done, particularly at Fort England Hospital ... is not in the best interests of the people in the custody of such institutions. It may be

> presented as such, but in reality, it is in the best interest of the institution and its operation. None of us deserves to be stripped of our basic human dignities. None of us should be forced to wear pajamas (as happens upon demotion to Group C), which apparently, is fine because it does not violate patients' rights. None of us should be humiliated that way. None of us should be deprived of opportunities to engage in therapy, which is a privilege that has to be earned through submission. Yet that is how the system works (Maya pers.comm. 1 March 2020[14]).

Much of what I observed on wards from staff was about controlling patients. This does not mean that a level of structure and containment is not required; but it appeared that the stark separation between staff and patients led to a fossilising of roles into a paternalistic relationship in which staff are cast as parents/adults needing to look after patients cast as children who do not know better. Staff-participant Maya reported how a nurse had defined an approach to patients as 'we want them to be like babies' (Maya pers. comm. recorded in field notes 8 February 2016). A literature review of staff-patient interaction in forensic psychiatric settings shows how this relationship is characterised as either 'paternalistic and behaviour-changing care' or 'relational and personal quality-dependent care' (Hölberg & Fahlberg 2015, p.2). On the wards and in ward round interactions I experience the former, whereas staff who participated in the theatre group expressed in their interviews and in their practice in the group, the latter.

To return to the circumstances of our 2014 year-end showing and the four participants who were demoted: three of these were female patients. We were having an end of year party after the successful – in spite of the last-minute cast changes - performance that was filmed. I had asked if we (myself, Luvuyo and Lauren) could bring some of the cake and treats to the women's ward so that they could watch the performance on a laptop and thus be included in the closing of the year. When we arrived, the doctor on duty said that herself and the nursing staff were very unhappy that the women were 'getting a party' as they were being punished and it was sending the wrong message: '[i]t is the only thing we have to control them' (field notes 8 December 2014). Goffman (1961) highlights the binary nature of the Total Institution that relies on an 'us' and 'them' relationship to uphold its power. He notes:

[14] This extract from Maya's reflective journal in 2016 was emailed to me in March 2020. Maya had resigned from FEH in 2019 and was processing her experience at FEH which she ultimately found highly traumatic.

> Each grouping tends to conceive of the other in terms of narrow hostile stereotypes, staff often seeing inmates as bitter, secretive and untrustworthy, while inmates often see staff as condescending, highhanded and mean. Staff tend to feel superior and righteous; inmates tend in some ways at least, to feel inferior, weak, blameworthy, and guilty (p.7).

For a long time I struggled with my conflicted views of the hospital as, on the one hand, a highly oppressive institution, because of practices such as the behaviour modification programme, which are at odds with the hospital's mission statement that includes 'striving for social justice and destigmatization' (Nagdee et al. 2015); and on the other hand, the caring and invested relationships with patients' progress that I encountered amongst some of the staff. However, through Goffman's study of the asylum as a Total Institution, and Foucault's theorisation of surveillance and discipline, I have come to understand how *all* people within the Total Institution become dehumanised. As contemporary scholars have argued, the paradoxical nature of care and control within the forensic hospital is hardpressed to be therapeutic or rehabilitative.

An ethical dilemma confronts the applied theatre researcher-practitioner too: if a theatre space is set up as liberating space of play and experimentation, how do I as a researcher work to maintain this, given the extractive nature of so much research which often only serves the researcher? Whilst running the theatre project was voluntary for myself and a paid position for Luvuyo, it brought significant rewards. I was able to gain regular research funding because the work fulfilled the community engagement research criteria valued by the university. Due to the unique nature of the MSU and running a theatre project there, I was given the vice-chancellors community engagement award for 2012; and twice I arranged to bring MA students to experience the practice. Snyder-Young (2013, p.27) problematises assumptions of goodness in applied theatre practices, highlighting how applied theatre practitioners seldom name what they gain such as 'status, job security, profile in the field, grant money … these, too, are *real* things that artists *get* … they do not benefit project participants and do not help make the world more just' (original emphasis). As a white South African woman who grew up during the height of apartheid and benefitted and continues to benefit from my whiteness, I need to confront the fact that I personally gained a great deal from project in the hospital. The patient-participants will either stay in this or another hospital for a long time or return to homes in poor, under-resourced areas. The theatre project intervention was unable

to change anything structurally. But by documenting these participants' theatre work within forensic psychiatry I intend to argue for the positive impact of collaborative artistic spaces within mental health settings, outside of a therapeutic framework that facilitates the potential and capability of people diagnosed as mad. The institution is oppressive for everyone within it in one way or another. By finding the human across the hierarchy, through creative ways of relating, the oppressive rigidity of the institution is gradually eroded too. All participants in the theatre playground are seen and *recognised* as part of, and contributing to, culture. Such recognition is often eroded in mental health settings and spaces need to be actively fostered for the type of visibility which embodied, creative, improvisational theatre provides.

3 Locating madness: historical, cultural and political perspectives

'The notions of madness and abnormal psychology as we understand them are particular and peculiar to our culture and our time' (Parker et al.1995, p.1).

The concept of madness and the institution of psychiatry discussed in this chapter are located within an historical, cultural and political realm. This chapter engages with key thinkers that situate psychiatry as a cultural institution that shapes how madness is understood and treated. In the case of FEH, the institution of psychiatry is the dominating framework while the theatre project in the hospital is the space where, within the institution, theatrical performance creates something new. Psychiatry, as a hegemonic institution, is juxtaposed with the conceptualisation of a theatre playground that embodies Vygotskian understandings of development. The theorists (Goffman and Foucault) who problematise psychiatry as an institution, turn the gaze of madness away from the individual towards institutions and discourses that construct and talk about madness (Fee 2000; Parker et al. 1995). The reorientation of this gaze provides an 'angle of repose' through which to observe the theatrical playground as a transgressive, resistant alternative to the institution.[15]

Part of a critical approach involves making visible the discursive strategies that have been used to name mental disturbances, from 'lunatic' to 'mad' to the current term 'mental illness', which locates madness in direct relation to a disease model: a model that has been criticised for treating mental disturbances as purely biological when the scientific basis for this is highly contested (Moncrieff 2010). Rather, such discourse can be regarded as a political strategy to depoliticise and decontextualize madness. Moncrieff (2010, p. 381) shows how psychiatric diagnosis, far from being a neutral, objective pursuit, is deeply embedded in social norms and contexts and functions as a political device:

> By purporting to indicate the presence of an objectively identifiable bodily disease, psychiatric diagnosis is able to re-designate social problems as medical ones, and the social responses to those problems as medical ones, and the social responses to those

[15] Richardson and Adams St Pierre (2005, p.963) use the image of a crystal that rather than triangulation to achieve research validity. 'Crystals are prisms that reflect externalities and refract within themselves creating different colors, patterns, and arrays that cast off in different directions. What we see depends upon our angle of repose'.

> problems as medical treatment. By concealing the political nature of the responses to the situations that are labelled as "mental illness", psychiatric diagnosis prevents these problems from being questioned and scrutinized.

Psychiatry is unique within medicine as it is the only branch that can legally compel treatment against a person's wishes. This directly links psychiatry with regimes of power and social control.[16] Some scholars and activists therefore reject the term 'mental illness', adopting a Foucauldian strategic reversal of power by using the term madness instead (Menzies, LeFrançois & Reaume 2013). The reclaiming of the term madness is a tactic within mad activism or mad pride (discussed in chapter four) to make visible the social, cultural and political identities that exist beyond a medicalised category (Lewis 2006). The reclaiming of the terms mad and madness is also used by activists as a way of 'affirming psychic diversity and repositioning "madness" as a quality to embrace', thereby refusing the associations with tragedy and weakness (Burstow 2013, p.64). Where appropriate, I adopt the term madness as a way of locating the notion of madness as a flexible concept, which shifts over history, culture and context and which is not reified within a medical model. When I use the term mental illness it is due to the context of the discussion where the content fulfils a more medical model approach.

I refer to two major theorists who analyse the institution of psychiatry to discern how power and control are exercised within the contradictory aims of care and confinement: Michel Foucault and Erving Goffman. A discussion about the performance and performative possibilities of the mad body with/in a psychiatric institution, is not possible without reference to Michel Foucault's writings about madness and the regulatory, internal controls that emerged with the advent of the asylum and modern psychiatry and (in the early twentieth century) psycho-analysis. Foucault interrogates the power structures and internal disciplines that the medical gaze legitimises as a benevolent approach to treating madness, which has - and continues to - create a binary opposition between rationality and irrationality and is set up to constantly survey and control the irrational.

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[16] In most parts of the world psychiatry is given legal rights to treat people without their consent. In forensic psychiatry the element of social control is extended to a medico-legal framework in which the court orders a forensic psychiatric facility to treat a mentally ill offender and reduce the risk that person poses to themselves and wider society.

Approaches to treating madness from the late nineteenth century onwards laid the foundations for the development of abnormal psychology and psychiatry. These approaches were imported to South Africa in the late nineteenth century by the British, who established South Africa's first hospitals to treat madness. These ideas will be expanded on later on in this chapter in relation to Erving Goffman's pioneering ethnographic study in a Chicago asylum in the 1950s. I elucidate how Goffman's findings about the domesticating function of the Total Institution hold true in a South African hospital today. Goffman's work on *Asylums* (1961) preceded Michel Foucault's, yet both theorists are considered complementary as both consider power and how it operates to regulate people's behaviour (Hacking 2004): '[T]he two theorists share a considerable amount of common ground with respect to the normalisation of order and the routine everyday ubiquity of power, its mundane invisibility' (Jenkins 2008, p.158). I start with the work of Foucault as it offers an historical overview of how madness has been viewed and changed over time to consolidate power within self-surveillance. I use Foucault's discussion of moral therapy to highlight how moral therapy manifested within the racially stratified treatment offered at the Grahamstown Asylum in the early twentieth century: a treatment that included watching plays as part of recreation and the fostering of a calming environment for the white elite.

Hacking (2004, p.278) notes how Foucault's work is directed at 'entire systems of thought' and is therefore more abstract and top-down, whereas Goffman's work is empirical and therefore more 'bottom up' in its analysis. Consequently, I move from Foucault to Goffman – from a philosopher to an ethnographer. Goffman's conceptualisation of the asylum as a Total Institution is valuable in helping me understand what he calls the relationship structure of the hospital in this study, thereby facilitating my interpretation of the oppressive nature of the hospital and how it relates to the freeing space of the theatre playground. I foreground the work of Goffman and Foucault as part of the lineage of contemporary critiques of how madness is treated within psychiatry, which includes scholarship and activism around the oppressive myth of the disease model.

Michel Foucault and madness

Michel Foucault's first book *Madness and Civilisation: A History of Insanity in The Age of Reason* ([1967]/2010a) is an important catalysing text for scholarship surrounding knowledge and power in relation to a history of madness. It is also the book that established the major themes in Foucault's thinking, in the linking of power, knowledge, and confinement. Foucault argues that our current approaches to madness need to be understood within historical cultural production that separates reason (as something good) from unreason, as something that needs constant surveillance and policing (Parker et al. 1995). Foucault exposes the myth of the enlightenment in that 'the reason that was supposed to liberate us has itself become the primary instrument of our domination' (Gutting 2005, p.76).

Foucault's narration of the history of madness, from the classical period of the seventeenth century towards the Enlightenment/Modernity of the eighteenth and nineteenth centuries, links madness to morality. However, Foucault (2010a; 2008) demonstrates how physical confinement and restraint were subsumed within tactics of power, 'a tactical arrangement that enables power to be exercised' (Foucault 2008, p.6). 'Madness will be punished in the asylum even it if is innocent outside of it. For a long time to come and until our own day at least, it is imprisoned in a moral world' (2010a, p.256). Foucault charts the shift from the classical period of the seventeenth century, when mad people were conceptually separated from the human world and associated with animals. This was the age of the 'great confinement' in France and across Europe, where the insane were locked up with the poor and deviant. During this period, Foucault maintains that the confining of social deviants was to enforce bourgeois norms of labour, family and religion through the portrayal of the deviant as lacking reason. He argues, for example, that the sole purpose of the Hôspital Général in Paris during the second half of the seventeenth century was one of order, and the prevention of laziness to ensure constant labour needed as part of an economic strategy (Foucault 2010a).

Foucault notes that until the end of the eighteenth century in Europe, the mad were not even seen as sick but due to their animalistic quality were physically separated from society through confinement and isolation from everyday life. The birth of the asylum, through the

liberation of the mad from chains and cruelty in penal institutions, marks the birth of a modern therapeutic view in the eighteenth and nineteenth century in which the mad were no longer associated with animals, but became *moral* offenders. Their treatment operated through the mad person's fear and guilt about their own condition resulting in the necessity to reform their attitudes and behaviour (Gutting 2005, p.73). Foucault demonstrates how the history of understanding madness in the eighteenth century culminates in the internalisation and responsibility for treatment and cure in the patient himself, through 'moral therapy'. Following the supposedly humane liberation of mad people from chains in prisons in the seventeenth century, Foucault argues that systems of power and discipline evolved to ensure that the madman (his term) became morally responsible for his own punishment and treatment. Systematising the responsibility for his/her own cure onto the mad person resulted in an internalisation of punishment connected to self-discipline, replacing the whips and chains of the prison. The former was ensured through fear about consequences of bad, or irrational, behaviour. The contemporary manifestation of such fear is seen in Behaviour Modification Programmes (BMPs), a system of reward and punishment that is common in most forensic psychiatric institutions.[17] Foucault cites examples from Samuel Tuke, who established a Quaker Retreat in 1796 for mad people in York which served as 'an instrument of moral and religious segregation' (2010a, p.143), and as a founding model for asylums around the world. Foucault (2010a, p.233) recounts Tuke's narrative of a 'maniac' whose chains were removed:

> He was taken to his room; the keeper explained that the entire house was organized in terms of the greatest liberty and the greatest comfort for all, and that he would not be subject to any constraint so long as he did nothing against the rules of the house or the general principles of human morality.

Foucault concludes that 'Tuke created an asylum where he substituted for the free terror of madness the stifling anguish of responsibility; fear no longer reigned on the other side of the prison gates, it now raged under the seals of conscience' (2010a, p.234). Fear thus becomes the basis for control – madness would no longer cause fear in others but would itself be afraid. Samuel Tuke is remembered for demonstrating how the insane could be managed

[17] See Holmes (2005), Hörberg & Dahlberg (2015) and Jacob & Foth (2013) who discuss behaviour modification programmes in relation to Foucault. I draw on these writings in chapter two.

without cruelty or restraint, heralding the reform of the treatment of the insane. Andrew Scull (1993), a prominent scholar on the social history of madness, critiques much of Foucault's narrative of approaches to madness as historically inaccurate. He does however provide support for the supposed benevolence of Tuke as a strategy inducing control and conformity to bourgeois values:

> From its architecture to its domestic arrangements, the Retreat was designed to encourage the individual's own efforts to reassert his powers of self-control. For instead of merely resting content with the outward control of those who were no longer quite human (which had been the dominant concern of traditional responses to the mad) moral treatment actively sought to *transform* the lunatic, to remodel him into something approximating the bourgeois ideal of the rational individual (Scull 1993, p.99).

Tuke and Pinel are recognised as the founders of moral therapy, in which the relaxing, attractive environment of the asylum itself is the cure. Victorian psychiatry, which was imported to South Africa, believed that controlling the environment, from the location down to the colour of the curtains, would result in the building and 'moral architecture' of psychiatry becoming the instrument, as well as the place of cure (Showalter 1987, p.33). Patients were distracted from negative thoughts through recreational activities such as sports, crafts, farming, and entertainments (including theatre and dances) within the calming environment of the asylum which, du Plessis (2013, p.103) notes of the Grahamstown Lunatic Asylum in the late eighteenth century, was aesthetically planned and 'cheerful' in both interior and exterior design. At the York Retreat, a family-like environment was encouraged, and the Tuke family would often dine with the patients (Foster 2014). Overall, moral therapy required the patient to adapt to, and to display the behaviour of, a rational, civil person as determined by prevailing norms of the ideal citizen. This is what distinguishes moral therapy from other examples that theorise how the physical and social environment that the patient is in can determine therapeutic benefit. Contemporary liberatory examples include Franz Fanon's experimentations in shifting the social relations within the asylum towards more collective and less hierarchical relations of care in colonial Algeria and Tunisia in the first half of the twentieth century (Gibson & Beneduce 2017); and recovery-models of mental health. These examples are explored in more detail in chapter four.

I turn now to the specific ways in which the asylum was imported to South Africa and how treatments developed along racial lines. This also introduces the history of Fort England Psychiatric Hospital, which started as the Grahamstown Lunatic Asylum in 1875.

The birth of the asylum in the Cape Colony

Within the history of the development of western based asylums in colonial Africa, Shula Marks (1999) points out that sub-Saharan Africa's asylum history is different from the European history as there is no evidence of a 'great confinement' on the scale that occurred in Europe. While Foucault links the rise of the asylum with the industrial needs of European society, Marks (1999, p.271) argues that the asylums established in the Cape Colony in the late nineteenth century were governed by a different set of circumstances which 'bore little relation to the labour and social demands of industrialising South Africa'. A ready supply of labour, argues Marks, was more effectively provided by an oppressed black work force. The Cape asylums that were established were modelled on the British model of therapy and management. These included the Grahamstown Lunatic Asylum (1875) as South Africa's first dedicated hospital for the mentally ill and which was later renamed Fort England Hospital; Port Alfred (1888) established as a result of overcrowding in Grahamstown; Valkenburg in Cape Town (1891); and Fort Beaufort (1894), the Colony's first black-only asylum. Except for Valkenburg, all of these asylums in the Cape were either converted prisons or military barracks and therefore built on sites of established power and control (Sukeri, Alonso-Betancourt & Emsley 2014).

The history of Fort England Hospital as the site of this case study suggests an application of moral therapy along colonialist racial lines preceding its establishment as a whites-only institution in 1908.[18] The application of moral therapy was characterised by differentiated treatment according to the race, gender and class of the patient. For example, black women were not permitted to go on daily walks as it interfered with their laundry work. Black men were expected to carry out hard labour such as farming, something that was not expected of white men (Swartz 1995; Marks 1999). Swartz' research notes 'the emergence of a distinctive

[18] The intersection of psychiatry with colonialism is discussed in more detail in chapter four.

colonial psychiatry which determined the treatment of black patients for much of the twentieth century' (1995, p.400). Marks (1999) points out that the development of a racialised psychiatry was not necessarily uniform and systematic. Much like the Victorian asylums of England and Scotland, classification based on social status was applied, and then became racialised as segregation became wholly accepted as normal by the South African settler population. For example, Showalter (1987, p.34) notes that in Victorian asylums in England and Scotland 'lunatics were to be classified and segregated according to the nature of their disorders, but also according to their social class and sex'. In the South African context of colonial segregation, a 'particularist vision of the world' emerged within South African psychiatry for the rest of the twentieth century, whereby racial characteristics were attributed to nature and therefore could legitimise social inequalities (Marks 1999, p.286). When the Grahamstown Lunatic Asylum/Fort England Hospital was reserved for white patients, the Medical Superintendent at the time, Dr Thomas Greenlee, sought to ensure that the asylum was attractive to middle class and private patients. The economic context of depression following the South African War (1899-1902) played an important part in Greenlee's strategic collection of income from private patients and publicising the asylum directly to the white population (Marks 1999). He made an appeal in 1904 for the separation of white and black 'lunatics' (Sukeri, Alonso-Betancourt & Emsley 2014). Greenlee viewed Philippe Pinel's legendary liberation of the mad from chains at Bicêtre Hospital 'as positively saintly in halting cruelty and restraint of patients' (du Plessis 2013, p.124). For Foucault (2008), the discipline, order and regulation required within the asylum (which was further differentiated in South Africa according to race), was necessary for the medical gaze and the authority of medical knowledge: an arrangement that continues to this day.

The application of moral therapy included certain artistic activities. Swartz (1995, p.411) discusses how ideal treatment in the early twentieth century in asylums in the Cape Colony 'came to consist of regular and routine employment doing asylum work such as farm work, laundry, sewing, sports such as cricket and football, indoor games such as chess, draughts and card games, *plays, dances*, and excursions' (emphasis mine).

As there was a direct importation of asylum management and the implementation of moral therapy from Britain, it is likely that theatrical productions by staff or other groups did occur.

The literature from the South African context is unclear as to whether patients put on plays; however, du Plessis (2013) notes that as part of Greenlee's agenda to create a positive public image for the middle classes (that is, white people), members of the Grahamstown community would come to the asylum to perform. Greenlee wished to de-stigmatise mental illness and narrow the gap between 'normal' society and patients, whom he wished to be understood by the wider community as similar to themselves (du Plessis 2013).[19] Plays performed *for* patients by people who entered the institution from outside remained a feature of moral therapy and continued into the twentieth century as psychiatry and psychology developed. For example, Bethlem Royal Hospital in England (the original Bedlam) built a hall with stage and dressing rooms in 1896, which was used by outside companies for dances and for performances by staff for their families (Alleridge 1997).

Theatrical production in British asylums

Juliet Foster (2014) has written a comprehensive account of the various uses of theatrical production in Victorian and Edwardian asylums in Britain. Her archival research indicates an increasing number of amateur dramatic companies who included the asylum as part of their touring itinerary. Farces and music hall performances were regularly performed at asylums, including minstrel entertainments such as 'Jake the Naughty Nigger' performed by the 'Wandering Dodo Amateur Minstrels' at Bethlem in 1887 (Foster 2014, p.48). There is also evidence of staff putting on productions for each other as well as for the benefit of patients. There are some instances of patients putting on theatrical productions, particularly in Scottish asylums. However, the distinction between rational and irrational was maintained as there is little evidence of mixing of staff and patients, either as performers on stage or as audience members. This separation reinforced the overarching rationale of 'moral management', whereby those with rationality might gently care for those whose rationality was impaired. Harpin (2013) notes how a mixture of care and cruelty dominates narratives about asylums, and a historical reading needs to navigate stories of 'humanitarian intervention' with 'a story of domination' (Reiss 2008, cited in Harpin 2013, p.337). In her

[19] This attempt to breakdown the division between mad and sane distinguishes moral therapy from the development of psychiatry as a medical speciality after the world wars. Goffman's work shows how the separation of inmates from wider society is a key characteristic of the totalising nature of the Asylum.

examination of the theatrical history of Broadmoor hospital in London, Harpin (2016) documents the shift from performances by external theatrical companies in the late nineteenth and early twentieth century at the hospital, to the establishment in 1945 of The Broadhumoorists which was ‘a theatrical troupe comprised of patients for the purposes of recreational therapy. The company performed annually for staff, patients and the public from 1945 to at least the mid -1990s’ (p.585). She documents how the type of productions done (predominantly comedy and farce) ensure that patients avoid any risky emotional material, thereby highlighting the paternalistic nature of the institution. Harpin (2016, p.588) shows how ‘through cultural activity patients were invited to engage with social scripts of normalcy’. This example shows the type of play that is permitted within certain hospital contexts, and that which is deliberately excluded, reinforcing the potential domesticating consequences of certain types of theatre that are intended to instil particular behaviours as normal and acceptable:

> [O]ne encounters the paradox of artistic practice at incarcerated sites. It is at once both salutary and humanising that theatre forms an active presence in the total institution, and yet the tightly defined limits of acceptable play render the cultural life somewhat hollow and infantilised (Harpin 2016, p.586).

Broadmoor hospital is also the site of one of the first and widely cited experiments of the use of Shakespeare in prison contexts. Murray Cox’s *Shakespeare come to Broadmoor* (1992) is widely regarded as one of the first texts to examine the use of theatre within prisons. It involved professional actors from the Royal Shakespeare Company who performed Shakespeare productions for patients and staff at Broadmoor during the late 1980s and early 1990s. The book documents actor’s, director’s and some staff member’s experience, but no in-depth views from patients. Although references are made to wishing to rehearse Shakespeare plays with patients, there is no documentation of this happening. However, Harpin (2016) suggests that the prestigious introduction of the Royal Shakespeare Company to perform tragedies at Broadmoor marks a significant shift in acknowledging that patients are able to manage more emotionally challenging material. This project was enabled by the rise in drama therapy and the recognition of the value of the arts in healing. Harpin argues that although patients did not themselves perform Shakespeare with the actors, their engagement with the actors through workshops and witnessing productions marks a shift

towards acknowledging the ability of forensic psychiatric patients to engage with complex human emotions and experiences.

The introduction of theatrical encounters in asylums highlights the ways in which theatre can be co-opted into the regimes of control within the institution (such as part of the domesticating intentions of moral therapy) as well as ways that theatre can challenge assumptions about patients towards experiences that showcase capability and ability. However, the association of madness with a medical model has produced a far less humanising approach to those who suffer madness. Leader (2011) argues that *unlike* psychiatric practice today, the proponents of moral therapy genuinely listened to people's different experiences of madness. The next section addresses the political implications of the medical model when addressing madness as mental illness.

Psychiatry as biomedicine: the political implications of a scientific model

Foucault argues that the centralisation of the medical gaze in the asylum reached its climax in the conversion of the asylum to a medical space, in which the physician held absolute authority over entry through the issuing of certificates. Parker et al. (1995, p.7) notes that up until the early part of the twentieth century, madness was not associated with disease, and therefore the interventions by physicians were 'little more than helpmates of moral improvement'. Rather, the asylum doctor's role as a physician was more psychological, as he was expected to find ways of appropriately occupying patients through diverse experiences.

The identification of madness as mental illness is, according to Foucault, not a result of scientific discovery, but a means to justify the continuing authority of physicians in the asylum (Gutting 2005). The moral therapies of men such as Pinel and Tuke did not necessitate medical personnel. As the nineteenth century developed, medicine became dominated by the ideal of objective, value-free knowledge, which left no room for value-laden moral therapies. This results in madness becoming an object of a medical gaze and 'objective' positivist enquiry (Fee 2000).

Docile bodies and theatrical embodiment

Foucault's persuasive historical account of how the mad are treated reinforces his argument for the indissoluble relationship between power, confinement and knowledge. He demonstrates how a person's social body is regulated through a complex system of surveillance, which controls space, time and activity.

This raises the question of the significance of a collective embodied theatre practice in relation to the ongoing politicised disciplining of bodies within the institution. In the prison and the hospital, inviting participants to use their bodies in creative, spontaneous ways, became central to the practice as a means of overcoming the docile, institutionalised bodies that are required within these institutions. At FEH I was struck by the passivity of patients in wards: either lying down, sleeping, or sitting watching television – the most docile of 'docile bodies', a term defined by Foucault (2010b, p.182) in *Discipline and Punish* as 'bodies that not only do what we want but do it precisely in the way we want'. For Foucault a docile body is produced through the disciplinary regime of surveillance and the system of reward and punishment. Foucault (2010b, p.180) states that '[a] body is docile that may be subjected, used, transformed, and improved'. The visits to the wards and my fairly minimal experience of ward rounds highlight three tactics Foucault identifies as producing docile bodies (2010b, pp.189-204): through 'hierarchical observation', which is the process of controlling someone by merely observing them, a surveillance that operates throughout the hospital. The second, 'normalising judgement', operates as the continual threat of being judged abnormal in which 'individuals are judged not by the intrinsic rightness or wrongness of their acts but by where their actions place them on a ranked scale that compares them to everyone else' (Gutting 2005, p.84). At FEH this is expressed through rewards associated with progress through to different wards and the three levels associated with the behaviour modification programme. The third tactic Foucault names 'examination', which combines the first two to consolidate power. In the FEH context these records are held in a case file for each patient: records that materially represent the patient's fate but to which the patient is never privy. The ethics forms and procedures approved for this study also contribute to the patient's ongoing assessment. Is the patient, as observed by a clinician, able to consent to participate in the research? Examination 'both elicits the truth about those (patients, student, job candidates)

who undergo examination and, through the norms it sets, controls their behaviour' (Gutting 2005, p.87).

In inviting participants to play with the institution within the theatre space, we are by extension playing with the three surveillance tactics that Foucault identifies as producing docile bodies. For example, when a participant re-enacts their version of the LOA process, and plays a psychiatrist clutching the file containing all of the patients' assessments, they are not only embodying a position of absolute power within the total institution, they are also inverting the consolidation of that power within the 'examination' process by rearranging it on their own terms. The disciplining of patients through various means of surveillance is experienced corporeally, manifesting in passivity and dependency on other people with more authority to tell one what to do. The removal of these layers of surveillance, such as types of watching and judgement associated with reward and punishment, within the theatre playground, invites a more holistic engagement with embodiment and embodied relations. The permission to play with our bodies and modes of expression that are sometimes not rational or ordered is embraced by participants, as is practicing performances associated with cultural expression: rituals, songs and dances.

The theatre practice engages creative embodiment among men, many of whom have violated the bodily integrity of others. The former's bodies are then subjected to disciplining throughout their incarceration within an institution that treats minds and bodies discretely. Whereas theatre, as an embodied creative practice, foregrounds the centrality of our bodies and offers people who experience madness an experience of corporeality that disrupts the body mind separation: a separation that is harnessed to legitimise a medical approach to madness, which renders psychiatric diagnosis and treatment into a political process.

The politics of psychiatric diagnosis and treatment

The word psychiatry originated in Germany in the nineteenth century. The suffix '-iatry' is derived from the Greek *iatros* meaning physician (Fernando 2010). Psychiatry officially became a branch of medicine following the treatment of shell-shocked soldiers during the First World War (Burns 2006). It developed as one type of medical speciality within a western scientific tradition in which diagnosis is linked to a biomedical model of illness (Fernando

2010). However, in the decades following World War Two, psychiatry suffered a series of challenges. These included the success of the talking cures that were increasingly offered by psychologists, social workers and counsellors (who by the 1970s in the USA had successfully fought to practice independently of medical supervision). The anti-psychiatry movement also highlighted inhumane conditions in psychiatric hospitals such as the abuse of anti-psychotic drugs viewed as 'chemical straight jackets' (Moncrieff 2013, p.2), and invasive treatments with debilitating side effects such as electro-convulsive therapy and brain surgery (Whitaker & Cosgrove 2015). A professional crisis was averted in the 1980s when the bio-medical model of mental illness won the argument. With financial backing from pharmaceutical companies, who have vested interests in a bio-medical model, it was argued that psychoactive drugs were the best way to treat mental illness. This coincided and concurred with the launch of the third edition of the *Diagnostic and Statistical Manuel III* (APA DSM 3 I985) which is now in its 5th version (*Diagnostic* 2013) [hereinafter DSM]) and is used internationally along with the International Classification of Diseases (1989). These are the only recognised sources for diagnosing mental illness. The shift in language in these manuals to 'disorders' with 'symptoms' legitimises the move from psychoanalytically oriented explanations of madness to scientific and biologically based ones.

The DSM is the standard diagnostic manual for all clinicians adopting a westernised model of classifying mental illness, including psychiatrists and psychologists in South Africa. The manual has been the subject of much criticism for its tendency to universalise symptoms and advocate a bio-medical disease model of diagnosis and treatment. Its positivism and focus on the individual cannot take context into account. Many critics point out that diagnosing people's behaviour is a political, value-laden business, as is evidenced by notorious examples such as the inclusion of homosexuality (until 1973) and pre-menstrual syndrome (until 1986) as mental disorders in the DSM (Gilman 2014). The current DSM-V (2013) has been criticised for pathologising a range of what were previously considered normal human emotions, such as grieving, rebellious features of teenagers; and for further extending the reach of psychiatry and drug-taking into daily life:

> The DSM has enormous impact on the public health. It determines which conditions insurers will cover, which drugs regulators will approve, which children will receive

> special-education services, and which criminal defendants will be able to stand trial and, in some cases, how they will be sentenced (Greenburg 2013, p.4).

Whitaker and Cosgrove describe the DSM as a political document that serves the interests of psychiatry as an institution. 'Adopting a disease model would lead to a focus on treatment that allayed symptoms and it would only be psychiatrists, thanks to their prescribing powers, that would provide patients with access to psychiatric drugs' (2015, p.21).[20] Harpin (2018, p.5) summarises the political relationship between psychiatry and the DSM:

> One of the dominant structures of thinking in contemporary society as made manifest in DSM is categorical, fixed, and authored by a homogeneous, privileged group. In highly problematic ways, then, its systemic and notational performance of objectivity serves to obscure the implicit and explicit influences on these 'objective', 'stable' criteria, criteria that profoundly impact the life-paths of people.

It is true to say that twenty-first century psychiatry is dominated by a biomedical model of illness, sometimes called biopsychiatry, that is backed by the pharmaceutical industry. Treatment is primarily with drugs 'with social and psychological intervention as adjuncts to drug therapy' (Fernando 2010, p.56).

Foucault (2008), explicating his ideas on the nature of power within the asylum, concludes that rather than power being held exclusively by the physician, power is spread relationally through a network of professional staff. This model is very evident at FEH, where the psychiatrist is at the top of a hierarchy of treatment within the multi-disciplinary team of psychologists, social workers, OTs and nurses.

In Foucault's later writings on *Psychiatric Power* (2008, p.2), he likens the organisation of time, activities and actions that regulate life in the asylum as 'an order ... for which bodies are only surfaces to be penetrated and volumes to be worked on, an order which is like a great nervure of prescriptions, such that bodies are invaded and run through by order'. Foucault

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[20] The ongoing relationship between 'Big Pharma' (the term used to describe the hegemonic control of pharmaceutical companies) and psychiatry is in continuous question and critique. Several scholars highlight the ways in which the pharmaceutical industry creates diagnostic categories resulting in drugs defining illness (Burns 2006; Leader 2011; Mills 2014; Moncrieff 2013; Whitaker & Cosgrove 2015). This is a large area of study and critique but is beyond of the scope of this thesis.

argues that the modern psychological approach to inner transformation is a move to control bodily behaviour by disciplining bodies to conform. In relation to forensic psychiatry, where 'mental health care users' are both prisoners and patients, Holmes and Murray (2011, p.296) demonstrate how Behaviour Modification Programmes co-opt all staff into a level of surveillance and control which they conclude is unethical:

> From a Foucauldian 'top-down' systemic perspective, practitioners such as psychiatrists, psychologists and social workers and nurses might be understood as bolstering state apparatuses by implementing and providing crucial power/knowledge in order to shape and transform human material. As such health care professionals working in forensic psychiatry settings are directly involved in what Foucault calls the discipline of individuals at the atomo-political level (at the level of the body).

Fernando (2010) and Moncrieff (2010; 2013) emphasise the differences between a diagnosis for a bodily illness and for a mental illness, and the social implications of this. For bodily illnesses, a physical examination is undertaken, whereas for mental illness, the patient's mental state is scrutinised by examining thoughts that are shaped through speech. This is because, despite decades of research, there is minimal biological evidence for many psychological disorders, supporting Foucault's view that the shift from madness to mental illness is a move of power to secure the authority of the psychiatrist. Schizophrenia, for example, one of the most prevalent diagnoses in forensic psychiatry, is still framed as a neurological disease and treated with anti-psychotic drugs, yet '100 years of research has failed to produce evidence of any defect in the structure or function of the brain or any other part of the body that is specific to schizophrenia' (Moncrieff & Middleton 2015, p.2).[21] Making a diagnosis by observing behaviour and speech can never be objective and value free.

The resultant biomedical treatment model separates the mind and the body and erases possible environmental sources of distress (such as poverty and violence), elevating the use of psychiatric drugs as the primary and sometimes the only mode of treatment. In South Africa psycho-pharmaceuticals are the main source of treatment (Emsley 2001). By locating what needs 'fixing' within individual pathology, broader structural issues such as gross

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[21]This is a central point in Thomas Szasz *The Myth of Mental Illness* (1961), which I discuss in chapter four.

inequality along gender, class and race lines, which directly impact upon people's well-being, are elided as part of what needs changing. Madness becomes depoliticised. Yet when the patient profile of Fort England Hospital is examined, it shows that the majority of patients are men from poor backgrounds with a very low level of education. 'This is not to claim that mental health and mental illness do not exist. Only that they are so categorized because of how we imagine madness' (Gilman 2014, p.441). When madness is imagined through a biomedical lens, it becomes individualised and decontextualised. Fernando (2010, p.35) argues that:

> psychiatry is ethno-centric and carries in it the ideologies of western culture including racism … the practice of psychiatry including its ways of diagnosing, is influenced by the *social ethos and the political system* in which it exists and works (emphasis mine).

It has long been observed in Britain and the USA that black patients are more likely than white patients to be diagnosed with schizophrenia (Fernando 2010; Barnes 2013). Metzl (2010) highlights the link between institutional racism and a schizophrenia diagnosis by exploring how the political context of the civil rights movement in the USA in the 1960s and 1970s directly led to schizophrenia being associated with angry black men and the subsequent pathologisation of protest as mental illness. The use of mental illness for social and political control is well documented: from the diagnoses of hysteria in women (discussed in chapter three) to the lifetime psychiatric incarceration of Dimitri Tsafendas, the man who assassinated the architect of apartheid, Prime Minister Hendrik Verwoerd in 1966.[22]

Forensic psychiatry often operates in ways similar to police and prisons and is therefore aligned with other institutions of social control (Sashidharan 2001). Fernando (1998) highlights how issues surrounding the disproportionate incarceration of people of colour in prisons internationally are found in forensic psychiatry: '... based on general impressions, forensic psychiatry and the criminal justice system are jointly involved in law and order, especially when issues of 'race' are involved' (Fernando 1998, p.xv).

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[22] Harris Dousemetzis' (2018) detailed account of the life of Dimitri Tsafendas shows that his assassination of Verwoerd in parliament was a deliberate political act against racism. However, the apartheid state declared him schizophrenic, unable to stand trial, and he was incarcerated in various psychiatric hospitals until his death in 1999. This was a far more palatable way for the state to respond to the murder of Verwoerd – by a madman- rather than someone committed to ending apartheid.

Foucault argues in *Discipline and Punish* ([1977]/2010b) that the disciplinary control developed for modern prisons became the model for discipline in all other avenues of society. He names prisons, asylums and hospitals as institutions that practice disciplinary regimes within society. In both *Madness and Civilisation* ([1967] 2010a) and *Discipline and Punish* ([1977] 2010b),

> the rise of rationality should be read as the legitimizing of power rather than as a challenge to it. This collusion of knowledge and power created institutions of disciplination – schools, prisons, reformatories, psychiatric facilities – which, though often promoted in the name of "improvement" in reality consolidated administrative authority [and] bureaucratic regulation' (Jones & Porter 1994, pp. 1-2).

For sociologist Erving Goffman, 'institutions of disciplination' are 'Total Institutions' in which the total character of the institution is cut off from normal social interactions.

Forensic Psychiatry as Goffman's Total Institution

I turn now to Goffman's *Asylums* and relate his observations to similar characteristics I observed at FEH, and how these impact upon the theatre space. Sociologist Erving Goffman (1961) carried out an in-depth ethnographic study in a Chicago asylum in 1956. The study examines the culture of the mental institution and is published in the book *Asylums: Essays on the social situation of mental patients and other inmates.* This book is regarded as his most controversial work, described as 'a passionate and sensitive portrayal of people whose every movement is monitored and judged' (Manning 1992, p.106). This study led him to name institutions such as prisons, monasteries and asylums as Total Institutions: 'a closed environment where time and space is controlled' (Manning 1992, p.107):

> A total institution may be defined as a place of residence and work where a large number of like-situated individuals cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life. Prisons serve as a clear example, providing that what is prison-like about prisons is found in institutions whose members have broken no laws (Goffman 1961, p.xiv).

Asylums has been in continuous print since 1961, and the text continues to be used to understand the effects of institutionalisation. The book influenced the move to de-institutionalisation and community-based care which escalated from the 1960s around the

world.[23] Many of the aspects of Total Institution that he discusses, such as the selective allocation of privilege used to rebuild identities and reward good behaviour, are prevalent in the psychiatric hospital discussed in this study. Goffman's work provides a lens that brings the all-encompassing regime of the hospital into sharp relief and prompts me to explicate the possibilities of a space in which inmates are not continuously monitored and judged. Mac Suibhne (2011, p.2) observes that 'Goffman is not critiquing some neurochemical paradigm of psychopathology but the overall *relationship structure* within the asylum' (emphasis mine).

Goffman argues that in Total Institutions, a 'mortification of the self' occurs, a civil death in which 'recruits' lose their civilian clothes and rights. 'His self is systematically, if often unintentionally, mortified' (1961, p.24). Central to this process is the shedding of past roles and adoption of purely institutional roles, leading to what has been termed 'institutionalisation' to describe 'a set of maladaptive behaviours that are induced by the tension of living in any institution' and that include 'depersonalisation and the loss of one's identity' (Chow & Priebe 2013, p.9 & 13). Goffman regards this mortification as a means of power and control that recalls Foucault (2010b):

> Unlike accountants or lawyers who are committed to roles that define what they do, the mentally ill are committed to roles that define who they are. As a result, the mentally ill are subjected to a 'discipline of being' obligating them to act in certain ways (Manning 1992, p.112).

I argue in chapters six and seven that one of the significant aspects of the theatrical playground is the opportunity to reclaim past roles, often associated with family and cultural traditions, as well as playing with future roles beyond hospital life. Some theatre forms facilitate the interruption of the pathologising gaze and surveillance that defines how people are related to in the hospital. Within improvisation, which is the dominant mode of play within the theatrical playground, the self is invited to be in a continual state of becoming. The invitation to engage with the unpredictable disrupts the 'discipline of being' that both Foucault and Goffman theorise as integral to the Total Institution.

[23]Chow and Priebe (2013, p.1-2) highlight how the widespread deinstitutionalisation of psychiatric patients is concurrent with the civil rights movement in the USA, as well as advances in the effects of antipsychotic drugs and the high cost of inpatient hospitalisation.

At FEH the contradictory ideals of therapeutic care and incarceration are manifested through disciplinary procedures such as a Behaviour Modification Programme 'which control and mould a patient's behaviour, expression and action' (Holmes & Murray 2011). This system of reward and punishment and the continual threat of demotion dominates the surveillance of the patient. Goffman argues that control through the attainment of privileges is as harmful and threatening to the personal identity of the patient as the mortification of the self, as a person must try to maintain self-respect while gaining access to small privileges (Manning 1992).

The Behaviour Modification Programme at FEH (hereinafter referred to as BMP) organises how patients progress through the system towards discharge or a transfer to another hospital. Every patient enters the hospital at the lowest level (C) and must behave his way to level A. The process of moving from level C to B to A takes a minimum of two months. The withdrawal of privileges at FEH includes further restrictions on freedom of movement to attend programmes or activities outside the ward such as gym, attending OT programmes, buying from the tuckshop and visitation rights, and when in level C, having to wear FEH issued blue pyjamas all the time – purportedly in order to identify them as level C patients. The standard day uniform is beige top and trousers with embroidered 'Fort England Patient' across the back. But such costuming is not an innocent sign. As it appeared to my eyes in the hospital, men in pyjamas during waking hours are set apart from their fellows - marked both as not part of everyday life and in need of extra care and surveillance. The costume both infantilises the individual and emphasises his status of being extra 'bad' and sick, thereby exacerbating stigma.

Within FEH, there are on-going debates about the BMP and what its actual effects are. While the mandate of a psychiatric institution involves rehabilitation by fostering agency to make appropriate choices outside of the hospital, mostly, behaviour modification programmes demand silence and surrender. Patients are given virtually no choices or opportunities to adapt to diverse situations. As psychologist Lauren observed during her interview with me, someone is perceived as a 'good' patient if s/he is silent and conforming (Lauren 2015). A patient therefore learns to perform obedience within the hegemony of the institution.

Lauren highlighted the contradiction of trying to foster agency within patients: '*but how can you do that when you put them in pyjamas and take all their privileges away'* (2015)?'

Within the OT Department, a person is no longer able to attend OT when they are demoted. Only therapies that happen within the ward are then permitted. My interviews with the three occupational therapists who participated in the theatre group demonstrate their frustration with the system and with how a patient is denied a therapy under the guise of care and support. For example, staff-participant Thandiwe argued that a patient would never be denied psychiatric drugs during demotion, yet the OT aspect of their treatment is eliminated and therefore becomes associated with punishment. Bulelani and Thandiwe both spoke about how the BMP is misused by certain staff members to punish and threaten, creating '*an environment that is very hostile…and when they come out of demotion, they are even worse. It scares the patients into not being themselves'* (Thandiwe 2016). Thandiwe's statement echoes Goffman's observation of how fear of losing privileges is connected to the mortification of the self.

The system of BMP within the hospital negatively influences the theatre project. If a patient is demoted, he loses a ground pass which means he may not leave the ward to attend the group. This affects the degree to which the group is ever able to achieve cohesiveness and weakens the working familiarity and trust amongst participants, but the top-down authoritarianism of the hospital is so pervasive – continually undermining social cohesion and co-operation - that possibly it was only Luvuyo and I, accustomed to facilitating drama groups in less coercive contexts, who could be said to have regretted the lack of consistent attendance. Goffman (1961, p.43) argues that part of the process of the mortification of the self is to disrupt any sense that the inmate has any power or influence over the world, 'that he is a person with "adult" self-determination, autonomy, and freedom of action'. For Goffman, the sanctioning of actions and expressions such as insolence is what distinguishes the Total Institution from civilian life. By continually policing how a person expresses himself, the sense that the person has agency in the world - 'that he is an adult with self-determination, autonomy, and freedom of action' – is stripped away (p.147). Self-determination is connected with self-expression. The choice of being affectionate or sullen or angry is part of autonomy. When this is policed, such as not being 'cheeky' to nursing staff in

fear of demotion, self-determination is policed too. At the start of our weekly theatre workshop I repeatedly learnt of patients from the theatre group who were absent because they had been demoted due to insolent attitudes to nursing staff. Goffman shows how in the Total Institution of a psychiatric hospital, patients are required to monitor their expressiveness, and perform the role of 'not fully adults' (1961, p.108).

Being forced to wear pyjamas all day connects with another feature of Total Institutions: there is a deliberate breakdown of the everyday distinctions between sleep, work and play. The patient's infantilisation is therefore visually evident because he is required to enter a liminal zone that is not part of the everyday. His fall from grace is marked. Goffman observes that 'punishments and privileges are themselves modes of organization peculiar to total institutions' (Goffman 1961, p.51). Using punishment to shape behaviour is associated with inmates, animals and children and seldom applied to adults.

Goffman demonstrates how a distinct separation between staff and patients is part of the institutional logic which ensures power and control over the inmate. As a way of managing large groups of people a staff/patient divide is continually fostered. Such a divide maintains antagonistic relationships and facilitates the 'ownership' of the institution as belonging to staff. Groups of people and supervisory staff exist for each other within the system but are deliberately distinguished: staff can integrate with the world outside the institution but patients cannot. For example, I learnt from staff-participants that staff requested separate opening times for themselves at the tuck-shop so that they would not have to interact with patients. And during one of the theatre group's end of year performances, I had to ask psychologists and psychiatrists to sit with other audience members (that were patients) after they had selected seats at the side of the hall separated from the assembled audience of patients. The notion that a patient is not quite of the world is continually fostered through such subtle, and at times not so subtle, othering. For patient-participants in the theatre group, the fact that a few staff participated with them on an equal footing held significant meaning. It was one aspect of the group that all patient-participants remarked on as making them 'feel human'.

FEH seeks to control patients in multiple ways – through clothing that marks a patient and his ward, to where and when he can move and eat, what he is allowed to do with his time, to the enforced taking of psychiatric medication with its physical side effects. Sexuality is policed too – on the one hand, sexual desire and activity is understood to be part of normal healthy human functioning by psychologists and psychiatrists but in a psychiatric ward where many men stay for years, there are no spaces for these basic needs and rights to be met. There have been instances where a patient has been demoted when 'caught' masturbating in as private a space as can be found within a hospital ward. But the moral gaze of some staff polices this, whilst on a number of occasions some clinical staff informally confessed to me, the outsider, that these sanctions on normal sexual functioning are an ongoing dilemma for them.

The two occasions on which I have found myself accidently in a ward round, where a patient appears in front of the multi-disciplinary team, it appeared to be obligatory that the patient perform gratitude and subservience. Goffman refers to institutionally arranged confessions that become part of a Total Institution. To have an opinion or to be resistant in any way might result in a demotion in front of the gaze of everyone 'working' on your case. An example of this was provided by staff-participant and psychologist Lauren (2015) when reflecting on what happens when a decision to demote a patient is made during a ward round:

> *And of -course that news was not going to be welcome to the person, and it is couched within in a 'you know, we are trying to help them modify their behaviour' discourse. But there was a certain, I will use the word violence, and obviously this is not always reflected on, but there was an attitude of 'oh well this is what we are going to do' without enough time and consideration and negotiation. Or allowing the mental health care user to understand or to protest, because if there was a protest, everyone else would say 'look, we've done the right thing as a team'.*

Lauren also refers to her own sense of institutionalisation – or an acceptance of the status quo - reflecting on how critical she was as an intern during her first year working at the hospital. As an intern she had questioned the various processes at the hospital, like the BMP processes, which over time became '*like wallpaper*' and *'you stop questioning, because they just "are" which I think is dangerous'* (2015).

If self-expression is linked to autonomy that is disciplined within certain institutions to ensure conforming behaviour, a theatre space becomes an alternative site for self-expression away from the regulations of the wider institution. One of the major tensions in this and other theatre work within restrictive institutions is that theatre participants must return to the disciplinary structures of the institution as soon as they leave the creative space (Balfour 2004; Thompson 2004). Kershaw (2004, p.36) asks, 'how do the practices of drama and theatre best engage with systems of formalised power to create a space of radical freedom?' This question has particular resonance in the context of a psychiatric hospital where the systems of power are maintained through reward and punishment within the framework of care, rehabilitation, and reintegration into community structures. Theatre as an art form involves the deliberate transformation and manipulation of time, space and bodies. But in institutional settings, such as the closed ward of a psychiatric hospital, these are all rigidly controlled. The contrasts between a space of relative freedom created through play and improvisation, and the extreme restrictions of forensic psychiatry and the medical gaze are continually foregrounded in this study. In the final conceptual framework with which to understand the theatre practice, I define the theatre playground and relate the space created to Lev Vygotsky's theories relating to play and development.

Explicating the Theatrical Playground

The relationship between safety and risk in applied drama and theatre

Hunter (2008) interrogates the notion of a safe space, a concept that is often assumed as a pre-condition for applied drama yet needs to be critically engaged with. She asks if the creation of a safe space in applied drama can move beyond the feel-good factor that it brings towards broader social transformations (2008, p.10). This question is central to my practice too. At the heart of her inquiry is the role of tension and risk in creating safe spaces. Creative tension is a core ingredient in drama and theatre: tension is the driver of stories. Taking risks is a core part of improvisation – being able to step into the unknown and to open oneself (and be vulnerable) to the offers in the moment and in the space. The paradox of risk taking in most drama work (and applied theatre work in particular) is that risk taking is only possible when players feel safe to do so.

A theatrical playground invites players to take risks within the safety of a group who will support their play. Yet no playground is innocent. Risks taken can lead to differing outcomes, some negative. Playgrounds can be transgressive spaces where boundaries are tested. In our playground a patient-participant like Lunga would do everything on his own terms: when he appeared in the group, which exercises he would participate in, who he would partner with. Playgrounds are at once a microcosm of society reflecting power plays, negotiations, experimentation, relationship building and contesting, but are also potential liminal spaces that exist alongside and beyond ordinary life. Similarly, improvisation is rooted in spontaneous activity that can be liberating but also can affirm stereotypes. No practice is inherently progressive (Knowles 2010). In the FEH theatre group, members who had participated for a long time would assume authority over newer members, berating them if they did not get a game structure correct. In these moments I would become the playground monitor asking for patience so that new players could learn and make mistakes without sanction.

In play, realities may be rearranged

Peterson (2011) reflects on historical approaches that value the place of risk in child development in relation to his identification of what he names as radical playgrounds: workshop theatre pioneer Joan Littlewood's concept of the *Fun Palace* in the years following the second world war in London's East End, and the Natural Theatre Company's *Adventure Playground* in Bath in the 1970s. Peterson connects risk with notions of the radical, arguing that 'radical environments which enable risk operate on a calculus of uncertainty: outcomes may be negative or positive but what is important is the movement towards future possibilities and rearranged realities' (2011, p.387). Such future orientation and 'rearranged realities' are, I argue, the site of change, or in Vygotskian terms, the zone of proximal development (Vygotsky 1978) for participants engaging with the theatrical playground in the hospital. The site of theatrical playing disrupts the hegemony of the Total Institution and its impact on institutionalised bodies and identities. The theatre experience as playground facilitates experiences of being, beyond those imposed by the institution, and moves the theatre space towards a socially transformative possibility.

Playgrounds are spaces of potentiality in which players work within the structure of the playground to play freely as a means of exploring relationships, rules, story creation, physicality and the creative combination of all of these. A key feature is providing spaces for spontaneous actions. Within the Total Institution, spontaneity is not permitted: under constant surveillance patients need to monitor their behaviour in order to seek reward and avoid punishment. Establishing a theatrical playground within the institution but under a different gaze that is not connected to pathology, therapy, or discipline, allows a space for the spontaneous and unpredictable.

The playground and theatrical events

A theatrical playground is further distinguished by the relational exchange in roles between player and witness: or as theatrical event theorist Wilmar Sauter (2006, p.28) has posited, when player becomes performer and witness becomes a spectator:

> …there are forms of playing, which are played for someone, i.e. the spectator must be understood as a participant. If the spectator is understood as a participant, then the player is not simply playing any longer, but she or he is performing.

Sauter (2004) distinguishes between the playing culture of performance and the written culture of drama. In playing culture the performer and spectator are two partners in the performance event. A theatrical playground therefore, like a theatrical event, distinguishes the playing space from everyday life. Sauter (2004, p.11) explains that to mark an event as theatrical

> someone who does something in a different way than in regular life; on the other hand there is also someone who sees and acknowledges this difference …[T]heatre becomes theatre by being an event, in which two partners engage in a playful relationship.

This playful relationship between performer and spectator is the activity and site of change within the theatrical playground that I propose in this study.

Problematising the playground within the institution

If the playground is at all transgressive, why then is it tolerated within the institution? In some ways the theatre project was beneficial both to the participant players and the

institution. Having a project like this at FEH was advantageous as it demonstrates an innovative approach to forensic psychiatry that highlights one of a range programmes that patients can get involved in. The visual art project and the theatre project were named as examples of a recovery approach to mental health in statements such as the FEH art group exhibition information, when patients art work was displayed and sold at the National Arts Festival, and in conference papers (Nagdee et al. 2014). Both projects were driven and funded at the hospital by resources from Rhodes University. They would not have occurred or been sustained unless through voluntary contributions and access to resources. Nagdee et al. (2014, p.123) conclude that these projects at FEH are 'aligned to a holistic approach to mental health recovery while also being cost-effective in the South African context'. In such ways arts projects and therapies are harnessed superficially by institutions as examples of good practice with minimal investment by the institution. In this way the arts become co-opted into superficial discourses around care and innovation that appear to offer patients a range of options with therapeutic and rehabilitative benefit. However this public discourse supporting the arts within psychiatry does not manifest in meaningful integration, recognition or support at FEH.

There is a further argument that a project like the theatre group is a domesticating rather than a liberating space. Harpin (2018, p.578) examines the history of artistic practices at Broadmoor hospital in London and asks: 'What pressures are exerted upon arts practices in a total institution such as this? If arts form part of the fabric of rehabilitation, does this rob them of their resistive potential?' Although the FEH project attempts to position itself outside of rehabilitation discourse, a similar critique is that in providing a feel-good respite from the demands of the institution, patients feel better and are therefore pacified when they return to their wards. A critique of moral therapy concerned the conformity that was required to adopt a bourgeoise notion of a rational, middle class sensibility (Scull 1993). As Foucault (2010a) argued, moral therapy initiates a process of self-surveillance. The relaxing environment and gentle activities on offer as part of moral therapy required the adoption of a contained behaviour which requires self-discipline. Moral therapy offers a choice of recreational activities that appear to enhance agency, but these choices are in service of maintaining an inner surveillance. I argue that the theatrical playground is different in nuanced ways. In the theatre playground the collective performer-spectator-facilitator

relationships support experiments with roles and narratives about and beyond being a staff participant or patient, ill person or offender. As shown in chapter seven, patient-participants play with a range of pro and anti-social roles and moral positions. Within the space of the theatrical playground, agency is genuinely practiced as it is not bound by the regimes of the institution. While the intervention itself is bound by the weekly experience, the experience of playing with possibilities away from an illness gaze is an important liberatory process. Enabling an environment that opens up the possibilities to risk and make mistakes in a playful encounter facilitates 'the movement towards future possibilities and rearranged realities' that Peterson (2011, p.387) outlines as part of the space of radical potentiality.

The Theatrical playground as a Zone of Proximal Development

Russian psychologist Lev Vygotsky argued that learning and development are socially mediated processes. His theories on cognitive development (published in the 1930s) are based on an understanding of the social and cultural context in which they occur in which cognitive development is not a linear process (as espoused by his contemporary Piaget) but mediated socially in that higher mental functions can be enabled in a supportive social context.[24] His theories about play and its role in childhood development (1933) and enabling spaces that create, what he terms, a 'Zone of Proximal Development' (ZPD), provide a conceptual basis for understanding what is achieved in the theatrical playground and why. In creating the playground, I used conventions and techniques from theatre games, improvised drama and devised theatre that facilitate an experience of how the collective activity of theatrically playing and relating to all participants as creative, capable theatre-makers and performers leads development. This methodology echoes Vygotsky's notion of the Zone of Proximal Development (ZPD). For Vygotsky, the ZPD is a group process where, within a supportive environment, a person performs 'a head taller' than where they may be thought of developmentally:

> What we call the Zone of Proximal Development ... is the distance between the actual developmental level as determined by independent problem solving, and the level of

[24]Vygotsky's work was translated into English in 1962, but Newman and Holzman (1993) argue that it was the translated publication of *Mind and Society* in 1978 that received significant attention and established his reputation in developmental psychology.

> potential development as determined through problem solving under guidance or collaboration with more capable peers (Vygotsky 1978, p.86).[25]

Vygotsky's writings about the role of play in the development of the pre-school child argue that learning (through play) leads development (Vygotsky 1976; 1978). This is the inverse of Jean Piaget's linear model in which the level of development determines the level of learning. This and his writings on the ZPD have been applied to other forms of formal and informal education including adults. The most significant interpretations of Vygotsky's writings is provided by Lois Holzman whose works influence my research. She rigorously shows how the ZPD has been misinterpreted and should be viewed as a collective activity of creating in which people can transform themselves and their environment (see Holzman 2009; 2010; 2018).

In the FEH project the method of collectively creating a theatrical playground is not solely designed to result in change (therapeutically or otherwise) but exists as a creative process in and of itself. Holzman's colleague, philosopher and Vygotskian scholar Fred Newman, argues that in order for theatre to have any personal, political, social, or educational meaning or 'effect', theatre should be conceived of as a playground, and not a classroom or therapeutic space (in Holzman 1999). My research is based on the premise that the theatrical, playful processes of theatre and theatre making are not only a tool for change, but that the activity of play and improvisation is simultaneously a tool for change and the result of change. 'Vygotsky proposed a qualitatively different conception of method – not a tool to be applied, but an activity (a search) that generates both tool and result at the same time and as a continuous process' (Holzman 2018, p.32).

Holzman (2009, p.9) posits that any 'tool for result methodology' is limited as it results in a 'linear, instrumental and dualistic' relationship between the tool (in this case an applied theatre process) and the result (often cited as education, social or behavioural change, or community development). What Vygotsky advocates as an alternative is a 'method to be practiced not applied' (Holzman, ibid). This notion of method as practice directly aligns with applied theatre as research. Hughes, Kidd and McNamara (2011, p.194) discuss three applied

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[25] See also Peter Smagorinsky's scholarship on Vygotsky (2012a; 2012b; 2013; 2018).

theatre research practices which show how 'knowledge was not generated from the discreet application of research method to practice, but from a research method that was itself part of the practice and *practised'* (original emphasis). Newman and Holzman (1993, pp.32-47) call this reorientation a tool-and-result methodology to describe Vygotsky's radical break from the conventional scientific paradigm in which method is a tool that is applied to produce result. A tool-and-result methodology is a practice-led-research methodology: Holzman's reading of Vygotsky is epistemologically aligned with practice-based research methods in the Arts. A tool-and-result approach moves away from a problem-solution paradigm, which is another dualistic cause and effect that is 'over-determining and severely limiting human capacity to continuously create the world' (Holzman 2009, p.10). Holzman (2009, p.10) rejects a deterministic approach 'in favour of a more unified and emergent and continuous process approach'.

Dan Friedman (2010; 2013), a theatre scholar who works with Holzman, extends Vygotsky's argument to theatre. The instrumentalism inherent in theatre *for* social, personal or political ends fundamentally limits the developmental potential of any theatre. In his critique of some applied theatre practices, Friedman argues that human development is not linear, nor incremental, and to apply a dualistic cause-effect, problem-solution, or tool-for-result methodology to how theatre might be part of personal, social or political change is problematic:

> Human development doesn't proceed according to the rules of Western logic – or any static set of rules be they generated by science, psychology, religion or political ideology. That is precisely why theatre is so fertile an activity for social development. Theatre is where we are allowed to do the un-doable, to be who-we-are-we-are-not, to transgress and transform with others through play (Friedman 2010, p.3).

Vygotsky's scholarship also addresses disability through a realm of study (unfortunately) named 'defectology' (see Vygotsky [1925]/1994). Vygotsky's work on defectology theorises the notion of secondary disabilities affecting people with a range of differences from an evolutionary norm. These secondary disabilities are associated with feelings of inferiority, incapability and low self-esteem. 'This "secondary disability" of feeling inferior, [Vygotsky] argued, was far more debilitating than the original source of difference' (Smagorinsky 2013, p.195). Vygotsky, way before his time, is thus promoting a social model of disability, whereby

people who deviate from a norm are treated socially in a noteworthy way, which, because it draws attention to itself, is the site of the disability: it is not the physical or mental difference that holds them back, but how society treats them. Vygotsky initially wrote about deaf and mute children and the kind of education they needed. For him 'blindness or deafness as a psychological fact, is not at all a misfortune, but, as a social fact, it becomes such' (Vygotsky, [1925]/1994, p.20).

For Vygotsky, a key means of countering such secondary disabilities concerns the involvement in cultural activities that will increase self-esteem and well-being. Peter Smagorinsky has written on the contribution that Vygotsky has made to understanding the cultural conditions that are necessary to reach the best potential for people he terms '*extranormal and neuroatypical* (sic) to account for those whose mental makeup stands outside the norm – not in deficit, but in relation to different orientations to the social and natural worlds' (Smagorinsky 2012a, p.68, original emphasis). He highlights how Vygotsky promoted the idea that the arts promote the connection between emotion and thinking. Smagorinsky's scholarship advocates a need to create the circumstances (often through the arts) for promoting a feeling of inclusion and to structure experiences that promote empathy (Smagorinsky 2013, p.195). I argue throughout this study that theatre processes provide the opportunities for this to happen. Vygotsky's approach to method, his theorisation of the ZPD, and his understanding of the way cultural activities can mitigate secondary disabilities are key to how I approach this research.

Hughes, Kidd and McNamara (2011) argue that because the contexts in which applied theatre practice and research occur are complex and unpredictable, method and practice should not be separated. The context of the rigidity of the hospital as a Total Institution, in which linear and deterministic orientations dominate, is directly contrasted with the theatrical playground. The theatre space as research site requires a conceptualisation of research method as practice in which theatre processes are both the method of change and the result of change. This thesis therefore locates applied theatrical practices as research that adopts a Vygotskian approach to theory and practice in which the results of the research and the tools that create the results co-exist in the activity of the creative practice.

In this chapter I have introduced the reasons for and thinking behind the insertion of a theatrical playground in the context of the power and control – after Foucault - wielded through the application of a bio-medical model to treat psychiatric patients within a Total Institution – after Goffman. Performing and spectating in the demarcated and distinctive space of theatrical improvisation affords an aperture for patient and staff-participants, just for a limited time, to transform, shape and create worlds, thereby experiencing subjunctive power and control over their lives when they visit the playground. In the following Chapter I consider current thinking about madness and how other initiatives have recruited performance as a strategy of resistance and hope.

4. Theatre performance and representations of madness

For Foucault, madness exists only as something that is seen; madness, therefore, has an inherently performative quality, as it rests on the visual spectacle of embodied behaviour (Harpin 2013). In this chapter I discuss madness in relation to performance, exploring the ways in which signs of madness have been made into a spectacle that dominates how people understand madness. Such spectacles contribute to the stigma associated with madness, which then informs practices that link madness and performance. These 'displays' often deny those who suffer madness self-representation, as the distortions dominate what is seen and consumed. As people labelled with mental illness are also constructed as incapable and incompetent, the ways in which people who experience madness engage with theatrical performance, and how these performances are witnessed, uncovers complex ethical considerations. This chapter engages with how the theory and practice of the radical psychiatry and Mad Activism movements have resisted the distortions of madness by the medical model by reorienting the representations of incapability and tragedy associated with mental illness towards a more complex and empowering representation. Robcis (2020, p.306) uses the term radical psychiatry instead of the more commonly used anti-psychiatry which she defines as 'a psychiatric current that developed in the post-war period and that sought to treat the asylum as a microcosm for society at large in the hope of promoting non-hierarchical and non-authoritarian political and social structures'. She does this to include psychiatrists not usually spoken about under the umbrella of anti-psychiatry such as revolutionary psychiatrist-intellectual Frantz Fanon who was influenced by a French psychiatric tradition, which believes in the medical potential of psychiatry but that understands the reciprocal effects of the psychological and the political (Hook 2004). These critiques of the oppressive nature of mainstream psychiatry and the possibilities of reclaiming madness as a positive identity is foregrounded in the rest of the chapter, which on the one hand explores the ways in which certain performances become spectacles that can reinforce stigma and, and on the other explores how other artists have found ways to engage people who experience madness to work with theatrical performance in an ethical way that reorients self-representation. The discussion starts with a contextualisation of how

resistances to psychiatry have developed, and how certain models resonate with the particular context of South Africa and the Eastern Cape.

Radical psychiatry, mad activism and resistances to the medicalisation of madness

The writings of Foucault and Goffman discussed in the previous chapter are fundamental to activist and critical scholarship about psychiatry. In the following section I briefly explore how contemporary critiques of psychiatry are positioned within a lineage that leads to Mad Activism in the twenty-first century. I also discuss the recovery approach that has roots in the psychiatric survivor movement and aims to reorient healing, in relation to mental illness, away from a purely medical model.

The US psychiatrist Thomas Szasz's *The Myth of Mental Illness* (1961) and British psychiatrist R.D. Laing's *The Divided Self: An Existential Study in Sanity and Madness* (1965) are frequently associated with Foucault and at times Goffman as 'anti-psychiatry', a term coined by Laing's colleague David Cooper in 1967 (Burns 2006; Rissmiller & Rissmiller 2006). However, as Bracken and Thomas (2010) outline, these scholars come from starkly different disciplinary and ideological positions. They show how Szasz reinforces binaries such as the mind-body split and centres on a modernist philosophical belief in individualism, whereas Foucault takes a post-modern approach that is not trying to understand whether there is or is not a biological basis for madness but 'the way in which madness is encountered in our lives' (Bracken & Thomas 2010, p.223). While the term anti-psychiatry is often used for any resistance to mainstream psychiatric practice that emerged post second world war (and had its height in the 1960s and 70s), as will be shown, the grouping of diverse critical perspectives on psychiatry under one label is misleading.

Szasz (1961) argues that mental illness is a myth, which has no basis in biological or scientific claims. He maintains that the disease model used to understand mental illness is highly coercive and flawed as there is no biological evidence for mental disease, and 'insanity' describes a person's behaviour and not their bodily function (Manning 1992; Poulsen 2012). He concludes that psychiatry is a major agent of social control that pathologises behaviour

that is not socially acceptable. There should therefore be a separation of psychiatry from the state (Lewis 2006). Szasz' work was highly respected when published, but subsequently criticised and rejected by powerful bodies such as the American Psychiatric Association - an association whose links with the pharmaceutical industry have been well documented (Whitaker & Cosgrove 2015).

Scottish psychiatrist R.D. Laing (1965) argues that madness is a healthy way of dealing with a sick social and family structure (Gilman 2014). He believes that psychosis is not a sign of an illness but an adaptation to an oppressive social context. This implies that psychotic episodes are not disease-based but 'rather an existential fight for personal freedom' (Rissmiller & Rissmiller 2006, p.864). Like Szasz, Laing believes that imposing a diagnosis, and pathologising people who think and behave differently, is repressive and will not lead to helping people who suffer madness (Burns 2006). Menzies, LeFrançois & Reaume (2013, p.5) note that 'for the European anti-psychiatrists, the objectification of so-called "mentally ill" people under the guise of science was a deeply de-humanising pursuit that required challenging through a wholesale rethinking of human consciousness and being'. These thinkers inspired the growing activism of ex-psychiatric patients who rejected institutional terms. Talking about people as patients was regarded as too passive and shifted to the term 'consumers', which in South African policy becomes 'mental health care *user*'. However, the latter term may well falsely imply a sense of choice and engagement with treatment, as well as recruiting the language of the marketplace. Burstow (2013, p.87) argues that adopting such discourses masks the ongoing struggle in activism to expose the real crisis, 'that choice is not real, that bogus medicine is still the order of the day, that psychiatry is a coercive institution.'

Robcis (2020) maintains that Cooper, Laing and Szasz need to be distinguished from their French contemporaries Francois Tosquelles, Jean Oury (who mentored Frantz Fanon) and Felix Guattari. Cooper, Laing and Szasz are committed to the destruction of the asylum and reject the medical model, whereas Tosquelles, Oury and Guattari believed in the potential of the medical model of psychiatry and rejected the idea that mental illness is a social construct. Their resistance to mainstream psychiatry is a political move away from individualistic and what they term concentrationist approaches to locking patients up in asylums and the stark separation of madness from every-day life. The notion of 'concentrationism' is rooted in the

experiences of German occupation in France during the second world war that led to the deliberate extermination of people with mental illness (Robcis 2016). Doctors at one hospital in the small town of Saint-Alban developed a method that aimed to practice psychiatric care in a more collective way and fight against 'what Tosquelles called the concentrationist logic of asylums' (Robcis 2020, p.305). This method became known as institutional psychotherapy.

> Institutional psychotherapy is perhaps best defined as the attempt to fight, every day, against that which can turn the collective whole towards a concentrationist or segregationist structure (Oury 1970 cited in Robcis 2016, p.212).

The work of Frantz Fanon in colonial North Africa emerges from this approach towards psychopolitics (Hook 2004). Fanon had worked in Saint-Alban and extended institutional psychotherapy as a method of treatment within the political context of colonialism and violence he witnessed in Algeria and Tunisia[26]. He argues that the physical structures of colonialism (such as segregated communities) shape the psyche of oppressed people; and the experiences of racism have direct psychological effects (Fanon [1961] 2001; Robcis 2020). Fanon's work has particular resonance for this study as he developed a model that conceptualised a link between mental disorders and cultural practices in order to revolutionise psychiatry as well as the oppressed colonial subject (Gibson & Beneduce 2017). Fanon's writing reveals the ways in which colonialism not only 'creates mental disorders, it emphasizes the complicity of psychiatry in the colonial enterprise' (Eromosele 2020, p.169). He developed an approach in North African clinics in which the environment and activities in the hospital needed to be culturally affirming and relevant. His aim was to reinstate the collective and the social as a way of fighting against the alienation patients experienced in mainstream psychiatric practice and under colonialism (Robcis 2020). This involved narrowing the separation of the psychiatric hospital from every-day life and included meetings and activities involving both staff and patients, removing medical uniforms, staff and patients eating together, and involving staff and patients in culturally affirming activities that included films, concerts and theatre (Robcis 2020). These different activities were aimed to reshape social relations so that patients would feel less politically and psychologically alienated.

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[26] Institutional therapy is sometimes translated as sociotherapy in literature about Fanon as a psychiatrist. See Gibson and Beneduce 2017.

Robcis (2020, p.314) explains that 'the idea was to constantly imagine and reimagine institutions that would produce new vectors of transference, different forms of identifications, and alternative social relations'. For Fanon psychiatry is a political practice and he understands the psychiatric hospital as a political space that needs its own revolution. For Fanon there is a direct connection between colonialism and psychiatry: colonialism tries to mummify the cultural life and forms of the colonized while psychiatry fixes patients into narrow diagnostic categories (Gibson & Beneduce 2017, p.96). Fanon's practice seeks to resist hegemonic power relationships that result in concentrationism. In newsletters written by and for staff and patients at Blida hospital in Algiers, Fanon warns:

> If care is not taken, the hospital establishment which is above all a curative establishment is gradually transformed into a barracks in which children-boarders tremble before parent-orderlies' (Fanon cited in Robcis 2020, p.318).

Fanon's writing echoes Goffman's observations in the Chicago asylum and the paternalistic relationships in which fear is used to legitimise domination over patients. His emphasis on developing collective social relationships that dismantle hierarchies and embrace cultural practices as a means of humanising psychiatric practice resonates with some of the characteristics of the theatrical playground at FEH.

Mad Activism in the twenty-first century and the development of the recovery approach to mental health

Contemporary activist approaches such as Mad Studies attempt to bring the lived experience of those who have been through madness – some of whom may embrace a medical model and some may not - to counteract dominant narratives of psychiatry (Beresford 2014). Mad Studies and activism is a bottom-up approach to understanding and coping with mental distress or difference – although the dominance of activism and theory emanating from the global north needs to be critiqued when universally applied to the global south.

Mad Studies define madness as follows:

> Madness refers to a range of experiences – thoughts, moods, behaviours – that are different from and challenge, resist, or do not conform to dominant, psychiatric constructions of 'normal' versus 'disordered' or 'ill' mental health … madness is a

> social category among other categories like race, class, gender, sexuality, age, or ability that define our identities and experiences (Liegghio 2013, p.122).

Within this study, the relationship between the theatrical performances of patient-participants and staff-participants in the theatre group and the performances of power and submission of the hospital staff is interrogated. Theatrical performance becomes a resistant strategy that is aligned with the activist approaches I describe below.

Advocacy and activism around madness has had a particular impact in the global north. Mad Studies is firmly rooted in a political, human rights-based agenda that grew out of the psychiatric survivor activism of North America and the UK. The term 'psychiatric survivor' is used by people who consider themselves to have 'survived' psychiatric treatment and often refers to someone who has been treated by force (Menzies, LeFrançois & Reaume 2013). Mad activism has evolved to incorporate a range of epistemological approaches. People who have been through psychiatry refer to themselves as 'consumer/survivor/ex-patient groups. This hyphenated designation... highlights … a coalition of critical activists – some of whom have a more radical epistemological critique than the others' (Lewis 2006, p.344).

Within mental health literature, the recovery approach to mental health has gained currency within the last two decades. The recovery approach has its roots in the psychiatric survivor movement and embraces a holistic approach to mental illness by acknowledging the cultural, social and political milieu that may contribute to mental illness. Morrow (2013, p.324) notes how the psychiatric survivor movement used 'the notion of recovery in ways that challenged the medicalization of mental health and the power of psychiatry to define people's lives and experiences'.

Recovery is an approach to mental illness as a journey encompassing a range of personal, social and cultural processes that promote a feeling of hope that is necessary for recovery. John Parker, from Lentegeur Hospital in the Western Cape, outlines the principles for the philosophy of recovery which positions mental illness as a journey rather than an endpoint with a cure:

> The focus is on acceptance of the reality of the illness but also on the fact that one is still a whole person with the possibility of a satisfying life, full of *hope and meaning,*

> regardless of whether symptoms are present or not. This also involves the realisation that recovery is about the *whole self and not just the illness* (2014, p.77, emphasis mine).

A recovery approach is significant for this study as several of the principles and conditions of a recovery approach are modelled in the theatre project. The analysis of the practice will show how the project allows participants to play with key concepts of the philosophy, which include *hope* as a *social* process of finding *connection* with others and oneself, beyond and apart from, illness.

Jacobson and Greenley (2001, p.482) outline the internal and external conditions for recovery. The internal conditions they name as 'hope, healing, empowerment, and connection'. The external conditions are 'the implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services'. These internal conditions resonate with my experiences and observations as to what participating in theatre processes can enhance: in particular, the notion of hope – of projecting oneself into a future scenario, role, story; and of connection: the social process of creating with others as a humanising activity. In addition, the conditions for a sense of empowerment as a counteraction to hopelessness, are facilitated by three behaviours that echo the principles of the theatre space. The first is autonomy, defined as 'the ability to act as an independent agent ... including knowledge, self-confidence and the availability of meaningful choices'. The second is courage: 'a willingness to take risks, to speak in one's own voice and to step out of safe routines' (Jacobson & Greenley 2001, p.483). The third is responsibility: this addresses the individual's accountability and obligations.

These three internal conditions resonate with the conditions needed to create theatre, and for improvisation in particular. The principle of connection, too, has strong resonances with the theatre space, as it is linked to finding the roles we play in the world, 'an aspect of recovery that has to do with re-joining the social world' (Jacobson & Greenly 2001, p.483). As will be discussed in chapters six and seven, patients reflect on the significance of creating and enacting scenarios which, as patient-participant Mandla (2015) articulated, '*actually happen in real life'* or are connected with a cultural identity that is often rendered invisible within the hospital experience of patients.

The theatre group provides opportunities for hope and meaning by focusing on the rich social process of making something together. Jacobson and Greenley (2001, p.483) state that 'recovery is a profoundly social process'. They link recovery to healing, 'a process that has two main components: finding a self apart from illness, and control' (Jacobson & Greenley 2001, p.483). This approach to a whole person, of which the illness is one but not the defining feature, links to the approach I adopt with the theatre group.

Paradoxically, these characteristics are very difficult to achieve in a psychiatric hospital in South Africa when the external conditions for recovery posited above are not in place. The institution defines people in relation to illness and removes any control around how a person understands their condition or approach to healing, taking away even the most basic choices that ordinary people make each day. For Morrow (2013, p.324):

> Mental health care practitioners struggle to foster recovery from within service systems that place constraints and controls on people diagnosed with mental illness … this makes fostering the underlying philosophy of recovery, which includes supporting autonomous decision-making, difficult if not impossible'

In the *South African Medical Journal* Parker (2014, p.77) discusses the conditions needed in the services available to mental health care users of which 'self-determination or self-choice' is one. He further relates hope to a positive environment within services. My observation of the way FEH was run did not align with a 'recovery-oriented service', despite a recovery approach being verbally promoted as important in the hospital in relation to certain flagship projects, such as the art project.[27] One staff-participant is part of both the art and drama groups and reflected on the hospital's approach*:*

> *At the heart of recovery is hope, hope for a different way of being; but we pigeon hole patients and we sit them in rooms and we psycho-educate until everybody is blue in the face. It is important people gain information, but they don't actually get to experience it themselves, as being something different than being a forensic patient* (Maya 2016).

[27] Both the art project and the drama project are, according to one staff-participant, exemplars of the recovery movement (Maya interview June 2016).

In the South African mental health sector, it is the external conditions for recovery that are sorely lacking.

Morrow and Weisser (2012) highlight recent debates in North America concerning the shift in the recovery concept away from the political impetus of the survivor movement, towards a co-option into dominant biomedical policy and approaches. These debates are fairly particular to well-resourced, northern mental health care services. In South Africa, recovery is often talked about as valuable and in alignment with the Mental Health Care Act in South Africa (implemented in 2004) but, as discussed, the on-the-ground conditions of mental health service provision need a massive overhaul for a recovery approach to be implemented. I highlight throughout chapters six, seven and eight that the theatre project embodied key aspects of recovery, particularly in relation to fostering hope and choice, and providing a sense of connection and community. The roots of the recovery approach are in Mad Activism, to which I now return in order to examine how notions of madness and madness as disability are contested.

Madness and Disability Studies

In mad approaches, madness is situated within Disability Studies, wherein the political and cultural identities, experiences and expressions of people are made possible beyond the limitations of a medical condition (Lewis 2006). Disability Studies is a field of knowledge-creation in relation to disability activism that interrogates stereotypes associated with disability such as 'tragedy, loss and dependency' and understands disability beyond its medicalisation to include cultural and political aspects (Kuppers 2003, p.6). One of the motivations for the theatre project in the hospital is to create a space within an oppressive environment that actively moves away from individual pathology towards a collective and embodied acknowledgement and celebration of participants' lives, cultures, and stories.[28] In so doing, improvised performance is used as a strategy to disrupt the 'tragedy, loss, and

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[28] See Sutherland (2017), *Method and Madness: de/colonising scholarship and theatre research with participants labelled mad*, Research in Drama Education: The Journal of Applied Theatre and Performance, Special Issue on disability and applied theatre.

dependency' tropes associated with mental illness and certain portrayals of mental illness. However, the use of the highly contested, value-laden term 'disability' in relation to madness is not without its controversies. What, or who, is included within a disabled category is not universal or value-free, nor are conceptions of mental illness/health. Some people within Mad Pride activism feel that their struggles are distinct from other disability struggles due to the level of state coercion that leads to involuntary commitment and forced medication (Lewis 2006, p.340). What perhaps does unite a broad range of differences, concerns issues relating to categorization of medical characteristics and treatments:

> Wheelchair users, people with chronic pain conditions, mental health system survivors, people of different stature, people with sensory impairments, people who experience cerebral palsy, people with 'disfigurements', people with cystic fibrosis, cancer fighters and survivors, people with learning difficulties: each and every-one of these 'medical' descriptions has been contested (Kuppers 2003, p.7).

Within disability movements and activism, debates continue as to whether madness should be included, and the various medical, cultural, social and political implications of the term disability. Gilman (2014) notes that one of the defining ways of situating madness in relationship to disability concerns psychic pain (or anguish/suffering). However, in situating madness within a Disability Studies framework, 'madness has now not only to figure itself in relation to ideas about competency, moral ability, curability etc. but also in relation to questions of access, stigma and advocacy' (Gilman 2014, p.442). For Lewis (2006, p.341), despite the range of approaches within mad activism itself, more unites than divides mad activism and disability activism in terms of the 'combined political and epistemological struggle'.

When locating madness within Disability Studies, disability and therefore madness become a social category realised in relation to normality and is made known or accepted in terms of difference from the normal. Kuppers (2003) likens disability to the social constructions of race and gender, in which the meanings and metaphors associated with race, gender or disability are attached to binaries which exchange social and biological meanings. Drawing on the feminist theories of Judith Butler and Elizabeth Grosz, Kuppers (2003, p.5) discusses how 'performativity has become the name by which the social/biological meaning exchanges can be focused: the body comes to be seen as an arrangement of meaning that is produced by

social knowledges'. As the body is central to theatrical performance, understanding the discourses that inform how we come to know different bodies is vital. Following the thinking of Michel Foucault, the body is a discourse representing ideas and constructed knowledges and assumptions (Conroy 2010). Kuppers (2003, p.3) asserts that '[d]isabled performers are often aware of the knowledges that have been erected around them: tragic, poor, helpless, heroic, struggling etc. In the laboratory of the performance situation, these knowledges can be re-examined, and questioned again and again'. Not all performances by and with disabled performers are produced to, or result in, questioning or re-imagining stereotypes. However my rationale for establishing the FEH project was to establish what Kuppers refers to as a 'laboratory' to harness the possibilities of some performance strategies to resist and disturb demeaning identities often associated with incapacity and incapability. One of the over-riding themes within the practice of the FEH theatre project, and the participants' reflection on it, concerns the sense of achievement and capability that is facilitated through the creative encounter.

However, there is almost no evidence of any psychiatric survivor or mad activist groups in Africa. Activism around psychiatric institutions and the impacts of psychiatry and psychiatric drugs has grown in the global north in ways that are not in evidence within the gross social and structural inequalities that exist in most of Africa, often as a direct result of colonialism.[29] In South Africa, these are connected to racism, sexism, apartheid and colonial structures that both exacerbate mental illnesses and contribute to their onset (Morrow & Weiser 2012). This critique of Mad Studies as assuming universal application is extended to Disability Studies. Meekosha (2011, p.668) argues that Disability Studies claims universality yet perpetuates a 'scholarly colonialism' due to an almost exclusive transfer of knowledge from north to south, seldom taking the specific lived experiences of people living in the global south into account. She further highlights how the processes of colonialism (and neo-colonialism) are directly implicated in creating and sustaining disabilities in the global south.

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[29] When reference is made to the existence of Mad Pride or Mad Activism in Africa (Eromosele 2020; Nabbali 2013), these are linked to a US organisation called Mind Freedom International (MFI - see www.mindfreedom.org). MFI claims to be international and support a mental health NGO in Ghana. However, MFIs board and scientific advisory board are all US citizens, and their Academic Alliance list is predominantly US based and the global north. MFI may have been involved in Mad Activism in Ghana but it seems that this is limited and a MFI initiative rather than a grass roots, ground up movement.

I wish to situate this study within a framework that interrogates the dominant medicalised psychiatric narrative around madness, a narrative that necessitates treating people in a distanced, dispassionate, ahistorical and decontextualized way. I have outlined these approaches above, mindful that such advocacy and activism is not in evidence in South Africa to any significant extent. In a country that continuously battles with the racist and sexist legacies of colonialism and apartheid, disability activism in general is far less advanced than countries in the global north. Eromosele (2020, p.83) suggests that Fanon's work is a 'critical interlocuter' with Mad Studies, in his insistence that the cultural and political context of mad people is vital, thereby offering a critique of the 'nationalist rhetoric that attaches to much Mad scholarship'.

Intellectually I am drawn to approaches espoused by Fanon and Mad Studies as they resonate with an emancipatory politics that drives the theatre work and assists in formulating the lens through which the research views the institution and the theatre practice. I see the political impetus for applied theatre, and the advocacy and critiques arising out of radical psychiatry and Mad Activist movements as having resonance in collapsing binaries and situating people's lived experiences within a political, historical and social milieu. This milieu is explored through playmaking and improvisation in the theatre project. Ethically, however, I feel uneasy as I am keenly aware that I need to reflect on the choices I make in locating the people and practices in the study. Russo and Beresford (2014) critique scholars whose research is based on the consumption and recycling of mad people's stories, lives and experiences. They discuss the potential for a research approach that appears to be sensitive to the need to include and acknowledge psychiatric 'survivor' voices and experiences, yet ends up marginalising, and potentially re-colonizing, such perspectives. This ethical navigation is something I have been aware of through-out this research. A research document, like a performance, is also a representation of people in a context. I am continually conscious of how I represent patient-participants in this study, so that the tone and style in which I narrate the patient participants is respectful and dignified. This requires a heightened reflexivity that balances respect for the participants with interrogating the practice: a practice that exists because of those who participate. Possibly, my cautiousness as a researcher has interfered with a critical, objective interpretive lens. I will return to these issues in the conclusion to the thesis.

Madness as metaphor and spectacle

I start an exploration of madness and performance by exploring the historical example of hysteria as a staging of madness through carefully constructed, medical theatre. This example recalls issues raised concerning how mental illness as performance is subsumed within constructions of power in medical institutions. The case of hysteria illuminates several issues raised in the previous chapter in terms of how the institution of psychiatry exists in an historical, cultural and political realm and can violate human rights. Rather than madness as mental illness being understood as part of a medical model of objective, value-free science, the marriage of the diagnosis of hysteria with dramatic display highlights how regimes of power play out under the guise of scientific neutrality. This is one of the most discussed examples of a medical theatre in which a doctor manipulates performance to provide evidence of a diagnosis. The gender and class dynamics at play are particular to this historical example and is contrasted with contemporary theatre practitioners who have forged progressive alternatives in the uses of performance with and by people who experience madness. These performance strategies are intended towards humanising ends that respect people's creative capacities to explore and decide how they wish to be represented and witnessed.

The stigma associated with mental illness is perpetuated through performances constructed through cinema, reality television, and through a dramatic literary tradition dating back centuries in which madness functions as metaphor: from Aeschylus to Shakespeare, Ibsen to Artaud to Soyinka, madness as metaphor permeates dramatic literature (Conway 2015; Harpin & Foster 2014; Oyebode 2012). Our fascination with insanity is shaped by an ambiguous relationship between fear and desire that has been harnessed by the popular media in the twenty-first century. Harpin and Foster discuss the framing of insanity as voyeuristic spectacle through reality TV programmes which focus on 'dotty cleaners, hoarders and eaters' (2014, p.2). In contemporary popular imaginations and constructions of madness, the metaphors associated with madness disproportionately focus on danger, violence and unpredictability (Conway 2015). Conway's study of films and plays, which represent madness, show how madness is used to exemplify 'otherness' and that our fear of unpredictability facilitates the link between insanity and violence. In films and television

shows, madness is always ‘so visible, so tangible, so audible’ (Leader 2011, p.9). Kuppers (2007) highlights how these representations are often gendered, ranging from animalistic sadists in men (such as Hannibal Lector) to hysterical fits in women. Harpin and Foster (2014, p.4) observe how madness becomes ‘knowable’ in popular culture: ‘this bonding of madness and sensational visual imagery both sustains a diagnostic gaze towards individuals and offers up superficial surface behaviours as decipherable clues to inner enigmas’.

The history of stagings of madness, or madness as imagined and sustained through literary and filmic metaphor, is important to recognise as it influences how one engages in performance work with people labelled mad. Kuppers (2007) argues that any performance work with people diagnosed with a mental illness occurs against a history of other theatricalisations of madness, and it is therefore important to understand how madness is constructed as knowable through different types of performance. But when mad people create their own performances and modes of self-representation, such performances can be understood as politically resistant within the history of popular stagings, media, and images that distort, simplify and often further stigmatise madness.

When understanding madness as part of a historical and cultural context, a key example is the diagnosis of hysteria which is now understood as a socially constructed disease of women in Victorian England (Scull 2009). The history of hysteria as a diagnostic label is a fascinating example of how an illness is categorised and legitimised as real, only to disappear. Andrew Scull charts the history of hysteria, mapping the varying interpretations of the fits, paralyses, loss of voice and emotional instability associated with the ‘illness’. Hysteria is no longer medically recognised as a mental illness and disappeared as a diagnostic category when it was removed from the DSM-III in 1980 (Orr 2000). However, in the present day the iconography of hysteria prevails in the visual and performing arts, particularly in the staging of symptoms. Male psychiatry’s fascination with treating hysteria in women resulted in one of the most perverse examples of a medical theatre. For Kuppers (2003, p.39), ‘medical theatre is a place of public performance: a body performs its materiality and meaning to a doctor, a specialist, who is empowered to read hidden histories and signs’. The ward rounds I observed at FEH become a medical theatre in this way too. The patient presents him/herself

to the team headed by the psychiatrist who asks question and observes responses and behaviour.

Scull (2009) shows how the understanding or interpretation of the symptoms of what came to be named as hysteria changed with shifting cultural and historical contexts. In the 18th and 19th centuries hysteria was thought to have physiological causes, chiefly connected with female biology and sexuality. Towards the end of the nineteenth century Jean Martin Charcot (1825-1893) took the Chair of Pathological Anatomy in 1872 in Paris and attempted to confirm the biological bases of hysteria as a medically diagnosable category by treating male and female hysterics at Salpêtrière. Charcot made extensive use of the visual (photography and live display) as his method of medical documentation, resulting in Freud commenting that Charcot 'had the nature of an artist – he was, as he himself said, a 'visual' man who sees' (in Appignanesi 2008, p.128). Charcot created medical theatre out of hysteria, performing lectures with a female subject who staged fits for the audience at Salpêtrière (Scull 2009). Initially, the audience for Charcot's displays of hysteria were male medical and hospital personnel, but due to its overwhelming popularity, the 'show' drew an increasingly diverse audience, including the Paris fashionable, journalists, and actors (Scull 2009; Showalter 1987). Madness is therefore performed and made 'real' through the (male) medical gaze.

Many believed that women were faking their hysterical symptoms, but Freud and Breuer's *Studies on Hysteria* (published in German in 1895) restored hysteria's status as a 'genuine' mental illness, with a sub-conscious basis that was not controlled by the sufferer (Scull 2009; Showalter 1987). As Showalter (1987) notes, it was because of Charcot's treatments using hypnosis, and then Breuer and Freud's study, that psychoanalysis was born. However, the 'talking cure' that was to mark the advent of modern psychology practice was only taken seriously when hysteric symptoms were recognised in shell- shocked men surviving World War 1.[30]

When examining how madness has been performed or conducted as a performance by clinical professionals in the above example from recent history, questions emerge as to how

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[30] 'Only when hysteria… became a widespread malady of men, did the talking cure enter English psychiatric practice' (Showalter 1987, p.164).

those labelled mad might use theatre and performance, and how these performances might be witnessed or received. The violent history of medical theatres, as exemplified in the case of hysteria, means that when people diagnosed with mental illness do perform, careful attention needs to be given to the politics of looking, and how to challenge the stigma often associated with mental illness.

Resistant performances

I now turn to examples of performance projects with people labelled mad that are framed as artistic projects and not as part of a primarily therapeutic intention, and that actively rebel against 'the repressive powers of a Cartesian model of psychiatric medicine' (Evangelista 2015, p.235). These are theatre processes that do not explicitly aim to fix or heal but acknowledge that the experience of participating in making and performing theatre may well be experienced as therapeutic.

In the global north there are several well documented and effective drama and expressive arts therapy projects with psychiatric patients. For example, Schattner and Courtney's (1981) seminal text on drama therapy contains chapters on drama therapy in prison and psychiatric settings (see for example Reif 1981). Smeijsters and Clever (2006) document a number of art therapy interventions within forensic psychiatry in the Netherlands that show that participation in arts-based therapies reduces recidivism and aggressive behaviour. McAlister (2000) evaluates the use of drama therapy in a forensic psychiatric setting using the case of one patient diagnosed with paranoid schizophrenia. She concludes that the patient's engagement with drama therapy resulted in a greater capacity for insight, a decrease in symptoms and an ability to plan for the future. Landy and Montgomery's book (2012) examines theatre practices in education, social action and therapy. They describe the benefits of using theatre as therapy:

> In the city's psychiatric hospitals, there are groups of adults who have lived their lives in and out of delusional thoughts and flaccid, medicated bodies. Their imaginative capacities have been maligned and neglected by their keepers whose only recourse is to steer them into solid walls of reality. Drama therapists work with these groups to open the door to the body and the imagination and help the people experience the difference between imagination and delusion (2012, p.197-198).

Landy and Montgomery (2012, p.219) argue that both drama therapy and applied theatre practices strive to move groups and individuals towards change. However, drama therapy is more about 'the emotional geography of change'.

While acknowledging the therapeutic benefit of arts therapies, my intention here is to provide an overview of a few specific projects initiated with people experiencing madness that are *not* part of a therapeutic intentionality but are aesthetic experiences in and of themselves. There are other studies that document the uses of the creative and performing arts within mental health settings that are not framed as therapy but as an activity offered within an institutional setting. Both Dolling and Day (2013) and Stickley and Hui (2012) document a range of participatory arts projects in mental health settings that highlight the benefits of participation such as 'increased self-confidence and self-esteem, and reported feelings of greater control and meaning in their lives' (Dolling & Day 2013, p.36). These authors highlight how participation in arts activities provides a sense of hope and future for patients, a finding that resonates with my own practice discussed in chapters six to eight.

If madness is often distorted by how it is represented in some films, television programmes and theatrical productions, how people who suffer madness play with theatrical performance outside of a pathologising gaze is important to understand in relation to the case study that is examined in this thesis. The three examples discussed below offer insights from diverse contexts. I discuss a theatre programme in Switzerland first and in less detail as it is only documented through one article. The two other projects from Brazil and Wales that are documented more widely surface further provocations and resonances to my own practice.

Theatre director Walter Pfaff (2018) documents his theatre workshops in a psychiatric hospital in Switzerland in 2011 with long-term schizophrenic patients. He frames the work in terms of play and the use of theatre to release a play instinct in the patients, particularly for people with schizophrenia who can become fixated in an inner world. Like the FEH project, Pfaff distinguishes the project from therapy by framing the work as purely recreational and for entertainment of patients, insisting that 'what can be seen onstage will not be psychoanalysed afterwards' (p.129). All participation is voluntary and at the pace of the participants, and what I name as invitation in my own work as a central characteristic of the

space, Pfaff calls temptation; 'creating a tempting space for play, which is experienced as safe and dependable' (p.117). Pfaff discusses the effect of cutting patients off from society as they adapt to the authority of the hospital. Through theatre workshops that are based on exercises that build an ensemble, simple acting tasks, and scene building through improvisation the theatre work aims to invite 'a state in which joy in playing could help the actor find a creative connection to the world' (p.115). While there are striking similarities between the FEH theatre project and this one in terms of the kind of play space that is established and the rationale for the work, the way Pfaff establishes the project is notable. His approach to establishing and running the project was as an ethnologist. He spent six months corresponding with hospital personnel through plans, letters, and visits to explain the project and in essence, winning over all levels of staff to convince them the potential value of the project despite their resistances. He then spent a month visiting patients once or twice a week to get to know them, gaining trust, and inviting them to participate.

> The situation of a theatre-maker in a clinic does not differ so much from that of an ethnologist working within a culture that seems strange. It is necessary to come to terms with whatever is foreign in a constant dance of interpretation between what is unfamiliar and what is one's own "local knowledge" (Pfaff 2018, p.116).

Pfaff is working in a very well-resourced health context in which he and the hospital personnel have time and are open to engagement, and he is able to build relationships with patients over time in a relaxed way. He gets to understand the terrain in depth and insert himself inside the world of the clinic. While there is an ethnographic component to my work in that I was able to spend some time observing the workings of the hospital, this was not possible nor permissible to do in the depth ways that Pfaff managed. This example highlights the integration of a theatre project that although a part of the therapeutic aspects of the hospital, is recognised as having significance and value, particularly for long-term patients who often resist therapy. As a pilot project, Pfaff has extended the work to research and teaching contexts that can integrate theatre in psychiatric settings. This is achieved in one of the wealthiest countries in the world that offers quality comprehensive mental health services and a low psychiatrist- patient ratio.[31] Against this background, despite the obstacles

[31] Switzerland has twenty six psychiatrists per one thousand people (Schneeburger & Schwartz 2017). In South Africa there is less than one psychiatrist per one thousand people.

and severe limitations that the context of mental health care in a peri-urban environment in a low-income country present, what the FEH theatre project did manage to achieve through a sustained engagement is worth careful research.

The Madness Hotel and The Olimpias

I have selected two performance projects to discuss in further detail in relation to my own practice. The first project concerns a radical performance laboratory in a psychiatric hospital in Brazil: The Hotel and Spa of Madness (also referred to as The Madness Hotel in the literature, and henceforth in this thesis) was established in 2011. This practice is led by Dr.Vitor Pordeus in two unused wards of the the Nise da Silveira psychiatric hospital in a poor suburb in Rio de Janeiro. Pordeus names his theatre troupe the DyoNises Theatre to reference the influence of anti-asylum pioneer Nise de Silveira and Dionysian ritual. [32] It involves an informal collective of artists, psychiatric patients, citizens of Rio and medical practitioners, who collaborate to create dance, music and performances of Shakespeare that are performed within the hotel and on the streets of Rio. It is called a hotel as people can stay there in simple accommodation and there have also been 'occupations' in which up to four hundred people participate for a week at the hotel in collective art-making (Heritage & Ramos 2016)[33].
Heritage & Ramos (2016, p.87, original emphasis) locate the hotel as a type of cultural activism that recognises all contributions:

> Theatre is not introduced at the *Hotel and Spa of Madness* as therapy, entertainment or as a form of cultural or social rights but rather as a means of overcoming a limited understanding of the world – *an antidote to* an approach that considers only some of us as able to contribute to its meaning and value.

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[32] Nise de Silveira (1905-1999) was a leader in psychiatric reform and the anti-asylum movement in Brazil. She was a pioneer who rejected invasive electro-shock treatment and lobotomies, which were accepted practices in the 1940s and 50s. She developed an alternative practice that included the arts as therapy. De Silveira established the Museum of Images of the Unconscious (1952) to exhibit the art work of psychiatric patients, which still exists at the same hospital (Heritage & Ramos 2016; Low & Pordeus 2017).

[33]Occupation of unused buildings is a key political strategy used in both Brazil and South Africa. Such occupations are connected with grass roots political organising around urban land justice for the poor.

The second project, called the Olimpias, was founded in 1996 by academic, artist and disability-activist Petra Kuppers with mental health system survivors in a rural village in Wales (www.olimpias.org). The Olimpias developed to become an artist collective in which people with disabilities lead the collective along with non-disabled allies, and thus reconfigure the power relations that are often assumed in many arts projects (including my own), in which non-disabled members assume power and authority in relation to people with disabilities. In the Olimpias a network of artists 'create collaborative, research-focused environments open to people with physical, emotional, sensory and cognitive differences and their allies' (www.olimpias.org). Kuppers' practice as a disability culture activist, and her theorisation of disability and performance in her scholarship, has been highly influential for my theatre work within the mental health sector. Kuppers' work is unusual in that its intentions are couched in artistic rather than social or psychological terms. In a recent project centred on performative reactions to the asylum Kuppers et al. emphasise that '[o]ne core concern of disability studies and mad studies is who counts as someone with expressive means' (2016, p.221). The emphasis on questioning notions of who can or cannot be considered to contribute to meaning making is shared with the Madness Hotel as well as the FEH theatre project. I focus here on Kuppers' explication of one Olimpias project with people who experience madness called *Traces.* In these collaborations, the framing of the work as artistic resonates with my own practice.

> The vision fuelling the collaboration was that of an artistic rather than a medical or therapeutic intervention… our prime impetus was toward experiencing movement not as a mimetic vehicle but as an expression in and of itself (Kuppers 2003, p.124).

Both examples articulate a political motivation in finding ways for people who experience madness to engage in artistic practices as whole people who are within culture and create culture.

Vitor Pordeus and the Madness Hotel

A significant example from the global south is the Madness Hotel in Brazil, established by Vitor Pordeus, a qualified immunologist and medical doctor who specialises in psychiatry. He considers himself a transcultural psychiatrist and artist who believes that involvement in making and performing theatre is healing for everyone and reconnects us to ritual (Low &

Pordeus 2017; Heritage & Ramos 2016).[34] For him, ritual is vital to health and creating community. 'Pordeus trained in street theatre and is influenced by Shakespeare, Brecht and Molière, 'and all those who made theatre in open spaces as a collective, political act' (Heritage & Ramos 2016, p.101). Pordeus established the Madness Hotel as a collective theatre of public performances based on the notion of Dionysian pageants and carnival that embrace playfulness, participation, and the unpredictable (Evangelista 2015). Descriptions of the Hotel suggest it is an open, chaotic space of dancing, singing, music-making, rehearsing, and painting. Heritage and Ramos (2016, p.85) describe it as a 'deliberate confusion' in which 'patient, doctor, nurse and artist become unidentifiable from each other as they combine to participate in the performance rituals'. Evangelista's analysis connects the disorder of the practice with social transformation because it 'reinstates possibilities for democratic "action", dialogue and unpredictability through theatrical encounters' (2015, p.234). Embracing disorder is a tactic to disrupt hegemony and reimagine social relationships. The Madness Hotel is also a playground, one that is distinct in embracing disorder and collapsing the boundaries between the hospital and the social world by inviting anyone to join.

The Madness Hotel locates the intentionality of the work as artistic, while acknowledging that it is the involvement in a collective ritual of theatrical creation and performance that is healing, and necessary, for *all* people. 'There are no lessons to be taught in the *Madness Hotel*. It is, instead, the process that determines what is learned' (Evangelista 2015, p.233). This philosophy aligns with the Vygotskian approach outlined in chapter three in which the artistic process in and of itself creates the environment for people to extend their skills and learning. Like the FEH project, the act of participation not the quality of the performance is what holds significance, and the rationale for the hotel is that all people are creative and have knowledge that has value and is worth sharing.

While there is no automatic alignment between projects because they are in the global south, certain aspects of the hotel have resonances with the FEH Theatre Project. Both exist in poorer areas and service patients from poor and working-class backgrounds. Mcloughlin

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[34] Transcultural psychiatry is a branch of psychiatry that focuses on how 'social and cultural factors create, determine or influence mental illness' (Moldavsky 2004, p.1).

(2015) reports that there is a lack of support for the Hotel from the rest of the hospital who criticise the dissolving of the boundary between doctor and patient. However, Pordeus' qualifications as a medical doctor and the wide visibility he has managed to provide for the project mean that it is highly regarded within theatre and arts therapies as an inspiring example of artistic practice within psychiatry. While some of Pordeus' medical colleagues might feel that this project is illegitimate and will not result in any healing, Pordeus and the participants voice change and transformation that is publicly disseminated through four films made about the project, essays by Pordeus (2014; 2019) and academic and popular media articles (McLouglin 2015; Tavener 2015). Pordeus has established a legitimacy and visibility that I was unable to achieve in the FEH project, beyond research authored by 'experts'– in the main my own[35].

The site of an abandoned wing of a psychiatric hospital in Rio recalls the very first space allocated to the first phase of the FEH theatre project: an abandoned, never-been-used wing of the MSU. The integration of relegated cultural forms at the Madness Hotel has echoes with Fanon's practice in Algeria aimed at decolonising the hospital space and restoring collective cultural encounters. Evangelista (2015, p.231) notes that at the Madness Hotel

> the popular Brazilian ways of healing that traditionally involved rituals based on music and dance and that were systematically devalued by the dominant culture and profit-driven forms of medicine are restored and reincorporated as part of the healing process.

This resonates with the FEH patient-participants' re-enactment of Xhosa rituals, which I argue in chapter seven, is a culturally resistant strategy within the colonising world of the hospital.

Pordeus (2014, p.3) argues that 'in an affective, caring environment coupled with creative cultural activity, even severe chronic psychosis can develop affective relations, express

[35] This includes one journal article (Sutherland 2017) and three conference presentations: papers presented at *The symposium on healing and social transformation in mental health in South Africa* Cape Town (2014) presented with staff-participants Lauren Creese and Bongisa Shumane; *Performing the World*, New York City (2014); *The International Applied Theatre Symposium,* Auckland New Zealand (2015); and one presentation by Dr Mo Nagdee on behalf of all involved in the art, drama and greening projects at FEH at the *South African Society of Psychiatrists Congress* (2014) and published abstract (see Nagdee et.al. 2014).

feeling, and understand more about life and society'. This is the type of environment that we attempted to create in the FEH theatre project. The Madness Hotel created a radically inclusive space that is open to all who wish to participate in art-making, irrespective of 'religion, age, economic class, academic level, and gender, and not specifically for people with mental health issues' (Evangelista 2015, p.231). Although Pordeus often works with Shakespeare scripts, for him the heart of the experience is through ritual and improvisation as part of the theatrical encounter. Through years of experimentation and intervention from artists, Pordeus likens the actors of the Madness Hotel to Commedia dell'Arte performers in which the improvisatory impulse is paramount (Pordeus 2019). A troupe of actors, consisting of patients and staff, perform extracts from *Hamlet* every week at sunset on the promenade of Rio's glamorous Ipanema beach, observed by upper class citizens (Heritage & Ramos 2016). The work breathes in a way that the work at FEH was never able to, in that it is visible as part of street performance in Rio. It therefore claims artistic space for people experiencing madness in collaboration with allies, performing relationships and interactions between people that dissolves boundaries between sane/insane, /sick/healthy.

Such public visibility was not permitted at FEH. In the tight security of the hospital absolute anonymity of patients was required at all times. In my second selected example, the Olimpias project, innovative modes of presentation are sought to reconfigure ways of looking that deconstruct a diagnostic, knowing gaze, so that the performance work can be shown and shared without re-stigmatising the performers. One of the dilemmas I have concerning the FEH theatre project is how to share the performances we create in an ethical, dignified way. If the witnessing of our performances remains within the group, we could be accused of contributing to the silencing and invisibility of people labelled mad. However, as Kuppers argues, innovative methods are needed to disturb an audience's potentially patronising, exotifying, and pathologizing gaze. This is not something I managed to achieve – and it remained an ongoing, unresolved practical as well as ethical dilemma as to how, when, and where to share the work of the participants. I consider both examples – the Olimpias and the Madness Hotel – radical in how they approach performance with people who are either within, or who have experienced, psychiatric institutionalisation. Both examples allow me to understand the opportunities and limitations of my own practice within the particularities of a psychiatric institution in South Africa.

Petra Kuppers and The Olimpias

One Olimpias project in mental health contexts that Kuppers documents (2000,2003, 2005 and 2011) entitled *Traces* (1999-2001) explores multimedia techniques to gain visibility for artists who experience mental illness without getting co-opted into the patronising gaze of what she names the 'theatre of stares' and the 'vision machine' that heightens difference and otherness. Such ways of looking fixate madness or neurodiversity as other and strange. Kuppers connects this to the history of Charcot's staging of hysteria that becomes 'the staging of visible evidence of difference' (Kuppers 2005, p.149).

Traces was one outcome of an artistic process with users at a mental health day care service in an economically depressed area of rural Wales (Kuppers 2000; 2011). During initial meetings in setting up what the group wanted to do, Kuppers reports that one of the 'prime objectives for the creation of art works was to reimagine ourselves, to speak for us and for others about our lived reality of mental health as people living where we did' (2011, p.75). This project therefore seeks ways for people who have experienced the mental health system and madness to find their way into representation and recognition in a context where people labelled mentally ill are unrecognised in public life. The notion of being seen on one's own terms permeates the work of the Olimpias. Their artistic outputs explore innovative ways to control how the work is witnessed in ways that deconstruct a patronising or stigmatising gaze.

The group's first process engaged with legends associated with Welsh mythology. The workshops used a combination of performance and writing modes, such as tableau, ritual, chorus and creative writing to engage with the myth of the Lady of the Lake (Kuppers 2011). While the thrust of the work was process based, the group did create short performances for the public. However, 'it became clear that, while we felt a desire to show our work, we acknowledged a multitude of problems in bringing the performance 'live' to local events' (Kuppers 2011, p.81). This catalyses the group's process towards video as a way of sharing the work.

Kuppers documents another movement-based piece in which video installation becomes the mode of presentation. In this case the process involved using meditative exercises that

focused on breath and guided imagery to facilitate bodily awareness with participants whose sense of self in space and time was debilitated. The process was designed to foster body ownership and the pleasure of embodiment.

Traces was thus primarily a movement/choreographic exploration that made use of a multi-media gallery installation of the performers' process, which positioned the audience in the middle of the arrangements of screens. It was designed to be shown in many different community spaces such as small rooms or gallery spaces (Kuppers 2003). Monitors showed close images of bodies moving together, as well as still images, to the sound of vocal narration. This positioning required active involvement from the audience as 'their own bodies won three-dimensionality as they decided where to sit, and how to negotiate the video beams that made their silhouettes part of the visual experience' (Kuppers 2005, p.154). Kuppers notes how some of the performers demonstrate symptoms that are part of the bodily repertoire of hysteria (such as twitching and speech impairments) and therefore the recorded performances found ways to avoid a gaze that would be 'read for "symptoms" of mental health issues' (2005, p.153). Since madness has been made readable through distorted films, television and medical theatres, it begs the question of how it is possible to frame a performance to avoid further stigmatisation and stereotyping. When the FEH theatre group's performances have been shown, it is within the hospital and its attendant hierarchies and medical gazes, such as the weekly consultations between medical staff and patients. The medical gaze has limited expectations of patient-performers, so the political motivation to share the FEH project within the hospital environment is driven by the intention on all our parts to share performances, created by patients, which may surprise psychologists, psychiatrists, and nurses who work with the performers as patients. As I will argue in chapter seven, staff members get a glimpse of how psychiatric patients can be part of a collective creative engagement in which they create and make a vision of the world. Each person's contribution to the ensemble, their giving and taking of focus and helping to shape the aesthetic whole, provides a view of a patient who is creative, capable, and can step into a range of characters and contexts to tell a story that is important to them.

However, a fundamentally different gaze would operate if these performances were shown outside of the hospital context, and radically different techniques would need to be used to

frame the performances to escape and deny a way of looking that would confirm, rather than deconstruct, stigma. Kuppers' use of film and photography of performers allowed an intimate engagement with the performers in a performer-audience interaction, while denying the audience any sense of a secure reading:

> Rather the multiple-screen event fostered the intense presence of the performers' bodies while withholding "truth"…The use of multi-media in a performance context allowed us to work with our images – not so much by withholding our bodies, but by placing ourselves in a liminal space between presence and absence, framed mediation and full availability (Kuppers 2005, p.155).

Another aspect of Kuppers work with mental health system users/survivors that resonates with how we approached the work at FEH concerns the importance of embodied practice. As discussed in chapter three, psychiatry continues to separate the mind and the body. For State patients, who are forced to take medicine, to be physically and psychologically examined when the clinical staff require it, who are isolated from family and society, and whose sleeping, eating, hygiene, recreational, and sexual experiences or needs are controlled by the (total) institution, their sense of bodily integrity is continuously compromised. Kuppers (2003) notes how the participants' sense of embodiment is impaired in terms of how they can own or occupy the spatial and physical dimensions of the artistic work. She highlights in her own work how the 'performers' physical experiences seem to mirror the representational silencing or distortion in the media' (Kuppers 2003, p.125). This impacts on how participants feel they can claim space and feel confident in their bodies.

However my research at FEH found that patient-participants embraced the invitation to embodiment. In particular, the analysis in chapter seven demonstrates the ways in which the performative and embodied nature of black South African culture and ways of life has positively influenced the aesthetic processes and political impact of the project. Patient-participants have claimed the space for themselves and each other in ways in which staff who work with these participants in therapeutic contexts such as OT do not encounter (Maya 2016; Thandiwe 2015). The performance/playful body and the ease with which patients enter the invitation to embodiment, is rooted in what Morris (2014) refers to as a

playing/performing cultural repertoire in most South African indigenous cultures.[36] This recalls the influence of the playing/performing cultural repertoire of Afro-Brazilian culture: rituals and pageantry replete with songs, dances and collective embodiment recruited by the Madness Hotel (Evangelista 2015; Heritage & Ramos 2016). The improvisation form that is the basis of our practice in the hospital has roots in the expressive traditions of Black African cultures (Coplan 2007; Morris 2014). These performance cultures in which song, dance and orality are collectively shared, also underpins the performative nature of political resistance in South Africa (Penfold 2015).

Comparing and contrasting theatre projects within mental health contexts

The two exemplary practices differ in how embodiment and an inclusive aesthetic is approached. Both exist within cultural, historical and political contexts that influence how madness is perceived and what this means for the making and showing of performances.

The FEH project, the Madness Hotel and the Olimpias mental health user project all involve patient-participants from the lower socio-economic sectors of that society. The patient-participants at the Madness Hotel are both long term in-patients as well as out-patients of the hospital, whereas the participants in the Olimpias Welsh project were part of mental health day care centre. Pordeus has included 'the direct participation of acute and chronic psychiatric patients, as well as professional actors, painters, dancers, directors, poets and educators and graffiti artists' (Heritage & Ramos 2016, p.84). While his vision is expansive, Kuppers's project is smaller and intimate.

My sense of the Olimpias project's work with mental health users/survivors is that the experiences are sensitive and careful, which resonates with sections of our workshop sessions in the FEH Theatre Project. The Olimpias project is undertaken by out-patients who are not trapped within the institution. The Madness Hotel embraces disorder and an 'anything goes' approach which is accessible to anyone who wishes to play: patients, family

[36] Morris' study focuses on urban isiXhosa speaking youth in Cape Town, and argues that '[t]ownship residents not only relax by means of playing and performing, they utilise performance-based practices to embody and communicate their history, ethical standpoints, social mores and last, but not least, to make plays' (Morris 2014, p.204).

members, artists, psychiatrists. For Pordeus, the hotel is 'a space for free creation where everything is possible as long as there are ethics and people are safe' (Evangelista 2015, p.231). The approach to playmaking and embodiment references the carnivalesque cultural repertoire in which improvised singing, dancing, recitation and collective artistic collaboration dissolve the boundaries between sick/mad and healthy/sane. Pordeus' focus on spontaneity and choice as to when and how to participate (or not) aligns with my own practice.[37] Pordeus proposes that '[t]he first rule is the acknowledgement that anything can happen. Improvisation is the basis of theatre; dialogue is the basis of theatre' (Low & Pordeus 2016, p.225).

Kuppers reiterates that any traditional stage performance carries the burden of the politics of display and the audience's gaze that can ultimately re-inscribe stigma and otherness.[38] The Olimpias emphasises process-based projects rather than working towards an end product (Kuppers 2003). Her work therefore seeks to make visible performance processes and reframe these as a means of 'subvert[ing] representational certainties' (Kuppers 2003, p.123). However, the strategies used to do this through multi-media anticipate an audience that is able to read and experience the performance with some knowledge/background of this kind of aesthetic. In a South African context where the majority of people have little to no access to a wide choice of artistic products or arts education this kind of technique would be alienating. The Olimpias manages to stretch the possibilities for dignified representation through innovative integration of video, voice, and audience physical positioning in relation to the screen-based performances. This is an aspirational practice that was not viable within the context in which I was working but has challenged me to consider how an audience might witness performers with disabilities in ways that disrupt patronising or exotifying gazes.

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[37] Chapter seven explores how certain processes in the FEH Theatre project also embrace moments of disorder and how important these are within the regimes and need for containment that is part of psychiatric care.

[38] Although actors from the Madness Hotel perform extracts from Hamlet each week on the streets of rich suburbs in Rio, Pordeus is less concerned with the frame and the gaze. 'He insists always on drawing attention to the artistic skills of the patients as actors, to their capacity to give themselves to poetry, music, dance and theatre and their freedom from the need to please the audience' (Heritage & Ramos 2016 p.101). The street performances create visibility, decrease isolation and insert those labelled mad as citizens into a society that often denies such belonging.

At FEH, hospital staff assumed that the theatre group create play performances from scripts – much like the art group creates finished and tangible art works - which therefore have material value. The art group indeed became an income-generating activity that could showcase the activities offered by exhibiting patients' artwork each year; whereas the notion that each week's session involved a *process* of exploring theatrical playing and creation as an 'expression in and of itself' was alien (Kuppers 2003, p.124). For many staff, any art activity needed to generate outcomes in line with the healing and rehabilitation agenda of the hospital: a deterministic means to an end. These views were expressed in the interviews with staff-participants regarding their frustration with the misconceptions about the theatre project. The ephemerality of performance is hard to 'sell' when contrasted with the art project in which patients produce art that is then sold. Art, in the latter, is useful: both because it generates income and allows a constructive visibility for FEH when displayed.

This chapter has highlighted the complexities around how madness is performed against a backdrop of historical and contemporary images that collapse madness into limited and stereotyped embodiments of the 'other'. The three contemporary practices discussed exist in diverse international contexts, and yet they encourage me as a facilitator-researcher to acknowledge what the project at FEH did achieve. Like mine, theirs are projects that frame performing arts processes and approach theatre work with people labelled mad with a politics that does not start from their diagnosis, but from participants' identity as creative people who can create art. Like the FEH project these examples insist on mad participants as existing in culture and creating culture: not outside of every-day life and stories. And as with FEH, each example exists in a particular socio-economic-cultural context that informs the process, aesthetic, and visibility/witnessing of the theatre work. Pfaff's immersion into the world of the hospital in Switzerland facilitated a depth of relationship building with staff and patients that created trust between all role players within the hospital system. Pordeus' work creates a truly radical playground within a psychiatric hospital that spills out into street theatre, collapsing the binaries between madness and sanity, inside and outside the world of psychiatry. The Olimpias finds ways of sharing creative work by people who experience madness that deconstructs the way this work is witnessed to ensure representational strategies that are empowering. It is the above three distinct aspects from each example that I could not achieve at FEH, yet they offer a provocation and ways of understanding possible

strategies to develop resistant performances: to discern the smallest aperture in which to manoeuvre: even within tightly controlled forensic mental health contexts. In the following chapters I focus on the specific nature – the challenges and opportunities - of creating a theatrical playground in a forensic hospital in South Africa.

5 Method and Madness

The context of implementing a theatre project in a forensic psychiatric hospital in South Africa, which is then undertaken as part of a doctoral study, brings together a complex mix of people, purposes, procedures and protocols, which are at times incongruous and often potentially explosive. I begin this chapter by outlining some of the most suitable and challenging aspects of applied theatre research for the purposes of my study. Thereafter the chapter explicates the means I use to collect – and discern significance within – the data. I include limitations of, and challenges to, the research design.

Research rooted in applied theatre practice inevitably leads the researcher towards a non-linear and unpredictable methodology. Paradox permeates the research process and output, which in this instance is this thesis. When trying to write about the embodied practice, a crucial paradox emerges: the obligation, within the academy, to capture in words an embodied collective process in an individually authored text is a conundrum of research that emerges from a body of theatre practice (Fleishman 2009; 2012). The practice itself is at the heart of this research. Therefore, documenting a selection of workshops to analyse moments from the practice is a fundamental part of my research design. This shifts the analysis from a reflection back at the practice (which interviews and my own reflective field work journals undertook) to an understanding of the 'now' of the practice as it exists moment to moment, captured in time through video documentation. Yet I need to translate this back into words, to somehow translate the untranslatable into the one-dimensional text of a written thesis. The interviews, then, reflecting on the practice, afford me a lens, honed by distance, to discern how the theatre project was experienced by selected participants. However, as writers advocating practice-led-research have indicated, some practices and experiences are untranslatable into written text, and value needs to be accorded to research and knowledge that exists in the practice itself (Fleishman 2009; Haseman 2006; 2015; Leavy 2009; Nelson 2013). I was in the middle of experimenting with the theatre methodology before I began framing it as research for doctoral study. I discovered that the fluid and performance-based nature of how the group was run was at odds with the imperative of formalised research

projects to rigidly pre-define what the research is about and why. Conquergood (2002, p.145) articulates this as the 'transgressive travel between two different domains of knowledge: one official, objective and abstract … the other one practical, embodied and popular'.

Writing about research design is a similar journey between these domains. Although much of the design and interpretation of data collected was practical, intuitive, and difficult to define, as a researcher I am required to demonstrate a mastery of a research process that will build a rigorous conceptual scaffold for my empirical evidence. Furthermore, because I was dealing with research participants that are deemed vulnerable due to their illness and criminal status, the 'official' domain of knowledge threatened to overtake the minimal space I had to manoeuvre because the research process demands (through ethics and/or research committees) 'protection' of both researcher and researched. This protectionist framework is supposed to ensure that no harm is done to any party. I discuss the critiques of protectionist approaches to research with vulnerable groups (such as people with disabilities, mental illness, and prisoners), which tend to position these groups as universally vulnerable or incapable of making decisions. When applied to people with disabilities, protectionist approaches espouse a medical model for research, thereby reinforcing some of the reductionist critiques discussed in chapter three, which can deny the humanity of research participants under the guise of protection (Allbutt & Masters 2010; Holland 2007; Nuwagaba & Rule 2015).

Within the conflicting demands of a theatrical playfulness, scrupulous record-keeping and rigorous analysis on one hand and absolute anonymity of the subjects on the other, I opted for a case study research model. Caroll (1996, p.77) maintains that '[t]he case study is useful when, as is usual in drama, the researcher is interested in, and deeply involved in, the structures, processes and outcomes of a product'. As I play the roles of researcher and theatre facilitator, I am intimately immersed in the structure, process and research outcomes of the theatre group in the hospital. Within this study there is no attempt at distance: I care deeply about the people in the practice and how the people doing the theatre work experience it. The depth and detail that is part of a case study allows me to maintain an intimacy with the research and research participants.

Stake (2003, p.136) identifies some of the characteristics of a case study, the basis of which is that it is a 'specific, unique bounded system'. Merriam (1998, p.19) notes that

> A case study design is employed to gain an in-depth understanding of the situation and meaning for those involved…[and is] distinguished from other types of qualitative research in that they are intensive descriptions and analyses of a single unit or bounded system such as an individual, a program, event, group, intervention or community.

In this study, I provide an intensive description and analysis of a theatre programme within the setting of a forensic psychiatric hospital in the Eastern Cape province of South Africa. The specificity and uniqueness of the case concerns the context of South Africa's oldest psychiatric hospital; issues relating to forensic psychiatry; the framing of the theatrical activity as a site of play and outside of the medical, therapeutic, and legal mandate of the institution; the participation of therapists as fellow players with patients; the use of a variety of theatre processes including movement, music, improvisatory structures, and story/playmaking; the intersectionality of race, class, mental illness and creative processes within this milieu. A case study therefore allows a level of depth or 'thick' description that can honour the participants and the theatre practice. 'Thick description' is a method developed by anthropologist Clifford Geertz (1973) and refers to relating observed behaviors to their cultural context as a means of understanding the significance of these behaviours for the people within that context; it is a detailed interpretation of actions observed, and in this case study, chapter seven provides a thick description of what participants did and therefore how I interpret their choices and behaviours within the context of the hospital, South African and Xhosa culture: all of which need to be richly described as a means of adding credibility to the writer's interpretations (Ponterotto 2006). Norman Denzin (1989) - the 'father' of qualitative inquiry - extended Geertz' definition of thick description that resulted in its application across disciplines:

> A thick description … does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. .. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard (Denzin 1989, p.83 cited in Ponterotto 2006, p.540).

In this thesis, chapters one to four provide the contextual basis to interpret the actions and talk of participants in chapters six to eight that together surface the meaning the theatre playground has within the context of a total institution. Due to the lack of documentation of long-term theatre (or arts) practices within mental health institutions in South Africa (and on the continent), an in-depth description and analysis of this particular project is important in contributing to an understanding of the particular nuances, context, and approaches at play within this case.

O'Connor and Anderson (2015, p.30) situate applied theatre research approaches within a critical research tradition, a tradition that concerns bringing to the surface power relationships within research practices.

> Applied theatre, which always exists in the intersection of the aesthetic, the performative and the political can be seen ultimately as an act of resistance… the central interweave between research and applied theatre is political activity.

This study inevitably led me to examine the institutional power of psychiatry and its impact on self-representation, and how the creation of a theatrical playground within the institution consciously tries to redistribute power. Locating theatre practices as research acknowledges an embodied form of knowing and knowledge production that denies the mind/body and theory/practice division that is part of many research approaches. Collapsing these binaries is part of a politics that locates participants as knowers and knowledge producers, thereby resisting incompetent and incapable labels often assigned to people labelled mad.

Liampattong (2007, p.7) argues that research with vulnerable groups, which includes prisoners and people diagnosed with mental illness, should use the flexible and fluid methods associated with qualitative research. She suggests exploring innovative methods of data collection and analysis, including arts-based approaches, as these flexible methods allow the examination of meanings and experiences of vulnerable people on their own terms. There are an array of research methods and terminologies that fall under the umbrella of arts-based research (see for example Barrett & Bolt 2012; Conrad 2004; Finley 2005; Kershaw & Nicholson 2011; Leavy 2009; Nelson 2013; Riley & Hunter 2009; Smith & Dean 2009). Within theatre and performance, the terms 'practice-as-research', 'practice-based-research', and 'practice-led-research' are used to identify the relationship between the performance

practice and where the research output ultimately lies. I identify my research method as *practice-led* research in which research is initiated and pursued through practice (Haseman 2006; Smith & Dean 2009). Unlike most research sequences, this approach is not problem-led but starts from the messy unknown of the practice in which curiosities emerge for further exploration (Haseman 2006; Hughes, Kidd & McNamara 2011). 'Indeed they may be led by what is best described as "an enthusiasm of practice": something which is exciting, something which may be unruly, or indeed something which may be just becoming possible …' (Haseman 2006, p.3). This aptly describes the excitement that I and staff-participants felt when observing how patients responded in the theatre space – a space that was often unruly and required moment to moment responsiveness. The research emerged from this practice, in my desire to rigorously find a way to build a case for the affect and effect of inserting a space of theatrical play into a Total Institution.

For Dallow (2003), this distinguishes research *through* arts practice from research *into* or *for* arts practice. Haseman (2006; 2015) and Hughes, Kidd and McNamara (2011) suggest that practice-led research requires other methods to complement the practice, such as reflective practitioner research approaches and participant observation or action research. In my research design, the research that existed in the practice occurred alongside reflective practitioner, participant observation and action research methods.

Hughes, Kidd and McNamara (2011, p.206) argue that 'the research of applied theatre is a performed and performative process intimately connected to questions of power and identity'. Issues of power and identity surface when determining an approach to ethical theatre practice. They also surface in all considerations of ethical research procedures. However, the procedures set out by Ethical Review Committees may conflict with the value systems of applied theatre approaches as I discuss below.

Ethics procedures

This study required ethical approval from four different departments across three institutions in the following order: the University of Cape Town (UCT) Drama Department; UCT Human Research Ethics Committee; the Department of Health (Eastern Cape) Epidemiological

Research & Surveillance Management; and the Fort England Hospital Academic Research Committee.[39]

The construction of the theatre space within the hierarchical structure of the hospital requires myself as a researcher-practitioner to think through ethics continuously, and at times in the moment of practice, to discern and decide what the most ethical course of action might be to ensure the dignity and humanity of all participants. However, these ethical navigations within the creative practice did not necessarily align with the often technicist and protectionist requirements of ethical review committees. These committees are focused almost exclusively on 'capacity to consent' issues and ensuring the absolute anonymity of patients. The main ethical clearance procedure was through the UCT Human Research Ethics Committee. This committee's ethics clearance is the primary one on which the Department of Health and the hospital committees depend. For the sake of research ethics protocols, it was important to ensure that informed consent was granted as well as the right to withdraw at any stage. I accordingly designed an invitation to participate in the research, which was introduced in a group discussion with participants and also handed to each participant in written form in the language of the potential participants' choice (English, Afrikaans, or isiXhosa). If people expressed a wish to participate, their capacity to consent was assessed by a clinical staff member (either Lauren the psychologist or Bulelani an OT). If a patient was perceived as able to make decisions about consent, they were then given a form to sign that was explained verbally in the language of their choice (usually isiXhosa, with the help of Luvuyo), and then in written form. These three documents: the invitation letter, the hospital capacity to consent form, and the final document to sign stating the participant understood the research, that they had the right to withdraw at any stage, that withdrawal would not mean they could not participate in the theatre group, and that their confidentiality would be maintained, can be found in Appendix C.[40] For patients with severe learning, and mental health disabilities, such as Mzwandile, Bulelani spoke to him and his guardian, and it was agreed that his participation in the group was beneficial and that the research would not

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[39] Refer to Appendix C for all ethics documents.

[40] It was stressed that a person could continue to participate in the theatre group even if they had elected not to participate in the research project.

harm him in any way; in fact the research findings could be beneficial to him. This is in alignment with Allbutt and Hunter's (2010, p.214) argument:

> While a person's capacity to exercise autonomy and to give informed consent might be impaired by poor mental health, the risk of harm from research activity must also be balanced against the benefits of participation in terms of user empowerment and improvements in service delivery.

I was required to ensure as part of the ethics procedures that at least one clinical staff member was at each workshop to monitor participants' well-being and respond accordingly. In this case, the staff-participants were able to be fellow players but also to safeguard the patients should the necessity arise. In total forty-two patient-participants and four staff-participants consented to be part of the research. Two patient-participants decided they did not want to be part of the research but continued to be part of the theatre group. The ethics period was from May 2014 to April 2017. This covers almost the whole of the second phase of the theatre project (in the forensic wards from March 2014 to May 2017).[41]

The standard form used for an application for ethics clearance from the Human Research Ethics Committee is designed almost exclusively for scientific (in the narrow sense) quantitative research. It uses a format and discourses (such as 'research protocol' and 'principle investigator') that are alien to humanities research. This form is designed for medical experiments and adopts a medical model to the research process. The committee is based in and staffed by Medical School staff. Holland (2007, p.899) refers to the 'epistemological bias' towards a medical model of some ethics review procedures, noting that 'a "moral panic" – resulting from abuses in biomedical research – permeates the ethics review process and creates a problem for nonmedical researchers'. My application was initially rejected and further information and assurances were required. Most of these requirements were easily met (such as number of interviews, including an interview schedule, and the addition of a line to the consent form explaining that tape recordings are used to capture findings accurately). The biggest re-writing of the proposal concerned 'more definite structured informed consent and patient assessment'. This required ongoing monitoring of patients in the group. Lauren and I were required to put in levels of what I

[41] Initial ethics clearance was granted for one year but was extended.

regard as surveillance for each participant. For example, we decided that the only effective way of addressing this requirement was to place a note in the patient's file to remind the psychiatrist during weekly ward rounds that the patient was part of the research and should be monitored regarding involvement. Power was reverted to the psychiatrist as to whether a patient could continue to participate. These processes question a patient's agency and ability to make choices; yet the way the theatre group was structured was to offer choices continuously. The group was one of the only structured activities for patients within the hospital where a patient could choose whether he wished to attend on any given day. If a patient wished to leave early or sit out, he was free to do so. Nuwagaba and Rule (2015) examine ethical procedures in disability research in Africa and show how a medical model is inappropriately applied. They suggest models that are more culturally sensitive and based on human rights to ensure the dignity of all research subjects.

Another paradoxical ethical tension concerns the erasure that comes with being a state patient. These patients are cut off from their families and society in an enclosed system and anyone working with them is required to sign a form assuring complete confidentiality and anonymity. This contributes to my sense that the academy and the prison system deem such patients as existing outside of everyday life and, in some senses, eliminated from it. In terms of research practices this necessitated my using pseudonyms and destroying data after a certain period. But most patients expressed pride and joy at being part of the group. When reading through the invitation to participate in the research letter and signing the form to acknowledge that they understood the research and procedures, every single participant said that they did not wish to remain anonymous. I am compelled to provide a pseudonym for all patients. Staff gave permission to use their names, but since the patients were offered no choice as to whether they could be named in the research, I have chosen to adhere to the same ruling for staff. Since I have chosen a practice-led research approach that involves treating all participants as equal fellow players, that same approach needs to be applied when it comes to the ethics of who gets to choose how they are represented in research and who does not. Strict anonymity of research participants can be critiqued as treating all persons with disabilities as vulnerable irrespective of the context, and most importantly, of their own wishes (Nuwagaba & Rule 2015). Universally acceptable protocols need interrogation, particularly in a post-apartheid and neo-colonial context where such protocols

may maintain a long tradition of erasing people on the margins. At the same time (and there is another paradox which I am mindful of), I am aware that it might be difficult to gain ethical clearance for this research in most northern research contexts.

Disability rights movements, following the pioneering work of Oliver (1990), advocate that disability research improve the lives of people and that it be participatory and emancipatory.[42] I argue in this thesis that the theatre project at FEH achieves this. Medical and research ethical protocols may re-inscribe the very paternalistic and disempowering practices they seek to avoid. The laborious process of going through forms and asking for signatures from participants is the antithesis of the playful anti-structural nature of the theatre group. It immediately made our relationships institutional and co-opted us into an institutional logic which re-inscribed power relations. Ironically, these forms and processes required by standard ethical procedures felt remarkably unethical.

The ethical questions concerning the theatre practice as research concerned finding ways to make visible mad people's representation through performance on their own terms, whilst avoiding a patronising gaze that witnesses outside of the theatre group might adopt whilst watching the work. I was also determined to find ways for participants to discover and maintain an artistic identity that was empowering and an alternative to the 'mad bad' label associated with being a forensic psychiatric patient. A further critical ethical dilemma concerned the return of participants to the Total Institution following a session in the theatrical playground: what are the ethical implications of opening a world of possibility and agency in one space, when this is denied in so many other areas of everyday life in the institution? This is partly addressed in the analysis of the practice and in charting how the creation of a ZPD provides a developmental platform for certain men considered unable to learn or grow. Nevertheless, this did not stop the regimes of control interfering with the nature of the theatre space. There were several times when it was reported that nurses on a ward had threatened patient-participants with sanctions if they did not attend the theatre group.

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[42] Parts of this argument have been published in Sutherland (2017) *Method and Madness: de/colonising scholarship and theatre research with participants labelled mad.*

Type of data collected

Gallagher (2008, p.70-71) suggests that when researchers 'do' practical rather than observational research, it requires the researcher to continually reflect on questions such as 'How *do* we become available to different readings?' and 'How do the research site and those in it affect us?'. For example, when analysing the workshops, I struggled with how to honour the 'now', and see with fresh eyes, lest I fall into the trap of justifying the practice in ways that would correspond to the very regimes of surveillance operating when the activity is constructed *for* a particular goal (such as therapeutic or educational), which I was so strenuously attempting to resist. I wanted to make sure that my reading of the practice did not become merely advocacy masked as research.[43] A way of doing this was to understand the three types of data (reflective practitioner field notes; transcribed individual interviews, and video documentation) in terms of their temporal proximity to the practice. While the video documentation was the only data that was 'live', I decided to interpret it through the lens of the field notes. This was because the field notes were written directly after each workshop as I tried to process and notice what occurred: there is a personal and temporal proximity to the narration each week that is part of an emergent process. I treated the interviews separately to the field notes and video recordings. This is because they are reflections back on the experience by participants and are verbal text. However, I began with analysing the interviews as this data was, to be honest, the easiest to handle. Unsurprisingly but paradoxically for a practice-led researcher, my entire academic training had involved analysing verbal text. The study is constructed so that the patient-participants' and staff-participants' discursive reflections on the practice serve as book ends through which to view the embodied practice; they are placed on either side of the analysis of the practice. In a sense these reflections hold the analysis of the practice as without the reflective voices of the participants, the view of how the theatrical play is experienced would be dominated by my gaze.

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[43] Omasta and Snyder-Young's 2014 study reveals that there is little evidence of the assumptions that are made regarding the benefits of applied theatre, which often confuse genuine research for advocacy.

Limitations of interviews

As part of the research design, I wished to hear from participants about their experiences in the theatre group. Incorporating the voices of the participants is an ethical attempt to address the academic 'failure to incorporate the voices of mad people (without whom there would be no madness' (Venn 2018, p.50). However how to do this in a way that would have value for the researcher and the interviewee posed an ethical dilemma. At all stages I wanted the research process to be mutually beneficial. The choice of interviews as a means of gaining some insight into how patients felt about the group was the best albeit flawed option available at the time. I had originally planned to design a drama process to gain feedback about the group's experiences; however, this was abandoned as it felt like it was something that would benefit me rather than the participants. Gallagher (2008, p.14) discusses the limitations of using theatre processes to superficially engage participants as co-researchers, as introducing these research methods within the theatre frame can disrupt the integrity of the aesthetic experience. She says 'In making a system of our method, in contriving a form of participation, we had limited the art experience, the search, or the movement of ideas'. Like Gallagher observes, I was concerned that trying to gain feedback from participants through a theatre process would disrupt the integrity of the theatrical playground that is co-created. Individual interviews with a few carefully selected participants allowed those participants to talk about what they observed and felt in the theatre space and to be listened to. While the data is limited as it captures the voices of a handful of participants at a particular period of the research through one interview, the themes that emerge support the other data as well as troubling some of my own perceptions.

I am mindful that it is not possible to create a free space of exchange of views with patient-participants in an interview relationship due to power imbalances, and against a backdrop of how the interview encounter is present within the institution. Much of the patients' hospital experience with clinical staff is interview based: in therapy, with medical doctors, and on ward rounds. Interviews that occur with patients within the hospital and cognate research contexts are extractive rather than dialogic.

I opted to only interview people who had been involved with the theatre space over an extended period of time, which limited the staff in the hospital that were interviewed. This was because other medical staff either did not know or show interest in what we were doing in the theatre group and I was not sure what I would gain from other staff that would have bearing on the study. I imagine that there would be general support for the inclusion of this space as had been voiced elsewhere (such as during the journal club presentations or conference presentations) but the research was ultimately interested in the people who co-created the theatrical space. In retrospect I acknowledge that I could have engaged other staff such as Dr Nagdee – the clinal head – or other psychiatrists or psychologists about aspects of the institution that I felt strongly about such as the behaviour modification programme. However, at the time, my strategy was to keep the group running regularly and to do so meant staying under the radar to ensure the work continued unheeded. I was positioned as a guest within the hospital and during my time there I played the role of good guest who played by the rules and did not ask too many difficult questions of those in power. When I was in the process and within the institution (and representing another institution – the university) this seemed like the most constructive option.

In the thesis I avoid giving equal emphasis to interviews due to the power dynamics of the interview space and the limitation of the interview as method in this context. The heart of the research exists in the collective relational encounters in the theatre practice, and this is where I observed participants thrive. I recognise that the interviews are limited in relation to the data that emerges from the practice, due to the context and choices that follow. I contend however that the voices of the patient-participants provide insights and support for the study as a whole.

Interview procedures, processes and method

The table below outlines participants that were selected for interview based on their commitment to the group. Out of the eight patient-participant interviews attempted, six were successful; the four staff-participants who were part of the group were all interviewed.

Patient Interviewed	Date of interview	Place	Who present
1.Themba	7 November 2014	FEH Administration building	Alex, Luvuyo, Lauren
2.Vuyo	18 November 2014	FEH Hall	Alex, Bulelani
3.Monde	2 December 2014 (interview terminated)	FEH Hall	Alex, Luvuyo, Lauren
4. Khaya	7 April 2015	FEH Hall	Alex, Bulelani
5. Mandla	24 June 2015	FEH Administration building	Alex, Luvuyo, Lauren
6.Akhona	11 July 2015	FEH Administration building	Alex, Luvuyo, Lauren
7.Athenkosi	16 September 2015	FEH Administration building	Alex, Luvuyo, Lauren
8. Thando	15 July 2016 (Interview terminated)	OT building office	Alex, Luvuyo
Staff Interviewed			
1.Bulelani	7 November 2014	OT building office	Alex
2.Thandiwe	25 September 2015	OT building office	Alex
3. Lauren	14 October 2015	FEH Administration building	Alex
4. Maya	14 July 2016	FEH grounds	Alex

Table 1: Participant interviews

Two interviews were terminated for reasons I discuss further and cannot be included in the data analysis because it became clear that capacity to consent was impaired. These failed interviews are part of the practice in a broader sense because both illustrate how rapidly a research process can become co-opted into institutional hierarchies. Both patient-participants adopted an institutional performance in relation to facilitators and staff.

Patient-participant interviews

The men were selected through a purposive sampling technique in which people are selected 'who fit the criteria of *desirable participants*' (Henning 2004, p.71 original emphasis). Each interviewee had been part of the group for at least eight months so had demonstrated a commitment that indicated that they enjoyed or benefitted from the group. Each person was also high functioning, meaning that they were able to express themselves verbally and understand the purpose of the discussion. Another significant factor for selecting participants to interview was if they had each moved through the system from a closed ward to a more open ward, and were either due for a leave of absence (a LOA) to visit home, or were being transferred to a non-forensic hospital for chronic patients. This meant that they were able to see a future beyond the hospital and were therefore able to reflect on certain experiences, such as the theatre group, more effectively than someone who felt stuck in the system.[44] The seemingly random spread of interviews from November 2014 to July 2016 is due to the logistics required to ensure that a clinical staff member was available to be at the interview, which was a requirement of the ethics process, and to screen each interviewee to ensure that they had the capacity to participate. Some participants would also leave the hospital to visit family for a short period or get demoted and not be allowed to participate in the group. The planning and execution of an interview required permissions and availability of other people (such as Luvuyo to act as a translator) so that diverse variables needed to align.

The very first person I interviewed, Themba, had been part of the first phase of the FEH theatre project in the MSU in 2012. He then joined in the second phase of the theatre group when it became part of the other secure forensic wards in 2014. All the other interviews were with men who had started participating in the group when they were in the general forensic wards as part of phase two of the project (i.e. not in the high security MSU). I interviewed Themba just before he was released back to a hospital near to his home, and he

[44] An exception to this is Thando, one of the failed interviews who had remained in a closed ward for over two years. I selected him because he was totally committed to the group and seemed to gain a great deal from participating, finding a sense of meaning and leadership.

had the perspective of being part of two different groups, which threw up interesting reflections from him about how he responded in different contexts.

The interviews were semi-structured and involved a conversation between people that were all involved in participating in the group together.[45] In accordance with my research orientation, there was no attempt at objectivity or distance by any of those in the conversation– rather the interview was constructed as a way for us all to understand what meanings the theatre group might have. Henning (2004, p.57) names this approach a 'discursively oriented interview' in which talk is conceived as social action in which all parties co-construct meaning.

The interviews followed a basic interview schedule which groups questions around three areas I wanted to elicit views on: the patient-participants reason for deciding to attend the group long term; what they felt the reasons were for having a theatre group in the hospital; and the personal impact their experience in the group had on them.[46] The question about their experiences of having clinical staff participate with them in the group is influenced by my readings on Vygotsky. Holzman (2009) shows through diverse case studies how Vygotsky's notion of the ZPD can be observed in array of settings that are constructed as activities of social creation and the impact this has on building functional relationships. I wanted to understand from patient-participants how clinical staff playing with them made them feel and how they might articulate this. Staff-participants are asked a similar question. I try within the limitations of the verbal encounter to explain that there are no correct answers as the interview is about their own experiences of the theatre group and to help me understand more about the space. The questioning in the interview asked for specific examples (such as stories or activities that they remembered and any that made them feel uncomfortable or they did not like), and to position the interviewee as expert of their own

[45] Refer to Appendix D for examples of interview questions for patients and staff.

[46] The interviews did not attempt to get the participant to discuss the physical experience of the practice in detail, first, because I had the video footage which provided detailed evidence of this, and secondly, such a question would have necessitated the ability to name their experiences and this is a verbal challenge.

experiences. For example, instead of saying 'what are the possible reasons for having a theatre group in a hospital' I asked 'if you had to tell another person such as friend or family or someone on your ward what the reasons are for having a theatre group in the hospital, what would you say?' This simple shift in perspective elicited richer responses. In the interview transcripts, I notice how I affirm and summarise what I think patient-participants are communicating. I try to be an active listener that centres the talk of the interviewee.

I asked questions in English and encouraged responses in either English or isiXhosa. Luvuyo was there to help translate for seven of the interviews, and staff-participant Bulelani assisted for one of the interviews when Luvuyo was absent. Participants related well to Luvuyo who always established a relaxed atmosphere, and it was important that the participants felt at ease to express themselves in a language in which they felt comfortable. Four of the interviews took place in a staff office that patients were not familiar with: an administration building that patients never visit. This was intended to provide a space that was not associated with patient wards or therapy. The other three interviews took place in the hall where the group takes place. Both spaces are uncontaminated, so to speak, in terms of being spaces that are removed from associations with illness or with therapy. This choice of venue proved to be significant. On one occasion, we tried to conduct an interview with a participant who had been an important contributor to the group for three years, in a back office in the OT building – a building referred to as 'therapy' by all patients. This interview with Thando was terminated as it became clear that he was not well and he started to treat the interview as a therapy session, confessing his crimes and his despair. I discuss Thando further, and this incident, in chapter seven. My other failed interview was with Monde who had been part of the hospital for a long time and remained – like Thando – fairly unpredictable in that psychosis was often present and he referred to delusions or voices that fed certain narratives. This interview was terminated after he suggested that he should be paid for this interview, as it was close to Christmas time. After explaining that this was not possible, and it became clear that some of his delusions of being a prophet were infiltrating the interview space, we decided to terminate the interview. Nonetheless Monde had skilfully turned the gaze back on us (myself, staff-participant Lauren, and Luvuyo) as we scrambled around trying to work out what he was saying and how to end the discussion. On reflection he was using certain strategies to say 'actually, if you want to extract information from me, I should be

paid because I am important'. This could be interpreted as a decolonizing tactic with which a research participant, framed as vulnerable and needing protection, uses his power to drive the interaction in a direction advantageous to himself.

Five of the six completed interviews were conducted in a mixture of English and isiXhosa. When they were transcribed, all the isiXhosa was translated, including Luvuyo's translation for the participant in the interview, allowing a double translation: Luvuyo's translation for me during the interview, and the translator-transcriber's translation of the interviewee and Luvuyo's speech. This allowed for a richer and more accurate sense of what the interviewee was trying to express. Luvuyo would often freely translate back to Lauren and me based upon his knowledge of the person and what had occurred in the group, which the interviewee would always richly endorse after Luvuyo had spoken, even though Luvuyo's translation differed slightly from the word-for-word translation provided by the transcriber. In a sense, I was provided with one translation based on an in-depth knowledge of the context of the opinion, and one that was completely objective and unknowing of the context and interactions. Each interview lasted between fifteen and thirty minutes, depending on the level of detail the interviewee wished to include.

Analysing the interview material followed standard steps of thematic analysis. I began by familiarising myself with the data by reading the interview through at least three times, in the order in which they were conducted (earliest to most recent). Once I had an overview of all the interviews, I started coding the data that occurred across the interviews. My process involved clustering phrases on a grid under different codes that then became named themes. Each interview transcription was identified by page and line number that I plotted on the grid in relation to the broad theme. The identification of themes related to prevalence across the data: for example, observing repeated phrases (such as 'feeling human'). The two themes that I call 'relief from boredom & stress' and 'feeling human' were the most common and obvious to elicit. This was because at least two of the questions resulted in responses that corresponded to these themes as I tried to probe why patient-participants consistently attended the group each week. The other two that I name 'achievement & motivation' and 'hope and future projections' had less common exact phrases or terms, but were prevalent across the interviews for codes that resulted in these themes. In trying to draw meaning from

patient-participants' repeated references to, for example, the link between the theatre group and becoming a television star, I started to read these narrations as a politics of hope that defied abnormal labels.

Staff-participant interviews

There were four hospital staff members who participated as regular players in the group, and I conducted semi-structured interviews with each of them. I conducted an exit interview with co-facilitator Luvuyo when the project ended in 2017 which was not analysed but is used as a colleague's perspective on the project.

Each interview with staff lasted between thirty and forty-five minutes and all were conducted in English. All took place at the hospital: three in the staff member's office, and one outside (but on the hospital grounds) at the end of the day. Bulelani participated in the project from 2014-2017, Thembi from 2015 (before resigning), and Maya had participated intermittently (due to her varying status as student, then community service post, then full time staff post) since 2015. Maya had heard about the theatre and art project at Fort England whilst studying and came to the hospital for three weeks in 2015 as part of a study elective as she was interested in learning more about the integration of the arts within mental health services. She then requested placement at the hospital for her community service year (2016) and was absorbed as a full-time employee in 2017.

Bulelani was my first interviewee, and I adapted the interview schedule from his for the subsequent three. The interviews were therefore semi-structured, and I allowed the conversation to go where the interviewee took it. As with the patient-participants interviews, a similar process of coding and identifying themes was used. I read each transcribed interview (at least) three times through, and isolated recurrent codes that then became clear themes around which to discuss these interviews. As an interviewer, I was far more vocal in co-constructing the dialogue, sometimes expanding on a subject based on my own observations. With the patient-participant interviews, I held back from trying to shape or intervene due to the power differentials in the conversation.

Because each interviewee comes from a profession that requires them to reflect on their practice, the interviews revealed rich and detailed insights. However, each person was also quite distinct in their 'take' on how they understood the group, and I found isolating themes less obvious than with the patient-participant interviews. However, one theme dominated throughout, which I called 'Release'. Staff-participants uniformly discussed the ways in which their experience of the group released them from fixed roles and ideas around their practice as therapist. These are named as 'Release from institutional roles' (or 'just being human in the space') and 'release from a therapeutic gaze' in chapter eight.

Analysing the theatre practice

The analysis of the practice consisted of the following data: video recordings of two end-of-year performances (December 2014 & December 2015) and seven workshops (three consecutive workshops in 2015 and four in 2016). The videos enabled a focus on workshops at different times within the research period but from a distanced perspective, since they were viewed many months after the sessions. The timing to record the workshops was practical: I needed to make sure I had consent from the group to do so before each one, and to gain permission from the hospital to allow the videographer to enter the premises to record. This required a letter from a senior clinician to allow him to enter with the video equipment. I ensured that recordings were consecutive so that the group would grow accustomed to having the videographer there, and also to observe participants in consecutive weeks in case there were particular progressions. It also captured participants at a certain phase of their hospitalisation. The nature of the design for this research needed to emerge from an established practice that I was deeply invested in. While there is an emergent quality to the unpredictable and improvised nature of practice-led research that is then retranslated into written text, I do impose a political reading on the practice. The choice to frame the practice as political (rather than therapeutic) means that I do come to the analysis of the data with a lens that selects moments that highlight how power and institutionalised roles are fooled with and subverted.

As stated, I understand the practice through the lens that the field notes provided. In total, three A4 sized one-hundred-page hand-written note-books were generated over the total

period of the FEH theatre project (2012–2017).[47] The field notes that fall within the ethics period (2014–2017) assisted me to understand and reflect on how I located myself as a co-participant in the process. Conquergood ([1985] 2013, p.93) names this role 'co-performative witnessing' to locate 'the intimate involvement and engagement of "co-activity" or co-performance' that the participant-researcher takes. For Taylor (1996), a reflective practitioner research design involves the ongoing process of action and reflection in artistic meaning-making (both during and after the artistic event), thereby acknowledging the power of the lived artistic experience. Reflective practitioner research 'honours the intuitive and emergent processes that inform artistic meaning-making' (Taylor 1996, p.29). Part of the approach to understanding the in-the-moment experiences was, paradoxically, through writing. This was initially through reflective field notes written after each session that described what happened in the theatre space and then moved towards analysis and interpretation of key moments. Once I had analysed and written up the interviews, I approached the videography by writing detailed descriptions of the spontaneous moments I observed when watching the video documentation. This data allowed me to look at the practice through a double lens: I watched myself facilitating and it enabled me, through the camera, to discern spatial and personal relationships and behaviours that I had not consciously noticed whilst facilitating. This initial description led to analysing and interpreting exercises and key moments that are discussed in chapter seven.

The method of interpreting the field notes involved reading through them several times to elicit recurring motifs that emerged. By highlighting recurring motifs, I could trace patterns across time with which to mould discussion of the theatrical playground. The field notes provide an overview of a body of practice over a sustained period and capture patterns of observation during and after the practice. Due to the volume of writing, I colour-coded recurring motifs in my journaling with tags. This allowed me to discern how frequently a pattern of behaviour (by participants and facilitators) or relationships or choices of narrative and character occurred, resulting in my coalescing these recurring motifs under seven headings. These were: *Bodies, stories and roles in excess* that refer to moments in the videos

[47] Appendix A details the three different sources analysed (including dates, venues,and how they are referenced in text).

and my field notes where I noted how participants played with larger than life characters (such as a loan shark or famous rap artist), or playful uses of the body (such as dramatic dying or extreme facial expressions); *Stories of future, hope and meaning of the group* became central to the choices made and pointed to the future orientation of theatre and performance, which is always in a state of becoming. Institutionalisation results in being stuck (in time, space, being), and the rehearsal towards narratives beyond the institution held meaning for all participants. *Intimacy:* those moments in which participants found a sense of connection with others through gentleness, touch, and physical closeness were profound to observe and important to document as they demonstrate a way of being and relating that is often not recognised or given space, particularly with men. *Ethical Dilemmas* became a motif where I questioned what choices I had made and why. *Mastering and recreating the hospital experience* refers to the many examples where participants chose to re-create key moments of hospital life on their own terms. *Cultural expression* refers to the many examples where participants relished participating in traditional cultural songs, dances and rituals that connected them with a stable, affirming identity from civilian life prior to being imprisoned or hospitalised. *Development of certain patient-participants* foregrounds certain individuals as I noted their progress, creativity and choices that rendered the developmental possibilities of the theatrical playground visible. These last reflections led me to identify three participants and the ways in which they developed through the process that I highlight in chapter seven. The reflective practitioner field notes therefore form the overarching frame within which the practice is analysed.

The initial analysis involved charting the different sections of each session (warm-up; physical trust and partner exercises; Improvisation games; discussion; theatre making) and noting activities and interactions that highlighted some of the motifs identified in field notes (such as intimacy or the body in excess). This allowed me to focus on the ways that certain individuals engaged with the creative activities and how certain exercises facilitated the supportive conditions that created aspects of the space that I highlight as contributing to the growth and development of patient-participants. A close reading of the narratives and roles that were chosen in the theatre-making parts of the recorded practice led to a detailed analysis of three dominant themes centred around different types of theatrical play: playing

with deviance, playing with the Total Institution, and re-enactment of Xhosa cultural practices (playing with culture).

One of the methodological dilemmas I have had throughout this study concerns how I position the research – as there seem so many connected possibilities in a research basket which is aligned to a political or social justice research approach that attempts to narrow any divide between knower and known, researcher and researched. I am wary of making claims for a democratic, collaborative research approach, which suggests that research participants influence and have more power than they realistically do. It seems that often claims are made for a collaborative participatory research approach which perhaps belie some of the complexities and power-shifts that truly occur when a researcher comes from a privileged position socially and epistemologically. For example, O'Connor and Anderson (2014, p.6) position applied theatre research as radical. 'We argue for research that engages in processes where the marginalized might be the authors of their own stories, as co-researchers, and equal collaborators'. And yet I doubt how realistic or viable equal collaboration is within certain research contexts. While I position the research orientation here as emancipatory and argue, in the chapters that follow, how and why the research processes have been empowering for participants, it would be disingenuous to claim that participants were co-researchers and equal collaborators. I do argue for the role of participants as knowledge-producers and makers of culture. In a metaphorical sense they too become authors within the theatrical playground, rearranging the reality of the hospital by creating new scripts for themselves and others.

This chapter, and those that preceded it, have set out the possibilities and limitations of this case study as applied theatre research and have explicated the conceptual frameworks, which allow a best understanding of the theatrical playground within FEH. In the subsequent chapters I turn to interpretation of the actual evidence generated by the practice itself, as well as the staff and patient-participant interviews.

6. Glimpses of the possible: patient-participants' reflections

The analysis of the theatrical playground we created in FEH starts with the voices of the patient-participants to centralise their status within the research. Given that they have little autonomy and voice within the institution, it is all the more important that their voices are heard, not only in the theatre space, but also concerning what they think of that space, as well as in comparison with and in relation to, the voices of the staff-participants discussed in chapter eight. The patient-participant's perceptions, discussed here, have also coloured how I have explicated the practice in chapter seven.

The participants' voices validate the ways in which inserting a theatrical playground into a Total Institution creates a space of hope and agency. Participation in making theatre together is a practice that navigates the past, the present and the future. It is an activity of the 'now' and the 'next', which often draws on the 'what was'. Participants are invited to play with the 'what if', proposing and stepping in and out of a variety of aesthetic frames.[48] In dramatic play we are in an ongoing state of becoming as we generate new possibilities together: characters, movements, games, scenarios and proposals. Within the theatre space discussed in this and the following two chapters, we experimented with new relationships, notions of time, ways to use our bodies, self-expression and self-representation. This generative activity is not possible if those who are participating feel hopeless, as it requires us to take part in the spontaneous and unpredictable. What is clear from the interviews of all participants is that their participation in the drama group was a hopeful, future-oriented activity.

In this analysis I deemed it important to retain a sense of the personhood of each interviewee because the perceptions and responses of each was so particular. Nevertheless, over the six interviews, certain common themes repeatedly emerged. In the discussion that follows these

[48] I take Neelands' definition (2012) that theatre involves a transformation of self, space and time. Different aesthetic frames encompass these but are differentiated by how meaning is made within the activity. For example, a simple warm up involving throwing mimed objects which are received and transformed across the circle encompasses a physical/gestural aesthetic, which is different from a paired role play where participants improvise a scene between a father and a son.

common themes often overlap because that is how the interviewees came to hold their views. For clarity I have grouped them in the following way.

First there is relief from boredom and stress. Secondly, afforded the opportunity to practice being other people in different contexts – and to be seen by other people in these different guises - develops a greater sense of self, self-confidence, joy and a feeling of success. Thirdly, the creativity fostered in the playground opens the space to imagine beyond the present and thus to experience a sense of hope. Related to the latter, is that hope of alternative futures can be simultaneously useful and utopian. It is also important to note that it is not only the patient's predominant responses which are captured below. Their responses suggest significant contributions which can be attributed to the work we did in the theatrical playground that are key to my thesis.

Relief from boredom and stress

A strong theme that emerged across all interviews was how, at the most basic level, the theatre group interrupted the mundanity of life in the institution. This theme 'relief from boredom and stress' corroborates other studies that document arts programmes within psychiatric institutions and is captured by Mandla (June 2015): *'As we act, the mind begins to clear up and the stress goes away'*.

For four of the interviewees, the drama group was a relief from boredom. This was expressed by Khaya (2015) who said, *'we are just smoking and sleep, smoking and sleep, we do nothing, so to come to the drama, it gives us something to do'*.

Themba made a similar comment referring to his time in the MSU: *'we just sit in the courtyard and keep smoking, keep smoking',* later adding, '*it was something would release our stress, and just enjoy yourself for that one hour*' (Themba 2014).

I empathise with Themba, since I had observed that smoking becomes an activity that measures time – something to do while waiting with not much to do. My field notes remark (21 November 2014):

> I always find wards E,F,G,H quite disheartening due to the number of bodies collapsed around, inert, lifeless, asleep. One of the negative symptoms of schizophrenia is lack of motivation to do anything as well as isolation.

Some men are not permitted out of the enclosed ward areas if they have been demoted, so they are also deprived of activities associated with the OT department (such as gardening, sewing, and an income-generating car-washing project), resulting in extreme boredom. The system of reward and punishment for ways of behaving is central to producing boredom too: agency is discouraged. The contrast between how one sees patients in the wards, and what they are invited to do with their bodies and relationships in the theatre group, is remarked on by staff who participated in the group:

> *If I drive past different users, I might see them standing, sitting, waiting… Always just waiting for Godot, I mean, it's also waiting without having a sense of agency…you know, sleeping, lying, just disengaged, and in this [drama] space it's just an awakening of the body* (Lauren 2015).
>
> *It [the drama group] is a play space, and that's a very big deal when your days look like the days that these men live out. When most of what you do is sleep and then eat and then smoke and then sleep… And so a space in which people could come together and laugh was quite remarkable* (Maya 2016).

Athenkosi (2015) suggested that the group fills a gap for people who do not attend therapy or do sport, leaving them with little else to pass the time:

> *There are some of us who do not go for therapy and other things like sports. So that's where the drama group comes in, so that it can cater for those people who get left behind in the wards, to ensure that they have something to do*.

Several writers have highlighted how the affective aspects of engaging in performance need acknowledgement as having value. Thompson (2011) argues that experiences of joy and pleasure should not be seen as separate from the ways in which aesthetic engagement can be part of change. To solely focus on 'effect' is to bracket off the potential and need for people to have aesthetic experiences in and of themselves: 'by failing to recognise affect – bodily responses, sensations and aesthetic pleasure much of the power of performance can be missed' (Thompson 2011, p.7). For writers such as Thompson, and White (2015), aesthetic expression and experience can offer a respite from darkness, while being part of change.

As has been noted, there is minimal literature or documentation of the use of the performing arts within mental health settings outside of a therapeutic framework. However, Stickley and Hui (2012) discuss a participatory arts programme in the UK that offered arts activities in mental health units as a way to provide meaningful activities to improve the environment in wards, and to address the main complaint of boredom by service users. They note that 'boredom and frustration of the inpatient routine are factors repeatedly recurring within the literature' (Stickley & Hui 2012, p.403). Their interviews with participants show that their participation in arts activities counteracted a feeling of powerlessness that service users (their terminology) often expressed in relation to boredom. What is significant about their study is that the overall findings resonate very closely with my own: they conclude that participation in arts activities 'helped people to think about their future', which they link to hope and recovery. This is a theme that recurs in my own data and consolidates a link between participation in artistic activities and a recovery approach to mental health. However, all of the articles that argue for participation in artistic activity as linking to the arts refer almost exclusively to visual arts (Hacking et al*.* 2006; Meeson 2012; Spandler et al. 2007). This study argues that the performing arts are distinct due to a whole-person approach that includes physical engagement and encourages spontaneity and collaborative improvisation.

Linked to this theme of relief from boredom and being 'stuck' is the way that participants express how the group lifts mood, and is associated with relaxation and de-stressing. Consistent with other literature, for some interviewees, this was also associated with a distraction from the stress of missing home, or of thinking about one's illness all the time. For example, Mandla stated,

> *Now when we meet for the group session, the day, the time passes by quickly and when you come back even the stress is gone and the constant thoughts about home are gone* (Mandla 2015).

When we were recruiting from the forensic wards at the start of 2014, Themba had moved relatively quickly through the system from the MSU to ward E, the pre-release ward. He stood up to encourage others in his ward to join the group because 'drama relaxes your mind. It takes your mind off your illness for a while' (cited in field notes, 12 May 2014). This

idea that participating in a collective aesthetic activity provides an enjoyable space to 'block out' the negative is supported by research into the effect of artistic interventions in mental health settings.

Experiencing success

Another key theme emerging from the interviews is the sense of achievement participants feel when creating or doing something they never thought they would be able to do. For example, one patient-participant reflected on a partner trust exercise (leading one's partner who is blindfolded): 'You think you cannot do something, then realise you can. You think you will not trust to close your eyes and then you do!' (field notes, 10 September 2014). Participants are continuously invited to step into unusual situations in a non-judgemental way that allows experimentation and challenges perceived limitations. This leads patients to feel capable and motivated to keep participating. '*The most important thing about being in this group is confidence: knowing yourself and being sure of what you are doing'* (Athenkosi 2015).

Liegghio (2013, p.126) argues that people labelled mentally ill are part of an epistemic violence that disqualifies certain people in society as people who can have knowledge and participate in knowledge creation. 'Constructed as disordered, the psychiatrised person is disqualified as a legitimate knower and deemed incompetent'. These assertions of confidence and capability are taken further in chapter seven where I point out how certain narratives and characters made for performance are evidence of how patient-participants make appropriate, moral decisions, and through their theatre making choices, show how they care for themselves and others. Such constructions challenge the disqualification of mad people as legitimate knowers, who are incompetent and dangerous (Liegghio 2013).

Khaya's interview was challenging as he has a low level of education, so his ability to express himself in detail is limited, and his interview was the shortest – less than fifteen minutes. In addition, this was the one interview where Luvuyo was not present, which may have been a factor as hospital staff member and drama participant, Bulelani, assisted with translation of my questions. But Khaya chose to respond in English throughout so the extracted quotations are the exact transcriptions of his English expression, which limited the detail and complexity

of his speech. Nevertheless, his expression of positive feelings associated with performing something that others could enjoy is telling. This is also expressed as confidence-enhancing, as he gained pride in performing in front of others. Early in the interview, when I asked him how he felt the first time he did drama, he said: *'When I tried for the first time, I feel happy because the people who were looking to us were very happy … so even me I feel very happy to do the group'* (Khaya 2015). He reiterates this later: '*because when I'm making the people happy, because when they see me doing that group, they feel happy, so I like for people to stay happy'.* For men who have been labelled dangerous and mad, this is meaningful. Hatton (2009, p.92) argues that 'fictional role-taking can counteract mental health stereotypes as it can enable participants to demonstrate to an audience a wide range of complex feelings and attributes that subvert "dangerous" or "incapable" labels'. Chapter seven discusses the sense of intimacy that is created within the playground, that allows the space for a range of aesthetic relationships that require care for another, trust, physical and emotional closeness. This level of intimacy defies the diagnosis and labelling associated with dangerous men. While these men have committed acts of violence and may always be potentially dangerous, the theatre playground invites a range of relationships, some of which are intimate. It attempts to open up experimentation with alternative ways of being, and for these to be witnessed and recognised.

Khaya names the confidence to present himself in front of others as the most important thing that he learnt from participating in the group: '*I learnt to do something in front of many people. Sometimes when I want to do something for the people I become ashamed'* (Khaya 2015). Khaya alludes to the significance of positive social interactions that are part of this space, a key feature of a recovery approach to mental health.

Vuyo, another patient-participant who has been in the hospital for many years, felt that his participation in drama created learning and achievement: *'you get to become something you've never been before and <u>do it well</u> ... it seems like it's actually who or what you are'* (2014 emphasis added). Mandla discusses the sense of achievement when working with others through the messy business of figuring out how the group is going to enact their story: *'At first we get very nervous because we don't know how we are going to do it. But the more we did it, for instance, we started of* [sic] *practising…'* (2015). He refers to a scene in which he

participated about characters in a hair salon, and how it connected to his ideas about hope: '*I liked the story about the salon, ja, you know you think about what it going to be like in five years time, we are dealing with stories about our dreams'*.

At various points within the year, I use a mix of process drama (in which participants choose a role and then enact in an extended improvisation from that role's point of view) and devising techniques, to place participants in positions of authority and influence. This may include choosing medical roles, or roles involved with helping others, such as social workers, nurses, traditional healers, teachers, ambulance personnel, etc. In these instances, my colleague Luvuyo will become a less powerful character who requires other's help. Participants are given a choice of a range of roles in relation to the protagonist, who is often a transgressive or rebellious character, such as an adolescent who is smoking weed, or a patient who refuses to take his medication. This sense of helping to solve a problem, as opposed to being the problem – which is how many of the participants are positioned in their families and communities – is remarked on by Themba:

> *[A]nd even doing stories like there's a naughty boy whose age is 16 years and he is doing drugs and he don't listen and he don't go to school…, so we had to get a social worker, a teacher, a lawyer, a police, a nurse, and a* sangoma*, we all got that together to go there and give some warning to the same child, that she…he mustn't, he's a naughty boy, we all gathered and discussed things about their family is, that the parents are too old to raise or to be a guardian of the child, because the child is taking advantage that he can do anything so, it was a very nice story about that … so we discuss everything with the family of the that boy, and.. what was his name…Asanda! So Asanda, we, were all there, Dr, psychiatrist, lawyer, so we discuss in the family, and the problem was solved* (Themba 2014).

Mandla referred often in his interview to how the stories that are made and enacted reflect different aspects of life that assist participants to process those moments:

> *I'm saying, you find that sometimes the things we act out on stage are very helpful and actually happen in real life. For example, when someone is being fetched by their family and they say their good bye, we also act all of that out, we do all that, we act them out and they encourage and motivate us not to do the wrong thing* (Mandla 2015).

The narratives that involve enacting parts of the LOA process I understand as part of a 'hope' narrative, as once a patient is granted their first LOA, this signifies a potential end to their

hospitalisation, depending on how the LOA goes. My sense is that LOA is both desired and feared, especially as men are mindful of the stigma and often genuine fear, families and neighbours feel about them and their 'mad bad' status.

As a conclusion to this section on feelings of accomplishment and how these link to hope, a sense of future, and building of confidence, I turn to Akhona who presented a very particular persona as part of his interview 'performance'. A tall and imposing man, Akhona's dominating personality claims space and attention. His persona manifests in a narcissism that dominated the interview too, which focused on his brilliance as an actor. His projection of a preferred self was magnified as he spoke about his brilliance in many aspects of his life: from being a talented pastor to convincing us that he always had a gift as a performer from a young age. While he spoke often of his achievements, in the following extract he speaks about his *sense of achievement* relating to creating and then enacting stories:

> *what I enjoy about the drama group is that, before it ends, there's always a story that needs to be told. ... There is always acting there in the drama group on Monday you see. It's not only by playing games, throwing balls at each other and that kind of stuff you see ... It's acting in general, for me it's acting, that's what I enjoy. When I come, when I depart from my ward and come to the drama group, I know that the last portion of the duration of acting of the drama group, there's a story that needs to be told, that needs to be acted you see. That's what I enjoy the most ... That's what keeps me going there* (Akhona 2015).

To be able to tell, make, and listen to stories by and with others is a profoundly humanising activity that enacts witnessing, empathy, authorship and making in the world. Akhona's reflection that '*there's a story that needs to be told, that needs to be acted',* encapsulates an a motivation for creating with others. As reflected by the interviewees, this in turn leads to feelings of accomplishment that have had impacts on their sense of confidence.

Hope, future projections, and the utopian

A number of remarks from the patient-participant interviews refer to faith in a future beyond the hospital. Interviewees alluded to a transfer between things they felt they had learnt or discovered in the group and how they felt this might be useful to them in the world beyond the hospital.

Vuyo felt that he learnt how to experiment with a range of roles or characters that might help him outside of the hospital environment:

> *You know how to act and become someone else, you imitate a certain person … you also choose what you like in drama, in drama you choose what you like so that even when you go out there, you can choose to become what you want to be* (Vuyo 2014).

Themba talked about how he might 'do drama' with his children, or at the hospital he was going to be transferred to: '*One day when I am with them [his children] and they are feeling bored I will do drama at home…maybe they can call their friends, when its holidays … we can play drama'* (Themba 2014). These extracts indicate that these men felt that the group had meaning for them that could transfer to a context outside of the institution. In addition, the element of choice is important: the choice of 'who you want to be' or of activities and games that you will teach to others in order to alleviate boredom.

Part of this theme is the question of *connection,* which is a key word that I use to refer to moments where patient-participants talk about the scenarios that were created which connected them with 'real life' or home environments. Staff-participants noted the broadening of identities that are enacted through the honouring and acknowledgement of selfhood that is part of one's past, present, and future identity.

This thread between past, present and future references the principle of 'connection' in the recovery philosophy and is indicative of a performance of hope. In the next chapter, the analysis of the theatre practice illuminates the ways in which the theatre-making sections of the workshops facilitated a dynamic relationship between past, present, and future.

Themba reflected on how his sense of hopelessness prevented him from participating when he was not progressing out of the MSU:

> *I didn't have a problem with drama, I had a problem about being in the MSU because everyone was leaving the place because you're not supposed to stay, if you behave, more than twelve months… they were delaying everything … so I left drama, it was not that I didn't like drama, it's just that I was stressed, so, if you do drama, you need to be open you see, so that you perform well, you need to be in a good mood you see* (Themba 2014).

Themba's interview (two years after his time in the MSU) identifies how his sense of feeling stuck was an obstacle to his participation in the group which requires participants to be creators and initiators of experiences and stories – i.e. a future. Later he emphasises '*you can't do drama if you are stressed out'*, while indicating his awareness that if in the right psychological space, it can also be part of de-stressing: '*if you go to drama, you'd be released from your stress'* (Themba 2014).

Themba's interview suggests that his participation in drama, when he could see a future and progression through the hospital structures, was meaningful, particularly in helping him realise that he could *create* something with others. In a context of an institution which allows little initiative, user participation, or agency, several interviewees discuss the significance of enacted story making as having meaning for them. Through creating stories to enact together as part of every session, participants are invited to be creators, authors, and doers in the world, rather than passive receivers of the world, which is often what is required of a patient in a hospital environment. Themba's view resonates with a central tenet of a recovery approach to mental health, which emphasises the need to look forward in cultivating optimism and hope. 'Hope is a frame of mind that colours every perception' (Jacobson & Greenley 2001, p.483). Themba's reflections here reveals how hopelessness changes perception too.

Finally I turn to 'performing on TV' – a recurrent motif in the interviews, which is related to a sense of future and which is underpinned by hope within the recovery movement:

> *You never know that it might lead to, no one knows what the future holds, we might end up on TV one day!* (Mandla 2016)

Four of the six interviewees named television and television acting as the reason they were interested in the drama group, because they believed that perhaps one day they too would end up on television. On the one hand this suggests a hope for the future. However, this hope is utopian: a fantasy or desire that has no realistic basis. I was always confounded by this discussion and tried to interpret what was being said, as it felt like in each case that this was not an authentic belief, but a playful discursive tactic that named a dream. A man would often laugh when he expressed this. However, the fact that this emerged in most of the

interviews with no prompting suggests that I need to address the possibilities these projections represent. These are extracts from the four interviews where this theme emerged. Themba (2014): *'… so now I wish one day to be a star myself (laughs) to take one day drama seriously'.* Later he says, '*see those actors on TV ... how did they get there, you see?'*

> Khaya (2015): '*Sometimes it can be luck, to get something that you need. So, starting from this group, maybe I can be on TV one day'.*
>
> Mandla (2015): *You see, some of the people who are actors today when they first started they didn't really want to act but maybe they ended up enjoying it and even got opportunities to go overseas, got some training and became great that way.*

Mandla refers to how the people in the drama group are well respected on the wards and people are always asking about it, concluding, *'And we even encourage each other to keep going maybe we might even make it on TV'.*

> Akhona (2015): *I felt maybe, in the near future, if I start this drama group maybe it will open doors for me you see … So my ultimate goal is for me to act in an action movie, also a romantic movie.* Later, he observes, '*Acting is a passion of mine … because of seeing myself in seven or ten years time as an actor of martial arts languages, or martial arts films. It is a start. It's a start of the drama*'.

In each of these extracts, patient-participants suggest that they see what they learn in the group as potentially a means to a 'better' future.[49] They ponder about where the TV stars they see now began: from ordinary people, to extraordinary celebrities, who often then play 'ordinary' people. In some ways, actors in soap operas represent hope: not only are they enacting stories about South African life that viewers relate to, but there is the background knowledge that these actors were not always famous; that they began as ordinary people, possibly with no intention of becoming an actor, and some have very little formal training.

Each time a participant referred to this wish to become a TV or film actor, I was perplexed by the naivety of such an idea, and unsure of its origins. It is the suggestion of a near impossible

[49] It is important to recognise that the majority of South Africans have very little exposure to formal theatre, either as an audience member or in education. 'Acting' is almost always associated with the mass media such as radio and television.

dream, particularly for someone who has been labelled and diagnosed with a chronic mental illness. However, having read, watched, and interpreted the data, I suggest that this can be interpreted within theories of hope and the utopian. Jill Dolan (2005) draws on feminist theorist Bammer who distinguishes utopia, as something fixed, in favour of the utopian as 'an *approach toward*, a movement beyond set limits into the realm of the not-yet-set' (Bammer 1991, cited in Dolan 2005, p.7). This idea of moving beyond set limits resonates with my sense if what patient-participants gain from the theatre group as well as with propositions in disability studies, which foreground the need to allow for spaces of potentiality rather than containment. For Dolan (2005, p.13),

> Thinking of utopia as processual, as an index to the possible 'what if' rather than a more restrictive 'what should be', allows performance a hopeful cast, one that can experiment with the possibilities of the future in ways that shine back usefully on a present that is always, itself, in process.

A reading of the references to TV acting and participating in the group as a means towards a professional acting career also suggests a need for the group to have some use value: the feeling that participation will lead to some identifiable material or personal gain. Members of the art group have sold some of their art, and so the precedent for art having material benefit is there. Consequently, beyond the other use values already attributed to the drama space articulated above, it is hard to identify and articulate further associations with concrete value participating in a group like this may have for patients. This is particularly the case when every activity that one does within the institution is never purely for one's own enjoyment or personal development. The binary languages of cause and effect, means to an end, dominate our world and the hospital. Therefore, although performing is embedded into social, political and spiritual life in much of South Africa in the form of song, dance, and other oral performative forms, the idea of 'acting' is quite distinct and reserved for the fictional worlds of TV and film, where acting generates social and material benefits. Performing on television can accord you symbolic power and status when the characters you portray are richer, more successful and more powerful than you, the actor. But even when the characters you portray are very ordinary, you gain financial reward because you are paid for your portrayal. The question gains weight in light of the proposition that finding identities beyond illness is a critical factor in a recovery approach to mental health. In some ways, the

projection of a desire to be seen as an actor on television is also the projection of a hyper-normal, hyper-*visible* identity which attracts admiration and recognition. This is opposed to the hyper-visibility (as a focus of the exotic and stigma) *and* erasure (in the looking away) that haunts people with disability and is how the social world constructs them. The desire to be on television connects with a desire to be seen, acknowledged, recognised and have a voice.

Several writers discuss the gaze of disability that encompasses a process of looking *at*, as a site of curiosity and inspiration, as well as looking *away*: a gaze of fear and exclusion (Ignagni & Church 2008; Kuppers 2003; 2005). Siyabulela and Duncan (2006) argue that because mental illness is not physically visible, and is often purposively concealed, people suffer added stigma and resultant isolation as their behaviour is not understood or framed as a disability but as an inherent characteristic. In the theatre space, mental illness is not the organising principle of our work: it is not the basis on which we gather, although the group is part of a psychiatric hospital. Theatrically playing together as staff, patients and university guest-teachers, normalises the activity as something we all engage with, in which every contribution is considered and matters. Possibly the articulated dream that some might end up on television one day is also a projection of an idealised identity where one's mental illness is not a defining identity, just as it is not within this artistic space. The group therefore models a world of inclusion, however distant this space might be. For Dolan, 'The very present-tenseness of performance lets audiences imagine utopia, not as some idea of future perfection that might never arrive, but as brief enactments of the possibilities of a process that starts now, in the moment of performance' (Dolan 2005, p.17).

Dolan (2005) references Victor Turner's notion of *communitas* to think about the social potential of utopian performances, (which also calls to mind Vgotsky's ZPD). Dolan argues that theatrical performance can provide a momentary sense of affinity between people: 'They can imagine, together, the affective potential of a future in which this rich feeling of warmth, even love, could be experienced regularly and effectively outside the theater' (Dolan 2005, p.14). In their less scholarly responses, I think the interviewees were saying much the same thing.

7. Analysing the theatrical playground

I begin this chapter by introducing the patient-participants and explain why I have foregrounded three in particular. This is followed by the analysis of the practice, which starts with a discussion of exercises that open up each session and lay the foundations for the theatre-making section that takes up the second half of most workshops. This is a means of elucidating how the pre-theatre-making exercises establish the principles of the space that I characterise as a theatrical playground. This is followed by an analysis of three favourite narrative topics that participants explored through the theatre-making section of the workshops. These I have titled 'playing with deviance', 'processing hospitalisation' and 'cultural belonging'.

Introducing the participants

As I worked through the video recording and my own fieldwork reflections, three participants compelled my attention because they were so typical of the predicament of incarcerated subjects at FEH. They are exemplary instances, in that their long-term chances of a better life are very low, both because of their difficulties and how they have been diagnosed, and consequently treated, within the Total Institution; nevertheless their engagement and creative participation in improvisation are notable instances of patient-participants observed within this theatre project. As a way into analysis of the practice, I have consequently chosen to introduce these three players, as I believe profiling them enriches the reader's understanding of what transpired in the theatrical playground. Note that in the subsequent analysis, many other patient-participants are introduced as their contribution gains prominence.

These men had been hospitalised for several years and were likely to remain institutionalised indefinitely. Mzwandile and Lunga both have speech impediments and struggle to express themselves verbally, and Mzwandile has a severe intellectual disability. Thando told us several times that he had never learnt to write, yet he was a highly articulate, imaginative participant, who had long been in a closed ward due to the violent nature of his delusions

and the fact that his symptoms were considered regressive. These participants represent what Jacob and Foth (2013) name as a-potential, a term that refers to patients who stay for a long term within forensic psychiatric care (sometimes for life) and who demonstrate minimal potential for recovery. Lauren recalls how when we started the group in the main forensic wards in 2014 and Mzwandile had expressed interest, nursing staff on his ward had tried to convince us that it was a waste of time as he would be unable to participate (Lauren, 2015). Mzwandile is highly dependent on others as to what to do or where to go and requires constant affirmation and guidance. He seldom seems to understand instructions initially. According to Jacob and Foth (2013) these patients' exceptionalism can create ethical tensions among forensic nursing staff, whose job and training it is to provide therapeutic care. When this therapeutic function is deemed to have no value with an a-potential patient, the meaning of nursing care changes as a therapeutic relationship is no longer necessary, rendering a nurse powerless. This results in a change of attitude towards a-potential patients, something we observed when some clinical staff expressed surprise that some participants managed to contribute anything to the group.

> Unless nurses consciously decided to continue working with the individuals who continuously fail to produce the desired clinical outcomes, a negative differentiation process may take place; that is, the patient is no longer categorized within a medicalized scheme of reference and comes to be conceptualised as something else than a patient in its own right (Jacob & Foth 2013, p.183).

The authors define this process as constructing a 'zone of exception' after political philosopher Giorgio Agamben's theorisation of the 'bare life' that results when people no longer exist as legal subjects (such as in concentration camps) and are 'excluded from the political and social context they once belonged to [and they] … also no longer belonged to the world of humankind' (Jacob & Foth 2013, p.181). The attitude exhibited by some staff towards patients such as these suggests that they have been consigned to a zone of exception, to live a 'bare life', with minimal potential for growth or social contribution. However, as I observed (and documented in my field notes) in the theatre space, each participant showed improvement in, for example, their verbal and non-verbal expression and creative capacity. In examining my data, I concluded that their prominence indicated their worthiness as examples of what a theatre process can achieve in facilitating people to

‘perform a head taller’, in Vygotskian terms, as well as to play within and beyond the Total Institution.

Mzwandile

During the interview with staff-participant Lauren (2015), I recalled when Mzwandile came to our first ever session, and I wondered if he would be able to manage in the theatrical playground:

> *Alex: I remember when he first came I was like ‘oh my heavens’, because he could not understand a thing that was going on. And then by week four he was in the middle initiating things. So you know, it was just giving him that little aperture to be able to perform something different.*

My field notes from May 2014 when we started the group for the forensic wards highlight my concern about Mzwandile and his ability to participate:

> There is one man with clear learning difficulties. Lauren mentioned they think he is regressive. He really struggles to follow and does a lot of mimicking. But he does seem to gain pleasure and we decided that if he wants to be there and likes it, he should.

One month later my field notes reflect on a change following a spontaneous decision to do a different exercise involving sending and receiving a mimed shape and sound to different people across the circle. I note that:

> everyone managed to spontaneously receive a sound and object and propose a new one. It became an amazing space of “what will happen next?”. Even Mzwandile was able to receive and send with little hesitation – his growth has been phenomenal (25 June 2014).

In July my field notes observe the first time he holds and initiates a group space:

> Luvuyo asked for volunteers to do the shakeout ... [two people volunteer] and then, Mzwandile took centre and led us all in a shakeout and stretch. He was able to take space and lead in ways I doubt he can in so many other areas of his life’ (30 July 2014).

This was his eleventh session, and the following week he started to attend OT programmes outside of his ward for the first time.

I subsequently discovered that before joining the theatre group he had not been attending any other programmes, as staff had decided that they would be of little benefit to him. However, after starting at the theatre group, he also started to attend and benefit from other hospital programmes offered by the OT division, such as gardening and woodwork. His increased confidence and ability to participate with others and initiate activity extended his participation to other programmes in the hospital.

Lunga

Lauren and I observed how a participant such as Lunga uses the voluntary aspect of the group to exercise agency. Lunga is a patient who comes across as intellectually impaired due to the way he steps in and out of concentration in activities and how he relates to others. He is hard to understand due to his speech impediment and can get frustrated trying to express himself. He always comes to the group, but always comes late. He utilises the aperture of freedom he has by capitalising on the journey to the group, taking his own route such as visiting the tuckshop or someone on another ward. He worked out very quickly that he was not going to be sanctioned for being late and possibly leveraged this for his own sense of control and choice of what he did with his time: something that he was not afforded elsewhere. In the following dialogue, Lauren and I attempt an interpretation of Lunga's participation in the group as a ritual:

> Lauren: *I just thought, that despite the fact that he comes twenty minutes late, he comes religiously every week…that communicates something special… Like he finds his way, and it is his own individual ritual.*
>
> Alex: *It is his ritual. He leaves ward H and goes to find tobacco or visit his mates and then he arrives, with a grin on his face and knows exactly what is going on and participates very willingly* (Lauren 2015).

Thando

I identified Thando as a good candidate to interview because he is extremely articulate, very sensitive, and had been a dedicated member of the group for three years. But due to the persistence of his psychotic thoughts, which continued to be violent, he had remained in the closed wards (G & H). He was stuck in the system and yet he clearly enjoyed being in the

theatre group and benefitted from it. On the day of his interview, we could not use our usual administration office space and so were directed to an office at the back of the OT building – a building referred to as 'therapy' by all patients. I thought this would be convenient as Thando was already involved in a programme in the building. However, as soon as Luvuyo and I started the conversation, Thando resorted to a confessional therapeutic mode, telling us about his crimes and psychological pain. It seemed to me that this was the only way he knew how to perform in such a context; as if what was expected of him, when seated with myself and Luvuyo in an enclosed environment that was part of the everyday life of the hospital, was to account for his crime and to express his trauma and some of his psychotic delusions. Despite working in the MSU and the hospital for five years, this was the only time I had ever felt that we were in a potentially harmful situation and I ended the interview. I felt ethically compromised by this experience, as it became clear how quickly we could slip into a therapeutic and confessional mode, however unintentionally. He expressed a fragility and brokenness, and I found myself tumbling into terrain that was potentially harmful for all of us. The termination of his interview was a pity from a research perspective. We were surprised by Thando's response, which, I believe, reveals the extent of his institutionalisation because, it seems, he had learnt to conduct himself in distinct ways according to who his audience was, as part of long-term hospital life.

I am highlighting Mzwandile, Lunga and Thando as the 'core protagonists' in my account of the data, due to the ways in which their progress and participation shows how long term, a-potential, 'exceptional' patients can 'perform' potential and defy perceptions regarding their capacity and agency. Rather than being 'excluded from the political and social context' as theorised by Jacob and Foth (2013), in theatre-making activities their participation shows how they can actively co-create political and social meaning through theatre.

Introducing the practice

This section introduces the reader to the practice, first outlining the principles that inform the practice and then a typical workshop structure.

These principles that guided how we worked developed over time, and are not made explicit, but are implicit in the way the sessions are structured and facilitated, how my drama work

has developed in relation to a wider body of my experience, as well as within the perceived rigidity of the Total Institution. They will become more evident as I discuss and analyse the practice.

The founding principle is that every person is related and responded to as a creative person and the potential capacity in everyone to create is a fundamental principle of our work. Creating, or making things – in this case in the drama space – fosters a sense of agency, of possibility and perhaps self-confidence in the long term. Related to this is that everyone in the space (even observers) are seen as fellow players, and each player is invited to participate in a variety of ways should they wish to. If a security guard is present, he is invited to participate and they often did. Thirdly, every participant has a right to choose not to participate, or to alter their mode of participation, as long as the physical and emotional safety of other players is respected. Related to this principle is the notion of choice: choice is integral to participation and, within each workshop, players make choices in different ways, either individually or collectively. Fifthly, within this space, touch is important: the process supports touch and connection that is part of creative collaboration, building relationships, connection, and intimacy associated with finding the human in each other. Sixthly, making something is part of every session: seeing and constructing ourselves as fellow players and makers (of stories, music, performances), and being witnesses to other stories, is an integral part of the methodology. The final principle is that every contribution matters and is to be valued and recognised.

In planning for each session, I try to involve diverse experiences for participants, so that we experience a variety of spatial, temporal, and relational activities. Often this means that we move from a whole group game in the circle structure, to partner work and to the involvement of a non-verbal activity which requires a more intimate, careful interaction with another. The last third of the whole session (which lasts between sixty and seventy-five minutes) involves creating a scene or performance to show. Throughout the whole process, Luvuyo and I are ensuring that all participants are both performers and spectators, partners in creating performance events (Sauter 2004; 2006). In this way all participants see and recognise themselves and their fellow-players as creative contributors, and this short play

time of improvisatory theatre becomes an experience which is complete and satisfying in itself.

Each session will start with an ice breaker to physically warm our bodies and change the nature of our interactions and the space we are in into a collaborative play space in which spontaneity and creativity can be explored. We always start in a circle, which suggests that no single person is the leader but all have an equal responsibility to both lead and follow, thereby establishing a contract based on democratic and active participation. This section of the workshop usually lasts around fifteen minutes.

The next activities are what I term a transition phase, which usually requires less active, quieter or non-verbal exercises, often with a partner. These exercises require a level of vulnerability and trust in working with a partner. An example might be mirroring exercises, sculpting or moulding a partner's body into a representation (a parent, a politician), or creating a short gesture/sound sequence with a partner. I usually dedicate around ten minutes to this phase.

The next phase moves towards original creation of material. This might first involve exercises that develop collaboration and creativity: improvisational skills that involve give and take, or experimenting with bits of costume, characterisation or frozen, physical images. It is usually in this phase that participants start to trust working spontaneously with each other, extending the physical possibilities with their bodies and how they relate to each other, and experimenting with a range of roles, stories, verbal and non-verbal play. This section usually takes up around fifteen minutes of the workshop time.

The final creation phase usually involves small group or pair work in making or crafting something to show or share, usually a short scene. However, it may also be a movement sequence, or an abstraction such as creating a machine with bodies that makes a product or a feeling or a song. We usually spend around twenty minutes making decisions about what each group will do and rehearsing this.

The workshop ends by witnessing each other's work and a brief reflection on what we have seen; depending how many groups there are, this can take between ten and twenty minutes.

A brief closing ritual concludes each session and that involves holding hands in a circle and taking breaths in and out together as a group.

My plan for each workshop recording can be found in Appendix B, in chronological order.

Theatre games deconstructing the Total Institution

The basic building blocks of theatrical play, performance or improvisation involve bodies in time and space. As a means of honouring the belief in improvised performance as affective and effective within a rigid institution, this analysis will be organised around the ways in which certain activities and the ways they are responded to are played with spatially, temporally and physically, in ways that offer alternatives to institutional scripts.

The opening ritual for every session involves inviting any participant to enter the centre of the circle and initiate a physical warm up that everyone follows. This is the one activity that is constant across all sessions. This consistency allows me to take note of how the invitation to participate is used, and how this starting ritual initiates a way of working that invites us to use our bodies in ways that are playful, unusual and unfamiliar. For Boal (2002, p.2) working with and on our bodies, as actors and spect-actors, is aimed at dismantling inhibitions towards full aesthetic participation, as well as at creating what he calls 'theatrical communion'. Part of creating theatrical communion is transforming the ways our bodies have been habituated through school, religion, politics, family (i.e. institutions), so that we learn to undo our habitual musculature to create discomfort. This allows us to experience our bodies, selves and relationships differently. By experiencing our familiar bodies strangely, we experience ourselves and how we relate to the world differently too. My reading of the practice shows that the framing of the group as primarily for enjoyment releases how we play with our bodies, so that our bodies become sites of potential joy. In a context of dis-embodiment – where the mind is treated as separate from the body, and where the lifeless body is normalised due to drug side-effects, illness, boredom or the effects of institutionalisation – such theatrical communion invites an alternative to the institutionalised body.

The group starts seated in a circle. I then invite us all to stand up, and either I invite someone to start us with a physical action in the centre, or a group member will spontaneously start

this. These entrances and exits from the centre of the group are brief and turn-taking is random. The physical actions are often aerobic – star jumps, body twists, kicking actions, shadow boxing, although some participants experiment with abstract or expressive movements such as dancing, flying, or a brief movement sequence. This ritual evolved within the first few months of starting the group. Initially, myself or Luvuyo would lead a physical warm-up. My field notes indicate that gradually certain participants were either invited to initiate something by one of us or they volunteered. This developed into a starting activity that participants spontaneously took ownership of, whereby someone voluntarily entered the circle and initiated a movement, and then others joined in one by one. The ownership of this starting activity developed to the extent that patient-participants started to pick staff-participants or facilitators to enter the play space if they had not volunteered. Spatially, the holding frame of the circle is established, as are brief moments where individuals initiate and lead a physical action in the playing space of the centre, based on their own spontaneous sense of what they do, when, and how. As there is no established sequence, participants need to decide when to go, when to hold back if someone else takes the space and work out within the order/disorder of the game how we (the group) make it work. We need to establish a sense of timing through listening and observing.

This activity establishes several key features about the space. According to Neelands (2016, p.30) the circle structure 'challenges hierarchical relationships of power, encourages participation and dialogue and does not artificially separate participants into actors and spectators of action'. This opening exercise establishes choice and openness as to how one wishes to participate; rules of give and take; a valuing of spontaneity; the sense of uncertainty within containment; and the challenge to initiate and lead a unique action that the rest of the group will follow. To use terms key to improvisation, it is about observing and listening, giving and accepting offers made by fellow players and developing ensemble playing. What I observe from the recorded sessions is that every participant is able, and invited, to participate, and most take up the invitation. Some participants with physical impairments might watch first, then find their way in and propose a movement that is within their movement range. For example, one man with a motor disability proposed an upper body swaying motion which everyone duly copied. This starting exercise is open enough to be non-threatening in that a person can decide what to do and how, and the focus on holding

the space by entering the centre is brief, before returning to the security, or anonymity, of the circle. Staff-participant Lauren and facilitator Luvuyo often use this exercise to enact comic, clowning-like actions, playing 'the fool' and playing with their status.

For some participants, the permission to enact a wild energy is important. For example, Lunga will watch carefully, then might choose his moment by slowly walking into the centre, gaining focus, and then taking on a frantic shake-out which we copy. This simple sequence of actions demonstrates his use of time, space and movement: from a slow deliberate entry into the centre, stillness that results in the group anticipating what he might do, followed by a burst of an immersive bodily experience of shaking the whole body, and retreat. Sometimes he chooses not to participate at all (or he is very late) but if he does, each time he initiates a completely different type of movement, suggesting that he is able to step into the moment spontaneously. Over the years of his involvement, he has used the space and activities in several ways to gain focus and carefully time his contributions to achieve maximum witnessing. Lunga has moved from a sense of being lost for the first few sessions, to his unique means of claiming leadership and focus in how he responds to different creative tasks. Lunga is also a committed and successful member of the art group, informing us that he had earned money to buy himself new clothes when some of his art-work had sold at the festival exhibitions. For him, the drama group is a social space of connection (a core principle of a Recovery approach), where he seizes the opportunity to interact with the outside world. This became clear when watching recording three (31 August 2015), and observing a small action from him that I would never have noticed while facilitating. Two student nurses are there for the first time. Mzwandile is sitting next to one nurse, and Lunga next to Mzwandile. During my opening introduction, he whispers to Mzwandile to swap seats, so that he can sit next to the nurse. Every time there is an outsider who joins (for example student nurses) Lunga ensures that he partners with one of them. Lunga's disabilities must mean that his integration and response to therapeutic interventions present challenges. His chosen identity as an artist and maker in these aesthetic spaces is a significant part of how I believe he maintains hope and a sense of future within the institution.

In creating a space of invitation and choice, this simple opening activity echoes a social transaction where power shifts, and respect is given to how people wish to participate. It also

celebrates difference – different ways of proposing we move and asks us to physically take on difference.

This activity echoes several other opening games that are played, which ask for rapid changes in focus and who might influence other actions. Examples of such games are ones where a person is caught in the centre and must call a category to initiate a chair swap as a means of trying to get a chair in the circle. Games like 'fruit salad,' or 'everybody who', involve different moments of disorder as we dash to find a new place, then order, containment and relief as we land on a seat, and then the anticipation as to whether we will have to dash across the circle again. The dance between knowing and then not-quite-knowing what will/might happen next is the cornerstone of improvisation and resonates with Pordeus and the Madness Hotel's focus on spontaneity and unpredictability as key to the transformative possibilities of collective theatre making (Evangelista 2015). These games ask for a spontaneous, playful body that is aware of space and time. This spatial and temporal awareness is something that hospital staff have observed as being more evidently skilful in some patients in the theatre space as opposed to a therapeutic space where time and spatial awareness is a therapeutic goal – and therefore under the gaze of diagnosis and therapy. A patient in therapy is aware of being watched and becomes vigilant about getting it 'right' or 'wrong'. In an institution like a (forensic) hospital, the place for playful disorder and the invitation to use our bodies in experimental, at times bizarre, ways is extremely hard to find. The remit of such an institution is about order/containment for lives that have often become disordered and uncontained by illness. The negative side of this is over-discipline or over-containment, so that one's day-to-day life becomes regimented, or in Foucault's terms, docile. Hence the need for this small interlude in a theatrical playground. The warmup section of our workshops reminds me of the carnivalesque where the body can exist as a site of excess and joy, a site where the disciplined body is briefly suspended.

Hyper-Embodiment in the Total Institution

One of the themes that emerged through video documentation and field notes concerns *the body in excess.* It is in these activities where I note the effect/affect of our physical activity as 'larger than life'. In these games, participants are invited to contribute a variety of physical

actions that are magnified through the kinds of activity that play requires. An embodied approach is significant within a Total Institution dominated by a bio-medical model that reinforces a mind-body split. 'The embodied experiences of symptoms [are] discounted in traditional discourses about mental illnesses. Conditions are presented as though the mind can be separated from the body it is part of' (McCann & Clarke 2004, p.784). If the majority of participants' lives are dis-affected and dis-embodied, as I observed when they were in the wards, what then is the significance of aesthetic or playful activities which are larger than life? Below I describe and interpret two warm up exercises often played and I argue that these games breathe life and celebrate embodiment with participants whose illness and institutionalisation are experienced as disembodied. Embodiment can be defined as 'the sense of being in a body or having a body, a conscious engagement with the materiality of sensing bodies or the experience or practices that are physically manifested' (Parker-Starbuck & Mock 2011, p.212).

Two types of warm up activities fit into a category of games whereby the body is invited to be in excess of the ordinary. The first is a standard opening game in which participants are asked to say their name at the same time as they make a bodily movement unique to them, which expresses their name or how they are feeling, and which the whole group then copies before moving on to the next person's individual contribution. The second is a game in the circle, which involves fairly complex sequencing: a person turns to face the person to the left of them in the circle, offers a sound/rhythm and gesture, which their partner then accepts by mimicking back to the former, then the partner turns and offers their own sound/rhythm and gesture to the person on their left. The group watches each interaction, waiting their own turn, and offering their own unique, spontaneous sound and action when their time in the circle arrives. This requires holding an interaction with a partner, acknowledging and accepting their proposal by mimicking it, and then taking charge of the space while the group witnesses – to create something totally new. When some participants get stuck – for example, a man will face his partner, then forget to copy his proposed gesture, and just turn to the next person – the group reminds him to take on the rules of the sequence. Two participants in one workshop reversed the interaction (own proposal and copying partner), which was accepted by the group as it did not interrupt the flow, and the exercise continued. The game can be bizarre, with a diverse range of sounds and gestures which shift from

emotional, to animal, to abstract, to clown-like responses. This game invites the irrational in an institution where the irrational is under surveillance. Spatially and relationally, the game requires an interaction with one person on either side of you. For the rest of the exercise, in the circle, participants are witnessing the range of sounds and actions, giving energy and support to other players.

Sibongile struggles to communicate with a partner – for example in a more intimate mirroring exercise he will get distracted or avoid holding the interaction. Or he participates accurately during the first round, and then struggles when I ask that we do the exercise again, faster, the opposite way around the circle. As a facilitator I am trying to encourage improvisation, so that participants are asked to come up with something different with little preparation on the second round. This results in a different range of movements and sounds and more abstract expression. However, this participant gets stuck, and we (myself and Lauren who is his partner) quietly ask him to repeat Lauren's gesture, before proposing his own, which he does after the third attempt. In so doing, we are challenging him to step into the complexity of the sequencing and rhythmic structures of the exercise, particularly as he has done this before. As a facilitator I am intent on finding ways for us as a group to support slower participants to achieve within the game. For Vygotsky (1978) the ZPD fosters development in group processes where more capable peers support the potential in others. This example speaks to the nature of the gaze that is fostered within the theatrical playground. I have argued that the dominating gaze in the wider institution is paternalistic and pathologizing while the gaze in the theatre space is non-judgemental in that all contributions are valued. The scaffolding of rules that make games or activities work collectively is part of a wider recognition (and belief) that all participants are capable of sequencing, turn-taking, and other characteristics associated with ensemble playing, such as listening and being accountable and responsive to the whole group. In performing *as if* we all are able to do these things and supporting those who have not quite mastered something - by relating to them *as if* they can, participants are enabled to perform 'a head taller' than what is expected of them.

These two warm up games were played twice across the seven recordings made. Observations from the name and gesture recordings indicate that the game introduces a

range of physical movements, rhythms, and vocal expression, which each person is asked to take on and which is enjoyed by everyone. It therefore extends the sense of how people use bodily movements and express themselves vocally and physically. It also places focus and value on each person's contribution: each person in the group gets to lead and initiate other people's movements and gestures. Conceptually, participants learn the value of spontaneity in the space because sound and action do not need preconceived meaning or communication for the game to work. Shyer men, or men whose affect is blunted in their usual interactions, resulting in limited bodily movement or emotional expression, demonstrate a far wider range of movements than normal. For example Patrick - who Thandiwe refers to in her interview, noting how much more extended his use of physical space is in the drama group - shuffles into the middle and, even though he appears quite stiff, extends both arms up and down in a quick motion while saying his name.

The range of physical and vocal expressions demonstrated in this one game is significant. One of the features of conditions such as schizophrenia is disembodiment, and several studies use phenomenology to explore the schizophrenic's experience of feeling outside of, or disconnected from, one's body (de Haan & Fuchs 2010; McCann & Clarke 2004; Stanghellini 2009). Some side effects of psychiatric drugs can also result in bodily stiffness and involuntary shaking, which can lead to distorted perceptions about one's body (McCann & Clarke 2004). These features can be observed in several of the participants (for example shaking, or minimal physical movements before the start of the group). de Haan & Fuchs (2010) argue that the main characteristics of schizophrenia can be understood as bodily in nature, and that further research is needed to explore how body and movement approaches might strengthen embodiment in schizophrenic patients.[50] The experience and observations of participants in the group show how participants meet the challenge of the game, by contributing physical proposals, which use the whole body, as well as taking on the physical expression of others, as part of the rules of the game. Some participants who appear slower or uncoordinated due

[50] Within FEH and forensic psychiatry generally, schizophrenia is the most prominent diagnosis.

to medication or motor disorders (such as *dystonia*) participate in ways that they are able, supported by the group.[51]

Another feature of improvisation concerns expressing and experiencing the orderly and disorderly in the theatrical playground when the heightened characterisations of the carnivalesque occur within the context of a game with rules. For example, field notes record how a game of 'winking murderer', in which we improvise a cocktail party involving very famous people, generated the creation of several famous South African politicians (such as Jacob Zuma) and rap stars (Tupac) 'all eating snacks and champagne served by myself and Luvuyo playing waiters' (4 October 2015). This improvisation ended with every participant dying in an excessive, exaggerated corporeality of performing a gruesome end, with much laughter and joy. An exercise such as this one gives permission to play with the macabre in which the dying body becomes a site of excess and joy. The game has rules, but within the rules that apply to the experience, participants can play with excess, the chaotic, and the uncontained, in a finite 'as if' experience of dying. Within this enactment of a painful, slow death, there is life and joy.

Another improvisation exercise, which encourages heightened embodiment and enactment, occurs in a circle and is based on the giving and acceptance of proposals. Each person gets a turn to introduce the person to their left, as any role or character they wish, with any attribute. For example, I might introduce someone as 'this is Themba and he is the world's most famous opera singer'. Themba is then asked to step into the circle and improvise my proposal. The suggestion on the spot of their partner's role, as well as the taking on of another's introduction, involves spontaneity and creativity, and often results in exaggerated physical actions and characters, particularly as suggestions are often sports related – boxers, expert football strikers, cricket heroes. As a group, we watch a range of solo improvisations of accomplishment. My field notes remark on how a participant like Mzwandile demonstrates an awareness of the turn-taking and rules of the game, as well as creativity and stepping into the unknown space of the improvisation. He was given the role of a singer: he performed a

[51] Drug-induced Parkinsonism is associated with certain psychiatric medications, particularly those used for Schizophrenia.

song for the group, then introduced his partner with another role. I note how 'Mzwandile was amazing in his ability in contributing to the play and ensemble – no assistance required. He gave Vuyo the role of kwaito singer which was enacted with clapping from us and great joy' (23 July 2014). The circular structure of the audience for each improvisation contains and supports each performance of sporting and artistic excellence. As an ensemble we relate to each performer as someone who is capable – who can respond to the proposal in their own way. Every participant becomes an initiator, a creator, a generator of a range of ideas and characters as well as a witness and spectator to the achievement of others.

The less structured improvisation activities in which spontaneity is encouraged, can be helpful for participants for whom order, structure and containment is challenging. For example, one patient-participant, Vincent, had a wild energy and struggled with sequencing and body-boundaries. Thandiwe (2015) commented on this in her interview:

> *But it [the drama group] does really create a lot of self-awareness because a lot of the patients, for example Vincent, his self-awareness is so low, he is not aware of his body and he is not aware of other people in his space… but in the drama group you could see him trying to interact with other patients ... because here we have a lot of structure in drama it's a lot of, 'how would you like to do this, this is what we're doing, and you can be creative in doing what you love doing.' And it's very interesting to watch them, like…come up with things because in different contexts they behave differently and that was fascinating for me.*

I observe during recording four (7 September 2015) how one improvisation game allows Vincent to adapt his uncontained body to the activity, fostering his ability to step in and out of the improvisation appropriately, as well as a sense of when to start and when to stop. He demonstrates a spatial and temporal awareness that is above his usual capability.

The exercise of inviting participants to transform an everyday object, such as a plastic shopping bag or a pot, by acting as if it is something else, is regularly used to orientate people to the skills of improvisation. For example, a plastic bag might become a cape and the person acts as a super-hero. In the context of the hospital, this standard game demonstrates that in this playground we can *make* something new out of the ordinary and the everyday. To become *makers* and *creators* in the world is highly significant in a context where one's illness

and social transgressions mean that one's day-to-day existence is routine, regulated and monitored, and where people's everyday actions are prescribed.

For the exercise documented, Luvuyo is the first player to enter as he demonstrates how the game is played. He immediately turns the first object, a paper towel inner tube, into a horse to ride extravagantly, then uses the inner tube and the second object, a clothes hanger, to create a violin and beg for donations. Three participants enter and improvise with the objects in quick succession. Vincent is on the edge of his seat throughout this exercise and enters the play space to improvise on four different occasions. This is unusual for him, and I observe how he structures his physical engagement and performance of each interaction. Vincent is fourth to enter and copies Luvuyo's horse example, but extends the action using a rhythmic galloping, and then uses the hanger as a whip as Luvuyo coaches him from the side. He times his improvisation so that it is neither too long nor too short. Around a dozen other participants take turns. Then Luvuyo steps in and asks within role for assistance, using the hanger as an aerial trying to get signal for a television. Vincent immediately responds and Luvuyo subtly draws him into the scene, asking for help with finding the football channel, and changing channels with the tube as the remote. After this scene, Vincent can be seen on the edge of his seat, trying to find another moment to enter the play space. When Thando completes his use of the objects as a periscope, Vincent quickly takes his place in the middle. This time, he uses the hanger as motorcycle handlebars and throttle, alternately accelerating and decelerating. Luvuyo steps into the scene as a traffic cop who chases, then stops him, resulting in Vincent doing a rushed then sudden 'braking' action to stop the motorbike. Usually, Vincent's means of resolution in some scenarios is to 'hit out' or resort to violence in a scene. He starts by angrily saying, 'Tell my why you want my name' to Luvuyo. However, he then tells Luvuyo (as traffic cop) that he, Vincent, is also a cop, and they 'high five' and ride off together. A few minutes later, he tries to enter in an improvisation with someone else who is using the hanger as a saw, cutting the tube as a piece of wood, finding a moment to expand on a proposal by creating a duologue like Luvuyo has done with him, but the person has ended their turn and he retreats to his seat.

In this example, a participant like Vincent experiments with the unpredictability of improvisation, which can adapt to his often wild or excessive, unstructured physicality, but

also contains it in a directed, contextualised way that reinforces his capabilities as a story-maker. He experiments with a focused, intentional use of his physicality, demonstrating a bodily awareness that is witnessed and appreciated by others.

Generating intimacy and connection

Some of my favourite moments in our sessions are exercises that involve a contrast from the whole group warm-up games, which are often high-pace and energy, to more intimate exercises that involve a nuanced, sensitive connection between players. Sometimes this involves touch – a human action that can become taboo in certain situations (for example between a therapist and client). When people do touch each other within the hospital context, it is usually during medical examination, when the body becomes a site of a medical procedure or examination. The issue of touch and boundary-crossing is discussed in detail in my interview with Lauren. Participation in the group requires a level of intimacy, touch, and human connection that is often at odds with what might be appropriate within a therapeutic relationship. While these behavioural codes might protect therapists and clients, they may also become restrictive or problematic in other contexts. Within professional protocols that are adopted from Western-based contexts the hypothetical client and their context may radically differ from clients within African contexts.

Lauren reflected on initially feeling uncomfortable about touch and the kinds of interactions that were asked for in pair work for example. However, by participating, she started to shift her understanding of the role of touch within a therapeutic relationship and the ways in which part of her own tactile way of relating was cut off when acting professionally.

> *The word intimacy relates with me because some of the games we play - you break down those physical [boundaries] and what is allowed and not allowed in terms of a professional relationship. There have been parts where I've felt uncomfortable, a lot so in the beginning, but it is still there actually. But it is quite interesting when you are head to head with someone, that communicates again that we are all just participants together, but there is a certain connectivity, a physical connectivity that's safe, not*

> *threatening. There is a level of intimacy that is allowed, that does not feel inappropriate* (Lauren 2015).[52]

Lauren further discussed how as a person she is quite tactile but that part of herself has become alienated within the hospital environment. This led her to reflect on the overall alienation that can occur in an institutional environment such as a psychiatric hospital, for both staff and patients. She discusses how

> *touch can communicate so much, it's a connection with someone else. If you think about the sense of alienation that can happen in this place, never mind the extra layers of alienation that can come from a mental illness and how you are treated. The only touch that you experience is when you are examined, not just from doing something with another human being.*

Lauren's reflections resonate with Foucault's notion of the institutionalised and docile body and relationships that become functional and reified, servicing the logic of the power structure of the hospital (Foucault 2010b). The theatrical playground attempts to disrupt this logic to provide an experience of an alternative.

Field notes (27 July 2015) reflect on another exercise based on careful touch:

> Next was an exercise which I put in to create gentleness and intimacy – working in partners with eyes closed each person was asked to get to know their partner's hand [by touching/feeling]. Some did it delicately, but someone like Sibongile was fairly uncareful. However it was mostly done with interest, and then in small groups, with great mirth, each person tried to find their partner's hand. It was a fun, small, intimate exercise which eventually involved everyone as groups joined together.

These exercises ask for participants to work with care and trust. They involve a delicacy and sensitivity within the one-on-one relationship which I find beautiful to watch. Examples of such exercises include mirror activities in which partners mirror each other's movements, and can be extended to a dramatic frame that orients participants to step into the 'as if'. Field notes (8 June 2015) discuss this exercise and the different ways participants respond:

> The next exercise aimed for a transition into a quieter, observational more intimate relationship with a fellow player. Seated in pairs, they were asked to think about

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[52] When Lauren refers to 'head to head' she is referring to a game such as 'body part to body part' where partners change connection between body parts in quick succession based on the facilitators prompt.

> getting dressed for an important occasion such as a wedding or funeral, an interview, or a dance. One person is the mirror to the other person getting dressed. Thanduxolo and Mzwandile struggle with something like this – Thanduxolo doing actions very quickly with no detail and Mzwandile's physical limitations (shaking etc.) preventing him from mirroring. However the others seem to relish in weddings, sporting events etc. Mary wanted to show us all with Phindi – she did an elaborate putting on of make-up, a dress that then split because it was too small, and then telling us all (after we asked questions) that it was a black knee length dress with boots with a gold zip up the side and a gold handbag … when observing the couples doing this task there is a gentleness and responsiveness to an-other within it… a kind of connection or intimacy that certain exercises take.[53]

This extract highlights how not every exercise is successful due to the physical and neuro diversity of the group: some men do find it challenging to work with a partner and adapt their ways of interacting; others find connecting with another person and holding that connection difficult. However, everybody tries, and because partners always change, over time each participant experiences a range of ways of interacting and adapting. When stronger, more capable participants (be they staff or patients) partner with participants who may find an exercise challenging, they work to accommodate that person and his abilities and potential. For example, during a partner improvisation exercise which explored status and how it can shift, one of the strong female patient-participants, Thina, who is a gifted performer, partnered with Mzwandile. My field notes from this session in only the third month of the project observe:

> What was great was how Thina paired up with Mzwandile deliberately then performed with him - she performing lower status, and very effectively. Although he was still slightly passive and reactive, it was the first time it was him, showing, in a way that was strong and accepted (25 July 2014).

During another session months later, Mzwandile played the role of a gangster boss, supported by Luvuyo who 'treated him like a superstar, combing his beard – I loved that he was in such a position of still power' (field notes 16 February 2015). In these examples a participant like Mzwandile, who has complex physical and intellectual challenges, is supported to perform beyond his usual lost, inert way of being in the world. Because he is treated as a fellow player and performer he becomes one.

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[53] Phindi is a post-graduate drama student who attended this session. Mary took an immediate liking to her.

These partner exercises also involve an exchange and honouring of each other's ideas or proposals, so that a person has the opportunity to take on a partner's physical suggestions, extending the range and possibilities for embodiment.

One of my favourite games that I have played with any and every group I have worked with is Columbian hypnosis. It is a classic Boal game, which can be extended in a variety of ways, and was documented in recording three (31 August 2015). We play two versions: one with a partner, and one in groups of four. In this exercise, one partner is the 'controller', whose palm is the focus for his partner, who must follow their partner's hand with their face, always maintaining the same distance between palm and face, as if he is hypnotised by the hand. This is not a mirroring exercise, but an activity in which one partner has power and takes their partner on a physical journey, which the other partner follows. In the group version, one player controls the three others with one or two hands. Each person gets to experience leading and following. This is an exercise that requires us to experience taking complete responsibility for another person, as well as accepting the physical journey the leader takes us on. It is an exercise in which players are asked to commit to silence, and to be respectful and gentle with their partner. It asks for care, closeness, trust, and all participants respect this to varying degrees, while also experiencing new embodied journeys with their partners. I notice how Patrick, a participant whose physicality is stiff as a result of medication, and whose physical movements are often small, finds a range of movements and physicality in this exercise when following his partner. Staff-participant Thandiwe observes how differently Patrick behaves in the space. Thandiwe's interview is rich with examples of patients-participants' interactions and abilities in the drama group in comparison with how she observes them in other contexts within the hospital. She points out that allowing participants to create in the drama space, where each creation is honoured, releases certain attributes and skills:

> *One of our (OT) patients, Patrick, when he gets to drama, he is like a different person. I've never seen him participate like that and having an opportunity that won't put you on the spot, like (one of us) saying: Patrick move faster, Patrick, do this. But rather he is involving his whole body in a space where he can now do all of these things, which is amazing* (Thandiwe 2015).

Vincent (who was discussed in relation to his improvisation engagement) demonstrates a control and containment of his physicality that is remarkable. He can lead and follow with a slow, steady pace and focus. After the pair exercise I ask the group what it felt like, and Vincent volunteers, 'it made my body feel good' (transcription, 31 August 2015). In this exercise, he seems to experience his physicality as purposeful and controlled and demonstrates a physical awareness of time and space within the containment of his partner relationship that is very different from his chaotic interactions and use of energy.

Analysing theatre making

The next section of analysis draws on field notes and video documentation to substantiate the ways in which participants navigate past, present, and future identities that centre on hope and the possibilities for participants to author and participate in the world. Two of these categories, 'playing with deviance', 'processing hospitalisation' focus on a future-oriented projection based on hope, while the third, 'cultural belonging', reorients participants to connection with lived experiences and significant relationships before hospitalisation (and a mad/bad identity).

When participants choose to tell stories of anti-social behaviour, or portray such characters as muggers, township-style *tsotsis,*[54] drug dealers and takers, drunks, abusive leaders etc., an immediate connection could be made between a participants' past offending behaviour and the playing out of illegal acts within the drama space, as a means of processing their own identities as 'criminal' and 'doing bad' within their families or homes. Similarly, the mastering of the hospital experience, usually through a re-enactment of the different stages leading up to a leave of absence, granted for staying with a family member or guardian for a short while, could be interpreted as a way for patient-participants to process and practice the different steps leading up to permission to be released on LOA.[55] Both readings may be true for some

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[54] Township in South Africa refers to areas to which black people were forcibly relocated during apartheid to live in specially constructed 'ghettos'. The term today refers to these large suburbs, usually removed from the city centre, where primarily black poor and working-class people still reside. *Tsotsi* is township slang for criminal.

[55] During one workshop (14 September 2015), these themes merged when, during a partner improvisation exercise, David became a patient who had run away from Fort England because they refused to release him and Thando became a taxi driver who found him and returned him to the hospital. This was in strong contrast to

participants, and the effect of participation may be therapeutic for a variety of reasons that range from a break with routine and the everyday to more complex mental processes during which alternative identities and behaviours are explored. However, in alignment with the thrust of this thesis, my reading of these narrative choices is an attempt to offer an interpretation which examines how participants might be playing with institutionalisation, reorienting power and exercising agency on terms of their own devising. In each of these three themes, which align with the themes most commonly surfacing in the interviews with patient-participants, performances of hope are experimented with through their theatre making.

Duncombe (2002, p.7) maintains that

> … the very activity of producing culture has political meaning. In a society built around the principle that we should consume what others have produced for us … creating your own culture takes on a rebellious resonance.

In the act of improvised performance participants enact agency and autonomy. Through their theatre-making they are creating their own culture and become authors of new scripts.

Playing with deviance: taboo performances and self-representation

Over the years of running this group, in the 'no penalty zone' of the dramatic space, certain participants seize the opportunity to play with badness or anti-social behaviour. This is against the backdrop of a Total Institution where any negative behaviour is strictly controlled: to be a good patient means conforming to the rules and logic of the behaviour modification system and even minor infringements are sometimes punished by demotion. For example, Lunga, after selecting a cap from the costume pile with the Rastafarian colours of green yellow and red, has enjoyed playing a weed-smoking Rastafarian. I have a photograph of him lying casually on the floor and taking long, mimed inhalations from an illegal substance. This action is the epitome of forbidden behaviour, which is repeatedly emphasised as dangerous

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Thando's expressions of hopelessness in our failed interview. In the theatre processes he generated complex narratives of hope and change. Thandiwe in her interview remarked how different he was in the drama space, compared to his conduct on the ward.

during psychoeducation sessions.[56] However, such characters are present and identifiable in everyday life and sometimes admired. For Lunga, performing a deviant character who smokes weed may also be a performance of an ordinary person who is able to make choices for himself.

During the period when female forensic patients from ward D participated (2014–2015) Mary decided on a scene within a small group task, about a woman (a mistress) who steals her lover's wife's new-born baby from the hospital. The wife was played by Thandiwe, a staff-participant. Mary played the mistress, whose act is an act of revenge against the father/lover. In this soap-opera style drama, Mary relished her role as the baby-snatcher, who eventually got caught and arrested. In my field reflections I note how Mary 'takes such delight in the action and the arrest, I quite like the energy and rebellious spirit' (9 March 2015). This scene occurred during the time of a prominent news story that involved the discovery of a lost child who had been taken from a hospital fifteen years previously and raised by another woman. Mandla (2015) specifically mentions this scene in his interview as an example of how the drama group relates to the real and the everyday: *'For instance, that lady, Mary, I remember when we did the story about baby theft, I enjoyed that story very much. In fact, just within two weeks during that time a baby was stolen in Cape Town… so these are real life stories'.*

Mary's choice of an extreme role represents the excess of female taboo: the stealing of another woman's child. In this, and most other stories of crime enacted by the group, the offender is caught and punished: justice is performed, and the perpetrator must pay. This echoes what each patient-participant is doing now – paying for their offence – as a state patient within the system of care and custody. Therefore this enactment could be said to be morally reinforcing for the participants. But Mary not only suggested this this story to her group, she also selected to play the ultimate female villain. She did not portray a vulnerable woman whose snatching of a child was possibly due to a traumatic reason, or due to psychopathology; she played a woman who consciously made the choice and accepted her fate. Female forensic psychiatric patients represent less than ten percent of forensic patients

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[56] As part of their rehabilitation, patients are required to join a number of programmes which educate them about their illness, adherence to medication, side effects, and the dangers of using alcohol and drugs.

at the hospital, and most violent offences are related to children, often neo-nates (Nagdee & Erlacher 2010; Nagdee 2017). Mary is a state patient as she has been assessed as not having criminal responsibility for her offence due to psychopathology. In the re-enactment of a crime story relating to a new-born child, I question whether Mary is unable to discern the wrong of stealing the child or whether she is relishing enacting an alternative to an aberrant woman.

The containment of women, and femaleness within the institution, includes bodily control such as banning the wearing of bras as they are considered a suicide risk, controlling sexuality by demoting patients who have sex with male patients, and not consistently providing underwear to women who do not have the resources to supply their own. I read Mary's choice to play a female villain as a choice to play an empowered role of a woman on the far extreme of 'unacceptable', on her own terms, in her own way, in a context where such performances are prohibited and female transgressions – particularly those involving infanticide – are moralised and regarded as more severe than most male offences. For example, Nagdee (2017) reports that almost all women who are accused of killing a child are sent for psychiatric evaluation by the courts, indicating a perception that such a crime is so heinous that the person committing it must be mad. Female offenders in general are criminalised and stigmatised, as they have transgressed a gender norm of who becomes a criminal, which, in the South African context, is imagined as a black male (Gqola 2015). In addition, an offence such as infanticide that betrays the ideals of motherhood, is socially regarded as more transgressive than offences associated with men such as rape and murder, violent acts that are so common that they form the backdrop to everyday life in South Africa. Female violence is 'exceptional', and I argue that women are then expected to continuously confess and express shame. A female inmate is imprisoned, literally, in what it means to be a woman and a mother, and by becoming a criminal, she is required to atone for her actions, far more than men. However, Mary radically defies this expectation, performing instead another kind of crime that is gendered, without any sense of explanation. Her choice of deviance I read as a choice of defiance – as a woman already branded as 'bad' by virtue of her forensic patient position, she chooses to celebrate her status in a melodramatic drama.

The permission to experiment with roles and scenarios, that are outside of the law or would be punished within the hospital, is partly promoted by how a theatre-making task is set up, which often involves my pushing for dramatic conflict. For example, participants are asked to think about a problem that needs to emerge, or something that goes wrong in the scene. In recording six (13 June 2016) the final task is to establish a scene in a specific location where people have a pre-established relationship. As part of setting up the structure, I give suggestions such as a hair salon or a traditional ceremony, or a tavern, or a family kitchen. I give instructions that the scene should revolve around a moment when someone who has been away for a long time reappears. The group needs to decide why that person went away, why they have returned, and how people react to them.[57] What emerges from the performances from the three groups are stories about someone who has done something bad and returns to make amends: stories of forgiveness. In the classic tradition of melodrama, each group selects a family scenario, in which a family member has disappeared and let the family down in some way but is welcomed back. For example, in one scene, David plays a son who smokes marijuana and had been caught stealing, but returns to the shop which he stole from, with his family, to show how he has reformed. The family shows great pride in him. In another scene, we see a family who are struggling financially: dry bread is passed around while they watch television. Siya plays an uncle, who agrees to become a custodian for Thando, the family member who has returned from a hospital, because as is stated in the scene, 'he has changed his behaviour, he is no longer hitting people and taking drugs, so Uncle needs to sign as a custodian' (transcription of recording of 13 June 2016). In both scenes of forgiveness and acceptance, a wrongdoer who has been involved in offending behaviour proves that he can change and belong to family or society, again. I read these choices of stories of reformed offenders as performances of change and hope, a relay between patient-participant's current situation and an imagined future of acceptance and citizenship.

[57] These kinds of relationships have been set up in the previous exercise, which involved a range of partner improvisations whereby two characters meet up in the street: a player from soccer team Kaizer Chiefs and one from Morocco Swallows who had played a match the previous day which ended in a draw; An ANC and an EFF (opposition) politician; two friends who had not seen each other for a decade as they had an argument.

Despite the performances of anti-social behaviours, which are either portrayed as negatively affecting other people's lives, or the joy of performing a prohibited state such as extreme inebriation, the participants tend to resolve the scenes in a way that promotes justice or morality. I was struck by one example of reframing a narrative so that justice prevails, badness is punished, and the vulnerable gain dignity. This occurred when the group re-created an aspect of a play they had seen at the National Arts Festival.[58] One group had seen a three-hander performed by women who had won a prize at a theatre festival in Hillbrow, Johannesburg, concerning the rape of the main character, Nomzamo, by an uncle.[59] The play was skilfully performed, using a non-naturalistic physical storytelling style. After the festival, I asked groups to create a performance in response to anything they had seen at the Festival. Akhona, a tall, charming, domineering participant who likes to be the centre of attention, took on the role of the protagonist, Nomzamo. My field notes comment on his subtlety in re-creating the young woman: 'He found a bodily adjustment (e.g. bum slightly out) which was effective – not over the top – and a woman's "essence"' (13 July 2015). The narrative told in the original involved family secrets and silencing, in which Nomzamo's violation is not believed or reported. However, in the participants' re-imagining of this play, the narrative is reframed so that justice is done: Nomzamo tells her grandmother, who calls the police, and the uncle is arrested. In the FEH version, a simple moral narrative is placed over the original version, which was layered in its excavation of rape and the cultures of rape that legitimise and silence the violation. In this and other stories created by the drama group, a positive, hopeful resolution is enacted. These stories that identify good and bad, push for a hopeful and just future and are a performance of the utopian. Although the binary reduction to good and bad could be perceived as simplistic and unrealistic, the participants' choice to enact a neat linear narrative of justice done can also be read as a construction of performances that are on the side of justice. Participants construct performances of themselves, within the aesthetic frame, as good and moral citizens, who know what is right and wrong and will act to

[58] Each year the participants of the drama group (and other groups attending OT programmes) attend various plays or musical events at the National Arts Festival.

[59] *Nomzamo* performed at the B2 Arena, National Arts Festival, 7 July 2015, produced by the Hillbrow Theatre Project and performed by Tsholofelo Pouline Mmbi, Neliseka Maling and Thobeka Malinga. Written and directed by Gcebile Dlamini.

prevent injustices. Within the theatrical playground, participants experiment with stories of justice and positive social participation that are witnessed by fellow patients, staff members, and at times security personnel, who have accompanied participants to the session. This performing and witnessing of moral actions and decisions allows participants to construct alternative, positive representations of themselves on their own terms and in their own way.

In the following examples, deviance or abusive behaviour is embraced by those with privilege, and those with less power mediate to negotiate fairness. In these examples, rather than the law ensuring that justice prevails, ordinary people work to challenge those in power.

In recording two (24 August 2015), the creative section started from my asking the groups to create folk stories involving important people (kings, queens, warriors, chiefs), where something has gone wrong. The exercises described below prepare participants to create the final scenes around people who hold power. This was part of an intention for participants to experience and play with wielding power and its concomitant responsibilities. What resulted, in the final stories created, was an exploration of abuses of power and resistance to such abuse. The mythical or epic framing for the narrative, which for me is an invitation to step into a world removed from the 'now' and everyday, is foreshadowed by the themes and role choices suggested.

The first improvisation and bridging activity is a storytelling exercise in small groups of four sitting in a circle. The topic I provide is 'the time I met the king', in which one person speaks gibberish and another in the group becomes the expert translator. This exercise involves improvised storytelling, as the translator is required to produce a translation of the gibberish story for the other listeners in the group. When we share the stories that were told at the end of the exercise, four of the stories involve kindly chiefs and royalty who share food and wealth with ordinary people. For example, Athenkosi recounts their story about visiting the king and being offered food and *vetkoek* while waiting for the king. [60] Staff-participant Bulelani tells the group how the chief gave him R30 000 and he used it to feed his siblings and buy a second-hand car. Thando's translation of Lauren's gibberish constructs himself as lowly

[60] Vetkoek ('fat cakes') are a popular street food. It is a savoury deep-fried dough that is then filled with mincemeat, chicken etc.

and feeling great honour to be able to dine with the chief. The subordinate role he has chosen here is developed as a tactic to leverage power in the mediation role that he subsequently adopts in the final rehearsed scene. In each of these stories, privilege is shared and accepted as a moral responsibility that is enjoyed by those with less social power. This generosity is reimagined in the last playmaking section that involves a more complex narrative structure in which something goes wrong around or with leaders who wield alot of social and political power. The former positive sharing of privilege is in stark contrast with these latter scenes, which are discussed below.

This gibberish/interpreter storytelling exercise is followed by a sculpting exercise in which I instruct participants to work with a partner to mould their partner's body into a position that represents an image of a father, a king or queen, a hero, and/or a healer. My explanation of this to the group is 'in all these old stories, there are types of people, so what we are going to do now is experiment with those types of people in our bodies' (transcription from recording of 24 August 2015). The shift from orality to embodiment is part of the preparation to combine orality and embodiment that will be needed when enacting the story that they will create. Partners take turns to be a sculptor or the 'sculpted', experiencing the shift from being a creator to accepting a partner's decision of what this role type looks like. As is discussed in the previous section, there is a physical intimacy and trust required here, and in the video a notable delicacy can be observed, as each partner accepts the responsibility involved in sensitively touching and shaping their partner's body.

Finally, I ask each group to select one hat per group, that will be used to represent the 'important' figure. These hats ranged from crowns, to African-style chief headwear and are used as a simple sign to enhance the playmaking process.

Four of the five groups created powerful figures who abused their position: a greedy King who withdraws help from his poor subjects, a Chief who tries to get out of paying his labourers, a King and Queen whose labourers are on strike, demanding an extra bag of maize meal. In one scene, contemporary life is enacted, in which Lauren plays a mugger who steals an old lady's brooch, and a taxi driver helps the old lady by taking her to the police station, resulting in the police catching the mugger. In each of these stories, a social problem is

addressed by means of pushing for justice and protection of those who are vulnerable. In each scenario it is striking that one person takes on a crucial intermediary role between the oppressor and the oppressed, usually succeeding in maintaining stability and gains for the vulnerable. In at least three of these scenes, this role is assumed by the participant who initiates the idea for the scenario. For example, Thando, who can be observed in the video driving the creation of the story, becomes a Chief as mediating character between the aristocracy and the people. When the group are planning what their scene will be, he is observed summarising: 'so we have downed our tools, we don't go to work anymore because we get paid very little and we work so hard, the fields are huge, its manual labour' (transcription of recording of 24 August 2015). His means of negotiating with the King and Queen is to submit to their authority, referring to the King as 'my Lord', and kneeling at his feet while trying to deliver the peasants' demands. This lower status role has been constructed earlier during the storytelling gibberish exercise, which is used here as a political strategy: simultaneously to surrender to and respect the ultimate authority of the King and Queen while delivering the worker's demands and mediating between the two parties:

> Chief: Hail, my Lord.
>
> King: Where is everyone? Why are they not at work?
>
> Chief: My Lord, the workers are on strike, they are striking for an increase in their compensation. They want an additional bag of maize meal.
>
> King: On top of the already huge amount we give them?
>
> Chief: Plus R10.
>
> King: These people are crazy!
>
> Queen: They are crazy, they think we have a lot of money.
>
> King: I must beat them with my cane.
>
> Queen: No my husband, you cannot do that.
>
> Chief: Oh my Lord, I am begging you on their behalf. What they are doing is not great.
>
> King: Ok, talk to those people, ask them to come back to work, I will adjust their salaries (transcription and translation, 24 August 2015 recording).

This and another scene involve a political rebellion from below, challenging the power of the aristocracy, in which a mediator appeals to morality to solve a political issue. In the second story, Bulelani (a staff member) plays a beggar who is rejected by the King after he begs for assistance, and the King's assistant tries to convince the King to give the poor something. The beggar returns and kills the King, with the scene ending with Bulelani shouting, 'the King is dead Hallelujah!' The resorting to violence after attempting other channels to try and be heard and gain dignity, echoes the political process of some protests in South Africa, whereby communities attempt, often for years, to leverage basic services such as water, sanitation and roads, and are often given repeated promises of delivery that are never met – as is the case in Grahamstown/Makhanda. This results in anger and people resorting to destruction of property, or the blocking of roads with burning tyres. Within the mythical, or fairytale, framework of this type of storytelling, I read 'Kill the King' as a political metaphor for one way in which the oppressed use violence as a political strategy: a means of gaining justice when power is abused extensively. When someone with means and responsibility denies the basic need for food to someone who has none, 'the King is dead' is a political action towards justice.

In each of these scenes, a political fable is enacted in which the less powerful push for dignity, challenging greed and autocracy and demanding justice and morality. In playing with absolute authority, the participants construct themselves through the theatre-making as moral, ethical subjects, enacting agency as an antidote to absolute power. This is significant, given the stigma associated with the patient-participant's ill-offender status. As state patients, these men have been granted exemption, by the law, from responsibility for certain social mores and cultural processes and are therefore not seen as actors. This 'ambiguous personhood' casts people like forensic psychiatric patients as being outside of culture and by extension humanity (Nash 2005, p.192). However in the above scenes, each person contributes to the creation and enactment of a story and characters that resist such ambiguity, deliberately positioning themselves as social and political actors in the world.

At the end of 2014, the group worked on a ten-minute piece for performance to share with the wider hospital staff and patients. In this piece, which was set at a taxi rank, one participant played a drunkard with relish, another a devious loan shark who was withholding

the identity book of a poor debtor who could not pay, and others played gambling dice players. The scene opened at a vibrant taxi rank peopled by a range of identifiable street characters: cigarette and food sellers, commuters hurrying to their taxi; a taxi driver and his conductor calling for customers. The story involved a taxi driver who knocked down the drunk man and then disappeared. A psychiatric patient from FEH tries to help resuscitate the victim, yet other onlookers dismiss him, pointing out that he is a psychiatric patient and therefore unable to help. When the patient nonetheless saves the man's life by administering CPR, people's attitudes towards him change. Another witness declares to others in the taxi that 'this man is a hero!' The patient-hero is played by Thando who also played the chief/mediator. He was the originator of this story too when we were brainstorming ideas for the showing (field notes 29 October 2014). This is another example of Thando constructing a role for himself that is helpful, caring and constructive: roles of citizenship and ethical social participation created by one who dwells in the 'zone of exception'.[61]

The short play discussed above is a story of capability and competence for people labelled mad, a story about stigma, hope, and positive social action. The range of roles adopted play with a range of moral and ethical positions, and the hero of the story is someone who suffers the stigma of being perceived as outside of the ability to take a helping, heroic, or moral stance. He challenges this perception, challenging stigma and representing, for the wider audience of patients at the event, a gentle defiance of the stereotypes and stigma that surround people labelled mad. The group's choice to act out this story to share with the wider hospital audience is significant. It enacts a hopeful future for a person living with mental illness in society. Not only is a hero narrative portrayed but a range of useful, appreciated roles are performed by patient-participants, ranging from a woman selling *vetkoek* to commuters, to ordinary people making their way from work to home. Patient-participants do not play sick people: they play ordinary citizens getting on with their lives – some within the bounds of the rules of society, others not. This short play was a connection

[61] There is one amusing deviation from this: during the improvisation exercise in recording three (31 August 2015) he transforms a paper towel tube into large drug pipe which he inhales at length, causing Lauren to burst out laughing at his innovation and realistic performance of drug taking.

to the everyday, to a life beyond the institution and being defined by one's illness, which is witnessed by a large audience of fellow patients, nurses, psychologists and psychiatrists.[62]

Mastering the hospital experience

In this section, I analyse moments in which participants author the hospital experience. That is, they create and enact their own understanding of the institution, becoming agents in crafting the hospital narrative rather than passive receivers of a pre-determined script. Over the three-year period of this project, patient-participants regularly chose to enact different parts of their institutional experience or played with new ones in which desires for a better institution were articulated. The playmaking choices that reference the hospital and hospitalisation (such as becoming a doctor and giving an injection, or a psychiatrist examining a patient's file and agreeing that he has progressed well and should be granted leave), also reference a life beyond the hospital: performing the process of leaving and being part of the ordinary world. Staff-participant Bulelani understands this adoption of roles in relation to hospital events as a key reflective device for patient-participants that also contributes to breaking down self-stigma within patients:

> *One of the biggest things in mental health is self-stigmatisation which manifests in denial. Once you start assuming these roles of power within the hospital setting, you are chiselling down that self-stigma in a way. Because you see yourself in a different position by what you [in role] is saying making sense to you and what you are supposed to do [such as taking medication]* (Bulelani 2014).

One session (9 May 2016) encapsulates this projection into a future beyond the hospital in a particular way. I asked participants to imagine and design one street: they could choose where in the world the street could be. Initially, there were suggestions of Johannesburg and Cape Town. This changed when someone suggested York Street, to which there was majority agreement. This is the street that ends at the hospital gates, and leads out of the hospital,

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[62] A limitation of this study is that I did not manage to gather responses to these performances from the audience. Managing to pull off each short performance was in itself a challenge as we had minimal rehearsal and there would always be someone in the cast who could not be there on the day – either they had been demoted, or had an appointment, or had been granted leave to go home for a period. As a researcher the choice of stories that participants want to craft is more important than how it was received – although I recognise that feedback from other staff and patients who watched would provide a more nuanced picture of how the patient-participants are perceived by their medical staff and peers.

intersecting with the main road that starts at the National highway on one side and ends, five kilometres later and way past the hospital gates, on the far edge of the sprawling township. Participants were asked to decide what was on that street, which would serve as locations for short scenes to be created. The choices were the police station, the Shoprite supermarket, a taxi rank, a butchery, a doctor's surgery (all on or near this street in reality), a pharmacy, and a recording studio (a choice by a staff-participant). When I asked about the hospital, all were unanimous that this was not part of their vision of York Street. While the hospital as a location was deliberately excluded as a landmark for their York Street, their choice to locate immediately outside of the hospital suggests a performance of becoming, away from what can be a stuck narrative of being ill and a patient, towards a future where these features do not define how a person navigates their world. However, the scenes that were created (in the supermarket, at the police station and the taxi rank) suggest an awareness of the proximity to offending behaviour. My field notes at the time question the choices made: 'The theme of arrest and capture emerged in three of the scenes … Is this a reflection of watching action movies and TV – good guy/bad guy? Or is it a space to play out deviance?' (field notes 9 May 2016). Thinking back to this workshop with the distance of time, I read the choices differently. As the patient interviews in chapter six indicate, film and television are influential motivators for participating in the theatre group and watching action movies and soap operas are a major part of recreation on the wards. The high drama of capture and arrest and the enjoyment of playing anti-social characters and seeing justice performed (and *doing* the justice for those playing policemen or security guards) is very appealing. However, I now wonder if patient-participants are skilfully storying *proximity* in two ways: in the material location of the scenes to the imposing presence of the hospital at the end of 'our' York road; and the closeness of ordinary world and identities and how these can quickly slip into negative choices and confrontation with the legal system. The hospital experience in these scenes is not trapped within the containment of the liminal world of the hospital, but just beyond its barbed-wire fences. In the world beyond the hospital, participants perform a future reality where the proximity to offending or illegal behaviours is part of lived experience. This is part of these patients' reality. As I have argued with regard to the previous scene set, these scenes also perform a clear 'right' and 'wrong' in that the transgressor is caught and arrested. The performances employ dramatic fiction to demonstrate an

awareness about social mores and to enact the multiple roles and experiences of citizenship. Once out of the hospital, a patient will be required to navigate these roles. The way that these scenes navigate near to the hospital and illness and far beyond the former but never completely away, suggests a recognition of living with the hospital identity and experience, and beyond it. The categorisation of state patient is a defining one in a person's life journey as one's release from incarceration is determined by absolute adherence to psychiatric drugs, eliminating alcohol and other substances, and having a family member agreeing to custodianship. Patients are often anxious about how their family and friends will react to them and these varied reactions are narrated in performances discussed in this chapter. In playing with the hospital and a world just beyond it, I read these performances, by those who are certified as mad, as taking on the responsibility of citizenship.

This playing with the real world outside of the hospital was reflected on by Mandla (2015) who valued the fact that '*some of the stories that we do are things that are happening in real life'.* Khaya remembered enjoying roles he played at a taxi rank as a dice player and as a social worker in a scene about a loan shark. These roles and their worldly contexts expand a participants' sense of self beyond the hospital and illness, providing a space in which to play with scenarios they are familiar with yet are not physically able to participate in due to hospitalisation.

The acting out of the steps towards being granted a leave of absence to return home and the ways a returnee is received into the home, is a regular choice for some participants. A therapeutic reading of the enactment of a story that is very close to many participants' own life stories and desires might be that this choice is a way in which patient can master a story that causes anxiety, by working through it and gaining control of it to minimise stress related to obtaining the illusive LOA. Many patient-participants found the stress of not knowing one's 'sentence', of being suspended in time at the mercy of a psychiatrist and his/her team to decide when and if he could leave the hospital, understandably demoralising. The choices available within the space to create scenarios of participants' choosing and the permission to play with these is about gaining ownership of this narrative and processing it on a patient-participants' own terms. By working out how to play the multiple roles and the complicated sequence of actions and events involved in being granted a LOA, participants are playing with

positions of power and projecting an imagined future of life beyond the hospital. The performing of the process of promotion, from the depths of the restrictions and ultimate mad label in the MSU towards more open wards and the pre-release wards of E and F, is an embodied, collective affirmation of progress and possibility.

Some of these enactments include the dramatisation of the ward round: a space where a patient becomes an 'object' of display, under the gaze of the multi-disciplinary expert clinical staff. In the MSU, the ward round takes place in a space that is designed as a theatre: rows of raked seating look down towards the patient in a style of medical theatre (discussed in chapter four) that directs the medical and pathologising gaze in a very deliberate way. Ward rounds in other wards are spatially different: the team sits in chairs around the edge of a medium sized room, and the psychiatrist sits behind a table, distinguished from the others. The patient will be summoned and sits facing the team, who question him/her about how they are feeling or any issues they have.

Some of my workshops in phase one of this project in the MSU consciously invited patient-participants to play with roles other than patient in the hospital. While this work precedes the practice that is the focus of this chapter (and study), my experiences of structuring contexts for patient-participants to play with the institution were significant in influencing my practice going forward. In one workshop in the MSU I asked participants to think about three key moments from a psychiatrist's day. My field notes record the way that the participants played with power and the institution as 'a pivotal point of transgression' (field notes 26 April 2013). One participant distributed activity books that were in the space (an OT office) to become patients' files. I note how in role 'they clutch the file and focus on it – this is what gives them authority'. In this improvisation, men who are imprisoned within the MSU skilfully locate the source of power and control as the file which contains all their assessments, recommendations, diagnoses – and therefore potential for transfer out of this space:

> They re-enact their version of a ward round. Something each is subjected to. Yet they perform what happens *before* a patient comes in and how he is talked *about*. They develop a professional script, the authority to talk about and make decisions about others. The improvisation takes charge of a process which they are excluded from, demystifying and fracturing the authority and hierarchy of expert (field notes 26 April 2013).

This moment from one MSU workshop, which was performed with stillness, conviction and integrity, illustrates the possibilities of playing with the institution and institutional power. It is not done as an act of rebellion, but as a way of re-orientating authority and authoring. By imagining and reimagining key institutional moments such as the ward round and the process of achieving a LOA, patient-participants use the dramatic frame and improvisational possibilities to situate themselves, their illness, and their futures, from multiple perspectives. From a Foucauldian perspective, these performances also disrupt the surveillance tactics that culminate in all that is kept in this file to judge and determine a patient's fate.

It is significant that in phase two of the project the three end of year performances for the forensic wards (shared with staff and patients) all involved an explication of the process of being a forensic patient. I have discussed the play made in 2014 above. In 2015, the narrative involved a patient being granted his LOA, and returning home. Neighbours are worried that he is back and will start doing crime. However, he saves the day when he calls the police on burglars at the neighbour's house, resulting in a ceremony and celebrations from his family and community. These two short plays make the ex-state-patient an unexpected hero, counteracting stigma and labels of incapability. In 2016, scenes showed the journey through the hospital system: a move from the madness of the MSU, to a patient in the closed wards being promoted to a pre-release ward, to a patient playing pool in a pre-release ward phoning his mother to tell her that he is coming home, and then being granted 'town parole' and going to town to get money and shop for civilian clothes. The choices to share these stories of being a patient, and also not-being-a-patient, are, I argue, performances of hope.

The following section analyses the 2015 and 2016 showings, which were presented as a collage of different scenes.

In the 2015 piece (ten minutes in length) a cast of sixteen participants (that included one clinical staff member, Bulelani, and facilitator, Luvuyo), constructed eight short episodes to narrate the story of one patient. Bongani plays the patient (named Ntokozo) and is the only consistent role throughout the play: something that is reflected in his own life narrative as he is a long-term patient in the hospital. All roles were chosen by patient-participants as the piece developed, and it is interesting that Bongani/Ntokozo plays his projected desire of

returning home and being accepted back into his neighbourhood, *as well as* the one role that does not change throughout. The newly- released patient (Ntokozo) contributes to community life in a positive way, and the traditional ceremony that marks his return reiterates that he may no longer drink alcohol. The play ends with his family and neighbours expressing their understanding that he was sick and that his behaviour has now changed.

The choice of this story and key people who have a stake in how a patient-participant will be received back into his community (family, friends and neighbours) also performs an awareness of what is required within the system to be reintegrated into 'normal' life, such as abstaining from alcohol, and adherence to medication protocols. For example, his father says in a speech during the welcoming ceremony at which a goat has been slaughtered as thanks to the ancestors (transcription and translation, 5 December 2015 recording).

> Father: Ladies and gentleman, we are so excited to have you all here to celebrate with us. Err, here is my son, according to where he is from, he is not supposed to drink alcohol, we are also not supposed to drink. But he also knows that he will not be drinking alcohol because we also do not drink. Because where he comes from, he was advised not to drink, not to do drugs or even smoke dagga. So we are very happy that you are all here.

What is key about this narrative, is that the site of responsibility for ensuring that key aspects of health are maintained, such as alcohol abstinence, is shared amongst family and friends: in this performance, all express their understanding of what is required to support the returning patients into health and change. In the transcript of the dialogue, there is continual reference to knowledge and acceptance that Ntokozo was not well before and he is well now.

Luvuyo and Bulelani were crucial in helping with transitions between scenes to ensure the cast recalled where they were meant to be on stage. Reflecting on this piece, I am struck by the sophistication required in terms of transitions between scenes and modes of performance: a chorus is used at times to focus and comment on action, and there are quick and diverse changes in rhythm, tempo and phrasing adeptly handled by the cast. For example, the play opens with the cast moving onto stage singing and finding their places in two groups: a chorus on stage right who give focus to the processing line of a doctor, a social worker, and the psychiatrist, which the protagonist, Ntokozo moves through, using a

theatrically stylised sequence. This is followed by a quick scene-change to a taxi rank scene that will transport him home. The whole cast transforms into either being part of the taxi, or different people at the rank shining shoes, playing dice, or selling *mielies*.[63] A chorus device was used to emphasise the internal emotions of the patient: when he is injected, they shout in pain, when he is told that he is not being discharged, they cry, when he returns to the line of experts (social worker, doctor and psychiatrist) to be told that he is being discharged, there is collective jubilation from the chorus. His journey is the chorus's too, and they share in his disappointment and joy, echoing the collective sharing of his hopes, desires, stigma and journey towards citizenship. The chorus device echoes the call and response format of many Nguni performance traditions where performer and audience interchange roles continuously. It also contains resonances of belief in the ancestor's engagement in the everyday affairs of their descendants. In traditional African spirituality, the ancestors are believed to be conscious of, and empathetic with, living family members.

Given the range of capabilities in the group, the cast deploys a form of ensemble playing that amplifies vital performance-based skills such as listening, giving and receiving focus, and understanding space, time, and rhythm, as well as finding the collective courage to perform in front of a large group of staff and patients, on an elevated stage in the hall. In the short interviews to the camera after the performance, two participants describe feeling nervous and then feeling good about performing their play for others: 'we were nervous at first, but half-way through, we became very excited' (recording six, 5 December 2015). Another participant expresses his anxieties about not trusting others to be capable of carrying out the task: 'I was a bit nervous because there are others who are not usually serious, so I didn't have much faith in them but they acted so well today' (recording six, 5 December 2015). The collective creativity of performing together for an audience of peers and staff, about the life of a patient who becomes or *transforms into* a citizen-hero, is a process of collective authorship and ownership. The ensemble also creates the space for patient-participants, perceived as less able, to perform beyond most people's expectations. As with the weekly process-based exercises and playmaking in the playground, these short plays can be

[63] Corn on the cob, a staple street food.

conceptualised as a zone of proximal development where the process and product of change is in the performance.

In the 2016 piece we witness a patient gain independence, edging towards a 'normal' life, as he moves from locked wards to open wards, into town and belonging to society. The episodes initially focus on the three types of wards in the hospital: the MSU, the closed forensic wards, and the open forensic wards. This play emerged from a preliminary workshop where I had asked three groups to show two moments in the day from each of these wards. What they performed demonstrated stages of recovery and progress as well as bodily ownership, capability and understanding (field notes 31 October 2016). The MSU is where all state patients are first sent to be observed. If they have stayed there for any length of time, their recollections of the MSU are of being surrounded by people whom they describe as mad. 'People are so mad there they eat nits from their hair' (reported to me by a participant and recorded in field notes 31 October 2016). This statement was made by Nyaki, a man whom I observed flourish once he was transferred out of the closed wards into the pre-release ward E. His participation in the group when he was in ward H was erratic and far more subdued, yet once he was transferred to ward E and the hope of a transfer out of the hospital became possible, his mood, energy, creative participation and leadership in the group was notable. Nyaki generated many of the ideas for this piece and supported his fellow actors in navigating various scenes. The scenes show the MSU with a 'mad' performance of one patient (played by Nyaki) who is given an injection to restrain him on the order of an authoritarian psychiatrist (played by Thando). This scene is frozen and the next scene takes over, a scene from the closed wards (G or H) in which a patient is in consultation with the psychiatrist who tells them that they are ready for transfer. When we move to the scene in ward E, we see patients structuring their own time in their own way. The whole stage then transforms as we follow a ward E patient who has been granted 'town parole' and the patient goes shopping in town with a clinical staff member. We watch him drawing money from a bank teller, buying goods at a busy supermarket, and finally purchasing some formal shoes from Knights shoe shop, an established independent shoe store in Grahamstown that is supported by the Xhosa community as it supplies shoes and accessories for young men returning from circumcision school. My field notes, documenting this year-end performance, summarise its meaning: 'When I think of it now, this was a story of hope – from denial and

resistance at the MSU to a patient being told by David as the psychiatrist that he was promoted ... to a patient on town parole taking some agency in his life. All played a range of hospital or civilian characters' (7 November 2016). Each participant performed being part of the hospital staff (or patient), and beyond it as a citizen in and of the world. Unlike the exceptionalism used to de-stigmatise mental health care users in the 2014 and 2015 plays, where a protagonist becomes a hero of sorts, these were performances of the ordinary.

The man playing the patient on town parole is Bongani, a patient who features in each example analysed in this section: he plays the patient who goes to town in this 2016 showcase, the patient who is released and demonstrates how he has changed for his family and friends in the 2015 showcase, and the patient discussed in the failed experiments with different dramatic processes in the last section of this chapter. Bongani is a long-term patient in the hospital and has been there for over a decade. He is a consistent, dedicated member of the group. There is significance in his prominent role in the group in being the protagonist who performs the process of being granted a LOA and then the navigation of the everyday world. This is a performance of his hopes and desires. The stakes for this patient-participant and how he plays with the drama process and the storying possibilities are particularly high. The examples of these performances where he is the protagonist in a successful progression out of the hospital story, are contrasted with the disintegration of the boundaries between fact and fiction that I discuss in the next section.

Experimentations with metaphor

This section analyses an example of the processing of the hospital experience that emanates from 'above', and not from the participants themselves, resulting in an ethically compromising situation:

> Following my planning for a [student] course, I decided to incorporate metaphorical/projective techniques in my planning this week. It proved evocative, interesting and took the work into another sort of space, whereby the social and aesthetic were feeding off each other as the space became far more of a discussion and performance of issues (field notes 3 August 2015).

This section discusses a workshop held in August 2015, which had mixed results and for one participant became an ethically problematic experience. In a messy attempt to 'give

ownership' and voice to participants about what they desired about the hospital, I created a situation which resulted in simulations of a fake sense of agency on the part of some participants that was facilitated by methods I had chosen to experiment with. While my field notes suggest a positive result in my overall impression of the workshop, due to the rich metaphors that emerged as participants grappled with the contradictory meanings of the hospital, the fairly directive way these workshops were structured requires interrogation because it trapped participants into a space where they *seemed* to have power to suggest changes about the hospital: a role imposition so superficial that it slipped into ethically dangerous terrain. Whereas the shape of most sessions, and a method that had emerged over time, resulted in participants claiming and discovering agency through the stories and scenarios that they themselves had chosen and created. This suggests that an approach that trusts participants to tell the stories they wish to tell on their own terms, in which we support each other to do so, is empowering because participants find the source of agency from within and between one another other. In the workshop I critique in this section, agency is superficially imposed through the structure of the activities and the requirements of in-role and out-of-role episodes.

I make use of metaphor from time to time as a group or pair creative activity: for example, asking participants to consider: if they were an animal or a food, or colour, what would they be, and why? The extension towards metaphor is different from individual to individual, but I have always found that participants choose something that they connect with as an extension or expression of something about who they are or how they are feeling that day: a gentle and playful activity that is often surprising. A patient-participant whom we may expect to be quite literal or concrete will come up with an unexpected choice and capacity to reflect on that choice that demonstrates an ability to think in abstractions, to use and understand metaphor or irony.

For the workshop on the 3rd of August (2015), I decided to structure the session around generating metaphors that would culminate in a metaphor for the hospital: if the hospital was an animal, what would it be, and why? The participants were divided into three groups to collectively generate opinions about what they liked about the hospital and what they would like to change. This was intended to lay the foundation for thinking about the hospital

as an animal, of which participants would then embody or perform aspects in small groups. However, each group was ‘led’ by a staff-participant who also became a scribe for the initial idea generation. Athenkosi and Monde – both established ward E patients – seemed able to speak their minds in the groups (field notes 3 August 2015). Monde had started with us in MSU in 2012 and was therefore at least in his fourth year in hospital. He was a loyal member of the group, as he would go on three-month breaks to his home, and even if he was back at the hospital for one week to have a check on his progress and integration into his home life, he would attend the group for that week. Both he and Athenkosi were in the about-to-be released but not-quite-yet phase of their institutionalisation, resulting in a far more engaged critique of the institution and its powers. Table 2 is a transcription from the newsprint from each group and what they discussed. It indicates how reasonable the changes requested are, and the sense of mystification around the LOA process and why it takes so long for someone to be released home. What the patient-participants like about the hospital is that which makes them feel safe and human, such as the health care, and activities that are part of everyday life such as church, sport, the drama and art groups. The changes relate to reasonable demands for being treated more humanely: from clearer communication by staff, to a dislike of demotion as punishment, to better food portions, and education and work opportunities. Even the suggestion for ‘free tobacco’ is weighed against what those who do not smoke might need, such as ‘free snacks’. Their suggestions indicate the authors as fair and rational, a far leap from the many spaces in the hospital where patients are positioned as helpless children who have little imagination for change or alternatives.

What we like about FEH Group 1	What we would like to change
• Treatment helps people • Good care • Rehabilitation • Dignity and respect • Can go to church • Confidentiality	• People to go home sooner (marked in red) • Tuck shop to stay open longer • More information from staff (written or spoken) about treatment and diagnosis
What we like about FEH Group 2	**What we would like to change**
• Food (the meat) • ~~Clothes~~ (crossed out and transferred to other column) • Teaching (groups) • Soccer • Drama • Cricket	• Stay too long (far away for the family) • Food – small portions; samp is grainy[64] • Demotion • Clothes • Want more food, healthier and cleaner food; • Don't like demotion – removal of activities.
What we like about FEH Group 3	**What we would like to change**
• Church • Food • Activities (drama, art, gym, sport) • FEH name • Staff	• Clothes colour • Inter-ward transfer (H to E to F) • Should have access to ward rooms during the day – so can sleep if want to • All wards should be open – no security wards • Tuck shop over weekends • Access to money and town parole • Sufficient food • Free tobacco for smokers, for non-smokers free snacks. • School or educational opportunities • Conjugal visits

Table 2: 3 August 2015 transcription of group suggestions

While some patient-participants were able to use the space to vent their frustrations and suggestions for improvement, there were moments where the session became a bit like a psychoeducation space when staff-participants slipped into clinician mode to try to explain when and how the LOA process happens. At one point I overheard a staff-participant explain in a teacher-like tone, 'And what holds up the LOA process? The social worker's report' (field

[64] Samp is a staple African corn-based side dish.

notes 3 August 2015). No longer was this a space of fellow players working through creating something together. My structuring of the workshop facilitated the slippage into the hospital space of patient/staff power dynamics and expectations. This was due to a shift in methodology which became instrumentalist, rather than open, in terms of storying and choices. The approach felt, and became, akin to the educational and/or therapeutic activities used in different parts of the hospital, such as brainstorming about the hospital, with a staff member. This became evident when, later on in the session, Bongani – a patient-participant who had been in the closed wards for over a decade and frustrated by his lack of progress through the system - started to narrate his life-story of being at the hospital for a long time as his family feared him, so he was unable to go home as no-one would offer to become a custodian. I had asked each group to choose an animal metaphor to represent the hospital, and then to find a way of performing their animal or discussion. Bongani's group elected, unlike the other two, to re-enact a successful leave of absence and release process: a performance of the group's wishes and imaginings as to when the process goes smoothly. Bongani got caught up in this projected fantasy. My notes indicate the ethical issues we were confronted with:

> The conversation tipped into somewhere else, when the exercise merged with his desires for something different. I was naively trying to get them to perform the "hope of another world" and change: "think about the change you would like to see" – and there was a complex slippage into him saying "from here (the drama group) I will go and tell the Dr I can leave". Nervous eye contact between me and Lauren. After careful negotiation and discussion he retracted. But it felt like a moment of empowerment and hope that was dashed as reality set in (field notes 3 August 2015).

Bongani's inability to hold the aesthetic 'as if' frame as a distinct way of being and experimenting highlights the potential dangers of certain drama processes. Unlike a few other patient-participants whose illness did manifest in the group at times, this was not an example of a participant blurring fact and fiction due to psychosis. As a patient who has felt trapped in the liminal world of the hospital space for well over a decade, the opportunity to realistically imagine the possibility of being granted an LOA, created with people he trusts, resulted in a collapse of the subjunctive, aesthetic holding- frame towards the belief in the possibility of achieving his long-desired reality. In this case, the performance of a projected desire arose out of a workshop process that falsely suggested a sense of change and power.

The brainstorm discussion that was led by hospital staff suggested for this patient-participant a real plan for change and the scene selected by his group became, for him, a rehearsal of his own LOA process. There was a lack of aesthetic distance in how the workshop was set up and evolved. I have argued that the processes involved in the theatrical playground changed institutionalised behaviours in players whilst they are playing: uses of the body, ways of relating and behaving that are prescribed by the regimes of institutionalised power, as well as playing with past, present and future narratives. The example of Bongani, however, highlights that this is not possible for all players. Bongani remained stuck in his institutionalised role. He was not able to play with the institution or a future beyond it.

For the other two groups, the metaphors chosen were rich and complex in articulating their multiple feelings about the hospital: a recognition of how the healing aspects of their hospital experience brought containment and safety, as well as how some of the more restrictive experiences resulted in feelings of resentment and anger at the lack of choices and agency. What resulted, for some participants, was an opportunity to literally play with the institution, envisioning it as different animals with different characteristics. For example, the animals chosen in one group included a donkey (with associations of an animal who is stubborn, strong, and unyielding); and a dolphin for one of the female patient-participants (Mary), who described it as being human-like because it has memory, understanding, listens well, and saves other people's lives. This choice suggests an animal that is sensitive and represents an institution that understands her and offers her safety.

Athenkosi decided on a shark as the animal representing the hospital. For him, the hospital experience was about keeping people in and then eating them up: a powerful image of Goffman's hypothesis about Total Institutions that rely on the mortification of the self to enact their totality. The other animal selected in that group was a tortoise: an animal that specifically represented a controversial hospital administrator and the slow pace of decision making within the institution. The tortoise also represented the slow pace of receiving the crucial social worker report that is instrumental to securing a LOA. The third group also hooked onto the shark image because it is 'big and eats a lot', a dog who is 'loyal' and a lion that is 'intimidating and big' (field notes 3 August 2015). One group took the animals into the final performance, 'physicalising a shark that swallowed people unawares and a slow tortoise

not getting very far. It was extremely entertaining and I liked the embodied potential of becoming the beast and playing with it – really playing with the institution' (field notes 3 August 2015). For some participants, there was a release in transforming and playing with the institution.

Re-enactments of Xhosa cultural practices

The final theme concluding this analysis concerns the choice to re-enact rituals and ceremonies, songs and dances from Xhosa cultural practices. Such scenes involve the slaughtering of an animal to thank ancestors, and the passing around of *umqomboti* (traditionally-brewed beer) by recognisable character types (the Uncle, the respected elder, the young men who must pass the meat around, the person who carefully distributes the brandy). The ceremony (*umgidi)* to welcome young men who have undergone ritual circumcision (*ulwaluko)* as boys, and return to their family as men, has regularly been incorporated into participants' narratives. Most Xhosa men in the group will either have undergone this ritual or will have participated in the *umgidi* that welcomes an initiate home.[65] The referencing of Xhosa cultural practices occurs in other activities, such as the improvisational game in which a participant will transform an object and improvise a stick-fighting dance, or when we sing well known *Nguni* songs in warm-up activities, as well as part of the final showings that utilise Xhosa songs and dances as the opening and closing episodes in the piece.[66] Early on in this project my field notes recognise the shift in affect when Xhosa songs and dancing are introduced, and how the group frequently references culturally-specific means of expression. These choices reference a spiritual and cultural identity which, I will argue, is routinely rendered invisible or ignored within the medical-legal culture of most South African forensic psychiatric hospitals.

Unlike my previous arguments about participants performing and making a future for themselves within their theatre-making, in the scenes that re-enact Nguni rituals, participants

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[65] The demographic profile of patients at the hospital indicates that 85% of patients are Xhosa-speaking (Nagdee et al. 2015).

[66] Nguni refers to a group of closely related languages and people in Southern Africa. It includes Xhosa, Zulu and Ndebele peoples and cultures.

perform a sense of belonging to a stable collective identity connected with their family life before their institutionalisation. These re-enactments facilitate a reflection on experiences and life-histories that hold significant meaning. The interview with staff-participant Bulelani highlights his interpretation of how theatrical play helps patient-participants reconnect with who they were, as people, before they became stuck in the sick/patient role in the hospital (November 2014). Staff-participant Lauren regularly spoke about how many patients' life stories get suspended or stop altogether when they are in the hospital. As I have argued, in most spaces that patients navigate within the hospital, their only means of identification and relation to others is as a sick patient: this becomes the defining means of how they identify with the world of the hospital, and how the world of the hospital relates to them. The staff-participants in the group reflected on how theatrical play created a thread that connects past, present and future identities for people, and how they could meaningfully situate their life story before, during and beyond their hospital experience.

For example, the narrative sequence of the end-of-year show in 2015 involved the journey from the LOA process to the home environment and ended with a ceremony to thank the ancestors for the safe return of a son from the hospital. In this scenario, the holding identity of belonging to a community is celebrated through ritual and song as the final scene of the play. This expression of Xhosa culture was an act of self-determination, celebrating the return of the patient to a community that welcomes him. It reintegrates him into a cultural identity that has been denied to him because it becomes suspended during a person's healing process (much like the patients' life story often is) within the domain of a psychiatric hospital, which primarily focuses on a bio-medical approach to change. By including these moments of ritual celebration in the theatre-making, which is then performed at the hospital for a wider audience of staff and fellow patients, patient-participants resist the cultural dissonance that is part of the Total Institution. Institutions like this hospital require a cultural dissonance in that patients are compelled to conduct themselves in ways that serve the purpose of the institution, often supressing parts of their lives that have meaning.

There is a political and aesthetic significance associated with choices to create scenes and characters from cultural rituals and traditions. Most patients interviewed referred to these scenes as memorable and important. This needs to be understood within the context of a

person being involuntarily removed from their home environment to a hospital, which is essentially a colonial space in which one's cultural beliefs and identity are partitioned off or occluded as part of healing. Such exclusions are also an erasure of parts of identity that may be essential to a sense of agency, autonomy and citizenship. These scenes celebrate indigenous cultural forms as well as providing performances of leadership and capability for men who are regarded as problematic long (life) term cases within the wider context of the hospital. Three men I have discussed as patients, who have a dual diagnosis of having both mental illness and intellectual disability (Lunga, Mzwandile and Sibongile) and are perceived as beyond hope of rehabilitation or healing, have found significant roles within these scenes (expanded on below). As long-term patients, their visible thrill and sense of place within these scenes, and the recognition received from those watching, is a connection to a memory from a time before hospitalisation when they were contributing to, and part of, society. Each of these patient-participants performed a key character within these ceremonies: Lunga as the person who advises on the correct and humane way to slaughter a cow (August 2014); Mzwandile as the person who passes round the bottle of brandy to share with the elders in a scene created for an Easter event (April 2015); and Sibongile's role in leading songs that connect with and celebrate the ancestors as part of the ceremony for the end of year show in 2015.

Each of these is a performance of contribution and capability within the holding frame of a respected cultural tradition. Not only do these performances disturb a view that they are incapable in many ways due to the dual diagnosis of mental illness and intellectual disability, but they also centre these men within culture as carriers of established cultural traditions. Often people with dual diagnoses are perceived as exempt from the responsibility and mores associated with society and cultures and therefore not fully human. These patient-participants' leadership roles, within these scenes of cultural affirmation, position them as creators of culture and leaders within cultural practises. I discuss below one performance over Easter that is an example of a performance of culture and renewal that navigates diverse spiritual experiences.

The OT department at the hospital regularly plans events for patients involved in the OT programme to participate in. These are often around key days in the year, such as a

Valentine's Day dance, and a Heritage Day event where different cultural foods and traditions are experienced. As a run up to Easter (2015), the department had asked for some plays for an Easter celebration day. I asked participants to think about scenes that represented 'birth' or 'change' as this is the key theme of the Easter story. Three scenes were proposed, one of which was a story about the celebratory ceremony welcoming an initiate home as an adult man following his circumcision.[67] This scene highlights the way that spirituality is navigated and understood by many South Africans in which the Easter story and ritual initiation exist concurrently.

Many African South Africans navigate a spiritual world that encompasses both Christianity and African spirituality. Many South African families that attend church on Sundays will also sacrifice animals for ancestral rituals when required. They might also consult with a *sangoma* (a traditional healer who consults with ancestors to prescribe healing processes that may involve rituals and/or herbal medicines).[68] However, within the hospital context, only Christian spirituality is acknowledged. Church services are held every Sunday and Christian religious holidays are celebrated. A patient, for example, would not be permitted to consult with a *sangoma,* whereas a consultation with a priest or pastor would be perfectly acceptable. It is therefore politically significant that one group chose to enact a story about a man returning from the initiation school, as part of the Easter celebrations.

This scene was created in one of the workshops in March 2015. When the group performed it for us, Mzwandile started to gesticulate a drinking motion to us, pointing to the ceremony being acted out and gesturing drinking. He was not initially in this group but identified with it and asked to join the dramatic action, which he subsequently did. He started to distribute the brandy to the other men. The scene apparently triggered his memory and had meaning for him so that he found a way of participating. He was subsequently integrated into this scene

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[67] The other two scenes centred around the LOA and hospital process, showing a man being granted an LOA and his father's journey to collect him and take him home in a minibus taxi. Long term patient-participant Thando who had played the patient-hero in the 2014 end of year show, played the father, a powerful social position that disrupted the many patient roles he assumes.

[68] 'A large proportion of the African population uses indigenous healers pluralistically alongside western biomedicine and psychiatry' (Yen & Wilbraham 2003, p.550).

as part of the Easter sharing. During a rehearsal when I brought an empty brandy bottle as a prop, he asked permission to put water in it – a simple action that indicated a sense of initiative and a degree of authorship. My field notes remark on Mzwandile's progress in the group: 'I marvel at Mzwandile and the extent to which he has grown – from not being able to follow the rules or logic of the activity to actively initiating and participating in it' (field notes 23 March 2015).

The scene was performed in the common area of the OT building – a tight rectangular space. The department had lined up couches and chairs for the audience which consisted of nurses, OT assistants and OTs as well as other patients who are part of the OT programme. The story involved a family who needed to send their son to initiation school but had to go to a loan shark (a common term for informal money lenders, many of whom charge exorbitant interest rates) to raise the money to do so. The scene ends with his return from initiation and the *umgidi* ceremony. As soon as Mzwandile entered the scene and started distributing the brandy to elders, the staff who were part of the audience expressed amazement. They identified with the character Mzwandile portrayed, which was probably reminiscent of such persons who presided at initiations ceremonies that staff may previously have participated in. They relished Mzwandile's portrayal in the scene, his focus and clarity. He was demonstrating an ability way beyond most staff's expectations, and his performance meant that he was being taken seriously as a social and aesthetic actor. I imagine that this was one of the few times when he was given attention due to the nature of the performance frame, and that his identity as a patient, with not much hope of rehabilitation, was disrupted. I read the surprise that was expressed by the audience, who kept saying his name, as evidence of this disruption and how they saw him in a radically different way. In this enactment, Mzwandile creatively participates with others and he then performs ahead of his perceived ability: in Vygotskian terms, he performs 'a head taller' than his understood developmental level. The supportive environment of fellow players and audience witnesses who relate to him as a social and creative actor in the world, catalysed this demonstration of abilities that far exceeded many expectations.

For patient-participants Sibongile and Lunga, who can at times be rendered silent and passive in scenes, looking like disaffected participants who feel pressurised by the need to

participate, scenes that celebrated and acknowledged Xhosa cultural practices engaged them in specific ways. I observed their immediate connection with the characters, songs, dances and rituals involved in such practices. Their participation became animated and highly engaged as they shared in the making of the scene and how it evolved towards performance.

Sibongile is a man who finds inter-personal connections difficult. He is easily distracted and avoids eye contact. When he was acting in scenes, he might break the expressive frame of the scene to berate an audience member who was laughing in the wrong place, or tell us what was about to happen, and then resume his role in the scene again. But like most other participants, he enjoyed singing Xhosa songs and dances and loved watching and performing in scenes about traditional ceremonies. For the end of year show in 2015, he took on responsibility to lead the Xhosa songs. Watching the video documentation, I noticed how his timing for starting the songs within the scenes was perfect. He is listening carefully and contributing to the ensemble to ensure the rhythm of the play is achieved. His loud enthusiastic singing demonstrates his joy and strength in leading the songs that the whole ensemble contributes to under his lead, as to when to start and end. This contribution demonstrates a focus and awareness off space, time and relationships, as Sibongile participated as a capable fellow player in telling a collective story.[69]

Lunga's first commitment as a fellow player occurred in a scene that was created within the first two months of the project (July 2014). Up until that point his participation had been peripheral, and I was concerned that he was not gaining much from the group. In this scene a ritualistic slaughter of a cow was re-enacted. Mzwandile was given the role of the cow and had to 'moo' loudly at the moment of slaughter (a signal that the ancestors are pleased with the sacrifice). Lunga's role became one of problem-solver as the other characters were unsure of how to go about the slaughter: that person who has expert experience. Lunga was able to advise the others about the correct way to go about the ritual slaughter that ensures

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[69] During his participation in the drama group (from 2015) his loud, uninhibited laughter permeated the group, providing instant feedback to all of us about his level of appreciation for aspects of the drama process, and exhibiting something that is a crucial part of why participants returned to the group each week: the collective experience of playing and creating together changed the mood and affect of us all. If nothing else, all participants spoke about a lift and change in affect, of feeling *better* after participating in the group. As facilitators, myself and Luvuyo felt this too.

continuity in the communal and spiritual life of a community. He therefore performed a character who has a meaningful social position and can influence important cultural events. As a long-term patient in the hospital, this role allowed him to play with power and influence in a socially meaningful way that was witnessed by others. Staff-participant Bulelani refers to this scene in his interview, and to how a patient like Lunga often appears stuck therapeutically. However, when he found an opportunity to tell a story that reflected his past, he discovered a meaningful way of expressing himself. Bulelani observes that '*in any other role he* [Lunga] *would dry up*', but when given the space to reference a cultural experience, he and other participants would take the opportunity to play with this and create meaning by *'reflecting on their past experiences'*. Bulelani further observed how theatrical play enables people to '*reconnect with who you are or who you were before you were in the hospital*' (Bulelani interview November 2014). This performance of leadership within a cultural ritual demonstrated a knowledge and expertise that is not recognised within the hospital environment. Here Lunga could demonstrate a skill that others did not know he had, and most significantly, he could be listened to and taken seriously. Luvuyo's interview with me highlights his observations of how performing socially meaningful roles was so important for participants: 'In that space you are able to become a soccer commentator, or a doctor and you can stand up and have other people watch you do that, and that kind of play is constructive play and it consolidates or proves that you are worth something' (Luvuyo interview May 2017).

If, as Cohen (2014), Fanon ([1954]),[70] Fernando (2010), Mills (2014) and others have argued, psychiatry as an institution replicates colonial ideals and power relations as a site of social control, the space to celebrate, make and remake stories around and about rituals and characters that are disregarded as part of the colonial space, is politically significant. Not only do these performances decrease the alienation patients feel when entering the liminal world of the hospital, with its own medical and legal cultures that are cut off from their own communities, but these enactments can also be understood as acts of resistance, in which the patient-participants represent themselves on their own terms in their own way outside of

[70] See Gibson and Beneduce (2017) for an analysis of translations of Fanon's essay on colonialism and psychiatry.

an illness or criminal narrative. Whilst these acts of resistance only occur within the aesthetic space of performance, that does not mean they lack significance for the players, as I have demonstrated in this account.

The openness of the theatre space means that patients choose to connect with cultural experiences and identities that are regularly suppressed within the hospital. Scenes that celebrate and integrate cultural life into the theatre-making restore a connection with a life beyond illness and the hospital, within a community setting that enacts belonging, acceptance and an affirmation of the values and beliefs of that culture.

I have argued that a theatre playground that is structured around the relations between performer and spectator – roles that shift continuously throughout the theatre process I have described in this chapter – enables players to risk stepping into uncertainty. As has been argued throughout this chapter, such a space opens up possibilities for experimentation that both grounds and empowers all players to play with the total institution. The release from constrained roles and expectations of staff and patient identities that this results in, and the humanising effects of this release, is a main theme that emerges in the staff-participant interviews discussed in the next chapter.

8 Releasing humanity: staff-participants' reflections

The final lens used to examine the practice discusses the four staff-participant interviews. In my method chapter five, I explained that it was themes, emerging from all of the interview material, which generated the lens with which I analyse the practice. Consequently, there are large areas of the discussion that follow which recall themes and propositions already familiar to the reader. But the perspective of the staff-participants adds further nuances and new insights to the analysis. In what follows I have also sought to highlight when the interview responses of staff and patients concur, so the voices of patient-participants are also heard in this chapter. I remind the reader that in these interviews I was by no means a silent listener. Rather I too was actively reflecting upon the work, so in what follows, my reflections are both captured in the interview quotes and interspersed in the discussion.

I have clustered staff commentary into four subject areas and attempt, in what follows, to deal with them consecutively. However all four areas also continually cross reference the others so while I highlight these areas here they often intersect.

As collated in this chapter, the staff are firstly concerned with their professional status and responsibilities and they reflect upon their overall attitude to the theatre project. Secondly staff interviewees reflect upon their increased understanding of the importance of play in their work and in the theatrical playground and the changes they observe in themselves and patient-participants. This promotes the discussion into the risky unknown adventure which is embodied in the theatre work, which renders vulnerable all those involved and which leaves participants feeling more 'human'. Fourthly, the theatre experiments are not always successful or even intelligible, but even when they fail they prompt a richer, deeper experience of living. For patients confined for many years, these experiences are significant.

Playing professionally

Within the hierarchy of the various therapeutic interventions in the hospital, OT is perceived as the least significant. OT straddles the humanities and sciences as a deliberate relay between objectivity and subjectivity. OT frequently recruits the arts, often incorporating visual arts and crafts as well as role play (even when 'drama' is not offered). Theoretically the

health professions espouse an inter-disciplinary approach - between social work, psychology, OT and psychiatry – but in most South African hospitals, psychiatry not only is considered the ultimate arbiter and wields the majority of power but also OT is deemed to have little status, and in the views of other medical staff, is sometimes regarded as merely occupying or entertaining patients. Perhaps OT's espousal of the value of play as an essential developmental feature of wellness (Rodger & Ziviani 1999) contributes to this perception because an affiliation to play might entrench its status as not as valuable nor as important as the other more scientifically aligned disciplines. Bulelani talked about explaining to a psychiatrist on ward round that one patient was part of the drama group, which was dismissed by the psychiatrist as '*oh play, play is for children' (*Bulelani 2014). Interviews with staff endorse the sense that they experience a distinct hierarchy, with psychiatry at the top, followed by doctors, psychology, and OT at the bottom. This was expressed by Maya (2016) who talked about a '*powerful but tacit hierarchy within our professions and we are at the bottom … psychologists are quite a bit higher up ... our voice does not really count as allied health professionals.* Nonetheless within the academy, disciplines such as Psychology and OT are deemed much more legitimate than the performing arts as they are affiliated with medicine and therefore perceived as more useful. Usually, it is the performing arts that are required to draw on other disciplines to legitimate themselves, thus the espousal at FEH of the theatre project by the allied health professionals demonstrated an instance in which the arts appear to have influenced a more valued discipline, and, as such, was unanticipated. Phil Jones, whose book *Drama as Therapy: Theatre as Living* (1996) is regarded as a seminal text theorising drama as therapy, suggests that there is a political potential for arts within therapeutic and health contexts because it can challenge the status quo or resist regimentation and conformity (Jones 2005). He suggests that the arts within therapeutic contexts have the potential to be radical. 'The necessary creativity and imprecision of improvisation and the arts offers an energetic challenge within settings that can often be experienced as at odds with these qualities' (Jones 2005, p.90).

Radical or not, my sense is that little explanation is required for anyone involved in OT for having a theatre group within a psychiatric hospital. One of the OTs interviewed has an arts background, but the other two had not experienced a drama process before. I found myself privileged to be working with therapists who were open to the possibilities of the theatre

project and who acted upon that resolve by being willing to step out of their status as therapists and 'play the fool' within the theatre space.

Recognising change in the theatre playground

The main goal of the hospital is rehabilitation and reintegration of forensic patients into their home life. This is not always possible due to the extent of the illness or the severity of the offence committed, or the lack of a support base at home. However, one of the contradictions of certain aspects of treatment, such as the behaviour modification programme and other infantilising aspects of a Total Institution, is that opportunities to exercise choice, autonomy and agency are limited. Another aspect of hospitalisation that limits rehabilitation, is the isolation of patients from the outside world. Rehabilitation involves preparing people to re-enter the outside world by providing them with the knowledge and practices that will enable them to live a life where their mental illness is carefully managed, and the choices they make (such as avoiding drugs and alcohol and engaging in pro-social behaviour such as helping and sharing) ensure that regression or re-offending is avoided. However, there are very few opportunities to navigate, experience, or practice a life outside of the hospital environment. Lauren (2015) reflects on the contradictions of what therapy and rehabilitation are trying to achieve in terms of enabling autonomy, yet how her experience of the drama space magnifies choice, bringing into sharp relief that lack of choice and autonomy that is nonetheless accepted as part of the hospital system:

> *Lots of what you do in the theatre space is honouring choices. Sometimes the options offered are so far away from each other but somehow we manage to find a way in which everyone's voice is kind of respected and heard, nothing is devalued. And I don't know if many other spaces, clinical spaces, can provide a sense of honouring, hearing and listening … you would expect that would be the cornerstone of what we do, yet I think it gets lost, sadly.*

Maya (2016) also provides insight into what she perceives as lacking from some therapeutic interventions that the theatre space addresses. Her interview talked about how activity analysis, a tool employed within OT, might analyse what is going on in the theatre space. An activity analysis might say

> *the men are partaking in pro-social behaviour and their social judgement is being rehabilitated, and their concentration – and you could dissect it and give a very comprehensive account in terms of pathology and the potentially remedial effect the space might have on them. But to do that would be to completely ignore what is gained through just being a human being in that space.*[71]

For Maya, the space is 'transformative' because it does not address underlying impairments or try to improve or fix: it does not start from a deficit/illness/disability. Rather '*it's about meeting you as a fellow human being, and that is what you have to be when you leave, when you are outside of this place. So that is the rehabilitation, which is inadvertent but very powerful'* (Maya 2016). Through discovering one another on a human level as fellow players, she suggests that the group aids patient-participants to prepare for the world and their relationships outside of the hospital.

For each staff-participant, the permission not to perform a therapeutic role is experienced as liberating. There is a sense that these institutional roles can become too rigid, which can lead to what Friedman (2013, p.162) refers to as 'fossilized performances that have been pre-determined for us'. Staff-participant interviewee's experience of the theatre group was concomitant with an ease of interaction and relationships with patient-participants that they did not experience elsewhere. This was the dominant discussion opening each staff-participant interview. Lauren reflected on how her prolonged engagement with versions of the group, from the MSU where she was a case manager and had a direct, one-on-one therapeutic relationship with certain participants, to her participation outside the MSU when she was not a case manager on the wards that participated, opened up different possibilities for relating to patients:

> *Being a staff member who is positioned as a participant opened up a different type of relationship… where I can say even more authentic interaction happens. Because it is about two people working together where you push away all that kind of structure, that hierarchy that is very restrictive sometimes* (Lauren 2014).

[71] Maya wished to clarify this point further after reading this chapter and I asked for comments: 'One of the tools we use - activity analysis - employs a clinical lens, but it does not characterise the profession's gaze as a whole. Activity analysis is useful in as far as it allows me to communicate gains in terms that my colleagues in other professions will respect' (Maya, pers.comm. January 2020).

Bulelani (2014) frames this as an ease he feels at not having to be totally responsible for what and how a patient does something:

> *Once we got to the session I could see how easily it is to interact in that different setting and out of a clinical setting … So my role was not necessarily as an OT, I was there as a participant as well … I also kind of relaxed because … as a therapist you are always analysing and looking at things from a clinical perspective. But that opportunity [meant that] I didn't have to be, because I wasn't there to do that, I was just there to be there so it was easier for me to interact with the patients and to actually be part of the group.*

Thandiwe (2015) remembered that *I liked what I saw in patients and also how I was relating differently to patients in that environment.* For her, the release from a clinical role was also therapeutic: *It helped release a lot of emotions, it helped me having a way of relating to patient where I am not in a superior position but rather we are all equal, we are all doing the same thing'.* Bulelani (2014) echoes Thandiwe's observation as he tells of his realisation that for patients the group was important, which motivated his own mode of participation: '*So just being part of the group and seeing what it means to them, I could also kind of relax and play'.*

Thandiwe (2015) relates this to some of the founding principles of OT:

> *In OT we talk about occupational opportunities and just allowing patients to participate in activities that bring meaning to them. And you can see when patients participate in the drama group, they are not doing it because they have to, it's a very voluntary sort of interaction that they were having.*

Maya (2014) juxtaposes the sense of life found in play in the drama space with the lifelessness that is observed and experienced by many patients. She comments,

> *a space in which people could come together and laugh was just quite remarkable also because of the effect that the illness processes themselves have on the participants in the group. Its not just institutionalisation that renders people lifeless, its also that they are living with a number of illnesses …, so their affect becomes less reactive*.

Bulelani identified the importance of play within healing and wellness. Elaborating further on his responses to colleagues who dismissed patients' participation in the theatre group:

> *I was thrown back a bit, there is a child in every one of us and whether we choose to reconnect with that child or not … It gives you a sense of freedom from your daily*

> *stresses and things like that because you are reconnecting with who you are or who you were before you were in the [hospital] (*Bulelani 2014).

This self-irreverence, openness to performing failure, to laughing with each other and at themselves, to being vulnerable and stepping out of their own comfort zones in front of and with those in their care, is critical for the success of the group. Thandiwe (2015) commented on how much she benefitted from the participation and the opportunity

> *to be myself, because when I'm in the role of a therapist, there are elements of myself that I cannot show because there is a specific goal I'm trying to facilitate. You know when I was in the drama group, I was very naked, I was myself, I was like, this is who I am and I can be very playful and silly*.

The insights that staff-participants offer in their interviews reveals the significance of playful spaces that disrupt the rigidity and hierarchy of the hospital. Thandiwe commented on how her participation in the group had led her to read up on the arts and movement in mental health settings, which resulted in her establishing a social group for singing and dancing as part of the OT activities. She reflects on how this has shifted her understanding of what can be released in patients: *'when we are singing and dancing it is a totally different reaction from patients, especially the low functioning patients that you would give tiny activities, but then it turns massive* (Thandiwe 2015). Thandiwe alludes to her understanding of how lower ability or a-potential patients are treated in a particular way and responded to accordingly, but certain collective, creative activities shift the scale of their expected responses and they perform beyond expectations as Vgotsky argued. Drawing on Victor Turner's language, the drama space becomes a liminal space where the structural order and logic of the hospital can be interrupted and inverted (Nash 2005).

On taking risks and playing the fool

The ability of each staff-participant to model playfulness and vulnerability is critical to dismantling expert hierarchies. Part of this concerns the structure of each workshop that is based largely on improvisation. Improvisation also demands a giving up of an expert or authoritarian position in order to build with others. When a patient-participant in an improvisation exercise suggests that his partner is giving birth, and his male, staff-participant partner drops to the floor to perform this, not only is he performing the impossible, he is also

honouring a choice and proposal made by another player: in this case, a player who has almost no power or agency outside of this space.

Lauren (2015) noted that

> *playfulness in [the hospital] is certainly not something that happens a lot. There is almost an earnest seriousness about being a psychologist or being a doctor or a nurse. There is not a lot of space for playfulness even amongst staff members or as an institution as a whole*.

Julie Salverson's work on the facilitator-participant as a 'foolish witness' encompasses the notion of the clown or fool 'characterized by truthfulness and a willingness to engage in the face of failure' (Salverson 2006, p.153). For Salverson, the clown or fool's innocence in the face of failure is also part of a naïve hope. Prentki (2012, p.205) links this innocence with Dario Fo's clowning, in which the clown's innocence provides a transgressive alternative to hopelessness and stasis. The clown keeps trying, in the hope that s/he will not fail. Perhaps then, the staff-participants and facilitators who often play the fool and play with failure are also playing with performances of hope. We relinquish our expertise and social power, and this is experienced as enjoyable. The interviews suggest that staff-participants' participation in the group is hopeful, in that it provides a freedom for relating and being that is often restricted elsewhere within the hospital and within their professional behaviour.

Given all these positive responses, there is, however, a tension therein. Whilst the ideal is to create a space of equality where every contribution matters, because of all participants' awareness of the social roles and power that they bring into the space, on the whole the needs and desires of patients are given preference. For example, in the small-group theatre-making that occurs towards the end of most sessions, staff-participants evenly distribute themselves across groups. In these groups, staff attempt to surrender their own ideas in order to pass ownership and agency to patient-participants. Nevertheless, they do take a facilitator role in helping to guide discussion around what the scene will be about, who will play which role, and ensuring that quieter, less skilled participants are included. The staff-participants therefore do take on a leadership role within the theatre-making group sections, helping to ensure that a group with diverse skills and abilities can create something that includes everyone. In doing so, they also find themselves assigned roles that can shift them

out of their own comfort zones or social expectations. For example, Lauren has often played a socially deviant role in a scene – a thief, or a rebellious daughter. By casting the psychologist as the deviant, other participants in the scene then adopt roles that are aspired to or respected, such as the policeman, or a helpful citizen. At other times, a staff-participant will be cast as a patient, and patients cast themselves as hospital staff.

Staff-participants therefore enjoy the release from the responsibility of watching and measuring what patients do, and creating with them, but also carry an awareness of the opportunity to hand power and choice over to patients.

Maya (2016) expresses a disappointment that patient-participants never fully engage with her as an equal because '*they often just don't know how to do that, they are used to engaging me as another 'staff' or 'doctor'... it really does sadden me because it speaks to the extent that they have internalised the kind of lay of the land'*. The truth is, that no-one ever fully surrenders their positionality, but that the space allows for experimentation with other possibilities in relating.

The exception to this is the choices that Thandiwe (2015) makes in terms of how she participated in the group. In her interview, I commented on this and asked her to explain:

> *Alex: Did you have a particular way that you chose to engage in the drama group – because my observation is that you engage slightly differently to patients than Bulelani or Lauren – was that a deliberate choice you made?*
>
> *Thandiwe: I relate to patients better than I relate to a lot of staff members ... The people in the environment where I grew up are very similar to the patients. Most of the patients in this hospital could be an uncle or a friend. And the decision I took when I joined the drama group is that I am going to be myself. Because when I am in the role of being a therapist, there are elements of myself that I cannot show because there is a specific goal I am trying to facilitate A, B and C … They [patients] don't need that kind of interaction in that space. I must be myself because I am also benefitting a lot, it also shifts a lot of things within myself. I relax a lot in these groups, I feel different walking away.*

Thandiwe's mode of engagement was to accept every offer of choice and go with whatever she chose in that moment, with little regard for what patients needed. She modelled, in effect, a truly authentic surrender of her expert role, playing as an equal to anyone else given

choice within the space. She did not hold back in order to give a patient-participant a space to step into an activity or censor herself in any way. My field notes from June 2015 remark on this: '

> Thandiwe is so into the sessions, she acts like any other participant, seldom thinking about giving over to the group. In a way it is an alternative that normalises her participation on the same level as the group – no holding back, not thinking about her 'role' as a professional caring for patients – she just goes.

Unsurprisingly, in her interview Thandiwe emphasises her desire to step out of her comfort zone, walk into the unknown and try something different, although she prefaces her remarks with caveats: '*I'm the kind of person, I prepare for things, I read up on a lot of things. And walking into the drama group, I had no idea what was happening and everything that was done, I learned as we were doing* (Thandiwe 2015). This willingness to step into the unknown is a profoundly human and vulnerable action that relinquishes expertise and 'knowing'. In doing so, staff-participants play with a part of themselves that is censored by the professional guise and expectations of their work roles.

Bulelani was the first OT who participated in the group. He joined the group three months into his first year of employment at the hospital. As a younger staff member, he was keen to explore new experiences. He expresses his motivation to join the group as a step into improvisation: *'let me just see where this goes'* (2014). Bulelani models a mode of participation that involves stepping into the unknown and experimenting with the possibilities and effectively performing a willingness to be vulnerable and to try whatever activity is on offer. I regard him as a risk taker: he has a physical disability that never limits or defines how he participates.

The meaning of the theatre playground for participants

Overall, the space of the drama group can be viewed as a boundary-crossing experience for all participants but for staff in particular, particularly when they experiment with creating new performances of themselves. Maya (2016) commented about her experiences of the performing arts in institutional settings: '*it was beautiful to see some very marked differences and firm boundaries become permeable in those* [aesthetic] *spaces'*. For several participants

interviewed, the word, '*open'* or '*opening'* is used with a wide variety of referents. It may suggest the opening up of relationships, or modes of interaction and role possibilities experienced in the group. For example, patient -participant Mandla (2015) referred to how his experiences in the group resulted in himself and therapists '*becoming more open towards each other'*. This is connected to the meaning of 'open' referred to by Themba in chapter six. He understood that to participate effectively in the drama group, one needed to feel 'open' (to new possibilities, the unpredictable), or an 'opening' – towards a future.

For all participants – staff, patients and facilitators – the opportunity to step into the moment as fellow players indeed holds significant meaning. It was referred to, a number of times, as the feeling of being 'human' with each other: relating to each other on a human level, not as a patient or a medical practitioner, or an expert:

> *And in that (drama) space, you are not sick, you are a person* (Thandiwe 2015).
>
> *For me to have a play space and to be able to relate to these men in a less formal, less clinical setting where I can just be one human to another, I loved it* (Maya 2016).
>
> *It was very exciting to see a psychologist, who are the ones who [are there] in ward round, someone like that who has more power, who knows exactly about mentally ill patients, who acts with them, 'cos sometimes it is scary you see, but to act with them is making us feel free that we are human beings too* (Themba 2014).

This shift in relationship is also considered central to a recovery approach to mental health:

> A true collaborative relationship is one in which both consumer and provider come to see each other as human beings. For providers, this means learning to see beyond the diagnostic—or racial, ethnic, and socioeconomic—categories they have been trained to use and rethinking "boundary issues" so they can allow themselves to relate to consumers on a human level. (Jacobson & Greenly 2001, p.484).

For patient-participants, this notion of feeling that 'we are one', as articulated by patient-participant Vuyo (2014), is understood as destigmatising, and enabling a patient to experience becoming someone who has a mental illness but is not defined by it: who is both ill and not-ill, or to put this in performance terms, to facilitate 'the universal human capacity to be both who we are and who we are not at the same time, that is, who we are and who we are becoming' (Friedman 2013, p.160).

Athenkosi (2015) expresses this holding of different parts of himself and the self beyond illness, in relation to feeling human:

> *I suppose you feel like a human being, there is no division or segregation because we are all together; I know that I'm a patient but for that moment or that time I feel like we're all normal human beings in one space doing the same thing at the same time, all together*.

Themba (2014) referred to the high level of stigma experienced by people with mental illness, particularly in their home environments, and alluded to women who may be wary of men with mental illness. This is probably due to the high level of sexual assault associated with forensic psychiatric patients.[72]

> *The stigma is high of mentally ill patients. So for some females, nurses, psychologists, and lecturers like sister Alex to be there and act with them, its making us feel free its making us feel welcome you see, you forget about everything and we are all happy* (Themba 2014).[73]

He took this idea further as he said how much he appreciates how outsiders like myself and Luvuyo willingly come into the hospital to collaborate with patients, because *'in the community there is stigma, some people don't take us as people, they take us as animals, so to find someone like [you] ... to be that strong to come and teach us about drama, that is exciting'*.

Khaya (2015) also refers to status and stigma, and the ways in which the participation of everyone, regardless of their position in the hospital, has meaning in reducing a feeling of inferiority in relation to others:

> *That shows me that the staff are not taking low the patient, they know that they can do something possible with the patient. Because to participate with the patient it's not*

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[72] 60% of forensic patients are categorised as violent and of these over a third are rape or attempted rape offences (Nagdee et al., 2015).

[73] Student nurses, most of whom were female, regularly attended the group during their three week placement at the hospital. Each nursing school in the region placed students at the hospital for practical experience at various times during the year. Their willingness to participate with patients was a wonderful injection of energy, laughter, and openness to engage, and it certainly assisted patients to navigate the potential for 'feeling human' in the hospital as a whole.

> *an easy thing but they do that. That means they don't take us as low people or people they say are mental.*

Khaya's reference to being thought of as 'low' by staff resonates with the secondary disability that Vygotsky theorised was the site of disability, which leads to a feeling of inferiority and low social status in relation to others. Vygotsky advocated that cultural environments be created where a person can achieve social status and acceptance (Smagorinsky 2012a).

Accepting everyone as equal participants is not necessarily easy, as patient-participant Mandla (2015) seems to understand, when he talks about the patience that is required from us all in the group and the supportive environment that then facilitates a less able person's full participation: *For instance, someone like Lunga, he is very slow, but you work with him and you are patient with him. You show us and eventually he gets it and gets involved in what is happening and it works so well*. Here Mandla refers to the approach of Luvuyo in playfully directing a slower person's involvement by improvising with him or assisting him with ideas for a game or task.

The social, relational and creative aspect of the group where we co-create together establishes an environment where the everyday outside world penetrates the isolation of the hospital space. On a material level, this includes the people who are there: hospital staff who relay between outside and inside, myself and Luvuyo who visit once a week for a short, contained period, or student nurses who inhabit the hospital space for a defined period. The social effects of the intervention are described by all participants as humanising. For Lauren, '*it has made me think of things differently and certainly it has been such a unique space to just interact with people, not to interact with a patient, to interact with people'* (2015).

'Release' is a cue word that encompasses much of what staff-participants reflect on about their participation. Release also refers to staff-participant observations of patients and how they respond in the space when released from the gaze of illness, assessment, diagnosis, and therapy. This theme of 'release' is captured in my field notes from a session we ran in 2014:

> Lauren talked about how in Schizophrenia, an identity can become fixed and fixated – and that in some ways this reduced, fixed, fixated identity is reinforced by institutionalisation. In this group a person is free to explore a range of other possibilities and beings. One patient said he thought the group was a 'release'…

> Another commented how 'we can tell people outside that we did other things here, not just treatment' (28 July 2014).

Maya (2016) compares the demeanour of patients she sees on the ward with their affect and embodiment in the drama group: '*What was so incredible for me was those people I saw in the ward with blunted affect, smiling and laughing and that is mind blowing*. Further in the conversation, she discusses how stigma and guilt associated with being a mentally ill offender is taken into the bodies of patients: a reflection on the institutionalised and docile body that is shaped through institutionalisation (Goffman 1961; Foucault 1977):

> *It is beautiful to see their human side coming out and their physicality and the way they present themselves… They do walk around, if not quite literally, with their heads hung low, and it is lovely to see a space in which that aspect of their identity doesn't disappear but it is eclipsed by what happens in that space*. *And that helps them to actually open up* (Maya 2016).

Part of the approach taken in the group concerns the level of choice and agency encouraged as part of the space. Related to this is the framing of all activities as an invitation to participate. Invitation is contrasted with prescription, a key feature of hospitalisation: from prescribed medicines, to pre-measured toothpaste allocation, to prescribed activities that a patient must participate in. Staff-participants also reflected on the non-judgemental nature of the space. These observations reveal the ways in which certain exercises or modes of interaction enabled participants to explore the openness of the dramatic space that often resulted in capabilities or skills that some participants did not exhibit elsewhere. *It is very interesting for me to watch them [patients] come up with things in drama, because in different contexts they behave differently and that was fascinating for me* (Thandiwe 2015).

The paradox of this 'release' and range of choices purportedly on offer is that the staff-participant has the privilege of having power to relinquish. The patient-participants have minimal power within the social arrangements of the institution. In the theatre space, all participants are given choice as to how they participate. Yet the stakes of how we participate differ based on a person's social role coming into the space. Nevertheless, what is significant and useful is how participants witness a range of roles with diverse statuses being played by each other. In the theatre space, unlike the total institution, power is not fixed, but continually shifts and changes. Participants therefore experience social relations that are

arranged and rearranged. These experiences contribute to how all participants see and value each other as creative collaborators in the space, regardless of the fossilised roles outside of it. We continue to make mistakes, surprise each other and support each other and the playground is full of unexpected turns.

Maya wryly recalls Philani, who regularly ran out of the space to drink water or to find discarded cigarette buts, which he then immediately lit. I often found him desperately inhaling a tiny end of a cigarette, before re-entering the space. In my interview with Maya, I comment on how initially he was quite low functioning, and then, like some of the others, found his place and ways to take initiative. Maya relates how in ward rounds other clinicians did not understand how the drama facilitators managed with Philani as his behaviour is quite erratic and he is often dealing with psychosis:

> *And I mean he is very psychotic and so he is very internally distracted, there is a lot of stuff happening, but he has not been precluded from that space because he is psychotic. He is not a risk to anybody, he is not disruptive. But if you were to just go based upon, say, mentally where he is, you would probably say no, do not take him into the group. But he is part of it, despite the fact that he is floridly psychotic but he is partaking* (Maya 2016).

I have already related how some patient-participants, who have been part of the group for a while, start to instruct and prescribe to other, less confident or capable members, how to carry out certain activities. When I reflect back on which patient-participants have dominated certain sessions by shouting across the circle and telling others who are slower what to do, it has been men who were initially less well-functioning in the playground but who, over time, have gained a sense of confidence and ownership that has resulted in a type of leadership role that they probably cannot play elsewhere. Bundy (2000) argues that involvement in playmaking processes for boys and men who have been considered aggressive, offers certain participants an experience of leadership and inclusion that they may not experience elsewhere. As a facilitator I find myself having to balance the need to honour expressions of ownership and leadership against ensuring that these participants allow other participants the space to process and respond in a way that works for them. So that the space allows for all participants to burnish their capacities.

Thandiwe (2015) notes how activities in the drama group lead to bodily awareness in several patients far more quickly than in other, goal-directed therapeutic environments. She remarked on a direct transfer to her OT practice of skills gained in the drama space:

> *An institution like this can swallow who you are and you could vanish and take the role of a patient and stop making decisions and stop trying. And that is what you see in the drama group, patients are trying, they are channelling themselves and it is very difficult to keep that and apply it in different areas. And I see it with patients that are in the drama group, and here in [OT] therapy, how they carry over from what we do there and what we do here and how we relate to people in this environment*.

In this reflection Thandiwe addresses my question as to the meaning of the theatre space within the Total Institution – how do the skills and experiences released in the drama space transfer to activities in the hospital? She affirms a positive 'carry over' into the therapeutic space.

As the lead facilitator of the group, I too find the space profoundly humanising. When the group started at the MSU, over time I discovered some of the crimes that the small group of men who participated had committed. These discoveries were not actively sought, but incidental to the evolving nature of the group and to times when I needed to understand why someone was suddenly transferred, or if something had emerged in our playmaking that had significance – such as a noted disconnect expressed by Lauren between violent behaviour exhibited on the ward, and contrasting gentle, considerate behaviour within the group. My experiences of working in the Grahamstown Correctional Services have armed me with ways to hold the diverse aspects of myself (as a feminist for example) and men who have committed acts of gender-based violence. I regularly reflect on the paradoxes of the work I choose to involve myself in. I have resolved not to ignore the reality that I work with men who have been violent, but to constantly remind myself that if I believe that every person should have the right and opportunity to participate in creative activities, that right is indivisible.

Where in the outside world, we share very little: language, resources, power, life experiences, the theatrical playground is a meeting ground of the seemingly impossible. The space disrupts a therapeutic and diagnostic gaze and promotes alternative experiences. As Maya so aptly postulated: *It is not just for us to see these men differently but because the*

gaze is different they present themselves differently and I think they experience themselves differently (Maya 2016). I experience the activities we do together as boundary-crossing. What is articulated by staff and patient-participants is that this traversing between hospital roles and the multiple roles on offer through theatre activities is a profoundly humanising experience that expands each participant's sense of who they might be or become beyond the Total Institution.

9. Conclusion: hope, paradox and change

Where I am now

The conclusion of this thesis marks other conclusions: the end of a body of practice working in forensic settings and the end of working in a university as an academic. The consequence of leaving the university for a job in another city was leaving the FEH theatre project and the theatre project in the Grahamstown prison. Both were significant parts of my life. The prison theatre continues through Luvuyo, and Lauren now runs a drama group at FEH with another psychologist. It was (partly) for political reasons that I left the university. Following two years of student protests (#RhodesMustFall and a campus rape protest #RuReferenceList) I became disheartened at how senior management silenced valid student concerns. I now work in the social justice sector designing arts-based political education programmes for activists. However, my current work is a lot less playful. It has been challenging to insert my belief in the possibilities of playing together, of honouring embodiment as critical to a successful learning space. In the drive to cover content (even though this is always done through innovative and diverse methodologies) we lose the important work of relationship building through collective, embodied praxis. The 'soft' skills of creating safe and respectful learning spaces and relationships are, I believe, the foundations for building a robust politics in times of uncertainty and deep crisis.

For Thompson (2011, p.2), attending to the joyful, rather than only focusing on the painful, is potentially radical and transformative: 'participation in the joyful… becomes an inspirational force. Far from being a diversion, it acts to make visible a better world'. This is the core argument in this study. Thompson advocates for critical attention to the pleasure of the aesthetic, which, far from having no use value in creating change or alleviating suffering, can provide inspiration, protection and therefore energy to resist suffering. 'In a world of inequality, social injustice and endemic violence, they could be acts of resistance *and* redistribution, made in an intimate sensory key' (Thompson 2011, p.11). This notion of 'making visible a better world' connects with hope and the audacity to imagine alternatives.

Imagination becomes a strategic act and hope is part of a resistant politics. Connecting us to our imagination is key to the move from, in Freirean terms, describing the world as it is, to subjectively imagining other possibilities (Freire 1970).

Harpin (2018, p.5) suggests certain artistic qualities have clinical implications in psychiatric practice and are also part of cultural attitudes to madness. One of these concerns how art links to notions of change.

> If perception is a dynamic experience, then art has a particular capacity to remind us of the possibility of change through the embedded promise of futurity and alterity. This runs counter to the fixity of diagnostic, identity-based thinking. Indeed, if perception is dynamic then a vital possibility of hope enters the frame.

Hope, uncertainty and change

Historian and activist Rebecca Solnit (2016, p.xiv) connects hope with the dislodging of certainties: 'Hope is an embrace of the unknown and the unknowable, an alternative to certainty'. Improvisation is therefore an act of hope as it asks us to step into the unknown and 'in the spaciousness of uncertainty is room to act' (Solnit, 2016 p.xiv). To act is to take action: to resist docility and dependence and claim space as an actor on the world; not to be acted upon. Yet what is the point of hope, or claiming agency for the long-term patient-participants in this study who appear to have not much to hope for? Why engage in hope if change outside of this space is not possible? Is this theatre playground not implicated in the oppression of mad people if the practice does not result in any changes to the rigid hierarchical environment outside of these sessions?

In her overview of theatrical performances at Broadmoor hospital in the UK from the end of the nineteenth century and throughout the twentieth century, Anna Harpin (2016, p.577) asks questions that forensic institutions raise for us regarding 'freedom and humanity: how do we treat vulnerable people, some of whom have committed terrible acts? What is care? What does it mean, practically and politically, to rehabilitate an individual into a social citizen?'. These questions speak to the meaning of an institution within society. As a theatre project within this institution, what are the implications socially? My response to interrogations around the 'why' of the project is to think through the very basis of my own

belief that every person should have the opportunity to experience themselves as a creative person who has imagination, and who can use that capacity to create something new. When we create something new with others, this social creative act is fundamentally what makes us human and allows us to discover the humanity in others. It is a joyful, generative experience of ourselves in the world that I believe every person should have access to, irrespective of what they have done to other people or their context. To experience ourselves as contributing positively to something, having it positively received or at least witnessed, having our contributions matter, is emancipatory and hopeful within the context of the total institution. The analysis of the practice in chapter seven, supported by the interviews of selected participants, show the ways in which the theatre playground achieved this.

Researcher bias

I do recognise however, in my fervent desire to create an enabling space and my joy at witnessing the engagement of the participants and the progress of particular individuals, that a critical lens on the practice was possibly compromised. While the study has problematised psychiatry and the institution, the space that was created, the theatrical playground, became quite precious to me, Lauren and some participants too. In my fervour to interrogate and advocate for my findings of capability and possibilities for patient-participants, who are often treated as having multiple limitations with little potential, I failed sufficiently to problematise how I interpreted what I observed and who I selected to speak to within the institution. With the benefit of distance, I understand how, during the time when I was inside the practice over the years, I could not name the extremity of how I experienced FEH as a carceral space. The theoretical lenses of disability studies, mad studies, Goffman and Foucault that I was simultaneously immersed in, facilitated my understanding of the layers of oppression operating in the hospital. Having worked in a prison for many years prior to FEH and comparing the former experience to the hospital, I experienced the pernicious notions of care, which legitimised the absolute domination of patients, impossible to accept. I therefore constructed the space and the study that emerged as a direct antidote to this oppression. The theatre playground became a space of social justice and that purpose dominated my enquiry.

Ben-Moshe (2011, p.389) highlights how the sociological work of Goffman shows the processes of dehumanisation in total institutions in which ‘the citizenship and personhood of those incarcerated is questioned when living in such institutions’. Inmates in the correctional facility, where we worked, were treated in a far less dehumanising way than inmates at FEH. At FEH, under the guise of therapy, I observed layers of surveillance and oppressive practices that were supposedly not about punishment, but for the ‘good’ of the patient and society. As I have argued in chapter seven, because of the way the theatre playground was delineated, because of the principles that guided the conduct of the workshops, and because of all that embodied, theatrical improvisation allows and facilitates, the theatre space was instrumental in fostering, acknowledging and practicing the citizenship and personhood of all who participated in it. The interviews with staff and patients support their experience of this too.

On change: inner and social change

While inner change has been demonstrated in this study, in how certain participants experience ability and capability within the supportive environment of the space (a ZPD), there is also a significant interplay between inner, individual change and broader, social change.

As identified in staff-participant interviews, ways of relating between staff and patient-participants changed beyond and outside of the weekly theatre workshops. The collaborative play engaged in the workshops modelled more caring, respectful relationships, which filtered into interpersonal communicative interactions within the wider hospital. In their interviews, all of the staff-participants relate how their experiences of rearranged relationships and collective play, within the theatre workshops, forced them to think about and make changes in their respective therapeutic practices. A concrete example is Thandiwe, who recognised, for the first time, the importance of cultural modes of expression and how these were embraced in the theatre playground (in for example, scenes containing Xhosa ritual ceremonies), and so she has incorporated group singing of well-known Xhosa songs into her OT work. This is not an example of the arts becoming co-opted into a therapeutic regime that reinstates its familiar lines of power, but rather recognises - as Fanon did in his attempts to decolonise the social arrangements of the hospital experience in colonial Algeria to include

arts, music and film - that culturally relevant activities and modes of expression are a necessity to address the social and psychological within madness. Fanon's most important mentor during his training at Saint Alban (discussed in chapter four), François Tousquelles, described their experiments of fighting against the concentrationist logic of the traditional clinic, through institutional psychotherapy, as a hypothesis that was being tested:

> …a hypothesis that stipulated that if you could assemble a group of people in an open space, some crazy and some not, and give them the means to articulate and rearticulate who they were and how they were shaped by history, they could, eventually, feel better (Robcis 2020, p.315).

The application of institutional psychotherapy by Fanon in North Africa introduced a range of cultural activities aimed at showing different social relations and possibilities for reimagining the institution. I argue that the theatre playground modelled alternatives in the doing of the practice. The theatrical play modelled diverse social relationships that might be possible between staff, patients, and each other, as well as providing an alternative model of ways of engaging with social life. The theatre space establishes a regular, ongoing experience of a way of working together that shows how the status quo of the total institution is not fixed: that alternatives are possible, that relationships within the institution can be shifted. It is in the space between playing with the institution in the theatre space, and the total institution outside of it, that hope and change lies. The experience of 'feeling human' with each other that participants have articulated, and experiencing this every week over a long period of time, is significant for patient-participants who are erased from society within the institution. The patient- participants reflect on this in their interviews in terms of feeling 'good' about performing for others, and as I have argued above, by rearranging social relationships through the generative possibilities of improvisation, where we try on and shed a range of roles and statuses, change outside of the theatrical space is sometimes within reach.

On paradox

Throughout this thesis I have highlighted different paradoxes. One of these concerns the seriousness of play: of finding moments of joy and belonging within the restrictions of the institution. I am reminded of this quotation from Baz Kershaw (2004, p.35)

> …in any system designed by some to control others, there will almost always be a space for resistance, a fissure in which to forge at least a little freedom. Such spaces and fissures are not best seen as an opening into which drama can be inserted, like a scalpel that can be used to dissect the body of ideology. Rather, we should see them as crucially constituting the dramaturgies of freedom because they present an absence which creativity seeks to grasp.

The absence within the hospital, this study has revealed, is the creative space to explore what it means to be human away from the gaze of pathology. Trusting the unpredictable non-linear characteristics of theatrical improvisation and accepting and building on all offers made in the space, is both the method of change and the result of change. Rather than a theatre-for-change, this study argues for an applied theatre practice that rejects a linear, cause and effect approach to how we understand the relationship between theatre and change. The practice analysed reveals how, when not starting with a deficit construction of participants as needing to be fixed in some way, but rather, like any other participant with creative capacity to determine the stories they wish to tell, participants are released to play within a space where 'there are no solutions or answers, but a process of becoming' (Murray 2015, p.354). This is a profoundly simple yet significant shift in how a theatre practice in an oppressive setting, with participants considered 'marginalised', is approached. What I have tried to demonstrate through a detailed analysis of key moments from the practice, is that relating to all people as creative collaborators in the theatre space facilitates 'a process of becoming'. This process of making and remaking who we are and might be in the world is a generative activity towards hope.

Another paradox emerges as to who witnesses these performances and how the performances are received. I discussed in chapter four my dilemma of finding ethical ways of showing and sharing the playmaking. Paradoxically, showing the group's performances to anyone other than the hospital community would re-inscribe stereotypes and stigma. Yet when the invitation to attend performances is extended to all members of the Total Institution, perceptions about certain patients who are performing become part of the 'promise of futurity and alterity' to which Harpin (2018, p.5) refers.

A further paradox that permeates this thesis concerns the reality of patient-participants' criminal acts and the enactments of moral choices as well as deviance within some of their

playmaking. While participation in the group does not start from the reasons people are part of the hospital, the labels that define identities of 'patient' or 'staff' are not eliminated. These labels also enact the binary within the institution of a 'bad' person and a 'good' person: a person who needs help, and a person who helps. I have argued that I reject a helper role as a facilitator. I invite everyone in the space to take on roles as fellow players. Yet this attempt at equality and inclusivity is not in evidence outside of the theatrical playground. However, there are glimpses offered by the staff-participants, about patients, that suggest that there is a transfer of confidence and an extended sense of being into other spaces in the institution. My focus in chapter seven on Mzwandile, Lunga and Thando highlights the profound developmental shifts we witnessed in these three patients, considered hopeless by some staff at the hospital. The collective creation of a theatrical playground, where time and again we participated in performances of becoming different people, facilitated many participants to perform 'a head taller', in Vygotskian terms, than their perceived level of capability.

Conclusion

The relationship between individual change in the theatre space and how this may be sustained outside of it is impossible to determine. However, the data reveals that inserting a creative space in which to experiment with the experience of oneself, outside the institutional narrative is significant. Jill Dolan (2005) argues that performance practices are social, relational moments where we 'capture fleeting intimations of a better world' and 'a way to reinvest our energies in a different future, one full of hope and re-animated by a new, more radical humanism' (Dolan 2005 p.2). It is this *radical humanism* that the data reveals. I will never forget the last meeting of the group in April 2017. As a closing, we hosted a party in the hall, between mouthfuls of cake and soda, we laughed and reflected on our time together. Lunga, who had never been very talkative, started to joke how he will 'sit with staff I am not a patient'. Later he stood up to try to express how important the group is to him: 'here, even though we are patients, we are like brothers' (field notes 11 April 2017). I understood this to be an evocation of belonging, that the group is a kind of family who look after each other. Lunga is a man who will remain in a hospital for a long time. His uncharacteristic expression of the meaning of the space to him suggests the radical humanism to which Dolan alludes.

Ultimately what this study foregrounds is the urgent need in forensic psychiatric hospitals to provide opportunities for all people who are part of the institution to practice a radical humanism. I argue that the theatrical playground provided this through an embodied, collective, improvisation-based practice that invited choice and valued contributions. This space of release from the demands of a Total Institution became a space for self-representation for mad people and the people who treat them. The effect of this on participants and on myself and Luvuyo, as facilitators, has been in discovering what it means to be human in an institution that compartmentalises people in fixed ways, which determine how and why they relate. As a researcher-facilitator I have learnt that anyone, given the right support, can step into the world of the 'as if' and experiment with the possibilities that an aesthetic frame can offer. When asked to do so as a fellow player, irrespective of who we are outside of that space, the potential for change is suddenly apparent.

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Appendices

List of Appendices

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Appendix D1: Semi-structured interview schedule for patient-participants

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Appendix A: Data collection resources

Interviews

All names of people from the hospital (staff and patients) are pseudonyms and are listed alphabetically by first name, as first names are used throughout the text.

1. Akhona. Patient-participant. 11 July 2015. Fort England Hospital clinical administration building. Interview by Alexandra Sutherland and Luvuyo Yanta, clinical staff member Lauren Creese present.
2. Athenkosi Patient-participant. 14 July 2016. Fort England Hospital clinical administration building. Interviewed by Alexandra Sutherland and Luvuyo Yanta, clinical staff member Lauren Creese present.
3. Bulelani. Occupational Therapist/ Staff-participant. 7 November 2014. Fort England Hospital OT department. Interviewed by Alexandra Sutherland.
4. Khaya. Patient-participant.15 September 2015. Fort England Hospital Hall. Interviewed by Alexandra Sutherland and clinical staff member Bongisa Shumane.
5. Lauren. Clinical Psychologist/Staff-participant. 14 October 2014. Fort England Hospital clinical administration building. Interviewed by Alexandra Sutherland, Luvuyo Yanta present.
6. Luvuyo. Facilitator. 29 May 2017. Rhodes University Drama Department. Interviewed by Alexandra Sutherland
7. Mandla. Patient-participant. 24 June 2015. Fort England Hospital clinical administration building. Interviewed by Alexandra Sutherland and Luvuyo Yanta, clinical staff member Lauren Creese present.
8. Maya. Occupational Therapist/Staff-participant. 14 July 2016. Fort England Hospital grounds. Interviewed by Alexandra Sutherland
9. Monde. Patient-participant. 2 December 2014. Fort England Hospital hall. Interviewed by Alexandra Sutherland and Luvuyo Yanta, clinical staff member Lauren Creese present. *Interview not completed.*
10. Thandiwe. Occupational Therapist/Staff-participant. 25 September 2015. Fort England Hospital OT department. Interviewed by Alexandra Sutherland.

Appendix A continued

11. Thando. Patient-participant. 15 July 2015. Fort England Hospital OT office. Interviewed by Alexandra Sutherland and Luvuyo Yanta. *Interview not completed.*
12. Themba. Patient-participant. 7 November 2014. Fort England Hospital clinical administration building. Interviewed by Alexandra Sutherland and Luvuyo Yanta, clinical staff member Lauren Creese present
13. Vuyo. Patient-participant. 14 November 2014. Fort England Hospital Hall. Interviewed by Alexandra Sutherland, clinical staff member Bongisa Shumane present.

Video recordings

All video recordings were done by the same videographer who worked with one camera.

1. Final performance recording. 2 December 2014, 15:00 – 15: 45. Fort England Hospital Hall
2. Workshop recording: 24 August 2015, 14:15- 15:30pm. Fort England Hospital Hall
3. Workshop recording. 31 August 2015, 14:15 – 15:30pm. Fort England Hospital Hall
4. Workshop recording. 7 September 2015, 14:15- 15:30pm. Fort England Hospital Hall
5. Workshop recording. 12 October 2015, 14:15- 15:30pm. Fort England Hospital Hall
6. Final performance recording. 5 December 2015,15:00 – 15:45. Fort England Hospital Hall
7. Workshop recording. 13 June 2016, 14:15- 15:30pm. Fort England Hospital Hall
8. Workshop recording. 20 June 2016, 14:15- 15:30pm. Fort England Hospital Hall
9. Workshop recording. 11 July 2016, 14:15- 15:30pm. Fort England Hospital Hall

Field note journals.

Book A: 1 June 2012 - 11 June 2014

Ethical clearance was granted from July 2014, but I have referred to personal facilitation reflections from this period and not participants who were not part of this research at this stage.

Book B: 18 June 2014- 29 June 2015

Book C: 13 July 2015 – 5 November 2016

Appendix B: Workshop plans

Appendix B1

Fort England Hospital Theatre Group: 24 August 2015

Warm Up: (10 minutes)

1. Group Shake: one person volunteers, leads others and exits. Encourage a little more time before exiting.
2. Pass a rhythm and sound to partner in the circle: partner repeats offer, then turns to give new rhythm and sound to next person.
3. Whole circle: throw an imaginary shape, weight, and sound to another person in the circle.

Physical expression: undoing habitual musculature (5 minutes)

4. Body part to body part – either in partners or doing keep the space alive and then body part (check gender pairs).

Bridge Improvisation (20 minutes)

5. Expert translation: example first with Luvuo- give a topic (eg the best party I have ever been to). One partner speaks gibberish, another 'translates' the story.
6. In pairs with another pair (4) -choose a gibberish speaker and translator around one story. Eg 'the day I met the King'.
7. Pair sculpting: A sculpts B as 'king'; B sculpts A as a 'hero'; A sculpts as a 'healer'; B sculpts A as 'villain'.

Small group ensemble creation (30 minutes)

In small groups: answer the following questions (one scribe) to structure your story scene:

A king or queen or chief needs someone in the village or community to help with a problem: What is the problem? Who do they ask for help?

The person helping to solve the problem encounters an obstacle. What is it?

Someone helps them overcome the obstacle; who is it?

How does the story end?

Appendix B2

Fort England Hospital Theatre group: 31 August 2015

Warm up: (10 minutes)

1. Group shake: person volunteers – encourage to sustain for a little time before exiting the circle DRUM
2. Say/move name how you feel today – whole group copies, move to next person
3. Everybody who! All sitting on chairs – change chairs if it applies to you
4. Group challenge – without talking, arrange yourselves in height order; age;

Move chairs back: Physical expression – undoing habitual musculature (10 minutes)

5. In partners – one person leads with hand, other follows – take partner of a gentle journey – try not to talk; swop over.
6. In 4s - one person, with both hands, takes group on a movement journey. When finished, another person takes over – try not to talk but to agree when next person has a turn.

Bridge improvisation: (10 minutes)

Pairs: one person is shop owner/seller; one person is buyer. Decide what kind of shop and what person wants to buy. Items to play with?

Owner – needs the sale, but doesn't want to bargain; customer wants to try and get a better deal on the item. SO each have a clear intention – and need each other. Play out and see what happens.

Making (10 minutes?)

Appendix B3

Fort England Hospital theatre project workshop: 7 September 2015

Warm up [10 minutes]:

- Shake out (drum?)
- Jazz breaks – 4 beats: in 4 beat interim everyone creates their own rhythm, which group repeats
- Pairs – create a rhythm/sound which you can repeat. Assemble an 'orchestra' which is conducted based on different sounds coming together; OR in groups of 6, merge sounds/one conductor.

Improvisation: [5 minutes]

This is not a: Use either colander OR cardboard tube – transform into something else. Invite other players to improvise with central player as extension.

Quick discussion: [10 minutes]

Who watches the news on TV? What sort of thing are covered? (hot items – war, parliament; sport; business; arts and celebrity; feel good stories).

Choose a famous fairy tale (eg 3 little pigs/Cinderella); How can this be imagined as a news story? Reporter – who might s/he interview? What 'scenes' would be shown?

Luvuyo as a reporter – reporting on the story, interviewing characters in the story

Small group creation:

In small groups, think about a news story that you would like to tell. The fairy tale was an example – so have a reporter/s and people interview, and a scene showing something about the story. If you had to create a story for the news, or investigate something to share, what would it be?

Use costumes/microphones once decided what you are going to 'report' on and structure and practice reporting and interviews.

Appendix B4

Fort England Hospital Theatre group: 12 October 2015

Warm up:

1. Group shake
2. Name and action – all repeat

Push chairs back

3. Who has the coin? A coin gets passed from person to person and everyone else acts as if they are passing the coin – freeze – guess who has it!
4. King's guard footsteps – King stands with back, when turns round, all freeze – if move chase back. Creepers must try to steal crown and put it on. *Extend – throw out a shape to freeze (soccer player; pop star; politician;*
5. Shape: arrange half into something like a soccer match, a political protest, praying at church, a traditional ceremony, at the hair salon. Group must guess where they are and what they are doing.

Pair work:

1,2,3 Bradford!

Whole group work: starting to devise a piece to show

Each choose one

Church; traditional ceremony; Iqhira; Hair salon; Chesn'yama.

1. Each group creates a still picture that captures something about that space and who is in it.
2. Decide on SOUNDS and ACTIVITIES: each person decide who they are, and what they do, and what they say or contribute to introducing us to the place, its sounds, actions, looks.

Appendix B5

Fort England Theatre Group: June 13th 2016

Warm Up:

1. Group shake
2. Passing face/gesture/sound to partner; who repeats, turns to do a new one. Then other way around the circle;
3. You/ permission walking/replace;

Pair/movement/ improvisation work:

4. Boal saucer exercise: find a partners opposite: imagine balanced on a saucer. Need to keep balance/equilibrium. Move with partner, being aware of other people in the saucer/space.
   Awareness of relationship/ moving together/differently
5. Different modes of meeting & greeting (no violence): as business men; as old friends; as people who had a fight long ago and have not seen each other for a long time; Politicians from different political parties; Gangsters; A fan and a famous rap artist; Soccer players from different teams the day after a match; a family member visiting a patient he hasn't seen for a long time.

Scene: hair salon; tavern; traditional ceremony – someone arrives who people have not seen for a long time:

Why has that person been gone?

Why do they arrive now?

How do people react?

Appendix B6

Fort England Hospital: Workshop June 20th 2016

Warm up: (15 minutes)

Invite for a group shake;

Throwing objects around the circle – catch and throw; throw with urgency; kindness; excitement; with a sound; light/heavy.

Keeping space alive: walking around (1): back to back; (2) freeze as (food; furniture; sports action – *counting down*; (3) *group decision? Photo pose in group number.*

Whole/small group physical animation

10 second object create: in smaller groups, you have 10 seconds to use your bodies to create: a Car; a washing machine; a plate of pap and vleis; Counting down from 10 (other ideas from the group?)

Pairs – edging into drama/story (15 minutes)

Sit down: turn to a partner next to you. Each person to reveal a small precious thing in their hands with their partner; take turns to show your partner what secret and precious thing you have.

With your partner, discuss: If I was an object/thing, I would be a… and why.

Introduce your partner to the group: This is Mr M. He would like to be a motorbike…OR show us using your object?

Scene building:

In small groups – a scene about an object: either create a 'thing' with your bodies around which a story is built (a washing machine that breaks and there are no clean clothes for a big event),

Or choose one of these objects I brought: think about what it is and means, how old it is, who is it important to and why? Create a story about this thing. What meaning does it have? Why is it important? What if it is lost? Or hidden? Or given to someone in a special way?

(*First task: show a still picture which shows something about who the objects is special to and why – a story about the object and what it means;*

Second task: a moment about the story of this object: when it was given away; used; lost; argue over; found – something which show some of this object's story.

Appendix B7

Fort England theatre group workshop: July 11, 2016

Warm up: (10)

1. Rub hands, wake up body. Luvuyo do fun shake
2. Fruit salad dash (cold day: soup ingredients) *set up chairs*
3. Funny walks: walking in a circle, people propose ways of moving which we copy (either in order, or with names).

Focus/trust work (10)

Partners: A and B. A gently moulds partner into a shape/person. Swap over. Look at pictures in the gallery (do in lines?).

With small groups of 4:

one person shapes partners into a picture called 'festival': what would your picture called festival look like?

Look at each others: what do we see?

One more person to mould: A picture called 'drama group'

Festival reflection:

Get into a partner, group with people who saw the same as you. If you did not see anything, partner with someone who can explain;

Talk about the show; decide on one moment that you will remember – that stood out for you; Find a way to re-create it or show us.

Brief discussion: what did you like? What did not work? Why? What sorts of things would you like to say/tell through theatre or performance?

OR: *if you had to create an arts festival, what would be included? What would you showcase (dance/song/drama etc). Do you have an MC to introduce different numbers (?)*
MICROPHONES

Appendix C: Ethics documents

Appendix C1

Dear Sir/ Madam

I would like to invite you to be part of a research project that is looking at the drama group you participate in at Fort England Hospital. The aim of the research is to understand the effects of a theatre programme in places such as this Fort England Hospital. I am interested in

- why mental health care users choose to do drama;
- what choices drama participants make within the group (such as characters, stories, how people use their bodies and voices) and how this can help us understand the ways mental health care users express themselves;
- how mental health care users who participate in this group experience it.

The reason for finding all this out is to share information on the effects of a drama group within a psychiatric hospital, so that other hospitals can read the research and become informed about the possibilities of the arts within hospital settings. I am also interested in describing and documenting what mental health care users achieve in the drama group, which I think will challenge some of the stigmas associated with mental illness, and challenge people who think that people with mental illness are not able or capable.

You do not have to agree to take part in this research. You can still be part of the drama group without participating in the research. If you agree to participate, you will are allowed to withdraw at any stage you choose to.

The research involves

- Video recording some (around 6) of the drama workshops;
- group interviews/discussion with drama group members which will be recorded so that I have an accurate record of what was said;
- possibly an individual interview about your experience of being in the group;
- using pictures, poems, scripts or other things made in the group. These will be photographed and stored on a computer.

Appendix C1 continued

The video, voice and picture records will all be stored safely on a computer that only I have access too. Everything will be treated confidentially.

Potential risks from participating in the research:

There are no serious risks to taking part in this research. The drama group will continue as normal and your attendance is voluntary. You may feel uncomfortable when we film the group, or when I tape record any discussions we have. If this happens, please let the research team know. You have every right to stop talking or not participate on that day if it makes you feel uncomfortable. If something happens in the group that you do not like, you are able to speak to the group leaders or a therapist on the ward. Any recordings I make (of what we do, or what is said) is confidential, and no names will be used in how I describe the drama group and the people participating in it.

Potential benefits from participating in the research:

I hope that being in the drama group as well as talking about it, will help you feel proud and confident about what you can do, and the different ways you can express yourself. I hope that by being part of the research you will feel like you are contributing to helping other people understand the role of creativity and performing within mental health settings. My aim with what I find in the research is to motivate for the value of including drama programmes within mental health settings. The research will therefore hopefully help other people to benefit from participating in drama programmes in different mental health settings.

Appendix C2

Consent to participation in a research study and the publication of results.

Thank you for verbally agreeing to participate in this research project which aims to understand the effects of a theatre programme in places such as this hospital. The purpose of this form is to obtain your informed, written consent for your involvement in this research.

The research process and your involvement involves the following:

- Allowing me to describe and discuss what happens in the drama group. The names of anyone discussed will be changed so that your identity will not be known to anyone reading about this.
- Individual or group interviews about your experience of the drama group, which will be recorded so that I have a record of what is said. This is to ensure that I am able to accurately capture what is said. These recordings will be safely stored and not be shared with anyone, and will be conducted in a language you feel comfortable with.
- Video recording some of the drama sessions so that I have a record of what we did together so that I can understand more about how people in the group use drama and theatre. These recordings are for research only, and will not be shown to anyone outside of the research team.
- Allowing me to photograph any objects we create or costumes we use/make such as masks, or drawings we do.

In the research, I will not use your name, and will always protect your identity. You are also able to withdraw as a participant from the research at any time. If you wish to withdraw, you can either inform Alex Sutherland, or a therapist on your ward.

I, ………………………………………………….. (research participant)

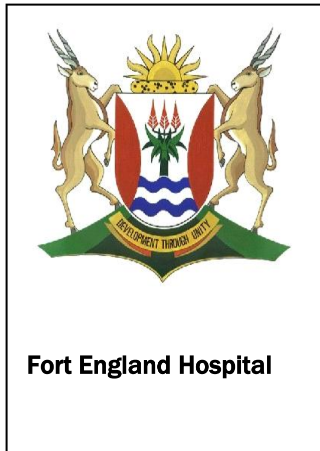
- acknowledge that I have enough information about this research project, and I give my informed consent to participating in the project;
- understand that my participation is voluntary and I can withdraw at any time. My treatment at the hospital will not be prejudiced in any way by my decision. I do not have to be part of the research and I can change my mind at any time about being part of this research.
- there will be written documents describing the research. I understand that all of my identifying information will be removed from any research documents that are produced from his project. All research documents will be kept securely and anonymously by Alex Sutherland;
- I am free to discuss any worries or concerns I have about the research to any members of the research team, and I understand that I can ask a therapist for a time to talk with her for support.

Signed: **Date:**

Name:

I, Alexandra Sutherland (the researcher) do hereby swear that all information obtained as a result of this research will be treated in such a way that the confidentiality of the provider of that information will be maintained.

Appendix C3



Fort England Hospital

Capacity to Consent Form

Matter for which consent being sought (please tick):

- ○ **Medication**
- ○ **ECT**
- ○ **Other (specify):...**

Patient Name: ____________________

Hospital Number: ____________________

Ward: ________

I confirm that I interviewed ....(Patient's Name) on .... (date). In relation to

his/her Capacity to Consent to the matter indicated above, he/she is able to (tick appropriate column):

	Yes	No
(a) understand the information relevant to the decision		
(b) retain that information,		
(c) use or weigh that information as part of the process of making the decision, and		
(d) communicate his/her decision (whether by talking, sign language or any other means).		
He/she has the Capacity to Consent in relation to the matter indicated above (Note: Answering "No" to any of the above indicates a lack of Capacity to Consent)		

Appendix C3 continued

If No answered to any of the above, please provide details:

………

Date: Clinician's Signature:

Appendix C4

HREC Ref 017/2013 - 21Jan2013

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences
Human Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6626 • **Facsimile** [021] 406 6411
e-mail: nosi.tsama@uct.ac.za

17 June 2014

HREC REF: 276/2014

A/Prof G Morris
Drama Department
Hiddingh Campus
Orange Street
Cape Town

Dear A/Prof Morris

PROJECT TITLE: THEATRE, PERFORMANCE AND THE TOTAL INSTITUTION: AESTHETIC STRATEGIES TO CREATE MEANING IN FORENSIC SETTINGS.

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

Before formal approval is granted, the HREC has the following issues that need to be addressed:

- More definite structured informed consent and patient assessment should be included in the methodology, to safeguard both the investigator and the patients. It must also be stated in the research proposal how many times this will be reassessed.
- With regards to semi-structured interviews it needs to be stated how many of these there will be and the questionnaire should accompany this application.
- It is states that notes and writings from previous creative work will be drawn on. It must be clear in the proposal that this will be used only to inform the researcher's thinking, and that 'data' from the previous work will not be used, as ethics approval cannot be given retrospectively.
- In the informed consent form, it is stated that the interviews will be tape and video recorded. Will these recordings be destroyed when the research is finished?
- In the consent form it is mentioned that 'Individual or group interviews about your experience of the drama group, which will be tape recorded so that I have a record of what is said'. Please add a comment that this is to enable the researcher to correctly capture the findings.

Please quote the HREC REF in all your correspondence

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

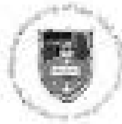
Yours sincerely

Signature Removed

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS

S Thomas

Appendix C5



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

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Email: Sumayah.ariefdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

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17 July 2014

HREC/REF: 276/2014

A/Prof G Morris
Department of Drama
Orange Street
Cape Town 8001

Dear A/Prof Morris

Project Title: THEATRE, PERFORMANCE AND THE TOTAL INSTITUTION: AESTHETIC STRATEGIES TO CREATE MEANING IN FORENSIC SETTING

Thank you your response letter dated 08 July 2014, addressing the issues raised by the Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above mentioned study.

Approval is granted for one year until the 30 July 2015.

Please submit a progress form, using the standardised Annual Report Form, if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

Please note that the on-going ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC REF in all your correspondence.

Yours sincerely

PROFE____ M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

Appendix D: Semi-structured interview questions

Appendix D1

Semi structured interview schedule: Patient-participants in Fort England Hospital theatre programme.

1. . Why did you decide to join the theatre programme?

2. If you had to tell someone what the *purpose* of doing this programme in this hospital is for, what would you say?

   Follow-up/rephrase: If you had to tell someone who was asking about the programme, what it involved and why you are participating, what would you say?
3. What do you think you have gained from your involvement in the programme?

4. Can you recall any moments or exercises we have done together that you have responded, or really remember, or enjoyed and how these made you feel?

5. Are there any activities we have done that have made you feel uncomfortable or worried? Why?

6. Lauren has always been part of the group. What is it like to have a psychologist or staff join with you in the drama? How does it make you feel?

7. What have you learnt about theatre and performance through your participation?

   Follow up question: have you observed anything from other participants and how they use theatre and performance that has contributed to how you feel about the theatre programme?

Appendix D2

Semi-structured interview schedule: Staff-participants in Fort England Hospital theatre programme.

1. Had you heard anything about the drama project before you became involved – and if so what had you heard?

2. Why were you initially interested in joining the group?

3. Can you recall what your initial experiences and impressions were like?

4. What did you observe that interested you about how Mental health care users experience the group, or responded?

5. What do you perceive as some of the challenges or limitations of this kind of 'intervention'?

6. Can you share your impressions about the use of playfulness within this institution – I deliberately do not wish to see this group as part of a therapeutic or 'fixing' agenda. What are your thoughts on this approach?

7. Can you talk to me about connections you might see between your profession, and the use of theatre?
    a. What is the role of using and engaging the body and activity creatively? How/does this link to some of the approaches in your profession?