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TOWARDS THE USE OF DRAMA AS A THERAPEUTIC TOOL TO ENHANCE EMOTIONAL REHABILITATION FOR PEOPLE LIVING WITH HIV/Aids:

A CASE STUDY OF PARADISO HIV/Aids SUPPORT ORGANISATION

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ABSTRACT

This study explores ways to address the emotional needs of people living with HIV/Aids, with specific focus on Paradiso group therapy in Lilongwe, Malawi. The study recognises that people living with HIV/Aids deal with physical as well as psychological challenges. Based on this premise, this study investigates whether the use of drama and theatre processes can enhance emotional rehabilitation for people living with HIV/Aids, and seeks to explore what drama and theatre methods would contribute towards their emotional health.

The study examines Theatre for Development (TFD), a methodology that has played a critical role in addressing various HIV/Aids issues in Malawi. In the assessment, it is argued that TFD remains a relevant model but only as an awareness building strategy about HIV/Aids. This study concludes that TFD is, however, unable to help people explore, confront and express the personal traumatic experiences of living with HIV/Aids. Likewise, the investigation finds the traditional method of teaching utilised by the Paradiso group therapy inadequate in the sense that it does not acknowledge the lived experiences of people living with HIV/Aids.

To this end, an integrated process-orientated drama methodology; drawing on the educational elements of process drama and the healing aspects of drama therapy is developed. The methodology was tested in a series of workshops with Paradiso group therapy members. The outcomes reveal that the approach is effective in providing a clear structure through which people can examine the trauma of stigma as a result of living with HIV/Aids. The study further reveals that an integrated process-orientated drama methodology is effective in enabling people to deconstruct negative HIV/Aids beliefs and narratives and in facilitating the reconstruction of new and functional ones that allow them to experience healing and emotional growth.

DECLARATION

I, the undersigned, hereby declare that this research report is my own work unless where appropriately acknowledged and that I have not previously submitted it at any university for a degree or examination.

Name of Candidate: Basimenye Nabatile Mwalwanda

Signature:

Date: 13th February 2009

DEDICATION

To my sisters Mungapashaga Julia Chagunda and Lusubilo Ruth Shaba, I am today because of your sacrifices, ndagha bana bayubo.

ACKNOWLEDGEMENTS

First and foremost, my salutation goes to Jesus Christ for being my Lord and God, for seeing me through once more. Indeed, what a friend I have in you!

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INTRODUCTION TO THE STUDY

1. Background to Research Problem

Theatre for Development (TFD) has been acclaimed as one of the most effective approaches in addressing HIV/Aids issues at community level. It is one of the popular theatre approaches used in Malawi for communicating, educating and informing people about HIV/Aids. A variety of reasons have been cited for its efficiency. First, TFD is said to provide an interactive and two-way communication process with communities. This feature gives the approach an added value over mass media channels like television, radio and newspapers. Second, it has the ability to engage and raise the critical awareness of people through participatory discussions. Thus, by involving participants in the debates, the approach provides people with the opportunity to explore behaviours and attitudes that promote the spread of the disease and how they could address them. Third, it is economical in terms of one performance reaching many people, easily adaptable to indigenous culture[1] and in Malawi where the illiteracy levels are comparatively high, TFD provides a better way of reaching the masses with awareness messages.

Years of using this approach alongside other communication forms in large scale HIV/Aids campaigns proved successful as they yielded 'nearly universal HIV/Aids awareness in Malawi' (Houston and Hovorka 2007:265). Unfortunately, they did not yield an equal changing power of people's behaviours. People acquired the information but did not apply it, which meant that the rates of HIV prevalence continued to grow.

Today, after 25 years since HIV/Aids was identified, TFD continues to focus on HIV/Aids education and prevention. This, however, is justifiable, considering the fact that Malawi still has a relatively high national HIV prevalence rate of 12% within the 15-49 age bracket (OPC 2007:5). Again, 'there are nearly 100,000 new HIV infections in Malawi annually, with at least half of these occurring among young people aged 15-24', according to the Office of President and Cabinet (ibid). In light of these circumstances, the government and all other stakeholders incontestably require augmented efforts to strengthen and scale up HIV/Aids prevention and behaviour change interventions.

[1] http://classshares.student.usp.ac.fj/TA101/Theatre%20For%20Development/ic-ld-theatre-bg1.pdf

The fact that there are almost 100,000 new infections yearly also means that there is another group of people that is emerging and which is not being catered for by the HIV/Aids prevention strategies. This is the group of the estimated 930,000 (UNAIDS/WHO 2007) people who are already living with HIV/Aids. While the preoccupation for the majority of the people might be the fear of contagion, the struggle for this growing population is to maintain life with every fibre of their being. For them, HIV/Aids is not a far-fetched idea that they may avoid; it is an everyday reality, an actuality with a deep emotional impression on their lives as illustrated by Soko's story which was covered by the *Daily Times* newspaper in Malawi. Narrating on how she felt when she discovered that she was HIV positive, Soko said:

> I felt like I was on my own, scared, the only right thing I thought of doing was to commit suicide ... I did not want to see my husband again because I thought he was a wizard... I asked myself, why am I dying when I am innocent? I never slept around with anybody else other than my husband (Luwanga 2008:5).

Soko's story underscores the trauma of living with HIV/Aids. Her narration reveals the depths of the usually unspoken and un-witnessed suffering that surrounds the inner worlds of the infected as they try to make meaning of their conditions. In telling her story, she provides illumination to 'the human side' of HIV/Aids (Tegius and Ahmed 1995). Writing on trauma, Herman (1992:33) states that 'traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning'. She talks about how trauma alienates the afflicted from themselves, from basic human and social relationships and how they are left disconnected from all relevant sources that keep one whole. She further articulates that 'traumatic events undermine the belief systems that give meaning to human experience' (Herman 1992:51).

2. Research Problem

This study explores how the emotional needs of people living with HIV/Aids can be addressed. This quest led me into the fields of drama and emotional rehabilitation and prompted the development of a research question: Can the use of drama and theatre processes enhance emotional rehabilitation for people living with HIV/Aids? Subsequently, what drama and theatre methods can contribute towards the emotional health of people living with HIV/Aids?

These questions were based on the view that HIV/Aids has become more intricate and that in the process of its change, our relationship to the disease has shifted. Whilst the motivation in the 1980s and 1990s was mainly on fostering prevention and raising consciousness around the condition, today, the issue is not only about awareness and prevention, but also looking after the welfare of those people living with HIV/Aids. Central to the aspect of welfare is the fact that people are living and not necessarily dying with HIV/Aids. We have seen over the years that, while there is still no cure(s) for HIV/Aids, drug treatments such as antiretrovirals (ARVs) have turned HIV into a treatable disease for those who have access to them. Substantiating the point are results released from a study by Hogg, Sterne and the Antiretroviral Therapy (ART) Cohort Collaboration (2008:293) which revealed that:

> Life expectancy in HIV-infected patients treated with combination antiretroviral therapy increased between 1996 and 2005, although there is considerable variability between subgroups of patients.

The report further proclaimed that 'these advances have transformed HIV from being a fatal disease, which was the reality for patients before the advent of combination treatment, into a long-term chronic condition' (Hogg *et al* 2008:297). A similar pattern was observed on the local scene where the HIV and Aids Monitoring and Evaluation Report (2007:7) highlighted that:

> The survival of patients on ART also seems to steadily increase from 55% in 2005 to 78% in 2007 at 12 months interval, which demonstrates the effectiveness of the programme especially in terms of reducing morbidity and mortality (...).

All these are riveting glimpses of hope that most people who lived in the early days of HIV/Aids never had the chance to experience.

Now that HIV/Aids is no longer a fatal condition, surely, being HIV-positive should not be as stressful as it used to be. However, if we look back at the story of Soko quoted above, we notice that though the HIV/Aids morbidity and mortality statics show declining dimensions at global and national level, the enormity of the problem persists at the individual level. At the intrapsychic level, HIV/Aids remain a traumatising and life-threatening condition.

There are several reasons why living with HIV/Aids continues to be a distressing experience even though there are drug treatments capable of managing the disease. But three factors have a particular significance for the purposes of this study. First, the side effects of the drugs

are said to cause irksome discomfort for many people taking them, hence, bringing in other distressing dimensions to the equation. This assertion is reinforced by Tsasis (2000:555) who states that:

> With the development of highly active antiretroviral therapy (HAART), prophylaxis and advanced treatments for opportunistic infection, HIV infection has become a chronic illness for many, in which the patient experiences multiple challenges over many years throughout the various stages of the disease. The specific challenges faced by the patient range from uncertainty and disruption of social relations, to coping with disease symptoms and aggressive treatments, while tolerating the frustrations of personal and interpersonal needs and aspirations. Because people with HIV and Aids are living longer, more attention must be focused on their adjustment to living with the illness.

Extrapolating from Tsasis, we can further the argument to say that the frustrations of HIV/Aids medication are made worse in countries like Malawi where issues of poverty shroud the condition, making its experience even more traumatising than might be the case for those with access to all the relevant medical and nutritional requirements. The lack of basic needs such as food worsens the plight of many and makes living with HIV/Aids an unbearable ordeal as Bates *et al* (in Ganyaza-Twalo and Searger 2005:11) established that, 'poor nutritional status is linked to vulnerability to progression from HIV infection to mortality'.

Second, the manner in which one contracts HIV/Aids. As seen from Soko's scenario, many people, especially women, are said to contract HIV from their loved ones within the confines of their marriages and love relationships. This is evidenced from the data that was integrated in Zambia's Demographic and Health Survey in 1996. In this report, 38.7 % of women regarded themselves 'as at moderate or great risk of getting Aids (sic) with 90% of them giving their husbands as the reason' (Baylies 2002:35). The study also pointed out that while many of them were aware of the risk, few women felt able to take or propose precautionary measures due to cultural obligations (ibid).

Such circumstances are not strange in Malawi where the majority of women are equally silenced by the fact that they cannot refuse or suggest safer sex with their seemingly unfaithful husbands. The stability of their marriages is threatened if they dare break the silence. A report on women vulnerability and risk to HIV/Aids in Malawi stated that:

> It is clear from these results that women, probably due to their vulnerable position, are afraid to raise issues concerning HIV/Aids with their husbands. While they know that their husbands are cheating, they will not raise a voice concerning Aids nor how to protect themselves from the virus. They simply accept the status quo (Ghosh and Kalipeni 2005:328).

Such oppressive customary acts often leave women in an emotional quandary as whichever way they might choose has serious repercussions for them. Thus, apart from the pain and shame that comes from witnessing their husband's infidelity, their deprived nature and what it exposes them to is enough damage to their self-esteem and may exacerbate feelings of anger and frustration with their lives.

Third, stigma and discrimination is another aspect that makes living with HIV/Aids emotionally challenging. Despite the advanced knowledge systems around HIV/Aids and how it is transmitted, stigma remains one of the most precarious phenomenon affecting persons living with HIV/Aids. It is the marginalizing factor that places 'them' aside from those considered 'normal', healthy and strong. And not only does stigma position them, it labels them as the 'other', the weak and incapable ones and as history has shown, stigma in whatever context reduces and silences individuals, making them lesser of human beings. A *Daily Times* article noted that stigma and discrimination drives those living with HIV/Aids 'into the closet, but one with splinters' (Mpaka 2008:8).

Having looked at these three factors, one thing that comes out vividly is the point that living with HIV/Aids requires more than medication. HIV/Aids is not just a sickness of the bones and the flesh, but also, of the soul and the mind. How then can we bring restoration to the pain and suffering that dwells in the deepest parts of those living with HIV/Aids? This study argues that, just as there is urgency and structured ways for treating HIV/Aids physical ailments, equal urgency and structured approaches are required to help those who are emotionally distressed to reclaim their lives, to help them re-discover themselves and transpose the adverse events in their lives so that they can acquire new and profound meanings. So the question is can TFD facilitate this process? Can it address the emotional burdens of living with HIV/Aids and bring about the deep adjustments required for the process of rehabilitation to transpire?

To that extent, this study hypothesizes that TFD has played a crucial but limited role in addressing HIV/Aids issues. Its contribution towards HIV/Aids information dissemination,

stimulating and empowering communities to critically discuss and reflect on the epidemic cannot be overstated; neither can its limitations be overlooked. With that in mind, this study makes the following primary claims:

- That TFD has a limited role in addressing the growing demands of HIV/Aids.
- That process-orientated drama can play a critical role in emotionally rehabilitating those experiencing HIV/Aids stress. It must be noted though that this approach would also be applicable to those affected by HIV/Aids. But for purposes of this study, we will focus on the infected.
- That process-orientated drama used as a therapeutic tool has a vital role in changing the personal and social narrative of HIV/Aids.

3. Case Study

This research is a case study of a group therapy run by Paradiso HIV/Aids Support Organisation in area 24 of Lilongwe, Malawi. The group therapy started in 2006 and is open to all people living with HIV/Aids in the community. It has 103 registered members but on average, 20 people meet every Friday. A detailed description of the organisation and the group therapy is incorporated in Chapter Three. The choice of this case site was based on two factors: that it is one of the few, well organised group therapy for people living with HIV/Aids in Lilongwe and because this research does not just focus on anyone living with HIV/Aids but on those people experiencing distressing situations and have the desire to address them.

4. Theoretical Framework

This study is an interdisciplinary one. It draws from various theoretical fields namely, process drama, drama therapy, social-psychology, trauma and narrative therapy. From process drama, the study utilizes concepts and techniques from the work of Heathcote (1980), Bolton (1979) and other prominent process drama practitioners. From drama therapy, the study uses the theoretical frameworks as advanced by Landy (1996) and Jones (1996) because they provide ways of using dramatic elements for healing purposes. From social-psychology, the study engages the social-psychological model of Scheff (1981) on aesthetic distance. From the trauma sphere, the study utilizes the psychological trauma theories based on Herman (1992)

and Tedeschi and Ahmed (1995) and finally on narrative therapy theories as developed by Freedman and Combs (1996). Together, these theoretical models provide a comprehensive account of addressing psychological trauma and provide practical procedures that illustrate how theatre elements and the re-telling of traumatic experiences operate therapeutically.

5. Research Methods

This is a qualitative research study. It employed case study and action research methods in its endeavour to evaluate the Paradiso group therapy approach and explore the drama and theatre techniques that would most appropriately address the psychological needs of people living with HIV/Aids. Amaratunga and Baldry define case study as 'a research strategy which focuses on understanding the dynamics present within single settings' (2001:99). The use of this methodology helped the study to attain a holistic and thorough investigation of the approach used by Paradiso group therapy.

Central to action research is the notion of collectively and reflectively using research to improve practice and methods of doing things. O'Brien (1998) defines it as 'learning by doing' where 'a group of people identify a problem, do something to resolve it, see how successful their efforts were, and if not satisfied, try again'[2]. He further postulates that:

> (...) there is a dual commitment in action research to study a system and concurrently to collaborate with members of the system in changing it in what is together regarded as a desirable direction (ibid).

This method was utilized later in the research process when the process-orientated drama processes and techniques were tried out with members of Paradiso group therapy. A detailed discussion of the research methods is provided in Chapter Three.

6. Research Phases, Data Collection and Analysis

The whole research process was divided into three phases: first, the observation phase, second, the process-orientated drama workshop planning phase and third, implementation of the process-orientated drama workshops where several dramatic processes and techniques were tried out with Paradiso group therapy members.

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[2] http://www.web.ca/~robrien/papers/arfinal.html

The observation phase comprised of observing the Paradiso group therapy in session, studying and assessing their approach to therapy. Apart from observation, other research activities included interviews with management in order to understand the history of the organisation and that of the group therapy. I also conducted a focus group discussion with Paradiso group therapy members to understand the impact of therapy on their lives.

Phase two involved planning and designing the process-orientated drama workshops. This process took into account the findings of phase one and the assessments of the Paradiso group therapy approach. The findings revealed the use of a didactic, content and leader-based approach that marginalised participants from deep reflection, interaction with each other and exploration of lived experiences. Based on this assessment, it was decided that the study should focus on a people and action-centred process-orientated drama approach that drew its concepts and techniques from two theatre forms namely, process drama and drama therapy. This was to create an environment where participants could engage with their personal problems. Definitions of process drama and drama therapy are offered below and will be dealt with in much detail in Chapter Two.

Phase three involved the execution of the process-orientated drama workshops with the Paradiso group therapy members.

The overall data collection tools included observation, interviews, focus group discussion, daily workshop entries, video recording, daily workshop reflections with the group therapy members and group therapy facilitators.

The study utilizes thematic analysis for analyzing the data. Braun and Clarke (2006:79) define thematic analysis as ‘a method for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail’. This method was applied because first, ‘it allows for social as well as psychological interpretations of data’ (Braun and Clarke 2006:97). Second, because organising the data into themes provided a clear framework through which to assess the therapeutic qualities of the process-orientated drama techniques tested in the sessions.

7. Ethical Clearance

This study followed all the necessary ethical procedures as required by the University of Witwatersrand's Human Research Ethics Committee (Non-Medical) for research that involves human subjects. Consent to work with Paradiso HIV/Aids Support Organisation was applied and obtained through MANET+, an umbrella body overseeing a network of HIV/Aids support organisations in Malawi (see Appendix A for consent letter). Participants' involvement in the research was voluntary as they all signed consent letters that explained the nature and objectives of the research and consent was also obtained to record the process-orientated drama workshops for transcribing purposes (see Appendix B for participant consent forms). Furthermore, a counsellor was arranged through Paradiso HIV/Aids Support Organisation to be present in all the workshops in case of eventualities.

8. Defining Key Concepts

Most of the key concepts in this study are widely used both in professional and lay circles. Different people understand them differently. To prevent multiple definitions and communication problems, this section will define and clarify their meanings as they are applied and understood in this study.

8.1. Emotional Rehabilitation and its Relevance to HIV/Aids

The term rehabilitation, sometimes referred to as healing, is enormously diverse and it has a variety of meanings depending on the context. Even within the HIV/Aids framework, the concept remains dynamic and multifarious and is used to describe both physical and non-physical events. Likewise, the goals of rehabilitation are wide and when this study talks of emotional rehabilitation, it realizes that it is dealing with just a portion of the bigger whole. Drawing from Lerner (1993), Kubler-Ross (1989), Rossman (1989) and many other theorists, Glaister (2000) illustrates its scope when she argues that:

> Healing is not just physical restoration of the body, but rather achievement of balance between physical, emotional, mental, social and spiritual dimensions of injured individuals. A biomedical cure is not necessary for healing to occur. The healing experience is broader than just absence of disease or illness and may include accepting, coping with and integrating the demands of one's illness (2000:64).

Tending to its attributes, healing is said to be active and requiring commitment and action from the individual. It is said to be multidimensional and 'not something that is done to the

individual but something that takes place within the individual' (Mulloney & Wells-Federman in Glaster (2000:64). Healing, and in this case emotional healing, is not a tangible or perceptible activity but rather, an inner felt experience attainable, for instance, when people living with HIV/Aids work through their emotional problems. It is a process that would facilitate their health, bringing about harmony and a sense of balance between their minds and their bodies. Herman (1992) views the same as the process of renewing connections with the self and others through individual reflection and socially recreating the emotional faculties that have been bruised as a result of one's traumatic experiences.

Furthermore, Scandrett-Hibdon and Freel (in Glaister 2000:64) identified five steps in healing that denote active participation, namely awareness, appraisal, choosing, alignment and acceptance. In the same article, Quinn (1989) stipulates that 'healing is creative, bringing forth patterns and connections that did not exist before' (ibid). This assertion draws a parallel to Jung's understanding of therapy as 'less a question of treatment than of developing the creative possibilities latent in the patient himself' (Jones 1996:5). This provides a clear link between drama and rehabilitation as they are both preoccupied with the aspect of expanding people's creative and imaginative capacities. Adding to the fact that the process of healing is fundamentally internal, Glaister (2000:64) asserts that it is influenced by factors such as body condition, personal attitudes and relationships.

8.2. Trauma and HIV/Aids

Just like emotional rehabilitation, trauma is another common and widely used term. There are numerous descriptions and conceptions of what it entails. However, there seems to be a wide recognition of trauma as a phenomenon that is linked to emotional shock. For instance, the International HIV/Aids Alliance (2003:3) defines trauma as 'an emotional shock, producing long-lasting, harmful effects on the individual'. They also define stress, a term related to trauma as 'an emotional condition, experienced or felt when an individual has to cope with unsettling, frustrating or harmful situations' (ibid). These definitions are highlighted in Herman's conceptualisation of what constitutes a traumatic event. For her, traumatic events refer to 'all those events that generally involve threats to life or bodily integrity and those events that cause a close personal encounter with (...) death' (1992:33).

In their quest to understand traumatic experiences, Tedeschi and Calhoun (1995:16) come to a similar conclusion. They postulate that trauma is usually characterised by shock 'when

things happen to us suddenly and unexpectedly'. However, this assertion does not, in any way, preclude problems that unfold gradually and neither does it exempt expected events from causing emotional distress. The finality of an HIV diagnosis, for example, still comes as a shock even to those who might have had subtle suspicions about their status. Tedeschi and Calhoun (1995:17) further stipulate that events become traumatic and more likely to challenge our psychological well-being when 'there is a perceived lack of control over them', causing people to experience powerlessness. The fact that Aids remains incurable and unpredictable evokes intense feelings of fear, helplessness and terror. The need to restructure and completely adjust one's way of living, the need to always anticipate chronic illness and the prejudices that come with being HIV-positive push people into a heightened emotional state.

However, it should be noted that not everyone living with HIV/Aids experiences trauma. As Herman (1992) pointed out, it is not uncommon for some people to remain 'clearheaded and calm' after enduring horrible events. However, most people suffer psychological harm and may experience depression. Similarly, other people's HIV/Aids emotional suffering may progress into extreme cases of neuroticism, dementia and psychosis, but that does not invalidate the trauma experienced by those exhibiting modest reactions like members of the Paradiso group therapy.

8.3. Drama and Theatre

Distinguishing the difference between drama and theatre is not always an easy thing because of the way these terms are usually equated. However, this study understands the terms according to definitions offered by Warren (1989) and Haseman and O'Toole (1986). Warren notes that:

> Theatre is a collective art. Theatre requires many people — actors, writers, designers, technicians, etc. — all working together in a period of rehearsal and creative exploration towards a common goal. Whatever the benefits experienced by participants along the way, theatre is evaluated by how well the performance communicates to its audience.
>
> Drama is an individual pursuit undertaken within a social context. Defined by human action and interaction, drama is primarily concerned with what happens to participants while they are engaged in activity. It is an extension of children's play and, like that play, is often free and spontaneous. Drama has no fixed end product, no right or

> wrong way of doing. As a result, its effects, unlike theatre performances, are often unique and unrepeatable.

The way Warren distinguishes drama from theatre correlates to how Haseman and O'Toole (1986) characterise what they call the two faces of drama. The private face is where individuals are involved in an activity through improvisation and role-play, experimenting and discovering things for their own benefit. Here, no one watches as there is no outside audience apart from the notion where participants observe themselves in action and witness others.

The public face is preoccupied with preparing something for an outside audience and involves performance, scripting and rehearsing of the materials to be presented. However, despite the differences, Haseman and O'Toole contend that both the private and public faces share one dramatic structure constituted by the following elements; the human context, dramatic tension, focus, place and time, language and movement, mood and symbols- all of which culminate in dramatic meaning (1986:1).

8.4. Process Drama and Drama therapy

Process drama is an educational method that conceptually and practically employs elements of drama to educate and to deepen the participant's quality of experience. The approach was developed through Heathcote's pioneering work with young children and her development of drama as a learning medium (Wagner 1999). It also arose from Bolton's theorising of drama for understanding and examining situations in a safe and playful manner (Bolton 1979). Thus, process drama focuses on the participants, on problem solving, exploration through improvisation and experiential learning. The aim is neither to perform for an external audience nor to produce a finished product but rather to create a safe forum where the individuals can learn by reflecting on what they do while they assume roles.

Drama therapy, on the other hand, is a healing approach that engages participants in issue exploration. And while they do so, they simultaneously explore and gain new insights of their own emotions, attitudes and perspectives. Meldrum defines it as 'healing through drama allowing the client, with the use of dramatic structures, to receive insights and explore emotions in a special place in real and imaginary time, within a social encounter (Jennings *et al* 1993:19).

9. Study Layout and Limitations

Chapter One introduces the historical and political context of HIV/Aids and Theatre for Development (TFD) in Malawi. It explains how and why TFD became linked to HIV/Aids and examines how it has fared thus far.

Chapter Two examines, in detail, the limitations of TFD in light of the effects that HIV/Aids has on individuals. I explore the fundamental concepts and basic processes of process drama and drama therapy and their pedagogical and therapeutical underpinnings. I further look at the concept of distancing according to Jones' (1996) and Landy's (1996) theoretical models.

Chapter Three explores the context of the case study. It looks at how Paradiso HIV/Aids Support Organisation was formed and why, how the group therapy came into being and the rationale behind its formation. The chapter also explains the research methodology that informs this study and describes the data collection methods and data analysis processes.

Chapter Four provides a detailed account of the two group therapy sessions that I observed in the first phase of the research process. I then discuss the findings and analyze the group's approach to therapy.

Chapter Five outlines the process of planning for the process-orientated drama workshops which include stipulating the objectives and the conceptual choices that were made for the workshops. The chapter further discusses the workshop implementation where various process-orientated drama techniques were explored with group therapy members. Then, it later provides a detailed thematic analysis of what was engendered from applying the process-oriented drama methodology in the group therapy sessions.

In Chapter Six I conclude and provide recommendations for the future.

There is one limitation that needs to be acknowledged regarding this study. It refers to the frequent criticism levelled against the case study methodology. O'Toole (2006:146) better explains it when he says: '(...) case studies have one limitation-that you cannot really generalise from it, not from single or even multiple cases'.

Lastly, the researcher would like to acknowledge the interdisciplinary nature of this investigation. Apart from drama and theatre, the research project actively drew from the

fields of psychology and drama therapy. Since the researcher is neither a psychologist nor a drama therapist, there is always a risk of misapplying the borrowed concepts. However, the researcher tried to address this gap by working hand–in-hand with a qualified and registered drama therapist specialized in using drama for healing purposes.

CHAPTER ONE

1.0. Introduction

This chapter provides a historical and political background to HIV/Aids, TFD and an overview of how TFD has responded to HIV/Aids in Malawi. This is important because it helps the reader develop a solid understanding of the basic subject areas that this study is occupied with, the link of how and why TFD became integrated in HIV/Aids communication and how it has performed so far.

1.1. A Historical Perspective of HIV/Aids in Malawi

The history of the discovery of Aids started in the early 1980s in Malawi. According to Cheesbrough (in Englund 2002:152), the first hospital cases of HIV/Aids in Malawi were identified in urban patients in 1985. These discoveries were later supported by escalating HIV prevalence rates at Blantyre antenatal clinics: 2.0 per cent in 1985; 8.2 per cent in 1987; 18.6 per cent in 1989 (Taha *et al* in Englund 2002:152). Of greater relevance to the history of HIV/Aids in Malawi is the national response that the epidemic received under the Kamuzu Banda regime and how that slowed down the country's response to HIV/Aids.

While some countries like Senegal and Uganda have contained their national HIV prevalence rates through high-level political commitment and rapid responses, Malawi has remained among those countries struggling to make progress with a national HIV prevalence rate among adults (15-49) sitting at 12% (OPC 2007:5). Several reasons have been sighted for this lack of advancement, and the political history has some influence on the general level of progress.

Since independence in 1964, Malawi was under the highly autocratic and idiosyncratic rule of Life-President Dr. Hastings Kamuzu Banda. His regime exhibited an unusual degree of tyrannical control and flourished on rigid control of all institutions of political and civil society. Like most African countries then, Malawi was a one-party state and the Malawi Congress Party (MCP) was the only recognised party. The Banda regime, famous for its four cornerstones - unity, loyalty, obedience, and discipline - tolerated no dissenting views and no one was immune from its ruthless rule. The administration further established rigid and incapacitating censorship protocols that regulated all forms of media and claimed to uphold

traditional morality. Though it was obvious that the censorship board formed part of the state machinery to quieten any form of political opposition and criticism, its grasp had far-reaching effects that then stifled even the national response to a major public health problem. As Lwanda (in Englund 2002:152) points out:

> This delayed response to the epidemic was seen in both the 'traditional' and 'Western' medical spheres. Expatriate practitioners, constrained by the paralysing governance, were hesitant to tackle an issue that involved discussions of sex, immorality, traditional culture and government action or inaction.

Thus, from 1985 to 1994, very little was done in terms of mounting strategic frameworks for addressing the HIV pandemic and the same mood of apathy was passed on to the next multi-party democracy government under Bakili Muluzi in 1994. Lwanda (in Englund 2002:160) affirms this ensuing inaction in his statement:

> Yet, during the first four years of its administration, the Muluzi government did not fare any better than the Banda regime. For most of 1994–95, there was a shortage of reagents for HIV testing and, despite the appointment of another medical doctor to be Minister of Health, no significant initiatives on the HIV/ Aids front ensued.

A general historical analysis of political response to HIV/Aids reveals that inertia and denialism at the highest level of government was not necessarily unique to Malawi. With an exception of Uganda and Senegal, it took an extremely long time before many sub-Saharan countries, admitted that HIV/Aids was a major crisis in their countries. Goliber (2002:1) points out that:

> Throughout the 1990s, a pervasive silence surrounded the HIV/Aids epidemic in sub-Saharan Africa. At an individual level, this silence meant that many adults were not finding out their own sero-prevalence status, were not recognizing the risks involved in certain sexual behaviours, and were continuing to engage in risky sexual practices. At a cultural level, the silence has meant limited public and private discussion on HIV/Aids and the continued stigmatization of those who are HIV-infected. At the public policy level, the silence meant that African political leaders were slow to recognise the crisis nature (sic) of the epidemic and to formulate a national resolve to use all available resources to address the emergency.

In spite of the fact that the Muluzi administration lacked a consolidated political stance in terms of its commitment to addressing HIV/Aids, its leadership managed to create a more favourable political environment. For instance, the lift of prohibitions on the freedom of expression meant that the media was now free to publicly expose the full extent of the HIV epidemic. This new freedom also liberated organisations and donor agencies who generally

felt that this was time to catch up on what was a long overdue process. Kakhongwe (in Englund 2002:161) narrates that:

> NGOs, now free of the research constraints of the Banda era, increased their research and service provision activities. In 1997, it was estimated that there were 73 international and local organisations dealing with HIV/Aids.

Recognizing the burden of work and the pressure from the skyrocketing HIV/Aids statistics, NGOs, mostly with support from the donor community, mobilized whatever resources and strategies that were readily available to develop concerted awareness and prevention measures. Mass media -radio, newspapers, television, billboards, posters and pamphlets- became one of the leading channels through which HIV/Aids information was disseminated. This strategy came to be formally known as the Information, Education and Communication (IEC) approach and was based on the assumption that increased knowledge leads to behaviour change, for example, the adoption of safer sex practices (Kishindo 1995; Airhihenbuwa & Obregon 2000; Melkote, Muppidi & Goswami 2000; Bandawe 2002; Gerland 2004). However, it was not long before government and the NGOs realized that there was a huge gap in terms of reaching out to the masses with this approach due to high levels of illiteracy and inaccessibility of most of these mass media modes to the rural masses. This was not the first time that government had faced this challenge in its attempt to promote public health as observed by Kerr (1989:3):

> From the outset the PHCU [Primary Health Care Unit] realized that the problems confronting them were not simply material but also related to communication and levels of community consciousness. They were very aware that Government attempts to promote PHC in the 1970s had met apathy in the 'target' communities. The PHCU diagnosed inappropriate communication media as one of the major reasons for this apathy. Campaigns had used pamphlets, though illiteracy in the rural areas ran higher than the national average of 87.45%.

Kalipeni and Kamlongera (1987:4-5) had earlier commented that 'Primary Health Education programmes on the radio were also ineffective among communities which have been estimated to have only about 12% access to radio receivers'. Though several years had passed, these challenges still characterised the rural landscape and like the Primary Health Care Unit at Liwonde, most NGOs resorted to drama and theatre, particularly Theatre for Development to compliment the HIV/Aids mass media campaigns.

1.2. Theatre for Development in Malawi: An Overview

Theatre for Development (TFD) denotes a theatre form that is primarily preoccupied with using theatre for collective exploration of social and developmental issues affecting a specific community. The model has grown rapidly and has become a noticeable development among most theatre forums in Africa, Latin America and the Philippines. Its eclectic nature and broad outlines encompass numerous variations and labels, making it extremely difficult to attach a distinct and restrictive definition to the concept. But on the whole, TFD has a specific essence, whether you call it Participatory Theatre, Popular Theatre or Theatre for Integrated Rural Development among other names. Central to the practice is an inside-out approach to communication and provision of space for communities to identify and solve their own problems. The contexts of the targeted communities may vary extensively, just like the concerns it addresses. As such, various theorists and practitioners have also grappled with its fundamental tenets from varied perspectives.

In consideration of a definition, Mda (1993:48) writes that TFD refers to 'modes of theatre whose objective is to disseminate messages or to conscietise communities about their social political situation'. Commenting on the same, Kidd (1984:264) argues that:

> Popular theatre is used as a means of bringing people together, building confidence and solidarity, stimulating discussion, exploring alternative options for action, and building a collective commitment to change; starting with people's urgent concerns and issues; it encourages reflections on these issues and possible strategies for change.

Mlama (1991:67-8) who also refers to TFD as popular theatre contends that:

> Popular theatre is intended to empower the common man with a critical consciousness crucial to the struggles against the forces responsible for his poverty. It is an attempt to enable the masses to break free from the culture of silence imposed on them and reawaken or strengthen their latent culture of resistance and struggle which needs to be part of the process to bring about their development.

It is clear from these descriptions that TFD involves dynamic processes to bring about liberation and transformation. It is about activism, critical analysis and expression of ideas and views stimulated through collective human stories and experiences presented in theatre processes. It is also about recognizing and trusting community members as knowing beings, capable of finding answers to their own problems and making decisions that are critical for their advancement. This frame of mind is strongly influenced by Freire's (1970) theoretical

innovations from his 'Pedagogy of the Oppressed' and subsequently by Boal's (1974) work in 'Theatre of the Oppressed'. Freire believed that oppression of the marginalised people usually manifests itself through a culture of silence. He argued that people can, therefore, be liberated, empowered and meaningfully partake in development if they regain their lost voice and confidence in their lived knowledge. He advocated for an education system that recognises people as subjects, not objects waiting to be filled with information.

Influenced by Freire's theories, Boal (1974) developed a genre of theatre that has had a major impact on educational and community development theatre. His approach demands active audience participation, reflection and establishment of egalitarian forms of interaction. Like Freire, he is preoccupied with techniques that transform audience members from being passive spectators to involved 'spect-actors' capable of not just watching, but participating in solution making. In this regard, we see that the pedagogic principles of both Freire and Boal further have a major influence on TFD methods. They all share in their desire to empower the less privileged groups and make them partakers of their own development.

The practice of TFD in Malawi started in the early 1980s and gained more momentum in the 1990s. The shift from the production of English script-oriented scholarly dramas to research and people-based performances was partly a response to a broader social and political movement in Africa concerned with the 'assertion of cultural identity' after attaining independence and partly to an 'increased demand for theatre to be linked to development' (Mlama 1991).

In Malawi, this movement was facilitated by the Department of Fine and Performing Arts at Chancellor College, mostly through the work and practice of Kamlongera, Kerr and the University's travelling theatre established in 1970. According to Kerr, the department's interest in developmental communication was strongly influenced by Wa Thiong'o's concept of 'radical vernacularism' and by a growing Theatre for Development movement which started in Botswana in the mid 1970's by a project called Laedza Batanani (1989:471).

Having been exposed to the new ideas in the discipline, it was not long before the University was approached to provide services that required a TFD approach. The major projects that they worked on included the one done in 1981 with extension workers at Mbalachanda Rural Growth Centre in Mzimba district and another one done in 1985 with the Primary Health

Care Unit (PHCU) in the districts of Machinga and Zomba. These projects 'tried to link performing arts to primary health care communications (...)' (Kerr 1989:469).

Kerr (1989) and Kalipeni and Kamlongera (1996) have written extensively on these projects and have highlighted a number of communication and developmental successes that were realized from the projects. However, this study will not go into the details of those projects. Instead, what is important to stipulate is that these projects laid a foundation that was going to be used later by numerous organisations in response to HIV/Aids. They provided perceptible evidence of the methodologies' ability to overcome most of the communication barriers and even be instrumental in terms of broad community mobilisation. Among the current established organisations that are extensively utilising or applying versions of the TFD methodology to HIV/Aids are CRECCOM (Creative Centre for Community Mobilisation), Story Workshop, ADRA Malawi, NAPHAM (National Association of People Living with HIV/Aids), Nanzikambe Arts to mention a few.

With the exception of established organisations like the one's mentioned above, there are numerous drama or theatre groups or individuals who claim to use TFD methodologies. These usually operate in both rural and urban communities as part-time or full-time freelancers and/or employed and /or commissioned by organisations. According to Magalasi's,[3] estimation in 2001, 'there were up to 600 drama groups with the majority operating in rural areas' (Braun *et al* 2001:70). The numbers may have gone up considerably as more organisations expand their scope of work.

1.3. State of Drama and Theatre Response to HIV/Aids in Malawi

The use of TFD for health and varied social aspects has grown and intensified over the years. Its practice is no longer confined to a small team of scholarly enthusiasts or groups of experts who oversee the implementation of the projects at community level. But it has become accessible to all individuals and groups who seek to tap into the potentials of drama and theatre.

The urgency of conveying basic information about HIV/Aids by government and non-governmental organisations (NGOs) led to the explosion of drama groups. For organisations,

[3] Lecturer in the Drama Department at Chancellor College

these drama groups have become convenient HIV/Aids communication outfits that offer achievability at relatively low cost as compared to mass media campaigns. However, to make the most out of them, the government, NGOs and other donor agencies have committed to building their capacities. The aim is to enhance and develop their confidence, skills and to acquaint them with basic HIV/Aids information so that they can develop effective HIV/Aids communication programmes. This aspect led to a rise in the training opportunities for drama groups and often, these are conducted by theatre orientated institutions like the Drama Department at Chancellor College and organisations like Nanzikambe Arts, Story Workshop, CRECCOM or individual consultants trained in drama and/or experienced in acting. The training workshops last, on average a week, after which the drama groups are expected to either create work independently within their communities or become protégés to organisations.

By and large, the trainings rarely cover whole groups but bring together selected representatives from various drama groups, communities and districts that are later expected to train their fellow group members. The groups normally work on a volunteer basis and where they are commissioned; it's generally to carry out short-term, activity-oriented programmes that are appendages to other programmes or one-off activities like Open and Aids day functions. Commenting on this tendency, Mwansa and Bergman (2003:29) state that:

> Donors who use Theatre for Development as late coming add-ons in projects, or organisations that prefer quick dramatic interventions, have not taken the TFD/drama instrument seriously. Theatre programmes carried out in isolation will have little effect on the audience and bring out frustration among the theatre practitioners, who would like their work to have proper effect.

However, through these workshops and training opportunities, the knowledge of participatory theatre methods has trickled down and 'attempts' have been made to make HIV/Aids performances more interactive and thought provoking. I have deliberately used the term 'attempts' because quite often, there is a predisposition for groups to regress to didactic methods of theatre presentation, in particular, the type that Kerr referred to as the 'Mr Wise and Mr Foolish' (in Braun *et al* 2001:88). Kerr expounds on this form saying:

> The main rationale behind some of the observed scenes seems to be the creation of 'advice settings', in which one person can be enlightened by another about HIV/Aids-verbally. Often the 'advising character' is a person of authority: chief, a doctor, an

> extension worker. In this way, the potential that theatre has –to make things visible through action-is not taken advantage of.

In view of this observation, there still remains a huge task for the groups to move from approaches that are purely sermonic and attain a level where they can trust the ability of action or images to engender learning. Many theatre groups still lack faith in people's capacities to think and generate their own knowledge based on their lived experiences. In addition, the groups fail to grasp the core of their work, which is not to teach but to stimulate and facilitate collective learning.

A study by Mwansa and Bergman (2003) offers some useful insights to further understand the state of these drama groups in Malawi and across Southern and Eastern Africa. Focussing on their identity, Mwansa and Bergman (2003:17) highlight that:

> TFD practitioners are diverse in terms of gender, education and size. Most groups are either *amateurs or semi-professional,* few are professional. The majority consist of untrained amateurs, most often school leavers from primary or secondary school level. They practice TFD without having more other formal training (sic) than a limited experience from performances at schools.

In 2001, a consultant team of the Centre for Advanced Training in Rural Development conducted a project in Malawi whose objective was to explore the possibility of integrating theatre into the department of Agriculture Extension Services. Within this project, they also looked at the role of theatre in HIV/Aids and recorded the work of twelve various theatre groups in Lilongwe and Nkhota-kota districts. This study will not consider all the groups that were observed but rather focus on one that will epitomise the rest and underscore what Kerr (in Braun *et al* 2001) and Mwansa and Bergman (2003) observed. Briefly, the excerpt will give you a general idea of what the performances are like and how they attempt to address HIV/Aids issues.

Chitedze HIV/Aids Awareness group is one drama group that was investigated. According to the report, the group consisted of twelve, mainly teenage members, some of which were secondary school students. The group was mobilized by the Chitedze Health Centre personnel to try out fresh ways of promulgating HIV/Aids information in the surrounding communities. At the time of the study, the group had no director, members had no prior theatre experience apart from a few who used to perform in school and they met three times a week to rehearse and held community performances two to four times a month. They further

had plans to establish more groups in other villages. Below is a detailed description of one of their performances that was performed in August 2001 in Njewa village, Lilongwe, Malawi.

> *A young woman meets a young man: 'People who are not married should use a condom', she tells him. 'I am married so I don't have to use one', he replies. They leave together. Later she meets her parents. The daughter is about to move out to attend a boarding secondary school when her parents warn her: 'Do not come back pregnant! You have to abstain. And don't you have any boyfriends'. The first person she meets at her new school is the headmaster. He hands her over to the headboy, who presents her to a friend of his. All find her very attractive and try to approach her. Soon, it becomes very clear that she is anything but abstaining. So when the headboy tells the Headmaster that she had been told in the hospital that she was pregnant and HIV positive, the Headmaster gets nervous. He confronts her with the rumours. She denies having been to the hospital and pleads not to be dismissed from school. Exploiting her unfavourable situation, the Headmaster approaches her again but is interrupted by the headboy. Desperate she asks first from the friend of the headboy, then the headboy and then the Headmaster to marry her because she is pregnant. All refuse. She leaves for her family and tells them she has been dismissed from school. Angrily the parents decide to see the Headmaster to learn what has happened. 'Why did you dismiss her', they ask him. 'Because she is pregnant!' The parents are horrified and want to know who did this to their daughter. The Headmaster blames the headboy. The headboy blames his friend. The friend denies any involvement. A nurse from the hospital interrupts them and informs them that the daughter was tested positive. All the men start to cry one after the other: 'We are going to die in a chain!' The nurse advises them on HIV/Aids and tells them to use condoms if they are infected* (Extract from Braun *et al* 2001:78).

This group is emblematic of the majority of the drama groups that are involved with HIV/Aids activities at the community level. Far from text-based drama, their performances are devised with straightforward storylines, usually with no depth, dramatic twists, or strong conflict to drive the characters' quest and to deepen the discussion of underlying problems. You will also notice either the perpetration of wrong narratives or a true depiction of how people still perceive HIV/Aids when the men start to cry that they are going to die.

Nowadays, the HIV=Aids=Death equation is no longer a given and people need to be given the right information.

Technically, there also seems to be a wrong conception of what audience participation means as quite often, groups consider posing a few closed ended questions and getting a resounding 'yes!' or 'no!' as participation. Commenting on the subject, Kerr recognises that, in the few instances where practitioners truly endeavour to engage participants, reactions tend to be genuine because the practice of participation fits into the people's 'indigenous participatory aesthetic practices' (in Braun *et al* 2001:106). He writes that some of these practices include:

> (...) the tradition of participatory moral debate on dilemma tales, audience intervention during oral performances of the Ngoni, and the closeness of participatory theatre and the tradition of democratic debate at village court cases (ibid).

What is more, the performances are highly dialogic, thrive on humour and de-emphasize most of the conventional theatre artistry. Instead, emphasis is put on the message. Testifying to this approach to performance, Mefalopulos and Kamlongera (2004:48) state that:

> One of the burning issues in theatre for development is the role and importance of the artistry. One school of thought believes that whatever the theatre producers do with their people should be well done, polished and professional. Other practitioners tend to de-emphasize this aspect. The message is all they really care about. This position seems to be more prevalent in most developing countries now.

The idea to de-emphasize professional artistry could be argued to have some merits in the Malawian context where opportunities for formal drama training are limited. As such, the majority of people who practice have no formal qualifications from reputable learning institutions like the University of Malawi, Chancellor College. In the case of the training workshops, they rarely focus on honing the professional artistic skills of the groups. On this basis, this idea enables 'artists' to work with whatever level of handiness they have. On another level, the message orientated approach is favoured by most NGOs and donor agencies because it is economical and it provides them with a wide range of human resource to use in transmitting information.

Nevertheless, the inherent lack of critical sophistication and rigour of these performances causes one to question their reliability and effectiveness for achieving social transformation. They fundamentally fail to create a forum for issue exploration, to incite deep and personal or collective reflection, discussion and expression of opinion, let alone challenge people's

beliefs. They literally reduce participation to a classroom like question/answer or teacher/pupil encounter, the very notion that TFD and its participatory techniques are meant to dispel. Again, the effectiveness of TFD lies in the critical fusion of both artistry and messages. Both components are important and separating them merely weakens the methodology.

Moreover, the oversimplification of the duties and processes that a theatre practitioner has to heed when creating work, that is, the notion that nothing else is important but the message, is problematic. It contains a danger of misconstruing the relevance of the methodology, the roles and skills that one is supposed to have in order to effectively design and deliver messages. The process of creating performances is complex, and it is even more complex when it involves dealing with issues like HIV/Aids that have various dimensions to them, be it cultural, ideological and perceptual. All these factors require careful analytical skills and creative rigor to be integrated. Even Boal, who is a staunch vicar of the theory that every man is an artist, takes time to acknowledge that it takes more than merely being a natural born artist to produce the work of art that has awakening powers upon those who experience it. He stipulates that:

> (...) since every citizen is an artist-each in his or her own way: even though some may not be capable of creating an Aesthetic Product [the finished work of art] which enlightens all of us, all are capable of developing an Aesthetic Process which enriches themselves (2006:39).

In this regard, I align myself with Boal's view, since I believe the success of TFD and facilitation of social transformative activities begins first and foremost with the discernment of this distinction; between those who are capable of efficiently creating and facilitating work that has an impact on the collective and those who should merely participate in a creative process for personal growth. Failure to make this judgement is what has led to the erroneous conception that any 'Jim and Jack' who knows as much as a joke can become a TFD practitioner. It is high time we started emphasizing the point that 'TFD is a field that requires keen specialisation' as stipulated by Ogolla (in Odhiambo 2005:191).

Again, the privileging of messages has led many theatre practitioners to overlook or undermine the power of images. Since most of them have not been sensitised of what an image is capable of communicating, they use them haphazardly and in the process, they have naively and animatedly exhibited undignified and wounding images of people living with

HIV/Aids. They have created images that defeat the very messages they aim to convey and have to some level contributed to the perpetuation of stigma and discrimination. All this goes to explain how delicate and how extreme drama and theatre can be if placed in the wrong hands.

Drawing us back to the heart of this chapter is the question of how theatre is responding to the HIV/Aids situation in Malawi. In short, if we consider the number of drama groups that are actively working in communities and the number of projects utilising drama and theatre approaches in their programmes, then theatre is making a tremendous contribution. Though there is currently no statistical evidence to substantiate this, theatre, and particularly TFD has played a significant role in raising HIV/Aids awareness and in helping people understand the basic facts about the disease. But alternatively, theatre in HIV/Aids is to a certain extent experiencing sedentary conditions. As a matter of illustration, the performances being put up today have not changed from the one that the Chitedze HIV/Aids Awareness group performed in 2001. The performances still carry the same messages portrayed in the informative manner as if HIV/Aids were a stagnant issue. Worse still, the dramas are performed to the same communities, meaning that people are subjected to the same message over and over again without developing new ones.

Thus, the greatest challenge is that theatre seems to lack the inner steering force in order to keep up with urgent contemporary issues and paradigm shifts within the HIV/Aids domain. Some of the causative factors are ideological, as suggested above, where some believe that theatre practitioners do not require extensive training in order to function. However, other reasons relate to issues of training where most trainers have lamented on inadequate training periods and resources. These restrictions hinder trainers from administering comprehensive training programmes that would familiarise practitioners with the types of drama and theatre, TFD theories and techniques, and the ethical considerations of dealing with sensitive issues affecting people. The limitations further obstruct facilitators from empowering drama groups with acting, facilitation and critical skills that would enable them to analyze and evaluate their practice in light of the changing times. Meanwhile, a close analysis of the theatre-HIV/Aids dichotomy in Malawi will reveal no major evaluations or adjustments to the methods that have been in use since the early 1990s. How then, can drama and theatre grow and effectively address the changing challenges of HIV/Aids if its methods and techniques are not evaluated?

In this chapter we have looked at the historical background of HIV/Aids and Theatre for Development in Malawi. We have also highlighted how TFD has responded to the HIV/Aids situation and discussed some of the problems and challenges related to the application of drama and theatre in HIV/Aids communication. In the next chapter we will analyze the specific limitations of TFD in addressing the current demands of HIV/Aids.

CHAPTER TWO

2.0. Introduction

Chapter One brought to light the way in which drama and theatre has responded to HIV/Aids in Malawi. This chapter intends to discuss in detail the limitations of TFD in light of the growing complexities of HIV/Aids on the individual. Over the years, the number of people living with HIV/Aids has multiplied and this group faces unique challenges. Hence, throughout this section, I argue that while TFD remains a relevant approach in addressing certain HIV/Aids issues, the model becomes limited when it comes to the specific issues of how the disease affects individuals personally and psychologically. The chapter will take the discussion further and demonstrate that there are other drama methodologies like process drama and drama therapy that could be used instead to address the complex needs of people living with HIV/Aids.

2.1. HIV/Aids and the Individual

Before a discussion on the limitations of TFD may be undertaken, let us examine in detail how HIV/Aids affects the individual at an emotional level and how people cope with such predicaments. This information will assist in our analysis of TFD. Beginning with Teguis and Ahmed (1992), they observe that, the majority of the age group that is diagnosed with HIV is between 20 and 40. In Malawi, the weight of HIV infection falls in the age bracket of 15-49 (OPC 2007:5). According to Erickson's model of life stages (in Ahmed 1992:13), these people belong to a developmental life stage called young adulthood. This is a critical stage in life and it is filled with expectations, aspirations and excitement for things yet to be accomplished. Based on this categorization, Teguis and Ahmed (1992:14) further stipulate that:

> [This is the] time when people reach a peak in terms of career and life goals established in their earlier years, many adult PWAs (People with Aids) see this fulfilment as abruptly aborted. This is the time when many people have reached the zenith in terms of productivity; PWAs [then] find themselves at their nadir, subject to forces external to themselves, beyond their ability to control.

While this was absolutely the case in the past, today we know that people can be rehabilitated and live healthy productive lives. With the right use of information and proper adherence to treatment and nutrition, we know that HIV/Aids can be controlled. As such, it need not

remain a menacing remote force that robs people of their careers and life goals. However, the problem is that Aids stigma continues to negatively influence people. It has proved to be a persistent 'sting' in the HIV/Aids equation, unshaken by the general advances and a cause for a lot of psychological distress. Holzemer (2004:165) points out that:

> Stigma is perceived as a major limiting factor in primary and secondary HIV/Aids prevention and care. It reportedly interferes with voluntary testing and counselling, and with accessing care and treatments, thereby increasing suffering and shortening lives.

All this goes to confirm the complexity of HIV/Aids and to support the argument that it is futile to address HIV/Aids from one dimension. HIV/Aids is a multi-dimensional condition and we have seen that while progress is being made on the medical front to address the physical ailments, stigma, the shame of living with HIV/Aids carries on to be the source of deep emotional pain.

Dayton (2000: xv), in her reference to the Chinese adage writes that, 'the deepest pain has no words'. For her, '(...) trauma has no words and does not evidence itself as we might imagine'. This proposition is theoretically reinforced by Herman's articulation and understanding of what she calls unspeakable violations. She compellingly illustrates how people, most of the time, would rather not talk about their intensely wounding situations for fear of being misunderstood or doubted (1992:1). Adams-Westcott, Dafforn, and Sterne (in Freedman and Combs 1996:48) also bring in a significant offering through their notion of internalisation. They write:

> (...) people who suffer abuse tend to internalise the traumatising events to which they have been subjected as inner dialogues, and how these dialogues colour the interpretation of subsequent events.

In my view, the construction of HIV/Aids in our societies is a form of abuse. The idea of associating the condition to aspects such as immorality or to the impression that once one is HIV-positive, they become incapable, for instance, is problematic. These are false, oppressive ideologies and at best serve to breed stigma and perpetuate silence and denialism. More often, instead of looking at HIV as the problem, the person is perceived as the problem and HIV becomes an indication and a yardstick for measuring how bad and corrupt they are. Such conceptions have far reaching effects on ones self-esteem and sense of self-worth. And fearing such misjudgements, people living with HIV/Aids tend to conceal their status and

suffer in silence. Miller, one of the first and very few Muslim women in South Africa to have disclosed her HIV status, provides us with a precise example of what HIV internalisation entails. She explains that:

> (...) the first thing that went through my mind when they told me I'm [HIV] positive was the shame I had brought on my family. I therefore decided to keep this information to myself; after all it wouldn't be long till I die (www.positivemuslims.org.za/beinghiv.htm).

There are many HIV-positive people who after weighing what additional pain the act of disclosure would bring to their already stressful situations, opt to keep it under wraps. But Herman sturdily forewarns us that silencing such matters does not work. But 'Remembering and telling the truth about terrible events are prerequisites, both for the restoration of the social order and for the healing of individual victims' (1992:1). Her argument aligns with what Psychodramatist and Experiential therapist Dayton proposes. 'Giving words to trauma begins to heal it. Hiding it or pretending it isn't there creates a cauldron of pain that eventually boils over' (2000: xvi). In the same light, giving words to HIV/Aids begins to heal it. I have a special friend who has been living with HIV/Aids for a few years now. Her status is known only to a circle of three people and several times in our conversations she has said: 'you girls have no idea how talking to you has helped me cope'.

Connecting to the same line of thought, narrative therapists Freedman and Combs (1996:29) provide a lucid conceptual base through their claim that: 'Speaking isn't neutral or passive. Every time we speak, we bring forth a reality. Each time we share words, we give legitimacy to the distinctions that those words bring forth'. In Malawi, there is a common saying which strongly correlates with the claim, saying '*mau amalenga'*, meaning that words have inventive powers. All this bears witness to the constructive and shaping power of words. The more you say something, positive or negative, the more you inject it with power, with influence and life and then it begins to shape who you are, what and how you think, act and feel. More precisely, we are our own narratives.

However, it should be noted that though our individual interpretation of our experiences is paramount in constructing our narratives, consequently 'the self'; our societies and the cultural contexts as well as the narratives existing therein influence the stories individuals formulate. Thus, the kinds of narratives that HIV-positive persons have about themselves are reflective of their societies. Freedman and Combs (1996:34) cogently frame this in their

statement that, ‘Selves’ are socially constructed through language and maintained in narrative.

Morgan (2000) sensibly extends the debate by linking problematic stories to therapeutic contexts. In accord with other narrative therapists, she explains that, when people are faced with traumatic events, they usually generate what are called ‘thin descriptions, meanings that are reached in the face of adversity’[4]. For her, thin descriptions [narrow stories] are problematic because they are rigid, exclusive, allowing little or no space to view or interpret the situation from other perspectives. Thus, one becomes oblivious to many other possible meanings and perceptions (ibid).

She also makes an interesting observation which is accurate to most HIV/Aids scenarios in Malawi. She writes, ‘often, thin descriptions of people’s actions/identities are created by others – those with the power of definition in particular circumstances’ (ibid). In the case of HIV/Aids, these could refer to the medical personnel and the media. Based on my experience with theatre in Malawi, drama and theatre practitioners also contribute to the creation of thin descriptions through their simplistic, black and white representation of HIV/Aids. A good example is the performance by Chitedze HIV/Aids Awareness group discussed in Chapter One. Morgan contends that such thin conclusions, drawn from problem-saturated stories, disempower people as they are regularly based in terms of weaknesses, disabilities, dysfunctions or inadequacies (ibid). Once the involved persons ‘buy’ into these descriptions, they with time become their dominant stories and gradually these problem-saturated stories get hold of their whole being and influence their present lives.

This is the stage where most persons living with HIV are trapped and where drawing from narrative therapy could be significant. Through narrative therapy concepts, facilitators would help to disengage people from their problems through a linguistic practice of externalisation. This idea was pioneered by White who conceived that ‘(...) the person is not the problem but the problem is the problem’ (in Freedman and Combs 1996:47). He further defined the notion of externalisation as ‘a practice supported by the belief that a problem is something operating or impacting on or pervading a person’s life, something separate and different from the person’ (ibid).

[4] http://www.dulwichcentre.com.au/alicearticle.html

Through this concept, one would distance and separate their HIV condition from the self to deal with it objectively. However, it must be understood that externalisation does not mean trying to locate or situate HIV/Aids outside the individual. HIV/Aids remain an individual's internal condition, but while being internal, it does not become the person and this is what the process of externalisation in the HIV/Aids context would try to achieve. Hence, the more people narrate their stories, the more they would engage in externalisation. As they tell and re-tell their stories, they would in essence be scrutinizing their narratives in new ways, deconstructing their dominant problem-saturated discourses and re-writing, reframing them with new meanings and alternative stories. Keen and Valley-Fox (in Emunah 1994:16) validate the significance of constantly developing new narratives for one's healthy functioning in their assertion that:

> To remain vibrant throughout a lifetime, we must always be inventing ourselves, weaving new themes into our life-narratives, remembering our past, re-envisioning our future, reauthorizing the myth by which we live.

2.2. Limitations of TFD in Addressing Individual, Emotional HIV/Aids Challenges

Having looked at how HIV/Aids affect the individual at an emotional level, the question to ask is whether TFD has the capacity to address these challenges. Can the TFD approach facilitate emotional expression(s) and the exploration of complex inner feelings; provide space for reconstructing personal narratives and re-envisioning life with HIV/Aids?

TFD certainly has a number of theoretical principles that if extracted and used in process-orientated drama would have considerable impact on addressing HIV/Aids emotional problems. But in this section, we assess the approach as a whole and discuss its limitations.

First, TFD in its intended form would not facilitate individual emotional healing because its purpose is to facilitate the collective exploration of problems affecting entire communities and not individuals. Its concerns are neither healing nor psychological in nature and if in any case they were, they would still relate to the broader perspective of the community.

Second, its objectives are general and are meant to conscietise and empower the local masses to take an active role in identifying, analyzing and developing solutions to their problems. It is about problem solving, about ideas, development and dealing with external problems. Thus, dealing with personal ordeals would not be in the domain of TFD unless the issues are

drawn out to epitomise the oppression of a collective. Addressing the psychological effects of HIV/Aids on individuals would require a framework that would personalise HIV/Aids and properly frame it as an internal problem.

Third, TFD stimulates people at a cognitive and analytical level. Its delight is in inciting and engaging people in a passionate and critical debate where they tap primarily from their rational selves. Unfortunately, HIV/Aids affect individuals at a personal level and is not like solving a mathematical problem that is outside the person, requiring only intellectual rigour. The depths of the traumatic experiences are difficult to access because they are intertwined in the very lives of the individuals and as such, cannot be reached with logic alone. There is need for an approach that balances both emotive and cognitive cogitations and takes into consideration the delicate and sensitive nature of HIV/Aids and the struggles that people go through as they try to sustain their lives.

Last, being a group approach, TFD does not have the inherent capacity to deal with matters of individual confidentiality which are crucial when dealing with HIV/Aids at a personal level. The kind of forum that TFD creates is ideal and open for addressing generic community issues and cannot in any way be suitable for handling private and sensitive matters belonging to individuals. Within the TFD created forum, people do not only discuss but question and challenge each other's conceptions in the quest of finding a solution, whereas a traumatized person requires a different environment where people will listen, empathize and offer support in the pursuit of helping the individual attain a healing experience.

Therefore, the process of psychologically re-engaging the hope of those infected evidently lies beyond the TFD domain, necessitating the search for other forms that would embrace the use of drama and theatre for emotional rehabilitation purposes. It is evident that while TFD is supplying people with quite relevant information, it is not and is unable of dealing with their daily dilemmas of living with HIV/Aids. There is need for an approach that will speak directly to the person's heart, an approach that understands the language of human psychological needs and is capable of turning individuals into spect-actors[5] that can reconstruct, re-story and re-invent their own lives.

[5] A spect-actor is someone who simultaneously watches and actively engages in the drama. Boal, A. 1995. Rainbow of Desire.

Within the discipline of drama, there exist a number of genres that are process and people orientated. Among them is process drama and drama therapy consisting of a mélange of transformative and therapeutic elements drawn from various theatre forms and processes. Each of these forms provides a useful synthesis of the cognitive/affective symmetry. For example, drama therapy has intrinsic therapeutic aspects that embody a powerful potential for healing. These approaches will become useful later when we begin to look at the processes and decisions that went into planning and implementation of the process-orientated drama workshops. As such, the succeeding paragraphs will look at what process drama and drama therapy is and familiarise the reader with some of their basic tenets relevant to the study.

2.3. Process Drama

Process drama, sometimes known as Drama in Education, was first advanced as a theoretical discourse from the 1960s by individuals such as Heathcote and Bolton. Then later by O'Neill, Neelands, Morgan and Saxton and many others who have refined the original ideas to create more situated ways of approaching learning. At the very core of process drama is improvisation and emphasis on process, on learning through intense personal exploration of the issues presented in the dramatic worlds. Neelands (1984:2) propounds that process drama puts the learner at the centre of the learning process and acknowledges the learner's own resources for learning as valid and useful tools for classroom use. Thus, in the HIV/Aids context, participants would become primary agents of their own learning, of discovering new meanings and perspectives through intimate involvement and connection to their personal problems.

Shedding more light on the characteristics of the approach, Wagner (1999:1) stipulates that: 'There is less emphasis on story and character development and more on problem solving or living through a particular moment in time'. According to O'Neill (in Wagner 1999:1), 'the aim is to explore a single experience through a nonlinear layering of episodes that cumulatively extends and enriches the fictional context'. Thus, unlike TFD, the facilitator's efforts in this approach are directed at helping participants investigate their life situations through the lens of fiction.

Furthermore, to deepen their experience, both the facilitator and participants take on various roles that enable them to engage and reflect on difficult matters which are far beyond their

own immediate experience (Bowell and Heap 2001:13). To effectively achieve this, Greenwood (in O'Connor 2003:18) suggests to:

> Engage participants in a dramatic experience that may, like other powerful theatre, lead participants to new and different insights into the nature of being human, but it is engagement in the art form that primarily constitutes the experience.

This perception is echoed by Bolton (1979:142) who goes further to say that it is in this dramatic experience that participants' ordinary habits of conception are challenged by invoking their 'as if' behaviour. The power of the 'as if' phenomenon captivates genuine enrolling, sincere exploration of situations and help participants discover the feelings of what it means to be the other person or be in a different situation. For him, the drama elements are there to help people come to a point where they can see the problem in a different light and be challenged to arrive at fresh meanings. Heathcote (in Taylor 2000:102) asserts that 'Drama is not stories retold in action. Drama is human beings confronted by situations which change them because of what they must face in dealing with those challenges'.

Absolute commitment to these imagined situations and challenges then lead participants into a level of deeper concentration called 'metaxis'. Bolton describes this notion as 'a heightened state of consciousness that holds two worlds in the mind at the same time' (1979:142). Here, the real world meets and becomes one with the fictitious world; the role meets with the self and it is considered to be the unique matrix for learning in process drama.

Boal (in O'Connor 2003:19) applies this concept of 'metaxis' to describe the process 'whereby the person in role is able to both perform and view that performance'. This is possible because while one is enacting a role, the 'self' can step out and observe. These two phenomena co-exist at all time even though one might be more foregrounded than the other at a particular point in time. This configuration, therefore, allows participants to separate role from the self and to exist on two levels that belong to distinct worlds. They can be an actor and the object of observation while at the same time existing as the observer and the subject that scrutinises simultaneously. Vygotsky (ibid) describes the same phenomena as a 'dual effect'. What is interesting about dual effect is the possibility of changing and influencing one's act and responses even as they unfold in the process of enactment.

In this regard, the created space becomes a negotiation ground where issues of power, role, context and interpersonal interactions between the facilitator and the participant are

negotiated to arrive at an array of meanings. In this space, participants are not only enabled to own and take an active role in determining their own learning, but are also facilitated to attain a lived through experience of the emotions. The drama provides the framework through which participants can experience living with HIV/Aids. It helps to broaden their understanding by not limiting it to cognitive awareness but making it complete through encountering the actual emotions of living with HIV/Aids in a fictitious scenario. Consequently, the exploration process leads to transformation as the participant acquires first hand information on situations. It is hoped that the problem solving strategies obtained in the process drama will help individuals in their daily lives should they encounter similar challenges.

2.4. Drama Therapy

Drama therapy refers to a field of drama preoccupied with the healing and treatment of problematic situations through the use of creative dramatic activities. The approach is unique for its ability to employ hypothetical circumstances for therapeutic outcomes. Its uniqueness also comes from its flexibility to draw from a wide range of disciplines like drama and theatre, psychodrama, psychology, psychotherapy and sociology. Jones (1996:6) conceived it as 'involvement in drama with a healing intention'. He further argues that:

> Drama therapy facilitates change through drama processes. It uses the potential of drama to reflect and transform life experiences to enable clients to express and work through problems they are encountering or to maintain a client's well-being and health (ibid).

Like process drama, this treatment procedure places the client at the centre of the dramatic processes where he or she is encouraged to actively ruminate over their difficult situations and in so doing, regain control over them. Emunah (1994:3) recognised it as 'the intentional and systematic use of drama/theatre processes to achieve psychological growth and change'. For her, drama therapy is not there to merely relieve clients of their suffering. It is there to help them change the perception of their painful and seemingly unchangeable aspects in ways that encourage growth, transformation and a new and deeper awareness of the self. She further indicates that drama therapy implies 'loosening the ties that bind us and limit our evolution', '(...) uncovering and integrating dormant aspects of ourselves, enlarging our conception of who we are, and finding our intrinsic connection with others' (1994:302). This process of rehabilitation, liberation and of expanding perspectives towards suffering are

instigated by suspending belief and immersing oneself into imaginary worlds where one confronts the depth of their painful inner experiences.

Vital to the whole process of emotional well-being is the concept of role. Moreno, founder of psychodrama recognised that, 'I become a person to the extent that I can play out many roles of myself and also play out the roles of others through the process of role-reversal' (in Emunah 1994:12). On the other hand, Landy defines roles as:

> (...) the containers of all the thoughts and feelings we have about ourselves and others in our social and imaginary worlds....it is in the doing and seeing and accepting and integrating of all the roles, the 'me' parts that the person emerges intact (in Emunah 1994:14).

Both theorists above enunciate the multidimensionality of human experience which is articulated as role repertoire by other writers. Blatner (in Emunah 1994:13) explains that 'an enhanced capacity to both understand and be flexible with a [multiplicity of roles] validates and expands our sense of self and enriches our experience in living'. Commenting on how roles directly impact on people's health Dayton postulates that 'psychological health is associated with the ability to move in and out of a variety of roles with relative fluidity' (1994:21). She further posits that:

> We become unhealthy when we become stuck in a role or two and cannot come out. When the role superimposes itself on our being and we become the role, we lose our spontaneity and freedom of choice (...) what occurs is not only a shift in reality but also a shift in how we participate in reality (ibid).

This impression closely correlates with views put forward by both narrative and drama therapists. They observe that the psychological trauma that comes with being HIV positive usually has shattering effects on one's identity. As a result, many people become engrossed in one role, in one narrative, that of an HIV-positive person. Through this process, many lose their sense of self and begin to perceive themselves from a narrow perspective. If we concede to Landy's definition of role as containers, then people with a negative HIV/Aids role may become overwhelmed by feelings and thoughts of despair, anger, fear and sometimes shame contained in the role they assume. Their condition and its resultant external prejudgements cause a negative shift in self image. As their role repertoire diminishes, they become trapped and imprisoned within that container, rendering the positive and diverse experience of their being impossible. They become engrossed in a chronic state of existential crisis and develop an identity of victimization. Such traumatic instances can only be rehabilitated if the person is

given a safe platform where they can consciously re-evaluate and deconstruct their situation, reclaim their control and learn to cope with the situation through innovative methods.

> Drama therapy is an active and creative form of psychotherapy that engages the person's strengths and potentialities, accesses and embraces the person's buried woundedness, and enables the practice and rehearsal of new life stances (Emunah 1994:31).

Furthermore, as the individuals plunge themselves in the creative dramatic activities, they undergo an emotional process called catharsis, which is central to therapeutic healing in drama therapy. The concept of catharsis [emotional cleansing], also key in psychodrama, dates back to the times of the ancient Greeks and is drawn from the practice of Aristotle in the 3rd century BC. He believed that, 'through the dramatic enactment and representation of a real life situation, violence within the soul (...) could be purged' (in Dayton 1994:14). Remarking on why tragedy has a strong hold on people, Aristotle noted that 'people enjoy tragic themes and observing human struggle because the hero's remorse provides a catharsis that is purifying and perhaps therapeutic for the spectator' (in Tedeschi and Calhoun 1995:2).

Thus, by watching the drama, the spectator is transformed by the process of recognition and identification with the sad story and the actor's perseverance and desire to overcome adversity. However, in drama therapy, the emphasis is not so much on witnessing someone else going through the struggle but rather, objectively projecting feelings, attitudes and observing the self through the technique of distancing. Landy (1994:114) indicates that:

> Catharsis in drama therapy does not need to be a large outburst of feelings, a gushing forth of tears or paroxysm of laughter. It is often a modest reaction, a gentle moment of recognition. Catharsis implies the ability to recognise contradictions, to see how conflicting aspects of one's psychic life or social life, of one's thinking, speaking, or feeling can exist simultaneously.

Thus, in the instance of HIV/Aids, this is usually characterized by the disintegration of one's whole being, catharsis and drama therapy become paramount. It offers one a means of breaking the traumatic psychological barriers and instead of suppressing the stressful feelings; the model enables the client to release those strong wounded emotions.

But mere expression of painful emotions is not enough. Herman's (1992:3) assertion that 'the fundamental stages of recovery are establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community' provides a clear link

between the therapeutic aspects in drama therapy and narrative therapy. As such, to provide an expanded potential for HIV/Aids emotional rehabilitation, this study privileged those dramatherapeutic forms with latent narrative therapy aspects such as storytelling, image theatre and sculpting for healing purposes.

2.5. Jones' and Landy's Theoretical Models

The paragraphs above have managed to provide a general exposition of what drama therapy is. This section attempts to explain how drama therapy works. To accomplish this, my study looks at Jones' and Landy's theoretical models which discuss the different factors and processes that are brought together or applied in drama therapy in order to achieve therapeutic outcomes. This study draws from a series of these fundamental concepts and methods in its quest to find the drama and theatre processes that might enhance emotional health of people living with HIV/Aids.

Jones, a British drama therapist lucidly encapsulates these factors in a discourse which he calls the nine core processes. He argues that these core processes underlie all practical procedures within drama therapy and are crucial for the effectiveness of the approach. They include: dramatic projection; therapeutic performance process; dramatherapeutic empathy and distancing; personification and impersonation; interactive audience and witnessing; embodiment: dramatising the body; playing; life-drama connection and transformation (1996:99-100).

In describing dramatic projection, Jones stipulates that it 'is a process by which clients project aspects of themselves or experiences into theatrical or dramatic materials or into enactment, and thereby externalize inner conflicts' (1996:101). He further specifies that this whole process 'enables change through the creation of perspective, along with the opportunity for exploration and insight through the enactment of the projected material' (ibid). He defines therapeutic performance as 'a process that involves identifying a need to express a particular problematic issue, followed by an arrival at an expression of that issue which uses drama in some way' (1996:103). Here, performance provides the participants with the necessary framework through which they can gain access to their inner material, explore and express it.

We will look in more detail at the element of dramatherapeutic empathy and distancing when discussing Landy's theoretical innovations, but meanwhile, let's see what Jones suggests by this factor. He writes:

> Dramatic empathy refers to the creation of a bond between actor and audience. It relies upon the audience being able to identify with and engage their emotions in the characters portrayed (1996:104).

He further elucidates that:

> Dramatic distancing refers to a way of approaching drama and theatre related to Brecht's verfremdungseffekt. The actor 'does not allow himself to become completely transformed on the stage into the character he is playing' Brecht (in Jones 1996:104). Rather than developing empathy and strong identification, the actor or actress is asked to emphasize their critical response; what they think, judge or wish to say about the role they play (Jones 1996:104).

Central to these factors is their ability to control the level of involvement, how close or distanced one is to their emotions when enacting a role. Moving on to personification and impersonation, Abrams postulates that personification is '[when] an inanimate object or abstract object is spoken of as though it were endowed with life or with human attributes or feelings' [my addition] (in Jones 1996:107). Landy describes impersonation as the '(...) ability to fashion a personality through taking on and playing out various personae or roles' (ibid). Personification and impersonation represent some of the ways in which the client may choose to deal with their personal material. Based on their needs and what they want to achieve, they might want to enact or illustrate their life stories using objects or through a created character.

In drama therapy, there are no exclusive audience members but rather, an interactive audience. This means that clients simultaneously play the roles of participants and audience members, witnessing and observing other people's work as well as one's own enactments. Dramatising the body simply entails a process through which clients physically encounter material through performance. That is, instead of explaining using verbal language, they might decide to express their deep personal feelings through body movement, mime, gestures, and sounds. This is critical because it offers participants with a wide range of expressive and communication forms. Summarising the element of play, Jones stipulates that it forms 'part of an expressive continuum, it is part of drama'. He argues that 'it is a specific

language (...) which can be a part of the way a client explores or expresses material in drama therapy' (1996:116).

Lastly, the life-drama connection refers to the process where clients are able to apply their life experiences in the drama therapy activities and to use the newly discovered experiences and perceptions to understand or influence their real life situations. Transformation relates to the 'changes in state which the client experiences through the enactments in drama therapy' (Jones 1996:120).

Focussing on the core processes, you realize that they are not the type of processes that progress in succession, but are strongly interconnected and intertwined. In fact, you might have all of them operating in a single process. However, I would like to draw attention to one specific element, that of dramatherapeutic empathy and distancing. Unlike performance or play, dramatherapeutic empathy and distancing is not an activity or an event *per se*, but a feature manipulating how events are framed or how clients relate to material. In this regard, it is a concept that cuts across many drama and theatre processes, constantly regulating the position of clients to their personal situations. It is a key concept, especially in contexts where participants have to deal with personal issues and where their position might impede or facilitate the process of creating perspective to their material. Jones discusses this principle but Landy provides a comprehensive examination of the concept.

Like Jones, Landy's distancing model is linked to the performance theories of Stanislavski and Brecht. But he also draws from the psychotherapeutic theory of Scheff who propounds that therapeutic healing lies neither in overdistance nor underdistance, but in the midpoint called aesthetic distance. He argues that when this balance is reached, participants experience catharsis which entails reliving of emotions but in a manner that is not overwhelming to the individual (Landy 1996:17). He writes that overdistance -defined as 'a state of repression- becomes a cognitive process of remembering the past' and underdistance- defined as 'the return of repressed emotion-becomes an affective process of relieving or re-experiencing a past event' (ibid).

With influence from these concepts, Landy advances a distancing model that he applies to his practice of drama therapy. He describes distancing 'as a means of separating oneself from the other, bringing oneself closer to the other, and generally maintaining a balance between the two states of separation and closeness' (1996:13). In drama therapy, this concept is not

limited to human interaction but is equally applied to a variety of dramatic elements like role and story, where it helps to ascertain how closely or far one will relate to those elements. For instance, where clients are dealing with intense and devastating emotions, using dramatic expressive forms that instigate overdistancing like scripted plays would be the most appropriate mode to help participants explore their life situations without getting overwhelmed. On the other hand, where clients exhibit detachment from their inner painful situations, expressive forms of underdistancing like, playing oneself in an imaginary situation would help them to work and gain access to their feelings. However, these are only examples of the extreme cases and in most scenarios; the modes of distancing will be determined by the specific needs of the client and the desired outcome.

Commenting on Scheff's paradigm, Landy (1996:17) suggests that 'at aesthetic distance, the individual plays both roles of participant and observer simultaneously; or he is able to move fluidly from one role to another, as appropriate'. At this point, participants are objective and engaged enough to be drawn closer to their inner selves, to a heart-based process of acknowledging and naming what they are feeling, while at the same time, having the ability to disentangle themselves from the issues so they can rationalise, reflect and create perspectives on the issues.

Taking the discussion further, Landy (1996:19) elucidates that there are numerous methods of distancing in drama therapy. These include storytelling, role playing, role reversal, doubling, using puppetry, dolls, sand play, masks, makeup and video tape among others. Depending on how it is structured, storytelling can yield both overdistancing and underdistancing effects in a drama therapy session. For example, a client who tells her own story of how something happened to her will, in the process of telling, experience again the intensity of the emotions she felt as it happened. Subject to how burdened she was with the incident, she may experience emotional release through crying, laughing or simply through a deep sigh. This process allows the participants to express their personal feelings directly without using any dramatic structures or shield.

On the contrary, clients may narrate or perform a fabricated story that has no direct link to their lives. This story could unfold in a fantasy land with participants playing imaginary roles. Each of these actions will operate as another layer of distancing and help participants to become more objective and universal in their analysis of issues.

Another distancing technique involves personification, the expression of inner feelings through objects such as dolls and puppets. But instead of using objects, a participant may decide to act out their personal story as a different person. In assuming a different persona, the story gets represented from another perspective. This process alone may be beneficial to the individual because of the opportunity it offers to experience the same situation from another dimension. By assuming a role, they will have picked up distinct attitudes, a different conception of life and beliefs that will help them to respond differently from the way the 'real' them would have responded to the situation. The more roles they play, the many the perspectives they create for the same situation hence, increasing their repertoire of responses and the ways of addressing the situation.

Within the same ambit of role playing, participants also have the liberty to play the role of self, enacting scenarios from one's real life experiences. This is an underdistancing technique that would encourage participants who are suppressing their emotions to become emotionally involved with their inner situations. If they become too overwhelmed with emotions, the facilitator would engage the participant in a role reversal, which is basically an exchange of roles with someone who will have been playing a supporting role. This is an important psychodrama technique which allows the protagonist [central character] to switch roles with auxiliary characters. In so doing, the protagonist experiences the situation from various viewpoints and also observes how others respond to the same situation. By the end of the session, not only will the protagonist have a single perspective of the issue, but s/he will have understood other perspectives as well.

The HIV/Aids challenges described in this chapter serve as a structure through which we can begin to understand the limitations of TFD. By limitations, it does not mean that TFD as an approach has become insignificant to HIV/Aids, rather that HIV/Aids has evolved and acquired new demands, some of which are beyond the scope of its inherent potential. The chapter has also highlighted some of the fundamental methods and techniques in process drama and drama therapy that the study draws on later to develop a process-orientated methodology which gets tested in Chapter Five.

CHAPTER THREE

3.0. Introduction

This chapter consists of three main sections. First, it provides a brief description of the context in which Paradiso HIV/Aids Support Organisation operates. The chapter then looks at how the organisation came into being and why. Second, it explores how the group therapy was established and the thinking and rationale behind its formation. Third, it explains the research methodology that informs this study and describes the data collection and data analysis processes.

3.1. Organisational Context

Paradiso is a community based HIV/Aids Support Organisation registered with the Malawi Network of People Living with HIV/Aids (MANET+). It provides various HIV/Aids-related services to people living with HIV/Aids in the areas surrounding Ngwenya in area 24, Lilongwe. The services include provision of care to HIV/Aids orphans and vulnerable children, HIV/Aids counselling services, group therapy for people living with HIV/Aids, behaviour change programmes for youth groups and voluntary counselling and testing (VCT) for community members.

The organisation is situated in an urban high-density residential area in Ngwenya, Area 24 near a huge stone breaking industry. As a location, Area 24 is characterized by a multiplicity of ethnic groups among which are Chewa, Yao and Tumbuka with their varying sub cultures. This diversity is also registered in their religious affiliations, the dominant being Christians of varying denominational groupings and Muslims. Outside their religious activities, Christians and Muslims in this area, and in Malawi in general, have calm relationships and interact well as noted by the Friends of Malawi (FOM) article on religion that 'conflicts between Christians and Muslims are rare in Malawi; when they do erupt, as it occurred in mid-2003, it is usually politically motivated'.[6] With regard to their social-economic lives, the majority of

[6] http://www.friendsofmalawi.org/learn_about_malawi/culture/religion.html.

the people are unemployed with a few earning their living as physical labour workers and small-scale entrepreneurs.

3.2. Paradiso HIV/Aids Support Organisation

The organisation started in 2003 as a response to the high levels of stigma and discrimination against HIV-positive people and their families in the community. I interviewed the Executive Director and founder of the organisation to learn more on how the organisation came to be and the reasons for establishing it. The following is her account:

> *The idea of Paradiso emanated from the stigma and discrimination I suffered when I was diagnosed with HIV*[7]*. I faced discrimination from all angles; my family, community and at work where I was dismissed immediately after I disclosed my HIV status to the boss. The discrimination got so bad that I started fearing for my children more than I worried about myself. I didn't know what would happen to them if I died. I knew my children would be stigmatized because I had seen it happen to others and this prompted me to think of how I could try to change this situation before I died. One day I decided to talk to other women who I used to meet at the hospital where we were all getting our treatment. These women expressed similar fears for their families and from our discussions, the idea of a support group originated.*
>
> *We then mobilized a group of surrounding chiefs and told them about the problems we were facing in the community and our plans. The chiefs were so supportive of what we were proposing. They knew how bad the situation was in their communities but they did not know how to intervene. We held community activities where we taught people about HIV/Aids and how they could not contract HIV by simply interacting with an HIV-positive person. For guardians of the Aids patients we taught them how they could protect themselves by following certain procedures. We partnered with the chiefs because they knew about all the sick people in their communities. Their information would help us to know who to visit and offer support on how they could help the patient. Soon people came to know about us and our clientele started to grow.*
>
> *As our client population grew, and so were the needs that we had to address. We were no longer just a group that was sensitizing the community against stigma and discrimination. People started coming to us with all sorts of HIV/Aids related problems. For instance, the orphaned children of our clients started coming to the office seeking assistance and we could not ignore them, so we started a children's programme. Later on when the number of children grew, others became older so we could not meet their needs in one group with the younger ones. This led to the establishment of a youth programme and thus how we came to be a community organisation* (Interview with Paradiso's Executive Director July 4 2008, Lilongwe)

[7] She has come out in the public about her HIV status.

Compared to the history of many HIV/Aids oriented organisations, Paradiso follows a very simple but critical rule. For instance, the organisation arose from the communities' need to address stigma and discrimination. This has remained the pattern for the organisation where each programme is inspired by, and is a direct response to the specific needs, identified and experienced by the people. As long as those needs persist and others arise, the organisation develops and is appreciated by the people. Stated from another angle, there is no doubt about the organisations relevance to the clients, individually and collectively. No campaigns or programmes are implemented merely because they are congruent with the wider HIV/Aids movement. Thus, the people's needs furnish the organisation with intrinsic mechanisms for sustainability. Intransience for this organisation is not enforced by outside forces but spurts from within, from the people's latent needs.

In terms of structure, the organisation has a management team of three people, the Executive Director, Project Coordinator and Administrator who together with the rest of their community-based task force work on volunteer basis.

3.3. Group Therapy Formation

Starting with an overall look at the field of group therapy, it is considered a new discipline within the broader framework of psychotherapy and is primarily thought of as an offshoot of individual therapy. It focuses on interpersonal relationships and the curative qualities that are said to be experienced as the individual interacts with the therapist and other group members. Writing on the subject, Earley stipulates that though group therapy was mostly seen as a second rate form of treatment, the discipline has gained more momentum over the years and 'has become a powerful treatment modality in its own right' (1999:1). He further writes on the two categories of group therapy; the general purpose and the problem-focused group. Based on his classifications, problem-focused groups tend to deal with specific populations and specific issues like sexual abuse, bereavement and Aids while general purpose deal with a wide range of issues (1999:2). Narrowing down to the sub-categories, self-help groups have emerged as an important subsidiary to problem-focused groups, even though they are not categorized as psychotherapy groups because they are not led by professional therapists.

In response to the growing HIV/Aids challenge in Malawi and many parts of Africa, numerous self-help groups have surfaced through the HIV/Aids support groups and organisations with the intention of helping one another to cope with the many challenges

associated with the disease. According to the above stipulated criteria, many of these groups fall outside the parameters of psychotherapy because, they are neither led by group therapists nor do they utilize the clinical practice guidelines. However, it would be inaccurate to conclude that they do not engender therapeutic aspects. Such an assumption would require more pragmatic evidence to verify whether the absence of a trained therapist adulterate the therapeutic elements inherent in group interaction.

The Paradiso group therapy[8] started in 2006. It has a population of about 103 members, the majority of whom are women. The age bracket of the group therapy members ranges from the 20s to late 60s. The group is open to all people living with HIV/Aids in the community and attendance is on individual discretion. But on average, there are 20 people meeting every week on Friday from 9-11 am.

The group therapy sessions are facilitated interchangeably by the Project Coordinator, who took both the sessions I observed, and the Administrator. Both the Project Coordinator and the Administrator are founding volunteer members of the organisation. They have no specific training in psychotherapy, psychology or theatre, but have accumulated vast knowledge on HIV/Aids through numerous readings, trainings and working with HIV-positive people.

Explaining the origin of the group therapy, the Executive Director said:

> *In the process of helping people, we became involved in home-based care, providing support and information to the sick and guardians. After getting better, most of them did not know what to do or relate to the larger community. Hence, some started coming to my house to pass time. Sometimes, more than five people would converge at my house, even when I was not there, they would sit there, chat with one another, watch TV and leave late in the afternoon. This became a trend and I soon realized that there was something that was missing. I understood that though most of them were feeling better, they were not strong enough to work and that they were also dealing with issues of stigma and discrimination and somehow my home was like a safe haven for them. However, I could not let them continue meeting at my house, we had to find a place where they could meet.*
>
> *Later, when we were given an office space through the chiefs, we set the lounge for people to come and spend some time with friends, we also bought a TV for them to watch programmes they liked and to watch HIV/Aids programmes. After a while, we realized that a lot of our clients were lacking information on how they could take care*

[8] Though this group is not led by a therapist in a clinical context, I will still use the term group therapy because that is what it is called.

of themselves for instance, what foods to eat, what to do when they feel sick and general knowledge about positive living. So instead of just coming to the office to chat and watch TV, we decided on having group discussions and our clients also started bringing in topics and issues they wanted discussed.

That is the basis of our group therapy, to share information, we don't know whether it is the right thing to call it group therapy but that's the name we use (ibid).

The group was theoretically formed to share information. Although there is no direct mention of using their group gatherings to achieve therapeutic goals, the need for it is explicit in most of the processes carried out. From their session's structure provided below, it is clear that the group tries to take advantage of these gatherings to also address their anxieties and fears of living with HIV/Aids. Thus, instead of having one main activity which deals with information provision, they have also incorporated another major section which deals with their personal worries. When asked on why they joined the group therapy, many participants related to this section, as exemplified by this participant's comment;

'Tikabwera kuno timatha kukambirana za nkhawa zathu momasuka'.

'When we are here, we are able to talk about our deep worries'.

3.4. Structure of the Group Therapy Sessions

The normal structure for their sessions is as follows:

- Opening prayer
- Singing of choruses
- Preaching of the word of God
- Recap of the previous topic
- The day's topic
- Sharing and discussion of worries
- Closing prayer
- Drama rehearsals (Drama is not used as part of their group therapy methods but they use it as a communication tool in their community outreach activities. This does not

involve every member of the group therapy and those willing meet sometimes to rehearse after the group therapy sessions)

3.5. Research Methodology

This study used a case study approach in grappling with the question of 'how drama can be used as a therapeutic tool to enhance the emotional rehabilitation of people living with HIV/Aids'. This segment explains the methods and decisions that were adopted in designing overall research procedures in the effort of answering the question.

The study falls within the qualitative research approach. According to Gordon and Langmaid (in Holibar *et al* 1994:54), qualitative research 'is concerned with understanding things rather than measuring them'. Webb (1993:112) also argues that:

> Qualitative research is mainly used for answering 'how' 'why' and 'what' questions. It is not used for 'how many' questions, that is the provenance of the quantitative research schools of thought.

Rossman and Rallis (in Marshal and Rossman 2006:2) further elaborate on the characteristics of qualitative research paradigm. They identify that qualitative research is (a) 'naturalistic', meaning that it studies things in their natural surroundings, (b) 'draws on multiple methods that respect the humanity of participants in the study'. This means that qualitative research recognises the wealth and complexity of people's stories and lived experiences which locates them as knowing beings and not just objects of study (c) 'focuses on context', meaning it recognises that human beings do not exist in a vacuum but rather, are part of an intricate system that influence their conceptions and perceptions, (d) is emergent and evolving, denoting that peoples life stories and experiences are never static but constantly changing and developing and (e) 'is fundamentally interpretive', implying that it endeavours to decode, to read happenings in light of the meanings that people attach to them.

Thus, the qualitative research approach follows specific principles where the researcher gains insight into people's lives, attitudes, behaviours and experiences using transparent and non-intrusive methods that value the researched as perceptive and varied beings. The approach respects people's stories and experiences told using their own voice within their settings. This approach was therefore deemed suitable for the research bearing in mind that the study's objective was to explore the expression of painful experiences in the pursuit of rehabilitation.

There are different types of qualitative research including action research, case study ethnography and evaluation which often intersect. This study used a case study approach essentially for its ability to provide illumination to difficult and complicated issues involving people's livelihood. O'Toole (2006:44) delineates that case study is:

> Where we examine some phenomenon by identifying, then observing and documenting a 'typical' or an 'untypical' or 'deviant' example, and then analyze the data, looking for its special characteristics.

Writing on the same, Yin (1984:23) describes the case study research approach as:

> An empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used.

Commenting on its attributes, Soy (1997) notes that case studies emphasize detailed contextual analysis of a limited number of events or conditions and their relationships. However, this research engaged with one case study because the intention was to maintain as much depth of analysis as possible and also because the focus of the research question lay not in the case study *per se*, but on exploring the drama processes that would bring about emotional rehabilitation to those experiencing traumatising situations. The question of multiplicity was therefore grappled with in light of the number of the drama elements and processes that this investigation was going to work with. Since the concern was on stimulating sincere exploration of traumatising emotions, the study placed itself firmly in dramatic expressive forms that encourage both verbal and non verbal expressivity and reflection through fictional story narration, image theatre, sculpting, role playing and improvisation.

Carroll (in O'Toole 2006:46) contends that the case study approach is actually useful to drama research because it 'honours the agency of participants and positions them as experts rather than merely a source of data analysis'. He further emphasises that the approach becomes even more valuable if the researcher is engrossed in all the research procedures and its product. However, this is possible only if the researcher is 'operating from inside the group using dramatic role conventions (Neelands in Taylor, 1996:77) that help to frame the constructed world of the drama' (Carroll in Taylor, 1996:77).

This assertion links us to the aspect of researcher positioning within a research project. The nature of this enquiry prompted me to reflect on the research paradigms the study was going to adopt based on questions raised by Carroll (in Taylor 1996:77); 'what is my relationship with the subjects of my research and where am I standing to conduct it?' The research processes were divided into three major phases; first, the observation phase, second, the drama-based workshop planning phase and third, the drama-based workshop implementation phase. In the meantime, the discussion is interested in elucidating the positions that the researcher assumed in the actual research processes of phase one and phase three where the researcher had direct contact with the researched.

During the observation phase, the researcher in this study assumed a position that is rooted in the interpretive paradigm to investigate the groups approach to therapy. This world view perceives reality as subjective and places the researcher on the outside of the group being researched. The researcher does not partake in what the subjects are undertaking but is detached and observes from an outer circle where her task is to 'interpret and understand the meanings that [are] operating within the group being researched' (Carroll in Taylor 1996:75). Here, the researcher is allegorically perceived to be in an all-knowing position like that of a 'god' and its key feature is description.

In the third phase where the principal activity was to experiment the drama techniques with the group therapy members, the researcher assumed a more involved role of researcher-facilitator. I, as the researcher, sometimes assumed a role of researcher-participant because I would participate in the activities, hence researching, observing and experiencing things from inside. This kind of positioning is more related to the critical theory paradigm which believes that reality is neither objective as understood by the positivist paradigm, nor purely subjective as perpetrated by interactivists but 'a complex combination of both perspectives' (Carroll in Taylor 1996:76).

In this phase, I, the researcher and facilitator worked collaboratively with the group therapy members where our mutual interest was making meaningful sense of our experiences on the inside of the dramatic worlds. This practice resonates strongly with a practice called reflective practitioner research. It is a dominant approach in education and the arts where teachers or researchers of drama based education consciously reflect to improve their own practice. O'Toole (2006:57) describes reflective practitioner research as follows:

> (...) means starting with 'me', the teacher. I observe myself to refine my own perceptions of what is happening in my classroom, how I am dealing with it, and indeed what are the problems that I perceive which may need addressing, rather than looking at the problems of an artist, a teacher or a classroom from outside, with a view to solving them.

Though the intent of this study was far removed from classroom activities and from developing my facilitation skills, the feature helped me to reflect on the processes and activities that were happening in the sessions as well as afterwards and how my facilitation inspired or uninspired responses and participation. Moreover, the aspect enabled me to exercise in-action reflection, which was vital to the reshaping of activities and sustenance of an exploratory atmosphere in the workshops. Furthermore, the process proved valuable in the sense that I was able to encounter the power of each dramatic element as I maintained my roles of researcher, facilitator and participant. Not only was I able to observe but was simultaneously part of the felt and lived experiences of the created fantasy worlds. I not only observed if something was not working, but experienced how it failed and decided on alternative processes within the framework of the work.

Again, taking part in the group activities strengthened the parity of our roles; I and the participants became partners in search of the elements that would enhance emotional expressivity. They observed me and I observed them and we all observed our individual selves and made comments about our experiences. With regard to my method of collecting data within the experience, the group therapy facilitators were part of the sessions and they provided feedback on how they experienced the workshops and commented on both the facilitation and how they observed the responses from the group members. Their feedbacks were insightful and helpful for comparison purposes, in the sense that they knew the group members and would, therefore, recognise any differences in their engagement.

As it was highlighted earlier, the forms of qualitative research usually tend to overlap and the case study approach in this study intersected with that of action research. This was in specific reference to the drama-based workshop implementation phase where the pre-occupation was on researching into the dramatic elements that would be valuable in enhancing emotional rehabilitation. What was appealing about this research method is its intrinsic exploratory nature, the trial and error aspect and its subsequent suppleness to allow for re-planning of workshop procedures, re-designing of dramatic activities and techniques in response to ensuing needs.

3.6. Data Collection and Analysis

In terms of data collection, the research utilized a number of methods including interviews, focus group discussions, observation, daily workshop entries, video recording, and daily workshop reflections with the group and with Paradiso group therapy facilitators. Data collection tools like interviews, focus group discussions and observation were employed largely in the first phase where the concern was to understand the background of the organisation, how the group therapy came to be and comprehend the approach used in the group therapy sessions.

Daily entries, group reflections and video recording were used mostly in the third phase when I was workshopping the process-orientated drama elements with group members. The entries contained records of each day's activities, experiences and reflections on what I anticipated for the day and later chronicled what transpired. The journaling of thoughts on ended workshops guided the beginning of the data analysis exercise. As the prepared process-orientated drama elements were put to test in the sessions, I became pre-occupied with determining which techniques had the greatest impression. I looked for methods that led to considerable connection and expression of emotion, reflection and analysis of inner conflicts. The expression of inner feelings was not only analysed in terms of verbal articulation, but rather, looked at all forms of expression including the embodied and enacted. The concern was to identify the dramatic processes that facilitated participant's accessibility to their personal complexities, elements that brought insight to their life experiences, those that shifted or had the potential of shifting their relationship to their inner problems. By and large, the utility of a process-orientated dramatic element was ascertained by the richness and sincerity of the discussions, reflections and questions it generated for the group and individual members and was discussed in light of engendered themes.

At the beginning of this chapter we looked at how and why the Paradiso HIV/Aids Support Organisation as well as the group therapy started. The next chapter will take the discussion further and analyse the approaches used in addressing the needs of group therapy members.

CHAPTER FOUR

4.0. Introduction

This chapter draws from the first phase of the research process where I observed two group therapy sessions by Paradiso group therapy. Part of the data collected in this phase has been discussed in Chapter Three where I was looking at how the organisation and the group therapy itself came into being. This chapter focuses on observations of how the group therapy sessions are conducted. It provides a detailed thematic account and analysis of what transpired in the two sessions that were observed and in the process, identify where their methodological gaps existed. Comprehending these aspects is crucial because they provide the basis upon which the process-orientated drama methodology was developed and later sampled with Paradiso group therapy members.

4.1. Space and Space Conventions

Space and how it is arranged says a lot about what is valuable for the people who meet in it. How space is arranged and treated also has an effect on how people do what they have come to do in it. Furthermore, the arrangement and treatment of space creates an atmosphere that either encourages or discourages the achievement of their mission. Because space has all these powerful potentials, many people responsible for running them set conventions that guide the users on how to behave while in that space. This is to ensure that a specific desirable ambience is maintained. All of these aspects are particularly relevant for theme-centred groups, drama therapy and theatre groups.

Analysing the Paradiso group therapy space and its conventions, I observed that it was one of the neglected aspects of the group and that it had an impact on the quality of their sessions. The first session observed was held in a TV room because there was another function happening in their usual space. In the second week, the session was held in the small hall that they normally use. In the first observation, there was no specific design to the sitting arrangement, the facilitator sat on a couch that was placed right in the centre of what could have been a circle. In so doing, he divided the little room into two sections and placed some members behind him where he could neither see nor respond to what they were doing. In the second observation, the space was arranged using a classroom set up. All the group leaders

like the chairman and other committee members were placed in front but the facilitator took the centre stage in front.

What was also interesting was how both these spaces were treated by the group members. On both occasions, many participants arrived while the sessions were already in progress. Those inside had the liberty of walking out and back in, some participants picked up phone calls while others had mini-meetings within the sessions. There seemed to be no one responsible for mobilizing and controlling people and the facilitator displayed neither consciousness nor concern that the group's behaviour was compromising the quality of their interactions. The unconcerned attitude by the facilitator was fuelled more by his unawareness of the importance of setting space in a specific way and the values that space would encourage.

Nonetheless, the manner in which the group treated the space was destructive and it disturbed the flow and concentration of the group. The group lacked strategic and skilled management. Beyond that, these undertakings communicated clearly what was valuable and not valuable to the group. For instance, lack of a circular sitting arrangement means that there was not even the visual indication that group interaction, hearing and seeing every member of the group were considered of much importance. Costin (2007:167) emphasises the value of such a sitting arrangement when she writes that 'group therapy is an opportunity for people to sit in a circle with others and be fully present, listen attentively, practice empathy and attunement, and tell the truth without judgment'. All these group therapy principles were vividly absent in the group. Instead, the positioning of the facilitator in front gave a visual indication that what was important in this group was for everyone to see, hear and communicate directly with the facilitator and not with one another. This is what was observed throughout the sessions as group members tended to interact more with the facilitator than with fellow group members.

Such an environment stifles progress and possibilities of growth as it cultivates a spirit of dependence on the leader. It creates a traditional teacher-student type of relationship which carries the assumption that participants have nothing to learn from one another. Process-orientated drama, through its collaborative nature, would challenge this way of doing things and help the group to create an environment where they could take advantage of the group dynamics and all the healing potentials inherent in group interaction. It would help the group to negotiate power between the facilitator and the rest of the group and cultivate a spirit

where problems are shared and owned by the whole group rather than presented to the facilitator.

4.2. The Ritual of Prayer

Prayers form an important part of the group's session activities. It is the first thing that they do when they meet and has the following order: opening prayer, singing of choruses, reading of scripture, preaching and finally closing with another prayer.

Leading of prayers is open to willing group members and since the group therapy is comprised of people from various religious groups, the spiritual sessions are open to any kind of spiritual exhortations, be it Christian, Islamic or any other.

What was important and interesting to witness from this section was what they said by the songs they chose to sing and the verses they chose to preach about. Apart from offering praise and thanksgiving to a higher power, songs and sermons, generally say a great deal about people's conditions. They form a powerful tool for expressing the realities of their situations and the deep wishes they hold as they go through those struggles. Writing on the place of music in the slavery struggle, DuBois (in Katz 1979: xx) says:

> Little of beauty has America given the world save the rude grandeur God himself stamped on her bosom; the human spirit in this new world has expressed itself in vigour and ingenuity rather than in beauty. And so by fateful chance the Negro folk song—the rhythmic cry of the slave—stands today not simply as the sole American music, but as the most beautiful expression of human experience born this side of the seas.

Likewise, songs played a major role in the struggle against apartheid in South Africa; it was one element that united and expressed the intensity of the oppression faced by blacks and poor communities. In these sessions, songs carried similar undertones, a rich subtext that spoke of the magnitude of their daily struggles of living with HIV/Aids. One song that was even dramatized is called '*katundu wam'muntima'* which talks of someone who is heavily burdened and is being asked to lay everything on Jesus. The preaching which was based on the beatitudes from Mathew 5: 3-11 spoke more to their hopes, to their deepest desires for comfort and rest from pain and suffering.

While all this is important, a danger exists in such rituals as sometimes, they tend to place the person outside the problem, make him/her a spectator and not a spect-actor of a problem they

believe they can do nothing about. Without undermining the power that this ritual has on the group, process-orientated drama would help participants to harness their inherent capabilities for dealing with oppressive conditions. It would provide a framework through which group members could begin to explore alternatives for addressing the problems expressed in the songs and develop skills and means of attaining the desires they dearly hold.

4.3. Group Facilitation

Inferring from the two observations, the emphasis of the group facilitation was on teaching and imparting information on topics that were relevant to the health of the group members. For instance, the first session tackled the theme of nutrition where participants were taught of the six groups of food and the importance of eating enough of the right food. They also looked at some of the local dishes falling within each food category and how they could prepare them properly. The following week was dedicated to pneumonia, to helping participants understand what causes pneumonia and how they could treat it using both clinical and local remedies

It must be noted that giving out information forms an essential part of many theme-centred group therapies where it helps to increase participants' understanding of the particular problem they are dealing with. In the HIV/Aids context where the disease and its medications are complex, this activity becomes even more relevant in enabling people to take care of themselves.

However, the problem observed was the lack of balance between information giving and exploration of individual issues, between intellectual understanding and emotional learning. It was established in Chapter Three that many participants joined the group therapy because it was the only place where they could talk about their deep worries. But unfortunately, the structure in use did not encourage them to explore their concerns, process and deconstruct their feelings deeply. To elucidate this claim, we will analyse one of the problems that was shared in the second session, how it was dealt with and the solution that was offered.

> Problem: *My son who is staying with his uncle (the husband's brother) called yesterday complaining that he is not being treated well. He was crying and needed to come back home. My dilemma is that my husband's brother insists that I leave him there and that he will sort out things with his wife whom he suspects is ill-treating my child, but I feel so helpless because I don't know whether I should listen to him or should just go and get my child back?*

> Solution: *The group advised her to leave her son with his uncle seeing that he was about to write his junior certificate exams. The group thought transferring him at this critical stage would only interfere with his studies.*

What is apparent from how this problem was handled is how the group failed to dig deeper into what might have been the real cause of this participant's dilemma. It would have been interesting to find out what was stopping her from following her 'gut feeling' in getting her son back. Why was she feeling helpless about it? Was it because she is HIV-positive and that made her feel incapable of looking after her son? Was she afraid that, maybe, if the son came back, he would find out that she was living with Aids? What were the internal words to what she was communicating? Though the solution was reasonable for the educational purposes of the child, the facilitation did not challenge the participant to grapple with her deepest fears. More detailed questioning would have deepened the participant's self-understanding and allowed her to explore the impact that such unprocessed fears could have on her health.

Another participant who also presented her problem in the same session makes a clear link of how such unprocessed traumatic situations impact on one's health and demonstrates why it is necessary for such complexities to be addressed. She said:

> *My sister is pregnant but the man responsible is not doing anything to help me with her upkeep. Every time we take her to his place, he negotiates for more time and now I am tired of looking after her. I don't have much myself and I can't afford to look after a pregnancy anymore. My weight has really gone down for these past few months because I am constantly thinking of what will happen if the baby comes*? (Case study notes 4 July 2008).

These are the finer details that process-orientated drama would engage with, helping participants to gaze deeply into what they experience, try to interrogate why the situations in their lives make them feel the way they do and in the process, develop a profound sense of self-awareness and psychological growth.

But despite the lack of a clearly defined structure to engage participants in an exploration of inner conflicts, some claimed to have attained emotional healing and they attributed it to knowledge. We see this from one participant who when commenting on how group therapy had benefited her, said:

> *I knew I was HIV-positive but I had no idea what positive living was about and because of that I lost my child who was also positive because I didn't know how to take care of him. Looking at my own situation, even when I started taking ARVs, I still*

> *felt that something was missing. I was going to the hospital as required but deep down I felt that something was missing and now I know that I wanted someone to talk to, someone who could really understand my problems. I know that's what I was missing because after I joined this group, I don't have that feeling anymore and I know that if I had the knowledge that I have gained from the group now, my child would not have died, I could have known how to take care of him. So for me, knowledge is treatment and that's what we get here* (Case study notes 4 July 2008).

This assertion was also echoed by several other participants. This is a demonstration of how the group members are unable to distinguish between what is an emotional need and an intellectual deficiency. Since they cannot tell them apart, they are also unable to recognise what aspect led to the change they feel. While I identify that knowledge is absolutely crucial, I would not completely attribute her emotional adjustment to it, rather to the power of the group, to a strong sense of belonging and fitting in. By joining the group, she became part of a larger community experiencing a common problem. Sometimes, seeing others dealing with a similar problem and recognising that one is not alone can be a source of emotional relief. These are some of the benefits of belonging to a group but by themselves are not enough to engender emotional growth and increase one's ability to solve personal problems. There still remains a need to go deeper and longer to where the source of the problem lies. The process-orientated drama methodology is that vehicle that would take participants into introspection. It is the methodology that would help brainstorm and practice creative ways through which to handle painful situations and re-invent the themes to live by.

Analysing the notion of data acquisition as treatment revealed why the group has such a didactic approach to therapy. It finally clarified the classroom style of dealing with situations and why more priority was given to generic activities that required cognitive processing. It made it clear why the exploration of specific, felt experiences were subdued and why there were no efforts to incorporate those members who were extremely distanced from the group discussions. For instance, there was one woman who was very quiet throughout the first observation session. She sat parallel to the facilitator and looked sad and lost into a different world. No one made an attempt to talk to her or find out what was troubling her. I wanted to have a separate conversation with her after the session, but she left just as the others were preparing for the drama rehearsals.

On another level, what the participant's commentary also did was to confirm that there is a need among people living with HIV/Aids to talk. This is not mere conversation, but a need to

seriously process and understand the meaning of HIV/Aids in their lives. For instance, what does it mean for them in the short and long term? What will their health living require them to relinquish or adopt? And, what does being HIV-positive mean for their family, social and even sexual lives? These are all complex questions that many people living with HIV/Aids grapple with.

In my assessment, process-orientated drama elements like dramatic projection and dramatic distance (see Chapter Two) would provide a structured framework through which group members could practically process such dilemmas. To use the analogy of surgery, both dramatic distance and dramatic projection are processes that would allow participants to practically operate on their difficult situations. But unlike a surgeon who operates and treats another person's problem, these dramatic processes would enable participants to externalize and objectively treat their life 'tumours'. Hence, they would examine them, remove or change the 'cancerous' substance and see how their new condition would add value to their lives. Depending on the magnitude of the problem, this can be a long, complex and painful process, but possible and bearable if done in a safe and supportive environment.

Thus, unlike talking, this process would go a long way in helping people to acknowledge the problems they have and develop meanings and a deepened understanding of their situations. The process has the ability of drawing people into self-reflection, self-discovery and would also help them develop perspective as they examine their situations from various points of views.

Another aspect that the group facilitation focused on demonstrated the group's adherence to what MacLachlan and Carr (1994:45) refer to as tropical tolerance. They define this as 'a dual or synchronised belief in both modern medical and traditional epidemiological explanations and forms of health service' (ibid). This was evidenced in the session when after narrating the medical causes and treatments for pneumonia, the facilitator also led the group into a discussion of indigenous remedies that the group members could alternatively use.

The duality of beliefs was also seen on the spiritual level where group members use the word of God/Allah and prayers to access celestial revelations for their situations. But regardless of their specific religious commitments, they also access modern medical and traditional healing modalities. Commenting on this integrated approach to healing, Rudnick (2002:182) states that:

> In essence, healthcare works best when it can draw on the best of everything. It is virtually impossible to isolate all the variables in healthcare, but amongst the variables that matter are sure to be a combination of medicines, talking, relationships, body, mind and spirit. On one level, it seems limiting to place restrictions on how any healing should operate. The criteria of having to have scientific and rational explanations for healing only serve to restrict the efficacy.

This assertion and the group's attitude towards healing confirm this study's argument that HIV/Aids is complex and requires integrated treatment modalities. Furthermore, Rudnick's affirmation opens up many opportunities for process-orientated drama to play its therapeutic role in the group without conflicting with other treatment procedures. As he has stipulated, this is possible because the different treatment paradigms do not contest, but rather provide the group with a comprehensive model for healing.

Apart from these features, it was also observed that unlike clinical psychotherapy, this programme's design is based on common sense more than on explicit formal theories or principles. As highlighted in Chapter Three, the organisation comes from a background where projects are developed based on the identified needs of the people and usually responds instinctively with strategies that best serve them. To put the matter into context, the organisation does not have all the professional and erudite paraphernalia to construct sophisticated and highly technical interventions apart from devising something that seems to work for them. This instigates one of the heated debates of all times in as far as the designing of behaviour change programmes are concerned.

The question is whether theoretically-informed programmes are more superior and effective than those that are not. Several scholars have grappled with this question and a dichotomy of thoughts has emerged (Eccles and Grimshaw 1999), (Doug *et al* 2006). On the one hand, there are those who favour conceptualisation based on cognitive theory and on the other hand, there are others who advocate for inclusive approaches because they believe in the multiplicity of theories, some of which are formal and informal and see no reason why one should be accorded prominence. They argue that:

> Many formal theories and concepts in the field of psychology had already been described recognizably using lay terms and ideas, suggesting that these ideas are accessible without theories (Bhattacharyya *et al* 2006).

They further claim that:

> Until there is empirical evidence that interventions designed using theories are generally superior in impact on behaviour choice to interventions not so designed, the choice to use or not use formal theory in implementation research should remain a personal judgment (ibid).

Clearly, this is an incessant debate that on a broader scale seems to question whether theory and practice should be separated or not. Like Taylor (2000), my view is that there must always be a blend of theory and practice informing and affirming each another. Taylor, through his notion of praxis, advocates for the amalgamation of theory and practice and a perception of these aspects ' (...) as a part of a complex dynamic encounter' (2000:5). Without theoretical underpinnings, the programme would have no support, no point of reference, no guiding force and may struggle to grow and achieve.

Again, when it comes to programmes like group therapy or group facilitation in general, their success is not only determined by theory but also by those elements of leadership and skilled interventions. This leads us to the role of the facilitator in the Paradiso group therapy.

4.4. The Role of a Facilitator

Outside the group therapy sessions, the facilitators have leadership roles within the organisation, both as Project Coordinator and Administrator. Within those roles, they provide advice to most members of their organisation and this greatly influences their orientation to leading the group therapy. The sessions I observed were conducted by the Project Coordinator and the duality of his roles were reflected in where he sat and how his word was positioned in relation to everyone else's. There was a tendency for these two roles to overlap and besides teaching on a particular topic; his leadership and advisory roles would surface in his attempts to make suggestions to solutions.

Failure to separate the roles and the fact that the group does not have any theoretical orientation led the facilitator to dominate the sessions. He did little to encourage participants to question and listen to one another. As such, there was little interaction between group members. It was also observed that comments were directed to the facilitator who did not redirect them back to the group to develop group relations and also to encourage participants to share their personal knowledge. This was defeating the whole essence of group therapy whose very power lies in group interaction, in developing relationships with one another and using those interactions to grow. It was further observed that the facilitator's words were

more privileged, were considered absolute truth and could not be challenged. This perpetrated the traditional learning method that Freire (1970) criticised in the banking concept of education instead of creating space for experiential learning by the whole person. Like many classroom setups, the approach deprived participants of their ability to question, challenge notions, and think for themselves. Like in the surgery analogy, the participants became immobilized patients unable to operate on their 'tumours' and therefore, totally dependent on the surgeon.

A process–orientated drama methodology would alter this approach as it thrives on negotiated and voluntary learning. It acknowledges that participant's involvement and knowledge are critical factors for the success of any learning venture. Neelands stipulates that these are vital because they broaden both the teacher/facilitator and the student's horizons. They help participants to 'see their existing experience of the world as valid and useful resources for further learning' and also help them to 'discover their own voices and how to use them for their own purposes in a rich variety of situations' (1984:24). It is only through this process that individuals would be able to attain growth and learn to solve problems that impinge them.

4.5. Facilitation Methods

In terms of facilitation methods, it was established that the group uses a very basic group discussion model to achieve a conventional level of interaction. To start with, the use of discussion as a sole method presents the group with only one form of expression. This is problematic because HIV/Aids is a sensitive issue and some people would rather conceal the truth than openly discuss their private feelings or sex lives for that matter. Wilde (in Emunah 1994:7) writes that 'Man is least himself when he talks in his own person, give him a mask and he will tell the truth'. This saying has proved to be true in many instances and would probably be an invaluable mode of working particularly in this group therapy where everyone knows everyone. It is inevitable that people would be uncomfortable talking about themselves because there are always 'unaccepted' parts of the self that, if found out, would destroy the pleasant and domesticated social identity people usually exhibit. In such a scenario, drama and its elements of role and character present an advantageous alternative that is 'both protective and liberating, enabling the expression of what lies buried beneath our real-life roles' (Emunah 1994:7). In the same vein, Goffman (in Emunah 1994:7) affirms this

trend of thought by saying that, 'given the dangers of expression...a disguise may function not so much as a way of concealing something as a way of revealing as much of it as can be tolerated in an encounter'.

Apart from being limited by the fact that it offers participants a single form of expression, the manner in which the facilitator also applied it was restrictive. At best, the model was used to relay information to the group members. Thereafter, the facilitator would pose questions to gauge if absorption had occurred and participants would regurgitate what was taught. As such, their responses were nothing short of the HIV/Aids rhetoric. Their answers were harmonised and mundane as if scripted. They lacked the nuanced personal fibre and forced participants to relinquish their individual, practical and embodied experiences and knowledges generated from the 'ground level, in the thick of things' as Conquergood (in Bial 2004) suggests. Metaphorically, it could be argued that this model slaughters the participant's inner voices and perspective.

These are some of the reasons mitigating the need to use process-orientated drama in such sessions. This is so because with drama, one draws from their creative talent and with creativity comes diversity. By encouraging diversity, participants are then persuaded to draw from their intimate experiences, analyse and represent their situations from various perspectives. With process-orientated drama, participants are liberated to tell their own stories and the pressures to recycle information is minimised as they work in an exploratory frame where they encounter, experience and interpret things spontaneously.

Bowell and Heap (2001:2) adequately summarise the opportunities that process-orientated drama would offer for such a group. They recognise that:

> Drama is empowering. Through the unique process of 'enactment', its diversity of form stimulates creativity and imagination, aesthetic sensitivity and fulfilment. Drama provides opportunities for investigation and reflection, for celebration and challenge. It is a potent means for collaboration and communication which can change the ways people feel, think and behave. By its combination of the affective and the effective, it sharpens perception, enables personal expression and the growth of intellectual and emotional literacy. It provides a framework for exploration of ideas and feelings and the making of meaning.

In addition, process-orientated drama acknowledges the complexities of life and people's experiences. It therefore encourages facilitators to develop a certain style of listening and non-judgmental probing that steers people to search deeply into their situations. Freedman

and Combs (1996) refer to this method as deconstructive listening and deconstructive questioning. These elements help facilitators to deepen and modify discussions from mere oral communications to meaningful procedures capable of shifting people's narratives and perspectives. They define deconstructive listening as:

> (...) a special kind of listening required for accepting and understanding people's stories without reifying or intensifying the powerless, painful, and pathological aspects of those stories (Freedman and Combs 1996:46).

They describe deconstructive questioning as a process that:

> (…) invites people to see their stories from different perspectives, to notice how they are constructed (or that they are constructed), to notice their limits, and to discover that there are other possible narratives (in Freedman and Combs 1996:57).

This way of engaging in discussion would have a far more reaching influence on the Paradiso group therapy members, particularly when we consider the way HIV/Aids was presented right from the beginning. It was conveyed as an enemy, and an enemy is always an outsider, external from the individual. If the enemy is deemed lethal and also associated to immorality, as HIV/Aids was, then, the natural response is fear, fight or flight and shame. However, after two decades, we are now clearly aware that HIV/Aids is not an external adversary that people have to fight against, but an internal condition that becomes part of their lives. In this regard, process-orientated drama would help participants to engage with various HIV/Aids narratives and help them deconstruct thin descriptions that fail to acknowledge changes.

For example, it was interesting to observe the kind of representations that the group was portraying for people living with HIV/Aids. I witnessed this in the first session of observation when the group was rehearsing for their community outreach programme. They rehearsed two sketches, one on a married man and woman who were both taking Anti Retroviral (ARV) medication in secret and the other one about a woman who slept with a man who sells charcoal after failing to clear her debit. Apart from the messages that they were trying to convey, what was captivating was how the group represented the HIV-positive characters in the plays. They created 'stereotypical' images of ailing and dying figures and their body language spoke of nothing but helplessness and humiliation. The word stereotypical is used consciously because those images could be read on two levels. It might be that the group was instinctively communicating the way HIV/Aids made them feel, i.e. vulnerable, ashamed and guilty, or it was mechanically reinforcing the old beliefs and common narratives about

HIV/Aids. All of them in the drama sketches were people living with HIV/Aids and none of them looked or behaved close to what they were displaying. The question is, why then were they depicting those self-abasing images? Why were they labelling and stigmatizing themselves in that manner?

One of the claims of this study is that used as a therapeutic tool, process-oriented drama would play a vital role in challenging such personal and social narratives of HIV/Aids. Drama would counter these ingrained HIV/Aids myths as well as the internalised stigmas and stereotypes about HIV/Aids because they are not helpful for people living with HIV/Aids. They interfere with the creation of new and positive narratives which are crucial for health functioning and growth.

With a range of these factors, we have managed to analyze the group's approach and to establish that they use a learning approach that is parallel to most classroom orientations. The approach is facilitator-centred, which drives the group members to the periphery where they exist as unknowing beings to be taught and advised. Again, by sidelining emotional learning and opportunities for active inquiry and experimentation, the approach stifles any possibilities for self-discovery, deepened inner reflection and expression. Though some participants expressed benefits from the existing approach, my argument is that HIV/Aids is complex and the need to deconstruct destructive images of HIV/Aids and to move beyond internalised stigmas requires a more structured approach than what the group has. Furthermore, the need for group members to grapple and fully comprehend the meaning and processes of living with HIV/Aids requires a strategic and skilled intervention that diligently addresses the whole person. Hence, the propositions for a process-orientated drama approach.

CHAPTER FIVE

5.0. Introduction

We have established in Chapter Four that some of the major drawbacks of the Paradiso group therapy approach were a tendency to neglect therapeutic aims in their sessions. Another shortcoming observed was their continued veneration of the facilitator and conceptualisation of HIV/Aids as an external problem to be fought. As established, there is also a legacy of information giving over the exploration of the emotional dimension of living with HIV/Aids. This tendency is problematic because it objectifies and does not personalise HIV/Aids. It reduces the complexities of HIV/Aids to simple topical issues to be learnt. By continuing to use a discussion mode that favours knowledge propagation, the practice downplays the psychological impact of HIV/Aids on the lives of its members and makes assumptions that their emotional difficulties are fuelled by ignorance. Of course, some anxieties are based on irrational beliefs and misinformation, but that does not invalidate those that come purely from their encounter with the disease and its medications.

These limitations offered us with an opportunity to consider a better way forward, a combination of affective and cognitive aims to help group members' deal with the emotional dilemmas of living with HIV/Aids. In light of this, a series of process-orientated drama sessions were devised, where a number of dramatic elements were tried out with members of the group therapy for their healing possibilities. This chapter will, therefore, discuss the process of planning for the process-orientated drama sessions and their implementation. The planning process highlights the conceptual choices that were made in framing the methodology necessary to achieve the desired objectives. On implementation, the chapter provides a detailed thematic analysis of what was engendered from applying the process-orientated drama methodology in the group therapy sessions.

5.1. Planning for the Process-Orientated Drama Workshops

The workshops were to take place over a period of five consecutive days and activities were planned for each day except for the last day, which was left open for issues that would emerge within the week. Below is a brief description of how the workshop planning was done. First, the entire planning process was supervised and done collaboratively with my supervisor. Second, the planning process was guided by the observations that I have made in

the previous chapter. Third, the workshops were planned on the understanding that I would lead the process-orientated drama workshops using the active researcher/facilitator roles. Fourth, since my supervisor could not supervise the actual proceedings of the workshops that took place in Malawi, the arrangement was that I would journal the workshop procedures, my observations and thoughts for each day's workshop and at the end of that day, report back to him and we would discuss and reflect on the material and way forward.

5.2. Conceptual Choices Made for the Workshops

It is important to understand the conceptual choices that were made for the sessions because, it is not just about the drama techniques that were used, but also about how the overall sessions were framed. The context and the techniques had to support each other in order to achieve the intended goals. In this case, the sessions were meant to engender therapeutic outcomes in the context of HIV/Aids. To provide a platform where emotional rehabilitation could be experienced as participants, individually and collectively, engaged with their personal material through dramatic group processes. As such, the following decisions ensured that these aims were met:

5.2.1. Process-Orientated Drama

In drama and theatre sessions, the goal to work with either a process or product-orientated approach depends on what the group wants to achieve. According to O'Neill (1995:xvi), 'process indicates an ongoing event while product implies conclusion, completion and a finished object' which mostly takes the form of a performance. Though process is inherent in the latter approach, the group activities are nonetheless motivated by what they have to put together for presentation, and most likely to an external audience. None of these features characterised our objectives. Our interest was on people and the provision of a safe space they could use to deal with their inner worlds.

5.2.2. Person-Centred Group Approach

Since the primary focus for the sessions was for the people to explore their life experiences, the participants had to be brought to the fore. It was assumed that the participants had inner problems that they wanted addressed and being subjects and knowing beings, they were better placed to address their predicaments rather than someone from outside. This approach to therapy comes from Rodgers (1959) who believed that self-motivation towards learning

and growth is the most important healing factor. This way of framing the sessions was going to help the facilitator to tap into the wealth of the finely nuanced, tacit and embedded meanings that are embodied in people's experiences.

5.2.3. Facilitated Theme and Action-Centred Group Approach

Because of limited time and for purposes of maintaining focus, a facilitated theme-centred approach was adopted based on a few topics around perceptions of life, stigma, sickness and co-existence with HIV/Aids. This acted as a template, a guiding manual which remained flexible to emergent themes during sessions. Furthermore, we decided the approach would be action-oriented for the many opportunities it offers for expression and understanding. Relating to the subject, Witkin's (in Jones 1996:113-4) states that:

> A deepened exploration can occur as two modes of experiencing are combined within the drama therapy session. On the one hand, the client, in physically portraying material in acting, explores something through immediate bodily experience. In addition the client can reflect upon the material.

In terms of group size, I planned to work with a closed number of 23 participants who had signed the consent forms during the observation phase of the research.

5.3. The Process-Orientated Drama Workshop's Objectives

The overall goal of the workshops was to explore the drama and theatre processes that would be most effective in bringing about emotional wellbeing for the Paradiso group therapy members. The specific objectives were as follows:

- To identify the real emotional obstacles that Paradiso group therapy members face while living with HIV/Aids;
- To identify drama techniques that would help participants deconstruct destructive and restrictive narratives in the HIV/Aids context;
- To find drama methods that would help rebuild a sense of control, a sense of connection and meaning making in participant's lives, with specific reference to HIV/Aids; and
- To find drama processes that would encourage a more supportive environment for participants to engage in critical self reflection.

5.4. Summary of the Process-Orientated Drama Workshop Structure

This section provides a brief description of the session outlines (A more detailed outline can be referred to in Appendix C). As established in Chapter Four, the Paradiso group therapy has its own traditions and ways of doing things that are valuable to them. If the process-orientated drama methodology was going to avoid alienating the group members, it had to take into consideration some of their important practices and traditions. One of the important traditions is their ritual of prayer which was maintained to allow the methodology to start from familiar grounds. Thus, the workshops would start with one of the group members leading the prayers. Then, I would take over directly afterwards with warm ups and drama exercises. These fed into the major activity for the day, which took the greater part of the time as we explored various process-orientated drama techniques. Finally, I would engage the group into a reflection of the day's events.

5.4.1. Workshop One

On day one, participants were asked to share their feelings and life stories using a symbolic road created on a paper roll. The road symbolised the traveller's life journey, from the beginning to the end. Then, they were asked to locate themselves on the road using visual and concrete objects like stones or bottles based on where they felt their lives were in general. Having marked their point on the road, participants were asked to stand next to their marked space and were then interrogated for their chosen location.

The idea for this exercise was to allow participants to introduce themselves and their concerns, but more than that, it was a response to what was observed in Chapter Four. It was established that the group therapy did not offer space for members to actively examine and reflect on their lives and situations. Thus, this activity was designed to see whether the use of dramatic and metaphorical elements of a symbolic road and fictitious role of travellers would enhance the participant's ability for personal emotional analysis.

5.4.2. Workshop Two

For day two, the major activity was set around issues of stigma and discrimination and how these social ills impact on the individual. The session was an attempt to interrogate the kinds of images that society has about HIV-positive people. By analysing society's perceptions, the participants were also analysing their own attitudes and images of HIV-positive people. They

were examining their own perceptions and images they create about the 'self' because they form part of the society. In the workshops, this was done using the Boal's 'image of transition' technique. According to Boal (1995:115), this technique unfolds in three stages:

> First the group makes the real image of the problem, then the ideal image of how the group would like reality to be. Then returning to the real image, each participant tries to show the image of transition, how it may be possible to go from the first to the second. This is a debate: people can disagree with one another.

Of major relevance in this exercise was the transition stage. The general idea was to establish whether this technique would stimulate participants to question and challenge the dominant images and underlying beliefs about people living with HIV/Aids. Was the technique going to incite them to re-story the way HIV-positive people are perceived? Was it going to reconstruct the images and explore ways through which HIV-positive people could achieve functional and enabling images?

5.4.3. Workshop Three

This session was designed to deconstruct the meanings of 'sickness'. Here, participants were challenged to grapple with the socially, culturally and politically constructed meanings of sickness and how they impact on their lives. This was done using the dramatic expressive forms of storytelling and metaphor.

5.4.4. Workshop Four

The objective for day four was to interrogate the warring attitude towards HIV/Aids, the conceptualisation of HIV/Aids as an external enemy to be fought and the impact that such thoughts have on their well being. Participants explored these notions through simulation and improvisatory role plays.

5.4.5. Workshop Five

Day five was intentionally left open to cater for those themes that would emerge in the course of the week.

5.5. The Process-Orientated Drama Workshops

The workshops started on a Monday morning, the 20th of October 2008 at Paradiso premises in area 24. I was slightly late in arriving as I had to buy extra workshop materials. By the

time I walked into the room, everyone was already seated in a classroom pattern and I felt intimidated by the people I saw. There were elderly men and women, all adorned in their best attires and suits ready for a typical workshop day where they would sit and listen to someone lecture them. I must admit that I was somewhat nervous.

My source of anxiety was that in Malawian culture, talking about sex is a taboo. In many circumstances, this hinders productive discussions of HIV/Aids issues because of its close association to sex. In my case, the issue was going to be even more complicated because of being a young and single woman. However, one of the things that I have learnt from my experience of working with communities is that respect transcends most of these cultural barriers. The way one addresses the elderly, acknowledges or fails to acknowledge them through dressing and choice of words will determine the success or failure of a venture. Therefore, dealing with my fears from this perspective helped as it was not long before I managed to establish a good rapport with the group.

5.6. Setting a Group Contract

One of the opening processes for Workshop One was setting up a group contract that would guide how we all treated each other, the space and everything that took place in it. This was a deliberate choice made to make sure that there were no unnecessary disruptions as observed in Chapter Four, but also to help the group members understand the significance of this convention to the success of group processes. Hence, the following group contract clauses were agreed upon:

- Every member was to keep the starting time;
- Every member was to participate fully unless excused by the group to sit out and watch;
- Members were expected to respect each other's views and keep strict confidentiality of group proceedings;
- Members were to switch off their phones;
- Members were to listen to each other and speak one person at a time; and
- Members were expected to be in the sessions all the time unless visiting the bathroom.

With the group contract also came the change in the sitting arrangement as now the group had declared that full participation and listening to each other were important group principles. I emphasized the importance of this convention through a game called tangle and knots. I was part of the game and when the group could not disentangle itself, the participants started looking at me for help. This was a typical response for the group as they had become accustomed to the idea that the facilitator would solve their problems. What was interesting was that some group members would shout ideas but none was listening because their attention was directed towards me. I told the group that I had no solution to the problem, but maybe, if we listened to the idea that someone was offering, probably it would help. Slowly the focus moved away from me into the group and surprisingly, the notion of being listened to generated more excitement and ideas.

5.7. Thematic Analysis of Healing

Considering the fact that this study is investigating an under-researched area, the ideal method of analysis would have been to provide a comprehensive account of everything that transpired in the sessions. However, this presentation would be too bulky for the size specifications of this report and moreover, the long and winding descriptions often lead to loss of depth and complexity. As such, this section will provide you with an equally detailed and nuanced analysis of a selected group of themes drawn from the data set. These themes strongly relate to the research question and objectives, and by using a set of carefully selected examples from the implementation process, the analysis will illustrate how the process-orientated drama methods and processes provided opportunities for participants to engage in therapeutic action.

This section begins by considering the fundamental question that this study was investigating: Can the use of drama and theatre processes contribute towards the emotional rehabilitation of people living with HIV/Aids? Based on what came out of the sessions, the answer is affirmative. This was discovered principally in the ability of the process-orientated drama elements to discern deeply into the issues that people harbour. What came out affirmed the ability of process-orientated drama elements to go beyond the facades to locate the source of the problem, i.e. to diagnose the underlying psychological concerns. This is vital because, often what people say is quite different from what they may be experiencing and if taken on

face value, one could be misled and end up focussing on things that may not necessarily be the issue.

This aspect proved true for the group members of Paradiso group therapy. Just like I had observed them in the first phase of the research process, they presented an image that was contrary to the stereotype of how an HIV-positive person should look. Listening to them talk would have made one wonder why they were in therapy. Except for a few cases, they looked and sounded healthy as they harmoniously echoed the rhetoric of how well and free of worries they were and jointly sang praises of how the group therapy had helped them move on with their lives. The group had a composed outward appearance, a group phenomenon that is better explained by Whitaker (1985:5) when she says:

> It is possible for members of a group to achieve a sense of safety by not taking any personal risks at all. In order to avoid pain or threat they may, individually or collectively, establish ways of participating which threaten no one but also reduce the likelihood that gains will occur. Individuals may sink comfortably into some familiar and customary way of behaving. Nothing new is experienced or tried. Collectively, members may establish collusive defences which render the group innocuous.

Yet, the dramatic processes revealed a different story altogether. The dramatic elements uncovered the deep seated feelings of un-dealt with resentment and despair, the ubiquitous fear of death, stigmatisation and underlying ideological disparities most of which could not be discerned by just observing the group. Thus, taking these elements into consideration, the analysis of each selected theme, as stipulated above, will proceed first by highlighting what the drama activities managed to uncover about that particular subject and then discuss how the dramatic elements provided a means of counteracting those problematic areas.

5.7.1. Deconstruction of Destructive HIV/Aids Beliefs and Attitudes

Before delving into how drama provided space for the actual process of deconstruction, the question we need to ask is: What are these harmful HIV/Aids beliefs and attitudes?

5.7.1.1. Representation of HIV/Aids as an External Enemy

> *That one (the virus) is my enemy, and beginning from that day he started torturing me, I have been keeping resentment in my heart and today when I saw him, I didn't even want to talk to him but just pounce on him to kill* (Case study notes 23 October 2008).

As stipulated in Chapter Four, there exists in the context of HIV/Aids a multitude of problematic notions and attitudes among which are fear, humiliation and shame of the disease, and the presentation of HIV/Aids as an outside adversary to fight with. Not only are these notions and their surrounding narratives based on false doctrines, but they have proved to be largely destructive and to deter those living with HIV/Aids from developing positive outlooks towards their conditions. One practical and straightforward solution to reverse this order of things is to engage participants in an undoing process.

Drawing from the process-orientated drama workshops, participants were, through the use of improvisation and role play, accorded the opportunity to deconstruct the perceptions of HIV/Aids as an enemy. In this activity, participants were asked to create three role plays of either a statue [a still picture made using their bodies] or a moving image based on a set of questions. It must be indicated that I slightly changed the major activity for this day to try out something more emotionally demanding. This decision came about after observing that participants remained emotionally disengaged and that their responses were more cerebral. As such, the following questions directed the dramatic action:

- If HIV/Aids were a person, how would she or he look like? What kind of features, characteristics and mannerisms would she or he have? What would be their body complexion, their body texture, and their voice? How would she or he move, behave, sit, look etc?

- If HIV/Aids were a person and one day you met him or her, what would you say or do to him or her? How would you say whatever you would wish to say?

- If, for instance, you were obliged to co-habit with this virus character, what kind of a relationship would you want to have with him or her and why?

The first two scenarios were framed in such a way as to draw out the real sentiments of how participants felt about HIV/Aids and to ascertain how they conceived the virus and the kind of relationships they had with HIV/Aids. To enrich the experience and exploration, the virus was personified, meaning it was played out as if it was a human being. This kind of framing was to provide the virus with a face and a distinctive personality that made it more tangible and more present for the participants to engage with. Again, by personifying the virus in the role plays, I managed to literally place it outside the body as an ‘external enemy’. This was a

deliberate decision to allow them to play in the 'incorrect narrative' with the hope that they would become aware of the paradox and realise that HIV/Aids was a part of them.

Already, it is clear that I was manipulating the notion of distance, and that activities were deliberately being framed in a style that would provoke a specific enactment. Adding to this, participants were asked to pick up a role of an HIV-positive person that was not necessarily themselves, but were encouraged to draw directly from their real life experiences with HIV/Aids. Thus, placed in a position of minimal theatrical shielding, participants were provided the opportunity to directly confront their feelings, to tell stories from their own lives and to re-live the ensuing emotions.

The last scenario was structured to become the focal point of the deconstruction procedure. Having painted a picture of how they perceived the virus and the kind of attitudes they had towards it, this scenario then challenged them to critically analyse their attitudes and to see if the attitudes helped them to live healthy productive lives.

All three groups came up with moving images for the first scenario, but the most interesting one came from group three. They created a sinister and slow moving image, but unlike the other two groups, they manifested three different expressions of the virus character. One manifestation was that of a fuming and seething person with a tense and rigid body and gait. The other expression demonstrated a sinister looking beast with scary claws and blood-curdling facial and body expressions and lastly, an image of a shivering and terrified creature. Of the three groups, this group's presentation elicited a lot of debate as many participants identified with the fuming and sinister looking monsters but failed to connect with the shivering manifestation.

However, another participant highlighted that he identified with all the three images presented by the group. For him, the group was manifesting the different faces of the virus and that the shivering manifestation was a metaphor for the virus in the body of someone who was on treatment. This explained why the virus was presented as weak and petrified. His perceptive interpretation was received with a lot of 'aha!' - meaning that it brought about a new and deeper understanding of the nuanced qualities of the virus.

The following role plays were a response to the second scenario where participants were asked what they would do if they met the virus character. Again, varied reactions were

presented with some fleeing in horror, others shielding themselves with bottles of ARV drugs and others beating it. A remarkable example of this scenario came from a group that portrayed a fierce fight where the people leaped on the virus character and started pouncing and stumping their feet on the floor in anger. Then suddenly, one player took out a knife and started making stabbing gestures. I stopped the role play immediately because it was an unsafe representation. Though the player's underlying feelings and expressions were sincere, the knife represented an object that breaks the illusion of the drama. Without the illusion, the 'essential lie', then everything that happens transcends into the reality frame and instead of identifying with the drama, those watching begin to worry for the safety of the characters involved.

Regardless of the knife scenario, this activity stimulated the most powerful embodied expression of inner feelings. Many times during enactment, participants would be giggly and those witnessing the action would throw comments and laugh. But this presentation was characterised by a grave stillness, engrossed witnessing of vigorous gesticulation and release of rage and resentment.

Commenting on the use of the knife, the participant defended her action saying it was the only prop available that could help her demonstrate precisely how she would react if she ever met HIV/Aids in that form. The effects of that role play were further summed up by several reactions that followed, '*This group has demonstrated exactly how I would react'* exclaimed one participant while another lamented: '*Actually I would do more, after killing it, I would burn it with petrol and throw its ashes in the lake just to make sure that I have killed it and have wiped it off the face of the earth*'. Focussing on the previously quoted comment, another participant said: '*That one (the virus) is my enemy, and beginning from that day he started torturing me, I have been keeping resentment in my heart and today when I saw him, I didn't even want to talk to him but just pounce on him to kill*'. From these remarks, it is noticeable how this exercise speaks of the complex nature of HIV/Aids, an illness that de-stabilises the body, a social illness that is stigmatised and how people are alienated from themselves and others. It is worth noting how the exercise managed to create an avenue through which people could express the repressed feelings of how they truly felt about HIV/Aids. We might say that by endowing the virus with human attributes, we created the necessary distance for people to actually vent and externalize their sentiments rather than maintain them as internal dialogues.

The exercise became even more interesting when participants were asked to work on the last scenario. The first reaction was a resounding 'ah!' as participants protested, saying it was impossible to even consider existing in the same space with this virus character. One participant went on to query: *'How can you ask me to live in the same house with someone who has killed five of my children? I don't think there would be any peace'.* It was a difficult matter that he was raising, an issue that is generally ignored that, while people living with HIV/Aids are struggling with their health, most of them are also dealing with grief and the trauma of losing their loved ones. It was a tough question indeed and an anguished outcry coming from a grieving and an overburdened individual trying to understand the challenges of living with this condition.

Pondering on the irony of living with HIV/Aids, one participant said in a small voice and a tone that seemed to acknowledge the pain of the other person: *'But that is the reality that we are living with, HIV/Aids has taken so much from us and yet we have to live with it'.* A moment of silence passed as each one absorbed the pain and awkwardness of this situation. This was a critical moment in the exercise as participants were no longer looking at HIV/Aids as a remote organism to attack. The exercise had now taken participants into a self-reflective and transitional space where the theatre world melted into the real world. The group was now using the dilemmas encountered in the drama to understand their real life predicaments[9].

Based on this new understanding, participants decided to carry on with the exercise and fascinatingly, the enactments sharply contrasted the ones presented in the previous scenarios. Far from flight and fighting, the role plays portrayed various images of participants striking a conversation with the virus character and negotiating for what seemed like a memorandum of understanding (MoU) for cohabitation. Trying to find out why they had changed their approach, one participant said: *'...it's our strategy to find out what keeps it alive and what drives it so we can easily control it'. 'We can only know how to handle it if we have the information of how it functions'* another participant added. From the responses above, it is evident that, not only had these exercises managed to stimulate the deconstruction of destructive notions but had further provided the opportunity for participants to start creating new narratives and to reclaim control over the virus. Instead of being disconnected,

[9] See Jones' life-drama connection in Chapter Two

participants were now immensely involved, taking on the centre stage in strategising and studying the virus intently so they could maintain control of their lives.

Further, responding to the change in approach, the participant who was initially objecting to the idea of coexistence with the virus because it had killed five of his children commented: *'(...) it is a complicated situation; you cannot kill the virus without killing oneself'.* This was a major shift from the attitudes that the group held initially when they were just beginning the exercises that day. By the time they were finished, participants came to a deeper understanding that fighting with their HIV/Aids conditions was essentially futile and damaging to their health. Thus, the drama techniques, particularly the notion of regulating the levels of distancing, had worked tremendously in enabling participants to access, articulate their feelings and consequently come to a better understanding of their condition.

5.7.1.2. Stigmatisation and Othering of Fellow HIV-positive Group Members

Apart from the internalised stigma witnessed in Chapter Four, where participants displayed negative self-perceptions for being HIV-positive, the drama activities also managed to unearth the existence of in-group discrimination and 'othering'. There is an extensive literature on the influence of stigma and discrimination on people living with HIV/Aids and most of it carries the assumption that it is those who are HIV-negative that stigmatise and discriminate those who are HIV-positive. Very little research, if any at all, has been done on how people living with HIV/Aids could possibly discriminate against other HIV-positive members and what impact that could have on the stigmatised. However, through the process-orientated drama based therapy sessions, a scenario came up that revealed the reality of stigmatisation within an all HIV/Aids group.

The incident happened on day five when we were playing the Agree-Disagree game. This is a game where you draw three circles on the floor and label them agree, unsure and disagree. You then ask participants to respond to a series of statements by walking into one of the three circles depending on whether they agree, are unsure or disagree with the statement. As we were playing this game, one of the statements that were given was, 'people living with HIV/Aids should never give birth'. But in the group was a woman who had a small baby. During my initial observation phase, this participant had shared her story several times in their group discussions and narrated how difficult it was for her. She said:

> *When I was pregnant a lot of people said negative things about me and the baby I was going to have. But deep down my heart I prayed and told the virus that I didn't want it to touch my baby, I kept telling it that I want my baby to be healthy and here he is. I have tested him several times and every time results have come negative, you see he is as healthy as any child she said rocking the baby on her lap* (Case study notes 4 July 2008*).*

Goffman (in Holzemer 2004:166) defines stigmatisation as 'an attribute that is deeply discrediting within a particular social interaction', as a 'spoiled social identity' while Harvey (ibid), describes it as 'a deviation from the attributes considered normal and acceptable by society'. Jones, in his paper presented at the African Research Conference in Applied Drama and Theatre describes 'othering' as an element that is 'used by majority culture to segregate, disenfranchise and silence' (2008).

Linking these definitions to how the group responded to the Agree-Disagree game highlights the traits of stigmatisation within the Paradiso group. The group therapy, as it stands, is a society for those who belong to it. It is a social entity for those people living with HIV/Aids, for those people who have accepted and have decided to come out in the open about their status and even more, a society of those people who have decided to seek help for their traumatic experiences of living with HIV/Aids. As a social grouping, this group has rules and regulations explicit and implicit that governs their behaviour as group members.

Judging by the responses where 12 out of 16 participants agreed with the statement that 'people living with HIV/Aids should never give birth', this participant who had given birth had clearly deviated from the expected norm. This event, therefore, separated her from the rest, making her the odd one out, the 'other'. It became her distinguishing feature, her mark of difference and the basis for not being equal. While incidences of gossip or name calling which usually characterise stigmatisation were not evident in her case, silence from her peers enforced her condemnation. She constantly repeated her story and each time, no one commented or acknowledged her and it was only after playing the Agree-Disagree game that it became clear that she was all along reaching out to her peers for validation. Their silence condemned her and true to what was noted in the *Daily Times* article (Mpaka 2008:8), stigma was driving her 'in the closet but one with splinters'. The article further highlights that:

> In all their forms, stigma and discrimination are imprisoning. They breed fear and silence. And silence is dangerous for it breeds despair and fatalism. It is a hot iron bar that sears through the heart.

What was interesting is that most group members totally disagreed with child bearing on medical grounds, stipulating that it was risky for the health of both the mother and the child. In this woman's case, thanks to strict adherence to prevention of mother to child transmission (PMTCT) medical procedures, things worked out well for her and so far, she and her baby looked to be in good health. All this notwithstanding, the group was still reluctant to accept what she had done. This caused her more pain because she did not understand their reasons for antipathy.

With this case, drama did not necessarily provide space for the deconstruction of stigma. This is a complex subject that would require serious time investments and a consolidated approach to alter beliefs. But of equal relevance was the fact that the drama revealed the underlying dynamics of internalised stigma that was now being projected on fellow group members. It ousted the prejudices out of the closet. Normally, this topic would be greeted by silence and fear of destabilising the status quo. But the game provided a safe channel, an alternative way for expressing and discussing divergent views and also the chance for participants to experience the effects of stigmatisation. For the woman, the exercise created space for her to genuinely and openly express how she felt about how the rest of the group treated her.

5.7.2. Construction of New HIV/Aids Narratives and Perspectives

While some people are currently surviving HIV/Aids and living healthy productive lives, others are suffering and consequently dying from the same condition. The reason is that without a lifestyle that is dedicated to renewing one's frame of mind, according to new narratives and meanings, the person becomes engrossed with old narratives which may not offer many opportunities for growth. The significance of this practice was emphasized in Chapter Two by Keen and Valley-Fox (in Emunah 1994:16) who argued that: 'To remain vibrant throughout a lifetime we must always be inventing ourselves, weaving new themes into our life-narratives (…)'.

What Keen and Valley-Fox are stating is that a healthy and functional life, characterised by psychological growth and transformation is based on renewing the mind. This happens with the unlearning and learning of new ways to understand the world through stories that are based on new possibilities, hopes and strengths. The notion of constructing new narratives is even more relevant to HIV/Aids because of its changing nature. Everyday new information and details about the disease are being discovered, which should challenge people to adapt

and re-adapt their responses towards more pro-life ways. However, for varied reasons, it is possible for individuals to suffer inertia in this part of life, hence, becoming fixed to a particular way of seeing and interpreting things. This is what was uncovered through the dramatic processes.

5.7.2.1. Hopelessness and Ubiquitous Fear of Death

Despite the evolution of HIV/Aids knowledge and increased evidence that improved treatments for HIV are sustaining lives for those who are able to take them, most social and personal narratives surrounding the condition have not changed. They have generally remained dormant and unresponsive to the new realities and developments. Illustrating the point is an excerpt drawn from a self-examination exercise carried out on the first day (see Workshop One). Using the symbolic road exercise to ponder on her life, one participant stated that her life was nearing the end. She lamented:

> *'I can see that I have walked all the way from the beginning up until this point (meaning the point she was diagnosed with HIV) and now as I am here I don't know what the future holds for me, I am no longer in control of my journey and I have left everything in the hands of God'* (Case study notes 20 October 2008).

Asked to comment on what she saw ahead when she looked into the distance, she said:

> *'Nothing much, all I see is that the end is very close and even though I am walking, I don't know what's there for me only God knows (...)* (ibid).

Physically, this participant did not exhibit the stereotypical attributes of an HIV-positive person. In other words, she did not look sick but the problem was that she, like many people who share those sentiments, was living with the despair of a negative, destructive personal narrative that is supported by the society and the media. She framed her life according to the old narratives that affirm the fatal nature of HIV/Aids. Despite all the radical evidence demonstrating that people are currently surviving HIV/Aids, the pessimistic grip proved too ingrained in her psyche for any new and positive narratives to develop. However, this was not surprising considering the fact that it took almost two decades of rigorous internalisation of gruesome HIV/Aids information; hence, the undoing process will equally have to take time.

But besides internalisation of negative narratives, this scenario demonstrates the complexity of HIV/Aids and the depth of the trauma that people with HIV/Aids live with. It validates what Herman says that 'traumatic events overwhelm the ordinary systems of care that give

people a sense of control, connection and meaning' (1992:33). From what was established in Chapter Two, these are the life scenarios that TFD cannot address as they are deeply ingrained in the psyche.

Another aspect that was discovered as participants talked about HIV/Aids was the contradictions in what they believed about HIV/Aids. When discussing HIV/Aids outside drama activities, participants expressed sentiments that run contrary to those motivated by dramatic action. For instance, outside the drama, participants had a positive view of their statuses, declaring that they were not dying and that they were, in essence, better off and would probably live longer than those people who did not know their HIV statuses. For them, knowing their status meant that they could better plan and control their lives, a privilege that was said to be absent in the lives of those who shunned testing. Alternatively, the drama exercises like the symbolic road revealed dismal images of people wearied by deep anxiety, fear of death, hopelessness and total loss of control as discussed above. Many of them worried and confessed that they did not know where their lives were going and what the future had for them.

What I realized is that as people who are living with HIV/Aids, the participants are exposed to numerous messages and moreover, for those who have come out in the open and are attending group therapy, there are certain expectations about what they should know, what they should feel and say about their situations. They are supposed to be the guardians of hope and this role comes with its conventional rhetoric which is mostly buoyant and optimistic.

However, the symbolic road exercise revealed the superficiality of this phenomenon. At a deep level, most participants were still struggling with the fear of death as evidenced by the sentiments quoted above and others who made similar remarks like: '*Am facing backwards because I want to see where I have come from... otherwise I know am headed to paradise'*. Death was found to be simmering deeply in their minds and there was no space for them to deconstruct these fears, to adjust or reconstruct their minds in light of new information and realities.

Realising the extent of the challenge in the group, the workshops provided a number of platforms for participants to create new narratives and meanings. Some of these platforms were planned while others were ad hoc events that surfaced in the course of enactment. One of the impromptu instances involved a sculpturing exercise where a participant in one of the

role plays stood far from the virus character and looked indifferent to what was happening. She was completely unaware of the image she was creating, but it nevertheless prompted us to interrogate the kind of relationship she was exhibiting. Analysing her stance and attitude towards the virus character, participants said she was portraying a hostile relationship where she harboured bitterness and was probably dealing with issues of denialism. They discussed the effects of such a relationship based on the meanings they had created earlier on in the improvisation exercises and then became engaged in a sculpturing process that was meant to change the relationship to something constructive.

The rest of the group members left the acting space leaving her and the virus character. Then, without using words or instructions, one person at a time went and changed their positions either by changing the distance between them or by moulding their bodies into an image that spoke to their ideal type of relationship. A number of images were created and scrutinized. The rate at which the participants picked up the technique and their interpretation of the images was encouraging. Reacting to an image where the two were closely hugging each other, one participant said: *'(...) I hope that this is not the kind of relationship we are looking for, they are too close and I don't think its good'.* Asked how he would like the relationship to be, he went and separated them and made them face each other while shaking hands. According to him, that was an ideal kind of distance and connection because they were still close but not too close that it blurred their vision.

Most of the participants expressed the need to watch the virus carefully and the desire to tame it. Though these narratives still exemplified their underlying suspicions for 'this enemy', positive changes were nonetheless noted in the sense that they were no longer despairing or talking of fighting the virus but domesticating it, a welcome development in its own right as it put them in a position of power, that of a domesticator.

As time went by, participants began to enjoy the exercise and more and more took turns in sculpting the two bodies and examining the mystery behind the images. But what they did not know was that as each new image was formed, a new way of perceiving and relating to HIV/Aids was developed, that they were at a subconscious level devising new narratives, challenging and re-authoring the old conventions for meaning making. This phenomenon only goes to affirm one of this study's claims that 'process-orientated drama used as a therapeutic tool has a vital role in changing the personal and social narrative of HIV/Aids'.

5.7.3. Rebuilding HIV/Aids Images

The Boal's 'image of transition' technique was used to enable participants cross-examine the images that society has for HIV-positive people. During this activity participants worked in three groups and created a series of three images each. Below is a table illustrating the images that each group developed:

Group	**Problem image**	**Transitional image**	**Ideal image**
A	We are beggars!	We help each other!	We are self-reliant!
B	We are stupid!	We persist!	We are prayerful!
C	We are lazy!	We think; we strategise and we have a vision!	We are innovative!

To start with, the problem images in the table above, revealed debilitating images of people living with HIV/Aids. They communicate society's impressions of the extent to which HIV/Aids is believed to alter someone's social status and identity. But more than revealing negative images, the exercise provided participants the opportunity to begin to restore them. The exercise also helped them counter the negative images with the creation of positive and functional images that best explained the reality of their situations. Furthermore, the three stages of the transition technique challenged participants to be proactive. It encouraged them to actively think and to engage in the experimentation process of how they could systematically achieve their desired lifestyles.

Progressing with the exercise, participants eagerly launched themselves into the activities and enjoyed creating and dynamising the images. Of course, some of their created images were weak and not specific enough. The reasons for that ranged from the group's lack of skill to eloquently communicate a viewpoint through imagery to the impact of the disease on their bodies. But despite all that, there were strong themes beneath the images, demonstrating the desire to be perceived differently. Group A and C, for example, indicated that they were perceived as beggars and lazy people, but they desired to be innovative, resourceful and

independent. In spite of how the disease had dealt with them, they recognised their strengths in supporting one another. They found hope in reminding themselves that the disease may have made their bodies weak, but it needed not to rob them of their thinking capabilities. Neither did it have to rob them of their abilities to plan ahead and set visions because they still had lives to live. To this extent, Boal's technique managed to start making some positive shifts from the dysfunctional problem images.

5.7.4. Expression of Emotion

It must be highlighted that this was one of the most challenging dimensions to achieve. Throughout these sessions it became apparent that it was relatively simple to access ideas and opinions, but extremely difficult to reach emotions. A number of factors contributed to this state of affairs among which was the following.

5.7.4.1. Unfamiliarity with Emotional Expression

Extrapolating from the Agree-Disagree game incident referred above, it was established that the group did not know how to handle moments of emotional outpouring and the only way they knew was to try to silence the person who was supposedly bringing in turmoil. As the woman expressed her discontentment, the group tried to silence her by saying: '*stop talking about it, it's over', 'we don't understand why she is getting angry because we are not talking about her', 'Let's just drop this subjec*t', '*we know this woman to be a good lady, it's the devil that is making her feel this angry'.*

These reactions were self-defeating and if people could not openly express their inner feelings in this space, then where else? Moreover, if people's feelings were being attributed to the devil, then how safe would they feel about revealing them? To a greater extent, the incident highlighted how some people find it extremely uncomfortable to be around a person who is upset. It usually embarrasses them because they don't know what to say, do or how to help. It further confirmed what Whitaker (1985:5) observed about therapeutic groups:

> More often, becoming a member of a therapeutic group is a frightening prospect. Group members often anticipate that revealing themselves to others and exploring their own feelings and experiences carries risks of being ridiculed or criticised or shamed by other members (...).

However, she adds, a group will only

> (...) be a more effective medium for help if its norms and shared beliefs support members in expressing feelings freely and frankly, sharing experiences, responding to one another's contributions and trying out new behaviours (Whitaker 1985:6)

This happening therefore provided us with a framework to collectively reflect on the purposes of group therapy, the importance of establishing a safe space within the group and to explore the roles that each one could play to ensure that such a space was created and respected. Whitaker (1985:4) stresses that this is a critical aspect because:

> If group members do not feel safe they will not involve themselves in the group. They will either flee, literary (sic), or stay in the group but find ways to insulate themselves from the experience. Personal gains [rehabilitation] will not occur or will be limited [my addition].

The incident further provided the opportunity to cross-examine the forms of emotional suppression. We looked at how people are blocked from articulating their feelings, how they are made to feel guilty for expressing their disenchantment and the psychological effects of such malpractices on the individual. Statements like *'let's just drop this subject'* or '*it's the devil that is making you feel this angry',* have a disempowering and silencing effect with connotations that say that what you are stressing about is not worthy pursuing and that it is evil to express emotions.

Unfortunately, this is a wide spread phenomenon in Malawi where people, especially women, living with HIV/Aids are almost expected to mutely accept their situations and move on. The following example is an illustration of how even institutions and professional care givers sometimes also perpetrate emotional suppression in the name of counselling. Thus, commenting on Soko's story, one counsellor said:

> Counselling and supporting women like Soko can assist in beating a disease that has captured the lives of many. *'We encourage them to remove their anger and negative mindsets they have against their husbands'.* 'They need to concentrate on the medication they are taking and on living healthier lives, it's the only way' [my emphasis] (Luwanga, 2008:5).

This way of addressing HIV/Aids is problematic because it often makes the assumption that dealing with issues of HIV/Aids resentment and frustration delay or contradict the process of healing. Expressing emotion is part of living a healthy and normal life. Hence, encouraging women to 'remove their anger' is not dealing with the problem, but is at most an admission that even some counsellors lack skills in handling emotional situations. Silencing, therefore,

becomes an easy strategy that forces people to inhibit and repress their feelings. Moreover, how are they expected to remove their anger if not by addressing it? Is it by just dropping it or telling them to forget about it and concentrate on the future? Commenting on the subject, Jones states that 'asking people to forget carries on the oppression and does not provide the space for exploring the emotions and working through the problems they are encountering'.[10]

5.7.4.2. Identifying, Naming and Expressing Emotion

Another feature that the workshops strongly brought to the fore was the difficulties of emotional expression which was anchored in the inability to identify and name emotion. Clarifying the point is an example of where participants were asked to analyse the problem images they had created using Boal's 'image of transition' exercise. It was observed here that almost everyone including those participants who were not very active became actively involved. It was an effortless exercise for them. However, most of them could not express with the same vitality how such images made them feel. The creative and analytical components were lively, embodied and illustrative but once the question came to analyse the impact that such images had on them, the energy would instantaneously drop and most of them would become blank.

There could be an array of underlying factors to this phenomenon. One may ask whether it is necessary to name emotion. Goleman (in Gunderman 2006:366) suggests that it is important to name our emotional states because '(...) people who can do so generally have more sophisticated and nuanced self-awareness'. Beyond that, it is vital to name emotion, particularly in groups where the overall objective is to help people recover or improve their emotional health and well being. But how can they achieve that if they have no idea what emotions they are dealing with? The naming process, therefore, helps people to clarify and locate the emotions that they are experiencing so that they can seek proper help. This is the diagnosing process. Hence, if participants limit their internal evaluations to general statements like 'it makes me feel bad', that does not provide adequate information to know what is making them feel bad. There are many things that could make one feel bad or sad, but what is it specifically that is raising those feelings in them? This is the detailed information that would help others and group facilitators to provide the necessary help.

[10] Interview with Dr. Jones November, 2008 at University of the Witwatersrand.

The struggle to identify, name and express emotion is a phenomenon that is neither exclusive to members of Paradiso group therapy nor to their situation. An interview with Mazloum, an independent Guidance Counsellor practicing in Malawi revealed that many Malawians in general manifest what I have termed high levels of 'emotional illiteracy'. This is the inability to locate and articulate their inner states in constructive and meaningful ways. She reported that:

> The greatest challenges I have with my Malawian clients is that they are unable to identify and verbalise their feelings. A Malawian will clearly tell you what they are thinking or doing, but it's so hard for them to tell you what they are feeling (Interview with Dr. Mazloum October, 2008 in Lilongwe).

This is an enormous challenge that is possibly rooted in our cultural and political history. Traditionally, Malawian men are not supposed to show that they are emotionally overwhelmed, no matter the level of trauma they may be experiencing. This is sustained through adages like '*mwamuna salira',* meaning, a man never cries and if he does he is weak and feminine. Similarly, sayings like '*mkazi azipilira',* 'a woman must persevere' teach women from a tender age to repress their feelings and pretend that everything is agreeable even where their husbands are being unfaithful.

Politically, Malawians learnt for the 30 years that Kamuzu Banda ruled that their survival and safety depended on suppressing their emotions and opinions. As such, in the process of growing up and of trying to refrain from political tribulations, many Malawians missed the opportunity to develop their capacities for emotional expression. Mazloum validates this conception when she says: 'In dealing with emotions, Malawians prefer to escape rather than confront them'. She also recognises that:

> When people are confronted with a problem, I notice that they laugh, they smile, and maybe that is a strategy or an escape route to simply laugh about it. But tension usually seems to bring about laughter and the laughter ironically does not mean that they do not care but because they do not know how to deal with it, so they laugh (Interview with Dr. Mazloum October, 2008 in Lilongwe).

Nevertheless, she stresses that confronting emotions is vital. For instance, dealing with HIV/Aids trauma helps people to move from the loss process that they experience mostly when they have just found out that they are positive, to dealing with those issues of anger, guilt and depression and finally reaching the acceptance level. If one does not deal with the emotional shock, it is so easy to get stuck at one level and the inability to deal with emotions

may lead to what she termed ‘emotional cancer’. Examples of emotional cancer have been demonstrated by the group’s self debasing attitudes.

The idea that Malawians struggle to verbalise and articulate their feelings substantiates the study’s argument for an integrated process-orientated drama methodology. Thus, instead of relying on verbalised communication of emotions, the process-orientated drama approach would provide people living with HIV/Aids a range of expressive forms drawn from process drama and drama therapy i.e. storytelling, embodiment, improvisation, metaphors (see details in Chapter Two). So far, this chapter has demonstrated the value of some of these expressive forms.

Coming in with a relatively different perspective, Boal (1995) cogently discusses the subject of emotion using the notions of consciousness and unconsciousness. He argues that the psychological make-up of human beings can be dissected into two levels, the conscious level where individuals are ‘capable of explaining, putting into words’ their feelings and ideas and the unconscious level which contains material that is not easily verbalised. He argues that:

> The depths of the unconscious are difficult to access: we do not reach them by speech alone. But we can get there by means of the dream, that *royal road to the unconscious*, as Freud called it, by means of hallucinations, word-games, slips of the tongue and act, and also by means of myths, by the arts, by the theatre. The great works of theatre penetrate directly into our unconscious and enter into dialogue with it (1995:34).

Through this assertion alone, Boal manages to set a strong context for the role of drama in dealing with HIV/Aids and corroborates the reason why this study is advocating for the use of process-orientated drama in group therapy sessions.

But as we move on to examine how the process-orientated drama techniques performed, the question would be why some were able to facilitate self-reflexivity and the expression of inner feelings like the improvisation exercise in Workshop Four while others like the Boal’s ‘image of transition’ in Workshop Two and storytelling in Workshop Three were unable to bring out a similar emotional response. Regardless of the fact that they are all drama methods, these techniques were designed to stimulate participants on different levels. The primary task for Boal’s ‘image of transition’ technique, for example, was to help participants interrogate the HIV/Aids images. It was a problem solving orientated activity hence, its emphasis on cognitive qualities. The fact that participants were vibrant and able to eloquently

articulate their opinions and not their feelings demonstrates that the technique only went as far as rousing them at a conscious level but failed to penetrate the unconscious.

On the other hand, the improvisation exercise in Workshop Four was set to reach the dwelling place of the emotions. Its distancing aspects were framed in a manner that allowed it to infiltrate the depths of the unconscious. For instance, participants were slightly underdistanced to their emotions when they were asked to play a role of an HIV-positive person who was not them. I say 'slightly underdistanced' because the process of projecting their HIV/Aids condition on another character created some distance for them. Second, participants were underdistanced to their emotions when they were asked to draw directly from their real life experiences. Third, their relationship to the virus was distanced by personifying it. Thus, by representing the virus in the human form, it was taken out of their bodies and placed outside; at a distance where they could see and interact with it.

A combination of these distancing levels in this exercise managed to bring out the most remarkable emotional responses, both verbally and physically. The existence and intensity of these emotions was unknown and mostly because the participants never brought them up in any of the discussions. Opportunities arose several times, for participants to express how HIV/Aids made them feel and every time, the responses garnered could not begin to compare to the emotions that were embodied in this exercise. The moment was intense and watching the role play, one could see and feel the streams of energy and anger rising and being released through body gesticulations, enraged utterances and seething breath and feet stamping. It was one of those moments in drama where the act spoke so frankly that there was no need to qualify it with dialogue. The performance of the feelings managed to bring out all the nuances that could not be expressed verbally and portrayed clearly how each participant related to HIV/Aids.

I recognised that responses in this session had a depth to them that was genuine and sincere. It was also observed that after the exercise, participants became more articulate to express their feelings and became equally aware of their vulnerability. This was in sharp contrast to all the other responses that were provided outside the drama and role. There was something to the performativity of the emotions that seemed to activate and make them accessible for articulation and that pulled participants into introspection. The image that kept coming to mind as I reflected on this moment was that of a glass cylinder containing water and

sediments on the base. The more participants became engaged with the drama; the cylinder stirred and triggered the silt, consequently, making it easy to access sensuously and verbally.

All these instances bear witness to the fact that the improvisation technique, and particularly the manipulation of distance in the role plays, played a major role in enabling participants to gain access to their inner traumatic worlds. Participants reached their unconscious domain and were able to articulate what was ingrained therein. Stated in another way, the exercise managed to make the unconscious conscious, and the 'unspeakable violations' speakable. This is the rationale for proposing the adoption of a process-orientated drama approach in groups that deal with HIV/Aids.

5.7.5. Restoring Sick Personalities

But is this the only reason why people should strive to reach their unconsciousness, merely to express how they feel? What does it benefit the individual to articulate what they could not articulate? To begin with, it benefits the individual because 'giving words to trauma begins to heal it' (Dayton 2000: xvi). Supporting the claim is Herman who acknowledges that, 'Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims' (1992:1).

There is another reason however, why I strongly believe that people living with HIV/Aids should be encouraged to access their unconsciousness. It is a cause that is again, aptly addressed by Boal (1995) using the central concept of the unconscious as a pressure-cooker. He says:

> We can compare the unconscious to a pressure-cooker. All manner of demons bubble away inside it: all saints, all the vices, all the virtues, everything that, not being act, exists in potential. Each of us has, within him, everything that all other men, all other women have; Eros and Thanatos. We have loyalty and treachery, courage and cowardice, bravery and fear. We desire life and death, for ourselves and for others. We have the whole gamut, in pure potentiality, boiling away, in a hermitically sealed pan. We have within us such a wealth of possibilities! (1995:35).

Boal takes his conceptualisation further by postulating that 'All possibilities being within us, it is impossible for us to manifest this potential in its totality' (ibid). As such, we are constantly involved in a selection process where we choose what we want to manifest and what we need to keep hidden. He claims that what we finally decide to openly portray

becomes recognised as our personality. The duty of that personality is to serve the individual, to help the person integrate into society and to live a 'normal' and productive life.

But what happens if that personality becomes weakened and overwhelmed by the pressures of life? What happens if someone encounters a life changing situation like HIV/Aids that ends up destroying their constructed self. Herman (1992:51) expounds that: 'traumatic events have primary effects, not only on the psychological structures of the self, but also on the systems of attachment and meaning that link individual and community'.

Given this base, going back into the unconscious becomes a valid option for restoration. Instead of looking outside for solutions, individuals can be encouraged to look internally, to search and draw out the underlying energies and potentialities that exist in the richness of their inner reservoirs. Thus, instead of letting vices such as fear, remorse, helplessness and many others characterising HIV/Aids immobilise someone, they could exhume a portion of their virtues to help them to once again live a 'normal' and productive life. Boal theoretically encapsulates the viewpoint in his claim that:

> (...) a sick personality can, in theory, try to awaken healthy *personages*, this time not with the goal of dispatching them back into oblivion but in the hope of mixing them into his personality (1995:38).

In the sessions, this was explored in Workshop Three where participants reflected on their attitudes and beliefs around what they consider sickness. Participants were also challenged to interrogate their fears; things that incapacitate their personalities through the metaphor of the monster.[11] It was interesting to witness how this process propelled participants into deep reflection and discussion of profound issues. For instance, linking this exercise to the symbolic road exercise in Workshop One, one participant said: *'many of us are scared of medication, but it is always helpful to think of them (ARVs) as some of the monsters we meet while we travel on that road, and if you drown yourself in denialism, then those monsters will grow big and probably kill you but if you accept, you will realise that life becomes easy and will see that those monsters are actually helpers that can even accompany you on the road'.*

However, looking back at the workshops, it took almost exposure to raw emotion for the group to finally gain access to their painful experiences. As elucidated in the chapter, most of

[11] See Appendix D for a brief synopsis of the 'Kiss Your Monster on the Nose' story.

the initial process-orientated drama processes tended to yield analytically rich sessions. This prompted the search for a tipping point, a point at which participants could also begin to meaningfully respond to their emotional states. Scheff (1976) and Landy (1996) hypothesise about this point through the notion called aesthetic distance, where participants are neither too close to real emotion nor too remote, that they cannot identify. But this group was far removed from their experiences such that the aesthetic distance for them could not be reached by a perfect 50-50 symmetry.

But though the role plays ended up placing the participants right in the middle of their emotions, they did not lose their critical element. They were able to examine their situations just as they identified with their feelings. This means that they had reached the aesthetic distance. In Scheff's (1976) terms, the group had arrived at a cathartic point because, not only were they able to relieve and remember or participate and observe their traumatic situations, but they were able to release the repressed energies and feelings through intense gestures and deep sighs.

In summary, this chapter has addressed a series of factors. It has highlighted the decisions that were adopted to address the methodological discrepancies that were identified with the group's approach in Chapter Four. It has also explained the workshop planning process and the thoughts and objectives that guided the designing and implementation of an integrated process-orientated drama methodology. The analysis of the data and themes engendered by the developed methodology affirmed the diagnostic abilities as well as the healing potentials of the process-orientated drama processes. It further revealed an iceberg of issues that lied unexplored and unreached but at the same time, highlighted how such issues could be accessed through intense personal enactments.

CONCLUSION

This study set out to explore the ways in which to address the emotional needs of people living with HIV/Aids. As established in the introduction, this is a crucial requirement because first, there is a growing community of people whose needs are unique and beyond what most HIV/Aids prevention and behaviour change programmes are offering. This is a population that is already living with HIV/Aids and whose problems are not only related to physical health, but also to their emotional wellbeing. Second, people living with HIV/Aids are now living longer and have to deal with many stressful conditions related to chronic and long-time illness. Tsasis (2000:1) corroborates this in his assertion that: 'Because people with HIV and Aids are living longer, more attention must be focused on their adjustment to living with the illness'.

The need for long-time HIV/Aids management and rehabilitation prompted me to investigate the following questions: Can the use of drama and theatre processes enhance emotional rehabilitation for people living with HIV/Aids? Secondly, what drama and theatre methods could contribute towards the emotional health of people living with HIV/Aids? My enquiry on these questions led to the examination of Theatre for Development (TFD), a methodology that has played a critical role in addressing various HIV/Aids issues in Malawi. In the assessment, I argued that TFD remains a relevant and effective model for HIV/Aids conscietisation, education and in enabling communities to critically discuss and reflect on the disease. However, TFD becomes limited when it comes to dealing with the complexities of HIV/Aids and how it affects people on a psychological dimension.

Not only did the study critique TFD, it also evaluated the value of education in addressing HIV/Aids issues and argued that the idea of information giving is equally not enough. This argument was based on the fact that learning, particularly the conventional model of education, addresses HIV/Aids from a single perspective. It objectifies HIV/Aids and reduces its complexities to simple learning units. It does not accord people the chance to personalise HIV/Aids or to explore the depths of its emotional dimensions. Furthermore, it operates on the assumption of ignorance and therefore fails to acknowledge the lived experiences of people.

Likewise, the study has argued that the model of discussion, talking about traumatic events is inadequate. Indeed, Dayton (2000: xvi) contends that 'Giving words to trauma begins to heal it'. Herman (1992:1) proclaims that 'Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims'. As rightly acknowledged, talking is vital, but according to Boal (1995:34) it does not reach 'the depths of the unconscious (...)'. This claim was substantiated in the workshops when we witnessed that participants would be articulate and engaged in the creative and analytical exercises but impassive and mystified when it came to exploring their inner selves. We also discovered that the participant's efforts to access the unconscious were hindered by cultural ideologies that do not encourage emotional literacy. What approach therefore could be used to address the emotional complexities of living with HIV/Aids?

In response to this question and to the research questions, the study proposed an integrated process-orientated drama methodology that draws on the educational principles of process drama and the therapeutic concepts of drama therapy to address the whole person. Like drama therapy, this methodology 'built upon the healing aspects which are present in drama and theatrical activities' (Jones 1996:8) which include creativity, playing and acting (ibid). Like process drama, the methodology drew on the concepts of living through a moment, solving real life problems and exploring inner anxieties through fantasy. As a result, the following underlying principles characterise the methodology: process over product-oriented activities, person-centred over facilitator-centred events, theme and action-centred activities over knowledge banking and dialogue-based exercises. The methodology is further characterised by an attempt to balance intellectual understanding and emotional learning in addressing issues that compromise the emotional health of people living with HIV/Aids.

As established from the analysis of the process-orientated drama workshops, the techniques which included storytelling, symbols and metaphors, improvisation and role playing, image theatre and sculpting, theatre games and the concept of distancing engendered a wide range of results. To start with, they provided a clear set of procedures and framework within which the facilitation of HIV/Aids emotional rehabilitation would function. We established in Chapter Four that one of the major problems with the group's approach was lack of a clear methodology to guide and consequently focus their sessions.

Secondly, the methodology provided a means for diagnosing the underlying traumatic issues held by individuals and the group. As it emerged from the workshops, most of the participant's challenges were not obvious. In other words, they were not easily detectable as most stereotypical representations of HIV/Aids would have us believe. Most of them and their intensity only came to be identified through intense enactments and personal reflections. For instance, individual claims outside the process-orientated drama processes portrayed participants in a positive limelight where they emerged strong and in control. Yet, these accounts could not stand the test of the self-exploration exercises. The symbolic road exercise among them, managed to penetrate the individual concealments to reveal images of a people devastated by deep anxiety, hopelessness and fear of death.

It is in this sense that this methodology becomes relevant for the facilitation of HIV/Aids groups. The approach provides a reliable assessment method that would help facilitators to identify the real problems affecting individual clients and the group at large. Again, in a place like Malawi where many people struggle to identify and articulate their emotions, the value that such a methodology would add towards problem analysis cannot be overemphasized. It goes without saying that if the actual problem is not identified, then all the efforts will be wasted addressing the wrong problem.

The value of the process-orientated drama approach was further observed in its ability to open space and provide a structure through which people could deconstruct immobilising HIV/Aids attitudes and narratives. It was established from narrative therapy constructs that people frame their lives according to the personal and social narratives that surround them. From the observation phase and workshops, it was observed that many participants were still organising their lives according to the old and restrictive narratives that espouse HIV/Aids as a fatal, external enemy to be fought. While these narratives made sense then, because there were no treatments to sustain life and there was not enough evidence showing the negative impact of warring with HIV/Aids, their perpetuation today poses a danger of negating the new possibilities and hope for healthy living.

This is why the process-orientated drama approach is relevant. It offered participants both the opportunity and a structured form to use in interrogating oppressive attitudes and narratives that hinder them from experiencing emotional growth. Thus, the methodology allowed participants the chance to develop new insights and to reconstruct functional narratives based

on their strengths, hopes and on the reality of how HIV/Aids exist today. The necessity of this phenomenon towards people's emotional rehabilitation is better summarised by Keen and Valley-Fox who assert that: 'to remain vibrant [healthy] throughout a lifetime, we must always be inventing ourselves, weaving new themes into our life-narratives (…)' [my insertion] (in Emunah 1994:16)

Above all, the process-orientated drama approach provides people living with HIV/Aids with a safe and integrated approach that endeavours to address their inner needs from many perspectives. It is an approach that understands the complexities of life, let alone those of living with HIV/Aids. But while it acknowledges that, it also understands that people have enough resources and potentialities to develop new insights and perspectives that can restore their wellbeing. To use Rudnick's (2002:182) phrase, this methodology 'draws on the best of everything' to come up with a rich healing modality. It draws on the aspects of drama and metaphor to allow people, even those who have difficulties articulating and expressing their experiences verbally or openly, to speak profoundly through the safety of symbols, images and embodiment. It further utilises dramatic distancing to facilitate participant's accessibility to their traumatising events. In addition, the methodology allows for a kind of experience that is communal, culturally sensitive, intellectually stimulating and emotionally affirming. It finds its way into established groups by honouring their traditions and strives for sincere self exploration and self reflexivity.

While there is need to further develop this methodology, I can nevertheless argue that an integrated process-orientated drama methodology is the most likely methodology to bring about emotional rehabilitation for people living with HIV/Aids in Malawi.

However, it must be pointed out that this methodology is not intended to be prescriptive in a binding way. Instead, it is aimed at providing group facilitators with a wide range of process-orientated options through which they could structure their sessions and address the varying emotional needs of their clients. As such, facilitators need to be well trained and skilled to know how to appropriately structure the sessions in line with the needs of their groups. Since this is the wish of this study to see this methodology further developed and applied in HIV/Aids groups in Malawi, I would like to make the following recommendations:

- Further qualitative research into the methodology would be vital; especially the study of its applicability to other HIV/Aids group therapies would provide additional insight into its effectiveness.

- For this methodology to become useful and beneficial to group facilitators and to people living with HIV/Aids, the need for comprehensive training cannot be overemphasized. Unlike TFD, this methodology is complex and requires high levels of expertise, sensitivity and integrity because facilitators deal with real and distressing problems affecting people.

- It is also recommended that a framework for evaluating the impact of this methodology be developed to help further define and refine the methodology.

- Finally, that it be introduced to Drama for Life practitioners as one of the methods to use when addressing the emotional needs of people living with HIV/Aids in Africa.

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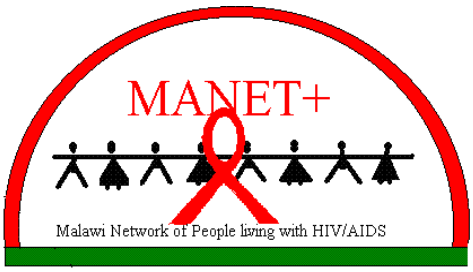
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APPENDIX A: CONSENT LETTER FROM MANET+.



29th May 2008

Basimenye Mwalwanda
Wits School of Arts
Drama for Life Programme
Private Bag 3, Wits 2050, Johannesburg
SOUTH AFRICA

Dear Madam,

RE: RESEARCH ON THE EFFECTIVE USE OF DRAMA AS A THERAPEUTIC TOOL TO ENHANCE EMOTIONAL REHABILITATION FOR PEOPLE LIVING WITH HIV/Aids.

With reference to your request to conduct your above stated research with MANET+, we would like to inform you that we are happy to work with you on your research and that we have made all the initial contacts informing one of our member groups for the Group Therapy that you are going to work on with them.

We have informed the participants that your initial research visit will be in June and your second visit will be in August 2008. Please inform us if you make any changes to your plan.

We look forward to meeting you.

Yours sincerely,

Victor Kamanga
ACTING EXECUTIVE DIRECTOR

APPENDIX B: PARTICIPANT INFORMATION LETTER AND CONSENT FORMS

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Wits School of Arts

Private Bag 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4654 Fax: (011) 339 7601

www.wits.ac.za/artworks

Email: basi_menye@yahoo.com

My name is Basimenye Mwalwanda, and I am conducting research for the purposes of obtaining a Masters at the University of the Witwatersrand. My area of focus is in theatre and how it could be used as a therapeutic tool to enhance emotional rehabilitation for people living with HIV/Aids. I am particularly interested in exploring theatre processes that would be most effective in restoring emotional well-being to those traumatized by HIV/Aids.

Based on my experiences, I believe that HIV/Aids if not dealt with at an emotional level can cause psychological death both to the infected and affected. However, the extent of psychological distress on HIV/Aids positive people is paramount as they have to deal with double loss, enduring other major non-death losses that are symbolic, psychological and spiritual in nature. However, this area has not received as much attention as those concerned with HIV/Aids information dissemination and the actual treatment of the Opportunistic Infections suffered by HIV-positive persons. However, overlooking this aspect of an HIV/Aids person poses serious threats to the whole notion of living positively that is endorsed by Paradiso HIV/Aids Support Organisation and other HIV/Aids campaigns.

As such, parts of the research aims at contributing to the expansion of this area of HIV/Aids and contribute to the consolidation of integrated drama approaches that are applied to HIV/Aids in Malawi. This is a unique opportunity for us to explore for drama approaches that will bring therapeutic aspects to our Group Therapy meetings and I would like to invite you to participate in this study.

Participation in this research is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. Considering the nature of the study, there will be high adherence to policies of confidentiality, privacy and security of all personal information gathered either through interviews, forum group discussions or workshops. With your permission some of these activities will be recorded on video and through a research journal to ensure accuracy. The interview material (transcripts) will not be seen by any person at any time, and will only be processed by myself. After transcribing the data, the interview materials will either be destroyed. No names will be used in any written documents and no information that could identify you would be included in the research report. You may refuse to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point.

If you choose to participate in the study please fill in your details on the form below and place it in the sealed box provided. I will empty the box at regular intervals, and will contact you within residency period in order to discuss your participation.

Your participation in this study would be greatly appreciated. This research will contribute both to a larger body of knowledge of both theatre and HIV/Aids and will be an added resource for Paradiso HIV/Aids Support Organisation.

Kind regards.

Basimenye Mwalwanda

CONSENT FORM: INTERVIEW, FOCUS GROUP DISCUSSION, WORKSHOPS

I _____ consent to being interviewed/ participate in focus group discussion and workshops by _____ for her study on _____. I understand that:

- Participation in this interview is voluntary.
- That I may refuse to answer any questions I would prefer not to.
- I may withdraw from the study at any time.
- No information that may identify me will be included in the research report, and my responses will remain confidential.

Signed: _____ Date: _____

CONSENT FORM: RECORDING

I _____ consent to my interview, focus group discussion, and workshops with _____ to be recorded for her study on _____. I understand that:

- The tapes and transcripts will not be seen or heard by any person in this organisation at any time, and will only be processed by the researcher.
- All tape recordings will be destroyed after the research is complete.
- No identifying information will be used in the transcripts or the research report.

Signed: _____ Date: _____

APPENDIX C: PROCESS-ORIENTATED WORKSHOP OUTLINE

Venue: Paradiso Offices in Ngwenya, Area 24.

Time: 3hrs (9.00-12.00)

WORKSHOP ONE: Monday 20th Oct 2008			
DURATION	**ACTIVITY**	**DESCRIPTION**	**ADMIN**
20 min	Opening ritual of prayer, singing and preaching.	One group therapy member will lead this session.	
10 min	Warm-up	▪ Name game ▪ Mingle mingle... ▪ Tangle and Knots	
10 min	Group contract	This is standard procedure for group work and is meant to establish rules and regulations related to confidentiality and respect and is planned to be done together with the participants.	Flip chart, Pental markers, glue stick
20 min	Map analysis	This process will prepare the group for the check in exercise. Participants will be asked to study a provided map and discuss two questions: ▪ What is a map? ▪ What is a map used for?	Map
70 min	**Main activity:**	Participants will share how they	Long roll of

	Check in exercise	are feeling at that time and share their life stories using a symbolic road that we will create using paper roll. The map will be laid down across the room and will symbolise ones life's journey from the beginning to the end. Participants will then be asked to locate themselves on this road map using visual and concrete objects like stones or bottles based on where they feel their lives are in general. Participants will then be asked to stand next to where they have placed their object on the paper and be interrogated on their chosen location using the following questions: ▪ In relation to the entire road/journey, where are you? ▪ How are you feeling about where you are and why? ▪ Where are you facing and why? ▪ What do you see with where you are faced? ▪ What is your condition; are you moving or not? ▪ If moving, at what pace, in which direction, is it forward, backward or in	brown/whitepaper, Cell tape Stickers in varying colours and shapes, small stones/bottles

		circles and why? ▪ If not moving, how long have you been there and what is keeping you from moving? Participants can respond using road or natural features to describe what is blocking them, for instance, a road block, a bridge, crossroads, a river, a cliff, darkness, rain, potholes, hills and so on. ▪ What is the condition of that feature, for instance, is it a broken bridge or a ferocious river? ▪ What does that stand for? ▪ From where you are; are there any other routes you can take? ▪ How safe are those alternative routes? ▪ What have you got to do to get to where you want to go?	
25 min	Reflection	Ask each participant to go back to their position on the road map. Ask them to take 3 minutes to look at the road map again, see where they are and think of what they wish for. And while standing or seated in their positions, reflect with them on the following questions: ▪ What has been your	

		experience of the session? ▪ Tell us one thing that the exercise has made you discover or realise about your life? ▪ How does that impact on how you understand yourself?	
5 min	Closing ritual of Prayer and song.	One group member leads.	
WORKSHOP TWO: Tuesday 21st Oct 2008			
20 min	Opening ritual of prayer, singing and preaching.	One group therapy member will lead this session.	
20 min	Warm-ups	**Animal game:** **Instructions:** Using sound, movement and gestures, illustrate the following: ▪ What animal do you see yourself as and why? ▪ What animal do others perceive you to be? ▪ What animal do you want to be? This exercise will require the participants to use their creative, imaginative and improvisatory	

		skills. This exercise will (1) introduce the idea of image theatre to the participants and (2) introduce the theme of stigma and discrimination.	
70 min	**Main activity:** A collective self exploration exercise through image theatre	In this segment, participants will create three images that portray the following sentiments: **The problem image:** Ask each group to create an image that portray the following sentiments: **We are this:** Displaying a dysfunctional image, the one that society has about people living with HIV/Aids and then ask them to dynamise it using sound, movement, gestures and phrases then collectively deconstruct it for meaning using some of these questions below: ▪ What does this image say to you? ▪ How does it make you feel? ▪ And how do you respond to this? **The ideal image:** Ask the groups to create an image that portray	

		the following sentiments: **We want to be this:** Through the exercise, the groups would be exploring the desired, functional and ideal image of how they would want reality to be. **Transitional image:** In this phase, ask the groups to create a transitional image, the one that is required to connect the problem image to the ideal one. The question to reflect on would be: what can we do to achieve the ideal image? Groups would have to debate on what those images ought to be. Then ask the groups to connect the three images, starting with the problem, the transitional and ideal image. Later ask them to dynamise the complete images using sound, movement, gestures and phrases and analyse the images to find out how they speak to the nature of their stigma.	
25 min	Reflection	Ask participants to sit in a circle and reflect on the workshop using the following guiding questions: ▪ What was your experience	

		of the session? What activities did you enjoy doing and which ones you did not and why? ▪ Share with us which image spoke to you the most? How did it make you feel and why? ▪ Were you satisfied with how you resolved the problem images? What could have been done better? ▪ Can you change the way people think about people living with HIV/Aids? If so, how? If not, then how can you live your desired life?	
5 min	Closing ritual of prayer and song	One group member leads.	
WORKSHOP THREE: Wednesday 22nd Oct 2008			
20 min	Opening ritual of prayers, singing and preaching.	One group therapy member will lead this session.	
20 min	Warm up	Use a song game called Chechekule where you will lead the participants in a ritualised process to create a relaxed and	

		reflective mood. Also incorporate moments of silence for individual meditation.	
20 min	Barometer exercise	Use the road map created in Workshop One as a scale. Put it on the floor and label 0 on one end and 10 on the other. Then ask participants to locate themselves on this scale of 0 to 10 depending on their perceived relationship with the notion of sickness. The number 0 on the scale represent a detached relationship with sickness while the number 10 represent someone who has an intimate relationship with sickness. Explain to participants that the notion of sickness is not confined to physical ailment but can be framed to allow definition in the broader sense. This process will give participants the chance to define 'sickness' for themselves and interrogate the reasons why they perceive a particular condition as sickness. Frame the exercise in a way that allows participants to work in a range of frameworks be it in the symbolical, metaphorical or	Long roll of brown/whitepaper, Pental markers

		realistic frame. Those who choose to work in the symbolic and metaphoric format will have the liberty of using fiction or someone else's story while those who choose to work in the realistic frame will work with their real personal stories. In the next section of the exercise, ask each participant to explain in a phrase why they chose that specific position on the scale. Then ask them to move and touch the person whose phrase they most identify with on the shoulder. It could be that they identify with that person because what they said resonate with their story or because it is a desirable trait that they would love to have for themselves. Having done that, ask participants to tell that person why they identified with their story. After that, ask participants to sit in a circle.	
70 min	**Main activity:** Story Narration	In this segment, narrate and dramatise the translated version of the 'Kissing the Monster on the Nose' story. Ask participants to listen attentively while you tell	Long roll of brown/whitepaper, a girl doll, 2 monster teddy bears, Plain white papers, lots of pens, pencils,

		and dramatise the story using a doll and teddy bears on the scale represented by the road map. (see a brief synopsis of the story in Appendix D). Having listened and reflected on the story, ask participants to draw their personal monsters. Then ask them to share the drawings first in pairs then in a group of four people before moving on to create and dynamise the consolidated image of the four stories. And based on their interpretation of what they feel, ask the groups to find a way of symbolically kissing each other's monsters. The group will have to decide what their kiss symbolically stands for.	crayons, koki's etc
25 min	Reflection	▪ How has this process impacted on how you understand and think about sickness? ▪ Why do you think fear was equated to the monster in the story? ▪ What does 'kissing the monster' stand for? And what does the process of getting to the point of kissing the monster require? ▪ What has the process brought up for you in	

		terms of how you relate to 'sickness? ▪ What is required to bring about transformation in terms of how you relate and think about sickness?	
5 min	Closing ritual of prayer and song	One group member leads.	
WORKSHOP FOUR: 23rd Oct 2008			
20 min	Opening ritual of prayers, singing and preaching.	One group therapy member will lead this session.	
20 min	Warm up	Blind Fold game: Ask participants to work in pairs. One person will be blindfolded and be led through the room by a partner and vice versa. The responsibility of the leading person is to make sure that their partner is safe and trusts them enough to lead them. Ship game	Cloths
70 min	**Main activity:** Negotiated existence	Ask participants to make three sketch drawings of themselves on the papers and tag them 1, 2 and 3. **Diagram 1: Society** On the first diagram, ask participants to label all the phrases and things that society said (1) about them (when they	Flip charts, Pental markers, koki's, crayons

		discovered they were HIV-positive), (2) about the virus. The labelling should include all the things that people said they could not do or achieve, for example, that they would not live longer, would be sickly etc. **Diagram 2: What I felt and said about myself** Ask participants to label the second diagram with all the thoughts and beliefs they had about themselves and the virus when they discovered they were HIV-positive. What kind of relationship did they have with the virus and what did they say to themselves and what did they feel. What did they think they were capable of because they were HIV-positive. For example, did they think; I am bad, I am dying. **Diagram 3: What I say and feel now** Lastly, ask participants to label the third diagram with what they feel and think of themselves currently. This should include all the things they feel they are capable of doing and achieving	

		and the phrases that stipulate the kind of relationship they have with the virus now. Having done that, ask participants to read out loud what is labelled on each diagram for recording on a flipchart. At the end, ask participants to identify all the negative things and list them on one side and the positive things on the other. Then using improvisation in three groups, ask participants to come up with 3 short movement dramas: ▪ The first one of what happens to them when they have negative thoughts, what does that do to their bodies and to their entire lives? What does that do to their sense of self, their self-esteem and frame of mind? What does that do to their relationship with the virus? ▪ Secondly, what happens to them when they are filled with positive thoughts, what does that do to their body and to their entire lives? What does that do to their sense of self, their self-esteem and frame of mind? What does that do to their relationship with the virus? ▪ Thirdly, what kind of	

		thoughts, relationship would they want to have with the virus and why? What regulations would they set up to negotiate their existence?	
25 min	Reflection	▪ What impact does thoughts have on your general well-being? ▪ Why is it important to reflect on how you relate to the virus and to negotiate your existence with the virus? ▪ How would this contribute to your safety, healing and personal growth?	
5 min	Closing ritual of prayer and song.	One group member leads.	
WORKSHOP FIVE: 24th Oct 2008			
20 min	Opening ritual of prayers, singing and preaching.	One group therapy member will lead this session.	
20 min	Warm up	Agree-Disagree game.	
70 min	**Main activity:**	To emerge within the course of the week.	
25 min	Reflection on the	Ask participants to sit in a circle	

	workshops	and reflect and share their feelings on the entire workshops	
5 min	Closing ritual of prayer and song.	One group member leads.	

APPENDIX D: A BRIEF SYNOPSIS OF KISSING YOUR MONSTER ON THE NOSE STORY

This is a story of a girl who goes on a long journey over the mountains to visit her grandparents. On the way she meets two monsters at a fork in the path. Initially she runs down the hill towards the village but something within her tells her to stop and go back. She goes back and the good looking monster tells her to take the road on the left because it is safe. She follows that monster while the ugly one guarding the road on the right continues to scream and howl even harder. But as she follows, something inside her again tells her to go back and take the road to the right. Suddenly, she darts back to the junction and on to the road on the right. Later that day an earthquake destroys the entire land where the left road was leading. The girl gets distressed thinking of what could have happened to her had she not returned. Then the ugly monster appears, looking calm and peaceful and tells her that as it was growling, it was trying to protect her from destruction (Full story in Friel, J. and Friel, L.1988).