Using Theatrical Practices as a Modality within an Intervention Plan for the Communication Impairment of Aphasia

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Thesis directed by Associate Professor Oliver Gerland

Abstract:

In the practice of theatre, actors communicate with the audience by both verbal and non verbal means. Commonly misunderstood as a comprehensive communication disorder, aphasia is a diagnosis given when the language center of the brain is damaged. Individuals with aphasia have trouble either understanding language, generating language, or both. Language, however, does not encompass the myriad of ways that humans are able to communicate. Actors explore these alternative communication strategies in multiple divergent forms of theatrical practices. This dissertation examines the ways that theatrical practices (primarily informed by the works of Augusto Boal) can be used to enhance the communicative abilities of individuals with aphasia through disrupting the perceived superiority of verbal communication over nonverbal communication. Outlined in this work are six unique interventions created for individuals with aphasia that use theatrical practices as a modality within treatment. These interventions are: (1) Théâtre Aphasique in Montreal; (2) The Rehabilitation Institute of Chicago's *Waiting on the Words*; (3) The Adler Aphasia Center Drama Club in New Jersey; (4) Laura Wood's and David Mower's Co-Active Therapeutic Theatre Model; (5) CU Boulder's Speech Language and Hearing Clinic's *The Wizard of Oz*, and finally (6) their subsequent production of *Charlie and the Chocolate Factory*. Ultimately, this research confirms the efficacy of theatrical practices in assisting individuals with aphasia to increase their communication confidence and subsequently their quality of life. Additionally, this dissertation identifies significant areas of overlap between

the communication goals of speech-language pathology and the communication outcomes of theatrical practices. As such, this research suggests the need for further study from both speech-language pathologists and theatrical practitioners in utilizing this modality of intervention for individuals with aphasia.

This dissertation is dedicated to the extraordinary group of actors that is CU Boulder's SLHC's Chat Group.

List of Images

Introduction

Introduction

In the fall of 2021, I led a 90 minute drama session with a group of actors working on their upcoming production of *Charlie and the Chocolate Factory*. I had been a little over zealous in getting the actors on their feet and working on embodied character work; subsequently, I found myself with 20 minutes left in the session and a group of exhausted actors. I knew we needed to sit, but had nothing planned that involved sitting. Luckily, I remembered one of Augusto Boal's theatre games, "Pot of Honey" (*Games* 31).[1]

"Pot of Honey" is an imaginative sensory exercise—and reader, I encourage you to do the exercise with me as you read this next section.

First, imagine sticking a large spoon into a pot of honey, and putting it into your mouth. Feel the texture of the honey, taste its sweetness, its stickiness. Next, imagine that a pinch of salt has been added to the honey, and let yourself experience what that might be like. Now, imagine a pinch of sugar has been added to the honey and…enjoy. Finally, allow the honey in your mouth to heat and to thin down enough so that you can swallow what is left and finish the exercise.

Could you taste the honey? If not, that's okay. Boal uses this exercise to develop an actor's imagination and sensory memory, to help build it. Why not try it again, to practice, and see if you can sense the honey a little more? We did.

Once our group had practiced "Pot of Honey" twice, we went back to the scene we were working on from *Charlie and the Chocolate Factory* and recalled the candies the actors had chosen to imagine in Willy Wonka's chocolate room. Then, each actor in the group mimed eating

[1] The way I do this exercise as described in this section is an adjusted iteration of Boal's original exercise.

a different candy. I could see the actor playing Augustus Gloop shove large chocolate bars into his mouth, and the actor playing Grandpa Joe enjoy a large lollipop. I could see that each actor understood the exercise and was excelling at it. We concluded the session by enjoying three performances from members of the group. Everyone else was able to sit back, rest, and laugh.

After leaving the session in high spirits and with a sense that the session was successful, I was suddenly struck by questions: *what in the world was I doing?*, *why did I feel that doing this exercise was a good use of our time?*, and *what can I call this practice?* In truth, though I was doing many of the same things I had done for the past decade as an applied theatre practitioner, this work seemed different from the applied theatre projects I had done in the past. And, in truth, it *is* different.

The session described above took place at CU Boulder's Speech Language and Hearing Clinic (SLHC) and each actor in the group had a diagnosis of aphasia. Aphasia is a language disorder caused by damage to the language center of the brain. The work I did in the session described above, the on-going collaborative work I do at SLHC, and the work I did on the 2019 production of *The Wizard of Oz* (described in the third chapter of this dissertation) emerges at a relatively new site of engagement for researchers and practitioners alike. This work could be called theatrical practice, applied theatre, art therapy, drama therapy, therapeutic theatre, or even speech-language pathology; however, to cover this work under only one of these umbrellas would be sure to leave some part of it out in the rain. As such, the work that emerges at this new site of engagement is its own entity. As yet unnamed, it is the process of using theatrical practice as an intervention for specific neurological impairments and degenerative diseases. In my work described above and in the research of this dissertation, I use theatrical practice as a modality

within the intervention plan for the communication impairment of aphasia in collaboration with speech-language pathologists.

Research and Inquiry

Recall to your mind the "Pot of Honey" exercise. Not all theatrical scholars and practitioners will recognize this specific exercise, but as a sense memory exercise, it may not be far from an exercise with which they are familiar. Now take one additional step—*what cognitive functions were used during this exercise?*, *what language functions were used?*, and *what communication functions not directly tied to language were used?* It is in the answer to these questions that I believe will illuminate an understanding of my primary research question: how do theatrical practices work as an effective modality within the intervention plan for individuals with aphasia in a clinical setting as part of their long-term recovery?

Project Beginnings

Late in the spring of 2019, I began an ongoing interdepartmental collaboration with CU Boulder's SLHC speech-language pathologists Holly Kleiber and Christina Riseman. I had been practicing applied theatre for ten years, and during this time, I had become deeply curious about the correlation between theatrical practices and contemporary research in psychology and cognitive neuroscience. For example, in my work using theatrical practices to teach Shakespeare in prisons, I learned that many program participants suffer from neurological impairments due to traumatic brain injuries[2] or side effects from medications. These participants were specifically concerned about their memorization skills and I found that their abilities to memorize seemed to improve with practice and participation in our activities. Additionally, in my inquiry into the ability of Prison Shakespeare programs to reduce recidivism, which I conducted for my Master's

[2] According to research conducted for the Traumatic Brain Injury Association of America, up to 60% of prisoners are living with TBIs (Shulein et al).

thesis in 2017, I was surprised to find research in neuroscience that demonstrated how embodiment of a character can cause biological changes in an adult brain resulting in behavioral changes.[3] This process is investigated as part of broader research being conducted in neuroplasticity. In their 2017 study, neurologists from Johns Hopkins University School of Medicine, Donna C. Tippett and Argye E. Hillis define neuroplasticity as "the adaptive ability of the brain to reorganize and modify tissue functions" (4). My curiosity continued to grow, and I took a graduate class at CU in cognitive neuroscience. In this class, I was introduced to many areas of research in cognitive neuroscience which overlapped with my own practice as a theatre artist and applied theatre practitioner. Therefore, when SLPs Holly Kleiber and Christina Riseman emailed the Department of Theatre and Dance[4] about their desire to do a theatrical production with their clients with aphasia, I jumped at the chance. I had already learned from Tippett and Hills that the treatment of aphasia involves the "reorganization of structure-function relationships in the brain associated with neuroplasticity" (4). I was excited to continue my investigations in this area. Our collaboration began immediately, and it is the discoveries I made preparing for, rehearsing, and producing *The Wizard of Oz* and our subsequent collaborations that will be the main focus of this document.

Prior to proceeding in unfolding my methodology for answering my research question, I believe it will benefit the reader to have a clearer understanding of both aphasia and of some of the umbrellas of practice that partially shelter this work.

Aphasia

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[3] A 2015 study detailed in Laura Maister's article "Change my body, change my mind: the effects of illusory ownership of an outgroup hand on implicit attitudes toward that outgroup," exploring how embodied experience can significantly alter implicit biases.

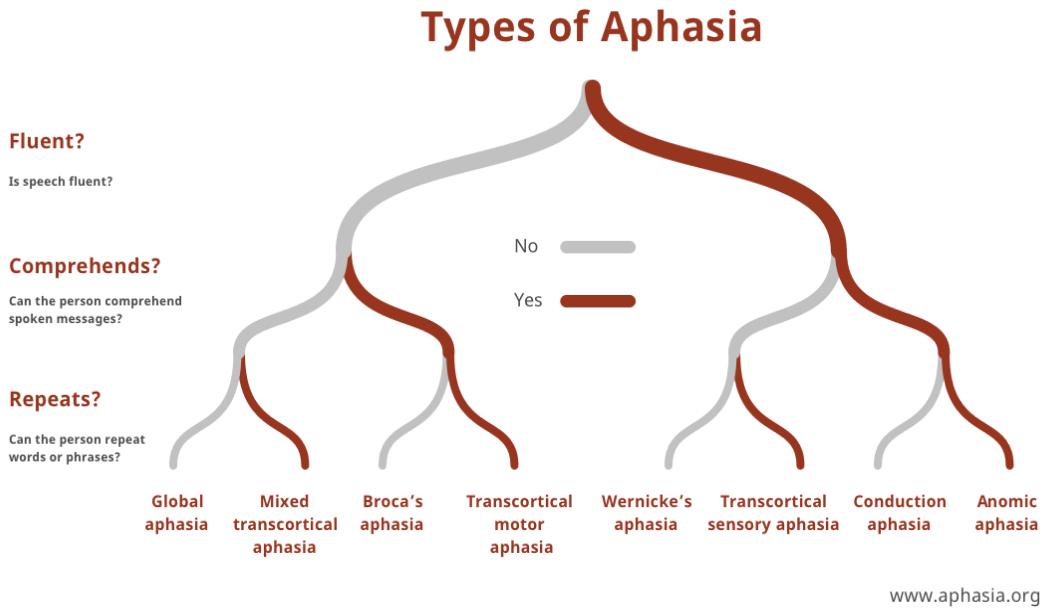
[4] They connected to the department of theatre and dance through SLP Jen Lewon who had previously collaborated with Dr. Beth Osnes in the Department of Theatre and Dance.

In my research, I was astounded to discover that the earliest known account of aphasia exists in a document known as the *Edwin Smith Papyrus*. The papyrus was written by a surgeon recommending treatments for brain injuries received by soldiers after battle and is believed to be over 5000 years old (Minagar 114). Case 20 in the papyrus is considered to be the earliest extant medical text referencing aphasia. The surgeon reports a patient who has suffered a deep head wound, writing, "he is silent in sadness, without speaking" (Howard and Hatfield 7-8). Unfortunately for that individual, "The case concludes with the advice that a patient with such a grave condition should only be comforted, not treated" (Minagar). Our knowledge of aphasia has significantly expanded since the *Edwin Smith Papyrus* was written.

Aphasia is a complex disorder and manifests uniquely in every individual. According to the *Oxford English Dictionary* (OED) aphasia is "Loss of speech, partial or total, or loss of power to understand written or spoken language, as a result of disorder of the cerebral speech centers." Disorder, or damage, to the cerebral speech center, or language center, can impair an individual's ability in reading, writing, speaking, and/or listening, and is different for each individual with an aphasia diagnosis. A diagnosis of aphasia can occur after a stroke, traumatic brain injury (TBI), brain tumors, certain infections, or widespread neurological degeneration (such as in individuals with Alzheimer's disease). Most often aphasia is caused suddenly by a stroke, and there is a wide range of ways in which it will impact an individual's life. Even very mild aphasia can restrict an individual from holding a job or participating in everyday activities. More advanced levels of aphasia can require constant care and impact other areas of the brain such as motor function and/or executive function. While individuals with aphasia often have co-occurring neurological conditions, for the most part, they are considered to be cognitively intact other than their language deficit.

There are many types of aphasia diagnoses that depend on what specific areas of the brain are damaged and how severe the damage is. A cursory search into aphasia by loved ones or caregivers to those impacted will bring the researcher to a very simplified explanation of what aphasia is and its different diagnoses. The Mayo Clinic's website's section on aphasia breaks down the impairment to only three types. These three types are 1) Broca's Aphasia (a type of Nonfluent Aphasia), 2) Wernicke's Aphasia (a type of Fluent Aphasia), and 3) Global Aphasia (Mayo Clinic). However, in truth, aphasia is far more complicated than these three subsets imply.

There are many ways to classify unique diagnoses of aphasia. One method is the Boston Classification System, demonstrated in the figure below, which is the most widely used system amongst speech-language pathologists. The Boston Classification System considers three domains of language ability for categorizing aphasia. And as you will see, performance in these three areas leads to eight unique diagnoses. These three considerations are speech fluency, comprehension, and repetition ability of words or phrases.



Imagae 1: The Boston Classification System for Aphasia, "Aphasia Definitions."

Speech Fluency

The first divide in the Boston Classification System is the fluency of the patient. In this case, fluency refers to the patient's ability to produce words, and not to their proficiency with another language (i.e., it is not the same as being fluent in a foreign language). For example, a patient who is fluent may be able to produce longer utterances, but they may seem nonsensical to the listener. In her book, *Language and the Brain* published at MIT in 2017, award winning professor, author, and cognitive neuroscientist Angela D. Friederici supplies an example from her research of a phrase uttered by a patient with fluent aphasia: "And I suppose also that this with the speaking or what else overall, this one, this is it, different to the legs that one I did not have" (7). Fluent aphasia can be caused by damage to Wernicke's Area in the left temporal cortex (named for Carl Wernicke (1848 - 1905)), as shown in figure 2). Whereas, nonfluent aphasia (when patients can only speak in short utterances, sometimes only using a few words that carry meaning and limited syntactical words) often occurs when there is damage to Broca's area. Broca's area (as seen in the diagram below) is located in the front of the language center and closer to the part of the brain that controls motor function and therefore nonfluent aphasia often presents with co-occurring weakness or paralysis in the right limbs (National Institute of Deafness and Other Communication Disorders).[5] Broca's area is named for Paul Broca (1824-1880) who discovered a brain lesion on the left inferior frontal gyrus of his former patient "Monsieur Tan" (Friederici 6). "Monsieur Tan" was so called as he was only able to utter the single syllable "Tan" when he came under Broca's care, though he still maintained elements of comprehensive ability.

[5] This is important to remember when working on theatrical exercises depending on gesturing.

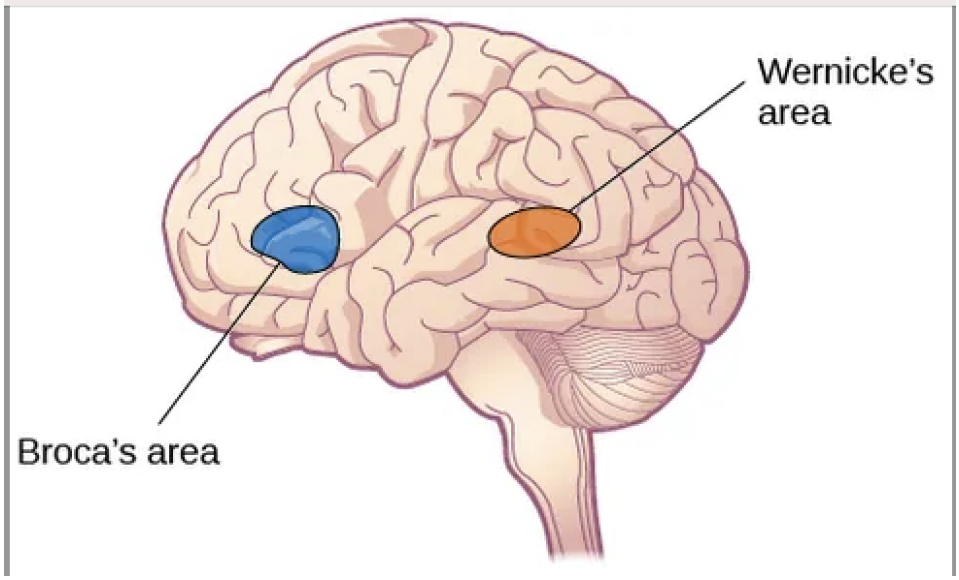


Image 2: Broca's and Wernicke's areas, "Wernicke's Area Location and Function."

Comprehension

The second divide in figure 1 is based on a patient's ability to comprehend spoken words (patients can sometimes understand written words when they cannot understand spoken words).[6] When a patient can understand words, but not speak them they have either Broca's aphasia or transcortical motor aphasia. Additionally, if a patient is nonfluent and also has trouble comprehending words then, according to the Boston Classification system they may have either global aphasia or mixed transcortical aphasia.

Repetition Ability

The third divide in figure 1 is based on the patient's ability to repeat words spoken to them (a separate cognitive process than retrieving words and naming words from a picture). According to "Repetition in Aphasia," an article published in *The Journal of Neurolinguistics*,

[6] This is important to remember when communicating with individuals with aphasia, having a white board handy to write a word down can help with comprehension.

Alfredo Ardila and Monica Rosselli found in their study that "repetition deficits" were detected broadly across distinct diagnoses of aphasia. Repetition deficits can be caused by aphasia or by co-occurring conditions. Ardila and Rosselli listed "limitation of the auditory—verbal short-term memory, difficulties at the level of the phonological production, defects in phoneme recognition, and deficits in semantic and syntactic comprehension" (103) as possible reasons for repetition deficits.[7] As a diagnostic tool, repetition tasks can assist in the differential diagnosis of aphasia, such as with conduction aphasia in which repetition is impaired while speech fluency and auditory comprehension are relatively spared. While the Boston Classification System is helpful at arriving at these additional subsets of aphasia, its eight diagnoses by no means encompass all the nuanced facets of the condition.

New Diagnostic Tools and New Frontiers

As shown above, these three divides lead to eight aphasia diagnoses. Now, with the advent of neuro-imaging technology such as the functional magnetic resonance imaging (fMRI), our understanding of the anatomy of the brain, and how damage to particular areas impacts language abilities has become even more precise. With an fMRI we can see what area of the brain is being used with any specific task. With this precision has come an understanding of further complexities in how damage to the brain affects language production and comprehension, including at the sentence level. For example, a patient may specifically have difficulty understanding syntactical information. Friederici supplies the example of the sentence "*The boy was pushed by the girl*...misinterpreted when only processing the content words *boy pushed girl*" (7). This adds to the complexity of diagnoses and is an example of why aphasia is highly

[7] It was extremely beneficial to have a student clinician who worked individually with each member of the cast as it allowed each clinician to cue their client uniquely.

individualized. Difficulty understanding syntax can occur when either the Broca's area or the Wernicke's area is impaired.

Progressive Aphasia

The aphasia types discussed in the above section relate to the Boston Classification System. However, there are other ways to classify aphasia. For example, when aphasia is caused by progressive degeneration of brain regions associated with speech and language, it is called Primary Progressive Aphasia (PPA). PPA breaks down into its own subsets of aphasia which is equally complex. My hope in this section is to give the reader enough examples to allow them to fully understand the complexity of the condition on which this research is focused; however, knowledge of each and every iteration of aphasia is not necessary to understanding the research question. It is necessary to understand that in my own work at CU Boulder's SLHC and in the other projects described in this study that when a group of individuals with aphasia is formed that each member of that group is unique in their language deficits and consequently, that many forms of communication strategies are necessary.

Theatrical Practices as an Intervention for Aphasia: A New Site of Engagement for Interdisciplinary Research

In addition to the unique diagnoses of each participant in the five projects described in this work, there will also be diverse individuals facilitating each intervention. The facilitators are drama therapists, speech-language pathologists (SLPs), professional theatrical practitioners, and, in my case, an applied theatre practitioner. In order to investigate this new site of engagement it is worthwhile to take a brief look at current disciplines that engage in this work, and why the work does not fall under the single umbrella of these disciplines.

Applied Theatre

Applied theatre has two primary characteristics: it takes place outside of a traditional theatrical setting and it is used for social change. *The Applied Theatre Handbook* defines applied theatre as follows:

> Applied theatre has emerged in recent years as a term describing a broad set of theatrical practices and creative processes that take participants and audiences beyond the scope of conventional, mainstream theatre into the realm of a theatre that is responsive to ordinary people and their stories, local settings and priorities. (9)

In other words, applied theatre is about serving communities. Additionally, it can take place anywhere, including but not limited to a classroom, a community center, a derelict building, an open field, and even a prison. Using shadow puppet theater in schools to teach children about energy use, playing theater games during corporate conferences to stimulate creativity, or creating a theatrical performance from interviews to bring a community closer together are all examples of applied theatre.

While applied theatre can be done anywhere, my work uses theatrical practices in a clinical setting. By clinical setting, I am referring to an establishment where services rendered are part of intervention for a condition. Working in a clinical setting denotes a complex set of rules and protocols and should be guided by evidence based practice standards. The work done in this setting must be supported by medical research or evidence based practices to qualify as a medical treatment. Using theatrical practices within a clinical setting creates a bridge between the sciences and the humanities. As an applied theatre practitioner, it is essential for me to recognize that I could not do this work without the collaboration of SLPs, familiar with the requirements of this setting.

Art Therapy

Using theatrical practices as an intervention for aphasia could also fall under the umbrella of art therapy; however, there are important distinctions. According to the *Oxford Dictionary of Psychology*, art therapy is defined as "A form of psychotherapy in which clients or patients are encouraged to express their feelings and inner conflicts through art" (Colman). In other words, art therapy is the process of using art (theatrical practices, painting, music, media art, etc.) as a way of expressing feelings. Art therapy can be a deeply meaningful and effective process. In their article, "Art therapy: an underutilized, yet effective tool" Robert A. Bitonte and Marisa De Santo write, "the American Art Therapy Association has succeeded in [conducting formal research], with studies showing improvement of the patient groups emotionally and mentally in many case types" (18). The value of improvements both emotionally and mentally should not be underestimated for individuals in any circumstance, and I am an avid believer in the benefits of art therapy. However, the emotional benefits of art therapy that an individual with aphasia receives from engaging in theatrical practices is only one of the goals of the interventions described in this dissertation. Not only do the interventions in this dissertation hope to impact the emotional well being of the participants involved, there is an additional goal to provide opportunities to practice communication strategies while participating in theatre activities. Giovanni Mirabella, a neuroscientist, biologist, and physiologist, in his essay, "Does Art Therapy Work as a Rehabilitative tool?" suggests that art therapy should not be used as a general cure-all for neurological impairments, but could be impactful as a targeted therapy towards building or repairing specific neurological functions (159-160). Therefore, traditional art therapy does not completely cover the area of research discussed in this work.

Drama Therapy and Therapeutic Theatre

Drama therapy's origins spring from Jacob L Moreno, a psychiatrist with a love of theatre who introduced its practices into his own work, creating psychodrama in the 1920s (Johnson 5). However, the field transitioned to drama therapy, incorporating a wider range of practice and inspired by other art therapies in the 1960s and 1970s diverging from the original psychodrama which was increasingly led by professional psychologists instead of theatrical practitioners (6). Today, drama therapists are in the process of widening the scope of drama therapy. For example, drama therapist Laura Wood and her collaborators on the *Aphasia Park* project define drama therapy as "the intentional application of drama and theatre processes to help individuals make emotional and/or behavioral change"(2). In her contemporary definition of drama therapy we see the addition of "behavioral change," distinct from the emotional change at the heart of art therapy, as drama therapy moves to create more targeted approaches to specific conditions.

This change in the field of drama therapy came with the advent of *therapeutic theatre* as a subfield. In their article, "Therapeutic Theatre and Well-Being," drama therapists Stephen Snow, Mirand D'Amico, and Denise Tanguay discuss this change: "the art of theatre, per se, can be shaped into a powerful vehicle for therapy that positively affects psychological well-being…the development of therapeutic play offers a unique opportunity for growth and change for many stigmatized populations, such as persons with psychiatric disabilities, prison inmates, war-traumatized veterans, at-risk youth and the elderly" (73-75). Drawing on Snow et al., Wood and Mowers expand on the concept of therapeutic theatre while working with individuals in recovery (including recovery from aphasia). In their article, "The Co-Active Therapeutic theatre model: A manualized approach to creating therapeutic theatre with persons in recovery,'" they define therapeutic drama as "the intentional use of the process and

performance of a theatrical piece with specific therapeutic goals and intentions for an identified population" (217). The above definition of therapeutic theatre may seem to fit the work I am describing in this dissertation. However, the reason I am avoiding adopting *therapeutic theatre* as the foundation concept of this work is that it requires a credentialled drama therapist to co-facilitate its practice. The requirement of the facilitator being a licensed drama therapist goes against one of the primary purposes of this dissertation, which is to illuminate how all theatrical practitioners can contribute to this field, not just those licensed in drama therapy. Just as psychodrama moved away from being practiced by theatrical practitioners, I am wary that letting this work be classified under the umbrella of drama therapy will inhibit a broader practice.

Speech-Language Pathology

Finally, let us look at speech-language pathology. Speech-language pathologists (SLPs) treat individuals of all ages with communication, speech, cognitive, fluency, and/or swallowing disorders. SLPs help people struggling in communication in *any* way, whether that is in creating fluent speech or learning social rules of communication. For example, I recently consulted with a group of people transitioning gender working with SLPs at the University of Oregon to find their authentic speech tonality and pitch. The American Speech-Language and Hearing Association (ASHA) explains that assisting clients who have communication impairments also extends to the cognitive functions surrounding communication:

"Cognitive-communication—how well our minds work. Problems may involve memory, attention, problem solving, organization, and other thinking skills," also fall under the umbrella of speech-language pathology. While my research has shown that SLPs are fully capable of running a theatre program on their own (as we will see later at the Adler Center for Aphasia), it is still my belief that this work should be interdisciplinary and therefore hesitate to say that it

falls under traditional speech-language pathology. It is for this reason that I will continue to refer to the practice of using theatrical practice within the intervention for aphasia as a new site of scholarly engagement.

Reason for Study

According to The National Aphasia Association, over two million Americans have aphasia, and there are 180,000 new cases each year. Additionally, aphasia not only impairs language and communication, but can also impact a person's engagement in social activities and their mental health. For example, in their 2011 article, "Aphasic Theatre or Theatre Boosting Self-Esteem," Côté, Getty, and Gaulin discuss how aphasia can cause co-occuring mental health conditions, stating, "Having lost normal communication skills [individuals with aphasia] will often hide and isolate him or herself" (11). Research from Tippett and Hillis also highlights that isolation is a primary concern for individuals with aphasia. They note, "Reintegration into school, work, and family life may be precluded given human dependence on the spoken word, and social isolation is an all-too-common consequence of aphasia" (3). In their article, "Waiting on the Words," Cherney et al. write that individuals with aphasia "Report social isolation, loneliness, loss of autonomy, restricted activities, role changes, and stigmatization" (230). Furthermore, Audrey Holland in her contributive essay, "The Social Imperative for Aphasia Rehabilitation: A Personal History" to the 2020 publication of *Neurogenic communication disorders and the life participation approach: the social imperative in supporting individuals and families)* writes that, "The current health care system fails to recognize that all of these [communication] disorders are chronic. Only limited benefits extend beyond the earliest periods of actually living with the disorder" (2). The number of individuals impacted, the social isolation

felt by those individuals, and the minimal long term treatment options for those individuals warrants further study in this area.

There exists another compelling reason for further research in this area more directly correlated to theatre artists. As advances are made in cognitive neuroscience and clinical treatments for chronic disorders, there will be a broader call for theatrical practices in clinical settings. The current available research on theatrical practices as an intervention for aphasia is very limited; however, if we broaden our lens for just a moment, theatrical practice as an intervention for neurological impairment and degeneration other than aphasia is significantly more extensive. One example is the research being done at Ohio State University which uses Shakespeare practices to help children with autism. In their article, "Shakespeare and autism: an exploratory evaluation of the Hunter Heartbeat Method" published in 2017 in the journal of *Research and Practice in Intellectual and Developmental Disabilities*, Margaret H. Mehling, Marc J. Tassé & Robin Root write:

> Drama-based interventions offer opportunities for children with autism spectrum disorder to develop social skills including awareness of others; empathy; perspective taking; turn-taking; balance between listening and responding; gaining, maintaining, and directing the attention of others; adopting different roles appropriate to the setting; recognising rules and conventions of different groups; and recognising the facial expression of emotion. (108)

The list given above of possible benefits from a drama-based intervention is extensive, and not far fetched. In fact, similar claims are being made across multiple projects. The anthology *Theatre and Cognitive Neuroscience* published in 2016, includes two additional case studies of theatrical practices being used as a clinical intervention. One is for autism and the other is for

Parkinson's disease. In their chapter, “Theatre as a Valuable Tool for Parkinson’s Disease and Rehabilitation,” Nicola Modugno, Imogen Kusch, and Giovanni Mirabella write, “Theatre training could be a very effective form of cognitive rehabilitation. In fact, due to its similarity to real-life situations, patients might learn, or re-learn, social and emotional strategies in a protective environment and transfer them to everyday life situations” (177).

Recognition of the immense possibilities theatrical practice can have as an effective intervention for neurological impairment is also met by a resounding need for further and systematized research. As written by Jenna Gabriel, Elisa Angevin, Tamara E. Rosen, and Matthew D. Lerner in their chapter, “Use of Theatrical Techniques and Elements as Interventions for Autism Spectrum Disorders”:

> While there are many gaps in the existing literature, there is abundant anecdotal evidence suggesting the potential of theatre to improve social skills, as well as a plethora of existing theatre-based therapies and successful, in-demand community organizations...The growing demand for similar programmes suggests an urgent need to clearly and precisely evaluate their efficacy. (174)

While more research is needed to develop evidence based best practices for theatrical practice as an intervention for neurological degeneration and impairments, there is an expanding body of research and numerous examples of studies extant in this area. The work we do as theatre artists is important in so many ways, and clinical settings are calling for our assistance—quite literally in my case. It is my hope in writing this work that theatre artists will join studies and projects in clinical settings with confidence that we have integral skills and knowledge to offer.

Methodology & Chapter Organization

Chapter 1

The first chapter of this dissertation will expound upon practices in both speech-language pathology and theatre. First I will present research on some of the current practices used in speech-language pathology to treat individuals with aphasia. I will examine three diverse speech-language pathology methodologies and theories behind current treatments. These three practices are: Constraint-Induced Language Therapy, Melodic Intonation Therapy, and the Life Participation Approach to Aphasia. These diverse treatment options provide a sense of scope of the available accepted clinical treatment options. Next, I will uncover a specific theatrical practice, founded by Augusto Boal, that underlies the theatrical work presented throughout this dissertation: Theatre of the Oppressed (TO). As I will elaborate further in Chapter 2, the available research on using theatrical practices as an intervention modality for individuals with aphasia is currently very limited. Surprisingly, however, within this limited available research, all projects that established a collaboration with a theatrical practitioner (including my own) turned to TO to complete their work. Therefore, this research would be incomplete without information about the practices of TO and its founder Augusto Boal.

Throughout this dissertation I would like the reader to keep in mind that when the term Theatre of the Oppressed is referenced, it may refer to three very different things: a practice, a philosophy, or a book. The philosophy informs the practice, but many practitioners use Boal's exercises simply as a good form of actor training without connecting them to their underpinning philosophies. In addition to these three references (in case you felt a bit too comfortable holding all three forms in your mind) we must also recognize that every practitioner of TO uses those practices in their own unique way. As Babbage wrote in Boal's biography, "Theatre of the Oppressed techniques have been applied, adapted and reinvented by practitioners all over the

world. Directly and indirectly, his practice has entered contexts as diverse as political protest, education, therapy, prison, health, management and local government, as well as infiltrating the mainstream theatre establishment – and the list goes on" (1). In other words, exercises and games have been passed from teacher to student so many times and in so many unique circumstances that the correlation to the original exercise may be very slight.

Chapter 2

After providing a background of practices used both in speech-language pathology and theatre, Chapter 2 of this dissertation will move into a detailed overview of four unique projects using theatrical practices as a modality within interventions for aphasia. These four projects are the work done by Théâtre Aphasique in Montreal, a case study done at the Rehabilitation Institute of Chicago, the Adler Center for Aphasia's annual musical, and an on-going project developing the Co-Active Therapeutic Theatre model to create a replicable intervention for individuals in recovery (including aphasia recovery). Each of these projects includes both a rehearsal process and a culminating performance by individuals with aphasia. I am not including studies using theatrical games without leading towards a performance, or studies using theatre as a means of informing the public about aphasia, but performed by actors without aphasia.

Chapter 3

In Chapter 3, I will provide a model case study of my own experience joining CU Boulder's SLHC Chat group to put on a production of *The Wizard of Oz* in the Fall of 2019. In this chapter, I will outline the process from choosing the play, through learning theatrical games, rehearsing scenes, and finally the production itself. This chapter concludes with a discussion of five useful practices. (Some of which I brought to our process and some of which I learned along the way.) These practices are (1) the indispensability of collaboration, (2) the development of

participant agency, (3) the importance of immediate and fulfillable goals scaffolding the larger project, (4) prioritizing nonverbal communication over verbal communication, and (5) the continual re-engagement and reliance on theatrical practices.

Chapter 4

Chapter 4 will review three subsequent semesters when CU Boulder SLHC's Chat group continued to use theatrical practices as part of their intervention for aphasia throughout the Covid-19 pandemic. This includes a remote session held in June and July of 2021. During this summer session, the company discussed possible stories for their next production and acted out scenes. Next, I will discuss the Fall 2021 semester. In this semester, the group did theatrical work primarily with SLPs and student clinicians, collaborating only minimally with the theatre department and myself. Finally, I will review my work with SLHC's Chat Group for the first two months of the Spring 2022 semester. For these two months I had full leadership of the group. In these three sessions, the balance of interdisciplinary collaboration on the project shifted significantly and was instrumental in informing Kleiber, Riseman, and myself how this project can move forward as part of CU Boulder's SLHC Chat group.

Chapter 5

In writing Chapter 5, I returned to the questions I asked myself after using the "Pot of Honey" exercise: *What cognitive functions were used during this exercise? What language functions were used?* and *What communication functions not directly tied to language were used?* At this point, the reader will have learned ways in which theatrical practices have worked as a modality within an intervention for aphasia. That is why, in the concluding chapter of this dissertation, I will introduce a slight shift in my research question from *how* do theatrical practices work as a modality within an intervention for aphasia to *why* do they work? To answer

these questions, I interviewed my collaborators (speech-language pathologists Holly Kleiber and Christina Riseman) to garner their perspectives on areas of intervention overlap between speech-language pathology and theatrical practices. When I use the term areas of intervention overlap in this chapter, I am referring to areas where theatrical practices directly overlap with goals held in speech-language pathology to either improve communication skills or assist clients in their process of living with aphasia. In addition to my interview with Kleiber and Riseman, I will draw on three key articles to illuminate the areas of intervention overlap. The first article is Edna M. Babbit's and Leora R. Cherney's "Communication Confidence in Persons with Aphasia." The second article is Fridriksson et al.'s "Functional communication and executive function in aphasia." And finally, Miranda L. Rose's article, "Releasing the Constraints on Aphasia Therapy: The Positive Impact of Gesture and Multimodality Treatments." These three articles were written by speech-language pathologists interested in uncovering the benefits in multimodal communication interventions.

Chapter 1: A Look at Practices Used in Speech Language Pathology and the Practices of *Theatre of the Oppressed*

Introduction

Before demonstrating how speech-language pathology and theatrical practices come together in the five projects reviewed in this dissertation (Chapters 2 & 3), this chapter will supply the reader with a background of practices used both in speech-language pathology and theatre. Constraint-Induced Language Therapy, Melodic Intonation Therapy, and the Life Participation Approach to Aphasia are all current treatments or ideologies used in clinical settings to treat individuals with aphasia. All have a unique approach derived from evidence-based practices to improve distinct facets of communication. Following the description of these treatments I will provide a brief background of Augusto Boal and set forth an overview of the practices of *Theatre of the Oppressed* (TO). Boal is at the heart of all the applied theatre work I do and, apparently, has proved useful to others who use theatre in the treatment of aphasia. While the number of available theatrical practices seems almost infinite, all theatrical practitioners discussed in this dissertation engaged with methods from TO. The prominent use of TO speaks to its salience amongst theatrical practitioners; in elucidating some of the practices of TO, my hope is that readers will become aware of the strong overlap between TO and its ability to improve an individual's communication abilities.

Current Treatments for Aphasia

Given the complexity of aphasia diagnoses, treatment options for individuals with aphasia are correspondingly complicated. Individuals with aphasia and their loved ones will have a variety of experiences when it comes to care and support. This section will explore both the

questions facing clinics and speech-language pathologists (SLPs) as they design treatment programs and some of the current treatment options available for individuals with aphasia.

Post-stroke pharmacological and surgical treatments for aphasia primarily treat the cause of aphasia (the damage to the tissue) and work to prevent further damage. After the damage to brain tissue has occurred and there are no more preventative measures to be taken, speech language pathology is currently the recommended treatment (Mayo Clinic Website; ASHA website; Friederici). According to the American Speech-Language-Hearing Association (ASHA) website, "the goal of intervention is to help the individual achieve the highest level of independent function for participation in daily living." This goal makes treatment methodology for aphasia incredibly diverse: should an individual's treatment focus on retrieval of brain functions lost (restorative treatment), focus on compensating for lost brain function (compensatory treatment), or a combination of the two? The kind of therapeutic treatment an individual receives depends upon their unique diagnosis, as well as the approach of the clinic.

To illustrate the diversity of the different types of treatment available, I will give three examples of treatment approaches an individual with aphasia might receive today. First, Constraint-Induced Language Therapy (CILT), which is a restorative treatment for aphasia, focuses on rebuilding lost language functions by restricting the use of nonlanguage based communication. Melodic Intonation Therapy (MIT), which is both a compensatory and a restorative treatment for aphasia, uses the nonlanguage based communication function of prosody (defined below) to help individuals with aphasia rebuild language function. Finally, the Life Participation Approach to Aphasia (LPAA), the ideologies of which lead to both compensatory and restorative treatments for aphasia, centers its attention on the needs and

desires of the individual with aphasia, and builds treatments based on what is most likely to assist the individual with participating in life activities.

Constraint-Induced Language Therapy

The theory behind Constraint-Induced *Language* Therapy (CILT), introduced as a therapeutic treatment for aphasia in the early 2000s, is based on copious amounts of research done on Constraint-Induced *Movement* Therapy (CIMT) (Cherney; Pulvermüller; Kempler). In CIMT, individuals with depleted motor function after a stroke constrain the use of their arm least affected by the stroke, in order to force themselves to make use of their arm most affected (Cherney et al. 1283). Forced use of the arm most affected enables the brain to repair the damage by creating new and more neural connections. As constraint-induced therapy was effective for motor function, the theory is that it is similarly effective for language functions. In their article, "Evidence-Based Systematic Review: Effects of Intensity of Treatment and Constraint Induced Language Therapy for Individuals with Stroke-Induced Aphasia" Cherney et al. write, "A constrained approach for aphasia is incorporated in the therapeutic setting by forcing the patient to communicate only through verbal channels, while limiting the use of all other communication channels" (1283). In CILT, individuals with aphasia spend considerable amounts of time working only on overcoming language impairments and practicing linguistic communication (Pulvermüller 1621), instead of practicing a multimodal approach to communication. Multimodal communication is an understanding that human beings communicate in multiple ways. Our actions, our bodies, our gestures, the sound and timbre of our voices are a few examples of ways people communicate without words. These alternative modes of communication are constrained in CILT.

Melodic Intonation Therapy

As early as the mid 18th century there were cases reported of patients who could not speak, but were able to sing the words to hymns they had known before their illness with minimal difficulty (Howard and Hatfield 14). In fact, Andrea Norton, Laura Zipse, Sarah Marchina, and Gottfried Schlaug of the Music, Stroke Recovery, and Neuroimaging Laboratory of Beth Israel Deaconess Medical Center observe, "For over 100 years, clinicians have noted that patients with nonfluent aphasia are capable of singing words that they cannot speak" (431). In their 2009 article, "Melodic Intonation Therapy: Shared Insights on How it is Done and Why" Norton et al. describe how rhythm and music became a formal treatment for aphasia in 1973 with the introduction of MIT. Using high probability phrases (phrases the individual is more likely to need in their lives, i.e., "water" and "I love you"), speech therapists practicing MIT, divide the syllables between two pitches, using the natural rhythm of the words. The phrase is then intoned by the therapist and repeated back by the individual with aphasia, followed by a methodical series of cuing of the musical phrases. As the individual with aphasia progresses, they are given longer phrases (431-432). While the original treatment protocol was systematic, Norton et al. found that when they published their article that speech therapists currently used a variety of intonation tactics: "there appear to be almost as many interpretations of the original protocol as there are people using it" (432). Individualization of the protocol increases the difficulty of systematized research of MIT.

The theory behind MIT is connected to the language phenomena known as prosody. In their article, "An Overview of Prosody and Its Role in Normal and Disordered Child Language," published in *The American Journal of Speech-Language Pathology*, LouAnn Gerken and Karla McGregor describe prosody as follows:

> Prosody is a general term used to refer to three types of language phenomena, phrasal stress, boundary cues, and meter. Phrasal stress refers to the phenomenon by which one word in a phrase is made more prominent or salient than other words by making it longer in duration, louder, or higher in pitch. Boundary cues comprise pauses, as well as changes in duration and pitch, that occur at the ends of units of language...Meter (or rhythm) refers to the regular pattern of stressed and unstressed syllables exhibited by words and phrases. (38)

In other words, our interpretation of intonation, melody, and rhythm all occur as part of prosodic phenomenon. As a theatre scholar and practitioner, prosodic phenomenon stands out to me as a very large component of communication, especially as someone whose primary background resides in teaching non-actors to speak Shakespeare's texts, which require the actors to heavily rely on prosodic function to navigate the iambic pentameter. As a major function of communication, I was surprised to learn that prosodic brain functions occur in the right hemisphere of the brain. As stated above, aphasia occurs when the language center, located in the left hemisphere of the brain, is damaged. Therefore many individuals with aphasia have full access to prosodic brain functions in the right hemisphere. In describing how MIT works, Norton et al. write, "treatment…uses the musical elements of speech (melody and rhythm) to improve expressive language by capitalizing on preserved function (singing) and engaging language-capable regions in the undamaged right hemisphere." MIT relies on engaging the undamaged right hemisphere to assist in the left hemisphere's processes of language. However, Norton et al. point out that dual hemispheric engagement might not be the only reason MIT works. The naturally slower pace of intoned phrases and the potential for increased inner

rehearsal (singing the phrases repeatedly, the way you do when you get a song stuck in your head) could also contribute to successes in MIT (435).

The Life Participation Approach to Aphasia

In the 2020 publication of *Neurogenic Communication Disorders and the Life Participation Approach: the Social Imperative in Supporting Individuals and Families*, co-editor Audrey L. Holland contributed a chapter based on her personal experience as a SLP over the years. In this chapter, "The Social Imperative for Aphasia Rehabilitation: A Personal History," Holland recounts her emotional response to the advent of the LPAA Project Group in 2000: "I felt free to be clinical me, not abandoning impairment work, but freeing me to confront the whole complex picture of aphasia and what I could do to help to minimize aphasia's effect on getting on with life as fully and as quickly as possible" (11-12). In expressing her excitement about LPAA allowing her to remain"her clinical self," Holland reaffirms the importance of restorative treatment that work directly on language impairment; yet, she also recognizes that appropriate attention to compensatory communication, and individual needs had been, to that point, lacking from current treatment options. As Holland says, LPAA would prove to be innovative in "confront[ing] the whole complex picture of aphasia."

The founding members of the LPAA Project group, Roberta Chapey, Judith F. Duchan, Roberta J. Elman, Linda J. Garcia, Aura Kagan, and Jon Lyon defined LPAA below:

> The "Life Participation Approach to Aphasia" (LPAA) is a consumer-driven service-delivery approach that supports individuals with aphasia and others affected by it in achieving their immediate and longer term life goals (note that "approach" refers here to a general philosophy and model of service delivery, rather than to a specific clinical approach). LPAA calls for a broadening and refocusing of clinical practice and research

> on the consequences of aphasia. It focuses on re-engagement in life, beginning with initial assessment and intervention, and continuing, after hospital discharge, until the consumer no longer elects to have communication support. (4)

At the heart of LPAA are continued communication support and insistence that this support lead to the individual with aphasia being able to re-engage with life activities outside of treatment for aphasia. Holland refers to LPAA as “a call to arms” (11), as indeed it is. LPAA was developed in response to the passing of The Americans with Disabilities Act (ADA) in 1990. In 1992, communication was defined in the ASHA bill of rights as "a basic need and basic right of all human beings." On the homepage of Aphasia Access, they write, “Communication is key to person-centered health care and a meaningful life.”

LPAA does not dictate specific treatments, but is rather an approach to treatments. LPAA values multimodal communication, measures of success that include quality of life or life enhancement, and priority given to individuals with aphasia self-selecting the activities they engage in (Holland 12). As shown in the diagram below, supplied by the Aphasia Access website, working directly on language and related impairments makes one of four parts of aphasia treatment that are equally balanced in LPAA. The additional pieces of the puzzle are: creating a healthy environment where an individual with aphasia can build their communication skills; self-selecting activities the individual is interested in and can be translated into life activities and engagement; and self-selecting activities that are personal and individual, to ensure the maintenance of personal identity instead of allowing the aphasia diagnosis to override the individual. The center of these four components is that an individual is “living with aphasia,” and aphasia is not defining who they are.

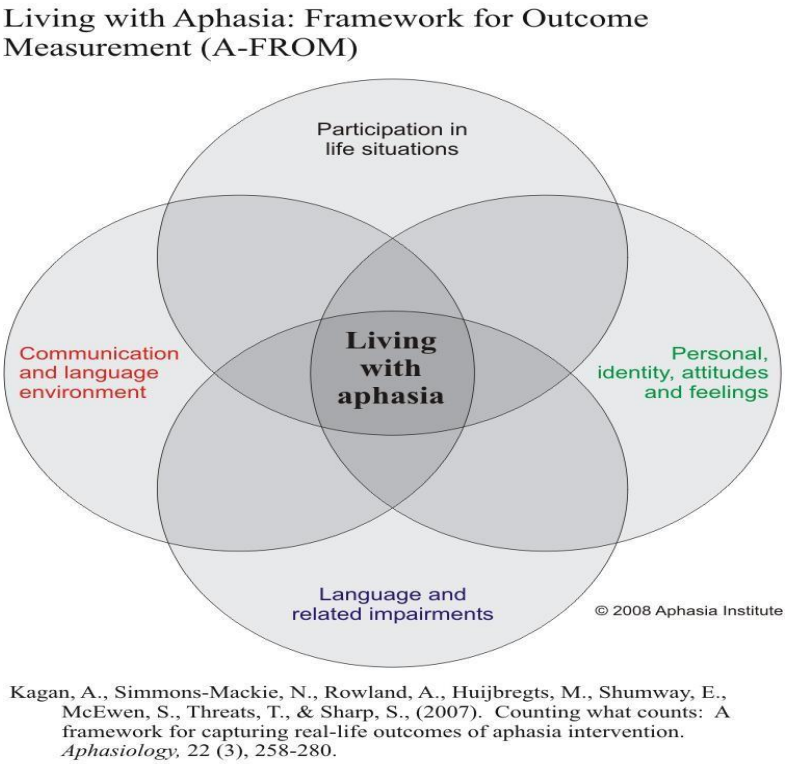


Image 3: Living with Aphasia, "Aphasia Access"

LPAA's call for "a broadening and refocusing of clinical treatment," was met by a shift in how aphasia is treated today. In fact, in the early 2000s clinical treatment centers began opening across the United States, such as the Adler Center for Aphasia, which included, as a treatment option, a drama club. Since then, theatrical practices have become recognized, though not broadly used, as an option for treating aphasia.

Augusto Boal

The limited instances of theatrical practices being used in the treatment of aphasia, of which I am aware, all use methods and techniques derived from the work of Augusto Boal. Augusto Boal was born in Rio de Janeiro in 1931 to liberal and middle-class parents (Babbage 4). To please his father, he went to the University of Brazil in 1948 to study chemistry, but found himself constantly pulled towards theatrical pursuits and met many of his future collaborators at

this time (5). After he graduated from the University of Brazil, he traveled to New York where he studied both chemistry and theatre at Columbia University. During this time, he became involved with Teatro Experimental do Negro in Harlem (6). With his father's support, he remained in New York for another year to focus entirely on his theatrical pursuits.

In New York, Boal studied playwriting under John Gassner. Gassner encouraged Boal to study classical and contemporary theatre. He introduced him to Greek playwrights and philosophers, Shakespeare, as well as the works of Bertolt Brecht, Elia Kazan, Tennesse Williams, and many others (7). However, Babbage suggests that while in New York, Boal was most influenced by the rehearsal techniques of Stanislavski as they were being used by The Actor's Studio (8). In fact, Boal himself writes of his beginnings at the Arena Theatre, "we created an Acting Laboratory in which we set about a methodical study of the works of Stanislavski" (*Games* 29). Bringing Stansklavski to Brazil in his work at the Arena Theatre would be the first steps he took in developing his own system of rehearsal in Theatre of the Oppressed.

When Boal returned to Brazil, he joined the Arena Theatre in São Paulo. Boal contributed to the Arena Theatre as a writer, director, and teacher. He served as the Artistic Director of the Arena Theatre from 1956 to 1971. However, his tenure there ended violently and abruptly. In his book *Augusto Boal,* Frances Babbage contextualizes the political environment in which Boal worked:

> Boal's years at the Arena Theatre of São Paulo shows how the company attempted to produce artistically innovative and politically radical theatre, and especially to foster the work of Brazilian playwrights and establish a genuine 'Brazilian aesthetic', all the while struggling against heavy financial constraints. The military coups of 1964 and 1968 were

> key points in a period of severe repression that continued, with fluctuations, throughout the 1970s. The power of the (military) government increased with civilliberties correspondingly restricted; oppositional parties were outlawed or refused to participate in the corrupt electoral process. All forms of cultural expression came in for heavy censorship. (3)

In response to his radical works at the Arena Theatre, Augusto Boal was arrested, imprisoned and tortured in 1971 for four months (Warren). Boal's imprisonment brought outrage from the international artistic community, and a petition, started by Arthur Miller, was successful in gaining Boal's release from prison. He was released, but subsequently exiled from Brazil for the following fifteen years (16). It was during his time at the Arena Theatre and during his first years of exile that Augusto Boal developed the Theatre of the Oppressed theatrical practice and philosophy. He first shared his practice and philosophy in an eponymous book, *Theatre of the Oppressed,* in 1974.

The Practice of Theatre of the Oppressed

"Theatre of the Oppressed…is not theatre in a playhouse, theatre with written script…because theatre is what we have inside. We are animals that have the privilege of being actors because we are acting all the time…We have theatre inside because we act"

-Augusto Boal 2006[8]

"We [practitioners of Theatre of the Oppressed] try to recapture this possibility that we have of expressing ourselves totally, and not only through verbal language"

-Augusto Boal 2004[9]

[8] See (Boal, Amy Goodman 01:49 -2:29)
[9] See (Augusto Boal 02:41- 02:54)

The above two quotes given by Augusto Boal point to what is at the core of his practice and philosophy. In Boal's eyes we are all actors. When Boal uses the term "non-actor," as he does in his book *Games for Actors and Non-Actors*, he is referring to an individual not yet trained as an actor. But, we all are actors, acting out our lives. However, as each individual travels throughout our daily lives, repeating the same actions in our work and routines, the body becomes mechanized. According to Boal, the mechanized body is "insensible to 70 per cent of [its] possibilities" as "the emotion may be blocked by a body already hardened by habit into a certain set of actions and reactions" (*Games* 29). Therefore, for Boal, the key to unlocking each individual's possibilities as an actor lies in demechanizing the body. Unlocking individual acting possibilities expands the expressive capabilities of the actor/non-actor.

. *Games for Actors and Non-Actors* (*Games*), first published in 1992, provides a detailed outline of how Boal unlocks the expressive capabilities of the body. Boal published *Games* decades after he began his work of Theatre of the Oppressed, and continued to add and update the book throughout his life. This book contains what Boal calls "the arsenal of *Theatre of the Oppressed*," including 190 pages of compact descriptions of over a hundred different games and exercises. It is a buffet of training techniques designed to increase possibilities of expression outside of verbal communication. As such, it is an ideal resource for helping facilitate individuals with aphasia grow their own potential for communication.

Boal divides his exercises into five categories: muscular, sensory, memory, imagination, and emotion exercises. Each of these categories of exercises consists of distinct series that the actors should move through as part of their training.

Muscular Exercises

Muscular exercises consist of five series: general exercises, walks, massages, integration games, and gravity. Many of these exercises require not only a physically fit body, but an able body unencumbered by injury. Therefore, many of these exercises are unsuitable to the population discussed in this work, due to the co-occuring conditions that can follow a stroke (impaired motor function and partial paralysis). For example, it would be unreasonable to ask a group of individuals with aphasia to participate in a wheelbarrow race (where one actor walks on their hands while another actor holds the legs of the first actor and they attempt to move together (*Games* 74)) or a "Kangaroo Walk" (where "the actors bend down and take hold of their ankles. They move forward in leaps and bounds, like a Kangaroo" (*Games* 73). However, many can do an exercise like a "Slow Motion Race" (actors set up to race across the room, and while they must always keep their body in motion, the last person to cross the finish line wins) (*Games* 71). Boal writes, "The most important thing is that the actors become aware of their muscles and of the enormous variety of movements they *could* make" (31). Ultimately, doing these exercises with individuals with aphasia requires a balance of finding new ways for the actors to move and recognizing the physical capabilities of the actors, including how much you can ask of them at one time. It was while doing a series of walking exercises that I over-tired my acting troupe and resorted to the "Pot of Honey" exercise described in the introduction to this dissertation.

Sensory Exercises

"Pot of Honey" comes in the next series of exercises described by Boal, sensory exercises. For Boal, sensory exercises are also closely connected with strengthening memory. He begins "Pot of Honey" by having his actors actually eat a spoonful of honey, followed by a pinch of salt, and then a pinch of sugar. After, "they enact the same thing without the original stimuli…This exercise is not about mimicry (smiles for honey, grimaces for the salt etc.), but

rather about genuinely experiencing the same sensation 'from memory'" (31). When I led this exercise, by not having them actually consume the honey etc, the actors were instead drawing on long term memory and their imagination. The discrepancy between the version of the exercise serves as an example of how each practitioner practices Theatre of the Oppressed in their own way. Boal's aim in sensory exercises is to develop a 'precision of recall' in his actors' that is genuine and rich and not mimicking an idea. To this end, Boal has invented a myriad of games to heighten the experience of each individual sense and an actor's awareness of them. Boal has his actors play with hearing the rhythm of their breath, a blind series (a series of exercises that the actors must perform with their eyes closed), and a series of exercises feeling their own bodies in space in relation to other actors.

Memory Exercises

Each of the above (and below) categories of games and exercises involve some memory recall; however Boal's actors do additional memory work every day as part of their training. For example, one exercise involves recalling in as much detail as possible everything that was done in a day before going to bed. The goal is for actors to remember more and more detail each time. Another exercise is to recall a specific event or incident of importance. Boal explains, "The point of this is not only to develop the memory, but also to enhance awareness; when everyone knows that they have to remember everything they see, hear and feel, their powers of attention, concentration and analysis develop" (32). It is exactly this attention, concentration, and analysis that are necessary for Boal's subsequent exercise category: imagination.

Imagination Exercises

Boal's imagination exercises are as mentally challenging as his muscular exercises are physically challenging. For an example, I offer his description of "the dark room":

> In a relatively dark place, an actor sits, with his eyes closed, with a tape recorder by his side. Another actor, or the director, starts giving him instructions which indicate where he is - in a particular street. The actor must imagine the said street and describe it in minute detail, right down to the clothes he is wearing and the faces of the passers-by. The director might, for instance, order the actor to go into a restaurant - the actor keeps talking, describing the waiters, the chairs, the customers -to sit down, and then to try to steal a briefcase belonging to a large man who is sitting quietly reading his newspaper. This is an imagination exercise which is also intended to release the actor's emotion. Having eaten rapidly, and described in detail the smells and tastes of the food, he goes to the toilet, fails to steal the case, pays his bill and runs out into the street in fear of being accused of the crime he has failed to commit. When the exercise is over, the actor listens back to what he has said and tries to recreate the action and relive the emotions a second time over. (219)

In this exercise, the actor is required to imaginatively build an entire world. The actor must construct enough to see in order to keep talking for the duration of the exercise. The memory exercises leading up to "the dark room" provide the actor with choices that come from their heightened sense of awareness of their surroundings. As a director, I use imagination exercises as they assist actors with building a sense of space that their characters live in. This sense space continually reinvigorates their embodied experience of that character. Therefore, imagination exercises also help the actors prepare for the emotional experiences of their characters.

Emotion Exercises

While all the exercises overlap, they are also all built to allow the actor full use of their emotions. At the beginning of his explanation of emotion exercises, Boal writes, "There is a wall

between what the actor feels and the final form which expresses it. This wall is formed by the actor's own mechanisms." The above exercises allow the actor the freedom to choose how they eventually play a role. Boal continues:

> The actor feels Hamlet's emotions and yet, involuntarily, he will express Hamlet's emotions in his own way: with his own physiognomy, his own tone of voice, etc. But the actor could also be in a position to choose, out of a thousand ways of smiling, the one which, in his view, would be Hamlet's; or out of a thousand ways of getting angry, the one which, in his view, would be Hamlet's way. (32-33)

After going through the rigamarole of Boal's training, the actor should be able to relax their body without the mechanisms created in them through their daily lives and work. "The starting point was to feel the character's emotions genuinely, so that these emotions would then find, in the relaxed [de-mechanized] body of the actor, the most adequate and efficient way of 'transmitting' themselves to the audience, so that the spectators might also feel them" (33). According to Boal, it is in the de-mechanized body in which the actor can experience more emotions and transmit those emotions most efficiently.

As Boal developed his practice, he admits to a change from the beginning of his career at the Arena Theatre to his later work with Theatre of the Oppressed. At the beginning of his career, influenced by the work of Stanislavsky, Boal and his actors spent a disproportionate amount of time on emotion exercise, but later he would focus more of his time on the de-mechanization process (33).

Conclusion

The aphasia treatments and philosophies of CILT, MIT, and LPAA either focus on restorative treatment and/or compensatory treatment; the exercises of TO can also be seen as

challenging the language impairments of an individual with aphasia, asking them to utilize compensatory strategies to communicate, or a combination of the two. The process of learning the exercise requires the individual to comprehend the instructions spoken to them. In other words, the actors have to understand the words of the explanation and act on them which could be used as restorative treatment. However, when they are using gestures, facial expressions, etc., they are using nonverbal communication modalities to compensate for their difficulties in producing spoken language. I will return to "Pot of Honey" as an example once more. The process of learning the exercise—hearing the instructions and comprehending the instructions—is a restorative process. In other words, the actors have to understand the words of the explanation and act on them. However, they do not need to respond verbally. By recalling to their mind the sensory experience and then acting it out, the actors express pleasure (at the sweetness of the honey), distaste (when the salt is added), discomfort (if their spoonful was too big), etc. Here, they are expressing nonverbally a myriad of emotions—a compensatory process, not rooted in language. While I will be explaining the overlap between theatrical exercises and speech-language pathology techniques in more detail in chapter 4, my hope is that readers can begin to see how these exercises can easily fit into aphasia treatments.

Chapter 2: Four Projects Using Theatrical Practice as an Intervention for Aphasia

Introduction

As I stated in my introduction the field of using theatrical practice as an intervention for neurological impairment and degeneration is quite large and expanding. However, while the field is expanding, there is very little extant research for interventions for individuals with aphasia. Research at this site of engagement remains scarce. The purpose of this chapter will be to shed as much light as possible on research that is available. Each of the projects I have selected to review include theatrical training, rehearsal, and performance. I will be reviewing four projects in this chapter where I was able to find published research and/or able to collect information from interviews with program leaders. The projects described use a hybrid of methodologies from speech-language pathology, drama therapy, Theatre of the Oppressed, and broader theatrical practices to shape their rehearsal processes and productions.

In order to assess whether or not an intervention was successful, I will document signs of participants' increased communication confidence in their progress toward their unique clinical goals. Research in speech language pathology has produced significant evidence that increased communication confidence is connected to an increased overall quality of life, hence my focus on participants' communication confidence as an indicator of a successful intervention. Chapter 5 will discuss in more detail the connection between communication confidence and quality of life. To demonstrate these markers of an effective intervention, I will report quantitative data collected in some projects; however, this data is limited, so a majority of my data will be qualitative data in the form of impressions from drama therapists, clinicians, and speech

pathologists leading those projects. When available, I will also incorporate information given by caregivers and family members, as well as communications from the participants themselves.[10]

Théâtre Aphasique

The Théâtre Aphasique was founded by Anne-Marie Théroux in Montreal in 1992. Théroux, a speech pathologist, professor, and theatre artist, collaborated with the Association Québécoise des Personnes Aphasiques (AQPA) to produce their first play of *LE SILENCE QUI PARLE* (The Silence that Speaks) (*Theatre Aphasique*). Since 1992, Théâtre Aphasique has produced eleven additional plays about aphasia and its impact, performed by individuals with aphasia. In 2011, Isabelle Côté (managing artistic director of Théâtre Aphasique) and Richard Gaulin (artistic development advisor of Théâtre Aphasique) collaborated with speech pathologist Louise Getty from the Université de Montréal to research the impact of the work at Théâtre Aphasique on boosting self-esteem for individuals with aphasia. Their article, "Aphasic theatre or theatre boosting self-esteem," was the only available article that details the work of Théâtre Aphasique until August of 2021 when *The Canadian Journal of Disabilities* published, '"I'm an artist, but with other tools!': Le Théâtre Aphasique and the intersection between artistic and clinical practices with people living with aphasia." The 2021 article, written in collaboration by Alberto Osa Garcia, Camille d'Anjou, Natasha Létourneau Edwards, Sandro François, Pénélope Goulet-Simard, Karine Marcotte, Richard Gaulin, Isabelle Côté, and Ingrid Verduyckt, summarizes in more detail the inner workings of Théâtre Aphasique and calls for further study at the intersection of disability arts and rehabilitation sciences (121). Garcia et al. stress the importance of the work of Théâtre Aphasique to combat negative stereotyping of and treatment for individuals with aphasia (145).

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[10] Communication from individuals with aphasia will be recorded with descriptions of facial expressions and intonations, so as to represent the communication to the best of my ability.

When Théroux founded Théâtre Aphasique, she also worked at the Villa Medica Rehabilitation Hospital in Montreal, which helped her create her approach for combining drama and speech pathology based on her theatrical experience, Theatre of the Oppressed, and her clinical practice. Théroux believed that adding theatre to clinical practices would support a new and enjoyable treatment for individuals with aphasia: "[Théroux] founded the Aphasic Theatre Company so that interested aphasic persons could become involved in communications activities in a successful and pleasant way" where the primary goal of the theatre troupe was "to create a shared, open, welcoming and respectful environment of peers and professionals" (Côté et al. 177). My research indicates that Théroux's work is the earliest to combine theatrical practices with clinical practices as an intervention for individuals with aphasia.

Théâtre Aphasique has two types of programs: drama workshops and theatrical play productions. In order to participate in the play productions, participants must first complete a drama workshop in preparation for a more intensive process. The drama workshops are done in collaboration with speech pathologists that help each individual with their specific aphasia diagnosis and clinical goals. In addition to workshops focusing on acting, Théâtre Aphasique offers workshops that focus on different components of both theatre and film, including script writing, and play reading and analysis as part of its program (Garcia et al. 131). This variety of offerings allows individuals to participate in creative activities that also address alternative components of communication. The play production (including rehearsals) is done without speech pathologists present; therefore, the only constraint on joining the performance troupe is the ability to participate and follow simple instructions without assistance from a speech pathologist (Côté et al. 179).

There is no one specific method at Théâtre Aphasique for the process of play development, which depends on the individual director: “There is, however, no specific formula to making a success with a theatrical play performed by aphasic persons” (Côté et al. 179). Théâtre Aphasique allows for individual artistry and adjustment of activity for each participant. For each production, the company hires a professional theatrical director. Given the flexibility in their program, each director is allowed to adapt their own theatrical process to fit the specific skills and abilities of their actors. The Théâtre Aphasique website includes links to excerpts from some of their plays and a video of a news segment done about the company from 2011, “Theatre Aphasique: When Ionesco meets Speech Disorder.” In the video, The Artistic Director of Théâtre Aphasique, Richard Gaulin (also a professional actor and director in Montreal) describes the rehearsal process as similar to a professional rehearsal process, only done more slowly (05:11 - 5:33).

Producing a play at Théâtre Aphasique often takes more than a year to both build the story and rehearse the final play. As seen in an excerpt from their play *Le Dernier Mot*, the production standards are quite high and a lot is asked of the actors involved. The image below, provided on the Théâtre Aphasique website, shows three female actors facing downstage, and another male actor sitting in a chair facing upstage. Behind them is a screen which adds to an abstract setting. The play begins with the three female actors coming on stage to music and

Image 4: *Le Dernier Mot*, "Play Productions"

repeating single words in a pattern. The video excerpt lasts for over seven minutes and contains consistent dialogue between the three female actors, and they are all off-book for the duration of the excerpt. This is unique to Théâtre Aphasique's program as none of the other programs described in this dissertation require actors to have all their lines memorized for the production. I was therefore not surprised to learn from the article published by Garcia et al. that artistic values remain a high priority in the development and rehearsal process. "Facilitators also encourage participants to focus on the goal of doing something with a good theatrical value. This underlines the vision of this workshop as an artistic activity and not only an opportunity for rehabilitation" (130). Co-author of the article, Pénélope Goulet-Simard, further comments, "Practically when you forget the word "aphasic", it gets possible to do something original and beautiful" (130). I was sincerely impressed by the quality of the production of *Le Dernier Mot* and the acting, and from my own experience agree that emphasizing artistic achievement can add a lot of value to similar programs.

According to the article by Côté et al. during the theatrical play production, "the rehearsal process includes imaginative exercises, exercises to assist in helping express emotions, line memorization and concentration exercises, and mime and expressive gesture exercises" (179). Garcia et al. provide a little more detail into a specific exercise the company uses to work on active listening:

> One example of these workshop exercises is the mimic game. Participants are asked to name different sports. Then, they are asked to link these sports to a representative movement. In this simple game two kinds of effects take place within the same task: first, participants make an important effort to listen, in that they have to try to follow other

> participants' movements and their intentions with these movements (engaging attention and memory in the meantime); second, by playing this, they give hints and ideas to the rest of the participants at the same time (this helps, for example, participants with ideomotor apraxia, a disorder sometimes present in people with aphasia hindering individuals from mimicking a specific movement or pattern). When good active listening is achieved, a little improvisation can be introduced into the exercise to wrap it up. (129)

Both the workshop and the theatre troupe emphasize the importance of active listening as a crucial component to work on both clinical goals and artistic goals. As Garcia et al. note, "Active listening is fundamental in this sense, and it has been highlighted as one of the best tools to achieve a feeling of accomplishment and reward through collective artistic empowerment. Unsurprisingly, active listening is also one of the challenges in theatre practice with non-disabled people" (128). By focusing on building good acting technique (e.g., an actor who reacts, not just an actor who waits to say their line), Théâtre Aphasique's program simultaneously helps achieve clinical goals of helping individuals with aphasia join in conversations in real life, which, of course, are unscripted.

The next step in the process of Théâtre Aphasique's acting troupe is script development. The script is composed of work done during the exercises stage and anything the director wants to add based on the theme of the specific play. Each play produced is about aphasia and is designed to promote a deeper understanding of aphasia to the general public and to care givers for individuals with aphasia (Côté et al. 180). Once the script is developed, rehearsals begin, culminating in public performances.

In their article, Côté, Getty, and Gaulin express that they found significant qualitative data from participants and caregivers to suggest that an intervention of theatrical practices boosts

self-esteem for individuals with aphasia.[11] Participants in the process reported "more and better interaction with relatives and strangers and with less stress" (181). They also reported increased self-confidence and reduced shyness. Côté, Getty, and Gaulin write, "the qualitative data assessment shows definite improvement of self-esteem for aphasic persons who have undertaken the theatrical play experience" (180). The article supplies a sample of quotes from participants, family members, and pathologists. One participant said after their experience, "I am living with aphasia and I thought that my life was over. But I was completely wrong. It is only different" (181). The daughter of a participant said, "I believe that the Aphasic Theatre helped my father to break through barriers, use all his will to keep trying to talk more and have fun on stage." Finally, a speech language pathologist said, "We do know that some aphaisic people will stay with limited speech abilities but their needs to communicate and interact with their relatives still remain. The Aphasic Theatre provides a means to express them and that is priceless…" (181). As demonstrated from these quotes, the impact of theatrical practice was powerful—not only for the individuals with aphasia who performed, but also for the family and caregivers of the performers. The research of Côté, Getty, and Gaulin shows that Théâtre Aphasique clearly offers a successful intervention, as outlined in this dissertation's introduction, by demonstrating that participants have increased confidence and increased perceived ability to communicate.

Rehabilitation Institute of Chicago, *Waiting on the Words*

In 2011, Leora R. Cherney, Ann K. Oehring, Keith Whipple, and Ted Rubenstein published the article, "'Waiting on the Words': Procedures and Outcomes of a Drama Class of Individuals with Aphasia," in *The Seminars for Speech and Language*. The article described the case-study of a collaborative team of speech-language pathologists and drama therapists who led

[11] In the article available by Côté, Getty, and Gaulin, the authors summarize collected data, but provide only limited examples of qualitative data and no examples of quantitative data received.

an 18 week drama class, meeting once a week for 90 minutes. The class, conducted at the Center for Aphasia Research and Treatment at the Rehabilitation Institute of Chicago (RIC), culminated in a performance of a devised play, *Waiting on the Words*. In their article, Cherney et al. detail the procedures of the drama class, how they built their play, and quantitative data on how participating in theatrical practices benefited the individuals with aphasia involved.

The methodology of this case study combined principles and practices from both drama therapy and speech-language pathology. From drama therapy, they pulled on projective drama, psychodrama, sociodrama techniques, and Theatre of the Oppressed.[12] From speech-language pathology, they drew on techniques and principles from LPAA including Multimodal Communication Techniques and Supported Conversation for Adults with Aphasia Techniques (SCA). SCA is designed to train caregivers and clinicians in communication skills for speaking with individuals in aphasia. As Kagan et al. state in their seminal article on the topic, "The approach is based on the idea that the inherent competence of people with aphasia can be revealed through the skill of a conversation partner" (624). The Aphasia Institute's website describes SCA on their website:

> SCA is designed to help people who "know more than they can say" express their opinions and feelings in a way that makes them feel valued and heard. By using the SCA™ method, conversation partners (such as family members, doctors, nurses, or friends) can help break down the communication barriers and help people with aphasia re-join life's conversations. (Communication Access)

The website also offers tips and instructions, such as tools you may use during a conversation with an individual with aphasia such as blank paper, markers, flashcards, and pictures. These

[12] The Drama therapy techniques are defined below and Theatre of the Oppressed was discussed in Chapter 1.

conversation tools will facilitate the conversation to become a multimodal conversation using written and spoken words, pictures, and gestures.

With the mixture of several techniques being used from two distinct disciplines, Cherney et al. felt confident that the practice of theatre would lead to multimodal communication being developed. They write, "regardless of the specific theory, methods, and techniques, drama therapy emphasizes the interplay between thought and speech and allows communication of ideas through both nonverbal and verbal means" (230). Here, Cherney et al. demonstrate their hypothesis that multimodal communication could be developed through practicing theatre. Subsequently, they led fourteen participants all with distinct diagnoses of chronic aphasia through the class and performance.

The process of the drama class had four stages, beginning by emphasizing communication opportunities and exchanges using various games from Theatre of the Oppressed and broader theatrical practices, followed by focusing on improvisation and scene development, later moving to practice and rehearsal, and ending in a performance (231).[13] In their article, Cherney et al. demonstrated a collaboration between drama therapy and speech-language pathology. For example, while the specific activities of actor development and the methods used to develop the script came primarily from drama therapy techniques (232), the type of play they developed was arrived at through practical application of LPAA. Cherney et al. write, "Group members began to suggest more and more what they wanted to tell stories about, and it became apparent that "aphasia" was the experience that they all wanted to focus on" (233). Principles of LPAA suggest that activities individuals with aphasia participate in should be self-selected (Holland 11). In the quote above, we see that while the framework of the drama class was

[13] As in Théâtre Aphasique described above, these four stages are very similar to those described by Côté et al. However, Cherney et al. went through these stages over a more condensed period of time: 18 weeks as opposed to over a year.

designed by the speech-language pathologists and the drama therapists, the content of the play was selected by the participants.

Watching *Waiting on the Words*,[14] it became clear to me how the different methods of drama therapy and theatrical practice were used. For example, the play began with gentle music as each member of the cast walked onto the stage and filled in the line, "I am" with the profession they held prior to their aphasia diagnosis (234): for example "I am a realtor" or "I am a homemaker." In this part of the play, each individual cast member performed their own experience, which is a form of projective drama in drama therapy. The play proceeds in this way for a couple of minutes. The first two actors who entered began to dance together slowly and gently to the music as each additional cast member joined them, stated their profession, and sat down around the stage. Some actors were able to say their whole line clearly, while others managed to partially say their line, or not at all. There were no corrections made; while some actors were cued to speak their line, whatever was spoken, or not spoken, was part of the play and the play continued calmly embracing every actor's level of participation equally. After the final actor entered with, "I am a composer" the play moved to a form of sociodrama. Immediately, harsh loud music was played, a screen behind the actors projected the image of a brain, and the couple that had been gently dancing walked past each actor to the sound of heavy drums. As the couple passed an actor, the actor dropped their head. After all the actors had their heads down the final pair took their seats and lowered their heads as well. Then, we heard a voice reading a litany of disorienting medical jargon which concluded with someone asking, "What happened?" (04:14-07:19). Together the actors demonstrated a collective experience. In a clear and compelling way, and in just about three minutes, *Waiting on the Words* illustrated what

[14] Available in full on youtube: https://www.youtube.com/watch?v=RdVDfEGDWdk&t=1061s

it might be like to be peacefully going through your life and to suddenly experience the life altering event of acquiring aphasia.

As well as seamlessly transitioning between both projective drama and sociodrama, the play also included metaphors developed from games from Theatre of the Oppressed. For example, one game they played during rehearsals from Theatre of the Oppressed they were calling 'space ball,' which is a variation of Boal's 'Peruvian Ball Game' (Games 96). Cherney et al. describe the instructions to this game as follows, "While in a circle, individuals passed and caught an imaginary ball of varying size" (232). In the 'Peruvian Ball Game' the imaginary ball changes in both size and weight. This game is for the actors to work on both improvisational skills and imaginative skills. Before passing the imaginary ball, the actor must clearly demonstrate the size and weight of the ball so that the actor catching it will know how to receive it.[15] In *Waiting on the Words,* an actor took a large sheet of paper with something written on it, and crumpled the paper into a ball. The actors then proceeded to pass the actual crumbled ball around from one actor to another, and as the ball was passed, the weight of the ball changed for each actor. Each actor handled how they receive the ball and how they pass the ball on, to represent the heaviness of the ball to them. At the end of the sequence, the final actor uncrumpled the paper to show that "WORDS" was what was written on the paper (12:25-13:14). A little later on in the play, another ball was used. Keith Whipple, the drama therapist who worked with the group, came onto the stage holding a ball with "words" written on it high above one of the actors heads. Whipple and the actor proceeded to enact a short game of keep away. The actor finally gets the ball by tricking Whipple and grabbing it when he's looking in another

[15] We also played this game at CU Boulder's SLHC Chat Group - and it will be described in more detail in the next chapter.

direction (17:19-17:41). These scenes demonstrated two different ways in which the 'Peruvian Ball Game' (also known as 'space ball') was developed into scenes for the production.

The content of *Waiting on the Words* consisted of similar metaphors expressing what it is like to live with aphasia. Some moments were comedic, and many were touching and powerful. Similar scenes to those described above were built from games and theatrical exercises that were then turned into scenes for the play, rehearsed, and presented to the live audience.

The theory behind the structure of this program is that drama and/or drama therapy, in whatever iteration it is used, produces multimodal communication. Cherney et al. write that in addition to working on multimodal communication, theatrical practices can be used as a template for fulfilling what they see as the major goal for LPAA: "to facilitate participation in personally relevant activities to help [Individuals with Aphasia] achieve and maintain a good quality of life" (230). In order to keep their process personally relevant to the participants, Cherney et al. "used drama and drama therapy to create an innovative communication experience in which individuals with chronic aphasia conceptualized, wrote, and produced an original play addressing their experiences of having, living with, and coping with the effects of aphasia"(232).. And, while the case study was small, the results of the practice demonstrated some positive results from the participants, which were measured through quantitative data.

Cherney et al. used two quantitative methods for measuring their outcomes: the Burden of Stroke Scale (BOSS) and the Communication Confidence Rating Scale for Aphasia (CCRSA). Cherney et al. described the BOSS as "a comprehensive, patient reported measure of functioning and well-being" and the CCRSA as containing ten questions to assess the confidence of individuals with aphasia in communicating in several distinct situations. For the BOSS a negative measurement of deviation demonstrates positive improvement as it shows the burden of

stroke to be diminished; contrary to this, with the CCRSA, investigators are looking for a positive measurement of deviation to show that individuals with aphasia have increased confidence in their abilities to communicate (239-240). While all participants took the surveys at the beginning of the class, only seven returned to take the surveys again.[16] According to their study they were able to measure a medium positive effect size[17] for the BOSS, and a small effect size[18] for the CCRSA. Cherney et al. summarized their findings as follows:

> Participation in the drama class for aphasia resulted in perceived improvements in both communication and mood. Communication changes were indicated by decreases in both communication difficulty and the distress associated with communication, as well as small, but increased communication confidence. Mood changes were determined by moderate increases in positive feelings and small decreases in negative feelings and the distress associated with these negative feelings and emotions. (240)

While the sample size of participants in the survey was small, the researches were not discouraged. They suggest that theatrical activity for individuals with aphasia should be used to target mood, confidence, and communication ability (241). While their report did not include qualitative data, they did cite a participant, who later wrote in a published work about the class and how it affected him after having lived with aphasia for ten years. The participant wrote, "So...My voice is….Found. My instrument is….Found. My vocabulary is...Found. The Articulation is … Found. The Enunciation is … Found. The Sequence is … Found. The Rhythm is … Found".[19] While not recorded as data by this case study, the quote above clearly indicates the powerful impact this experience had on this individual. The article concluded with a call for

[16] Collecting data is very challenging due to time constraints on the side of the participants and their caregivers, I have noticed this problem across multiple studies.
[17] Medium effect is a deviation of .5 (239).
[18] Small effect is a deviation of .2 (240).
[19] Punctuation reproduced directly from the participant's writing.

further research. Ultimately, by demonstrating increased confidence in communication from its participants, the RIC's *Waiting on the Words* case-study is an example of a successful intervention for individuals with aphasia, as outlined in this dissertation's introduction.

Adler Aphasia Center Drama Club

The Adler Aphasia Center was founded by Elaine and Mike Adler. Following Mike Adler's stroke and subsequent aphasia diagnosis, the Adlers were frustrated that while Mike could receive treatment in speech-language pathology for aphasia, there were few facilities to help the Adlers learn to cope with living with aphasia. In researching treatments available, the Adlers became aware of the Life Participation Approach to Aphasia (LPAA), as well as other treatments that focused on multimodal communication. In 2003, they founded The Adler Aphasia Center in Maywood, New Jersey that employed these practices to help individuals with aphasia, and their loved ones, re-engage in their life and community (*Adler Aphasia Center*).

The mission of the Adler Aphasia Center is "To Enrich The Lives Of People With Aphasia, Their Families, And Communities." They offer a multitude of groups formed to assist members of their community in improving their communication skills, as well as activities that emphasize creating social bonds and developing interests. In the spirit of LPAA's encouragement of self-selected activities, they make sure to provide their members with many choices of activities such as cooking, a science lab, and even drama and art. They can also work directly on communication strategies or participate in discussion groups on politics, books, tv shows, and movies. When a member arrives at the Adler Aphasia Center for the day, they participate in three groups and the center always has four groups running simultaneously in order to offer as much choice as possible in the activities provided. The Adler Aphasia Center has three different cites

that serve 150 individuals with aphasia (Caska). One choice the members have is to join the drama club and to perform in the Adler Aphasia Center's annual musical.

The annual musical has grown into a popular tradition at the Adler Center. I spoke with speech-language pathologists Karen Castka and Ginette Abbanat, who have been running the drama club since its inception, about the process they employed in bringing about their annual musical and the experience of the participants in the drama club. The musical had humble beginnings; neither Castka nor Abbanat, prior to starting the drama club at the center, had significant theatrical experience. Castka explained that "Neither of us...are theatre people by any means, we started because we had a need here at the center to have a group that was large enough to accommodate all different kinds of aphasia...so we thought, we can do this little play thing, what the heck?...And it's grown into what it is today, which is gigantic" (Abbanat and Caska 08:59-09:37). Indeed, their productions include far more participants than any other project described in this dissertation. For their last production in 2019, thirty individuals with aphasia participated in the play. Members can choose to participate as a lead, a chorus member, or as backstage crew working on props and costumes. When asked what motivates them to produce the annual musical, which creates a lot of extra work, Caska brings it back to the members: "it's all based on the members and their drive and desire, and what they bring to it. And how energized they are doing [the musical], energizes us, and makes us want to keep doing what we do (Abbanat and Caska 09:41-09:53). The energy and drive has led them through fourteen musical productions.

The musical is rehearsed and performed during a fifteen week long semester. They begin their process by watching the film of the musical they are going to perform. After this, they discuss characters and who might want to play which part. The play is then cast through an

anonymous voting process by the participants (Abbanat and Caska 20:31). In our interview, Castka and Abbanat reflected on how the casting process has changed over the years. They described how at the beginning of the drama club, and for the first few years, the participants were stuck in a mindset that the larger roles should be filled by individuals with aphasia who had more verbal fluency: "then as the years evolved, and they saw each other on stage, and they realized how they could pull off a role, and how many other talents that they had that had nothing to do with language, then they were like, "you know who would make a really good Gaston?...it would be so-and-so because she could pull that off"" (Abbanat and Caska 21:07-21:24). In other words, after years of working together, the group began to see how different participants had different skill sets to perform roles that didn't revolve around verbal fluency. Abbanat added, "How empowering is that, if you're a really low verbal person," and excitedly went on, "and you're the *star*" (Abbanat and Caska 22:11-22:16, including interviewee's own verbal emphasis). As the casting process is completed, participants are able to empower each other and celebrate each other's non-linguistic communication skills by looking past the language skills of their fellow actors.

Following casting, the speech-language pathologists put together a rough script, adapting each part to the language skill set of the actors. They then have weekly, 75 minute, whole-cast rehearsals, over a twelve week period. However, they do make efficient use of their time and add in extra rehearsals when they can. During their lunch hour, the cast watches the scenes they will be rehearsing that day. In addition to the twelve ensemble rehearsals, they have about a one hour block where they gather just the main actors of the scene to create blocking. They also split the groups up, so that people can be rehearsing different scenes in different rooms. Furthermore, cast members are assisted in learning their lines by having recordings made on their devices. After

twelve weeks of rehearsal, they have a dress rehearsal with a small audience, then the formal production with a 250 member audience. They conclude their process with an awards ceremony and a cast party (Abbanat and Caska 27:43-29:15).

While Abbanat and Caska recognize improvement in language skills during the drama club, these results are not the primary goal of the center's musical. In following the spirit of LPAA, Abbanat states, "there are no language or communication goals necessarily...We're doing this because we're a community, and it's going to be fun (Abbanat and Caska 33:54 - 34:55). The increased language abilities in their clients are a byproduct of doing the drama club and not its aim. In the 2010 poster presented at the ASHA conference, Abbanat et al. write, "As with any theatrical production, each actor takes something different from it. For some it is the joy and empowerment, for others it is the opportunity to find their voice and the words to express it, and still for others it is the confidence and fellowship." While both Abbanat and Castka expressed that they received extensive amounts of positive feedback from participants and loved ones, in order to protect personal privacy, no specific details were given. Therefore I will include two quotes from the ASHA poster that were given by participants with aphasia after a performance. Participant number 1 said, "They [fellow actors and center staff] don't criticize. They lift you up. In the outside world they would criticize. These people...in this place...lift you up." Participant number 2 said, "Since 2006 to present….you can't imagine….I feel more confident. I feel more proud than ever. It's so fun///we laugh and joke." These are two examples of qualitative data received by the program that not only speak to the positive environment created by the drama club, but also that participants feel "lifted up" and "more confident." Therefore, according to the definition given in the introduction to this dissertation, the Adler Aphasia Center's drama club is viewed as a successful intervention for individuals with aphasia.

Aphasia Park and the Co-Active Therapeutic Theatre (CoATT) Model

Drama therapists Laura Wood and David Mowers worked for six years developing the Co-Active Therapeutic Theatre (CoATT) model for eating disorders. They have implemented the CoATT model with individuals in recovery for eating disorders, for substance use disorders, and for aphasia (Wood and Mowers 217). They are currently beginning a 30 month long randomized control trial using the CoATT model with individuals with schizophrenia (Wood). The use of the CoATT model as an intervention for aphasia is unique among the above-mentioned projects, as the CoATT model has been strategically created to generate a structured and manualized approach for using drama therapy as an intervention for individuals in recovery. Wood and Mowers explain that the CoATT model is a response to the "demand for replicable models of creative arts therapy interventions across mental health and arts initiatives to qualify for government funding and access insurance reimbursement in the United States" (218). As seen in the above-mentioned projects, gathering large numbers of participants for a single controlled study is extremely difficult. As of right now, there are too many variations and variables from study to study to generate systematized knowledge accepted by the medical field. The hope for the CoATT model, and its manualization, is that it will allow multiple studies across the country to follow the same precise formula, thereby collecting enough data to support the efficacy of theatre as an intervention for aphasia to become an accepted and insured practice of treatment.

The CoATT model is broken down into seven movements. Wood and Mowers use the term movement to describe "a specific set of tasks with outcomes that are both independent of the other task sets and that build towards a final production, akin to the movements in a

symphony" (221). These seven movements are: (1) Recruitment, (2) Discovery, (3) Generation, (4) Intensive, (5) Rehearsal, (6) Performance, and (7) Launch.

Recruitment brings participants together who are selected based on their level of recovery. As Wood and Mowers note, "CoATT is specifically designed for clinical populations in recovery who are transitioning out of formal treatment settings into independent recovery" (220). The CoATT model works best for individuals who have completed the more intensive stage of recovery and are now moving towards, though not fully at, the post-recovery phase. Each member of the group who participated in *Aphasia Park* (a study using the CoATT model with individuals with aphasia described below) were at least ten months post onset of diagnosis (Wood et al. 3).

During the *Discovery* movement, the group begins to work together by exploring their experience of recovery. Wood and Mowers want the "Participants [to be] answering the question: what aspect of recovery do we want to explore and share with an audience?" (228). The facilitator helps the participants to find overlap and links between each individual's concerns and experiences. In the *Generation* movement, the group then begins to explore the themes selected during the Discovery movement through metaphors in theatrical exercises and games: "The group engages in a specific series of theatrical improvisation games, drama therapy exercises using metaphor, role and journal writing to explore the selected topic in depth" (228). The Generation movement was particularly valuable for individuals with aphasia working in this model. In an interview I conducted with Wood, she explained that exercises in Generation were so easily incorporated into the script that by the time the actors performed, they had been working with the scenes long enough to feel comfortable performing them in front of an audience: "when it came time to learn the script, they had done these scenes so many times, they

knew them, and they [the scenes] had lived within their body in a really valuable way, that allowed them to have success around the language" (9:07-9:14). The repetition early in the process is one of the ways that makes the CoATT model effective for individuals with aphasia.

The following movement, *Intensive*, introduces the participants to the stage craft and process of bringing a devised work into a produced play. During the Intensive movement, the participants develop the framework for the script. The facilitator leads the participants through understanding components of stagecraft and adds additional artistic components to their work, such as music, acting training, dance, and movement (Wood and Mowers 222). The group reads through the play they have composed and makes any edits or alterations they think are necessary. In this matter, the group has complete autonomy over the content and construction of the play. The facilitator's job is to help the contributions to be equal amongst participants. Though it is not a requisite component of the CoATT model, Woods and Mowers "recommend that the group material be shaped into a narrative play, with consistent characterization that proceeds with a unity of time, place and action." Their reason is, "Our experience shows that this type of acting is most familiar to the largest groups of participants. Strong narrative and clear characterization offer a meeting ground for the theatrical confrontation of an open-invitation public performance" (228). While they do not work with a preexisting story, as do the Adler Center, Wood and Mowers do work with a more traditional and familiar theatrical script than both the Théâtre Aphasique plays and the *Waiting on the Words* project.

The fifth movement of the CoATT model occurs when the group moves into the rehearsal process of the play they have constructed. During *Rehearsal*, the facilitator and the participant contribute differently, but equally to the performance. Wood and Mowers explain, "The drama therapist is mindful of process, empowerment and growth, with the primary focus on directing

the play. The participants' primary focus shifts to ownership of the recovery theme, presentation and the final product" (228). Rehearsal is also a time in which changes to the final script can still be made in order to deepen the connection between the play and the participant (229). During this movement, significant time is focused on preparing the participants to incorporate theatrical elements such as props, costumes, and stagecraft preparing the participants for the sixth movement.

Performance is seen as a crucial component of the CoATT model. Wood and Mowers assert, "In the CoATT model, the theatre production must culminate in a performance that includes a public audience; the paradigm [of recovery] demands reconnection to the world outside of treatment. The play provides an opportunity for participants to take risks, be vulnerable and offer value to their communities" (229). Not only does the CoATT Model require a performance, it also includes space for the audience to participate in part of the performance as a way of the actors reengaging with the public (230). Wood and Mowers supply an example of this coactive element:

> In a recent production with persons in aphasia recovery one of the themes explored was that there is value in slowing down. The coactive element involved audience members writing on an index card the things that help them to remember to slow down. The cards were collected and spontaneously read by the participants with aphasia. A community poem was made with these words and read back to the audience (230).

For Wood and Mowers, the co-active experience replaces the traditional talk back, and allows for a meaningful interaction between the audience and the performers.

The CoATT model's concluding movement is *Launch*. Launch brings the participants together after the play is performed. During Launch, the participants do spend time reflecting on

the experience and what was gained, but this session is led with an equal amount of time being spent on future goals. The goal of Launch is to focus the participants on moving forward and reentering the community—to post recovery (232).

In February of 2020, Wood and Mowers, in collaboration with drama therapist Dani Bryant, and speech-language pathologists Kerryann Scirocco, Hia Datta, and Susan Alimonti, published "Aphasia Park: A pilot study using the co-active therapeutic theater model with clients in aphasia recovery," describing the process of using the CoATT model as an intervention for individuals with aphasia. In a collaborative effort between drama therapists, speech-language pathologists, and graduate student researchers, the play *Aphasia Park*, was produced and performed by a small group of individuals with aphasia in the Fall of 2019. The study had recruited five participants, but only four were able to participate in the research. The four participants all had stroke-induced aphasia and each member had either Broca's aphasia or anomic aphasia (Wood et al. 5).

The play, *Aphasia Park*, was about a group who came together for a picnic on a summer afternoon. (Wood et al. 1). During the picnic, the characters took part in several activities that served as metaphors for themes of the participants' recovery. The activities include: setting a picnic table, cutting a cake, dancing, and noticing nature. The play concluded with the activity of flying a kite. In the scene the group is flying a kite together which flies up into the rafters. The scene was co-created by the participants with the aim to leave the audience with "a final vision of recovery from aphasia that is uplifting, oriented to the future, and rooted in relationship" (Wood et al. 1). More details about this specific process will be available in a book, to be published in 2022.

Results for the project were measured by qualitative data collected and analyzed by a focus group. The goal of the focus group was to amplify the participants' voices, allowing for discussions and back and forth between participants as they reflected on the project (Wood et al. 3). The participants' salient themes were identified by the focus group based on the number of times a topic came up in their conversation. The focus group recorded five themes that the participants viewed as ways they benefited by participating in the project were. These themes were: meaningful relationships; increased belief in self; invigorating experience; unique healing opportunity; perceived speech and language improvement (Wood et al. 4). The themes identified as "increased belief in self' and "perceived speech and language improvement" are both indicators of increased confidence, which makes the *Aphasia Park* project an example of a successful intervention according to the guidelines outlined in this dissertation.

Conclusion

All of the projects described in this chapter used theatre as an intervention modality for aphasia in unique ways. Théâtre Aphasique, *Waiting on the Words*, and Aphasia Park all produced plays about aphasia while training the participants in acting techniques derived from Theatre of the Oppressed and drama therapy. In contrast to the other three projects, The Adler Center neither used acting training techniques, nor did a play about aphasia. The Adler Center, *Waiting on the Words*, and Aphasia Park all produced their plays within a few months, while Théâtre Aphasique developed their plays over the course of a year or more. While both Aphasia Park and *Waiting on the Words* were one time interventions, the Adler Center and Théâtre Aphasique have been running for over a decade and re-engage in their projects year after year. While all groups overlap in script development, in that the actors adjust the script as they rehearse, each builds their scripts in different ways. At the Adler Center, Castka and Abbanat

write the play once it has been cast based on the communication skill sets of the actors. The Adler Center begins their rehearsal process with a script. Each of the other groups produce a script at different stages in the rehearsal process.

In addition to the projects' different processes, they also had unique aims. The Adler Center, following the philosophies of LPAA, simply wanted an activity to offer their clients that would be fun, and increased communication skills were merely a byproduct of that endeavor. Similarly, Wood et al. are focused on using theatre as a tool for recovery. They want participants to feel confident in moving on to the next phase of their lives: living with aphasia. Some researchers' interest extends beyond improving quality of life and into communication goals. Both Cherney et al., writing about *Waiting on the Words*, and Garcia et al., writing about Théâtre Aphasique, expressed additional communication goals, such as multimodal communication techniques and active listening. (The theoretical underpinnings as to why increased communication goals can be expected from these interventions is discussed in Chapter 5.) However, no matter the strategies or the goals, all projects used theatrical practices. They all chose a story, or a type of story, rehearsed, and performed that story; all projects yielded evidence that the participants had increased confidence in their communication abilities after the process.

Chapter 3: Journey to *The Wizard of Oz*

Introduction

In the Spring of 2019, I volunteered to assist speech-language pathologists Holly Klieber and Christina Riseman in their endeavor to put on a theatrical production with a cast comprised of individuals with aphasia. None of us knew exactly how this would turn out. Each of us was stepping into unfamiliar territory. Kleiber and Riseman were stepping into the world of theatre, and I into the world of a speech-language pathology clinic, directing a play with actors with a communication disorder. I will begin this chapter with a description of what we (Kleiber, Riseman, myself, the cast, the student clinicians, and the volunteers) accomplished: a beautiful production of *The Wizard of Oz*. Following this description, I will demonstrate the steps we took on our journey to this event.

The Event

On December 8th 2019, twelve individuals with aphasia, a neurological impairment impacting language, took the stage and, with the support of their clinicians and CU Boulder theatre students, performed a ninety-minute devised production of *The Wizard of Oz*—the culmination of a semester's rehearsals with CU Boulder's Speech, Language, and Hearing Clinic (SLHC) chat group.

Multipurpose rooms, transformed for the theatrical event, were filled to capacity by 170 audience members. This extraordinary audience came to the event with distinct and diverse expectations: representatives of the Mindsource grant to see what their generous funds had supported, family members to enjoy their loved ones' success, students and faculty to learn more about the project and support their colleagues from Theatre & Dance and SLHC, and, finally, other individuals with aphasia to cheer on their friends.

The event was designed to create an immersive theatrical experience by including the audience in the performance. This audience joined our show with energy and enthusiasm, becoming crucial participants in the unfolding of the story and the natural flow of this unique production. To prepare the audience to participate in the play, a Winged Monkey or a Munchkin from the land of Oz showed them to their seats.

The Winged Monkeys were performed by students from the Theatre & Dance Department, while the Munchkins were performed by the student clinicians from SLHC. Each group had been given a script of talking points and instructed to engage the audience with stories about Oz and their characters' histories. Additionally, the Winged Monkeys performed vignettes around the space, entertaining the audience and further revealing their characters before the play began.

My goal for all of this pre-performance activity was to break down the barriers between the stage and the audience, encouraging them to laugh with us, sing with us, and learn more about the history of the story. The audience would participate in the play, helping create the storm that brings Dorothy to Oz, booing the Wicked Witch, and ending our performance with "Somewhere Over the Rainbow." My hope was that the audience participation would give the actors on stage a stronger sense of support during the performance, and give individual audience members a sense for some of the activities we had been working on over the course of the semester.

During the formal announcements of thanks and appreciation which preceded the play, the actors prepared to make their entrance. The audience cheered as the familiar characters Dorothy, the Tin Man, the Lion, the Scarecrow, the Wicked Witch, the Wizard, and the Mayor of the Munchkins marched to their seats which had been strategically angled to create a playing

space in front of the screen. This allowed the actors, who sometimes have trouble moving long distances, to stay close to where they would enter their scenes. Finally, the Munchkins and Winged Monkeys took their positions. The Munchkins crouched behind the actors, and the Winged Monkeys moved behind the audience. Finally, the two narrators entered, taking their places on a raised platform, at podiums on either side of a large screen. (See diagram below.) As the applause died down, the play began.

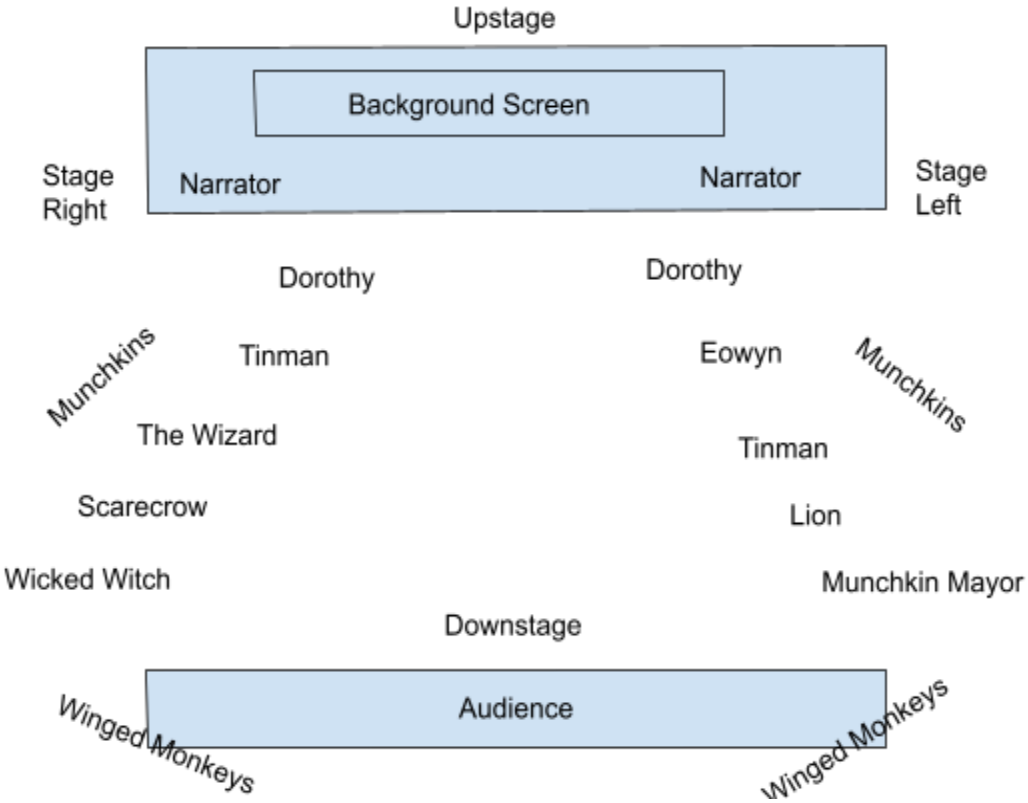

Image 5: Play Diagram

The role of the narrator was divided between two actors who have a mild aphasia diagnosis and more verbal fluency. Their role as narrators would facilitate all members of the cast in keeping track of where we were in the story and what came next. The narrators began by introducing the characters to the audience. The first narrator read, "This is a story of a brave young woman named . . ." and, to complete the line, both actors playing Dorothy stood, walked

to the center of the stage, said "Dorothy," and performed a gesture associated with that character. Each character was introduced individually in order to allow each actor to choose their comfort level with speaking and/or gesturing.

With the help of narration, we advanced quickly through the story. One of the actors playing Dorothy had a background in singing, and she beautifully sang “Somewhere over the Rainbow,” accompanied on the guitar by another actor, who played the Scarecrow. When the storm began, the narrator began a direct address to the audience to elicit their help in creating the sounds of the storm, “Ok, you know… we might need a little help.” The narrator instructed the audience to begin with light snapping, then whistles and a whooshing sound, then clapping rain. Of course, the Munchkins and Winged Monkeys helped by leading by example. Roles which were double cast alternated scene to scene. Eventually, Dorothy found each of her friends as she followed the yellow brick road and had her final confrontation with the Wicked Witch (See images below.)

Image 6: The Scarecrow, Dorothy, the Tinman, and the Lion

Image 7: Dorothy and the Wicked Witch

Early in the rehearsal process, the clients decided which lines they found important for their characters, and this dictated how the script was eventually pieced together. Because the clients and clinicians had worked together closely over the course of the semester, each clinician knew when their client was likely to struggle and need help; together they had worked out individualized cues to get them through the scene. In the image above, we see the Wicked Witch being cued by his clinician to threaten Dorothy.

The story proceeded as you might expect. "Follow the yellow brick road" and "Lions, and Tigers, and Bears, Oh MY!" made their way into the script. The Wicked Witch was splashed with water and melted, and eventually, Dorothy realizes, with the help of Eowyn the Good Witch, that she possessed the power to make it home all along. The play concludes with the narrator speaking of Dorothy's feelings on returning to Kansas: "And while she was happy to be with her family again, she would often wonder about the adventures she could have had somewhere over the rainbow." Here, the cast and audience began a final sing-through of the song (lyrics were available in their program), which brought the play to its anticipated and joyful conclusion.

The play had finished, however, the event itself was not yet ended. Rapturous applause filled the room as the cast took their bows. A move to the lobby was greeted with catered desserts and coffee. Family, friends, and loved ones were introduced to clinicians, staff, and faculty. Pride and pleasure filled the room from both the audience and the actors, and it wasn't until several hours after the metaphorical curtain fell that I found myself packing away the costumes and lighting equipment into my car. In the true, ephemeral nature of theatre, the

Kittredge Multipurpose Rooms were returned to a neutral state once more, and the event itself would live on in our hearts and memories.

The Process (in Movements)

I am inspired by the CoATT model, developed by Laura Wood and David Mowers, to break our process into movements, where the above mentioned event is merely the sixth movement in the overall symphony of our project. Unlike Wood and Mowers, we did not build our project based on a model we had developed over the course of six years; when our rehearsals began, our collaboration was measured in months. Subsequently, our process was adaptive. As we went along, we adjusted to the many variables and obstacles which presented themselves to us. For Kleiber, Riseman, and I, this would be our first endeavour practicing theatre with individuals with aphasia, and while all three of us, as a team, were confident that the project would be a success, we didn't have a clear vision of what that success would look like. Therefore, in organizing our process into movements, I am superimposing Wood and Mowers innovative metaphor for the purpose of clarity and organization. The seven movements of SLHC's Chat Group's presentation of *The Wizard of Oz* are: (1) Fostering Collaboration, (2) Transferring Agency, (3) Artistic Exploration, (4) Building Artistic Practice, (5) Rehearsal, (6) Performance, and (7) Celebration. I would like to add that the purpose of relating this practice in detail, unlike Wood and Mowers, is not to suggest replication of our exact process. Rather, I aim to relate a process that can inform future projects by offering adaptable methods.

Fostering Collaboration

Our first movement, Fostering Collaboration, stemmed from the genuine desire the three of us—Kleiber, Riseman, and myself—shared to create a transdisciplinary project that did not significantly favor either the discipline of speech-language pathology or theatrical practice. We

sought a meeting place in the middle. In the email in which Kleiber and Riseman first reached out to the department of theatre and dance for assistance, they openly professed to know nothing about theatrical practices, and I was equally aware that I knew nothing of clinical practices for aphasia. In a nod to my fellow collaborators, I want to note that in traversing the divide between the sciences and the humanities, they did not bring with them a preconceived notion of superiority in their practices, or ways of knowing. They were open and accepting of theatrical theory and practice in an admirable way. Each of us had much to learn from each other, and we began a process of sharing information and collaboration that continues today.

Our collaboration began in March of 2019 with regular meetings. The plan was for the fall 2019 aphasia chat group semester to culminate in a theatrical production. It became immediately apparent that two tasks needed to be completed. First, we needed funding, and second, we needed to learn as much as possible about each other's disciplines to uncover reasonable and significant overlap in practices. We worked on these two tasks simultaneously.

First, our team diligently searched funding opportunities in each of our fields. Fortunately, we discovered the MindSource Brain Injury Network which offered a grant either to assist individuals directly impacted by Traumatic Brain Injuries (TBIs), or to raise awareness of the possible impact of TMIs. Because TMIs are one of the causes of aphasia, we secured a $5500 grant to complete our project. The three elements of our project that appealed to the MindSource committee were (1) working with individuals with aphasia to produce a play, (2) offering a performance with information about aphasia and TMIs, and (3) Kleiber and Riseman's research on educating graduate students participants in the project from both the departments of SLHS and Theatre and Dance in each other's disciplines. Through working on our grant proposal

together, we also forwarded our second objective of discovering how our disciplines, both centered on communication, could work together as an intervention for aphasia.

Next, our team sought to educate ourselves in each other's disciplines. For me, the SLHC's summer session offered me ample opportunity to observe speech-language pathology. I attended their weekly chat group (that summer focused on music education), observed one-on-one individual sessions for the clients who would participate in the play, and watched recorded video from former presentations clients gave in different groups. It was in these sessions that I learned to distinguish between diagnoses of aphasia and methods of building communication for clients with distinct diagnoses and communication goals. In order to provide my colleagues with a similar learning opportunity, I led a workshop and invited fellow theatre practitioners to participate in a series of theatrical games. In this workshop, Kleiber and Riseman participated in each game in order to learn by doing and to experience the sensations of being placed outside of their comfort zone. Kleiber and Riseman specifically wanted to experience this discomfort, in order to more fully understand how their clients might feel when we introduce them to the games. At the end of the summer, we met to discuss the exercises and practices that overlapped in each discipline to decide the template for our rehearsals.

I had to take a step back as director because this was not a traditional rehearsal setting. Our rehearsals were doubling as clinical treatment sessions for individuals with aphasia. Additionally, these rehearsals acted as clinical training hours for graduate students seeking their masters in Speech-Language Pathology. As a theatrical practitioner, this is where it was absolutely essential I was working as part of a collaborative team. Kleiber and Riseman's knowledge of clinical practices and of supervising graduate students in credentialing in Speech-Language Pathology was essential to our project.

First we selected a group of theatrical games to be worked on over the course of the semester. The theatrical games we selected both met Kleiber and Riseman's clinical goals, and my goals for the development of acting techniques and for building scenes. Kleiber and Riseman approved the games that worked directly on language expression and comprehension, and/or developed multimodal communication skills. These games were: Name and Gesture, Building a Band, Mirroring, and Sculpture and Clay (to be discussed in more detail in the Artistic Development movement).

Our final task in the Foster Collaboration movement was to extend our collaboration with the student clinicians who would be working with us for the duration of the semester. As part of our rehearsal process, we needed to incorporate one-on-one interactions between clients and student clinicians, as well as group sessions led by student clinicians (requisite for the student clinicians experience). With very serious time constraints, student clinicians would have to not only learn the games, but learn to lead them. Therefore, we began the semester with an introductory acting workshop during orientation. The workshop was similar to the one I led for Kleiber and Riseman the previous summer. After the first rehearsal, a student clinician would be leading at least 30 minutes of each subsequent rehearsal, meeting with me for an hour the week before to plan and practice exercises they would lead for their session. It was a delightful surprise to me how much I enjoyed this unexpected element of our project. What had originally presented itself as an encumbrance to the project transformed into one of our greatest assets. The student clinicians' investment in learning theatrical practices and then in teaching them to their clients was a constant pillar of support for each client in their own performance. We now had a plan to move forward with our project; however, those plans had to be flexible in order to transition into our next movement, as the clients themselves made their entrance.

Transferring Agency

In our next movement, *Transferring Agency*, we needed to allow space for the participants in the program to take control of the direction the project would take. Our goal was to make it as much their project as our own. From our research during the previous movement Kleiber, Riseman, and I were aware of various forms the production might take. As described in the previous chapter, Théâtre Aphasique and The Chicago Center did devised plays based on their participants' experiences of aphasia, while the Adler Center for Aphasia did popular musicals[20]. Rather than having the three of us decide what *we* would do, we wanted to empower the participants to make this choice.

Our theatre group met for the first time at 8:30am on Monday September 9th, 2019. Holly, Christina, and I, the student clinicians, and twelve clients with aphasia were all gathered for the first of the only twelve rehearsals we would have before our performance. Our first rehearsal session would be spent facilitating the group in making choices about the play they would perform at the end of the semester. However, contrary to what one may expect, planning an applied theatre session in which you intend to empower your group to make as many of the choices as possible actually takes significantly more time than if the facilitator planned to make all the decisions themselves. This is especially true when working with individuals with aphasia, which requires pre-planning communication strategies at each possible fork in the road. In other words, we needed to be prepared with multimodal communication strategies to explain each of the options for the next round of choices, not only for the choices that they actually made during the session. We needed to ensure that every member of the group fully understood the choice they were making at every juncture.

[20] The work of Wood et al. had not been published at this time.

The first fork in the road that we presented to the group was to follow either the Adler model of doing a known play or musical, or the Théâtre Aphasique and Chicago Center models of doing a devised play about their experience with aphasia. We explained to the group what devised theatre was, gave an example of what a scene might look like, and showed images and clips of examples from YouTube. Similarly we showed them a clip from the Adler Center's musicals and explained that we could do something that had nothing to do with aphasia. After our explanation, each client spoke privately with their own student clinician. This was the easiest choice the group had, the decision was resounding and unanimous. They wanted to do an existing play or musical; they wanted to do something that didn't have anything to do with aphasia. Great, and just like that, we dropped all our plans for had they decided to travel a different path, and prepared to take them though the process of selecting a play to perform.

The next fork in the road had a few more options and was not as easily decided: did they want to do a play or a musical? Here again, we brought up how the Adler Center did their musical, piping in the songs, learning choreography, etc. This decision was not as collective, but democracy reigned and we decided on a play. In this case, we noticed who were more interested in the musical idea, and for those clients we were able to bring in a musical component. One of my favorite moments of the performance was when one client played guitar, while another sang "Somewhere over the Rainbow."

The next turn in our road had many more possibilities: what play would we do? We told the group we could do any story we wanted. Holly, Christina and I had brainstormed a few options ourselves before the session and wrote them up on the white board: A combination of fairytales, *A Christmas Carol*, *The Wizard of Oz*, etc. The clients again went to work one-on-one with their student clinicians to come up with stories that they loved, and that were well known.

Their own list was much more exciting, including *Pirates of the Caribbean*, *The Lord of the Rings,* Shakespeare, etc. Through voting and discussion we were able to eliminate stories that people didn't know very well, or they weren't interested in doing, until we eventually landed on *The Wizard of Oz.* The appeal of *The Wizard of Oz* was both the fact that most of the clients were familiar with the story to some degree, and that it would appeal to children. Many of the clients would be inviting their kids or grandkids, and they wanted to do something that they would enjoy. The same logic led them to choose *Charlie and the Chocolate Factory* for their 2022 production. *The Wizard of Oz* was not each client's first choice, but all but one of the clients was satisfied with the decision; this client had wanted to do *The Lord of the Rings*. Just as we managed to make our play contain some music for the clients who wanted it, we would do our best for this client. Eventually we landed on the compromise that Glinda would be transformed into the good witch Eowyn (his favorite character from *The Lord of the Rings*) and everyone then seemed happy with our choice.

In 90 minutes, not only did we accomplish our goal of selecting our play for the semester, we also managed to generate a group dynamic. The first component of that dynamic was that the clients were their own group, and they were taking lead in what would happen on stage. The second dynamic was that they would have to work collectively, and compromises would have to be made in order to move forward. Neither Kleiber, Riseman, nor I had entered the session wanting the group to do *The Wizard of Oz*; it was just part of a list we had generated of well known stories. Going in, each of us had hoped the decision making session would have gone a little differently, however, coming out, we all felt the session couldn't have gone any better. The clients had worked together to come up with the direction the performance would take, and we were happy. From this point forward, whenever we found ourselves at a crossroads in our weekly

meetings of how we should proceed, we made sure to bring that choice back to the group. This practice generated extra work: it meant that we had to meet weekly to review the choices and come up with a plan for the following session. Artistically, it would be challenging to me as a director, as I would have artistic ideas that I would have to let fall by the wayside. But deciding for the group goes with neither the theories of Augusto Boal nor LPAA, each of which support transferring the power to the participants to self-select their activities and empower their voices.

Before moving forward to the next movement, I would like to expand on Wood's and Mowers' metaphor of movements of a symphony. Reader, please imagine that each movement generates motifs (repeated short melodic phrases), and that each of the motifs plays throughout each subsequent movement of the symphony. No movement proceeds without the continuation of elements of the movements that came before it. For instance, Kleiber, Riseman, and I continue to learn from each other and build on our knowledge of each other's disciplines. And, throughout the rehearsal process we would continue to transfer agency to the clients. These motifs became embedded in our symphony as we moved on to our next movement: *Artistic Exploration*.

Artistic Exploration

As stated in the above movement, the clients very clearly wanted this project to move away from focusing on aphasia. They wanted to have fun and to learn acting techniques. Coming into this process with an applied theatre background, I knew that developing acting techniques enhances a person's ability to communicate. Having researched speech-language pathology and methods of developing communication on my own and with Kleiber and Riseman, I also knew that our activities would line up with clinical expectations to work on language and communication. Therefore, at this juncture, I was able to focus on the clients not as individuals with aphasia, but as actors and developing artists. Or, as Abbanat and Caska pointed out in their

process at the Adler Aphasia Center, communication goals were a byproduct of having fun and doing the play.

The basic template for our first five rehearsals was as follows: five minutes of greetings and getting settled in, then fifteen to twenty minutes of group warm ups led by student clinicians. Warm ups would consist of two or more of the theatre exercises or games we selected during the Fostering Collaboration movement: Name and Gesture, Building a Band, Woosh-Woosh-Woah, Mirroring, and Sculpture and Clay. This would be followed by twenty minutes to review the play and discuss characters and the objectives & emotions they might have. This part would be a combination of group discussion led by student clinicians and one-on-one client/clinician discussions. I would then have the final half hour of the rehearsal to step in and start building each scene. We worked this way through mid October.

When working with actors with aphasia versus actors without aphasia, the primary distinction is—pace.[21] We needed to allow sufficient time in our rehearsals for clear communication and understanding from everyone. Remember, we had a total of twelve rehearsals, and while we had to slow the process down to accommodate various forms of aphasia, we also had very limited time to prepare for a performance. Therefore, I needed to ensure that each exercise fulfilled a triple purpose: fostering artistic exploration and scaffolding the scenes for the play while also meeting clinical requirements. In the paragraphs below, I will illustrate how each exercise worked for the dual purpose of artistic development and scene development. I will clarify how these exercises also met with clinical communication goals in the subsequent chapter that discusses how these practices work as part of an effective intervention in the clinical treatment of aphasia.

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[21] Richard Gaulin of Théâtre Aphasique also proposed pace as the only distinction as mentioned in the previous chapter.

Name and Gesture

Name and Gesture is a common theatre exercise that exists in so many different forms; it would be impossible to credit its origins with a single source. In my version of Name and Gesture, a group stands in a circle, and each actor says their name attached to a physical gesture that (in some way) represents how they feel that day. For example, if a member of the group is feeling tired, they might say their name attached to a gesture of resting their head on their hands or perhaps stretching into a yawn. Before each member of the group performs their name and gesture, they must repeat all the names and gestures of the group members who have gone before them. For me, this simple exercise develops many artistic goals: (1) it encourages and assists the actor in using their body for expression; (2) it encourages each member of the group to pay attention to more than what is said. Even the actors who go early in the exercise will continue to pay attention (both because it's generally entertaining and to assist the group members who have not yet completed the task). When a participant struggles with remembering a name or a gesture, the other group members tend to perform the gesture to help the participant remember. Also (3), this exercise strengthens group dynamics and begins to create an ensemble that trusts and supports each other, and (4) it develops imagination as each participant has to come up with a gesture to represent their feelings.

This acting exercise was the first that we worked on in rehearsal. Adapting this exercise to a group of actors with aphasia simply required a little extra time and explanation.We explained the game verbally, and then three student clinicians demonstrated it. Next, clients and student clinicians worked one-on-one to discuss how the client was feeling and what gesture they may perform. Initially, we took out the part where they repeated everyone else's name and gesture and simply went around the circle twice with each actor doing only their own name and gesture. It is important to create an environment of acceptance, to continually assure the participants that the

verbal performance is not the most important thing. In our group, simply participating was enough to receive group applause and support. Just as in the performance of *Waiting on the Words* described in the previous chapter, whatever was performed at the time, whether it was just the name, a name mispronounced, a partial gesture… was all a good performance.

We would do this exercise at the beginning of each rehearsal, and every week we added to it. First, we added the process of recalling everyone else's name and gesture, which had the added benefit of working on the acting artistic skill of memory. Second, we encouraged them to repeat their gesture by making it bigger, longer, louder, which pushed them into more training of using their bodies and their voices. While time was of the essence, I was able to work on more artistic exploration by simply adding to an exercise the group was familiar with, rather than creating new exercises which would take up significant rehearsal time. Name and Gesture's true efficiency as an exercise came when I managed to work it into our play. As described in the event above, the narrator of the play would introduce each character, allowing the actor playing that character to perform the name and gesture of their character. To prepare for this moment in the performance, we simply adjusted the exercise. Instead of imagining a gesture that expressed how the client felt, the clients imagined a gesture that could represent something about their character and how their character may feel. Then, instead of their own names, they said the name of their character. And, just like that, the opening scene of the performance was created.

Build a Band

Build a Band is another theatre game passed from teacher to teacher, with each teacher creating their own unique iteration. It is connected to the more well-known Build a Machine exercise (where actors use their bodies to build a large complicated assembly line machine, with each student making a noise and a movement to connect the machine). Instead of Build a Machine, I chose Build a Band as it could be done seated, and it would be instrumental in

building the storm scene of the play. For actors, Build a Band helps to build focus, attention, team work, and creativity. Starting in a circle, one actor creates a single sound that is repeated with a steady beat. Each additional actor adds a sound that fits into the music that is already there until every actor has joined in. Once every actor is contributing to the cacophony of sound, you can either allow the band to continue and then cut the group off together or you can have each member stop making their contribution in the reverse order they joined the band, ending with the single sound provided by the original actor.

This exercise followed a similar trajectory to Name and Gesture. I taught the exercise to the student clinicians, then the student clinicians taught the exercise to the participants using multimodal communication strategies. After the participants were comfortable with the exercise, we were ready to transform it into part of our play. We converted Build a Band to Build a Storm. Instead of musical sounds, we began with two actors rubbing their hands together making a slight wind noise, two more actors snapping their fingers (for rain), then two more would start clapping (for louder rain), two more would stomp their feet, and finally two more added the howling of the wind. Then going backwards, each pair removed their sound from the storm, to allow the storm to slowly die down. When the student clinicians joined in and Professor Gerland began flashing the lights of the rehearsal room, the storm felt pretty fierce. All we had to do from there was have Dorothy stand center stage, give a wonderful performance of acting terrified as if the room was moving, and when the storm fully died down, look around her and say her iconic line, "Toto, I don't think we're in Kansas anymore![22]"

Woosh, Woosh, Woah, Sculpture and Clay, and The Mirror

The final three games and exercises Woosh, Woosh, Woah, Sculpture and Clay, and The Mirror didn't turn directly into scenes, but facilitated scene development by creating a shared

[22] Line was adjusted for the actor playing Dorothy

vocabulary and a template for scene work. In the game Woosh, Woosh, Woah, actors pass an imaginary ball of energy around a circle. The energy goes in one direction until an actor chooses to lift their hands up in a stop sign and say, "Woah." Then the energy changes direction and is passed back around the circle going the other way. As each actor passes the energy to the next participant, they make a 'woosh' sound. In this game, actors work on attention, energy, and reacting. Each actor must be ready to receive the energy, pass it on, and perhaps get the energy pushed back towards them. The skills they practiced extend into working on scenes. One example is the scene where the four friends Dorothy, The Scarecrow, The Tinman, and The Lion meet The Wizard. I had them stand in a row in the order in which their lines were given. In a warmup for the scene, we had the four actors play Woosh, Woosh, Woah, going back and forth through the line. Then when we substituted the 'wooshes' for the lines, I encouraged them to keep a similar energy and pace.

Another example of a game facilitating the rehearsal process is Statue and Clay. Statue and Clay is a game from Boal's *Games for Actors and NonActors*. In the exercise, the actors work in pairs and are instructed to only use silent, nonverbal communication. One actor performs the role of the clay, and the other actor performs the role of the sculptor. I give the participants a word, such as fear, strength, joy, and so forth. The sculptor then "molds" the clay into position.[23] This exercise is a fundamental component of my practice as an applied theatre practitioner. It introduces new actors to what, in my opinion, is essential to good artistry — intentional detailed choices. Seeing the sculptors take pride in their sculpture, going back and repositioning a hand just so, tilting the head just so, and adjusting the facial expressions just so, is often the moment I

[23] It's important to use safe practices in an exercise that has actors touching other actors. We modified Sculptor and Clay to restrict touching only to the arms and hands. For positioning the lower body and the face, the actors in the sculptor role would demonstrate what they wanted from the actor in the clay role and give silent directions. Before having any group of actors follow this exercise as originally given, one should include intimacy training.

feel participants in an applied theatre project connect with their inner artist. Because this game develops artistry, it's also very useful in building a scene. For example, when the four friends Dorothy, The Scarecrow, The Tinman, and The Lion walk through the forest and repeat the line, "Lions and Tigers and Bears, Oh My," the group agreed that the emotion the characters were feeling was fear. Therefore, before they began, I instructed each actor to make their character into a sculpture that physically represented fear. Instead of a stock characterization of fear, I saw four unique, intentional, and detailed choices of how each character might move fearfully through the forest.

In the Mirror Game, two actors face each other and together they move as if they are reflecting each other in a mirror. First, one actor leads, then the second actor leads. There is a third step in which no one leads and the pair move as one; however, the third step is generally for advanced actors, as it's incredibly challenging. We primarily remained in the first and second steps of the game where the actors learned to lead and to follow. Following is the simpler task, but still requires great attention. Leading is more challenging. If the follower is unable to keep up with the movements the leader is creating, then the fault lies primarily with the leader. The leader needs to pay attention to the pace and the physical capabilities of the follower. Additionally, the leader must be able to focus on cuing the follower to the next movement. This means that the leader is developing attention, intention, and physical communication all while also being creative. Initially, most actors will focus on just creating physical movements with the mirror. After a short while of practicing, I encourage them to add expression and emotion to the exercise. Next, the actors can develop a small journey or a story of emotions. As part of check in, the facilitator can ask the actor who was following to recount the narrative that was explored in the mirror. One way that we used this exercise to lead into scene development was having the

clients create an emotional arc of their scene. In rehearsals, clients worked one-on-one with their clinicians doing the mirror exercise. The clients would take the role of the leader, and lead their clinician through the non-verbal components of the scene. By doing this, the actors could see in the mirror (as the student clinician is replicating the client's movements and expressions) their own performance. From seeing their performance, they could make adjustments and fine tune their own performance.

Through using these games the actors were able to develop as artists, while also preparing for the performance. We would continue to work on these games and exercises throughout the twelve rehearsal sessions. Sometimes we would play games as an ensemble and sometimes clients worked one-on-one with their clinician to work on a specific skill set. As we built more scenes and began the rehearsal process, the games and exercises would remain a cornerstone of each rehearsal session.

Rehearsals

By mid-October we had developed enough scenes to transition to our fifth movement: *Rehearsals*. We used three classrooms during this period. At the beginning of the session, we would all meet in the same room to warm up. Then we would break the ensemble up into three groups to rehearse two scenes in the other two class rooms, while we continued to build new scenes in the main room. I would lead the session in the main room, creating the new scene while the breakout rooms would be led by student clinicians, Kleiber and/or Riseman, or Professor Gerland, in a rehearsal of the scene that was already created.

In rehearsals, actors practiced the scene that was created and continued to adjust and add to the scenes. I wrote a rough script[24] for each scene after it had been developed through

[24] The final script is available in appendix A of the dissertation.

improvisation and co-created between myself and the actors. However, it was in rehearsals of the scene that the script was refined and finalized. After each rehearsal, the student clinicians would send me an email with adjustments the client wanted for the script. Sometimes, these adjustments would be making the line more simple; however, it was not uncommon for a client to add to the script based on what they had achieved in rehearsal that day. In general, I found that the clients underestimated what they were capable of doing in the play.

As each rehearsal was led by a different person, the focus of what was done during that session varied. Every rehearsal involved running through the scene as many times as time allowed. In some rehearsals, they would work on reading through the lines, in others they would work on the objective of the character and work on acting choices, and other rehearsals were spent on practicing blocking and movements. If this seems haphazard and chaotic, to be perfectly blunt, it was. As often happens when rehearsing a play, time caught up to us, and opening night loomed ominously. However, there was some benefit to the time crunch. It gave our group momentum and energy. It was exciting, and the clients kept diving further and further out of their comfort zone. For the dress rehearsal, we moved to the Kittredge Multipurpose Rooms. Lights and costumes added to our enthusiasm. And, in true theatre fashion, it was all alright on the night.

Performance and *Celebration*

The performance of the event is described in the opening to this chapter. It was beautifully imperfect. Of course, there were things that didn't go as planned, but the group moved forward, and took their bows to thunderous applause. What was left, but to celebrate. After celebrating with family and friends directly after the performance, I wasn't sure that everyone would show up to the regularly scheduled 8:30 a.m. Chat Group the next day.

However, when I arrived at the Speech, Language and Hearing Clinic a little after eight, I found that much of the cast had already assembled in the lobby. Each individual's arrival that morning brought applause from everyone, and the conversation flowed as we recalled different moments in the play. Kleiber and Riseman put pictures up in a slide show. And folks applauded, laughed, smiled, and talked for the full ninety minute session. The room was loud with voices jumping into each conversation, as aphasia seemed to sit silently in the background. There was no "Silence in Sadness" here.

Discussion of Useful Practices from my Work on *The Wizard of Oz*

This chapter includes several specific exercises and processes that I used to build both acting technique and the scenes for the play; however, as I stated above, the purpose of relating my process is not to suggest that it be followed precisely, but rather, to give some sense of one way to create theatre with individuals with aphasia. What I hope will be even more helpful are some useful practices that I continually relied upon, and without which I sincerely doubt we could have succeeded as we did. I believe these practices will be useful to any practitioner beginning their own theatrical journey with individuals with aphasia even as new exercises and techniques are brought from distinct theatrical backgrounds. These practices are (1) the indispensability of collaboration, (2) the development of participant agency, (3) the importance of immediate and fulfillable goals scaffolding the larger project, (4) prioritizing nonverbal communication over verbal communication, and (5) the continual re-engagement and reliance on theatrical practices.

It is my hope that theatrical practices will be used more and more in clinical practice for a multitude of purposes. Wood and Mowers have already used the CoATT model for individuals in recovery, and have had significant success in using it as treatment for eating disorders (218). I

believe we are only just uncovering where theatre can work as an effective intervention. In order to keep this field of study growing, I cannot underestimate the value of collaboration. When taking a theatrical project into a clinical setting you need a variety of expertise in the room. As a theatre practitioner, allow your expertise to be in theatre, while collaborating with people who are experienced and credentialed in the field in which you are working. At CU Boulder's SLHC, I have two groups of powerful teachers when it comes to aphasia: Kleiber and Riseman, and the clients themselves. The clients knew I wasn't an SLP, and while I did my own research and practice to communicate with individuals with aphasia, I really only succeeded because of the helpful feedback I would receive from both Kleiber and Riseman, and the clients themselves.

In the spirit of collaboration, the next useful practice is to continually develop participant agency. This was done in the selection of the play we would perform, but continued into other key moments in our process. For example, when we cast the play, we had each participant list their top three roles in order. Luckily, and with some double casting, we were able to give each participant either their first or second choice. This is how we gave agency to individual members of the group. However, the Adler Center for aphasia also cultivated participant agency during their casting process. The difference was that they transferred that agency to the group by creating a casting process via voting. During scene development we allowed each actor to focus on what was important to them, allowing them to generate the script, and to make their own artistic decisions for their role. Transferring agency to the participants allows the project to become their own, instead of one that is being brought to them from someone outside their community.

The third useful practice is the importance of immediate and fulfillable goals to scaffold the larger project, and is most useful when working with a group for the first time. For those

outside of theatre, putting up a play can seem like a daunting task, even if they are not grappling with a neurological impairment like aphasia. In a traditional rehearsal process, I would begin with a read through, then table work, then stage blocking and improvisation, and then finally start giving the scenes their real shape well into the process. When working with a group who has never done theatre before, or thinks they can't do theatre, using the above mentioned process could be very frustrating or even confusing. For *The Wizard of Oz*, we developed single scenes in a single rehearsal. We would begin the rehearsal process by discussing the scene, go directly into some improvisation around the scene, and end the rehearsal with the framework of the scene intact. This allows the participants in the project to immediately see that they can accomplish the task they have set out to do. The foreknowledge of the participants knowing that they can complete the task is what allows them to complete the task.

The practice of prioritizing nonverbal communication over verbal communication is a practice I specifically recommend for working with individuals with aphasia. In a way, I envisioned my task as one of counterbalancing a societal over-valuation of verbal over nonverbal communication. Whenever I worked with a participant, I focused entirely on how they were using their body, their vocal intonation, their attention, their timing, and *never* on their words. The participants themselves would work on their lines with their clinicians or in practice, but it was never something I would comment on. This is primarily because, that societal over valuation of the spoken and written word, seems to be most heavily felt by the participants themselves, who are acutely aware of a lost or damaged skill set. My goal was to enhance their own knowledge of their own incredible power to communicate beyond language.

The final tenet is the continual re-engagement and reliance on theatrical practices. All the collaboration and the preplanning is there to allow me, as the director of the play, to focus on

what I'm good at—theatre. If you are the director and your actors happen to have aphasia, for you, they should be actors first. In other words, don't make the mistake of thinking that you are not practicing theatre because the participants hold other identities. As I have stated before, there is one fundamental difference between how I work with individuals with aphasia who are actors and actors who are not also individuals with aphasia: I create extra time in the rehearsal room for communication. The process slows down…a little.[25] Other than slowing down, rehearsals require my directing skills in the same way as they would in other productions. For example, when a moment in the play isn't working well, examine what you are asking the actor to communicate the same way you would directing a play with actors without aphasia. What is the intention? Does it match the blocking? Is there a problem with the script? Remember to re-engage with your theatrical work while also allowing time and space for communication.

Re-engagement with theatrical practices also means it's important to remember the way that theatre works. For example, as I wrote above, our rehearsal process got a little chaotic as we moved closer to the performance; however, as a theatrical practitioner, this is something that I should expect, as the rehearsals leading up to the performance often feel stressful. By recognizing that stress and pressure have been a component of almost every production I have participated in (rather than being unique to working in the clinical setting), I allowed the productivity of this stress to motivate our group to extend extra effort. It is known as "theatrical magic" when a show can come together at the last minute; however, I do not believe that it's magic. One of the things I love about theatre is the extraordinary effort that artists put into creating a performance for their audiences.

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[25] In the beginning of my practice rehearsals were significantly slower than when I worked with actors without aphasia. However, as we progressed as a company, I noticed we were able to speed our process.

Finally, there is a possible theoretical basis for continually re-engaging with theatrical practices that can be particularly useful in working with individuals with aphasia. As stated before, Boal believes that theatre is part of all of us. He says, "theatre is what we have inside. We are animals that have the privilege of being actors because we are acting all the time…We have theatre inside because we act" (Harvard 02:41- 02:54). If this is true—and I believe it is—working theatrically is an embedded form of communication in itself, as it's part of being human. Therefore re-engaging in theatrical practices can even assist in building communication in a space that strives to utilize multiple forms of communication strategies at all times.

Chapter 4: Continued Practice and Pandemic Gaps

Introduction

The original plan for this dissertation was to draw research from a second production to be performed in the Fall of 2020. The Covid-19 pandemic made this impossible. Initially, we (Kleiber, Riseman, and I) were disappointed as we had planned to gather both qualitative and quantitative data from clients and caregivers on client communication confidence and the quality of life index. Additionally, Kleiber and Riseman intended to continue their own research on the benefits of interdisciplinary programs for undergraduate and graduate education. However, even without these formal studies, together we were still able to advance the program. In summer 2021, CU Boulder's SLHC held a remote session in which the group practiced theatrical games and exercises while also exploring alternative stories to use as the foundation for the company's next production. These sessions included watching and performing scenes from *Alice in Wonderland*, *The Lord of the Rings*, *Romeo and Juliet*, and *Charlie and the Chocolate Factory*. In the Fall of 2021 the company decided to work on *Charlie and the Chocolate Factory* and began preparing for their production to take place in the Spring of 2022. This session was led predominantly by Kleiber and Riseman, alongside the student clinicians, without significant contributions from a theatrical collaborator. Consequently, the balance of our original interdisciplinary endeavor swung more toward traditional speech-language pathology. However, the pendulum swung back toward theatrical practice, as I became the predominant leader of the first two months of Spring 2022 rehearsals. The shifts in how the summer, fall, and spring sessions were led gave us opportunities to observe three additional applications of using theatrical practice as a modality within an intervention for aphasia. In this chapter, I will detail how these unique sessions transpired and how I found them to reinforce my takeaways of

recommended practices developed during *The Wizard of Oz*. As stated in the previous chapter, these practices are: the importance of interdisciplinary collaboration, the development of participant agency, the usefulness of immediate and fulfillable goals, the prioritizing of nonverbal communication over verbal communication, and the continual re-engagement and reliance on theatrical practices.

Summer 2021: Exploring Story Options for the Theatrical Production

At the end of the 2021 Spring semester, Kleiber, Riseman, and I decided we could use a remote summer session to explore which stories the company wanted for their next production. During *The Wizard of Oz*, there were serious time constraints, and the group picked that show during a single meeting. This time, the group would meet twice a week for a month over June and July to explore potential stories in more depth. Our hope was that using this extended time would also ensure that participants fully understood and owned the stories they chose. Our collaborations fell in line with both my recommended practices of continued interdisciplinary work and transferring agency to the participants.

Prior to the summer session, the group used a brainstorming session to generate a list of over 30 stories, ranging from Marvel movies, to Shakespeare plays, to the Myth of Sisyphus.[26] When the summer session began a few weeks later, the first step was to reduce this number. The group's desire to tell a story that they could share with children would prove important to this process. Each group member worked with their student clinician to list their top four choices and to veto one story they absolutely did not want to do. This simple strategy was surprisingly successful in narrowing our options to stories in which each participant held some interest. In the

[26] The inclusion of the myth of Sisyphus reminded me somewhat of our option of doing an original devised play about aphasia in the Fall of 2019. Most group members seemed to look toward escapism, and I was concerned that working this story might be too close to home for what the participants were going through.

end, we decided to work on the following four stories: *Alice and Wonderland*, *The Lord of the Rings,*[27] *Romeo and Juliet*, and *Charlie and the Chocolate Factory.*

As is true for many, transferring the work to Zoom created many challenges; however, in the end we managed to make it work. For many clients, meeting remotely was only an option if they had a caregiver willing to help with the technology, which meant some clients were unable to participate at all. For the eight clients able to join, the interface came with several constraints. Participants often had to share space with family members working from home or doing household chores; this meant we also lacked privacy to explore theatre and its inevitable moments of silliness. Additionally, Zoom limits non-verbal communication, as it is difficult to know exactly with whom a person is trying to communicate. However, eventually, we all got used to the constraints of Zoom sessions. Zoom even created an opportunity for us to explore the non-verbal communication of facial reactions in more depth. Each session began with a brief vocal warm up and an exploration of participants' Zoom space. We led the actors to move closer and further away from their screens, then pick up the screen and move it closer and further away from them. Next, clients would work with using different spaces within their screen, moving from left to right, and filling different corners. The mirroring exercise worked well on Zoom and was incorporated into the group's warm up. To do mirroring over Zoom a member of the group would volunteer an emotion: happy, anxious, sad, etc. Then two actors would use the mirror exercise to explore the full range of expressing the suggested emotion. We continued the exercise until each client participated in one part of the activity. The vocal warm up, the Zoom space warm up, and the mirror exercise filled the first section of each of our sessions.

[27] *The Lord of the Rings* actually received on veto and little interest from many clients; however, we had one client who was very passionate about working on the story. Consequently we asked the client who vetoed the story if they would be alright with us working on it for a week over the summer for the sake of their co-actor. Of course they agreed and it made the client who wanted to work on the story very happy.

Next, the group began exploring the stories. This section had two parts: story analysis and scene acting. Each week the group focused on one of the four stories: *Alice in Wonderland*, *The Lord of the Rings*, *Romeo and Juliet*, and finally *Charlie and the Chocolate Factory*. Using slides and screen sharing, the student clinicians or I would outline the key plot points and characters of each story. Then, together the group would watch clips from the films. Next, I chose a specific scene or two for us to act out. We watched each scene several times and identified key moments where a character's emotion or objective would change. For example, in *Alice in Wonderland*, I chose the Caterpillar scene as both Alice and the Caterpillar shift dramatically between anger and inquiry—not to mention the enjoyment I knew some of the clients would get out of smoking the pipe. Additionally, the scene holds significant repetition of the line "who are you?" that can be said in different ways. For *The Lord of the Rings*, I chose the scene where Boromir attempts to take the ring from Frodo. In this scene, Boromir has a dramatic shift once he is overpowered by the magic of the Ring. Boromir transforms from a protective soldier to someone crazed with need for the ring and choses several tactics to get the ring from Frodo. After analyzing the story and scenes we acted them out in breakout rooms. I created a shortened script which could be read from the shared Zoom screen.

Example of Rehearsal Script

Frodo: There is no other way
Boromir: Will you lend me the ring?
Frodo: No
Boromir: Fool! It is not yours. It should be mine! Give it to me!
Frodo: No!

(Frodo puts on the ring and disappears.)

Boromir: Curse you!

(The spell is broken on Boromir)

Boromir: Frodo?

I led one room while student clinicians led the others. In the breakout rooms, the actors identified emotions and objectives of the characters. While they did this the leaders of the breakout rooms would add visual content to the script on the shared screen to help remind the actors what they had uncovered about the scene.

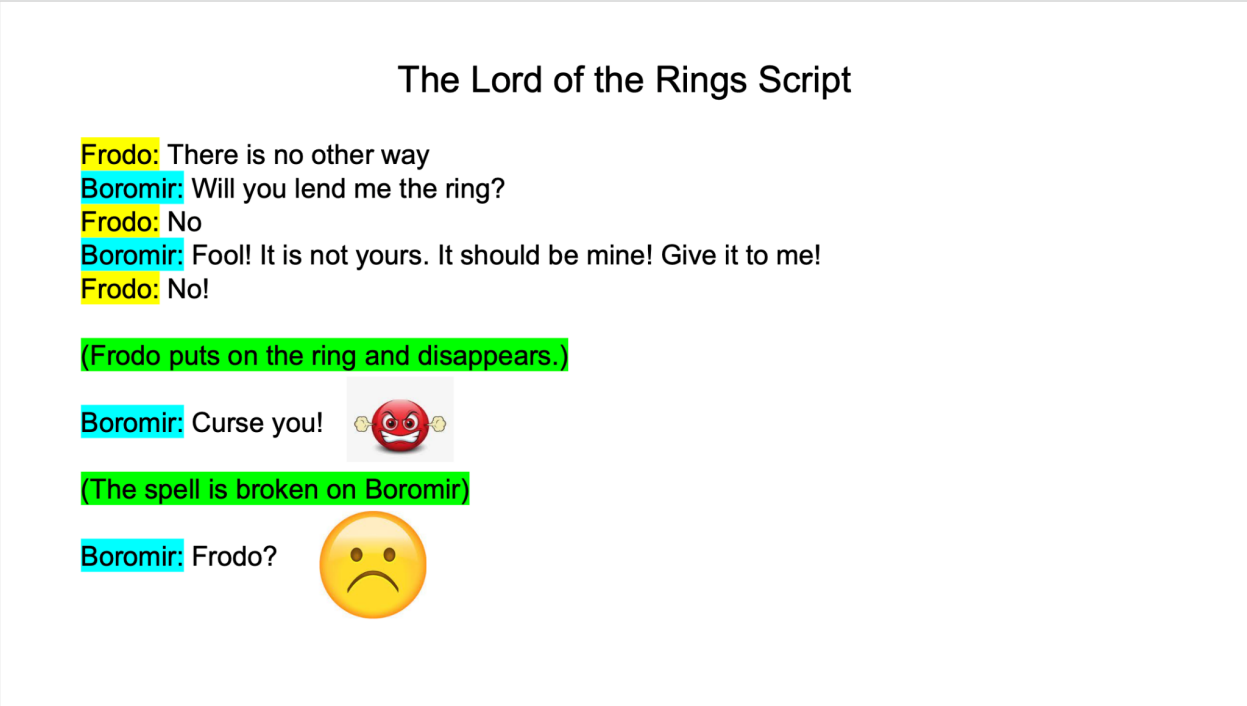


Image 8: Adjusted *Lord of the Rings* Slide

The student clinician who led this scene added color for each character, and color to identify stage directions. Additionally, they used emojis to signify Boromir's extreme emotional shift from rage to shame at the end of the scene. At the end of the session the company came back into the main room and different actors performed the scene.

We progressed in a similar fashion throughout the four weeks. One story was particularly enjoyable to me: *Romeo and Juliet*. I was pleased that the clients were interested in this

linguistically challenging play and our work on the show was surprisingly successful. (It is safe to say that I harbor a secret hope that I will one day get to direct a group of actors with aphasia in a Shakespeare play.) We began with the "Do you bite your thumb at me, sir" scene. I chose this scene as (1) it opens the play (the fight that breaks out between the Montague and Capulet servants), (2) it includes a very specific gesture, (3) it is less linguistically challenging than other scenes in the play, (4) it uses significant repetition within lines, and (4) it contains many beat shifts as the characters are each reluctant to be the one who begins the fight. To begin work on the scene, we watched both the Baz Luhrmann 1996 interpretation and the Franco Zefferelli 1968 interpretation of the scene. We watched each clip several times. We then used the breakout rooms based on which version of the scene the clients preferred (most preferred the Luhrmann interpretation).

After working this scene many of the clients were eager to go on and explore the balcony scene. Again, I reduced the script to about ten lines. Readers familiar with the balcony scene may remember that many of the lines fall into straightforward iambic pentameter (| But, soft! | what light | through yon | der win |dow breaks? |). To teach the iambic pentameter, I instructed the actors to use the phonemes |ba dum| while tapping on their chests like a heartbeat. The clients then practiced each line while continuing the gesture. We began doing this very slowly and then sped up. Even though I was familiar with the Melodic Intonation Therapy (discussed in Chapter 1), I was still surprised at how successful each actor was at learning entire lines. Using the prosody inherent in Shakespeare's verse allowed clients to speak more lines more easily. And they did a superb job.

In the final week of the summer session we worked on *Charlie and the Chocolate Factory.* Again, the group spent time examining two very unique movie versions of this story:

the 1971 film *Willy Wonka and the Chocolate Factory*, starring Gene Wilder, and the 2005 film *Charlie and the Chocolate Factory* starring Johnny Depp. It was clear that most of the actors in the company preferred this story for their production, probably because it appealed to children. However, we waited until the fall before taking a final vote in order to give voice to the actors unable to participate in the remote session.

The summer session expanded the actors' familiarity with the stories, thereby giving them increased agency in the selection process. Additionally, our sessions contained a balance of theatrical practices (when we warmed up and acted out the scenes) and more traditional speech-language pathology chat group methodologies (when we analyzed the story and characters). Each participant grew as an actor and expanded their ability to express different emotions and intentions.

Fall 2021: SLP-Led Rehearsals for *Charlie and the Chocolate Factory*

The Fall session proceeded without regular in-person input from a theatrical practitioner, consequently changing the structure of the interdisciplinary collaboration. However, the theatrical knowledge and experience each participant and my collaborators had gained from their work on *The Wizard of Oz* and during the summer session would support a successful program even without full interdisciplinary collaboration. All of the actors who participated in the summer session were able to participate in the Fall and before the performance three new actors would join the group. The positive energy held by the participants who had already participated in theatrical work was infectious as each new member who joined, even those who had been observed to be reserved in other sessions, seemed to jump into the fun of the process without skepticism expressed by the participants the first time around.

The success of the program was evident to me when I returned to lead a session in November 2021. In my absence, Professor Oliver Gerland visited the group and provided them with a structure of compiling scenes for the play. The group then focused on developing the scenes in order: from the announcement of the golden tickets, to each child finding their own tickets, to Charlie's birthday scene where he is disappointed not to get a ticket, and finally to the scene where Charlie finds the last golden ticket.

I was impressed with the work they had done; yet as I observed, I noticed some alterations in the way the group was interacting with the theatrical games and exercises. For example one alteration was to the game "Woosh-Woosh-Whoah." As you may recall, "Woosh-Woosh-Whoah" incorporates sounds with a gesture as a warm up game for actors to have quick, high energy, reactive responses to each other. The student clinicians felt the need to incorporate more verbal skills. To do this, they had each actor pick an emotion to add to their "whoosh" sound. Then the actors were encouraged to guess the emotion of the other actors. While this adjustment to the game is not outside of the realm of what we had done previously, it did impact the theatrical objective of the game. Adding the emotions and the guessing not only slowed the pace of the game, it changed the prioritization from nonverbal communication to verbal communication.

The above alteration is an example of why the presence of a theatrical practitioner, one who understands the communicative component of all theatrical exercises, adds value to interventions for aphasia. When I asked Riseman about the adjustment, she informed me that the student clinicians added the component to address their concerns that the game was too easy and did not directly help in developing communication skills. (In Chapter 5, I will demonstrate how the game, in its original form, does enhance communication skills and can be a valuable exercise

within interventions for aphasia.) However, having an interdisciplinary collaboration creates balance. The theatrical practitioner orients towards nonverbal communication and the reliance on theatrical practices, while the SLP orients toward established verbal communication strategies. However, even without a theatrical practitioner present, group members were still using theatrical practices and seemed to have a very enjoyable experience. Additionally, it's important to remember that the Adler Center works successfully without the aid or support of a theatrical practitioner.

During much of this semester, the group followed many components of the Adler Aphasia Center's approach to building a play. To this end, they proceeded to watch scenes from both the 1971 film *Willy Wonka and the Chocolate Factory* starring Gene Wilder and the 2005 film *Charlie and the Chocolate Factory* starring Johnny Depp. Through these very different approaches to the same story, the actors saw how the same role could be played very differently. They were able to choose between the two styles for their own character work and ideas; this helped to continue to promote participant agency. Only two aspects of our original practice were lost: the above-mentioned emphasis on nonverbal communication and the practice of having immediate fulfillable goals in each session. The latter aspect may not have had as much to do with the diminished interdisciplinary collaboration as it did with the *false* friend of additional time.

It was during this time that Kleiber, Riseman, and I began to become aware of the fact that the extended time we had to work on the play wasn't necessarily doing us any favors. What had felt like such a burden for us during *The Wizard of Oz* had also motivated us to move quickly. During *The Wizard of Oz* rehearsals we had to move through one or two scenes in a single session. For *Charlie and the Chocolate Factory*, we noticed that the group had been

focused on a relatively short section of the play for two months. It is my opinion that having both the Fall and the Spring to work on the play reduced my recommended practice of having immediate fulfillable goals that allowed the actors to see their work progressing into a play production during each rehearsal. When I returned again, my goal was to allow them to see how their hard work learning individual scenes would look both staged and connected. I organized the actors into a semicircle, facing the audience, placing the actor playing Charlie at the center. I then wrote a short narrative line that connected each developed section of the play. Doing this mini-performance was the culmination of the Fall 2021 Chat Group.

Spring 2022: Re-Engaging Interdisciplinarity with Theatrical Practices

I was happy to return to full involvement for the first two months of the Spring 2022 semester. For the first two months, I was entrusted to lead and plan each session, re-engaging strategies from my work during *The Wizard of Oz*. For the remainder of the semester, I will continue to meet with student clinicians each week, to prepare them to lead rehearsals themselves, as the student clinicians lead large sections of each rehearsal. The student clinician planning meetings serve as an opportunity to ensure the work remains interdisciplinary. Even when I am not in the room later in the semester, the clinicians leading the session will have gone over games and activities with me prior to leading the sessions. Below is an example of the plan we developed for rehearsal on February 28th. The student clinicians share this plan in Google docs in order to be prepared to assist their client. The plan always includes notes to the clinicians on how to prepare for the session, how to set up the room, and an agenda for the rehearsal period.

Sample Session Plan

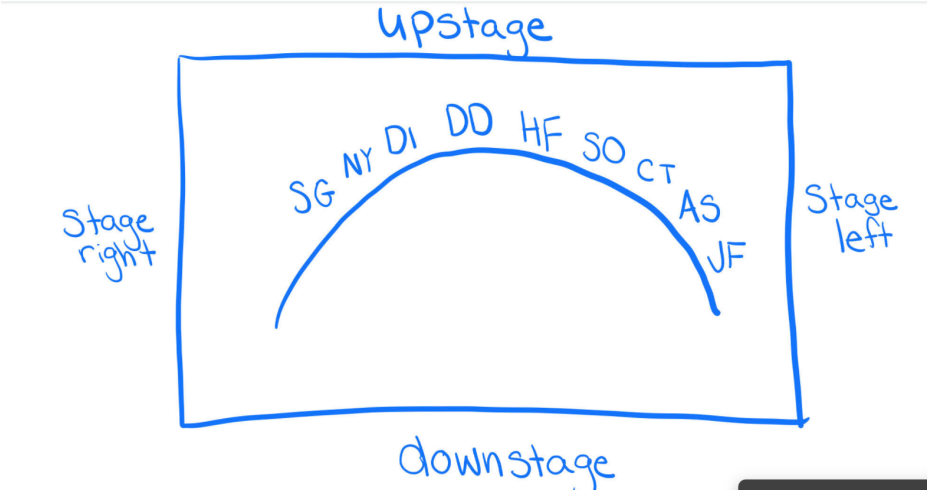
CHAT Session 6: Plan for **2/28/22**
Location: C230

Clients: DI, HF, JF, CT, AS, NY, SG, DD

Clinician Notes:

- **use client's first names in the session**, not initials
- Review script/changes have been made
    - Review notes on new client lines for scene three (Gillian will send this out on Sunday)
- When practicing lines, encourage improvisation and what comes naturally to them
    - (Lillie will print script for those that raise hand needing a new script)
- https://docs.google.com/document/d/1hVa3O7zapkoXU2v5rDw1AVsqFHHN20U2da0GYV_OkQw/edit

Set up:



***Setup note: Do not need to start session in these positions
Pull chairs back, but have setup for stage ready in advance

Notes:

-Class ends only 20 mins before Chat group, so will need to rearrange the room after everyone exits, push front row back a bit and make a circle- make sure there are enough chairs for all clients and clinicians to either sit next to or behind their client

-No clear masks- need to wear KN95 Masks
-Remember to screen clients down at clinic entrance!! -many clients like to come upstairs on their own and we forget to screen

Agenda:

Wait for people to come in/settle down 2:30-2:35

Part 1: 2:35-2:50

- **Introductions:** Lillie and Sammy

- **Agenda**
    - **Warm Up**
    - **Rehearse the Same as Last Week**
    - **Rehearsal Continued**
- **Warm up:**
    - **Breathing:** exhale, add sound, add movement (use visuals of ups and downs)
        - "Would anybody like to lead the vocal warmup today?"
    - **Voice Projection Exercise**
        - **Explain: "**We are going to do an exercise to work on our stage voices."
        - Pick a clinician and then do again with 1-2 clients:
        - "Choose one line, a couple of words"
        - Place your hand in front of your face
            - Say line into palm of hand
        - Now take hand down & pick point about five feet away in room
            - Send line right to that point
        - Pick far end of the room (10 to 15 feet away)
            - Now say this line as if you are talking into the entire space
        - Now put hand in front of face and use same energy to say line
            - This is your "stage voice"
    - **Warmup** with ONE game, group choice (raise hands to vote)
        - Zip Zap Zop, Pterodactyl, or Woosh-Woosh-Whoa
        - "You can either stand or sit"

Part 2: 2:50-2:55
Brief Line Review:
Client/Clinician pairs review lines

2:55-3:15
Rehearse scene as group, led by Gillian

- Begin with readthrough (sitting)
- Proceed to acting it out

3:15-3:20
"Do you want to go back to the beginning and continue working on this (A) or move forward in the play (B)?"

- Take a vote: A vs. B

- (prepare a slide where if we go on, we should watch a scene from Willy Wonka… watch "Chocolate Room Scene")
    - https://www.youtube.com/watch?v=LIYNk4ARUR8&t=75s
    - Find five minutes of kids coming into factory & song

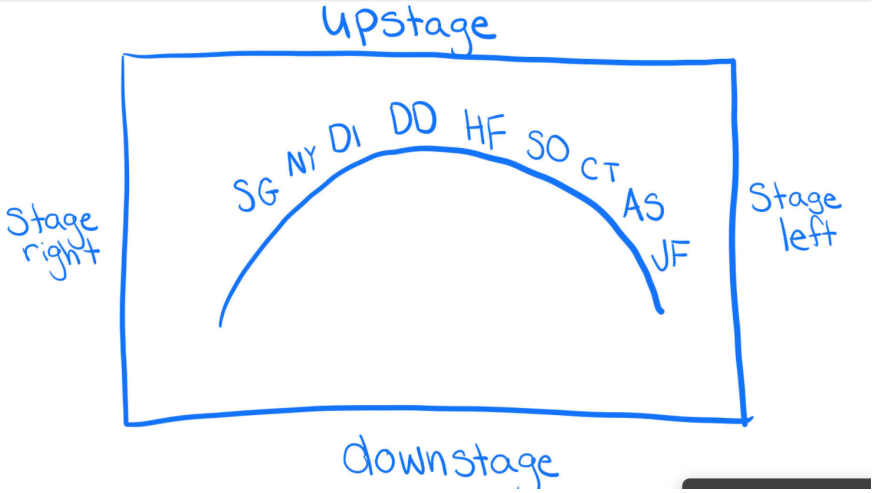
<u>Option A - Gillian leads; we take a break</u>
<u>Option B:</u>

3:20-3:35

- Create new lines
- Small groups
    - Will establish after we see who comes
        - Tentative:
            - SG & NY
            - DD & DI
            - CT & JF & HF

3:35-3:50
Readthrough of new scene

move clients to stage set up (see below)



At the beginning of the Spring 2022 semester, the first order of business was to re-establish the use of theatrical games and exercises focusing primarily on their non-verbal components. We started with “Woosh-Woosh-Whoah” in its original form and added two additional games: “Zip, Zap, Zop” and “Pterodactyl.” “Pterodactyl” was new to me and suggested by one of the student clinicians. It is similar to “Woosh-Woosh-Whoah” in that when it is your turn, you can either continue to pass the energy to the next person in the circle by flapping your arms as wings and saying “pterodactyl,” or you can reverse the flow of the energy

by standing on one leg and squawking at the person who said “pterodactyl” to you. They then have to turn around and pass the energy in the opposite direction. (This game is currently our company's favorite.) For “Zip, Zap, Zop,” an actor says the word “zip” while sending that word across the circle to another actor. That actor proceeds to do the same thing, but now their word is “zap.” The next actor's word is “zop,” and then the following actor returns to the original “zip,” and so it goes. In our rendition of this game, the actors focus on sending the words with high energy, full voice, and body movement (leaning forward or stepping forward in the direction they are sending the word). After playing for a few minutes, we quicken the pace. These two new games help to increase the actors’ use of their bodies and add a linguistic component. While observing the clients engage in the games, I also notice that they get to choose for themselves how much effort they put in to making the “correct” verbal response. As a rule, we (the student clinicians and myself) never correct them.

After reestablishing the emphasis in rehearsal on nonverbal communication, our (Kleiber, Riseman, and I) next goal was to bring improvisation back into building the scenes. During *The Wizard of Oz*, I developed each scene through games and improvisation and then wrote down the lines that the actors came up with. (Without the aid of a theatrical practitioner, I believe this process would be challenging for an SLP to replicate.) However, I wanted to keep elements of that improvisational process, while offering a tool to assist the SLPs leading the sessions. What I liked about how we developed *The Wizard of Oz* is that it was another way of giving the actors agency (they got to choose their lines) and that the story the company performed was entirely their own. Knowing that my intention is to take a step back from *Charlie and the Chocolate Factory* in a few weeks’ time, I developed what I am calling a “skeleton script” for the group to use. In this skeleton script, I have the narrator lead the play into mini scenes. In these mini

scenes, I give instructions about what needs to come across but leave the lines blank to be filled in by the actors (more specifically the student clinicians will write in the lines the actors come up with while improvising the scene). For example, I would provide the cast with the following script for the scenes when Augustus Gloop and Violet Beauregarde find their golden ticket:

Sample Skeleton Script

Narrator

This news just in.

Whole Cast

Breaking News!

Narrator as Reporter

The second golden ticket has been found. Let's go live to Düsseldorf in Germany.

Augustus, how did you find the golden ticket? [holds microphone out to Augustus]

Augustus:

XXXXX

Narrator as Reporter

How did you celebrate?

Augustus

XXXXXX

Narrator as Reporter:

This news just in. The third ticket has been found by Violet Beauregarde, daughter of Mr. Beauregarde who runs a car dealership. Let's go live to the scene.

Mr. Beauregarde

XXXXX

Violet

XXXXX

(Arthur Slugworth sneaks in to whisper in Violet's Ear)

Mr. Beauregarde

XXXXXX

The actors playing Augustus, Violet, and Mr. Beauregarde worked with their student clinicians and their fellow actors to come up with their own lines of choice. They developed the script below.

Sample of Developed Skeleton Script after Rehearsal

Narrator

This news just in.

Whole Cast

Breaking News!

Narrator as Reporter

The second golden ticket has been found. Let's go live to Düsseldorf in Germany.

Augustus, how did you find the golden ticket? [holds microphone out to Augustus]

Augustus:

I was eating a chocolate bar, and then I pulled a golden ticket out of my mouth.

Narrator as Reporter

How did you celebrate?

Augustus

I ate more chocolate!

Narrator as Reporter:

This news just in. The third ticket has been found by Violet Beauregarde, daughter of Mr. Beauregarde who runs a car dealership. Let's go live to the scene.

Mr. Beauregarde

Cars, cars, cars! Hi, I am Mr. Beau… *(CUT OFF BY VIOLET).*

Violet

COOL IT, DAD. Hi I am Violet. Look, look here's my ticket. I like to chew gum… How much gum are you smackin'?

(Arthur Slugworth sneaks in to whisper in Violet's Ear)

Mr. Beauregarde

I am so proud of you.

It is my belief that with the planning sessions and the skeleton script that CU Boulder's SLHC Chat Group will have a balanced interdisciplinary collaboration once more. The leading SLPs continue to demonstrate an increased fluency and confidence in their own theatrical skills and are aided by the energy and determination of the student clinicians. Most importantly, I continue to

be impressed with the acting talent and creativity of this incredible company of actors. I feel confident that they will have a tremendous production this summer.

Conclusion

Even though things did not go as planned these past two years, my practice with CU Boulder's SLHC Chat Group during the course of the pandemic, continued to bring me new insights into my research question. Each of the three sessions discussed above used theatrical practices in a unique way. Add to this the very different ways in which Théâtre Aphasique, The Rehabilitation Institute of Chicago, The Adler Center, and Aphasia Park ran their own interventions, I am left with a very simple and straightforward answer. How do theatrical practices work as an intervention for individuals with aphasia? In many different ways. This is why, in my final chapter, I will turn to speech-language pathology to examine why theatrical practices are effective within interventions for aphasia.

Chapter 5: Putting it Together

Introduction

Throughout this dissertation, I have outlined five different successful interventions for aphasia using theatrical practices. All interventions were unique, and all interventions produced signs of increased communication confidence from their participants. At this point, any of these programs could be used as models for future interventions and, in their own way, all answer my original research question of how to use theatrical practices as a modality for successful intervention for aphasia. While I maintain belief in my recommended practices, no one intervention showed signs of being significantly more effective than any other. Although research at this site of engagement remains scarce, I do believe that there is enough evidence to at least warrant further investigation. As an applied theatre practitioner, there is enough evidence for me to have confidence that this practice works. Therefore, in this chapter, I will expand on my original question to include *why* theatrical practices can work as an effective intervention for individuals with aphasia. In order to investigate the *why* of how this intervention works I interviewed my collaborators, speech-language pathologists Holly Kleiber and Christina Riseman, for their voices and perspectives on the practices we have been utilizing for the past three years.

In this interview, we critically examined the games, exercises, rehearsal process, and culminating performance, and considered how this work overlapped with established speech-language pathology goals for interventions. We discussed areas of intervention overlap between speech-language pathology goals and theatrical practices. I have divided these areas of intervention overlap into two categories. The first category includes areas of intervention overlap related to the individual participant's quality of life: enhanced sense of community,

communication confidence, and the reception of communication treatment without focusing on aphasia. The second areas of intervention overlap connect directly to improving communication skills: receiving and transmitting messages, and pairing gesturing and motion with verbalization.

This chapter will review these areas of intervention overlap through the observations of Holly Kleiber and Christina Riseman and pull from relevant literature in speech-language pathology to illuminate the current discussion of those treatments in the discipline. The qualitative interview data I collected from Kleiber and Riseman and the research collected from speech-language pathology will illuminate why theatrical practices are so successful as a communication intervention modality.

Areas of Intervention Overlap Connected to Quality of Life

Enhanced Sense of Community

CU Boulder SLHC treats aphasia in two modalities: individual therapy and group therapy. The purpose of group therapy is both to increase social interaction and to create a natural context within which to practice communication skills. Part of the group therapy modality employed at the clinic is Chat Group, which has been running for seven years. In the past, Chat group has engaged in many activities—for example, a music class, a class where the clients present in an area of their expertise, and a class where the clients take turns leading the Chat group in an activity of their choosing. While they have had many successful and fun times in Chat group before, both Kleiber and Riseman indicated that the process of practicing theatre and putting on a play deeply enhanced the sense of community in the group. Kleiber explained, "what I feel like is different with theatre is the sense of community. We're all in this together, we're all learning to let loose together, we're all learning to communicate together, we're all learning to navigate this new unknown of theatre together…and then when we get to that final

product, or performance, it's truly a group culmination of the group coming together to present something" (07:25-7:59). Riseman added to this idea by saying, "there is just that extra level of support and camaraderie that comes with a production" (08:31-08:38). This feedback should not surprise an applied theatre practitioner as building and serving a community is a key component of applied theatre as defined in the introduction to this dissertation. Nor should it surprise any theatrical practitioner who knows the camaraderie that is built during the production of a play. In the quote above, Kleiber refers to learning to let loose and navigate an unknown. In theatre, we talk about taking creative risks. There's a vulnerability to creating art, and in theatre, we navigate that vulnerability as an ensemble. Increased sense of community is an expected outcome of any applied theatre endeavor, and it is also something that speech-language pathologists strive to create in their group therapy modalities. As such, building community resides in the intervention overlap between our two disciplines.

Communication Confidence

Communication confidence refers to an individual's perception of their ability to communicate effectively. Evidence of communication confidence is also the measure I used to denote a successful intervention for the projects described in this dissertation. The first question I asked Kleiber and Riseman in our interview was what they believed to be the biggest benefit to incorporating theatrical practices into their intervention for aphasia. Kleiber responded with, "Improved Communication Confidence, improved confidence in the ability to have a successful communication attempt, and a stronger understanding of how that can be verbal or nonverbal" (02:49-03:15). Riseman agreed with Klieber and later in the interview, when discussing the production, stated "You just see that confidence happening, you see that confidence [that looks like an actor thinking], 'oops I said the wrong thing, but I'm still pushing through, and this

thing's amazing and the audience loves it!'" (31:39-31:49). From Kleiber and Riseman's perspective, it is clear that building communication confidence became an integral component of our intervention.

To explore this topic further, I will reference the 2010 article written by SLPs Edna M. Babbit and Leora R. Cherney for *The Topics in Stroke Rehabilitation* journal. This article, "Communication Confidence in Persons with Aphasia," examines the importance of developing a communication confidence measure as an indicator of successful interventions for aphasia. Babbit and Cherney argue that communication confidence relates directly to an individual with aphasia's quality of life. They write:

> The loss of communication in one's own "voice" can lead to loss of confidence. Continually relinquishing one's "voice" to others, whether one chooses to do so or whether it is imposed by others, can decrease autonomy and self-determination. Because we live in a culture that highly values independence and autonomy, increasing confidence by therapeutic intervention may have a great impact for the person living with aphasia. (215)

Babbit and Cherney argue that the implementation of a communication confidence measure can assist clinicians to more fully assess their clients' progress. For example, in Babbit and Cherney's case study they discuss a specific client who after an intervention showed moderate improvement on measures directly corresponding to communication skills; she also showed significant improvement on the newly developed communication confidence measure. At the same time, the client showed an equally significant reduction on her Burden of Stroke Scale (BOSS), wherein a lower score denotes less of a burden. The client went from 143 to 95 on her BOSS score (221). Therefore, the intervention had a focused result on improved quality of life

(reflected by the change in her BOSS score). The increased communication confidence score and reduced BOSS score signify the importance of the individual's communication confidence. Babbit and Cherney further discuss the impact of aphasia on an individual's identity and explain how the loss of their ability to communicate impacts their identity and quality of life:

> Regardless of the type of treatment or the outcomes of an intervention on language and communication, it is important that clients also believe they can communicate confidently in different situations. By improving confidence, people with aphasia may be more willing to attempt communication in difficult or complex situations involving personal, medical, financial, or legal issues. (215)

From the quote above, it is evident how communication confidence can evolve into communication abilities. If an individual with aphasia feels confidence in their communication attempts, they are more likely to participate in important conversations, thereby increasing their communication abilities through using their own voice. As Babbitt and Cherney put it, "If persons with aphasia lack confidence about their speaking abilities, they will not give themselves the authority to speak. Potentially, they will offer the authority to speak to someone else or choose not to speak at all" (221). Building communication confidence thereby enables individuals with aphasia to use their own voices. As I conclude my work with CU Boulder's SLHC chat group, I am continually pleased to see actors ask to take on more lines and volunteer to not only participate in, but to lead, games. What I have witnessed in our company makes me believe that theatrical practices have assisted them in improving their communication confidence.

The reception of communication treatment without focusing on aphasia

The third area of intervention overlap is that of supplying communication therapies without the focus being on aphasia. As a treatment philosophy, the Life Participation Approach to Aphasia (LPAA) advocates the self-selection of activities that are engaging and can build on communication skills without focusing on those goals. In my interview with Abbanat and Caska from the Adler Aphasia Center (which centers LPAA philosophies as foundational to their program), they insisted that enhanced language skills were merely a byproduct of doing their annual musical (33:54 - 34:55). Kleiber mentioned a similar sentiment in my interview with her and Riseman: "part of group is receiving communication treatment, but not focusing on aphasia. It's about succeeding in spite of [aphasia], it's about feeling a part of a community (11:14-11:32). Participating in theatrical practices offers the community a chance to learn a new skill (acting) while interacting with a subject distinct from what brings the group together. (This is one of the reasons why I prefer doing a play that isn't about aphasia.) Riseman discussed how she was struck by the quality of the production and how for a while she even forgot that the actors had aphasia: "after seeing the production, I just forgot that they had aphasia. It wasn't as prevalent in my mind, until thinking, 'wow, look at what they did *because* they have aphasia.' During the play itself I wasn't thinking, 'well it's pretty good for people who have a communication disability' … I was completely floored and amazed at what it turned out to be, and it just seemed like a theatre production" (14:04-14:48). Here Riseman illustrates how aphasia became a secondary component of the work, which ultimately enhanced the participants' experiences. While I agree with the spirit behind the values of LPAA, I am also excited by the prospect that theatrical practices do have communication benefits for participants with aphasia.

Areas of Intervention Overlap Connected Directly to Improving Communication Skills

While the first three areas of intervention overlap—enhanced sense of community, communication confidence, and the reception of communication treatment without focusing on aphasia—centered around improved quality of life, the subsequent two areas of intervention overlap focus directly on building communication skills. These areas are: receiving and transmitting messages and pairing gesture and motion with verbalization.

Receiving and Transmitting Messages

In reviewing the theatrical games we used during rehearsals for *The Wizard of Oz*, Kleiber and Riseman discussed the process of receiving and transmitting messages as important to any communication intervention. Kleiber described the process of playing "Woosh, Woosh, Whoah," by saying:

> Knowing it's your turn, being ready to watch carefully the person whose turn it is, receive their message, comprehend their message… "oh they said 'woosh', now my choice is 'woosh' or ' whoah', or they said 'whoah', I need to send it back the other way." So that sense of being the transmitter of that message and the receiver of the message…it included nice elements of timeliness (because part of that game is can we do it quickly) efficiency of processing the message and responding to it. So that had a lot of communication in it. (17:03 18:18)

By receiving and transmitting messages, participants are engaging in what is called functional communication. As explained in Fridriksson et al.'s article, "Functional communication and executive function in aphasia," in the journal of *Clinical Linguistics and Phonetics*, functional communication is the ability to send and receive messages in any modality (i.e., written, verbal, or gestural). Therefore, in these games, participants are practicing functional communication.

There is also reason to believe that working on functional communication can assist in additional cognitive processes.[28] According to Fridriksson et al. functional communication can be linked with executive function. Executive functions include cognitive processes such as accessing working memory, strategizing, moving between topics, concentration, and many more. Fridriksson et al. explain, "Executive functions are the highest level of human cognition and enable us to accomplish goal directed activities in a flexible manner and perform the tasks of daily living" (402). They also explain how executive function overlaps with functional communication: "For example, when holding a conversation one must retain what the other person said, plan a response, and, sometimes, inhibit an inappropriate response, relying on processes such as working memory, planning, and inhibition" (402). While the exact nature of the relationship between executive function and functional communication remains elusive,[29] participating in activities that require functional communication has the potential to act as an intervention for a wide range of cognitive processes.

To this end, Kleiber brought up the element of improvisation, which is connected to executive function: "Communication and conversation require a lot of improvisation. You don't know exactly what the other person is going to say, and you don't know exactly what we're going to say. And, I think a lot of these games incorporate the underlying skill of improvisation that is really critical" (20:19-20:39). The spontaneity, concentration, and reactive components of these games is precisely why I use them throughout my theatrical practice (not only when working with individuals with aphasia). When actors are working with a script and have set blocking, it can be challenging to remember to be responsive and in the moment, as if the scene

[28] Pinning down cognitive processes impacted alongside aphasia is a challenge in speech-language pathology. Impaired communication impacts the measures traditionally used to measure those impairments. There is a lively debate on this topic between scholars that is discussed by Fridriksson et al. (401-402).

[29] Fridriksson et al.'s data were inconclusive.

were *not* carefully rehearsed. Returning to these games can help actors to remember to make the script come alive—as if it's a conversation happening for the first time. In a way, the games remind the actors (subconsciously) to re-engage the cognitive processes used in functional conversation.

Pairing Gesturing and Motion with Verbalization

Discussing the games, "Name and Gesture" and "Mirroring," Kleiber explains the importance of nonverbal areas of communication, such as gesture and cueing. She stated, "sometimes the words don't come out right, but [the question of] what are the other ways we can convey a message comes across in "Name and Gesture." And also, [the question of] how can we get the verbal and the nonverbal match up and make our message bigger because both match?" (18:20-18:41). Of "Mirroring" she said, "it has this element of being in the moment with someone else, and carefully watching and being in tune with their cues. There's just so much that goes into communication—not speaking, but communication—that I think is around picking up on and following a partner" (18:46-19:12). In these quotes Kleiber expounds on the separate processes that are part of nonverbal communication. Riseman, also discussing mirroring, added how nonverbal interaction reinforces the participants' own understanding of nonverbal communication. She explained, "it can help people with communication disorders realize that this person is doing that because I did something, and I didn't tell them a single thing … It's all based on what they're communicating without saying anything" (19:47 -20:09). How much SLPs should focus on non-verbal communication and multimodal communication is a topic of debate in speech-language pathology as the reader may remember from Chapter 1's discussion of the differences in the practice of CILT and therapies that promote use of multiple modalities of communication.

In 2013, SLP Miranda L. Rose added insight to the debate over approaches to treatment in her article, "Releasing the Constraints on Aphasia Therapy: The Positive Impact of Gesture and Multimodality Treatments." Rose writes, "The central argument of my paper is that given the state of the empirical evidence and the strong theoretical accounts of modality interactions in human communication and their documented neural underpinnings, gesture-based and multimodality aphasia treatments are at least as legitimate an option as constraint aphasia treatment" (228). In other words, using multimodal communication strategies, such as gesture, can facilitate communication for those with aphasia. Drawing on research available in the field, Rose goes on to explain that gestures can assist communication in multiple ways:

> Gesture production has been hypothesized to have three possible functions: (a) to contribute to the communication of meaning (e.g., when a person is showing an interactant how to get from his or her current location to another and produces directional gestures or in noisy environments when pantomime dominates interaction…(b) to help facilitate word retrieval when difficulties are encountered…and (c) to assist in thinking for speaking when task demands are high. (228)

The above quotation lists three uses of gesture in communication: contribution to meaning, facilitation of word retrieval, and facilitation of thought processes.

Kong, et al. in their 2015 article, "Co-verbal gestures among speakers with aphasia: Influence of aphasia severity, linguistic and semantic skills, and hemiplegia[30] on gesture employment in oral discourse," support Rose's assertion. In this article, Kong et al. state that "The use of co-verbal gestures is common in human communication and has been reported to

[30]Hemiplegia is paralysis on the right side of the body which is often a co-occuring condition with aphasia. Paralysis may, of course, inhibit gesture. There was concern from Kong et al. that it would especially be impactful in the use of gesture from those who are right handed. However, Hemiplegia was "not found to affect the use of gestures in speakers with aphasia" (96).

assist word retrieval and to facilitate verbal interactions" (88). Both Rose and Kong et al. are referring not only to speakers with aphasia but also to speakers with no communication disorders. In fact, as part of their research on gesture, Kong et al. formed a control group of speakers without communication disorders and restricted their use of gesture while speaking. They found that "When participants were restricted from using arm and hand movements, an increase in non-juncture filled pauses and a decrease in speech fluency of verbal expression involving spatial content were found" (89). Putting it simply, restricting gesture will impact an individual's fluency of speech even in the absence of a communication disorder. Additionally, in comparing speakers with and without aphasia, both Rose and Kong et al. found that speakers with aphasia used significantly more gestures than those without (Rose 228; Kong et al. 88). Rose's and Kong et al.'s research clearly indicate that using gesture is not only part of nonverbal and verbal communication, but that individuals with communication disorders instinctively turn to increased gesture and unique gestures to enhance their communication compared to those without communication disorders. Kong et al. further discuss how individuals with aphasia use different types of gesture. They write:

> [Participants with aphasia in this study] who used gestures, content-carrying gestures, including iconic, metaphoric, deictic gestures, and emblems, served the function of enhancing language content and providing information additional to the language content. As for the non-content carrying gestures, beats were used primarily for reinforcing speech prosody or guiding speech flow, while non-identifiable gestures were associated with assisting lexical retrieval or with no specific functions. (88)

Here, Kong et al. affirm the three types of gesture discussed by Rose, with the final 'non-identifiable gesture' being used for lexical retrieval—the cognitive process of going from holding a concept in your mind to putting that idea or concept into words.

Theatre clearly uses what both Rose and Kong et al. refer to as "content-carrying gestures" or gestures which "contribute to the communication meaning." In "Name and Gesture," the instruction is to say your name with a gesture that represents how you feel. This gesture adds meaning. Recently, in rehearsal for *Charlie and the Chocolate Factory*, we added two gestures for Willy Wonka when Violet begins to turn into a blueberry after eating Wonka's three course meal gum. The actor playing Wonka said that he believed Wonka was both frustrated and disappointed, but also wanted to clarify that Wonka was not concerned about Violet's predicament, just that the gum wasn't ready yet. He decided his line would be, "It always goes wrong with the dessert![31]" The actor felt that when he said the line, the feelings weren't being conveyed. So, we added the gesture of him throwing his hands up in frustration, which was better, but didn't convey that he didn't really care about Violet. So, we added the gesture of him walking away from her as he said it. What is interesting about this moment is that it not only expressed his full meaning, but it also helped him to remember and say his line more clearly. Caution—don't jump to the conclusion that this means that the gesturing we do in theatre also contributes to what Kong et al. describe as lexical retrieval. There is a more simple explanation. By adding the gestures, we also repeated and rehearsed the line, which would have assisted in the line being more memorable and spoken better. However, I also don't want to discount the possibility that using gestures in a more specific and nuanced way does contribute to the process of lexical retrieval. Kong et al. describe that when using functional magnetic resonance imaging (fMRI) the neural system used during lexical retrieval was the same as the

[31] Similar to Gene Wilder's line in the film.

neural system that produced gestures (89). Drawing on studies from Hadar and Butterworth in 1997 and Krauss and Hadar in 1999, Kong et al. write:

> In particular, when a lexical item is activated at the stage of conceptualization, its corresponding gesture can be originated at the same time and interacts and temporally synchronizes with the language output. In other words, gesture use among typical speakers can facilitate lexical retrieval during spontaneous speech production, at least at the conceptual level where mental lexicons[32] are activated. (89)

That a connection between gesture and lexical retrieval exists is clear; exactly how that connection works and how it can fit into speech-language pathology requires further research. To that end, I agree with Rose that there is sufficient theoretical research and neurological research to support individuals with aphasia in receiving multimodal communication interventions that include gesture. As such, the use of theatrical practices as a modality of that intervention is beneficial in its ability to assist participants in increasing and expanding their gestural repertoire.

Conclusion

In this chapter, I was able to explore the theoretical underpinnings of why theatrical practices work as a modality within an intervention for aphasia because of the keen insights of my collaborators Holly Kleiber and Christina Riseman. Due to their training and many years of experience in speech-language pathology and working with individuals with aphasia, they were able to pinpoint the language and communication functions and therapeutic value in the integrity of the intervention. When we began our collaboration, both Kleiber and Riseman expressed reservations about how much practicing theatre would serve as part of their overall intervention plan for their clients. However, throughout the process of preparing for *The Wizard of Oz,* they

[32] "The mental lexicon is that component of the grammar that contains all the information – phonological, morphological, semantic, and syntactic – that speakers know about individual words and/or morphemes" (Emmorey).

became convinced that theatrical practices assisted in many of the goals they had for their clients. In an article published in *The Colorado Sun*[33] about our project, Kleiber states, "We'd like [the actors with aphasia] to improvise and generate those lines [for the play] themselves…Each client has personalized goals they're working on within each session. Theater is really more the mode of practice. The bottom line is it's still therapy with set goals."

Theatre as a mode of practice offers a new approach to aphasia therapies. To this end, this chapter has explored how and why theatrical practices overlap with speech-language pathology intervention goals. I have explored not only how theatrical practices directly correlate with practicing communication skills, but also how theatrical practices unite with the philosophies of LPAA to improve the quality of life for individuals with aphasia. In a different article about *The Wizard of Oz,* published in the *Colorado Arts and Sciences Magazine,*[34] Kleiber explains how one of the aims of the project was to re-engage participants in life activities. She said, "Part of the project was to help them get back to active life so they feel they are meaningful and participating in society again…It was really nice to see the audience getting larger and larger because it meant [the participants] had something to look forward to, to be proud of. It was something to give to their families, not just 'I need a ride to therapy.' It became, 'I've been working really hard on this, I want to entertain you, show you something I'm proud of.'" Ultimately, with the substantial research supporting multimodal, gestural, and life participation activities improving both communication and quality of life in individuals with aphasia, theatrical practices have an immense possibility of acting as a successful intervention for aphasia.

[33] The Full Article is available in Appendix A
[34] The Full Article is available in Appendix B

Conclusion

How do Theatrical Practices Work within an Intervention for Aphasia?

In my first session at CU Boulder's SLHC Chat Group, I asked the participants to say their name and incorporate a gesture that expressed their feelings. They practiced, and then shared their name and gesture with each other. In that moment, they embraced a new identity of actor. From each moment to moment and week to week that identity grew alongside the other identities each participant held, including, but not limited to, their identity as an individual with aphasia.

As this dissertation has suggested, alongside their growth as actors, the potential exists for the participants' growth in increased communication confidence, increased communication skills, and increased participation in life activities. My research question asked how theatrical practices worked as a modality within an intervention for aphasia. After reviewing the practices at the Théâtre Aphasique, the Rehabilitation Institute of Chicago, the Adler Aphasia Center, and Laura Wood's and David Mowers' research into incorporating theatrical practices in interventions for aphasia, I am convinced that there are numerous forms this practice can take and remain effective. Every group that incorporated theatrical practices into their aphasia intervention was able to show signs of increased communication confidence from their participants.

The first and most important step is deciding to do it—to decide that individuals with aphasia can succeed and excel at putting on a play. From there, whether you train your company with acting exercises or simply start the process of rehearsal and line memorization, engaging theatrical practices will be useful to participants with aphasia in many ways. As discussed in Chapter 5, increased communication confidence is connected to increased quality of life for

individuals with aphasia. If this was *all*—that is, if increased communication confidence and increased quality of life were the *only* outcomes from the projects—it would be enough to warrant both more research and more use of theatrical practice within interventions for aphasia. However, these outcomes are not the only ones that can be expected as a result of incorporating theatrical practices in an intervention for aphasia. It is clear that while participants are engaging in theatrical activities, they are also directly engaging in communication strategies that can assist them in communication skills.

To speech-language pathologists, I hope you will pursue more research that will allow theatrical practices to become a more broadly used and effective modality for aphasia interventions. And to theatrical practitioners, step forth with confidence that you have a truly valuable skill set to offer in these interventions.

Recommendations for Using Theatrical Practices in Interventions for Aphasia

There are numerous ways to begin using theatrical practices in an aphasia intervention. Some have been explored in this dissertation, but there are many more theatrical techniques, games, and exercises that could be applied and be successful. My first recommendation is that if you are having trouble finding exercises and games to incorporate into your practice, look to Augusto Boal. It's not a coincidence that four of the five projects in this dissertation relied on the practices of Boal. His useful games and exercises are designed to help expressivity and communication with the whole body. If you don't like the games related in Chapter 3, Boal's *Games of Actors and Non-Actors* have a plethora of activities that could be adjusted for actors with aphasia.

My next recommendation is don't reinvent the wheel from scratch: this dissertation has provided you with examples of techniques and processes used by a variety of practitioners. If

you are going to embark on this endeavor for the first time, I strongly recommend creating a structure you can replicate in some way. At the same time, don't aim for perfect replication. Remember that while each project was run differently, each produced the outcome of increased communication confidence from its participants. That means there is room to bring your own unique background in theatre to this practice, and there is room to explore. There are certain simple philosophies that I reiterate as frequently as possible in my rehearsal room. One of them is that "the only wrong choice is to try nothing." I use this specifically when working with actors with aphasia because of their uncertainty or mistrust of their nonverbal communication skills. I repeat this adage to encourage them to simply try despite their uncertainty about the success of their communication attempt. Very soon they realize that they are able to competently execute what is expected of them, even if the words don't come out. Now, I would like to repeat this adage to you: the only wrong choice is to do nothing. Don't allow your uncertainty of success to hold you back either.

When you begin, one of your first steps will be to choose between performing a story about aphasia or a story not about aphasia. As you do, consider these three things: (1) At the Théâtre Aphasique, actors were motivated by the goal of increasing the public's awareness of aphasia; (2) However, at the Adler Center & CU Boulder's Speech Language & Hearing clinic, participants enjoyed participating in an activity new and not related to aphasia, and (3) Is it really your choice to make? Why not let your group of actors decide what kind of play they want to participate in? If you chose to do a well known story, instead of a devised work developed by the actors about their experience with aphasia (as was done with *Aphasia Park*, *Waiting on the Words,* and *Le Dernier Mot*) you will still need to create a unique script that fits your participants communication abilities. Consider when to give the actors the script. Is it best for them to play

and improvise the scene until a script is created by the participants (as was done for *The Wizard of Oz*), or is it better to begin with a script that has been adjusted for the actors based on their communication abilities (as is done at the Adler Center), or is something in between better, working with a skeleton script (as is currently being done for *Charlie and the Chocolate Factory*)? Personally, I think giving the actors a script early on in the process can place too much importance on verbal communication (as there are words on the page they are trying to convey); however, as I am unable to participate in the final few months of the *Charlie and the Chocolate Factory*, I am happy to leave them with the tool of the skeleton script.

Due to the relatively limited research available in this area, and my strong belief that there are many ways of engaging theatrical practices within an intervention for aphasia that are bound to be successful, you will have found my above mentioned recommended practices somewhat equivocal. However, there is one practice that I have no intention to equivocate on: transferring agency. Whenever possible, empower the company or the actor to make their own choice on how to proceed. Empower them as a community and as individuals whenever possible. The whole point of this activity is to restore confidence to individuals who have lost some part of their ability to put their voices out into the world. Be someone who listens and empowers them and never someone who takes any part of their voice away.

Next Steps

This dissertation discussed using theatrical practices as a modality within an intervention plan for aphasia led by speech-language pathologists. I described this practice as a new site of engagement for research, not fully being covered by existing fields of study. I maintain my belief in the efficacy of this approach and would encourage any theatrical practitioner to begin their work in this area by first joining speech-language pathologists within a clinical setting in order to

further their understanding of the discipline and draw on the knowledge and skill sets held by speech-language pathologists. However, by doing this, there are elements shaded by the umbrella of applied theatre that are not fully incorporated. As stated in my introduction, applied theatre has two primary characteristics: it takes place outside of a traditional theatrical setting, and it is used for social change. Its primary purpose is to serve a community. In working at CU Boulder's SLHC, I was serving a community impacted by aphasia. But, the individuals with aphasia I was working with were also individuals who lived in proximity to the clinic, had health insurance, and had caregivers with the resources and time to take them to that clinic. Let us not pretend that our healthcare system operates without inequalities.

Such inequalities impact those with aphasia, which provides the opportunity for applied theatre practitioners to take up the second call of our discipline—social change—and engage with the philosophy of Theatre of the Oppressed (TO). For example, in their 2009 article, "Disparities in Stroke Rehabilitation: Results of a Study in an Integrated Health System in Northern California," Sandel et al. discovered that those who received more treatments for stroke were "patients from higher socioeconomic groups, from urban areas, and from geographic areas close to the regional rehabilitation hospital" (29), meaning that there exist large gaps in treatments for individuals with aphasia along socioeconomic and geographic lines. As stated in my reason for study, over two million Americans have aphasia, and there are 180,000 new cases each year. As people are living longer and there are more and more cases, there is significant urgency in providing more treatments for individuals with aphasia. Moreover, there is substantial research in related cognitive impairments that suggests theatrical practices can be useful for additional cognitive impairments. For example, research is being conducted in using theatrical practices as interventions for Parkinson's and autism. And, Laura Wood's forthcoming book

focuses on the use of theatrical practices in clinical settings for numerous types of recovery (including aphasia). This rapid expansion of inquiry into the benefits of theatrical practice further suggests the need for increased resources and attention to this area.

As advances are made in cognitive neuroscience and clinical treatments for chronic disorders, I anticipate a broader call for theatrical practices in clinical settings. While the population I was able to work with had the advantage of coming to CU Boulder's Clinic, even that resource is limited. For example, at CU Boulder, individuals with aphasia come for one day a week and only for a few hours. Establishments like the Adler Center are unique and few and far between. The immensity of the challenges that need to be addressed in this area reach far beyond this dissertation and myself as an applied theatre practitioner, but that doesn't mean nothing can be done. After working with individuals with aphasia for the past three years, my next step is to reclaim the practice under the umbrella of applied theatre. Stepping outside of the clinical setting once more, into whatever space may be available to create a company of actors with aphasia, will mark the beginning of assisting just a few more individuals with chronic communication disorders. And, if theatrical practitioners follow in my footsteps, that number can continue to increase. In doing so, we can reach individuals who want more treatment but either lack access (whether due to distance, absence of resources, or absence of insurance), or who have access to some treatment, but not enough. While this step barely begins to tackle the larger systemic barriers to accessing aphasia treatment, it is, nonetheless, a step forward and has the power to greatly impact the individuals able to participate.

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Appendix A

The Wonderful Wizard of Oz

Part 1

Act 1 Scene 1: The Introduction

[1. Entire Cast enters and takes their seats to the left and right of the stage and sit. 2. Narrators enter (holding books) and go to two podiums stage left and stage right. 3. Narrators lift their copies of The Wonderful WIzard of Oz up for the audience to see and then place the books down without opening them]

Narrator 1

This is the story of a brave young woman [Both Dorothy's stand and come together] named...

Dorothy

[Dorothy's face out to the audience and do a similar name and gesture]

Dorothy

Narrator 2

And her dog, Toto [Narrator tosses Toto do Dorothy]

Toto

Bark

Narrator 1

This is also the story of a Scarecrow [Scarecrow stands and comes center]

Narrator 2

(*wait for scarecrow to get to center stage*) Who desperately wants a brain [Scarecrow gives gesture]

Narrator 1

A Tin Man [Both Tin men come center HF holding the Ax]

Narrator 2

(*wait for tin man to get to center stage*) Who is seeking a heart [Tin men gesture - then HF hands the ax to JM and they both sit]

Narrator 1

And a Lion [Lion comes center and roars ferociously] who hasn't any courage [Lion whimpers and returns to his stage, perhaps frightened by the audience]

Narrator 2

Together with a good witch [Eowyn spins in place], A Wicked Witch [Wicked Witch Stands and Growls] a Munchkin Mayor [Mayor stands and bows and waves to all his people] and a wonderful wizard [Wizard Stands and gestures] they have an adventure of a lifetime.

Narrator 1

Now……

Act 1 Scene 2: Kansas

Narrator 1

[Both Narrators lift the books again and this time they open them to the first page, they smile] Once upon a time…

Narrator 2

In Kansas…

Narrator 1

Lived a young woman [NY stands and moves onto the stage, a Munchkin/clinician hands DW his Guitar, DW stays seated, NY moves to the stage] who wished she was somewhere else.

Dorothy

“Somewhere Over the Rainbow”

[When Nicole is finished singing the rest of the cast joins in by humming the melody Nicole steps down from the stage, YE approaches her, they pass Toto between them and NY sits down]

Narrator 2

In the distance the winds begin to blow [nothing happens] the winds begin to blow! [again nothing happens] Ok, you know… we might need a little help.

[Leading the Audience in the Storm - we can rehearse this when I Get back but give it a try now]

And the howls of the wind begin to frighten Dorothy [cast joins in with howls and cracks]

Dorothy

Oh no! What's happening?

Narrator 2

The storm gets bigger and louder and… louder [narrator gestures to the audience - suddenly the lights start flickering as the storm gets louder and scarrier….. When the lights come up Dorothy is in the center audience isle switch to YE]

Narrator 1

There is a sudden crash and Dorothy only barely manages to keep her balance.

Toto

Bark

Dorothy

Toto, where are we?

Narrator 2

Dorothy opens the window and is amazed at what she sees outside. [Dorothy opens a window and looks outside] Finally, she runs to the door and swings it open [Dorothy walks around the house, in awe of all she sees]

Toto

Bark

Dorothy

Toto, I don't think we're in Kansas anymore!

Narrator 1

Suddenly Dorothy realizes, she's not alone [munchkins pop up from around the stage - some help the mayor to his place and some make room for Eowyn who they are all happy to see. The mayor waves to two munchkins who collect Dorothy and bring her to the mayor]

Dorothy

Hello

Mayor

Welcome Friend!

Eowyn

You killed the wicked witch!

Dorothy

I didn't kill anyone

Eowyn

Well your house did!

Narrator 2

They all look to Dorothy's house and see the two legs of the Wicked Witch coming out from underneath. On her feet are a pair of ruby slippers.

Dorothy

Oh My!!!!

Mayor

She's Dead!

https://www.youtube.com/watch?v=0RHsb9LnD9Q

Eowyn

She was the Wicked Witch of the East.

Mayor

You set us free, thank you!

Dorothy

Thank you, but I didn't mean to kill anyone.

Eowyn

I am Eowyn, the witch of the north. (Dorothy appears afraid) but I am a good witch and a friend.

Dorothy

Oh, I am very grateful to be here, but do you think you could help me get back to Kansas?

Eowyn

I have never heard of Kansas. I'm afraid I can't help you get there, but perhaps the Great OZ can (Munchkins seem excited). You can find him in the Emerald City.

Dorothy

Where is the Emerald City?

Narrator 1

The mayor explains to Dorothy how to follow the yellow brick road through the beautiful…

(As the Mayor is talking some munchkins bring the witch's ruby shoes to Eowyn)

Narrator 2

…And sometimes frightening…

Narrator 1

…land of Oz to reach the Emerald City.

Narrator 2

The munchkins take the ruby slippers from the wicked witch of the east and give them to Dorothy.

(as Dorothy takes the shoes Eowyn signals to her to come closer to her. Eowyn kisses Dorothy on the forehead)

Eowyn

They're magic!

Narrator 1

Dorothy put the slippers on and….

Munchkin 9

The Wicked Witch of the East!

Munchkin 8

Hide! [The munchkins all flee]

Wicked Witch of the East

Who killed my sister????

Narrator 2

The Wicked Witch sees Dorothy and approaches her menacingly, but then sees that Dorothy is wearing the ruby slippers and stops.

Wicked Witch

Hey! Give me my shoes!

Eowyn

No don't!

Toto

Bark, Bark!

Narrator 1

The slippers had great magic.

Wicked Witch

Give me my slippers!

Toto

Bark, Bark!

Narrator 2

The witch wanted to take the slippers from Dorothy, but she cautious....

Narrator 1

...for Dorothy did have the slippers, and the witch did not have all her powers here in the West. She decided to bide her time...

Wicked Witch

I'll get you, my pretty!! [Exit Witch]

Dorothy

I want to go home!

Eowyn

Go to the Wizard.

Narrator 2

And so Dorothy began her journey!

Mayor

Good luck brave friend!!!!

Dorothy

(Dorothy begins her journey)

Follow the yellow brick road.

[Dorothys come center and switch]

Narrator 2

And so Dorothy began her trip down the yellow brick road to see the Wizard

Dorothy

Follow the yellow brick road, follow the yellow brick road [Dorothy Happily skips along]

Narrator 2

After some time passed, Dorothy began to feel tired, so found a place to take a rest. [Dorothy slows down and sits down and falls asleep upstage left]

Narrator 1

After sleeping awhile, she wakes up and looks around. And, to her surprise, she sees a Scarecrow [Scarecrow Enters and walks DR, Scarecrow waves at her, and then waves her over to him]

Scarecrow

Hello

Dorothy

Did you speak?

Scarecrow

Certainly, How are you?

Dorothy

Ok, you?

Scarecrow

Not well. I am stuck.

Dorothy

Can I help?

Narrator 2

Without any difficulty Dorothy lifts the scarecrow from his pole, for the scarecrow is made only of straw and is therefore very light

[Dorothy lifts the crow off the pole, he is light as he is made of straw]

Scarecrow

Ah, thank you very much!!!

Scarecrow

What's your name?

Dorothy

I am Dorothy and I am going to the Emerald City to ask the Great Oz to send me back to Kansas.

Scarecrow

Is OZ a great wizard?

Dorothy

Don't you know?

Scarecrow

No, I don't have a brain. Can Oz help me?

Dorothy

I don't know, but you can come with me and ask. You can't be worse off for asking.

Scarecrow

Oh, thank you! I would love a brain!

Narrator 2

And so the Scarecrow and Dorothy began their journey down the yellow brick road to visit the Wizard

Scarecrow

Follow the yellow brick road

Dorothy

Follow the yellow brick road

Dorothy and Scarecrow

Follow the yellow brick road

Narrator 2

As they walked on, eventually, they saw less farmland from the Munchkins and more trees and they guessed that they were leaving Munchkin land.

Dorothy and Scarecrow

Follow the yellow brick road, follow the yellow brick road.

Narrator 1

Suddenly, they noticed something strange by the side of the road. [Tin man enters (HF) and stand frozen holding his ax up]

Tin Man

Help me (the words should sound muffled and difficult to understand

Dorothy[YE]

Did you hear something?

Tin Man

Help me [the Tinman is encouraged that they hear him so he tries to speak more clearly and louder].

Help me!

Dorothy

Oh dear, he's trying to say something.

Tin Man

Help me

Dorothy

Help me! Oh yes, but how?

Tin Man

Oil Can

Narrator 2

(Hand Dorothy the oil can)

Dorothy and Scarecrow

Oil can, oh yes, but where?

Scarecrow

Over here, Dorothy.

Tinman

The mouth....the jaw....Oh, I can speak! Oh the arms, and the legs. Oh, oh what a relief. I have been holding that ax like that for a year! Thank you!

Dorothy

Your welcome

Scarecrow

What happened

Narrator 1

The Tin Man explained that he had come out to chop wood when it began to rain and he rusted solid. He had been standing there for a whole year.

Dorothy

Oh my!

Narrator 2

Dorothy and the Scarecrow told the Tin Man of their adventures and why they were traveling to see the wizard.

Tin Man

Do you think the Wizard would give me a heart?

Dorothy

I don’t know

Scarecrow

It couldn’t hurt to ask.

Narrator 1

And so the Tinman joined the Scarecrow and Dorothy

Scarecrow

Follow the yellow brick road

Dorothy

Follow the yellow brick road

Tin Man, Dorothy, and Scarecrow

Follow the yellow brick road.

Narrator 2

Pretty soon, the yellow brick lead them into a dark forest. And the friends became wary of the dark and the strange noises.

[Each member of the cast add in a forest sound - start with an owl - Character switch Dorothy and Tin Man]

Dorothy

I'm scared

Toto

Bark

Scarecrow

What kind of animals live here?

Tin Man

Lions?

Dorothy

...and Tigers?

Scarecrow

...and Bears

Tin Man

Oh my!

Tin Man, Dorothy, and Scarecrow

Lions, and Tigers, and Bears, Oh my...

Lions, and Tigers, and Bears, Oh my...

Lions, and Tigers, and Bears, Oh my...

[Lion jumps out onto the stage in front of them]

Lion

Roar!

Tin Man, Dorothy, and Scarecrow

AAAAHHHHHHH!

Toto

Growl leading to barking [toto jumps from Dorothy's arms and attacks the lion]

Dorothy

Toto come back

Lion

Oh stop, stop, please don't hurt me. -the lion cowers away from Toto

Scarecrow

You're scared of a dog?????

Lion

I'm scared of everything

Tin Man

But you're supposed to be king of the forest.

Lion

But I don't have any courage! I'm a failure as a lion!

Scarecrow

That's sad

Narrator 2:

The Scarecrow, Tinman, and Dorothy all feel sorry for the lion with no courage. They invite him on their journey to meet the Wizard. [dorothy and Tinman switch out]

Lion

But, how do we get to the Wizard?

Dorothy

Follow the Yellow Brick Road!

The Wonderful Wizard of Oz

Part 2

Act 2 Scene 1: The Wizard

Narrator 1

After finding their way to the Emerald City: Dorothy and the Scarecrow..

Narrator 2

The Tinman and the Lion...

Narrator 1

Were all shown in to the great hall to meet--the Wizard

OZ

I am the almighty and powerful Wizard of Oz! Who dares come my way?

Narrator 2

The friends were surprised by the voice that seemed to come from high above them in the room. For as far as they could tell the great throne room was empty

Dorothy

I’m Dorothy

Scarecrow

I’m the Scarecrow

Lion

I’m the Lion

Tinman

I’m the Tinman

Dorothy

Where are you?

OZ

I am everywhere, I am invisible!

Lion

I’m frightened!

OZ

What do you want?

Dorothy

We need your help!

Narrator 2

Dorothy explained about the storm that brought her from Kansas and how she wanted to go home more than anything.

Narrator 1

She told the Wizard of her journey down the yellow brick road and how she had met her friends along the way, who needed the Wizard's help too.

Scarecrow

And I want a brain

Lion

And I want courage.

Tinman

And I want a heart

OZ

Why should I help you?

Dorothy

Because you are powerful.

OZ

I will help you. But first you must help me.

Tinman

What can we do for you?

OZ

You killed the Wicked Witch of the East. Now, you must kill the Wicked Witch of the West. Bring me her broomstick and I will grant your wishes.

Narrator 2

Dorothy and her friends were heartbroken! They didn't see how they could do what the wizard had asked.

Lion

But what other choice do we have? We have to try!

Narrator 1

So the four friends began their journey West. The closer they got to witch's lands the darker and rougher the land became.

(Tinmans and Dorothy switch.)

Narrator 2

Now, the Wicked Witch saw the friends coming and she was angry! First the witch sent a pack of wolves to tear them up!

Wicked Witch

Grrrrr……

Narrator 1

But the Tinman defended the group with his Ax

Narrator 2

Next the Witch sent a flock of Crows to peck them to pieces

Wicked Witch

Grrrrr……

Narrator 1

This time, the Scarecrow made his friends hide and he stretched out his arms and looked as scary as he could, and the birds flew away in fear.

Narrator 2

Now, the witch was in a terrible rage and used all her powers to send the flying monkeys to put an end to them.

Wicked Witch

Grrrrr……

Narrator 1

And this attack the friends couldn't defend against..

Narrator 2

The flying monkeys tore all the straw from the Scarecrow

Scarecrow

Aaaahhhhhh!

Dorothy

Oh no!

Narrator 1

And they dashed the Tinman on rocks.

Tinman

Ahhhhhh!

Dorothy

No!

Narrator 1

But as they came for Dorothy they saw the shoes and dared not harm her.

Narrator 2

So they took the Lion and Dorothy to the Witch and the Witch made them her slaves, all the while plotting to get the shoes from Dorothy's feet. But Dorothy never took them off.

Narrator 1

One day, the Witch used magic to trip Dorothy and when one of her slippers fell off, she snatched it up.

Dorothy

Give me back my shoe

Wicked Witch

No!

Dorothy

You, Wicked Witch, how can you be so cruel?

Narrator 2

Dorothy is so angry she throws a bucket of water at the Witch

Wicked Witch

Oh, see what you have done?

I'm melting

Dorothy

Oh no, I'm sorry

Wicked Witch

You've killed me. I'm melting, I'm melting!

Narrator 2

Dorothy grabbed the Wicked Witch's broom and her shoe. With the Witch dead, Dorothy asked the newly freed flying monkeys to help her get her friends.

Narrator 1

The flying monkeys gathered the Tinman and bent him back into shape

Narrator 2

and restuffed the Scarecrow. Then they flew Dorothy and her friends back to Oz

Oz

I am the almighty and powerful Wizard of Oz!

Who dares come my way?

Dorothy (YE)

It's us - we brought the broom!

Scarecrow

Now can I have my brain…

Lion

And my Courage!

Tinman

And my heart

Dorothy

And I want to go home!

Narrator 1

The Wizard was surprised to see them all and even more so to hear that they had completed their task, and for sometime, he said nothing.

Scarecrow

Now, will you keep your promise?

OZ

I will will think it over

Scarecrow, Tinman, Dorothy

But you promised!

Lion

Roar!

Narrator 2

At the lion's roar, Toto ran away frightened...

Toto

Bark, bark, bark...

Narrator 2

(*knock over screen*) And knocked over a screen in the room.... Revealing the Wizard to be a regular man.

Wizard

Oops! Hello....

Scarecrow, Tinman, Dorothy

Are you the Wizard?

Narrator 1

The man explained that he was not really a wizard and how he had found himself in Oz after his hot air balloon flew to high?

Scarecrow

You're a humbug!

OZ

That's true…

Narrator 2

The friends were all terribly upset!

Scarecrow

Now I'll never have a brain..

Tinman

or heart

Lion

or Courage!

Dorothy

And I want to go home!

Narrator 1

The Wizard confessed he couldn't help them. (Wizard shrugs.)

Narrator 2

But he pointed out to the Scarecrow, the Lion, and the Tinman how they had all shown courage, used their brains, and hearts to survive their journey through OZ.

Narrator 1

And while this pleased the Scarecrow, the Tinman, and the Lion, they all felt for Dorothy who could still not go home.

Narrator 2

(*pause for characters to feel sympathy for Dorothy*) Suddenly, the Good Witch of the North appeared.

Eowyn

And now you've killed the other Wicked Witch!

Dorothy

Yes, but I still can't get home!

Eowyn

Oh dear [Eowyn laughs kind heartedly at the girl]

Dorothy

Why are you laughing?

Eowyn

Because you've had the power all along!

Tinman, Lion, Scarecrow

She has?

Eowyn

The Ruby Slippers can take you home.

Narrator 2

The Witch explained that all she had to do was click her heels together three times and say..... [Ask for the answer from the audience]. And the slippers would bring her back to Kansas!

Narrator 1

Dorothy and her friends had a tearful goodbye

Tinman

We'll miss you!

Dorothy

I'll miss you too! Ok…. there's no place like home, there's no place like home, there's no place like home.

Narrator 2

To her surprise Dorothy opened her eyes and found herself in Kansas once more.

Narrator 1

And while she was happy to be with her family again, she would often wonder about the adventures she could have had somewhere over the rainbow.

Cast

"Somewhere over the Rainbow"

Narrator 1

The

Narrator 2

End [close the books]

Appendix B

Note: Below is the text of the article written by Kevin Simpson for the *Colorado Sun*. The pictures have been removed (which linked client names to images) and the client and student clinician names have been replaced with initials to protect their privacy.

A condition called aphasia makes language difficult. This CU therapy group seeks to change the narrative — through "applied theater."

About a dozen clients at the university's clinic have launched rehearsals of their own interpretation of "The Wizard of Oz." Already, the experience is stretching their abilities.

Kevin Simpson 5:05 AM MDT on Oct 16, 2019

Credibility: Original Reporting On the Ground Sources Cited

BOULDER — They gather in a circle at the center of the classroom, players warming up for a performance by sending the energy of spoken language around the perimeter in one direction, with voices and hand gestures united to pass it along: "Whish-whish-whish- whish…" At a random moment, an actor receiving the whish! says, "Whoa!" and the sound and movement reverse direction and again pass quickly from person to person. With each whish-whish-whoa, the energy of the spoken word gathers speed.

It's a common theater warmup. For these players, who have aphasia — a condition that impairs the ability to speak and understand language — the exercise prepares them for a larger effort to stretch those barriers.

It will culminate in a little less than two months, when this therapy group of about a dozen individuals, who also get individual assistance at the CU clinic, will present its interpretation of "The Wizard of Oz" to friends, clinicians and family on the University of Colorado campus.

Each fall and spring, the group participates in a joint activity, and this semester — for the first time — faculty members Holly Kleiber and Christina Riseman, from the CU Speech, Language and Hearing Sciences department, have embarked on an "applied theater" project to encourage communication. While most of the clients have aphasia, usually due to stroke or traumatic brain injury, some grapple with dysarthria, marked by slurred or slow speech.

With graduate school clinicians, as well as guidance from CU's Department of Theater and Dance, the interdisciplinary collaboration attempts to build on similar therapy studied at the Center for Aphasia Research and Treatment at the Rehabilitation Institute of Chicago, which found that drama therapy produced improvement in client communication and mood.

The CU project also will generate data on client communication and quality of life, as well as on the collaboration between the two academic departments. In this, only the second "rehearsal" for their play, activities focus on clients generating lines and creating scenes from some basic prompts.

"We'd like them to improvise and generate those lines themselves," Kleiber says. "Each client has personalized goals they're working on within each session. Theater is really more the mode of practice. The bottom line is it's still therapy with set goals."

The idea hatched last spring, when a client who'd done theater in a previous therapy group suggested it. Riseman also had a personal connection. Her mother suffered a stroke in 2007 and benefited from the experience at the Adler Aphasia Center in New Jersey.

The CU group obtained funding from the MINDSOURCE Brain Injury Network, a survivor-operated nonprofit advocacy organization within the Colorado Department of Human Services. Once Kleiber and Riseman researched the Chicago project, touched base with the Adler Center for advice and figured out how they'd proceed, they reached out for help.

Speech and language were one thing. Acting was another.

The collaboration with CU's Theater and Dance department proved more than a little serendipitous. Gillian Nogeire, who's working on her doctorate in the department, saw the email from the Speech and Language folks broaching the idea and responded enthusiastically within the hour.

She'd worked with her own theater company in New York, where she took bilingual Shakespearean plays to underserved audiences in places like the Bronx, Brooklyn and East Harlem. But her life changed when she tuned in to a National Public Radio podcast that featured Agnes Wilcox, whose St. Louis-area Prison Performing Arts program had taken Shakespeare into a maximum-security prisons, where inmates often wrestle with his themes of justice, revenge and guilt.

The story brought her to tears. She emailed Wilcox and soon was working with her. Until her move to Colorado, her experience with applied theater happened mostly behind bars. Earlier at CU, she wrote her master's thesis on the ways that Shakespeare programs in prison could actually reduce recidivism. (In Missouri, data showed that inmates in the program were 20% less likely to return to prison.) Over time, she began "connecting the dots" to new research on cognitive neuroscience.

"When I did that, it kind of opened the floodgate of curiosity for me," she says. "I realized there was all this significant research that supports the things I intrinsically knew that applied theater could do, but didn't know it had this scientific backing." For her doctoral dissertation, she's researching the cognitive impact of applied theater.

"So when Christina and Holly emailed me," she recalls, "I said, 'I've gotta see how this goes. This is going to be great.'"

"The Wizard of Oz" storyline proved attractive for its adaptability, and the fact that it already has gone through many iterations. Even the book and the original movie are different. So a script is necessary only to sketch out a scene in its most basic form. There are few lines to memorize, and a premium on nonverbal communication.

“If we get them to respond in the moment and that becomes a line, the physical movement becomes how they tell the story,” she says. “That might bolster their self-confidence.”

Although this group differs in many ways from those she worked with in prison, she has noticed one common challenge: memory lapses when it comes to language. Many inmates suffer from traumatic brain injuries and reported trouble memorizing lines, either due to the injury or the medication to treat it. Difficulties stemming from stroke she finds not so different.

“The other thing that’s not new is the idea of identity that I feel is valuable in applied theater,” Nogeire says. “For the next hour and a half, you’re not a person with aphasia. You’re an actor, so let’s focus on that.”

Riseman and Kleiber will also focus on data — particularly surveys on how the project affects the clients’ quality of life. Frustration often accompanies speech and language difficulties, but the hope is that by exploring different ways the actors can express themselves, they’ll gain confidence from their success.

“A lot of the members will realize, ‘I just did the impossible by finishing participating in this play,’” Riseman says. “That gives them confidence in conversation. The fact they can do this on stage, conversation should be easier and less stressful. We’re hoping to have that carryover to real life, and maybe they’ll think, ‘Why not participate more in life?’”

With any group of untrained actors, Nogeire says, one of the first challenges is getting them comfortable with putting themselves out there, in a vulnerable position where the results might be embarrassing. Even in the acting class she teaches at CU she might spend a couple of weeks just on overcoming that shyness.

“What’s amazing about [this group] is that I didn’t have to do that at all,” she says. “[This group] is already courageous. Because of everything they’ve been through, it’s not so scary for them. Yes, they may be having trouble forming words, but they’re definitely communicating. In a way, they’re some of the best actors I’ve worked with in awhile.”

Graduate student [AJ] stands at the front of the room. Today is her turn leading the group through the day's activity, and part of it involves the actors getting into character. They've all been assigned parts, based on a listing of their preferences, and now [AJ] has them each say the name of their character — but also add a gesture that helps communicate it.

[AJ] already has a background in the performing arts and understood the connection with speech and language, so she was thrilled to get this particular clinical placement. But she'd never experienced applied theater firsthand and realized how fun it could be for everyone.

"The performing arts are just such a genuinely enjoyable thing," she says. "When you do it with a group like this, who all so obviously enjoy each other, and then put it in the context of a theatrical production, all of the sudden it just feels like fun theater games. It's such a great way to work on speech and language where it doesn't feel like work."

Scarecrow, played by tall and lanky, 71-year-old [DI], tilts slightly and puts a finger to his head. The scarecrow needs a brain. A second Dorothy in the cast, [YE], cups her hand to her ear and calls out "Dorothy! Dorothy!" [DW], playing the Wicked Witch, bares his teeth and growls.

And so on down the line.

[NY], does her best Dorothy as she pretends to make her way along the yellow brick road. [NY], 34, suffered a stroke three years ago. At rehearsal for a production of "The Wizard of Oz" on October 14, 2019 in Boulder she learns to use body language to help communicate to the audience.

Client [CM] — the one who first suggested a theater production — had lobbied hard for putting on J.R.R. Tolkien's "Lord of the Rings." He spent last summer re-reading the book and crafting ideas for scenes. When the group settled on "Oz" for its performance, a creative compromise seemed in order.

And so he plays the part of Glenda the good witch — but as a sort of hybrid character in which he channels Éowyn, the noblewoman from “Rings.” Besides, Nogeire suspects that Tolkien surely read “Oz” author Frank Baum’s work. And even though in the movie Glenda meets Dorothy when she crashes to Earth, in the book she’s met by the Witch of the North, who isn’t named.

“If they don’t have a name, why not make it Éowyn?” she says. “It also solidifies the fact that this is for this group of people, doing their own interpretation. And we want everyone to be happy with their part.”

Everyone got their first or second choice of characters. So now the work of transforming them into an actual play begins.

“Look what I have,” Nogeire says, waving a sheaf of papers. “Scripts. There’s some stuff from the movie, which is what everyone is familiar with, but I also included new details from the book. This is just an outline, though. We don’t have to stick with this.”

[NY] and [DI] — Dorothy and Scarecrow — take the first stab at creating a scene based on Nogeire’s direction, which focuses not on spoken lines at all, but body language that conveys Dorothy’s initial happiness at following the yellow brick road, and then her fatigue as she lies down to rest. A narrator’s lines serve as prompts.

[NY]’s Dorothy catches on quickly, beginning with tentative heel-to-toe steps and then gathering speed and confidence as she chants, “Follow the yellow brick road, follow the yellow brick road.” She suffered a stroke three years ago, at age 31, and initially lost some function of her right arm. That returned, though she still has challenges with language. She loves doing the part because her character repeats things.

“The most important thing we do is through our bodies,” Nogeire reminds the performers.

[NY] captures Dorothy’s shifting mood perfectly, earning applause from the group.

Fellow actors and graduate student clinician [AJ}, right observe as [DW] does his best Wicked Witch of the West. University of Colorado graduate student clinicians work along with their instructors in the Speech, Language, and Hearing Sciences to assist their clients who have speech disorders as they rehearse a production of "The Wizard of Oz" on October 14, 2019 in Boulder. Members of the Theater and Dance Department are collaborating with the group to assist in putting on a successful performance.

Enter [DI]'s Scarecrow, stiff and bored from standing in a field all his life. He spies Dorothy and waves her over to him. [DI], too, suffered a stroke that affected his language. Yet his skill on the guitar, which the group will put to use in the musical portion of the play, appears untouched.

"Hello," he says in Scarecrow character.

Dorothy responds by taking a frightened step back.

And….scene. Bit by bit, they've successfully constructed a segment of the play. More applause.

"From the top!" Nogeire commands. "I know it's a lot. But it's about remembering sequences."

The group disperses to work on their own scenes with the graduate students. With work, repetition and what looks like a lot of fun, they'll eventually have a production. On Dec. 8, they'll put on a private performance for friends, family and invited guests.

They've packed a lot into just 90 minutes of rehearsal, and soon most of them head to one-on-one sessions with their clinicians.

[NY] and [DI] move to a corner of the room where he pulls out his guitar and clamps on a capo. She scans a sheet of paper with the lyrics to "Somewhere Over the Rainbow."

[DI] deftly finger-picks the melody. Yehl follows her index finger word-by-word across the page, softly singing the iconic song with a voice that she honed in what she laughingly calls a “family band” with her parents and brothers. Icenogle plays in a register that’s a bit too high for her, so Joyce, the grad student clinician, suggests he move the capo down a few frets.

Dorothy and Scarecrow perform lines from the song again and again. Slowly, they settle into sync, and Joyce smiles.

“You got it!” she says.

Slowly, gradually, [NY]’s right hand slides away from the lyrics until she’s singing, purely and clearly, no longer needing to guide herself with her finger. Her hand drops to her side while she performs the final line of the song.

[DI] lays the notes from his guitar perfectly beneath [NY]’s rising voice.

“…And the dreams that you dare to dream really do come true.”

Appendix C

Note: “Artist’s whose medium is courage visit ‘Oz’” is an article written by Clay Bonnyman Evans for The Colorado Arts and Sciences Magazin in May 2019. Images that linked clients names with pictures have been removed.

Cross-discipline production of ‘Wizard of Oz’ at CU Boulder inspires confidence in actors with aphasia

The true courage is in facing danger when you are afraid. — L. Frank Baum, “The Wonderful Wizard of Oz”

One of the key themes in the 1900 children’s novel, The Wonderful Wizard of Oz—the]rst of L. Frank Baum’s classic series of children’s stories set in his mythical land, and the book behind the enduringly popular 1939]lm, The Wizard of Oz—is the young protagonist Dorothy’s recognition of her own agency.

Whirled off to Oz by a terrifying storm, Dorothy wants nothing more than to return home to her family in Kansas. But only after an epic journey with a curious collection of friends—an animate scarecrow, living tin man and cowardly lion—is she able to see herself clearly.

“Dorothy had the power to go home all along, but she didn’t know it,” says Christina Riseman, a clinical faculty member and therapist in the speech, language and hearing sciences department at the University of Colorado Boulder.

Clients of a CU Boulder therapy group for aphasia—a neurological condition, often caused by stroke, that impairs the ability to speak and understand language—undertook their own journey to epiphany in fall semester 2019, rehearsing and performing in a production of The Wizard of Oz, a collaboration between the departments of speech, language and hearing sciences and theatre and dance.

“One of the people who played Dorothy,” Riseman recalls, tearing up, “was not particularly con]dent in her communicative abilities, but actually turned out to be a great communicator. At]rst, she thought, ‘No way, no how,’ but here she is pulling off one of the lead roles in such an amazing way and coming out so much more positive, thinking she could do much more.”

The]rst bricks on this collaborative yellow-brick road were laid in a couple of far-away lands: Chicago’s Center for Aphasia Research and Treatment, where drama therapy has improved client communication and mood; and the Adler Aphasia Center in Maywood, New Jersey, where

Riseman's mother had been a client following a 2007 stroke and speech-language pathologists used theatrical productions as part of their therapy program.

After a previous client mentioned the idea, Riseman and her fellow clinical faculty member and speech-language therapist Holly Kleiber contacted both centers to explore whether they might do the same at CU Boulder.

Students from the SLHS department dressed up as munchkins and supported their clients with aphasia by providing cues throughout the play (from left to right: Dave Whalen as the Wicked Witch, student Andrew Blake, Carl Tinstman as the Mayor of Munchkin Land, and Yvonne Eyk as Dorothy)

Faculty, graduate students, and undergraduate students from the department of theatre and dance. From Left to Right back row: Wynne Royer, Dr. Oliver Gerland, Jeff Pincus, Mikayla Dennelly, Middle Row: Amanda Rose Villareal, Madeline Young, Sarah Fahmy, Front Row Samantha Piel, Gillian Nogeire, and Ashlyn Barnett . Or maybe we could just say faculty, grads, and undergrads from the department of theatre and dance. "Sure, we can do this crazy idea," Riseman concluded. "Except we really don't have that acting experience." And so, much like Dorothy, Riseman and Kleiber set about gathering faithful companions for the journey ahead. Jen Lewon, clinical assistant professor in the department, sent an email to her sometime-collaborator, Associate Professor of Theatre Beth Osnes. Osnes posted to the department email list seeking interested faculty and students.

The project caught the attention of Associate Professor Oliver Gerland and doctoral student Gillian Nogeire, who had written her master's thesis on the value of teaching Shakespeare in prisons. Having studied cognitive neuroscience research, she knew that theater could be a tool to develop empathy, con]dence and a host of other qualities.

"I wanted to do more outside the department in the]eld of science, to expand on and learn more about what happens in the brain when you do theater," she says.

Gerland, Kleiber, Nogeire, Riseman, with an occasional assist from Lewon, began meeting in spring semester 2019 to ponder possibilities. By summer, they had found funding for the project through the MINDSOURCE Brain Injury Network at the Colorado Department of Human Services. By fall, the therapists were asking members of their therapy group what kind of play they'd like to perform.

"We knew it was going to be a devised piece"—a collaborative, rather than strictly scripted, work sometimes referred to as collective creation —"and we presented two options, a show about aphasia, or a story that didn't have anything to do with aphasia," Gerland says.

“But regardless of what kind of show you do, ultimately, it’s going to be about the people on stage, and if the people on stage have aphasia, it’s going to be in some way about aphasia.”

The clients foated various ideas,]nally settling on the Wizard of Oz. Nogeire was soon meeting with 15 speech, language and hearing sciences clinical graduate students, coaching them on how to lead weekly rehearsals, beginning with basic theater exercises and advancing week to week.

“The way Gillian set it up, it was so well scaffolded,” Riseman says. “Initially, it seemed to (the performers) that they were just playing games, and they didn’t really see how it relates to a play. ... Gradually, it turned into something quite amazing.”

As dress rehearsals for the Dec. 7 performance approached, theatre and dance students joined the production to help with wardrobe, lighting and]lling out the cast as the Wicked Witch of the West’s cadre of fying monkeys.

As the performers gained con]dence, they began adding people to their lists of invited guests.

“Part of project was to help them get back to active life so they feel they are meaningful and participating in society again,” Kleiber says. “It was really nice to see the audience getting larger and larger because it meant individuals had something to look forward to, to be proud of. It was something to give to their families, not just ‘I need a ride to therapy.’ It became, ‘I’ve been working really hard on this, I want to entertain you, show you something I’m proud of.’”

Finally, on Dec. 7, the cast took the stage in three adjoined multi-purpose rooms at Kittredge Central Hall, with a fourth serving as a backstage area, performing before an audience of some 200 family members, friends, students, faculty, staff and others, to rousing applause.

The cast’s con]dence didn’t ebb after the curtain fell. One man reported that he’d been cured of his lifelong stage fright, while others, embracing the camaraderie they’d developed, some began spending time together outside therapy. And while the play may have only marginally improved their speaking ability, it greatly expanded their ability to communicate.

Nogeire, who also teaches undergraduate acting classes, came to see the cast as particularly well suited for acting.

“Because they had to develop strength and courage living with aphasia, they were almost more prepared to be actors than acting students,” she says. “They have the courage to be vulnerable, in the moment, on stage. They weren’t just actors. I was working with artists who were courageous.”

“Doing a play that was not about aphasia released them, creating a kind of space for them to inhabit with their imagination,” Gerland says. “Theater is a way that you perform not just with a voice, but with emotions, hands, feet, multiple communication channels.”

Although currently stymied by the coronavirus pandemic, the collaborators have “every plan” to mount productions with future therapy clients. Meanwhile, Kleiber and Riseman collected data through before-and-after surveys of cast members and their families, to document changes in communication and thinking skills, emotions and social relationships.

“This kind of project is what we should be doing at CU Boulder,” Gerland says. “The ability to work across disciplinary divides, involving so many different people, faculty, students. It’s a service project, an art project, and educational project, and a wonderful example of what the College of Arts and Sciences can do.”