Applied Theatre as Reflective Space: Engaging Professional Audiences with Potential Deception in Health and Care Practice

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Abstract

This thesis examines how live performance in applied theatre and arts in health and care can engage professional audiences with ethical and interpretive challenges in complex care situations. It clarifies how applied theatre addresses deception and contested narratives in professional practice. Using a practice-as-research methodology, the study explores live performance as a reflective tool for professionals in health, social care, and education, particularly when judgement is required under conditions of uncertainty.

The research centres on the creation, staging, and analysis of two original plays, *A Bitter Pill* and *The Art of Dissociation*, which were performed for professional audiences. *A Bitter Pill* addresses fabricated or induced illness, using affective proximity and participatory strategies to engage audiences with safeguarding responsibilities and the challenge of recognising harm within acts of care. *The Art of Dissociation* explores dissociative identity disorder and the potential for malingering, maintaining uncertainty about the authenticity of the protagonist's experiences and encouraging ongoing audience interpretation.

Using qualitative audience-response data from questionnaires and written reflections, the thesis analyses how professional audiences experienced these performances. It also examines how specific dramaturgical strategies fostered reflective engagement. The findings show that applied theatre supports professional reflection by engaging audiences affectively and interpretively with potentially deceptive behaviours.

This thesis contributes a practice-informed perspective to applied theatre in health and care contexts. It details how dramaturgical structure and audience positioning can create reflective space for professionals facing complex care situations. The work offers insight into how live performance can support ethical and interpretive reflection in professional practice, particularly when judgement is required in the absence of complete information.

Contents

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Author's Declaration

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as references.

Introduction: Theatre, Health, and Care

Research context

This thesis examines how live performance engages with safeguarding and health-related contexts marked by ethical and emotional complexity. Using a practice-as-research approach, it explores how theatre can create reflective spaces for professionals who must act under uncertainty and pressure. By focusing on professional rather than community or service-user audiences, the research aligns with emerging applied theatre practices that position performance as a site for professional reflection and responsibility.

The research develops and analyses two original plays. *A Bitter Pill* addresses fabricated or induced illness (FII), a form of abuse where a caregiver fabricates or induces illness in a child. Structured from the child's imaginative and emotional perspective, the play emphasises affective engagement and participatory strategies. It invites audiences to experience the pressures of safeguarding through empathy and proximity, highlighting the challenge of recognising harm concealed within acts of care.

The Art of Dissociation explores dissociative identity disorder (DID), a contested diagnosis involving disruptions in identity and memory, and the possibility of malingering. The dramaturgy maintains uncertainty about the authenticity of the protagonist's experiences, placing audiences in an ongoing interpretive process. This ambiguity prompts professional audiences to assess behaviour and credibility under doubt. Both plays were performed and evaluated with professional audiences in health, social care, and education.

A third play, *Sleep Paralysis: An Immersive Phenomenology*, explored immersive theatre techniques to evoke embodied states associated with paralysis. As this project was not tested with audiences, it is not included in the detailed analysis. However, it demonstrates the broader scope of the research and informs the conceptual and methodological concerns underpinning the thesis.

The thesis focuses on *A Bitter Pill* and *The Art of Dissociation*, as these works provide complete performance cycles and qualitative audience-response data. Together, they enable detailed examination of how different dramaturgical approaches, grounded in affective engagement in one case and interpretive uncertainty in the other, can create reflective conditions for professional audiences in health, social care, and education.

Research problem and rationale

This research examines a key challenge in contemporary playwriting and applied theatre: engaging with health and care scenarios where deception or contested narratives complicate professional

judgment. In cases such as fabricated or induced illness, dissociative identity disorder, or suspected malingering, practitioners must make decisions despite strategically presented behaviour and harm that is not immediately apparent. These situations require professionals to act under pressure, often with incomplete information and significant risk of serious consequences.

For theatre-makers, these scenarios prompt essential questions about how performance can support reflection on professional practice. Instead of offering clear explanations, theatre can place audiences in situations in which responsibility is negotiated, and trust is uncertain. When professional audiences encounter performances marked by ambiguity or possible manipulation, they are encouraged to examine behaviour, motivations, and their own interpretations. Theatre thus becomes a space to explore complex professional situations without immediate real-world consequences.

This research is driven by the need to understand how live performance can foster reflective engagement with these challenges. The thesis investigates how various dramaturgical approaches help professionals consider situations where fabrication or deception complicates judgment. By examining audience experiences and interpretations, the research explores how theatre can support reflection on risk recognition and responses to uncertainty.

Research aims and questions

This section outlines the aims, objectives, and primary research question guiding the study's investigation of dramaturgical practice and professional reflection.

Aims and objectives

To achieve this aim, the research established interconnected objectives that guided the development, staging, and analysis of the practice. The study aimed to understand how dramaturgical choices influence reflective engagement among professional audiences, focusing on affective engagement, participation, and uncertainty in performance. Insights were developed iteratively through rehearsal, redrafting, literature review, and professional feedback, rather than following a fixed model.

Another objective was to create and pilot two original performance texts, *A Bitter Pill* and *The Art of Dissociation*. Each play engaged professional audiences with potentially deceptive behaviours through distinct dramaturgical methods. *A Bitter Pill* used affective and participatory strategies to examine responsibility for safeguarding in cases of fabricated or induced illness. *The Art of Dissociation* maintained uncertainty about dissociative identity disorder and malingering, requiring ongoing audience interpretation.

The research also collected qualitative audience-response data from professionals in health, social care, and education. Through questionnaires and written reflections, the study examined audience experiences, focusing on awareness, emotional engagement, and interpretive effort. This data offered insight into how reflective space was encountered and negotiated in each performance context.

Finally, the research analysed how dramaturgical structure and audience positioning influenced reflective engagement in two case studies. The thesis explores the relationship between creative processes and audience responses, considering how performance supports professional reflection, especially in contexts involving affective pressure and potential coercion.

Research question

How do dramaturgical strategies in live performance depict contested health and care scenarios involving possible fabrication or malingering, and how do professional audiences use these performances to reflect on deceptive behaviours in practice?

Central argument

This thesis contends that playwriting can productively engage with contested health and care scenarios involving potential fabrication or malingering. It employs dramaturgical forms that maintain reflective engagement, even without a clear resolution. The research creates a reflective space through complementary strategies. In *A Bitter Pill*, this space is established through affective proximity, participation, and imaginative framing, drawing professional audiences into the emotional and ethical challenges of safeguarding practice. In *The Art of Dissociation*, reflective engagement arises from sustained uncertainty, prompting audiences to interpret behaviour and motivation without confirmation.

Both performances place professional audiences in situations that reflect the pressures of real care practice, where judgment is required despite unclear or misleading information. The staging and reception of *A Bitter Pill* and *The Art of Dissociation* demonstrate how live performance can provide a reflective space for professionals to examine how judgment is formed when deception may be present.

The research addresses emotionally charged and ethically complex material. The performances encourage audiences to engage with discomfort and uncertainty as part of the reflective process. Safeguarding and audience care are integrated as practice-based considerations throughout the research and are discussed in detail in the following methodological framing and case study analysis.

Structure overview

The thesis foregrounds creative practice alongside critical analysis, positioning performance texts as essential to the research. The literature review situates the study within applied theatre in health and care, and examines contemporary plays on this theme. It outlines key definitions, historical developments, critical debates, and identifies gaps in representation, professional engagement, and audience experience.

The first case study examines *A Bitter Pill*. A dedicated chapter outlines the safeguarding and professional contexts, describes the practice-as-research processes, and analyses its dramaturgical form. Qualitative data from professional audiences are included to assess how the performance fostered reflection on fabricated or induced illness in care practice. The complete performance text accompanies this analysis.

The second case study explores *The Art of Dissociation*. The chapter situates the work within debates on dissociative identity disorder and potential malingering, details its methodological development, and analyses dramaturgical strategies in relation to audience reception. It highlights how sustained uncertainty and audience positioning influenced professional interpretation and reflection. The full performance text is included.

The conclusion synthesises findings from both case studies, highlighting how different dramaturgical approaches supported reflective engagement among professional audiences. It reflects on the research's contributions, acknowledges methodological and conceptual limitations, and outlines directions for future practice and research in theatre, safeguarding, health, and care.

Literature Review: Applied Theatre in Health and Care Contexts

Definitions of applied theatre

The term applied theatre gained prominence in the 1990s as universities, policy-makers, and practitioners sought a way to describe 'forms of dramatic activity that are specifically intended to benefit individuals, communities and societies' (Nicholson, 2015, p. 3). Its definition centres on the belief that theatre can serve purposes beyond artistic expression and have a direct impact on participants and communities. Practitioners and scholars highlight its flexibility; Ackroyd (2000) notes it includes practices such as 'theatre education, reminiscence theatre, theatre for development, [and] theatre in hospitals,' all unified by the idea that theatre can 'address something beyond the form itself' (Nicholson, 2015, p. 4).

While the term is broad, applied theatre is typically rooted in specific contexts and shaped by its participants. Nicholson (2015) identifies its strength lies in the constant negotiation between action and reflection, noting that 'participation has become the new virtue in some aspects of contemporary theatre-making,' requiring 'time, involvement and affective engagement' (p. 10). Freebody et al. (2018) agree, stating that 'participation is arguably the most common element of applied theatre practice [and is often] what separates applied theatre from other more traditional activist or educative tools' (p. 12).

This focus on participation aligns with James Thompson's view of theatre as a rehearsal for life: 'Theater, in being an explicit play with and around "action matter", deals with the basic processes of how we learn to perform our lives. Actions undertaken or witnessed in theatre will leave emotional memories… Participation is, by all accounts in the field, a central tenet of practice' (Thompson, 2012, p. 50, as cited in Freebody et al., 2018, p. 12). Thompson suggests that applied theatre emphasises embodied experiences, not just messages or outcomes. The rehearsal process allows participants to practise social interactions. Similarly, Nicholson (2011), drawing on Rancière, argues that 'the idea that spectators link what they see to their own knowledge and experience challenges methodologies that equate spectatorship with passivity' (p. 202). This indicates that engagement in applied theatre goes beyond observation, involving active spectatorship that combines action and interpretation.

Other definitions also highlight active engagement and show how emphasis can shift among process, participants, and place. Baxter and Low (2017) describe 'applied theatre and performance [is] theatre-making with, for and by particular groups of people and in locations that are not traditionally associated with theatre… from conflict zones to inter-generational work, focusing on literacy or health' (p. 5). In health contexts, the field often divides into 'arts in health' and 'arts for health,' though these boundaries frequently overlap (p. 5). They identify four main categories: 'educational

work around health issues; art-making/making art in response to specific health issues; addressing health through creativity/artistry/art-making (wellbeing); and finally performance research' (p. 6). They caution against reductive didacticism, emphasising that 'creativity and the aesthetic [are] fundamental elements to all practice' (p. 6). Without attention to artistry, the work risks losing the very qualities that make theatre compelling.

Mermikides and Bouchard (2016) explore the connection between performance, embodiment, and health, noting that the relationship between medicine and performance is integral to modern healthcare. They argue that the rise of performance studies and the authority of the medical profession were mutually reinforcing. Both, they suggest, were part of a 'general biocentrism of the period' that 'focused attention on the body and taught people to "gaze" at it in ways that at once anatomized it but also made it an object of spectatorship and performance' (p. 37). Nicholson (2011) adds that 'the capacity of theatre to raise critical questions about the social implications of science is widely understood, but it is perhaps around conceptualizations of the body and nature that theatre, science and education have converged more fully' (p. 180), reinforcing the idea that both fields share a focus on observing, representing, and interpreting the body. This created a cultural moment where society became invested with a 'spirit of performance', becoming 'spectators of ourselves' and each other, and applying a 'diagnostic gaze shaped by the deepening cultural embeddedness of medical discourse' (Mermikides & Bouchard, 2016, p. 38). These insights challenge a simple division between theatre and healthcare, suggesting that performance is already embedded in medical practice.

Some scholars link the origins of applied theatre to broader political and cultural changes. Preston (2016) describes it as an 'evolved set of drama/arts/theatre practices that had themselves emerged out of counter-cultural alternative theatre movements,' and notes it 'came to prominence in the 1990s amidst a changing social and economic climate' (p. 5). She highlights that applied theatre often serves 'communities in deprived areas or with participants who are marginalized socially, culturally and/or economically,' focusing on 'community building, health promotion, self-reliance and well-being' (p. 5). Prentki and Preston (2020) expand on this, defining applied theatre as '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' (p. 8). The field's adaptability may explain its ongoing struggle to define itself, as its boundaries shift with the communities it serves.

Health-focused examples illustrate how applied theatre functions in professional and educational settings. Suzy Willson, co-founder and artistic director of Clod Ensemble, created Performing Medicine, an initiative that 'uses arts and performance methodologies to teach medical students skills that are central to clinical practice as well as curating events that engage the public with issues at the heart of twenty-first century healthcare' (Willson, 2014, pp. 31-32). Nicholson (2011) notes that

Performing Medicine is part of the company's work, 'where theatre contributes to the training of medical practitioners,' showing how performance can 'shed new light on medical processes and practice' (p. 185). While not always labelled as "applied theatre," such work demonstrates its principles by making performance both educational and a form of public engagement. Willson (2014) observes that the arts can encourage medical students to 'keep rediscovering not just what or who they are looking at but how they are looking' and affirms that 'a poetic and social understanding of the body can sit beside a clinical one' in ways that enhance how we 'relate to and care for others' (p. 31). This suggests that aesthetics and empathy are essential to healthcare training.

White, Balfour, and Preston (2015) dispute the notion that applied theatre is separate from 'pure' theatre. They describe the misconception that 'pure theatre' is confined to its 'proper places' and focused solely on artistic excellence, while applied theatre is only concerned with social aims. They argue this is 'a simplistic and unfortunate misconception… Applied theatre can create occasions of theatre as pure as any other' (pp. 1-2). Separating art from its social functions risks overlooking the aesthetic depth of applied work. Cohen-Cruz (in White et al., 2015, p. 4) further critiques the term, noting that "applied" can sound operational and reductive. She prefers 'engaged' performance to emphasise the reciprocal relationships the practice can foster (p. 4).

These insights indicate that applied theatre is best understood as a participant-centred, context-responsive practice at the intersection of art and social action. It is intentionally flexible, encompassing diverse forms that connect education, embodiment, and social participation (Nicholson, 2011; Nicholson, 2015, p. 4; Preston, 2016; Prentki & Preston, 2020). Participation is consistently described as a defining feature rather than an addition (Freebody et al., 2018, p. 12). The field is also contextually and socially responsive, often engaging with marginalised groups or addressing health priorities (Baxter & Low, 2017; Willson, 2014). It remains aesthetically and ethically contested, balancing art for its own sake with instrumental purposes (Mermikides & Bouchard, 2016; Mermikides, 2020; White et al., 2015). This suggests that applied theatre resists a singular definition, instead contributing by uniting artistic and social aims through active, situated practice.

Historical development of applied theatre

Applied theatre emerged from Theatre in Education (TIE) in Britain during the 1960s. Coventry's Belgrade Theatre formalised the model in 1965, when Richardson and Vallins proposed that 'Theatre in Education… would make theatre an integral part of education, and by this means … make the pupils more aware of the world around them' (in Wooster, 2016, p. 49). Nicholson (2011) notes that this was 'a period of political radicalism and educational change that created the first real opportunities for professional theatre-makers to work in schools on a sustained basis,' with TIE

reflecting ‘the counter-cultural spirit of the time, and seek[ing] to extend the participatory pedagogies of progressive education to theatre as a medium of political activism’ (p. 57).

TIE expanded rapidly across the country. By 1977, about ninety companies participated in Young People’s Theatre in various forms. Wooster notes a growing divide between companies focused on children’s theatre and those with educational aims (2016, p. 73). Nicholson (2011) observes that ‘the methodology that began in Coventry spread quickly,’ as TIE became a network of companies and training initiatives, shaping ‘an understanding of the educative potential of TIE’ (p. 67). The Standing Conference of Young People’s Theatre (SCYPT), established in 1976, provided a collective identity for the field and, as Wooster suggests, ‘in time [it] became the cauldron for the advancement of TIE theory’ (2016, p. 73).

By the 1990s, the field experienced another transition as new practices emerged, including ‘Theatre in Health Education, Prison Theatre, Theatre for Development and Museum Theatre’ (Wooster, 2016, p. 25). Not all branches, however, were equally valued. Wooster criticises the health strand, arguing that ‘it is with the rise of Theatre in Health Education in the 1990s that the ideas of “telling” and “giving a message”, sully the TIE form’ (2016, p. 44). Nicholson (2011) notes that ‘once separated from its oppositional politics that drove its aesthetic strategies, TIE was drained of its life and political energy and inevitably some programmes became predictable and formulaic’ (p. 73). As a result, Theatre in Health Education represents both a continuation and a narrowing of earlier practice, adopting participatory structures but risking the reductionism it once resisted.

By the late 1990s, “applied theatre” encompassed a range of community-based and socially engaged practices, building on the legacies of alternative, workers’, educational, and community theatre (Nicholson, 2015, p. 3; Preston, 2016, p. 5). Nicholson (2011) notes that theatre ‘continues to be charged with healing social division,’ and remains central to community participation and regeneration (p. 82). Preston observes that this growth reflected changing social and economic conditions, as projects increasingly targeted marginalised communities and aligned with social justice and health promotion agendas (2016, p. 5). He also identifies ‘a pendulum swing from the more overtly politically motivated practices of the 1970s and 1980s to a less obviously activist agenda,’ linked to ‘the growing proficiency and professionalization of arts provision in community settings, and importantly, accessing new funding streams and being seen as acceptable by all political persuasions’ (2016, pp. 5-6). This period marks a shift toward practices that adapted to the expectations of funders and policy-makers while maintaining a commitment to social purpose.

As these changes unfolded, health became increasingly central to applied theatre. Baxter and Low (2017) describe applied theatre as collaborative work with specific communities in non-traditional settings, often addressing health priorities. They identify four strands: health education,

condition-specific creative work, wellbeing-focused activity, and performance-as-research (pp. 5-6). This range demonstrates that applied theatre was evolving beyond education and community movements to engage with public health and wellbeing agendas.

In recent years, performance and medicine have emerged as a distinct field. Bouchard and Mermikides (2024) describe it as 'relatively new, but … a vibrant field, with more publications emerging in relation to an increased proliferation of artistic outputs relevant to this interface and a growing interest in health and wellbeing more widely' (p. 1). They note the scope now extends 'beyond the stage to include the use of theatrical techniques in medical training and modes of performance being engaged in public health campaigns, health education projects and health-related activism' (p. 7). This development has made performance integral to medical training rather than just a teaching tool. Mermikides (2020) argues that the clinical encounter itself is performative, with the 'medical gaze' echoing theatrical looking (p. 31). She further suggests that simulation-based training humanises clinical work by countering that gaze (p. 57).

Education-focused, participatory models of the 1960s and 1970s shifted toward health and wellbeing initiatives in the 1990s and 2000s. Today, these trends culminate in the integration of performance into health and clinical training. At each stage, the field has adapted to changing social priorities, consistently balancing activism and professionalisation.

Core arguments in applied theatre

Debates about the nature and extent of change are central to applied theatre, particularly whether it arises from individual transformation or collective development. Prentki (2018) asserts that 'applied theatre is inexorably connected to transformation' (in Freebody et al., 2018, p. 153). Gallagher describes this as a 'precarious dance between personal story and structural change' (Hughes & Nicholson, 2016, p. 10). Hughes and Nicholson note that applied theatre can 'transform, promote well-being, improve quality of life, and move people on,' but caution that it is 'preoccupied with a central tension between understanding itself as a force for imaginative resistance and as problematically entwined with networks of power and exploitation' (p. 4). They advise against 'grand claims for theatre's transformational powers' and suggest the field is best viewed as an intersection of aesthetic and social practice (p. 5). Applied theatre should therefore be understood not as a guarantee of transformation, but as a space for ongoing negotiation among aspiration, resistance, and structural constraints.

Whether applied theatre genuinely fosters agency remains a persistent challenge. Freebody et al. (2018) describe projects that 'enabled people to advocate for their rights, or advocate for the rights of others' (p. 49), suggesting that applied theatre can amplify marginalised voices and prompt those with

relative power to question oppressive systems. Nicholson (2011) notes a similar effect in Everyday Theatre, where the programme ‘offered young people [a] safe and public space to rehearse their private responses to disclosure and abuse, and provided activities that were designed to help them to make creative and empathetic decisions about how to act’ (p. 121). However, Freebody et al. caution that practitioners risk becoming part of the ‘poverty industry [using] the circumstances of the precariat to gain and keep employment, turning problems into currency’ (2018, p. 11). This underscores the tension between empowering marginalised voices and operating within, or benefiting from, the very systems under critique.

Demonstrating impact remains a central challenge in applied theatre. Jackson (2007, p. 270) warns that ‘if drama starts to make unreal expectations about direct transference to the everyday world then it is likely to have slipped from its anchoring within an aesthetic framework and veered toward didacticism, propaganda, or wishful thinking’ (as cited in Freebody et al., 2018, p. 7). The sector faces pressure to provide evidence, which can shift practice toward easily measurable outcomes. Snyder-Young (2018) critiques the ‘over-reliance on bullshit impact evaluation’ that ‘has prevented us from developing our own tools for capturing and analyzing what Michael Balfour (2009) calls “the affect of aesthetics”’ (in Freebody et al., 2018, p. 93). These perspectives suggest that the demand for proof of transformation may undermine the work's aesthetic and political value.

Debates in applied theatre often centre on the tension between aesthetic quality and social outcomes. Thompson (2009) warns that the field is ‘limited if it concentrates solely on effects — identifiable social outcomes, messages or impacts — and forgets the radical potential of the freedom to enjoy beautiful radiant things’ (as cited in Baxter & Low, 2017, p. 43). Baxter and Low (2017) note that ‘qualitative evidence from participants repeatedly affirms the felt experience of art as a counter to the circumstances and symptoms of ill health or social exclusion,’ and question whether ‘it is at all possible to sever the affect from the effect, the feeling from the thinking, the form from the content’ (p. 53). Shaughnessy (2015) extends this argument, suggesting that aesthetic expression itself is a form of social intervention. She contends that aesthetics are ‘integral and necessary parts of change itself. In a world of inequality, social injustices and endemic violence, they could be acts of resistance and redistribution, made in an intimate and sensory key’ (in White, Balfour, & Preston, 2015, p. 10). Together, these views challenge the funding logic that prioritises outcomes over aesthetics and process.

Participation remains both celebrated and contested, closely linked to debates about democracy and control. Prentki and Preston (2020) draw on Gramsci’s concept of hegemony, arguing that ‘harnessing the consent of a group through the communal spontaneity of “participation” might carry a “useful” hegemonic function in society. The seductive “feeling” of participating and “joining in” with others is less a neutral or benign act but, rather, manipulation into compliance with a social order’ (pp.

182-183). Nicholson (2011) similarly warns that ‘some forms of participation can be highly coercive,’ and calls for a reassessment of the egalitarian assumptions underlying participatory theatre (p. 200). Harpin and Nicholson (2016) further note that applied theatre often assumes ‘bottom-up’ involvement leads to empowerment or civic engagement, but argue that ‘participation is politically pliable, and it can no longer be taken for granted that its dramaturgical strategies carry specific political meanings or social imperatives. Nor can it be assumed that to participate is to claim space and voice in ways that might be considered “empowering” or anti-authoritarian’ (pp. 2-3). For them, participation is always ‘paradoxical and ambiguous,’ requiring attention to ‘what, and who, is considered legitimate or welcome participants and who is left outside or excluded’ (p. 14). This perspective positions participation as a contested political practice, rather than an inherent artistic or democratic good.

Analyses of altruism further complicate discussions in applied theatre. Nicholson (2015) notes that ‘the altruist presupposes that someone needs rescuing for a particular reason — whether they have asked for help or not — and assumes that the recipients’ lives will be enhanced as a result of this intervention’ (p. 37). She connects this to broader debates on the ethics of gift-giving, observing that ‘the gift of theatre may be well-intentioned and generously given, but it may be experienced as an expression of hierarchy, an imposition of values that are not to be shared’ (p. 16). In this context, altruism is inconsistent, sometimes generous and sometimes patronising, and is ultimately entangled with questions of motive and status.

Authority and competing agendas shape the dynamics of facilitation in applied theatre. Preston (2016) argues that facilitation is ‘not a neutral phenomenon but one practised against the backdrop of competing social and historical conditions, priorities, agendas and power relations’ (p. 6). She describes the facilitator’s role as unfolding in ‘dilemmatic spaces,’ where adaptability is essential for a sustainable career. ‘Building strategies of resilience is key to the facilitator’s survival and efficacy in difficult times’ (p. 8). Facilitation is therefore more than merely guiding a workshop or performance; it is shaped by, and often constrained by, neoliberal pressures, funding requirements, and institutional agendas. Nicholson (2011) similarly observes that the ‘commodification of creativity has placed theatre education in an ambiguous position,’ shaped by the very policy structures it seeks to resist (p. 84).

The idea that embodied participation enhances empathy more than passive observation is widely discussed in applied theatre. Sevrain-Goideau et al. (2020) provide evidence for this, reporting measurable increases in empathy after Forum Theatre sessions and concluding that ‘FT is a powerful tool for developing empathy. Moreover, we observed that empathy scores increased more in actors than in mere observers, which agrees with the functional MRI studies of empathetic resonance and mirroring theories’ (p. 6). However, Nicholson (2015) urges caution, noting that ‘drama, which often invites multiple forms of identification, is potentially a very good vehicle for extending understanding

of oneself in relation to others… There is an ethical ambiguity here… there is no guarantee that identification with others, however life-changing, will be for the better, in whatever terms "better" is construed' (p. 75). Empathy, therefore, is not inherently virtuous.

The ongoing tensions and contradictions in applied theatre reveal a field shaped by negotiation rather than fixed principles. It navigates between individual and structural change, balances aesthetic value with demands for measurable outcomes, and grapples with participation as both empowering and complicit. Altruistic intentions are complicated by power dynamics and by institutional and neoliberal pressures on facilitation. Even empathy, often seen as central to applied practice, is ethically and politically ambiguous. Ultimately, applied theatre is defined by these tensions, where artistry and ethics intersect in both productive and contested ways.

Methods and claims in applied theatre research

Applied theatre research has shifted from anecdotal assertions to more systematic evidence. Freebody et al. (2018) note that practitioners now design projects 'that align to specific learning aims and goals within an evaluation framework,' often using 'pre-post questionnaires… post project interviews, [and] statistical information about a group's engagement and participation' (p. 21). These methods reflect a commitment to the evaluative standards of health and social science. Nicholson (2011) observes that 'new epistemologies are developing as a result of collaborations between theatre-makers and scientists,' redefining the role of performance and experiential learning in research (p. 177). Bouchard and Mermikides (2024) emphasise practice research, defined as 'a research project in which practice is a key method of enquiry and where … a practice … is submitted as substantial evidence of research inquiry' (pp. 16-17). These developments indicate a growing convergence between performance and healthcare research, with artistic practice and empirical evaluation increasingly informing one another.

Large-scale quantitative evaluations

Sevrain-Goideau et al. (2020) conducted a quantitative study of Forum Theatre in medical education at the University of Angers. 'Three classes totaling 488 fourth-year medical students participated in the study' and anonymously completed the Jefferson Scale of Physician Empathy (JFSE) before and after two Forum Theatre sessions (p. 1). The authors report that 'being an actor in forum theater was a valuable tool for enhancing empathy' (p. 1), but they also warn that 'FT implementation was time and human resources consuming and should be carefully weighed against other methods' (p. 6). The study demonstrates that applied theatre in healthcare, measured with a validated psychometric tool, can foster stronger empathetic responses through embodied engagement than observation alone.

Burns et al. (2024) studied *As Much As I Can*, an immersive theatre production on HIV stigma among Black sexual minority men in the United States. The authors employed a public health approach,

surveying ‘322 audience members immediately after performances’ (p. 151). Measures focused on satisfaction, willingness to challenge stigma, and likelihood of seeking HIV-related care. Results showed that ‘75.4% intended to say something if I hear stigmatizing language against people living with HIV’ (p. 151), and participants were ‘almost three times… more likely to… follow up with their healthcare professional’ (p. 157). Without baseline measures, it’s difficult to draw firm conclusions about causality; however, the study’s large sample, random selection, and behavioural focus provide strong evidence that theatre can influence attitudes and intentions in health contexts.

Marzi et al. (2025) evaluated *Medicine at Theatre*, which staged historically informed plays in Florence and was followed by post-performance debates. A sample of ‘364 participants’ across three age groups attended four plays on medical themes (p. 3). The authors used a custom questionnaire, given to participants ‘before the play and… immediately after the performance,’ to capture ‘specific aspects related to beneficial effects and the communication of certain topics’ (p. 3). Analysis showed ‘a significant increase in well-being’ (p. 4), leading them to conclude that ‘theatre can efficiently promote well-being and spread crucial awareness about healthcare-related issues’ (p. 1). While they acknowledge the need for further validation, the study illustrates how quantitative methods can be adapted for public engagement, offering empirical support for the claim that performance enhances emotional health and awareness.

Medium-sized and experimental studies

Medium-sized interventions offer nuanced insights into how theatre techniques apply to education and health. Fekete et al. (2024) evaluated applied improvisation workshops with 50 health professional students in Hungary and France. Using the standardised Interpersonal Communication Questionnaire and the Intolerance of Uncertainty Scale, they collected pre- and post-workshop data, with a three-month follow-up in one cohort. The workshops included role-play, storytelling, and nonverbal communication. More than 90% of students rated the sessions as ‘above average or excellent,’ and many reported using improvisational strategies such as active listening and adaptability during clinical placements (pp. 177-178). Although the lack of a control group limits causal claims, the use of validated instruments and follow-up data supports the conclusion that improvisation can improve communication skills.

A smaller study by Stevenson et al. (2021) examined drama-based workshops in psychiatric training. Using pre-/post-surveys, they reported ‘a notable increase in participants’ self-reported confidence in their communication skills post compared to pre-workshop,’ and strikingly, ‘all of those participants who undertook the CASC examination during the workshop were successful’ (p. 158). While the design does not isolate the workshop’s specific impact, the findings suggest that applied theatre is increasingly seen as a tool for developing professional readiness. As a pilot study, this work shows

that such methods are feasible, affordable, and potentially suitable for psychiatric training and education.

Systematic reviews offer a broader perspective by mapping methods and outcomes of theatre-based interventions. Martí-Vilar et al. (2023) reviewed 29 articles on theatre-based interventions for autism and mental health, reporting improvements in 'socioemotional functioning, self-esteem, emotion management, empathy and listening, communication and social interaction, [and] adaptive skills' (p. 6). They conclude that 'theater creates a safe environment in which youth with ASD can engage with their own and others' emotions and perspectives, allowing them to develop a deeper understanding of the self and others' (p. 3). Meanwhile, Hall et al. (2019) proposed a scoping review of theatre as a knowledge translation strategy for health information. Their rationale pointed to 'substantial delays in translating evidence to practice' and suggested that 'alternative strategies, such as theatre-based KT, appear to be effective at targeting broader audiences' (p. 1). Their review aimed to include 'all study designs… ranging from descriptive only studies to evaluation studies (including feasibility, process, effectiveness or cost-related evaluations)' and to map 'evaluation characteristics (eg, outcome variables, assessment methods, study designs)' (p. 4). This underscores the diversity of methods in the field and the challenge of synthesising a varied evidence base.

Methodological reflections and limits of claims

As more evaluative studies emerge, some scholars caution against overvaluing their results and question whether such studies truly capture the core impact of applied theatre. Freebody et al. (2018) emphasise that 'the claims for change and transformation are extremely hard to substantiate' (p. 21), highlighting the difficulty in evidencing complex social or personal change. Similarly, Baxter and Low (2017) point out that the significance of applied theatre often lies in participants' felt experiences, which are difficult to quantify, as seen when participants describe the experiential power of art to counter ill health or social exclusion (p. 53). From a broader historical perspective, Wooster (2016) critiques the field's evaluation strategies, arguing that 'despite nearly twenty-five years of praxis, clearly neither the educational nor the arts purse-holders understood what they had been paying for' (p. 95). This frustration highlights a structural issue, where funders require evidence, practitioners attempt to provide it, but standard metrics often fail to capture the affective value of the work.

Gaps in research

Although the field of applied theatre and health has grown steadily, significant gaps persist. A key issue is the lack of longitudinal evidence. Most evaluations use pre- and post-testing, which only measures immediate change. Sevrain-Goideau et al. (2020) highlight the need to assess 'the long-term impact of the intervention as well as the impact of FT in the empathical behavior observed in real life'

(p. 6). Without follow-up data, it remains uncertain whether short-term gains lead to lasting improvements in empathy or practice.

Another concern is the heavy reliance on self-report measures. Few studies connect outcomes to observable behaviour or clinical indicators. Burns et al. (2024) note this limitation and recommend that 'future studies should… examine the relationship between structural discrimination and theater-based interventions… using randomized, longitudinal study designs… and mixed methods approaches' (p. 159). This broader approach is needed to capture structural impact.

Martí-Vilar et al. (2023) call for greater methodological depth, stressing the need for 'complete, systematic studies with experimental designs in order to obtain more scientific knowledge and greater development of this underexplored field' (p. 10). They advocate for broader search strategies and closer examination of intervention activities to 'support more in-depth knowledge of the methodological strategies employed and provide help and guidance for future studies' (p. 10). They conclude that 'future work should address, on the basis of a meta-analysis, the evaluation of the real impact of theater-based interventions through the analysis of effect sizes and sample sizes' (p. 10).

Beyond design and measurement, political and conceptual issues also arise. Prentki and Preston (2020) argue that applied theatre has often focused on 'the victims of personal or social oppression… [but] unlikely to make much impact in terms of wider questions of structural transformation.' They urge the field to 'cast its net wider to include the power-brokers at both national and local levels… to effect change' (pp. 182-183). Nicholson (2011) supports expanding beyond familiar boundaries, expressing an 'uneasy sense that there are too many stories that have been left untold, too many places unvisited and too many ideas and practices ignored,' suggesting that applied theatre must venture into less comfortable terrains to evolve further (p. 213).

These gaps fall into two main categories. Empirically, there is a need for longitudinal studies, less reliance on self-reporting, more systematic designs, and greater focus on structural impact. Conceptually, the field faces issues of over-claiming, underdeveloped theoretical and ethical frameworks, and a weak connection between interdisciplinary practice and measurable outcomes. Addressing these challenges is crucial for applied theatre to move beyond anecdotal evidence and become a credible, evidence-based contributor to health and social care.

Mainstream plays engaging with health and care

This thesis and its accompanying plays are part of a wider theatrical movement in which mainstream productions increasingly address health, care, and professional responsibility. These works reach broad audiences and shape public discourse on distress and treatment. Often set in hospitals or therapeutic environments, they use dramaturgy to examine how care is enacted and negotiated.

Although not classified as applied theatre, they demonstrate how contemporary playwrights develop strategies for staging care and responsibility. Theatre thus becomes a space to explore the complexities of care.

Nick Payne - Constellations

Nick Payne's *Constellations* demonstrates how non-theatrical theories can inform dramaturgy to explore health and care. Drawing on quantum physics, particularly the concept of parallel possibilities, the play avoids a single, linear narrative of illness. This is evident in Marianne's effort to express scientific concepts amid her cognitive decline: 'L-listen to me, please. The basic laws of physics – The b-b-basic laws of physics don't have a past and a present. Time is irrelevant at the level of a-atoms and molecules. It's symmetrical. We have all the time we've always had. You'll still have all our time… Once I'm gone' (Payne, 2012, p. 78). Here, theoretical abstraction and bodily experience are in tension. The fragmented speech highlights the limits of rational explanation, whereas the scientific framework offers a relational, ongoing understanding of care rather than one focused on cure or recovery.

Constellations also highlights the practical language of medical care, illustrating how professional discourse shapes lived experience. Marianne's description of treatment options, 'He said they can operate… try and remove it, remove as much of it as they can. Then they said radiotherapy… but if I'm too weak for radiotherapy, they said chemo… It's palliative … whatever they do… They said this is it' (Payne, 2012, pp. 59-60), frames care as a series of conditional decisions rather than a path to resolution. The repeated use of medical terms underscores the ethical pressures on both patient and practitioner when care becomes a process of management. These examples show how Constellations uses external theory as both a metaphor and a dramaturgical structure, allowing the play to explore health and care without sentimentality or closure, instead making space for uncertainty and reflection.

Peter Shaffer, Equus

Peter Shaffer's *Equus* exemplifies mainstream theatre that frames care as an ethical dilemma rather than a story of clinical success. Set in a psychiatric context, the play highlights professional uncertainty through Dysart, whose authority is continually challenged. This is most evident when Dysart admits his work raises questions he has 'avoided all [his] professional life', asking, 'what am I doing here? I don't mean clinically doing, or socially doing — I mean *fundamentally*!... These Whys… have no place in a consulting room. So then do I?' (Shaffer, 1993, pp. 60-61). The passage underscores the tension between professional authority and ethical uncertainty, showing how Dysart's expertise coexists with doubt about his role. Rather than treating clinical knowledge as sufficient, the play uses Dysart's questioning to highlight unresolved issues in care. Equus thus invites audiences to

consider the ethical dimensions of intervention, positioning care as a practice that requires both reflection and action.

This ethical tension deepens as *Equus* presents treatment as potentially harmful rather than restorative. Dysart says, 'I'll heal the rash on his body. I'll erase the welts cut into his mind by flying manes… Passion, you see, can be destroyed by a doctor. It cannot be created' (Shaffer, 1993, pp. 92-93). This highlights the ethical cost of care that seeks restoration through erasure. Care is depicted as producing normality by erasing difference, raising questions about what is lost in the process of treatment. By emphasising both loss and protection, Equus frames clinical success as an ethical issue and encourages audiences to engage with Dysart's ongoing self-interrogation, rather than offering a reassuring view of care.

Sarah Kane, 4.48 Psychosis

In *4.48 Psychosis*, care is depicted not as support but as exposure to scrutiny. The clinical encounter appears fragmented, impersonal, and surveillant: 'I am deadlocked by that smooth psychiatric voice of reason… Dr This writes it down and Dr That attempts a sympathetic murmur… Watching me, judging me…' (Kane, 2001, p. 209). Kane presents a patient who is documented and assessed but never truly engaged. The anonymisation of practitioners reduces individuality to interchangeable authority, replacing attentive listening with procedural record-keeping. As a result, care becomes procedural rather than meaningful.

This dynamic intensifies as Kane contrasts institutional care with moments of apparent personal connection. The passage, 'Inscrutable doctors… ask the same questions, put words in my mouth, offer chemical cures for congenital anguish… you… Who lied. And said it was nice to see me… your bare-faced fucking falsehoods that masquerade as medical notes. Your truth, your lies, not mine' (Kane, 2001, pp. 209-210), reveals care as a site of vulnerability shaped by trust and its breakdown. What appears to be human connection is later undermined, illustrating how institutional practice can overshadow personal experience. *4.48 Psychosis* presents care as ethically unstable, not through cruelty, but through the gap between genuine presence and institutional process. The play withholds reassurance, suggesting care requires ongoing ethical attention rather than repair or closure.

Duncan Macmillan, People, Places & Things

In *People, Places & Things*, Macmillan presents identity as performative and inseparable from the discourse of addiction and care. Emma's admission, 'If I'm not in character I'm not sure I'm really there. I'm already dead. I'm nothing. I want live a hundred lives… Acting gives me the same thing I get from drugs and alcohol' (Macmillan, 2024, p. 83), collapses distinctions between acting, substance use, and survival. Identity is shown as dependent on performance rather than coherence. This

instability intensifies when Mark parodies Emma's self-narration: 'Hello, I'm Sarah … I'm an alcoholic and drug addict … I'm a liar… I'm Sarah. Possibly. Who really knows? … I'm brilliant at being other people and totally useless at being myself' (Macmillan, 2024, pp. 85-86). By having Emma's words spoken by another, the play demonstrates how truth in care conversations can blur between sincerity and rehearsal, making identity provisional and complicating efforts to find fixed meaning.

Within this context of instability, *People, Places & Things* offers an alternative view of care, rooted in relational presence. Mark's reflection, 'But this. Here. Now. Listening and being listened to. Being *seen*. It's saving my life I think' (Macmillan, 2024, p. 78), frames care as attentiveness in the moment. Care occurs through shared presence, without requiring a coherent identity. While this does not resolve the play's tensions about ill health, it suggests support can persist even when understanding is incomplete. The play thus presents care as a practice that remains with uncertainty, highlighting the ethical challenge of responding to shifting self-presentation.

Duncan Macmillan, Every Brilliant Thing

In *Every Brilliant Thing*, care is defined by ethical restraint, avoiding narratives that promise prevention or cure. The line, 'The list hadn't stopped her. Hadn't saved her. Of course it hadn't' (Macmillan, 2015, p. 57), recognises the limits of care and does not present support as sufficient protection against harm. By acknowledging this limitation without sensationalism, the play avoids reducing care to an outcome. Instead, it highlights the ongoing challenge of responding to distress without overstating efficacy, aligning care with ethical modesty.

Alongside this restraint, *Every Brilliant Thing* presents care as a collective practice. The stage direction, 'The Narrator is in the auditorium as the Audience enters, talking to people and giving them scraps of paper. As he does so, he explains that when he says a number he wants the person with the corresponding entry to shout it out' (Macmillan, 2015/2020, p. 15), embeds care within audience participation. Responsibility is shared among the audience, who become active witnesses and contributors. Care emerges as a shared practice of noticing, voicing, and sustaining attention. The play thus demonstrates how theatre can model collective attentiveness and responsibility, offering a relational form of care.

A Bitter Pill: Staging Fabricated or Induced Illness through Affective Engagement and Participation

Introduction

A Bitter Pill uses theatre to explore the ethical and communicative challenges safeguarding professionals face, particularly in cases of Fabricated or Induced Illness (FII). The project was grounded in real-world practice through research and development with medical and safeguarding experts. In partnership with Arts Council England, NSPCC, and MIND, the 2024 production was developed as both a response to FII cases and an applied intervention. Its primary aim is to foster empathy, professional reflection, and improved practice through theatre.

Artistically, I aimed to convey the emotional complexities of FII without sensationalising the abuse. The play centres on Lucy, a seven-year-old girl, and presents the story from her perspective. Audience members are invited to participate in her fictional life, becoming the people she relies on. Interactive scenes blur the line between participation and observation, reflecting a commitment to what Nicholson (2015, pp. 60-61) calls 'affective pedagogy.' Audience engagement serves as a means of learning through empathy, embodiment, and critical reflection. In this way, *A Bitter Pill* functions as both socially engaged theatre and experiential safeguarding education.

The project was motivated by a lack of effective professional training materials. Research interviews showed that social workers and healthcare practitioners often face suspected FII cases but lack resources to manage the associated ethical and psychological pressures. Many expressed fear of making mistakes and noted institutional pressures around complex decisions. Poor inter-agency communication can cause confusion and hesitation, leading to missed opportunities for timely intervention. *A Bitter Pill* was designed to provide a reflective space where professionals can safely explore these dilemmas. Through performance, the play encourages critical dialogue and emotional awareness that extend beyond the theatre.

More broadly, the play addresses public misunderstanding of FII. While the term "Munchausen Syndrome by Proxy" is still widely used, healthcare professionals stress that this behaviour constitutes child abuse, not mental illness (Hoffman & Koocher, 2020; Roesler & Jenny, 2009). This distinction is crucial, as labelling perpetrators as "ill" can shift empathy away from the child. The play's dramaturgy reflects this by avoiding psychological justification for the mother and focusing on Lucy's experience. In doing so, *A Bitter Pill* amplifies the child's voice and confronts audiences with the ethical consequences of inaction.

The performance represents an interdisciplinary dialogue between theatre and safeguarding practice. Collaboration with care professionals and arts organisations enabled the project to serve as a tool for

continuing professional development (CPD) and public engagement, aligning with the Arts Council's goal of promoting community wellbeing. The 2024 performances at Hull Truck Theatre and Grimsby's Caxton Theatre attracted social workers, nurses, and mental health practitioners. Audience members reported that the performance made the ethical pressures of safeguarding tangible, describing it as 'sobering and impactful' and noting that it prompted them to reconsider their responsibilities.

A Bitter Pill integrates stylised performance, audience participation, and improvised music to evoke Lucy's emotional world. Live music serves as an affective mirror, translating her unspoken feelings into sound and deepening the audience's emotional connection. This approach enhances accessibility and reinforces the play's applied purpose by using artistic form to foster empathy and prompt professional reflection.

Ultimately, *A Bitter Pill* serves as a bridge between applied theatre and safeguarding practice, aiming to catalyse open and empathetic dialogue about effective safeguarding in real-world situations. By centring the child's voice and prioritising emotional engagement, the play challenges both professionals and the public to translate awareness into responsibility and action when a child's safety is at risk.

Methodology

The development of this play followed three interconnected stages. First, a literature review on Fabricated or Induced Illness (FII) and empathy established the foundation. Next, interviews with safeguarding professionals connected theory to practice. Finally, dramaturgical experiments in rehearsal applied insights from both earlier stages. Each phase informed the next, creating a cycle between research and practice. The literature review anchored the play in the medical and psychological dimensions of FII and examined how empathy can function in participatory or applied performance. Interviews then highlighted practical challenges, which the creative process translated into dramaturgical form, testing responsible representation of FII and encouraging emotional and ethical engagement.

The literature review served both ethical and dramaturgical purposes. It clarified how FII is viewed in safeguarding and healthcare, helping to avoid common misconceptions. The review also demonstrated how empathy can be fostered in performance without sensationalising behaviour. Through examining safeguarding, applied theatre, and psychology, I recognised the importance of balancing critical analysis with emotional engagement, allowing spectators to learn through feeling, interaction, and reflection. These foundational insights shaped the dramaturgy and guided the structuring of audience participation and emotional content in the performance.

Building on this foundation, the interviews added personal and professional perspectives to the research. Discussions with a consultant in liaison psychiatry, a psychoanalyst (see Appendix A), the local named safeguarding nurse, and several social workers highlighted the emotional and procedural challenges in identifying and addressing FII. Many interviewees described the anxiety of potentially misidentifying a parent and the difficulty of recognising FII. These insights directly influenced characterisation and structure. For example, the professionals' recurring hesitation in the play reflects the cautious language of the interviewees. The interviews also underscored how the child's voice is often overlooked, supporting the decision to tell the story from Lucy's perspective.

Drawing on the interview findings, the rehearsal stage explored how these concepts could be realised in performance. Workshops tested direct address, guided audience participation, and improvised music reflecting Lucy's inner experiences. While inspired by music therapy, the musical component was not therapeutic but instead expressed emotional states and externalised unspoken feelings. The process was iterative, with scenes revised based on discoveries and responses from small invited audiences. This practical phase completed the cycle by integrating all knowledge into the final performance.

This project aligns with the tradition of practice-as-research, where creative practice functions as both inquiry and evidence. It approaches performance-making as a means of generating new understanding at the intersection of performance and health (Bouchard and Mermikides, 2024, pp. 16-17). The rehearsal process served as analysis, revealing how aesthetic choices have ethical implications and how applied aims can be integrated into the work's structure.

Findings from pre-performance data

Pre-performance data revealed recurring insights that significantly influenced the dramaturgical framework of *A Bitter Pill*. Discussions with a consultant in liaison psychiatry and a psychoanalyst (see Appendix A) clarified that Fabricated or Induced Illness (FII) should be recognised as a form of child abuse, not a psychiatric disorder. The consultant stressed this distinction, noting that while perpetrators may exhibit traits linked to personality disorder, viewing them as mentally ill risks diverting empathy from the child. She stated, 'these people who do this … they are harming, they are abusing another person, a child… it's criminal behaviour.' (Consultant, Appendix A). This perspective shifted the project's focus from the perpetrator's psychology to the child's emotional and physical experience.

Both professionals described the discomfort of challenging a parent when their account is inconsistent. The consultant discussed the internal conflict involved in telling a parent, 'I don't believe what you're telling me,' since clinicians are 'taught, [and], we want to believe what our patients say'

(Consultant, Appendix A). She also initiated a spontaneous role-play, adopting the voice of a clinician confronting a patient. Although this scenario focused on self-fabricated illness, its principles were relevant. Her commitment to honesty, even when difficult, was both challenging and admirable. She demonstrated that empathy and confrontation can coexist, stating, 'I can tell the truth. I can be honest… [while] genuinely trying to be… empathetic.' (Consultant, Appendix A). This approach became a guiding principle for addressing difficult material and encouraging audiences to reflect on their own responsibilities.

When combined with discussions with social workers, these interviews revealed several themes. The first was the importance of precise language and framing. Professionals emphasised distinguishing between 'perplexing presentations' and the more severe 'fabricated illness,' and noted that 'Munchausen by proxy' is now considered outdated and misleading. These insights informed the script's terminology and highlighted a disconnect between professional and public understanding. This underscored the need for the play to address misconceptions and reflect current safeguarding discourse.

A second theme was professional ambivalence and shared responsibility. Social workers discussed the anxiety of making incorrect accusations and the hesitation that can delay intervention. They emphasised that safeguarding is 'everyone's responsibility' and encouraged reframing referral as an act of care, not punishment. This perspective influenced the play's closing monologue, where Lucy's line, 'I needed all of you to be my voice at a time when I didn't have one,' (ABP Script, p. 74) extends accountability to the collective.

A third recurring theme was the importance of centring the child's perspective. Professionals noted that the child's experience is often overshadowed by adult narratives in both practice and media. Their emphasis reinforced my decision to keep Lucy's voice central, presenting events through her understanding rather than through diagnosis.

Social workers suggested using subtle visual metaphors of control, such as a self-applied cast or a tightly-fitting medical boot, to convey harm without graphic depictions. They also recommended expressing Lucy's fear physically, for example, by having her sit in her wheelchair when her mother enters. These suggestions inspired gestures in the production that visually diminish Lucy's agency.

Their reflections on the father figure, portrayed as passive yet complicit, confirmed the relationship's dynamics. They supported his depiction as both manipulated and culpable for inaction, noting this reflects real safeguarding cases. The play uses these relationships to capture Lucy's divided emotional world, showing her attachment to her father, who represents safety but fails to protect her. Her instinct

to please both parents, even in danger, highlights the confusion and dependency common in abuse cases.

These insights guided the creative process to reflect the experiences of healthcare practitioners and social workers. Their focus on centring the child led me to abandon earlier drafts that alternated perspectives. The final version presents all events through Lucy's imagination, shaped by her perceptions of the adults' actions. *A Bitter Pill* is grounded in professional experience while allowing for artistic interpretation and emotional depth.

Fabricated or induced illness (FII) in health and safeguarding contexts

Understanding the medical, psychological, and safeguarding dimensions of Fabricated or Induced Illness (FII) was essential to establishing the ethical and dramaturgical framework for *A Bitter Pill*. Because the project sought to engage both artistic and professional audiences, accuracy of representation became a creative responsibility as much as an academic one. In the early stages of development, it became clear that there was some confusion about the condition, including its definition and causes. Clarifying these distinctions was essential to align the play with current safeguarding practice. The following overview draws on medical and child-protection literature to outline how FII is currently understood and how this understanding has shaped the play's tone and focus.

The terminology used to describe this form of abuse has shifted considerably over time. Earlier classifications included Munchausen's Syndrome by Proxy (MSBP), Factitious Disorder by Proxy, and Factitious Disorder Imposed on Another. Following consultations with social workers during the development of *A Bitter Pill* in 2024, the term Fabricated or Induced Illness (FII) was identified as the current professional and safeguarding standard. While earlier sources use different labels, this thesis will use FII consistently to reflect contemporary understanding and to maintain alignment with current safeguarding practice, referring to older terminology only when directly quoting or discussing the language used in previous research.

Fabricated or induced illness is described by Walters (2020) as 'the falsification of signs/symptoms or induction of injury or disease in a proxy, associated with identified deception', noting that these 'signs/symptoms are induced by the caregiver and can result in the child receiving unnecessary and potentially harmful [medical] care'. Hoffman & Koocher (2020) suggest that the 'parent initiates the abuse, but physicians can become *unintentional* contributors to this distress' (my emphasis, p. 753). FII was formerly known, and often problematically referred to, as Munchausen's syndrome by proxy. Roy Meadow, the paediatrician who introduced the term MSBP, argued that this phrasing has wrongly led 'medical professionals, social workers and lawyers to misidentify perpetrators of abuse as sufferers of a mental illness' (Roesler & Jenny, 2009, p. 21), and that this 'formal psychiatric

diagnosis [allowed] for a [legal] defence on the basis of diminished responsibility' (p. 24) which is why this misconception is so dangerous.

Many experts in this field (Yates & Bass, 2017; Roesler & Jenny, 2009) had called for the term medical child abuse (MCA) to be adopted when referring to these cases to place the emphasis and priority on the wellbeing of the child, rather than the perpetrator, and to reframe this disorder as a 'variant of child maltreatment' (Yates & Bass, 2017). *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) defines Factitious Disorder Imposed on Another (previously Factitious Disorder by Proxy) as follows:

> A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identity deception.
> B. The individual presents another individual (victim) to others as ill, impaired, or injured.
> C. The deceptive behaviour is evident even in the absence of obvious external rewards.
> D. The behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.
> Note: The perpetrator, not the victim, receives the diagnosis. (American Psychiatric Association, 2013)

It is worth highlighting the condemnatory terms used here: 'falsification', 'identity deception', 'deceptive behaviour', and 'perpetrator'. Importantly, these individuals are not considered to be delusional or psychotic, all of which suggests the notion of volitional abusive behaviour. Previous versions of the DSM included the perpetrator's goals and motivations, but note that this has been removed in this reformulation (Hoffman & Koocher, 2020, p. 754). It is, therefore, important to stress that FII is not a mental illness, and there is no evidence to suggest that perpetrators have a psychiatric disorder (Yates & Bass, 2017; Roesler & Jenny, 2009, p. 117). Certainly, FII is no more a mental illness than any other form of child abuse - 'it is not asserted [for example] that the neglecting parent has a syndrome known as 'child neglect'' (Roesler & Jenny, 2009, p. 19). Consequently, perpetrators of FII are now described using the term 'personality disorder' (p. 98). The legal system does not generally accept personality disorders as a severe mental illness as it is difficult to accurately place the disorder in terms of the level of dysfunctionality within the individual; instead, the legal system perceives personality disorders as under one's volitional control and, therefore seldom differentiates an individual from the population at large, particularly as we regard social deviance existing within the boundaries of what can be considered as normal behaviour (Johnson and Elbogen, 2013).

Several studies (Bass and Glaser, 2014; Yates & Bass, 2017; Roesler & Jenny, 2009; Hoffman & Koocher, 2020) have collated data on FII cases to identify specific patterns of behaviour among perpetrators. Yates and Bass' (2017) report found that almost 'all abusers were female (97.6%) and

the victim's mother (95.6%)... Perpetrators were frequently reported to be in healthcare-related professions (45.6%), [and had a history] of childhood maltreatment (30%).' In most cases, the child's father is absent or emotionally detached from the family (Bass and Glaser, 2014), and some perpetrators 'fabricate illness in their children purely for financial gain' (Yates & Bass, 2017).

With regard to prevalence, most sources do not present a consistent figure; however, Hoffman & Koocher (2020, pp. 753-755) suggest that FII 'occurs more commonly than initially expected', especially as it is likely underreported. 'Mortality rates in victims of fabricated illnesses reportedly range from 6 to 9%' (Hoffman & Koocher, 2020, p. 756; Yates & Bass, 2017; Sheridan, 2003), with prolonged or permanent disability occurring in 7.3% of cases (Sheridan, 2003).

There are documented instances where children have undergone a series of unnecessary medical procedures, including pancreatectomy, hemicolectomy, 'and limb amputation… under pressure from caregivers' (Yates & Bass, 2017). Perpetrators might also 'fabricate[] or induce[] apnea (respiratory arrest)' (Feldman, 2004, p. 126), and one of the most common forms of abuse reported is 'induced seizures… with 42% of the victims suffering from this abuse' (Bass and Glaser, 2014, p. 1413). This is in addition to the 'several hundred medical visits' a medically abused child will be exposed to (Roesler & Jenny, 2009, p. 177).

FII can also extend beyond medical contexts, particularly in cases involving charity- or sympathy-seeking behaviour. Schools, for example, can become key environments in which perpetrators operate (Feldman, 2004, p. 142). Hoffman & Koocher (2020, p. 756) similarly observe that children's 'school attendance, opportunities to engage in sports, organised activities or even typical childhood play outside the home' can be severely restricted. Roesler & Jenny (2009, p. 4) note that while the general public may hold some awareness of this behaviour, it remains 'by no means… well understood', and even 'the medical community continues to have difficulty understanding' FII.

These medical and safeguarding perspectives provided the foundation for developing the play's content. The research clarified that the behaviour commonly associated with FII is deliberate and volitional, positioning the perpetrator not as a patient but as an abuser. This understanding directly shaped the play's dramaturgy, portraying the mother not as psychologically unwell but as a manipulative caregiver whose actions are deliberate and sustained. The literature's emphasis on the child's vulnerability and the systemic difficulties of detection reinforced the decision to tell the story entirely through Lucy's perspective, with an applied theatre framing. Data showing that most perpetrators are mothers, with fathers often passive or absent, informed both the family dynamics and the portrayal of complicity within the household.

Most importantly, these sources established the play's ethical stance. By understanding FII as a form of child abuse rather than a psychiatric condition, the production resisted the temptation to

sensationalise or explain away the perpetrator's behaviour. Instead, the work focused on the moral and emotional consequences of inaction, inviting professional and lay audiences to consider their own roles within a wider culture of safeguarding. The medical and psychological literature thus served as factual grounding, ensuring that the theatrical presentation of FII remained responsible.

Theoretical framework: empathy and imaginative engagement

Through discussions with safeguarding professionals and a review of medical and psychological literature on fabricated or induced illness (FII), I found that representing this material on stage requires more than accuracy; it demands careful attention to emotional impact. I explored ways to encourage audiences to engage emotionally and ethically without feeling overwhelmed. Professionals stressed that empathy in safeguarding involves not only understanding others' feelings but also communicating care to build trust, even in challenging conversations. Practitioners must be 'genuinely… empathetic' while 'telling the truth,' (Consultant, Appendix A) balancing honesty with compassion to foster openness. This perspective led me to consider how theatre can evoke similar dynamics, enabling audiences to engage emotionally while recognising their responsibilities to others. The literature identifies three main pathways for activating empathy: emotional contagion, imaginative engagement, and sound or musical resonance. These frameworks help explain how spectators can move from emotional response to reflective awareness in applied theatre.

Empathy through emotional contagion refers to the transmission of emotions between individuals, often unconsciously. Decety and Ickes (2011, p. 19) describe 'primitive emotional contagion [as] a basic building block of human interaction' that enables people 'to understand and to share the feelings of others.' They note that emotions can be 'caught' in several ways, ranging from 'conscious reasoning' and 'imagination' to subtle, automatic mimicry (p. 20). Paz et al. (2021, p. 1) similarly define emotional contagion as 'the idea that affective states can be transferred during social interaction,' noting that humans communicate emotions both consciously and unconsciously by automatically synchronising 'speech, movements, bodily postures, gestures, facial expressions, [and] eye gaze,' with others (p. 3). Nickerson (2021) builds on Hatfield's foundational work, describing emotional contagion as 'the tendency to automatically mimic and synchronize expressions, vocalizations, postures, and movements with those of another person's and, consequently, to converge emotionally.' These processes demonstrate that empathy operates at both automatic and reflective levels, enabling people to align emotionally with others through both instinctive mimicry and conscious awareness.

Research on participation and experiential learning shows that active involvement fosters empathy and deepens understanding. Perry et al. (2011, p. 142) argue that experiential methods, such as participation, are more effective at building emotional connections than solitary study. Bates et al.

(2013, p. 171) highlight the value of aesthetic drama and activities such as rehearsal for developing empathy in medical training. White et al. (2015, p. 46) stress the importance of valuing and clearly communicating participants' engagement to encourage constructive participation. Together, these findings suggest that learning occurs through active participation and empathic engagement, making emotional involvement integral to the learning process. These insights guided my exploration of dramaturgical strategies that use participation to foster understanding and collective empathy within a theatrical framework.

A second mode of empathy is imaginative participation. In applied theatre, imagination is viewed as an ethical practice that enables audiences to rehearse care within a fictional context. Nicholson (2015, p. 66) describes theatre as an 'imaginary space' for moral reflection, where spectators can safely explore ethical choices. Decety and Ickes (2011, p. 3) note that empathy often involves projecting ourselves into another's situation, while Tobón (2019, p. 9) explains that this projection can evoke an 'internal imitation or reenactment of what others may feel, perceive or think in a certain situation.' These perspectives position imagination as a bridge between understanding and feeling, which is essential when addressing sensitive safeguarding material. This literature led me to consider dramaturgical devices that use imagination to create safe, simulated environments, allowing audiences to experiment with emotional and moral responses. It also encouraged me to explore how spectators might, through empathic imagination, connect with both the child's experiences and the challenges faced by professionals in safeguarding.

A third area of literature examines how sound and music serve as channels for empathy and emotional contagion. Egermann and McAdams (2013, p. 140) describe empathy in music as involving both cognitive 'perspective taking' and emotional 'feeling with someone else,' noting that emotional responses can arise through 'automated unconscious contagion' when listeners mimic expressive cues in sound (pp. 140-141). Juslin et al. (2015) show that music, though made of 'abstract tone sequences,' can evoke strong emotions, identifying empathy-related mechanisms in their BRECVEMA framework (p. 281). They define 'contagion' as internal mimicry of music's voicelike expression and 'rhythmic entrainment' as the alignment of bodily rhythm with musical rhythm (pp. 283-284). These processes suggest that listeners may mirror music's expressive qualities, making sound a vehicle for empathic connection. This literature led me to consider how empathy through music could inform dramaturgical choices in *A Bitter Pill*. Since both research and professionals noted that victims' voices are often silenced or dismissed, I explored music as an alternative way to communicate Lucy's emotional states without words.

These three strands of research, emotional contagion, imaginative engagement, and empathic sound, offer a multidimensional view of how empathy functions in performance. They demonstrate that empathy can arise through bodily synchrony, imaginative projection, and affective resonance, each of

which supports emotional connection and ethical awareness. This literature informed my approach to dramaturgical form, highlighting how participation can foster collective engagement, simulated environments can offer safe spaces for reflection, and music can centre the child's voice. The next section applies these theoretical frameworks to dramaturgical strategies in *A Bitter Pill*, exploring how empathy and safeguarding are enacted in performance.

Dramaturgical strategies

The dramaturgical approach for *A Bitter Pill* was shaped by research into fabricated or induced illness (FII), interviews with safeguarding professionals, and studies of empathy and applied theatre ethics. These sources highlighted the importance of exploring the child's perspective, addressing the silencing of victims, and providing space for professional audiences to reflect on caregiving. Three key strategies were identified: participation to foster collective emotional engagement, imaginative framing to create a safe environment for ethical exploration, and improvised music to support empathic resonance and restore the child's voice.

Audience participation and collective engagement

Audience participation is a central dramaturgical device in *A Bitter Pill*, designed to shift spectators from passive observation to active engagement. Audience members are invited on stage to play caregivers in Lucy's life, such as a community worker (ABP Script, p. 51), teacher (p. 60), or childminder (p. 66), immersing themselves in her fictional world and taking responsibility for her welfare through guided participation. Preston (2020, p. 127) notes that participation has become prominent in education, health, and applied theatre because it requires collective creativity. She explains that drama can be 'enjoyable' and can 'lure people, even those unused to drama, into participation'. Building on this, *A Bitter Pill* uses theatre's accessibility to attract a broad professional audience, expanding participation and increasing the play's potential for impact.

Each performance was structured to balance invitation with guidance. One participant at a time, representing the group, was encouraged to join Lucy on stage, often prompted by praise or early applause. This was made explicit in the script when Lucy approached an audience member with 'I'm going to ask you, sir, to be my class teacher. It's just that you look really smart, and you're giving me really cool teacher vibes' (ABP Script, p. 60), signalling both invitation and reassurance. This approach ensured involvement while maintaining care. Boal (1998, p. 72) describes participation as a representational act in which the individual acts 'in the name of all,' symbolically bringing the audience into the action. Here, one participant embodied the audience's shared responsibility, allowing observers to experience the tension between hesitation and action. Harpin and Nicholson (2016, p. 215) describe this as a 'bonding effect' that generates collective empathy through shared purpose, while McConachie (2008, pp. 18-19) links this connection to the activation of mirror

neurons, enabling audiences to internalise observed emotions and gestures. These mechanisms support the audience's affective alignment, turning participation into a collective act of ethical recognition.

Participation was not used simply to empower, but to reflect the dynamics of authority in FII cases. White et al. (2015, p. 46) caution that participatory forms can risk manipulation, though such discomfort may be justified for reflective or interventionist purposes. *A Bitter Pill* intentionally navigated this tension, as participants experienced gentle coercion through praise, direction, and subtle pressure to comply, mirroring the manipulations found in real FII cases. Hoffman and Koocher (2020, p. 759) note that professionals can unintentionally perpetuate harm by accepting deceptive narratives, and this dramaturgical structure safely recreated that dynamic within a fictional context. The aim was to provide a space for the audience to confront the complex safeguarding decisions that arise when empathy and manipulation intersect.

Participatory encounters were complemented by collective engagement. Scenes such as Lucy's birthday party invited the entire audience to sing, use party poppers, and eat cake (ABP Script, p. 59), reinforcing communal responsibility in safeguarding. Mermikides (2020, pp. 123-124) notes that applied performance nurtures solidarity through shared activities, a dynamic reflected here as participation emphasised shared responsibility. This mirrors the professional reality that safeguarding is a collective commitment. By engaging together, audiences experienced empathy as a collaborative practice.

Through these participatory structures, *A Bitter Pill* aimed to create an environment where empathy leads to reflection. Stepping onto the stage, or observing others do so, encouraged audiences to examine their assumptions and responsibilities toward vulnerable individuals. In the applied theatre framework, participation served as both an affective and pedagogical strategy, offering a contained space for collective learning through shared emotional experience and ethical consideration.

Imaginative engagement as ethical simulation

While imaginative engagement is fundamental to theatre, in *A Bitter Pill* it serves a specific dramaturgical and ethical purpose: simulating deception in a controlled setting and encouraging reflection on how perception can be distorted in both performance and professional contexts. This is made explicit when Lucy tells the audience, 'Now for those of you who can't tell, I'm not really six. I'm actually quite a bit older, so you're just going to have to use your imagination' (ABP Script, p. 50). This repeated reminder highlights the audience's imaginative effort. FII literature shows that perpetrators manipulate reality through exaggeration, inducing illness, fabricating medical evidence, and using authoritative tones to persuade others (Feldman, 2004, pp. 20-21; Hoffman & Koocher, 2020, p. 754; Walters et al., 2020). These actions rely on persuasion, role-play, and sustained illusion,

which closely parallel theatrical techniques. Recognising this connection was central to the play's conceptual development.

The dramaturgical design highlights its own artifice, drawing attention to illusion and belief. The audience is repeatedly reminded that Lucy is played by an adult (ABP Script, p. 50), her father appears only as an imagined presence (p. 51), and objects like a doll's head (p. 71) or imaginary pills (p. 55) are symbolic. These reminders encourage spectators to remain critically aware of the play's constructed world while empathising with it. By emphasising pretence, *A Bitter Pill* mirrors the deceptive strategies of FII perpetrators and prompts audiences to consider how easily empathy can be manipulated. The theatre thus becomes a space to explore perceptual uncertainty, allowing spectators to experience the tension between trust and scepticism in a safe environment.

This approach draws on Nicholson's (2015, p. 66) concept of theatre as a space for moral rehearsal, where participants can test ethical decisions without real-world consequences. Tobón's (2019, p. 18) idea of higher-level empathy, the ability to imaginatively enter another's experience while maintaining critical thinking, also aligns with the dramaturgical goal. The audience is encouraged to remain emotionally engaged while considering the implications of their responses. This balance between empathy and awareness reflects the challenge faced by safeguarding professionals, who must combine compassion with judgement.

By highlighting its own artifice, the production invites audiences to engage with a simulated environment where deception and truth can be examined safely. Here, imaginative engagement serves as a tool for ethical inquiry rather than mere aesthetic play. Spectators are encouraged to critically observe how perception is shaped, how empathy can be manufactured through illusion, and how moral choices might develop in such conditions. The safety of the theatrical frame allows exploration of failure and complicity without real-world consequences, supporting a reflective process that parallels the ethical demands of safeguarding practice.

Improvised music and the voice of the child

The child's voice in *A Bitter Pill* forms the play's emotional and ethical foundation. Medical and safeguarding professionals stress the importance of prioritising the child's experience over the perpetrator's actions, a principle that shapes the creative process. In cases of fabricated or induced illness (FII), perpetrators often silence or distort children's voices to maintain control and avoid detection (Feldman, 2004, p. 125). The play reflects this through Lucy's silence in her mother's presence, symbolising fear and emotional repression. Feldman (2004, p. 125) and Sutton (2002, p. 234) observe that abusive environments can cause children to internalise guilt, blame, or fear of abandonment, leading them to lose the ability to speak honestly or at all. By centring Lucy's voice, the play makes an ethical commitment to restoring agency where silence usually dominates.

Improvised music became the primary aesthetic tool for this purpose. Although inspired by music therapy, it serves here as a dramaturgical and emotional device to express Lucy's unspoken feelings. Sutton (2002, pp. 124-125) notes that music can externalise emotions too complex or painful for words, while Roesner (2016, pp. 17-18) describes it as a pre-linguistic form that conveys subtle affective states beyond language. The actor portraying the father figure performs live, improvised music in response to Lucy's gestures, tone, and movement (ABP Script, p. 50), reflecting the communicative principles outlined by Malloch and Trevarthen (2009), where pulse, quality, and narrative create shared meaning through sound. This live interaction allows the audience to perceive Lucy's changing inner state, turning sound into an empathic dialogue that connects her internal world with the audience's emotional understanding.

At a pivotal moment, the father stops playing (ABP Script, p. 72), creating a rupture that replaces sound with silence. Harpin and Nicholson (2016, p. 36) describe silence as a 'relational space' that restores expressive potential; here, it symbolises the complete erasure of Lucy's voice in both her imagined world and reality. The absence of music also signals the absence of support, highlighting the child's isolation and the emotional void caused by neglect. This interplay between sound and silence shows how musicality in theatre can express the tension between communication and suppression that defines FII.

Through improvised music, *A Bitter Pill* transforms Lucy's silenced voice into expression and invites shared reflection on her inner life. The dramaturgy centres the child's perspective and seeks to restore the voice that has been taken from her. In applied theatre, this use of sound encourages audiences to listen actively, focus on emotion as well as explanation, and take professional responsibility to hear and respond to silenced voices.

Applied theatre outcomes for A Bitter Pill

The applied theatre model for *A Bitter Pill* integrates aesthetic experience with social purpose, reflecting Nicholson's (2015, p. 3) view of applied theatre as practice 'intended to benefit individuals, communities and societies.' The play draws on discussions with safeguarding professionals, research into FII, and studies of empathy. It is designed to engage professional audiences, particularly those in health and child protection, through embodied reflection and emotional connection. The aim is to encourage practitioners to consider how empathy shapes ethical decision-making and to raise awareness of the subtle mechanisms of coercion that may silence a child's voice.

This approach aligns with Thompson's idea of theatre as a 'rehearsal for life' (2012, p. 50 in Freebody et al., 2018, p. 12), where embodied action serves as ethical practice. The participatory structure of *A Bitter Pill* allows professionals to test emotional and moral responses in a simulated environment. Nicholson (2011, p. 121) notes that theatre can offer a 'safe and public space to rehearse… private

responses to disclosure and abuse.' Through this, the play uses affective engagement as a pedagogical tool, enabling audiences to experience the pressures and complexities of safeguarding in cases of fabricated or induced illness.

Applied theatre scholarship often highlights the negotiation between affect and ethics. Freebody et al. (2018, p. 12) identify participation as central to the field, while Nicholson (2015, p. 10) notes its value in balancing 'action and contemplation.' *A Bitter Pill* embodies this duality through dramaturgy that shifts between emotional immediacy and critical thinking, using participatory encounters, imaginative simulation, and the empathic qualities of improvised music. These elements actively engage the audience, bridging the aesthetic and the applied.

The play's commitment to aesthetic integrity reflects White, Balfour and Preston's (2015, pp. 1-2) reminder that applied theatre should not be reduced to instruction alone. This supports the need to balance emotional and critical engagement. *A Bitter Pill* therefore develops its aesthetic form alongside its didactic aims, maintaining emotional depth and artistic complexity while advancing its social purpose. This balance between art and activism echoes Nicholson's (2015, pp. 60-61) discussion of Thompson's view that learning is an affective, felt state, and that meaningful social change arises from both emotional experience and critical engagement.

Ultimately, the applied theatre outcomes of *A Bitter Pill* are found in the reflective space it creates. Building on participatory dramaturgy, the play invites audiences to embody safeguarding scenarios, imagine the child's perspective, and listen empathically through sound. In this way, it serves as a rehearsal for professional awareness, showing how theatre can integrate affect and analysis to help practitioners navigate the complexities of safeguarding practice.

Post-performance research design

Post-performance data for *A Bitter Pill* were collected through an anonymised online questionnaire, accessible via a QR code in the programme at both venues. Participation was voluntary, and respondents could select which questions to answer. Time was allocated after each performance to encourage immediate reflection, supporting the work's applied focus. Audiences were asked to complete the questionnaire while their impressions were fresh to ensure authentic feedback. The design aimed to assess whether the piece served as a reflective space and influenced perceptions of safeguarding practice. Findings show that audiences valued the opportunity for reflection, with many reconsidering safeguarding as a result. However, as responses were gathered immediately after the performance, the study reflects short-term rather than long-term insights.

The questionnaire included demographic questions and open-ended prompts. Each item was designed to test whether dramaturgical strategies, embodied scenarios, imaginative framing, and improvised

music achieved the intended applied theatre effects. Initial questions established respondents' professional backgrounds, distinguishing social workers, medical or care professionals, those working with children, and theatre professionals. This differentiation helped compare practitioners' safeguarding responses with those of the general public. Identifying professionals working with children or in statutory services supported later data analysis. Including theatre professionals acknowledged that their familiarity with performance conventions might influence their perceptions.

Several questions assessed knowledge of Fabricated or Induced Illness (FII), asking whether respondents were already familiar with FII or learned something new. This helped evaluate the play's effectiveness as an informative resource and its ability to raise awareness without oversimplifying the issue. For those familiar with FII, follow-up questions on the accuracy of the portrayal provided an early credibility check by determining whether choices like presenting events through Lucy's perspective matched practitioners' observations.

Another set of questions explored empathy, safeguarding, and reflective practice by asking if the play encouraged respondents to be more proactive in child protection, and if so, how. The goal was to assess whether affective engagement led to professional motivation. While the study cannot establish causality, these questions examined whether the play's embodied structure, particularly involving some audience members in caregiver roles, prompted deeper reflection than passive observation.

The question about on-stage participation examined whether the environment fostered safety and trust, aligning with the project's focus on balancing affective intensity and ethical care in applied theatre, especially when audiences participate. The question about improvised music assessed whether Lucy's imaginary father's musical language served as both an emotional anchor and an interpretive cue.

Finally, prompts about key takeaways, overall impressions, and suggested ticket price served both practical and interpretive purposes. Open-ended responses revealed audience understanding of the experience, while the ticket-price question helped position the production within audience expectations and potential touring models.

While the methodology provided useful insights, it had clear limitations. Data were collected at only two performances during the research-and-development phase, which limited sample size and diversity. Immediate responses captured only initial impressions, with no long-term follow-up. However, the design offers a foundation for broader data collection. Future studies could involve university departments, safeguarding networks, and commercial theatre venues to support repeated engagement and long-term research.

Results and findings from audience feedback

The performance was held at Hull Truck Theatre's Godber Studio on 10 August 2024 and at Caxton Theatre on 11 August 2024. Supported by Arts Council England, the production primarily attracted social workers, medical professionals, and care sector staff. Attendance totalled 240, with 130 at Hull Truck Theatre and 110 at Caxton Theatre. Feedback was received from 82 attendees (see Appendix B), a 34% response rate, though technical issues at Hull Truck Theatre may have reduced participation. The audience included 8 social workers, 21 medical professionals, 32 care sector workers, 41 working with children, and 10 theatre professionals. The sold-out performances indicate the play successfully reached its target audience.

Post-performance questionnaire responses indicate that *A Bitter Pill* functioned as both an educational resource on Fabricated or Induced Illness (FII) and a space for audiences to reflect on their responsibilities toward children. The following analysis uses audience feedback to illustrate the play's impact on awareness, empathy, participation, listening, emotional response, aesthetic engagement, and safeguarding reflection.

Awareness of fabricated or induced illness

Most respondents were already aware of FII, often through professional experience or media coverage, yet described the play as deepening or reframing their understanding. One audience member wrote, 'Hearing it from Lucy's perspective was brilliant. I've had cases of suspected fabricated illness, and seeing the holistic team around her fail the child was so powerful.' Another noted they 'already knew about fabrication and illnesses like Munchausen's by proxy, however, I felt this play really reinforced it from the child's perspective. It hammered home the emotional and physical effects at the child's level.'

For others, the play further developed their understanding. One respondent noted, 'I didn't realise how young of an age it happened and the extent to which it happens, e.g. having unnecessary operations, suffocating the child etc.' Another stated, 'I couldn't believe anyone would actually go to suffocate their own child for attention. That was shocking but beautifully done.' Others commented on the extremity of the behaviour, with one saying they '[w]as surprised at the asphyxiation [not knowing] it went that far.' Some were not aware of 'the seriousness of the problem.'

Audience members also reflected on how FII can be concealed, describing deception as gradual, persuasive, and difficult to detect. One noted it 'made me conscious of the depths of deception,' while another commented on 'how manipulative the person can be,' highlighting an increased awareness of behaviours that may initially seem credible or caring. Observations that the mother 'hid it well' and

‘looked the part as a good mother’ reinforced this point. These responses suggest the play’s framing encouraged close attention to the subtlety of fabrication.

These responses indicate the play sharpened awareness of how fabrication and manipulation occur within care practices, even among those with prior knowledge. The performance reframed understanding by highlighting the emotional consequences of abuse and the persuasive strategies that sustain harm. By focusing on gradual, socially credible deception, the play prompted reflection on how safeguarding failures can arise. The production encourages audiences to remain vigilant to manipulation in safeguarding contexts.

Empathy and the child’s perspective

Empathy for Lucy is central to participants’ responses, with many expressing a strong emotional connection. One participant remarked, ‘How sad I felt for Lucy,’ while another emphasised, ‘The voice of the child.’ Another shared, ‘Although, my biggest takeaway was the joy of watching the actress play the young girl. I felt a real compassion for Lucy.’ These reactions highlight the play’s effectiveness in centring the child’s emotional experience.

These responses reinforce the importance of hearing the child’s perspective in effective safeguarding. Participants noted the ‘[v]oice of child [is] very important,’ that ‘[a]dults need to be the voice for children,’ and that ‘[i]t puts focus back on the child victim and their perspective, rather than the usual focus on the perpetrators.’ One audience member stated the piece ‘highlights the voice of the child,’ while another concluded, ‘Listen to the child!’ This underscores the play’s commitment to prioritising children’s voices.

Some respondents linked empathy to the play’s imaginative structure and its main message. One wrote the play ‘[m]ade me see it from the child’s view,’ while another said it helped them ‘see beyond what is visible.’ These comments show that presenting events through Lucy’s imagination and addressing the audience directly deepens empathy. This approach supports the play’s central argument: safeguarding must engage with the child’s lived experience, encouraging practitioners and audiences to pay close attention to the cues and imaginative signals that shape a child’s perception of harm.

Reflection on safeguarding practice and responsibility

Many responses identify the play’s main message as a call to reflect on safeguarding. One audience member said, ‘[t]hat safeguarding is everyone’s business!’ Another echoed, ‘[t]hat [it] is EVERYBODYS responsibility to safeguard children.’ The performance is viewed as an active call to recognise and fulfill this collective duty.

The follow-up question about being more proactive prompted detailed reflections on practice. One respondent wrote, ‘Awareness - showing the importance of proffesionals questioning parents/families,’ while another noted ‘how professionals did not raise or pass on concerns about the welfare of “Lucy”.’ For one social worker, the play resonated with daily practice: ‘This was really power full. As a social worker we are often told children are unwell sometimes even just common illness and we just take this as truth. This play highlights the voice of the child.’

Others described changes in their alertness and decision-making. Respondents wrote that the play would ‘make you want to look out for signs of this,’ ‘[w]ill make me look more deeply,’ and ‘[w]ill help me look differently at situations.’ Several connected this to instinct and professional curiosity, such as ‘[t]hat you should always follow your gut instinct with the use of professional curiosity,’ and ‘[i]t reminds you that it is always better to say something than not, even if it is the smallest thing.’ Another audience member related this directly to statutory processes: ‘[i]t’s certainly an awareness creator. I liked the line about not ignoring your gut when it tells you something isn’t quite right and to call social services.’

These comments suggest the performance served as professional rehearsal, encouraging spectators to consider when and how to speak up for a child. This aligns with the play’s aim to shift safeguarding from a procedural obligation to a more active, relational vigilance based on instinct, empathy, and understanding. By encouraging audience members to question parents more rigorously, notice subtle cues, and trust their professional judgement, the play created space for practitioners to rehearse decision-making in emotionally charged situations. In doing so, it advanced its goal of using theatre to strengthen practitioner sensitivity and reinforced that safeguarding is everyone’s responsibility, requiring ongoing reflection, engagement, and a consistent focus on the child’s voice.

Participation, discomfort, and embodied ethics

Audience responses to the participatory elements were marked by both nervousness and relief. One attendee shared, ‘[t]hankfully I was not [invited on to the stage], but was concerned that I would be,’ while another admitted, ‘I avoided looking at Lucy Most of the time just in case she picked on me.’ Those who did take part described complex feelings. One respondent wrote, ‘Yes… extremely uncomfortable with it, public speaking/appearance terrifies me.’ Another commented that they were ‘the teacher and yes it was very good,’ while another recalled being drawn in despite remaining in the audience: ‘I was not but the “child” interacted with me at the beginning of the play and magic[k]ed me into a fairy.. [it] was very engaging and drew you in to the character.’ Many attributed their discomfort to the overall performance. One remarked, ‘[r]eally enjoyed it but felt nervous as didn’t want to be picked to go on the stage,’ while another concluded, ‘Fantastic… and the audience interacting brings an extra dimension to the story.’

These responses show that both participation and its anticipation created a useful unease, mirroring the ethical pressures of actual safeguarding situations. Audience members described a low-level anxiety, which aligns with the state of alertness the play intended to evoke, being aware that one might be called upon to act or take responsibility. By inviting the audience into Lucy's world, and also positioning them as authority figures, the play allowed them to experience the discomfort and hesitation that are part of making safeguarding decisions. Participation was not just a stylistic choice but a key means of achieving the play's goals. It lets audiences, especially professionals, feel the weight of their roles and see how fear or uncertainty can delay action.

Improvised music and emotional connection

The improvised piano score prompted many responses, most highlighting its emotional and atmospheric impact. The music was often described as 'fitting,' 'really good,' or 'excellent.' One respondent noted, '[t]he music was amazing and you could tell the musician was really invested in Lucy.' Others observed that it '[s]et the tone,' '[a]dded tension, excitement,' and '[a]dded suspense.'

Several audience members directly connected the music to Lucy's inner life. One noted it 'made it powerful and sad at the same time,' while another wrote that it 'helped to build mood and energy, as well as allowing us to connect better with Lucy as the music reflected her feelings.' Another commented, '[t]he improvised music impacted me emotionally by sonically exporting the child's thought processes.'

Audience members also reflected on the music's volume and balance. Some felt it could be 'a bit quieter at times,' while others praised its integration, stating it was '[b]loody brilliantly, without the music the story would be flat,' and, '[b]eautifully done and the use of music was really effective especially when the music stopped.'

Overall, these responses show that the improvisation was not just background but actively shaped how spectators listened to and interpreted Lucy's story, creating an emotional connection. This supports the play's goal of using music as an affective and relational tool rather than a decorative element. The audience's recognition that the score 'helped to build mood and energy,' 'reflected her feelings,' and 'sonically exported the child's thought processes' demonstrates that the improvised piano achieved its purpose of mirroring Lucy's changing emotions. Comments praising moments 'when the music stopped' also highlight silence as a deliberate dramaturgical tool, providing space for reflection. These insights suggest that the music contributed to the play's broader aim of creating a sensory and affective environment where audiences could engage with Lucy's inner experiences and see how theatre can hold both emotion and analysis together.

Professional considerations and safeguarding complexity

Several responses highlighted the complexity and subtlety of FII. One audience member noted, '[h]ow complex these lives can be,' while another observed, '[e]verything isn't always as it seems.' From an educational perspective, a respondent reflected, 'I saw the situation through the eyes of an education provider, linking absence from school for fabricated illness and the potential for falsifying reasons for children being missing from school or absent for frequent and/or prolonged periods of time.'

Participants discussed the challenges of identifying FII, noting, 'How easily it can happen,' and questioning, 'Think where has that child gone. Think why does this child look so well when the mother is describing so much illness.' They also raised concerns about '[m]issed opportunities and spotting mum's behaviour.' Additionally, some highlighted gaps in communication between services, stating, 'services often don't speak to one another or are not allowed to disclose information.'

These comments indicate that the performance encouraged audiences to look beyond obvious signs of abuse and consider deeper organisational barriers to safeguarding. The play highlighted the uncertainty professionals face in FII cases, prompting reflection on assumptions and emphasising the need for stronger inter-agency communication. This aligns with the play's goal of helping professionals better understand FII's complexity and identify subtle harm.

Emotional impact

The emotional impact of the performance is clear in the responses. One audience member described the play as '[u]psetting,' while another noted, '[h]ow sad it made me [f]eel.' Another respondent shared, 'moved by the play. To say I enjoyed it would be a strange comment but I valued the message.'

Respondents reported that the performance evoked both sadness and anger, referencing '[h]ow sick some people are in the head that they would hurt thier own child which is after all, the point of the play to portray,' and feeling '[s]ad at some parts of humanity.' One shared, '[w]ell, I was crying by the end. Really pulled at my heart strings which I assume is the aim. It definitely increased my knowledge.' Others linked this emotional intensity to ongoing reflection, describing the play as '[f]ood for thought,' noting a '[j]ust heightened awareness of the issue,' or stating, '[t]hat these things can, and do, happen, and that it can ruin a child's life. Be more vigilant.'

These responses demonstrate that the performance used emotional impact to foster ethical awareness and deeper engagement with safeguarding. Facing emotional realities, rather than a detached approach, helped the audience appreciate children's vulnerability and the seriousness of FII. This resonance encouraged greater attentiveness and empathy, indicating the play met its applied theatre objectives.

Aesthetic and narrative engagement

Many respondents praised the performance's aesthetic and narrative qualities, using terms such as '[v]ery powerful,' and 'riveting, and emotional.' One summarised their experience as '[f]antastic, emotional, intense, funny and entertaining.'

Several respondents noted the balance of comedy and tension, describing it as a '[s]erious topic but with humour,' and stating the piece 'provide[d] humour in parts too, which balanced reality with theatre perfectly.' Others valued audience interaction, commenting that 'the audience interacting brings an extra dimension to the story,' and that the interaction activities and party bags were 'a really good idea.'

Respondents also offered detailed reflections on structure and style. One said, 'I came unsure what to expect and am leaving flabbergasted,' and praised the 'professional, delicate and quirky' delivery of challenging material, as well as the balance between seriousness, sadness, and light humour. Another described the work as '[a] great and challenging peace of theatre,' and noted its 'professional ability to explore sensitive subject matter with an element of fun and excitement.'

These comments show that the play provided a meaningful learning experience through its narrative and aesthetic strengths. Positive feedback on structure, humour, and interaction confirms these elements helped achieve ethical and educational objectives, making challenging content accessible and encouraging reflection on FII and safeguarding.

Conclusion

A Bitter Pill was developed to examine how theatre can support professional reflection on Fabricated or Induced Illness by combining aesthetic experimentation with practical objectives. The primary goal was to create a dramaturgical framework that made the child's emotional world visible and encouraged audiences, especially those in safeguarding and healthcare, to reflect on their responsibilities. The project aimed to avoid sensationalism, align with current safeguarding discourse, and create an experience that fosters empathy, imagination, and participation, thereby promoting learning and reflective engagement.

These aims were achieved through three key outcomes. The dramaturgy focused each scene on Lucy's imaginative perspective, allowing the audience to experience FII as an emotional reality rather than a clinical diagnosis of her mother's actions. Post-performance feedback shows this approach shaped audience understanding. Many respondents highlighted 'the voice of the child,' the child's viewpoint, and the focus on the emotional effects of coercion as most impactful. This indicates the production amplified the child's experience while avoiding narratives that might shift attention to the perpetrator.

The study also examined how participation and imaginative engagement foster ethical reflection. Audience responses indicate these strategies heightened attentiveness; participants reported feeling nervous about being invited on stage, aware of intervention possibilities, or relieved when not chosen. This unease aligned with the project's goal to simulate real safeguarding pressures. Those who participated reflected on their roles, supporting the idea that participation functions as both an artistic device and a rehearsal of responsibility.

The project also used music dramaturgically rather than simply as accompaniment. The improvised piano score reflected Lucy's emotional states, translating her inner life into sound. Audience members described the technique as 'powerful,' 'sad,' 'reflective of her feelings,' and 'sonically exporting the child's thought processes.' Respondents also emphasised the impact of silence, particularly when the father stops playing, thereby reinforcing the theme of the child's lack of support. These responses show that improvised music served as an empathic device, deepening emotional understanding.

These findings indicate the project achieved its artistic and practical objectives. *A Bitter Pill* provided a reflective space for audiences to explore the complexities of FII through a carefully crafted aesthetic experience. Feedback shows increased awareness, greater empathy, and more proactive reflection on safeguarding, demonstrating how dramaturgy can foster professional insight where emotional attunement and ethical judgement are essential.

Addressing gaps in applied theatre and health research

While *A Bitter Pill* was primarily a practice-as-research project, its design and evaluation address key methodological and conceptual gaps in applied theatre and health literature. Martí-Vilar et al. (2023, p. 10) note the need for studies with greater methodological depth, particularly regarding affective mechanisms of change. This project responds by embedding affective analysis, examining how dramaturgical strategies such as participation, imaginative framing, and improvised music influence spectators' emotional and ethical responses. Audience reflections on empathy, tension, unease, and attentiveness enabled the research to observe practitioner responses within the aesthetic encounter. This approach supports practices that prioritise emotion as both a focus of inquiry and a means of evaluation.

However, the project does not fully address the methodological gaps in the field. Sevrain-Goideau et al. (2020, p. 6) highlight the lack of longitudinal evidence and the need to assess the persistence of behavioural change. This study relied on immediate post-performance responses and cannot demonstrate lasting impact. Burns et al. (2024, p. 159) also note the limitations of self-report measures and the importance of mixed-methods or observational data. This evaluation depended almost entirely on reflective accounts, which offer insight into affective engagement but do not

provide evidence of behavioural transformation. These limitations are common in applied theatre research, where practical and ethical challenges often hinder systematic, long-term follow-up.

The project also addresses the broader political and conceptual tensions identified by Prentki and Preston (2020, pp. 182-183), who advocate for work that reaches both those affected by harm and the individuals and structures with authority to shape policy, culture, and professional practice. Although *A Bitter Pill* is modest in scale, it has begun to engage groups positioned to influence change. The audience included frontline practitioners whose collective reflection can help reshape local safeguarding cultures, and several respondents reported a stronger commitment to questioning parental narratives, sharing concerns, and acting with greater curiosity. The involvement of the named safeguarding nurse responsible for the local FII policy extended the project's impact beyond the rehearsal room. Her participation in early development and rehearsals ensured the work intersected directly with policy formation. The production also attracted the interest of the NSPCC's Head of Local Campaigns, who has committed to supporting future expansion. These developments indicate that, while the intervention is focused and localised, it is embedded within professional networks capable of driving broader conversations and gradual structural change.

In summary, *A Bitter Pill* makes a meaningful contribution to the field. By modelling a dramaturgical approach that incorporates affective analysis and professional reflection, and by engaging practitioners and policy influencers, the project advances applied theatre's practical and conceptual impact on safeguarding. While current methodological limitations remain, the project demonstrates the value of targeted, relational work in driving real change. Future research should build on this foundation by strengthening longitudinal evidence, broadening evaluative methods, and deepening connections between artistic inquiry and the systems responsible for children's safety.

Concrete applications and dissemination

A Bitter Pill is already being applied in safeguarding and community settings, with plans for further expansion through ongoing partnerships. Early performances showed that participatory and affective engagement supports professional reflection, prompting several organisations to consider its use in continuing professional development (CPD). Safeguarding practitioners who attended highlighted its relevance to frontline decision-making and advocated for broader adoption.

Partnerships are central to the project's dissemination. The NSPCC's Head of Local Campaigns supports further expansion and highlights the play's ability to prompt meaningful conversations about FII. MIND contributed during early development, situating the work within broader mental health discussions. Arts Council England supported both artistic development and public engagement. These relationships provide a foundation for collaboration with safeguarding boards, healthcare teams, and educational institutions, extending the play's reach.

A Bitter Pill's participatory design is central to its effectiveness as a CPD resource. Early feedback indicates that imaginative framing, audience interaction, and improvised music help professionals engage with the material emotionally and ethically rather than merely as instruction. Participants found this approach more engaging than traditional training, enabling them to practise attentive decision-making in simulated safeguarding scenarios. The play supports deeper learning through affective experience, directly advancing CPD objectives.

Future development and evaluation

The next phase will focus on developing more rigorous evaluation methods and expanding *A Bitter Pill*'s reach. A key priority is gathering longitudinal evidence, addressing a significant gap in applied theatre research (Sevrain-Goideau et al., 2020, p. 6). Follow-up with practitioners several months after performances or workshops will help assess whether initial impacts lead to sustained changes in practice.

Following the pilot, I produced a tour pack, professional video, and support materials to broaden the project's reach. Some commercial theatres have expressed interest in hosting, and I plan to approach universities with social work programmes to integrate the performance and workshops into undergraduate safeguarding training. I will also seek additional Arts Council England funding to enable a wider tour. These steps will create a richer testing environment and strengthen the project's clarity and impact.

Closing reflection

A Bitter Pill was developed with a strong focus on ethical representation and emotional safety. Throughout research, rehearsal, and performance, I carefully considered the sensitive topic of fabricated or induced illness and its potential impact on audiences, particularly those in safeguarding roles. The play's format was designed to enable safe participation and foster emotional connection without overwhelming the audience.

The main limitation of the study is uncertainty about its sustained impact on frontline practice. This raises a key question for future work: does *A Bitter Pill* lead to lasting changes for safeguarding professionals? To address this, methods beyond self-reporting may be required to capture changes in confidence and decision-making while respecting professional sensitivities, which will be a central focus in the next stage.

A Bitter Pill establishes a foundation for new partnerships among theatre-makers, safeguarding agencies, educational institutions, and health programmes. Practitioners and policy leaders involved in the pilot demonstrate that creative work at this scale can enrich safeguarding discussions. As the project develops, it may foster broader dialogue and shared learning across these groups.

The project reaffirms that aesthetic considerations are central to the effectiveness of applied theatre. Audience responses show that learning arose not only from the information presented but also from the structure of the theatrical experience. Humour, interaction, and music acted as catalysts for reflection, creating a space for ethical awareness to be felt and understood. *A Bitter Pill* highlights the ongoing importance of aesthetic craft in applied theatre and its ability to generate reflective, emotionally resonant learning. Looking ahead, this work aims to foster broader partnerships and shape best practices, confirming the enduring transformative potential of theatre in safeguarding and professional development.

A Bitter Pill

Characters

Lucy
Mum
Dad

Lucy should be played by an adult, and Dad should be an exceptional pianist.

Staging

The set is made up of all of the things in Lucy's bedroom, including her bed, princess books, dressing table, model doll's head on the dressing table, a stack of giant Jenga, her art easel, pictures painted by Lucy, fairy lights and other general six-year-old girl bedroom decor. Later in the play, adaptations to the room could be subtly added, such as rails or a commode. Maybe walking sticks could be leant against the furniture.

Notes

As the audience enters, they are given a princess party bag with a slice of cake and a party popper inside. Verbal note on entry - they should hold on to the bags and not do anything with them until instructed to do so by the cast. Note, ensure that gluten-free/vegan / egg-free / nut-free options are considered.

When interacting with the audience, Lucy should feel able to move between improvisation and the script as appropriate. As a general rule, when improvising, keep to an upbeat and playful attitude.

The lighting should be able to cover the audience in a way that can put them in darkness or subtly bring them into Lucy's world at various points throughout the production.

Dad is on stage playing the keyboard whilst the audience enters.
He accompanies the entire show, using the music to represent Lucy's emotional state, altering the musical tonality according to how she is feeling at any given moment. It would be appropriate for him to embody the expression of the music whilst playing.
Lights change.
Lucy is on the stage dressed in a princess dress, wearing a tiara, and holding a magic wand. She welcomes the audience as they enter, gauging willingness to participate. She plays games, perhaps firing a magic spell at them and asking them "personal questions" like "what's your favourite colour?". When the majority of the audience are seated, she might play a game with an imaginary musical ball.

Lucy: Hi everyone - my name's Lucy, I'm six years old and I'm a princess.
Now for those of you who can't tell, I'm not really six.
I'm actually quite a bit older, so you're just going to have to use your imagination.
I am, however, a real life princess, like a real life princess.
And over there on the keyboard making all that noise is my dad.

Dad stands up and takes a bow.
This invites a round of applause from the audience.

Now, he's a bit of a bastard.
Yeah, he kinda abandoned me to go off to find himself and become a musician, or whatever..
To be fair, maybe that is a bit harsh. I mean, in the first few years of my life you weren't too bad were you.

Dad innocently shakes his head.

He'd turn up at my mum's house every now and then to kind of pretend to be a dad and he was alright, you know. Once he bought me this humongous teddy to compensate for not actually being there; it was quite sweet. When he popped in, he would always give me cuddles, and tell me I was his princess.

As she speaks about dad, she builds the imaginary character by adding layers of costume.

But, as soon as he was given the chance to play piano for a touring band he was gone. He travels around America in his van with his friends. He can play jazz music (*he plays*) or even scary music (*he*

plays), or anything really. *(To audience)* What do you think he should play? *(audience member answers, Lucy responds, Dad plays).* And what about you? *(audience member answers, Liucy responds, Dad plays).* And he wears this really cool sparkly top, because he's basically a rock star.

If I'm honest, sometimes I think I don't fully blame him. My mum did make it pretty difficult… He'd come round and try to take me out somewhere or ask mum if I could stay over at his new house, but she wouldn't let him. I suppose though, if he cared about me enough, he would have tried a little bit harder wouldn't he… Things were difficult but instead of fighting for me, he just gave up. So yeah, as I was saying, he's a bit of a bastard.

Now, I know what you're all thinking, he's right there so he can't be that absent. Well.. just like I'm not actually six-years old.. he's not actually even here.
Yes that's right, he's in my imagination.
And what I do is, as a six-year old girl, I often use my imagination to see my Dad..here in my room like he is now, playing his music.. only he's playing for me... His little princess.

Lucy takes off her princess dress and tiara, and puts the wand away.
She gets ready for Story Time and puts her backpack on.

So, every Saturday, my mum would usually sleep in until like midday. To be fair, she needed a lot of rest because she had a pretty tough job. She worked in a care home for some old people. My mum said she has to give them medicine when they're poorly, and bandage their skin up when it bleeds and basically just stuff like that. When she finally woke up, she would sometimes take me to the Story Time at the library.

I suppose that was the least she could do considering I missed so much time at school because of all my health problems. I absolutely loved Story Time! My friends there were really nice, and mum got to chat with the other adults, so it was a win-win really.

There was this lovely lady who worked there called Sue, she had all of these really cool books, and she'd read them to us, and she'd do all these different voices and everything, and it was really cool. And she'd show us pictures of the dragons and the princesses in the tower. I love Sue.
(*To audience member*) I'm going to ask you to be Sue; it's just I think you look amazing and these funky glasses would really suit you. (*Hand Sue a pair of funky glasses*). You look so good in those.

(*Pointing centre stage*)
All you need to do is just stand right there, that's it.

Hi Sue.

Sue: Hi.

Lucy: (*To audience*) Now as soon as I got to the library, Sue would always make time to ask me how my week has been.

Lucy looks at Sue, and waits for a response, visually encouraging her to repeat the statement. The piano could support this.

Sue: How has your week been?

Lucy: Well, Sue! Let me tell you. I've been too poorly to go to school this week, so I haven't seen any of my friends and they've probably just outright forgot about me, and my teacher has sent me this huge pack of homework to do. Honestly Sue, it's tough being a kid, do you know what I mean?

Sue: Yes.

Lucy: And then, after that, what Sue would do, oh, it was so exciting, she would get all of the children to sit on the magic carpet, which was just a mat really, but I love it.

Lucy sits on the floor and looks at Sue.

Are you ready for Story Time, Sue?

Sue: Yeah.

Lucy: Yes! Then what she would do is, she'd go pick up that book from over there.

Lucy indicates the book on her bedside table. Sue retrieves it.

Lucy: Yep, that's the one.

Sue should return to centre stage, if not, indicate that she should "come back over here".

And then, before she told us the name of the book, we'd all get really excited, and we'd make loads of noise like this.

Lucy starts stomping her feet on the floor, encouraging audience members to do the same.
When the audience joins in, Lucy says "ooooooo". She then stops, and gestures to Sue to announce the story.

Sue: Cinderella.

Lucy: Yess! I love princess stories, they are the best!
Right, then what she would do is, tell us all to shut up and listen.

Sue: Shut up and listen.

Lucy: Okay Sue, so we're gonna try that again, but a little less Miss Trunchbull and a little more Miss Honey. Okay.

Encourage Sue to try again.

Sue: Okay, quiet then, listen.

Lucy: Much better! Well done. So we're all sitting there cross legged, snotty nose, eyes wide, ready for this story and then, she would open the book… and read with her loudest and clearest narrator-voice.

Encourage Sue to do this.

Sue then reads the very short adapted introduction of the story which emphasises the horrendous upbringings of the princess. It finishes on a cliffhanger, when the wicked step-mother enters…

Lucy: And then, every week, before we even got half way through, mum was like…

Mum enters, Lucy visibly changes.

Mum: Right then Lucy, grab your stuff, we're going to have to get going now darling. Sorry Sue, apologies for interrupting, I've got to take Lucy to the doctors for her breathing again. Is that alright?

Sue: Yeah, that's fine.

Mum: Thanks love. It's her sleep apnea. I've seen it loads at work, it's awful. I've tried everything, I am absolutely exhausted, you know, doing everything on my own. Lucy, hurry up please, go get your bag. (To Sue) You know, she's in a world of her own, that one. Yeah, it's been quite scary; she's been choking in her sleep. You're probably going to have to have your tonsils taken out, aren't you Lucy. Right, come on then, let's go.

Mum leaves.

Lucy: Sue, you have been a star as always, and your storytelling gave me goosebumps! Give our Sue a big round of applause please!

Indicate to Sue that she can sit back down, possibly helping her back to her seat.

The thing is, this happened almost every week. I never quite got to the happy ending part of the story. It was always cut short because of an appointment for my allergies, my feet, or my ears, basically stuff like that…

At least I had a bit of good news when I got to the doctors. Mum made them do extra tests to check my breathing and they said that I am doing much better now, and that I don't even need my brown inhaler anymore.

Lucy: When we finally got back from the doctors, mum was a bit stressed because she said people don't listen to her, and that she knew what was better for me, or something like that. She sent me upstairs to get ready for bed.

Lucy puts her dressing gown on.
Mum enters with her dressing gown on and has a hair brush, glass of water and Lucy's medication with her. Mum sets the water and medication down on the dressing table.

Mum: Come on then Lucy, let's brush your hair.

Lucy sits in front of Mum on the bed.
Mum brushes Lucy's hair.

Mum: Well I hope you enjoyed yourself at Story Time today. I was chatting with some of the mums outside and they were asking about your birthday party and I said I'd have to get back to them when I knew what was happening with your doctor's appointment… So I'll have to give them all a call tomorrow to let them know that you're not well enough and it's going to have to be cancelled… Which is a shame really because I've already bought the decorations and the cake but never mind eh darling. I know you're disappointed, I get it, I was a poorly child, too. We'll still have fun though won't we. Oh and I spoke to your dad over the phone and he said he's really busy with his tour so he won't be able to come…

Dad looks baffled.
Lucy's hair is slightly knotted.

Mum: Lucy, what have you got in your hair? It's all knotted… Is that tomato sauce?

Mum finishes brushing Lucy's hair and pulls the hairs out from the brush.

Mum: Bloody hell girl, you're moulting. Your hair's going everywhere.

Mum puts the clump of hair in her dressing gown pocket.
She then prepares Lucy's inhaler and pills.

Mum: Okay then, jump into bed please.

Lucy climbs into bed.
Mum approaches with the pill bottles and a glass of water.
Lucy takes them routinely while mum is speaking.
Note: whenever pills are taken throughout the play, this should be mimed. Placebos or empty capsules etc. should not be used.

Mum: I know it's not what we had planned, but we'll have a nice day tomorrow for your birthday, just me and you. You're not at school and I'll get the day off work to look after you, and we can sit and stuff our faces with chocolate and watch a film. That'll be nice, won't it.

Mum places the brown inhaler with a spacer and mask on Lucy's face.
Mum puffs the inhaler three times and Lucy takes this routinely.

I posted an update to let everyone know that you're really not well. And, some of the mum's from school have sent you some Birthday presents for tomorrow. They've written some really lovely comments as well. Look at this one, what's her name, the one with pigtails, well her mum, she's said "Happy Birthday - hope you get well soon, princess!". That's nice isn't it. And, if you're a good girl, I might have a little surprise for you too.
Straight to sleep tonight please.

Mum blows Lucy a kiss.

Night night darling. See you in the morning.

Mum leaves.

Lucy jumps out of bed.

Lucy: I was fuming! No birthday party?! What's that all about?! Now, to be fair, I can't fully remember what the doctor was saying… you know, because I was six and I was quite distracted by this poster on the wall, and there was this man on it, with his skin peeling off like a monster. And you could see its veins, its bones and its eyeball.
But despite my imagination running wild, I'm, like, ninety-four percent certain that the doctor said I was fine. I mean I don't feel poorly but mum said it's best to be careful.

No party though? Pfft… Well I was determined to go to the ball.
I got up the next morning, mum was still asleep in bed, and I got into my princess dress.

Lucy takes off her dressing gown and puts on her princess dress and tiara.

I borrowed some of mum's lipstick.

Lucy applies some of mum's lipstick.

And I made my way downstairs. At this point, I am starving, ready for breakfast. Now, I'd usually just make myself a bowl of cereal but today was my birthday, and I just thought, cake made so much more sense.
I went to the fridge, got this huge cake out that my mum bought, and I cut it up for all my friends.

Lucy takes all of her teddies and dolls from her bed and places them in a semi-circle around her.

(*To the audience*) So you lot are all going to have to be my friends at this party. If you could all take a look in your princess party bag and grab your cake, but don't eat it yet because it's my party and I have to go first.

Lucy hands out three balloons to audience members on the front row.

Excuse me, would you mind blowing these up for me please?
You see, I'm not allowed to blow balloons up because my lungs aren't strong enough and it'll set off my asthma.
That's it, just blow them up!

Lucy puts on a birthday badge and shows it off while audience members blow up the balloons

Lucy: Now throw them at me! Thank you very much!

Lucy plays a game with the balloons

Lucy then takes an LED candle and places it into her cake.
She also picks up the empty lighter from the tray.

Lucy: So I was being a bit sneaky.. and I borrowed my mum's lighter from her bag. I know it's naughty but how can you make a wish without blowing out the candles.
(*To an audience member*) Excuse me, can you light this for me please?
I can't do it because I'm seven and I might burn myself.

Audience member tries to light the candle.
Lucy turns the LED candle on, thanking the audience member.
Lucy stands centre stage holding her cake and lit candle.

Lucy: And then, it was amazing, everyone at my party sang Happy Birthday to Lucy. Are you ready?

She encourages the audience to sing Happy Birthday to her.
Dad plays the accompanying music.

Lucy: Louder!

Lucy blows out her LED candle.

Lucy: Wow, that really was amazing! I think there were a few people over there doing some harmonies. Well done you.
Okay, *now* you can all eat the cake!

Lucy takes back the lighter from the audience member, and everyone eats cake.
Lucy is really enjoying hers.
The music shifts tone, Lucy starts to play musical statues. She's winning. Whilst she is dancing, cake flies everywhere. When the game is done, she brushes cake off her hands onto the floor.

Lucy: I am so good at this game. I always win… (*To Dad*) Aren't I good?

Dad smiles and nods.

Lucy: (*with her mouth full*) Oh and if you have another look in your princess bag, you should have a party popper.

Audience members continue eating cake and take out their party poppers.

Lucy: Take your poppers out and get them ready. We're going to try and make the biggest explosion by doing it at exactly the same time. Everyone aim it at me though because I'm the birthday girl. We're going to count down from three and go on go, ready, three, two, one, go!

The audience pop the poppers towards Lucy.

Lucy is visibly excited and starts clapping.
She then picks up her own popper.

Lucy: Wow, that was so cool! Did you ever do this as a kid? Cameron, one of the naughty boys in my class, showed me how to do it and I think it makes you look like you're smoking.

Lucy pops the party popper but then quickly sucks the smoke into her cheeks. She holds it for a moment and then lets the smoke out and is amazed at what she has done.
Mum enters; lights change.

Mum: What are you doing Lucy?! You're not supposed to be blowing up balloons, putting your lungs under all that pressure. You'll give yourself an asthma attack. And what's this? So, I've gone out, like an idiot, to get you some nice things and a cake for your birthday and you just smeared it all over the floor. What did you cut the cake with? (*Mum picks up the knife*) What if you hurt yourself Lucy? *(Mum puts the knife back on the tray)* What would you do then? And for fuck sake, is that my lighter? (*Mum takes the lighter off the tray.*)
I could not be more disappointed in you right now. Why are you always so naughty? Well done, you've ruined today and I don't even want to look at you. I suggest you get this mess cleaned up right now.

Mum leaves, taking the tray.

Lucy: So I think my mum's a little bit mad at me.

Over the following, Lucy finds a large bin bag for the mess.
Then she gets on her hands and knees with a dustpan and brush and a new bin bag, tidying up the cake crumbs and streamers.

I was just excited. I don't mean to be naughty. I just do things sometimes without really thinking about it. And I didn't even use the lighter, it was you (*points to audience member*). (*smiling*) You got me into trouble. And that, my friends, is the life of a princess. "Cinderella, you shall not go to the ball! Instead you will get on your hands and knees and scrub this house until it's spotless!"
I spent my seventh birthday quite alone. Cleaning up. No ball. I am Cinderella.

Lucy stands and disposes of the bin bags and dustpan and brush.

Lights change.

Lucy: A couple of weeks later, when mum said I was better, I was allowed to go back to school. It was great - I loved it. Running around going crazy at play time, getting my name on the rainbow reward chart, chocolate concrete and pink custard for pudding. It was brilliant.

So we had this teacher, right, and he was fantastic. He always used to wear a smart shirt and trousers. He was one of those teachers who was really strict, but really funny, *(to an audience member)* do you know what I mean. One minute, you'd all be laughing your head off, then the next, you'd be dead silent with fingers on lips because he just shouted at Cameron for saying a swear word.

(*To an audience member*) I'm going to ask you, sir, to be my class teacher. It's just that you look really smart, and you're giving me really cool teacher vibes.

The audience member joins Lucy on stage. Lucy claps and encourages the audience to join. She gives him a tie and asks him to put it on.

Okay, can you start by announcing your name to the class.

Teacher: Hello, my name is ___.

If they don't use their second name then Lucy could say "I'm not meant to know that, if you could use your second name?".

Teacher: Hello, my name is Mr ___.

Lucy: And then the whole class would say, good morning Mr ___.

Encourage the audience to join in.

Audience: Good morning Mr ___.

Lucy: (*To the Teacher*) Cool innit.
Mr ___ would teach us the most amazing things about Maths, Science, History and everything, but

my favourite lesson was Art!

Lucy drags her art easel across to the Teacher with several paints and a paintbrush.
Lucy turns the easel so it's facing away from the audience and they cannot see the paper.

I always remember this one time he taught us how to do a self-portrait.
And he would begin the lesson by demonstrating exactly how to do it.
You have one minute Mr___, enjoy! Off you go!

The Teacher begins to paint a self-portrait.

Mr ___ was such a fun teacher. He had all sorts of little quirks. Like, he used to take his shoes off when he was teaching, and at Christmas time he wore a bright coloured tie with Rudolf on it, and when he pressed the button, it would play a Christmas tune. It was great.

This one time, he had to put my name on the board, which basically meant that you were in trouble. He shouted to the class (*Lucy puts finger on lips*) fingers on lips, but I didn't hear him and just carried on talking to my best friend. So then I was in a bit of trouble, but it was only that one time because I just loved his lessons so much.

How are you getting on Mr ___? You've got about ten more seconds.

Oh and one time, he brought his pet guinea pig into school, she was called Sally, and we were allowed to feed her and pick her up, and now guinea pigs are like one of my favourite animals. In fact, when I'm older, I would quite like to be a vet.

Right Mr ___, your time is up I'm afraid. Now, if you'd like to turn it around and show us what you've done.

Mr ___ turns the easel around so the audience can see.

Well, it's very erm… wonderful, Mr___.

Lucy then improvises a response to the picture, something like, "I love how your head is the same size as your arms".

Would you like to see the one I did?

Teacher: Yes, sure.

Lucy: Here it is.

Lucy reveals her picture of herself as a vet, bandaging up a guinea pig.
It has clearly been painted by a seven-year-old.

Lucy: That's me as a vet and that's Sally in a bandage, can you tell?

Teacher: Yes.

Lucy: And then, he would say exactly what he liked about it, because he was very inspirational like that.

Teacher responds and Lucy improvises her reply.

He was so knowledgeable about art and he'd tell us things like.. how to make the colour purple? (*Encourage him to respond*).

The Teacher replies.

And he'd tell us - who his favourite expressionist painter was. (*Encourage him to respond*).

If the teacher replies confidently, Lucy looks impressed and possibly digs a little further through improvisation. Then the bell for break sounds.
If he is struggling to answer the question, the school bell should ring.

Lucy: Right, that bell means it's break time.
Thanks for being the best teacher Mr ___.
High five!
Can we have a huge round of applause please!

Audience applauds and Lucy indicates that the Teacher should return to his seat.

I was propper buzzing after that class! Felt like I could take on the world! So, I ran outside, bounced off a couple of walls, dived in and out of a few bushes around the field like you do, and then, bang, I ran straight into Cameron, head first, because I wasn't looking where I was going. The problem is, as I hit the floor, I landed funny and twisted my leg. I heard this popping sound and I was in agony, crying my eyes out. I didn't even care that everyone was watching, it was the most pain I'd ever been in. My mum had to leave work to take me to the hospital and I had to have an x-ray and everything. They said I had quite a bad sprain and that I needed to be much more careful.

Mum, wearing her care uniform, enters pushing a clunky wheelchair. She is furious.

Mum: I am sick of this school. Every week it's something new, she's banged her head, grazed her knee; she comes home with scratches on her arms from the other kids. I'm telling you now, it's not good enough.

Lucy: So yeah, mum was a little bit mad. She charged into the school and demanded to speak to Mr ___.

Mum: (*To Mr* ___) Well what I want to know is, what are you going to do about it? I should not be made to feel like my daughter is not safe at this school. It's supposed to be an environment where she comes to learn, not break her bloody leg. You know she's got a medical condition, so you should be looking out for her. If you don't do something about it, I'll be taking her out of this shit hole and I'll be sending a letter to the council. She'd be better off home schooled. Look at this.

Mum shows a printed image of an x-ray of a broken leg.

This is the x-ray from the hospital. Look at it. Her bones have snapped; she's seven. And I'm surprised she doesn't have a concussion! She's in agony. They've had to put her on painkillers, and she's going to be in this thing for at least six weeks. I don't want her doing anything that's going to make things worse. I'm telling you now, if she comes home one more time, with so much as a scratch on her, I'll have you out of a job. And I tell you what, I'll be going to the papers with this, you'll be all over social media, and don't think I won't be taking legal action. Sort your school out.

While Lucy is saying the following, mum places a moon boot on her leg.

Lucy: Ever since that point, I wasn't allowed to go to choir because of my breathing. No more PE or sports day. I wasn't allowed to go on any trips and I couldn't even go to the school disco.

Lucy goes over to the bed and stuffs a pillow under the duvet so it looks like she's in there. She then moves downstage.

Lucy: So that's me, fast asleep in my bed. At about two o'clock in the morning, my mum came into my room to check on me.

Mum enters carefully. She observes Lucy.

She'd had a few glasses of wine but she was very careful not to wake me. And she just stared at me for a moment and listened for my breathing.
Then she took out her phone.

Mum takes out her phone which creates an uplighting effect on her face.
Mum proceeds to enact the following statement.
Lucy looks directly into the audience - her face reveals an emotional journey.

She set a timer and placed it on my bedside table. She then climbed on top of me, placing her knees either side of my little body, pinning me under the duvet. I was obviously very dazed and confused, I didn't know what was happening. She then took a pillow and forcefully pressed it against my eyes, nose and mouth. With the precision of a surgeon, she completely blocked my airways and I couldn't breathe. Whilst she was suffocating me, her gaze was fixated on the timer that she'd set. She knew exactly how long it would take for me to stop breathing but not quite die. And then, after that time had passed, she stood, and paused for just a moment, and she then began to resuscitate me. She'd had CPR training at work, so she knew how to do this.

Mum becomes emotional whilst she is resuscitating Lucy.

Mum: Come on then baby, wake up, wake up please. It's okay I'm here, come on, come on wake up then beautiful. Lucy, can you hear me darling?

Lucy gasps for air and mum stops.

Lucy: And with that gasp of air, my mum stopped, and began sobbing.

Mum: My beautiful girl, you just stopped breathing. I had to save you darling. Mummy had to save you didn't she? Don't worry, I'm going to call for an ambulance, okay.

Mum stands, takes her phone, and dials for an ambulance.
Mum leaves.

Lucy: So, the ambulance arrived and took me to hospital. I had all sorts of tests and scans. Mum said I had a hy-pox-ic seizure because of my sleep apnea. I then had to have an operation, where they had to put me to sleep, which was very scary. Mum told me that they had to put a camera down my throat and the whole thing was a nightmare. They didn't even find anything and I had a really bad reaction to the medicine. But mum said it's good that they listened this time and they've given me some new tablets to stop me from having seizures.

I told you I was a princess. Sleeping Beauty was cursed into a slumber and kept isolated from the world to keep her safe. I am Sleeping Beauty.

Lights change.

Lucy goes over to her dressing table and starts putting on her princess jewellery.

Lucy: Because mum was spending loads of time at home looking after me, her boss at the care home was getting pretty mad at her. After a bit of an argument over the phone, they put mum on a final warning and basically said she isn't allowed any more time off or else she'll get sacked. The thing is, sometimes they'd get her to do really long shifts, like nine to five, and that didn't really agree with my mum. It made her stressed out because she was always tired. She'd start shouting about the tiniest things, like, "where did you put your school uniform, you're going to be late".. I didn't know, I was seven. I came home from school and threw it somewhere. I had important things to do.

So, to help her out a little bit, she employed a childminder, someone to pick me up from school and basically just look after me if mum was working late.

His name was Gary, and he was quite young, I think he'd just finished college; it might have even been his first job, I'm not sure. But I tell you what though, we had so much fun!

Over the following, Lucy scoots the wheelchair around the space, and then spins and sits in it.

He'd whizz me around in my wheelchair super fast until I was dizzy, and one time we made wet tissue balls and threw them at the patio door to see if they'd stick.. They did, it was great. We played all sorts of games.

(*To audience member*) I'm going to ask you to be Gary, it's just that you look super fun and very friendly.

Lucy holds out a leather jacket for Gary to wear and claps, encouraging the audience to join.

Now all you have to do is stand right there. Yep, there, that's it.

Just a heads up, I think my mum fancies you a bit. Now I'm not saying it's why she hired you.. but it probably helped.
So, before me and Gary would go off on one of our adventures, he had a couple of chores to do.
First, he had to make sure that I took my medication.
They're just in that drawer over there, Gary.

Lucy encourages the audience member to fetch the medication.

Gary really was the coolest childminder. He'd let me boss him around like I was in charge but he loved it really. Didn't you Gary?

Gary: Yeah.

Lucy: Are you managing?

Gary: Yeah, I think so.

Gary returns with two pill bottles without labels on them.
If he doesn't instinctively bring the glass of water, Lucy could say something like "did you bring the water?".

Lucy: Oh good… Now which one am I supposed to have?

Gary: Errm.

Lucy: Don't look at me, I don't know, I'm seven! *(or, if he responds unexpectedly, 'I hope you're right Gary, because I don't know - I'm only seven')*
Pause
I'm just winding you up, I need two from each please.

As the bottles are empty, if Gary says something like, "they're empty", then Lucy could reply with something like, "you're going to have to use your imagination Gary; I don't really want to be high on meds when I'm performing".
Lucy opens her mouth wide.
Gary feeds her the pills and Lucy takes them with water.

(*Referring to the boot*) This is really tight Gary, my leg's hurting. Can you loosen it for me, please?

He does.

Thank you.
Then, Gary's next job was to tidy my entire bedroom, from top to bottom…

Lucy pauses and stares at Gary.

Only joking, Gazza!
I'm going to be nice to you and let you skip that one for today.
However… I am going to challenge you to a game of Jenga!
Are you any good?

Gary: I'm alright.

Lucy: Awesome, could you just whizz me around so I'm a bit closer to the tower.

Gary wheels Lucy round, Lucy waits until she nears the tower.

Woah Gary, careful! Don't knock it over because that wouldn't be very entertaining watching you set it all back up again.

Gary wheels Lucy round to the Jenga tower

Right, I'll go first because I'm the princess and you're the loyal peasant. Okay, here we go.

Lucy takes the first block and carefully places it on the top with ease.

Then, Gary would say something about how awesome I am at Jenga.

Gary: You are awesome at Jenga.

Lucy: Don't give me none of that sweet talk Gary, it's not going to work. This is serious. Right, your turn.

Gary starts to make his move.

Make sure you don't knock it over on your first go or you'll ruin the entire play.

Gary takes his first piece and places it on top.

That's it Gary, don't go easy on the seven year old.
Here we go.

Lucy takes another piece and places it on top.

Did you see that level of skill.. Did you see that.. Your turn.

Gary starts to make his move.

When concentrating, he'd pull this face like he was having a poo.

Gary takes his second piece and places it on top.

(*clapping*) Well done you! My turn.

Lucy nonchalantly gets out of her wheelchair looking for the next best piece to take. She moves

around to the back of the tower and starts to take a piece out.
If, prior to this moment, the tower falls, Lucy can get out of her wheelchair cheering in victory or wallowing in defeat and could then start picking up the pieces instead.

Mum enters.
Lucy pulls a piece low down in the tower to make it fall away from Gary, jolting as Mum speaks.

Mum: Get yourself back in that wheelchair right now!

Lucy darts back into her wheelchair.

Mum: (*To Gary*) I gave you this job, and brought you in to help me, Gary. I'm working all these hours, I'm juggling everything as a single mum. The least you could do is follow simple instructions, and just do as I've asked. I trusted you to look after my daughter and you have her running around as soon as my back's turned. She's got a broken leg, Gary. Look.

Mum gives Gary the image of the x-ray from earlier.

Look at that. If she has any pressure on it, it might not heal properly. She could be in a wheelchair for the rest of her life if she doesn't take this time to properly recover. I hope you've at least given her her tablets. I honestly feel betrayed… Look, I don't think this is working out. You won't be looking after Lucy anymore.

Mum leaves the stage in frustration.

Lucy: Yeah, so Gary, I think mum is a bit mad that you let me out of my wheelchair.
My mum might not like you but I still think you're ace.
Can we have a huge round of applause for our Gary please.

Lucy indicates that Gary should take his seat. He should keep the image of the x-ray.
Lucy stands up out of the wheelchair, then walks forward.

Poor Gary - I really liked having him look after me. He genuinely cared and always tried really hard to make me smile and we had lots of fun. The thing is, I can actually walk fine, but I daren't tell my mum.

Mum printed the picture of my x-ray to show everyone how bad it was. But it doesn't hurt or anything. And my mum only gets stressed out if I'm standing up around other people.

Lucy puts on her dressing gown and sits on the front of her bed.

My mum started having these little outbursts more frequently. And I get it, she's exhausted. Obviously I can't say anything to her about it. At seven years old I don't quite have the strength to ask her to calm down, but I wish I did.

Lights change.

Mum enters the stage wearing her dressing gown; she has Lucy's hairbrush in her hand.

Mum: Right then Lucy, time to get ready for bed.

Mum sits behind Lucy and starts brushing her hair.

I just wanted to say, I might come across a bit strict sometimes but I want you to know that, the reason I'm stressed and angry is because I don't want people to think that I don't look after you properly; we don't want social services to come and take you away, do we? No matter how much I shout, I do love you very much and I am so proud of you. Don't forget that mummy works really hard at the care home and it's not easy. There's a lot of pressure on mummy to make sure everyone there is looked after, and sometimes that means I forget to look after myself.

Mum puts down the hairbrush and takes out two large clumps of hair, held in each hand.
Mum retrieves the brown inhaler with a spacer and mask and places it on Lucy's face. Mum puffs the inhaler three times and Lucy takes this routinely.

Okay darling listen, I've been a bit worried about something for a while now but please don't get upset because, I promise you, everything will be absolutely fine.
I've noticed that some of your hair is falling out darling. Look…

Mum shows Lucy the clumps of hair.

I think you have something called alopecia. And what that is, it's just when something strange happens to you, it can sometimes make your hair start to fall out very quickly. Do you understand? I think it's probably a reaction to the anaesthesia that you had to have for your bronchoscopy. Do you remember? That can happen sometimes, so don't worry because we can fix it, I'm trained to care for people, I'll look after you. I've got some medicine that will help. So, what we are going to do is, start taking these tablets, but we will also have to shave your hair, because when it starts to come out on its own, it goes patchy. So some bits will be really long and other bits won't have any hair at all, and you don't want to look silly do you. If we shave it all off, we can make it look smart and I can get you a really nice hat can't I… I know you don't want to darling, but we have to.

Mum retrieves her pills, including the new medication from work.

Here you go.

Mum then gives Lucy two pills from multiple bottles, and she swallows each with water.

Good girl. And if we keep taking these every day, it'll make you better won't it. And then all of your hair will grow back.

Lights change.
Lucy stands and moves downstage.
Mum retrieves a cordless shaver and places it on the bed.

Mum takes Lucy's model head from her dressing table and moves it over to the front of the bed.
Mum starts to shave the model head.

Lucy: These new tablets were not very nice.
I felt hot, everywhere.
She sat me at the bottom of the bed.
And she shaved all my hair off.

Lucy looks directly into the audience - her face reveals a deep emotional pain.
She takes out a child's bobble hat and puts it on, tucking all of her hair into it.
Mum stops shaving. The model head is completely hairless.

Then she took a photo of me for social media.

Mum takes a photo of the model head on her phone.
She then moves round behind the model head, wrapping an arm around her neck. She then smiles, and takes a selfie with the model head.

She said that she could use the pictures for a Just Giving page to raise some money for my care.

Mum then takes the bald model head back over to the dressing table and puts it down.

Then, she tucked me into bed, said, "goodnight Lucy, love you"… and left.

Mum leaves.

Lucy then goes over to the hair left on the bed and picks it up.

This is one of the worst things about being a princess; all of the hardship that you have to go through. But it's your dream to be just like Rapunzel, isn't it. To be locked away in a tower, and have your hair cut off. I am Rapunzel.

Lucy leans her elbows onto her bed with her face in her hands.
She appears to be in some discomfort.

Lucy: For what felt like weeks, I was kept at home, in this room. Why didn't anyone look for me? Taking a handful of pills four times a day. They made me feel blistering hot; my skin itched from the inside. I had hives flare up and a rash all down my neck. And I just thought, I wonder if my dad would come to see me.

Lights change
Dad stops playing. He stands, takes off the sparkly jacket, and takes one step towards Lucy.

Lucy: I miss you.

Dad: I miss you too.

Lucy: I wish you were here… Like actually here with me… I don't feel very well dad.

Dad: I know princess.

Lucy: When are you coming home?

Dad: Soon darling.

Lucy: No you're not.

Pause

Lucy: Why did you leave me?

Pause

Will you tuck me into bed please?

Pause - he doesn't.
She looks directly into the audience - her face reveals a deep emotional pain.
Dad goes back over to the keyboard and sits.

Will you play me a song?
Just for me.

Dad plays.
Lights change.

Lucy: Fever, pulse, exhaustion, seizure. After a few months, I'd been fed so many pills that my little body just couldn't handle it anymore. I was entirely alone; in this tower. And just like Snow White, who ate the juicy red apple laced in poison, I too was given a lethal dose disguised as a remedy. I am Snow White. I am a real life princess.

Lights change.
Lucy stands, takes the dressing gown off, and walks forward.

It's hard to imagine how someone could bring a little girl into this world, and wish for her to be terminally ill. To lie so obsessively about her health; to overfeed her salt, or inject her with faeces to make her sick. So sick that she needs the drugs, and the operations, all to satisfy a deep urge to be seen as the world's best mum.
I know it doesn't happen very often but when it does, it's a child's life that is broken.
I needed someone to recognise my mother's pretence. I needed someone to help me, friends, family, anyone.
You all saw how aggressive she was, parading it as care, and you fell for it. Why didn't you speak to me?
(*Directed towards Sue*) That little voice in the back of your head, telling you something's not right, you've got to listen to that, and do something about it; call social services, call the police.
(*Directed towards Mr ___*) You were the best teacher I ever had and I thought you were brilliant but why didn't you speak to safeguarding or anyone. You really let me down.
(*Directed towards Gary*) It was your job to look after me, and you fed me pills from a bottle without a label on it. Why?
I needed someone to be my voice, I needed all of you to be my voice at a time when I didn't have one; I was seven years old.

Lights change.
The actor removes the hat.
Bow.

It might be appropriate to hold a Q&A to discuss the play and to share up-to-date research and local agency contact details.

The Art of Dissociation: Staging Dissociative Identity Disorder through Post-Dramatic Ambiguity

Introduction

The Art of Dissociation originated from interviews for *A Bitter Pill*, where professionals emphasised that caregiver behaviour in cases of Fabricated or Induced Illness constitutes abuse. This prompted questions about how practitioners distinguish genuine from feigned behaviour and whether similar diagnostic ambiguities arise elsewhere in clinical practice. These inquiries led to the case of Billy Milligan and the broader, contested field of Dissociative Identity Disorder (DID), a condition marked by distinct identity states and significant memory disruption. Divergent professional opinions highlight the challenge of differentiating authentic dissociation from malingering. My teaching experience reinforced these concerns, as students often referenced DID knowledge from TikTok and YouTube, frequently accepting online self-diagnoses without recognising the risk of misrepresentation. If clinicians struggle to distinguish genuine from fabricated cases, this raises concerns about how uncritical engagement with social media may influence younger audiences' understanding.

The project's early development focused on three main areas: reviewing clinical and theoretical work on DID and malingering, analysing high-profile cases and online representations, and testing ideas through rehearsal, including diagnostic role-play with a psychoanalyst. These activities shaped both the methodology and aims. The primary objectives were to examine interpretation and judgement processes in DID, highlighting how ambiguity functions in clinical, public, and theatrical contexts. Support from MIND and Arts Council England enabled research and development, culminating in the October 2022 performance at Hull Truck Theatre, where the central questions and objectives were first presented to an audience.

Artistically, I aimed to develop a theatrical language that reflects the diagnostic challenge of distinguishing genuine dissociation from malingering. The play operates within what Hans-Thies Lehmann (2013, p. 100) calls the 'grey zone' between the aesthetic and the non-aesthetic, blending actor and character to mirror the difficulty of discerning authentic dissociation from performance. Post-dramatic strategies, including frequent shifts between actor and character, created deliberate narrative instability that echoed fragmented identity. Trauma theory, particularly Van der Kolk's (2014) work on how trauma is embodied, informed a series of theatrical metaphors. This approach supported a dramaturgy of fragmentation, directly linking the play's aesthetic strategies to trauma's disruptive effects on identity, perception, and embodied experience.

Pedagogically, the project was informed by an interest in Interpretive Phenomenological Analysis (IPA) to understand how audiences engage with and interpret the performance. This emphasis on

precise interpretation aligned with the play's exploration of diagnostic ambiguity, providing audiences with a framework for examining how they interpret behaviour and assign meaning. This approach created a parallel between theatrical spectatorship and the clinical diagnostic gaze, encouraging audiences to recognise the limits of their interpretive certainty when faced with contested presentations of identity and trauma.

The Art of Dissociation aimed to create a theatrical environment in which audiences could practice interpretive and diagnostic reasoning, similar to Interpretive Phenomenological Analysis. The main objective was to help both professional and general audiences attend closely to behavioural cues and ambiguity, using the performance to develop critical interpretive skills. The project specifically encouraged younger viewers to scrutinise DID-themed online content and question the authenticity of digital personas. More broadly, it sought to prompt public reflection on the risks of uncritical acceptance of contested psychiatric categories and to examine how trauma narratives can be stylised or commodified, potentially distorting psychological and ethical complexities.

This applied focus shaped the interdisciplinary context for *The Art of Dissociation*, positioning theatre as a tool for continuing professional development by providing practitioners with a reflective space to rehearse diagnostic sensitivity without clinical pressures. The play also aimed to enhance community engagement by encouraging audiences to develop critical awareness of how psychological conditions, especially DID, circulate in digital culture and to foster empathy for those who have experienced trauma. Early audience feedback indicated that the play's deliberate ambiguity prompted significant reflection, with many noting the discomfort and uncertainty of not knowing whether behaviours were authentic or feigned. As one viewer remarked, it was 'a fantastic, thought-provoking, gritty piece of theatre that blurred the lines between what is real and what is acting'. Another observed that the piece 'poses more questions than perhaps it is able to answer', reflecting the intended unsettled interpretive space. Individual feedback echoed this, with several viewers highlighting the interpretive demands placed on them. One audience member wrote that they were 'definitely doubting my own knowledge of what I had consumed about DID', while another commented that the work appeared 'very "real"', underscoring the oscillation between authenticity and performance the play sought to explore.

To advance this aim, *The Art of Dissociation* used aesthetic choices that made uncertainty central to the audience's emotional and interpretive experience. The work explored an aesthetic/non-aesthetic continuum, using shifts between character performance and the actor's presence to create deliberate instability. This approach was extended through post-dramatic devices such as sudden changes in register, metatheatrical acknowledgements, and intertextual references to Hamlet. Trauma theory further influenced the dramaturgical design, shaping the use of physical theatre, testimonial monologues, and puppetry as metaphors for dissociation and self-fragmentation. These elements created a dramaturgical texture that mirrored the challenge of distinguishing genuine dissociation

from feigned presentation, aligning the aesthetic form with the interpretive demands placed on the audience.

The Art of Dissociation sits at the intersection of applied theatre practice, contemporary trauma discourse, and debates about malingering and the interpretation of psychological symptoms. The project was designed as a critical invitation, encouraging audiences to reflect on contested behaviours and recognise the limits of their diagnostic certainty. While the play aimed to prompt greater critical awareness among professional and younger audiences, the current draft did not fully achieve these goals. Its aesthetic strategies fostered ambiguity and reflection but did not position audiences as clearly or confidently as intended regarding the applied questions. These limitations and their implications for the play's development and framing within applied theatre will be discussed in later sections of this chapter.

Methodology

I developed *The Art of Dissociation* in three stages. First, I reviewed literature on dissociative identity disorder, malingering, and trauma theory to understand scholarly debates and risks of misrepresentation. Next, I examined high-profile cases and social media depictions of DID to assess how public portrayals shape cultural narratives and audience expectations. Finally, I applied these insights in rehearsal, using dramaturgy and role-play to stage ambiguity and encourage audiences to engage critically with shifting identities. Each stage informed the play's dramaturgical framework and my goal of fostering critical engagement.

My literature review analysed clinical writings on dissociative identity disorder (DID), trauma, malingering, postdramatic theory, and embodiment. This research established a foundation in diagnostic disagreements about DID and highlighted ethical risks in staging contested mental health conditions, particularly the potential to reinforce stereotypes or sensationalism. Recognising the challenges of diagnosing DID, I made ambiguity a central dramaturgical principle and not just a stylistic choice. I adopted postdramatic strategies to enable uncertainty without misrepresentation. The review clarified my aim for the project: to place audiences in moments of interpretive uncertainty, encouraging them to critically reflect on the limits of understanding another's mental state rather than instructing them about DID.

In the second stage, I examined high-profile DID cases, such as Billy Milligan, and analysed social media where individuals display dissociative identities on TikTok and YouTube. I studied how these narratives are structured, how identity shifts are presented, and how performances circulate online as both testimony and consumable media. My analysis revealed that digital culture often blurs self-expression, entertainment, and simulation, particularly when visibility and monetisation influence content. I also observed that many diagnosed with DID pursue artistic careers, especially painting,

highlighting a connection between dissociation and creative expression in the play. These findings shaped the play's focus on authenticity and supported my aim to foster critical media literacy among audiences frequently exposed to DID through algorithm-driven content.

The rehearsal period provided a practical testing ground for postdramatic devices, actor/character blending, and shifts between aesthetic and non-aesthetic registers. I designed a key role-play session with a psychoanalyst experienced in treating DID, who adopted different diagnostic perspectives to model the interpretive pressures of assessment and to explore how dissociative or simulated states might manifest physically. This phase allowed us to experiment with physicality, voice, and transitions between states to ethically stage fragmentation, avoid sensationalism, and encourage audience interpretation. These investigations clarified which moments produced productive ambiguity and which required more precise framing, helping me shape a dramaturgy where uncertainty supported analytical engagement. The process also informed my applied aim of fostering an IPA-like attentiveness to detail and context, encouraging audiences to evaluate and reflect rather than simply accept or reject what they observed.

A key limitation of my methodology is that I did not consistently consult healthcare professionals during the early writing phase. Unlike *A Bitter Pill*, where practitioner insight directly shaped the identification of need and the development of applied aims, I initially relied on my own literature review rather than practitioner-defined priorities. Earlier, more comprehensive conversations would have clarified immediate professional needs and likely influenced both the dramaturgical composition and the applied objectives. While I later arranged a valuable role-play session with the psychoanalyst, I recognise that more structured, ongoing engagement with clinicians or experts would have provided a stronger foundation for the project's applied elements.

Despite these limitations, my methodological approach aligns with practice-as-research principles, using dramaturgical experimentation as a mode of enquiry. By combining theoretical research, cultural analysis, and embodied rehearsal, I investigated the ethical and interpretive challenges of representing DID on stage. This multi-layered methodology supported the development of a dramaturgical framework that examines blurred boundaries between genuine and simulated identity and explores how audiences might engage critically with these complexities.

Dissociative identity disorder, malingering, and digital representations

The Art of Dissociation centres on the psychological, clinical, and cultural debates surrounding dissociative identity disorder (DID). The play's ethical and dramaturgical approach aims to represent DID's complexities without reinforcing stereotypes. Integrating artistic expression with mental health discourse, the production prioritises accuracy and sensitivity. Given ongoing disagreements about DID's diagnosis and validity, the play directly addresses these debates. This overview references

clinical texts, documented DID cases, and YouTube accounts to inform the play's contextual and ethical framework.

Dissociative identity disorder, previously known as multiple personality disorder until its renaming in the DSM-III in 1980, is characterised by the presence of two or more distinct personality states and recurring episodes of amnesia (Pietkiewicz et al., 2021; DSM-5, 2013). Each personality state possesses unique traits such as self-awareness, personal history, and even a distinct name, reflecting the disorder's complexity (Renzo et al., 2022, p. 2). Additionally, disruptions in identity can lead to significant changes in behaviour, memory, and perception, often accompanied by emotional and cognitive alterations (DSM-5, 2013). The condition is widely understood as a result of dissociative defence mechanisms developed to cope with overwhelming trauma during childhood. These mechanisms function as a survival strategy, enabling children to mentally detach when consciously processing extreme experiences becomes too overwhelming, often in response to severe abuse or neglect (Renzo et al., 2022, p. 2). This inability to bear such experiences generates significant anxiety, which dissociative defences mitigate by creating a psychological escape, allowing individuals to continue functioning through unbearable situations (Kalsched, 2021b, 13:11-14:10). Diagnosing DID is challenging, as its manifestations vary widely among individuals. Symptoms such as flashbacks, vivid sensory reliving of traumatic events that disrupt current reality, and distinct episodes of amnesia, including gaps in memory for personal history, are common but not uniform (DSM-5, 2013). Adding to this complexity, the diagnostic frameworks provided by ICD-10, ICD-11, and DSM-5 offer no specific guidelines to help differentiate between patients with personality disorders and those with dissociative disorders based on the way symptoms are reported (Pietkiewicz et al., 2021). Research on prevalence estimates a range of 1.1%-1.5% of the population (Renzo et al., 2022, p. 2). However, the precise prevalence of DID remains the subject of ongoing debate and varies across global health organisations, influenced by factors such as research methodologies and diagnostic criteria (Pietkiewicz et al., 2021).

Feigned dissociative identity disorder refers to the deliberate simulation or exaggeration of symptoms associated with DID, often motivated by external gains such as financial compensation, legal advantages, or the desire to assume the identity of a patient (Renzo et al., 2022, p. 2; Pietkiewicz et al., 2021). Some individuals have planned future careers around their diagnosis, such as writing books, pursuing academic roles, or creating films, often seeing the diagnosis as an opportunity to attract attention (Pietkiewicz et al., 2021). Pietkiewicz et al. (2021), drawing on the work of Boon and Draijer, note key behavioural distinctions between genuine and feigned dissociative identity disorder, highlighting that genuine patients often feel ashamed and reluctant to discuss their symptoms, while imitators tend to present eagerly and sometimes exaggerate their issues to convince clinicians. Simulators frequently recount their history chronologically and coherently, even when distressed or

portraying an altered personality, and are typically comfortable disclosing experiences of abuse (Pietkiewicz et al., 2021). Those who feign DID often adopt traits from cultural, media, and medical portrayals, such as paranoia, delusions, and antisocial behaviours, whereas genuine DID patients report symptoms tied to trauma, depression, fearfulness, family conflict, and self-destructiveness (Renzo et al., 2022, pp. 2-3, p. 9). Pietkiewicz et al. (2021), referencing Boon and Draijer, noted the rise of individuals self-diagnosing based on information from literature and the internet. These individuals often presented symptoms 'by the book' during assessments. This trend persists today, with individuals accessing books, videos, and websites to learn specialist terminology and core symptoms to express 'multiple personalities' during evaluations (Pietkiewicz et al., 2021). Popular media, including platforms like YouTube, Hollywood productions, blogs, and personal testimonies, frequently depict DID in dramatic and atypical ways, influencing how individuals perceive and potentially understand the disorder (Pietkiewicz et al., 2021). Such portrayals can lead to false-positive diagnoses, potentially reinforcing damaging behaviours.

The diagnostic challenges of differentiating genuine from feigned dissociative identity disorder are exacerbated by inconsistencies in clinical guidelines, practice, and limited research into effective methods for detecting malingering in DID cases (Brand et al., 2006, p. 63). Pietkiewicz et al. (2021) further emphasise that the ICD-10, ICD-11, and DSM-5 lack clear diagnostic guidelines for dissociative identity disorder, making it particularly difficult to differentiate genuine cases from imitated or false-positive ones. Numan Gharaibeh (2009, pp. 30-31) emphasises the importance of maintaining informed scepticism when diagnosing DID, highlighting this as central to best practices in clinical diagnoses. He cites a 1999 U.S. survey of psychiatrists, where 21% affirmed strong evidence for DID's scientific validity, 43% expressed scepticism, and 15% advocated for its exclusion from the DSM (p. 30). Pietkiewicz et al. (2021) acknowledge these varying perspectives, noting that some experts view DID as an exceptionally rare condition or even a 'trend'. Additionally, they point out inconsistencies in data reported by leading organisations such as the World Health Organisation and the International Society for the Study of Trauma and Dissociation, underscoring the challenges of achieving consensus on this diagnosis. Renzo et al. (2022, pp. 1-2), Brand et al. (2006, p. 63), and Pietkiewicz et al. (2021) argue that while progress has been made in developing tools to distinguish genuine DID cases from feigned ones, significant challenges remain. Research indicates that skilled and motivated individuals can successfully manipulate tests like the Structured Interview of Reported Symptoms (SIRS) to simulate psychological symptoms, underscoring the ongoing difficulty specialists face in achieving reliable and consistent diagnoses (Renzo et al., 2022, p. 2; Brand et al., 2006, pp. 63-64).

As highlighted by Gharaibeh (2009, p. 36), the potential for professional malpractice includes conflicts of interest where clinicians may exploit diagnostic ambiguities for personal financial or

reputational gain. Nathan (2012) provides a compelling example in the case of Dr Cornelia Wilbur and Shirley Mason (Sybil). Wilbur allegedly manipulated Mason into adopting symptoms of DID for professional benefits, bypassing scientific publication to pursue a mass-market book deal (Retro Reports, 2014, 5:00-5:11). The resulting book, released in 1973, sold over six million copies and was adapted into a 1976 TV movie watched by nearly one-fifth of the U.S. population (Nathan, 2012, 1:05-1:29). Pietkiewicz et al. (2021) also underscore how clinicians can influence patients, noting cases where doctors encouraged patients to research DID symptoms independently. Nathan (2012, 13:24-14:19) claims that Wilbur followed this practice by recommending that Mason read *The Dissociation of a Personality*, effectively providing a guide for mimicking symptoms.

High-profile DID cases and DID artists

High-profile cases of dissociative identity disorder have significantly influenced public understanding, often through media, legal cases, or artistic works. For example, Chris Costner Sizemore's experiences inspired *The Three Faces of Eve* (1957), but the film reduced her more than twenty personalities to three, which Weber (2016) and Brozan (1989) describe as a misleading simplification. Sizemore's psychiatrist, Thigpen, was later criticised by Ross for ethical breaches and possible exploitation (Weber, 2016). Other cases highlight legal complexities. Mark Peterson's conviction for sexual assault was overturned after the complainant stated that an alternate personality, six-year-old Emily, had emerged during intercourse, raising important questions about consent and responsibility in DID cases (Imrie, 1990; Grimminck, 2015). Earlier examples, such as Louis Vivet, show a longstanding medical interest in dissociation. Vivet developed the condition after a traumatic encounter with a snake and reportedly manifested up to ten personality states (Exploring Your Mind, 2018). More recent public figures include Robert Oxnam, whose memoir *A Fractured Mind* (Weber, 2005) describes the emergence of multiple identities during therapy, and Billy Milligan, whose 1970s case sparked debate after his acquittal by reason of insanity when psychiatrists identified twenty-four personalities (Keyes, 1994; Watson, 1978; Associated Press, 2014). Similarly, Shirley Mason's story in *Sybil* (1976) has been questioned for its authenticity after Mason admitted to embellishing symptoms under her psychiatrist's influence, leading to broader debates about clinical conduct and the cultural shaping of DID (Nathan, 2012a; Nearly, 2011).

A recurring pattern in these cases is the development of artistic careers or public profiles after diagnosis. Billy Milligan pursued film production, founding A Stormy Life Productions in California, though the company closed without releasing any projects (Top 5 Unknowns, 2018, 10:08-10:30). Chris Sizemore became a successful figurative painter and author, publishing *A Mind of My Own* (1989) and reflecting positively on her later life (Weber, 2016; Brozan, 1989). Christine Pattillo started a jewellery business and gave public talks to educate others about DID (USA Today, 2014, 6:10-6:19). Judy Castelli found healing and creative expression through singing, sculpture, and

stained glass. She nearly signed with a record label, later headlined an off-Broadway production, and went on to teach art to others with mental health challenges (Grimminck, 2015). Truddi Chase gained national recognition through her memoir, *When Rabbit Howls* (1987), a subsequent television adaptation, *The Voices Within: The Lives of Truddi Chase* (1990), and an appearance on *The Oprah Winfrey Show* (Oprah, 1990). Kim Noble, diagnosed with post-traumatic stress disorder after severe childhood trauma, has produced a large body of visual art, with each "alt" contributing a distinct style. As artist-in-residence at Springfield University Hospital, she has exhibited widely and shares her work online (Ross, 2017; Independent, 2006; Noble, Our Work).

As these examples show, DID is often viewed through public visibility, authorship, and creative output. The frequent memoir writing, artistic production, and media engagement among those diagnosed with DID highlight a complex relationship between diagnosis, creativity, and socioeconomic opportunity. This pattern informed *The Art of Dissociation*'s investigation into how DID serves as a point where clinical labels, individual agency, and cultural production intersect.

YouTube: identity, authorship, and commercialisation

Drawing on the diagnostic, clinical, and high-profile case material discussed earlier, this section examines YouTube as a space where personal testimony and crafted personas often intersect, and where performing vulnerability can lead to financial gain. These observations align with my initial reflections on malingering and performative self-presentation. Many DID-themed channels combine lived experience with curated storytelling, often resulting in economic benefit. The platform provides a useful perspective for considering how a theatrical work might explore the tension between authenticity and performance in online representations of DID.

YouTube is a platform where identity performance and monetisation converge. As Lavender (2016, p. 120) notes, it enables individuals to present both themselves and curated versions of themselves, blurring the line between the personal and the performed. YouTube functions simultaneously as an archive, a marketing tool, and a testimonial space, producing videos that appear unmediated yet are in fact shaped by subtle edits that increase audience engagement (p. 122). The result is a highly intimate mode of spectatorship in which creators cultivate a 'doubling' self, a persona that is private yet public, actual yet virtual (pp. 122-123). This curated intimacy plays a central role in audience-building, and, as Lavender explains, fame on the platform grows through repeated visibility and sustained interaction (p. 129), establishing YouTube as a significant cultural space for self-performance and promotion.

For those seeking information or validation regarding a diagnosis, YouTube acts as both an educational resource and a model for self-presentation. Pietkiewicz et al. (2021) observe that many individuals study online DID content to better understand the condition or to see how others present their symptoms. Actor James McAvoy also used these videos to prepare for his role in *Split*, drawing

on them to inform his portrayal (Today, 2017, 3:40-3:56). This demonstrates how online material has become a cultural template for representing DID. Many videos that appear unmediated are intentionally constructed, shaped by scripted elements, staging, and stylisation (Lavender, 2016, pp. 122-123). The platform's flexibility allows creators to mix rehearsed and spontaneous moments, which deepens audience engagement (p. 28). Deliberate choices, such as wardrobe changes and expressions of gratitude, further enhance relatability (pp. 130-131).

The commercial strategies used by DID-themed channels further highlight the intersection of identity and commercialisation. For example, DissociaDID (2018a) has 1.15 million subscribers, and their videos regularly attract hundreds of thousands of views. Viewers are encouraged to shop at their store or purchase artwork, indicating a well-developed business model. Their Ko-fi page (DissociaDID, N.D.) promotes a 'Secret Project' for trauma survivors, using intrigue to encourage fundraising and inviting viewers to 'buy a coffee' in support. These approaches demonstrate how personal testimony can generate commercial opportunities.

A closer analysis of their videos reveals the aesthetic and editorial decisions that shape their presentation. The DissociaDID (2021) video begins with a stylised title sequence featuring falling shards of glass or mirror (00:00-00:12), establishing a dramatic tone. Frequent edits, such as a noticeable frame jump (00:37-00:38), highlight the intentional production process. At one point, the creator appears to experience a dissociative episode, interrupting their speech. While other sections are edited for clarity, this moment is retained, foregrounding trauma symptoms as key points of engagement. Later, the addition of the text 'still dissociating' (2:01-2:03) and the introduction of 'Jade Gatekeeper / F / Protector' (2:20) further frame these shifts as significant narrative events. These choices illustrate how identity transitions are selected and emphasised, encouraging viewers to perceive these moments as authentic within a carefully constructed digital narrative.

The commercial aspect is even more pronounced in DissociaDID (2024). The video opens with an advertisement and includes clickbait-style prompts almost every minute, directing viewers to playlists and merchandise. Mentions of new makeup content (7:29) and artwork for sale (7:42-7:49) create additional revenue streams. The Patreon page (2018b) offers subscription tiers from £1 to £85 per month for exclusive content, including artwork, speed drawings, and voting rights for future projects. The creator also solicits donations to support ongoing legal cases (DissociaDID, 2024, 7:53-9:33). These elements demonstrate a deliberate integration of personal narrative, performance, and commercial strategy, highlighting the platform's ability to monetise personal disclosure.

These insights directly informed the dramaturgical framing of *The Art of Dissociation*. Observing how creators navigate the boundaries between testimony and performance strengthened my interest in structuring the play around interpretive ambiguity and the shifting relationship between authenticity

and construction. The protagonist's engagement with an artistic medium, and the imagined reach of that work beyond therapeutic or private contexts, reflects the dynamics of online self-presentation on YouTube. The case study also highlighted how economic incentives can influence the portrayal of trauma, prompting deeper reflection on motivation. In future revisions, I plan to include scenes where the protagonist interacts directly with their YouTube channel, creating moments where creativity and aspiration meet. Through this approach, the play encourages audiences to critically consider digital depictions of mental illness and the ways online platforms create both opportunities and pressures that blur the line between self-expression and performed identity.

Insights from clinical literature, high-profile DID cases, and YouTube analyses shaped both the dramaturgical framing and applied focus of *The Art of Dissociation*. The contested nature of DID diagnosis and the challenges of detecting malingering highlighted the need to stage ambiguity as an ethical necessity, reflecting the interpretive difficulties clinicians face. Professional disagreements and diagnostic uncertainty informed the play's approach, leading to a dramaturgy that emphasises doubt and critical reflection. Patterns in public cases and digital portrayals of DID, especially the overlap of identity performance with artistic or financial gain, further influenced the exploration of motivation. These sources shaped the play's applied aims by stressing the importance of critical media literacy and inviting audiences to consider how authenticity is constructed and how trauma can be stylised or commodified online. While the play addresses health-related topics, it serves as a reflective tool rather than a clinical authority, encouraging audiences to question representation, motivation, and interpretation without making diagnostic claims.

Theoretical framework: trauma theory, postdramatic techniques, and interpretive phenomenological analysis

This section outlines the theoretical framework for *The Art of Dissociation*, focusing on its dramaturgical and applied objectives. Unlike *A Bitter Pill*, which centred on empathy, this case study highlights ambiguity, interpretation, and diagnostic uncertainty to reflect the complexities of dissociation, trauma, and potential malingering. It draws on trauma theory, postdramatic theory, and Interpretive Phenomenological Analysis (IPA) to establish the conceptual basis for the play's dramaturgical strategies and to position interpretation as its primary concern.

Trauma theory and dissociation

Trauma theory provides a key foundation for understanding the psychological conditions explored in *The Art of Dissociation*, especially how overwhelming experiences can fragment memory, identity, and perception. Gabor Maté (in Benazzo & Benazzo, 2021a, 03:38-04:02) highlights a growing mental health crisis, marked by increased anxiety, depression, and addiction. Van der Kolk (2014, p. 348) identifies societal factors such as poverty, unemployment, and inadequate housing as catalysts

for trauma. According to Maté (2021b, p. 1; 2021c, 00:54-01:08), trauma is a psychic wound that disrupts personal growth and disconnects individuals from their authentic selves when they cannot process threatening events. This disruption often leads to defensive responses, including emotional numbing or heightened anxiety (Van der Kolk, 2014, p. 3; Maté in B. & B., 2021b, p. 2). Developmental trauma is especially harmful. Adverse childhood experiences hinder nervous system maturation and impair cognitive, social, and emotional development (B. & B., 2021b, p. 4). Van der Kolk (2014, pp. 53, 66) explains that when children are overwhelmed, their brains may continue to signal danger long after the event, resulting in stress responses and behavioural patterns that persist into adulthood. Doty (in B. & B., 2021a, 04:44-04:57) notes that these children often become withdrawn or impulsive, carrying unresolved burdens into later life. Manifestations such as hyperarousal, emotional numbing, and reactive behaviour are neurobiological responses to distress, not moral failings (Van der Kolk, 2014, p. 3).

Understanding dissociation is central to this framework, as it explains how trauma can disrupt and compartmentalise consciousness. Dissociation serves as a survival mechanism, allowing individuals to detach from overwhelming experiences (Kalsched, 2021a, 11:37-12:11). Van der Kolk (2014, p. 66) notes that dissociation fragments traumatic memories, isolating sensations, thoughts, and emotions into disjointed episodes that may resurface unpredictably. For some, dissociation creates a protective 'alternative reality' that feels authentic because it shields survivors from intense pain or shame (Kalsched, 2021a, 40:48-43:20). In its most extreme form, dissociation can develop into dissociative identity disorder, where parts of the self become compartmentalised and operate outside conscious awareness. Van der Kolk illustrates this through cases where traumatised children mentally detach from their bodies and observe abuse as if it were happening to someone else (2014, pp. 131-132). While this strategy supports short-term survival, it can later destabilise a coherent sense of self and hinder emotional integration, consistent with depersonalisation as a dissociative response (p. 71). Dissociation can also block self-reflection, leading to destructive behaviours as individuals externalise unresolved internal conflicts (Kalsched, 2021a, 23:46-24:04; Van der Kolk, 2014, p. 348). Healing requires safe, supportive conditions where repressed or dissociated experiences can be acknowledged and gradually integrated, enabling individuals to reclaim fragmented aspects of the self and rebuild connections with others (Van der Kolk, 2014, p. 26; Kalsched, 2021a, 18:18-20:08; 20:56-21:08).

These accounts of trauma and dissociation form the foundation for *The Art of Dissociation*. Theories that emphasise fragmentation and rupture, rather than coherence, best represent the behaviours and internal dynamics depicted in the play. By adopting a dramaturgy of discontinuity, the play aligns its artistic strategies and central argument with contemporary trauma theory, prioritising interpretation over explanation.

Postdramatic theatre and the aesthetic/non-aesthetic continuum

Postdramatic theory provides a useful framework for examining how theatrical form stages doubt and ambiguity, both central to *The Art of Dissociation*. Lehmann distinguishes between the aesthetic sphere, representing the fictional world of performance, and the non-aesthetic sphere, representing the tangible reality shared by performers and audiences (2013, pp. 98-100). He describes the overlap as a 'grey zone' where the real intrudes into the aesthetic, creating perceptual ambiguity (p. 100). Lehmann argues that these moments, when reality produces a shock, are essential for challenging audience perceptions and fostering critical awareness (p. 98).

Theatre's ability to sustain ambiguity is well established. McConachie (2008, p. 40) notes that performances often merge the aesthetic and non-aesthetic through metaphor and embodied action, prompting spectators to navigate multiple interpretive frames. States (1985, p. 36) observes that while onstage actions are absorbed into the aesthetic field, some elements resist full integration. For example, an animal's spontaneous behaviour can disrupt the illusion and remind spectators of material reality. Tomlin's account of God in Ruins (in Aragay et al., 2021, pp. 93-95), where an actor disguised as an unhoused man disrupted the performance, shows how such interventions can quickly shift audiences between shock and reflection as they reconsider the event. These examples demonstrate how postdramatic form unsettles habitual perception by allowing the real and the fictional to coexist in an unstable relationship.

This instability also shapes the relationship between actor and character. Theatrical performance relies on the audience's ability to shift between seeing the performer as a real person and as a fictional role. States (in Mirodan, 2018, p. 154) describes characters as both present and absent, rooted in the actor's body yet situated within a fictional narrative. McConachie (2008, pp. 42-45; 2013, p. 26) notes that spectators navigate this doubleness by rapidly shifting attention between the actor's identity and the character's world. Lavender (2016, pp. 108-109, 118-119) defines persona as a liminal construct mediating between self and character, blending authenticity and theatricality for the audience. Mermikides (2020, p. 90) observes that acting destabilises the relationship between the performer's body, self, and character, allowing multiple identities to coexist in performance. These perspectives position performance along a continuum from the non-aesthetic presence of the actor to the fully immersed character, with persona operating in between. The audience's awareness of these shifts is central to creating theatrical meaning and ambiguity.

Conceptual blending theory explains the cognitive basis of theatrical doubleness. Mirodan (2018, p. 155), drawing on Fauconnier and Turner, describes how spectators combine the 'mental spaces' of actor and character to create a new blended identity. McConachie (2008, pp. 40-45; 2013, pp. 22-26) similarly argues that audiences integrate selected elements of the performer and the role, suppressing

irrelevant information to experience a coherent actor/character. States (1985, pp. 168-169) adds that psychophysical reactions, such as blushing, show how the performer's real body can reinforce this blend and heighten the tension between presence and representation.

These aspects of postdramatic theory show how theatre can use the slippage within the aesthetic and non-aesthetic continuum. They offer a conceptual basis for understanding how techniques such as interruption, actor/character blending, and metatheatrical acknowledgement can reflect diagnostic uncertainty and make interpretation an active part of the audience's experience.

Interpretive phenomenological analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is the central conceptual framework for *The Art of Dissociation*, shaping both the play's approach and the interpretive engagement it seeks from audiences. IPA is a qualitative methodology that analyses lived experience in small samples to reveal how individuals make sense of specific events (Tuffour, 2017, p. 1). Drawing from phenomenological and hermeneutic traditions, it clarifies the meanings people assign to their experiences through description, exploration, and interpretation (pp. 2-3). By focusing on specific cases and combining attentive listening, contextual awareness, and reflective interpretation, IPA articulates how experience is understood (pp. 2-4). This interpretive focus informs Suzy Willson's arts-based medical training, where 'the development of skills used by artists, such as those of detailed observation and interpretation… was considered to be transferable to clinical practice for application in, for instance, medical diagnostics' (de la Croix et al., 2011, p. 1094). *The Art of Dissociation*'s dramaturgical design also uses ambiguity to encourage audiences to question their perceptions. Perry et al. (2011, p. 142) show that exposure to the arts can strengthen diagnostic observation, supporting the value of interpretive training. Through IPA, the play models and rehearses interpretive engagement, bridging clinical, artistic, and educational aims.

This methodological approach closely parallels clinical work on dissociation and DID. Pietkiewicz et al. (2021) observe that clinicians assessing possible DID must carefully consider how patients present their symptoms, histories, and affective states, and note that IPA provides a structured framework for interpreting these presentations. Like IPA researchers, clinicians must listen for nuance, identify inconsistencies or omissions, and remain aware of how social, cultural, and historical factors influence communication (Tuffour, 2017, pp. 2-3).

A core concept in IPA is the double hermeneutic, where the researcher interprets participants who are themselves interpreting their experiences (Tuffour, 2017, p. 4). This dynamic parallels the play's exploration of malingering and diagnostic uncertainty. The protagonist's accounts of trauma and dissociation may be influenced by prior narratives, online templates, or strategic self-presentation, while audiences interpret these accounts through their own expectations and knowledge. The ethics of

IPA, which combine open-mindedness with awareness of preconceptions (pp. 2-4), align with the principle of informed scepticism in clinical discussions of DID and malingering. Instead of asking spectators to judge the protagonist's authenticity, the play encourages careful observation and interpretation, reflecting the discipline of IPA.

Intersection of trauma, postdramatic form, and IPA

Trauma theory forms the conceptual foundation of the play by showing how overwhelming experiences can fracture memory, identity, and perception. This establishes the psychological context for the protagonist's instability and highlights the challenge of discerning intention in behaviours shaped by dissociation. Postdramatic theory provides the formal structure for staging this instability, using ambiguity and shifts between aesthetic and non-aesthetic modes to resist linear meaning and create an environment of ongoing uncertainty. Interpretive Phenomenological Analysis offers the interpretive stance needed to engage with this ambiguity, emphasising close observation, contextual reading of behaviour, and recognition of assumptions. This approach echoes clinical practice and encourages audiences to approach the protagonist's shifting states with informed scepticism. The alignment with interpretive and embodied attention also reflects Suzy Willson's *Performing Medicine* programme, which uses multidisciplinary arts to develop awareness, sensitivity, and reflective judgement in healthcare professionals (Willson, 2014, pp. 31-37). Together, these frameworks create a dramaturgy focused on interpretation rather than explanation: trauma theory shapes the content, postdramatic form structures ambiguity, and IPA guides audience engagement. Their synthesis positions *The Art of Dissociation* as a work that rehearses critical attention to uncertainty rather than seeking resolution.

Dramaturgical strategies

The dramaturgical approach to *The Art of Dissociation* is informed by trauma theory, debates on DID and malingering, and postdramatic concepts of theatrical slippage. These strategies intentionally stage ambiguity, requiring spectators to interpret shifting behaviours and identities. This section details these methods, starting with trauma and dissociation aesthetics, then examining techniques that highlight actor and character blending, postdramatic ambiguity, and double readings. Together, these approaches translate the project's conceptual vision into practical theatrical methods and situate the work within applied theatre.

Trauma and dissociation aesthetics

The production uses metaphors and aesthetic strategies to externalise trauma and dissociation. The puppet-puppeteer relationship serves as a visual example, guided by the script's instruction that 'the puppet should be operated without concealing … intentionality' (AoD script, p. 151). Van der Kolk

(2014, pp. 131-132) describes dissociation as a severing of the self, where survivors may feel detached from their bodies or observe themselves externally. Kalsched (2021a, 11:37-12:45) also highlights dissociation's ability to partition the psyche. The puppet reflects this by acting both as an extension of and as separate from the protagonist. McConachie (2008, pp. 83-84) explains that human intentionality animates objects, allowing audiences to perceive 'life' through movement and visual cues, and notes that performers must integrate objects into their gestures for this effect (p. 87). Haughton (2018, p. 66) observes that objects on stage gain symbolic meaning through embodied interaction. Together, the actor and puppet create a dual image of the internalised self and its dissociated fragment, offering a metaphor for dissociation without literal re-enactment.

Testimonial monologues reinforce this visual metaphor by exploring trauma through witnessing and disclosure, as highlighted when Laura states, 'Thank you for listening to me. Listening makes it a bit easier, some of the time' (AoD Script, p. 133). Walsh (2012, pp. 49-53) describes the dramatic monologue as both a 'talking cure' and 'listening cure,' emphasising the therapeutic value of narration and reception. Duggan (2018, p. 14) notes that first-person testimony increases authenticity by positioning the audience as a witness. These dramaturgical choices align with psychological trauma theory, which holds that narrating traumatic experiences is essential to healing (Van der Kolk, 2014, pp. 24, 134; Harpin, 2018, p. 2). Haughton (2018, p. 24) highlights the ethical responsibility in witnessing trauma, noting that witnesses must confront the dynamics between victim and perpetrator and adopt a moral stance. In the play, monologues transform trauma symptoms into narrative, encouraging audiences to engage thoughtfully with the protagonist's disclosures and consider their interpretive responsibilities.

Physical theatre sequences build on these strategies by translating clinical insights about traumatic memory into embodied performance. The script instructs that 'a physical theatre sequence ensues with movements that represent violence. It is important that the movement is symbolic, rather than literal. The percussive sound increases in volume as the struggle proceeds' (AoD Script, p. 132). Van der Kolk (2014, pp. 43-45) explains that trauma engages the right hemisphere of the brain, which processes sensory, emotional, and nonverbal experiences, and that traumatic memories are stored as fragmented images, sounds, and sensations without a coherent narrative (p. 135). The staging uses symbolic movement to evoke the disorientation and embodied nature of trauma. Haughton (2018, p. 3) links these qualities of live performance to trauma, arguing that theatre's immediacy and potential for disorientation mirror how trauma is encoded. This approach allows physical theatre to represent trauma affectively, enabling audiences to engage with its psychological impact without graphic depiction.

These dramaturgical devices create a performance environment where trauma and dissociation are experienced through metaphor and embodied movement rather than explicit demonstration. The puppet externalises fragmentation, monologues present testimony as a relational act of witnessing, and physical theatre evokes the sensory embodiment of traumatic memory. Together, they encourage audiences to reflect on the play's broader themes of dissociation and ambiguity.

Strategic ambiguity between actor, persona, and character

The script's instruction to use the actor's real name for the protagonist, 'should be referred to using the actor's name who is playing this role. In the script, this will be indicated using [Name]' (AoD Script, p. 105), immediately blurs the line between self and role, prompting spectators to see the performer as both person and character. This approach draws on conceptual blending (McConachie, 2008, pp. 42-45), persona as a mediating construct (Lavender, 2016, pp. 108-109), and the coexistence of multiple identities in performance (Mermikides, 2020, p. 90). The play develops these ideas by having the performer speak candidly as themselves, then shift into character or persona, as in the line 'she's right, it's true, however, [Name], not me [Name] but the character [Name]' (AoD Script, p. 107). This deliberate ambiguity is a central dramaturgical tool, prompting spectators to consider multiple interpretations at once.

Multi-roling acts as a deliberate dramaturgical counterpoint to the protagonist's unstable presentation. Early in the script, the performer states, 'I'll be playing Laura, but I will also be multi-roling as well. So, for those of you who don't know what multi-roling is, it's basically…' (AoD Script, p. 107), establishing the device as intentional and controlled before later ambiguities arise. McConachie (2013, p. 64) notes that multi-roling encourages spectators to reflect on how identity is constructed and perceived in performance. In the play, one actor shifts rapidly and distinctly between several roles, providing a controlled contrast to the protagonist's uncertain transitions. This contrast highlights the diagnostic ambiguity central to DID. Renzo et al. (2022, p. 2) note that involuntary identity shifts are key to the diagnosis, while Pietkiewicz et al. (2021) show that individuals feigning symptoms may use clinical literature to create convincing presentations. The protagonist's use of medical vocabulary and familiarity with diagnostic discourse, reinforced by his possession of *The Psychology of the Actor* (AoD Script, p. 118), further blurs the line between symptom and simulation. His fluency in terms such as 'MMPI tests and the Malingering Index,' (AoD Script, p. 144) suggests expertise in both clinical and theatrical frameworks. These elements prompt spectators to consider not only what they are witnessing but also how they interpret it, encouraging them to question the reliability of observable behaviour and to reflect on the boundary between deliberate performance and involuntary dissociative experience.

Parallels with Shakespeare's *Hamlet* provide a dramaturgical lens for examining whether the protagonist's behaviour is performed or genuine. Hamlet's decision to 'put an antic disposition on' (Shakespeare, 1603, 1.5:171-172) raises the enduring question of feigned versus authentic madness, which resonates in debates about DID and malingering. This parallel is reinforced when the protagonist coaches another character in producing convincing emotional expression, urging, 'just to use your voice in a different way, like sell it to me' (AoD Script, p. 127). This moment mirrors Hamlet's instruction to the players in Act III, Scene II, highlighting the protagonist's sophisticated understanding of performance and suggesting that his own dissociative presentations may be consciously crafted. Clinical research supports this ambiguity: Brand et al. (2006, pp. 63-64) and Renzo et al. (2022, p. 2) note that motivated actors can simulate DID symptoms with considerable accuracy, complicating professional judgement. The audience is thus invited to question whether the protagonist's shifts reflect involuntary dissociation or deliberate display, deepening the play's exploration of authenticity, deception, and interpretive uncertainty.

These dramaturgical strategies create a performance environment where identity remains unsettled. The interplay between actor, persona, and character highlights the instability underlying dissociation and allows for the possibility of deception, leaving spectators to navigate competing interpretations. This dynamic supports de la Croix et al.'s (2011, p. 1094) view that nuanced interpretation relies on attention to subtle physical and emotional cues, and aligns with Lavender's (2016, p. 115) claim that contemporary performance often occupies an 'apparently-actual' register that blends fabrication with authenticity. By spanning the aesthetic and non-aesthetic continuum, these devices encourage spectators to remain vigilant and navigate this uncertainty.

Strategic slippage between aesthetic and non-aesthetic spheres

A key strategy in *The Art of Dissociation* is the intentional rupture of the theatrical frame, exemplified when 'The director emerges from the audience, approaches Laura, uses her real name, and consoles her.' (AoD Script, p. 132), intervening as the actor appears to cry. Because this intervention seems spontaneous, spectators must determine whether the distress is genuine, performed, or a blend of both. Lehmann's concept of the theatrical 'grey zone' (2013, p. 100) clarifies this effect, noting that reality intruding on fiction creates perceptual uncertainty and sharpens attention. Here, the director addresses the performer by their real name while remaining outside the fictional world, yet the moment is still integrated into the dramaturgy. This deliberate ambiguity blurs the line between aesthetic and non-aesthetic spheres, prompting audiences to question what they witness and reconsider their interpretive assumptions.

The jagged, dome-like chicken wire structure (AoD script, p. 106) serves as a scenographic anchor that disrupts the boundary between theatrical illusion and material reality. As a mutable backdrop, it

shifts meaning throughout the performance. Paintings suspended on the wire transform the structure into various locations, while its exposed mesh reveals the theatre's actual architecture. This layering of façade and reality reflects the principle of double reading, encouraging audiences to consider both the constructed world and the material conditions of performance. Its incomplete, skeletal form carries metaphorical weight: it mirrors the protagonist's identity as an artist, resembling an unfinished sculpture, and evokes the defensive psychic enclosures described by Kalsched (2021a, 7:30-8:19; 40:48-43:20), which trauma survivors use to contain overwhelming experiences. Bouchard and Mermikides (2024, p. 8) show how spatial design reveals psychological dynamics, while Haughton (2018, p. 26) observes that scenography can frame trauma by shaping perception and emotion. The chicken wire structure thus embodies productive ambiguity, functioning as both an artistic and metaphorical element while exposing the real, drawing spectators into a continual oscillation between representation and material conditions.

Displaying the protagonist's artwork in the foyer (AoD script, p. 158) extends the performance into the audience's real-world environment by relocating an object created within the fiction. Visitors encounter pieces signed in the actor/character's name, prompting hesitation about whether they belong to the play's world or the theatre's reality. This approach draws on McConachie's concept of conceptual blending (2008, p. 28), as spectators shift between viewing the artwork as a narrative prop and as a tangible artefact outside the fictional frame. Haughton (2018, p. 66) notes that objects gain symbolic meaning through direct engagement, and the foyer display leverages this by encouraging audiences to reconsider the artwork's significance outside the theatrical context. By reframing fictional artefacts as real-world exhibits, the production intensifies the slippage between aesthetic and non-aesthetic spheres, inviting questions about authenticity, authorship, and the protagonist's creative identity.

These dramaturgical devices intentionally blur the line between the aesthetic and the non-aesthetic, encouraging spectators to shift between the fictional world and their own environment. By challenging assumptions about what is performance and what is real, the production requires audiences to interpret rather than passively receive. This ambiguity supports the play's focus on dissociation and authenticity, prompting reflection on how meaning is constructed. It also advances the work's applied goals: professional spectators are invited to practise attentive, interpretive skills linked to IPA and diagnostic engagement in complex cases. Younger audiences are encouraged to develop critical awareness of how trauma and illness are performed and shared online, fostering a more reflective understanding of these displays. The play thus serves as both an artistic exploration of ambiguity and a rehearsal of the interpretive skills needed to navigate complex presentations of DID.

Post-performance research design

Post-performance data for *The Art of Dissociation* were collected through an online questionnaire accessed via a QR code in the programme. Participation was voluntary and anonymous. Responses were gathered immediately after the performance to capture audience reactions while the play's impact was still fresh. The questionnaire used open-ended prompts to encourage reflection on interpretive processes, such as perceptions of authenticity, experiences of uncertainty, and responses to the actor/character dynamic. It aimed to measure specific applied theatre outcomes, including whether spectators adopted an IPA-like interpretive stance, how they processed ambiguity, and whether dramaturgical strategies promoted critical awareness of DID and trauma portrayals. While the design provided valuable insights, the scope and phrasing of the questions limited the depth of responses. More targeted prompts could have yielded greater detail on interpretive reasoning and media literacy.

The study was designed for a mixed audience to examine how varying expertise and experience influenced interpretive engagement. Including mental health practitioners provided a comparison for understanding how clinical training affects responses to the play's ambiguity and diagnostic themes. Theatre practitioners and students were also considered, as their familiarity with performance conventions could shape their interpretation of dramaturgical strategies. The questionnaire collected basic demographic data, including age, to explore how younger spectators engage with portrayals of DID found online. General spectators without clinical or theatrical backgrounds were included to reflect the project's dual focus on applied-theatrical inquiry and public engagement. However, the sampling was limited to a single performance with voluntary participation, resulting in a self-selected rather than representative audience.

The open-ended questions explored how spectators navigated the play's ambiguity and whether they engaged in interpretive reasoning aligned with the project's aims. Questions about whether the protagonist genuinely had DID or was feigning symptoms encouraged respondents to articulate their diagnostic assumptions and reflect on the uncertainty created by the actor/character dynamic. Prompts about sympathy for different characters provided insight into how audiences balanced empathy and suspicion, a key concern in staging contested conditions. Mental health and care professionals were asked if the performance prompted reflection on their practice, allowing the study to assess whether the dramaturgy encouraged applied enquiry. Additional questions about new learning and overall impressions offered broader perspectives on how the work influenced understanding and engagement.

The methodology had several limitations affecting the interpretation of findings. Data were collected from a single performance, resulting in a small and demographically narrow sample. The immediate post-show format captured only initial impressions, not long-term interpretive changes. Technical issues, such as unreliable Wi-Fi, further reduced participation and limited response diversity. The

questionnaire lacked pre-performance items, preventing comparative analysis of perception shifts, and its phrasing limited insight into interpretive processes. Without longitudinal follow-up, the study cannot assess lasting diagnostic sensitivity or media scepticism. Limited early engagement with healthcare professionals meant the applied needs tested were shaped more by theory than by practitioner priorities, reducing the data's relevance to clinical contexts.

Results and findings from audience feedback

The Art of Dissociation premiered at Hull Truck Theatre in the Godber Studio on 21 October 2022, with support from Arts Council England and Hull City Grants to Arts. The performance drew 127 attendees, and 31 completed the post-show questionnaire (see Appendix C), though Wi-Fi issues at the venue likely reduced this number. Respondents came from diverse backgrounds, including 9 from the theatre or performance industry and 6 from medical, care, mental health, or psychology fields. This demographic mix suggests the performance reached a varied audience aligned with the play's applied goals. The questionnaire assessed whether the production provided a reflective space that encouraged critical engagement with the interpretive ambiguities of DID and malingering. The following analysis draws on audience responses to examine how the work influenced emotional reactions, interpretive engagement, and feedback on the dramaturgical strategies tested during this research-and-development performance.

Emotional impact and empathic response

Audience feedback shows the performance generated a strong emotional response, with several spectators describing it as 'intense, powerful, [and] emotional'. One viewer noted the piece 'brought out a lot of emotions'. Many responses highlighted the performance's emotional credibility, with one describing it as 'believable, very thought provoking'. Several expressed sympathy for 'both' protagonists, indicating a willingness to consider each character's experience rather than adopt a single moral or diagnostic perspective. One audience member wrote that the play 'captured the essence of developing empathy for both sides and the importance of humility and humanity', showing that spectators maintained interpretive openness even with challenging material. These reactions suggest the emotional intensity engaged viewers more deeply with the characters' psychological landscapes, supporting the play's objectives.

For some spectators, emotional resonance was closely linked to reflective engagement. One respondent described the experience as 'very emotional and hard hitting for personal reason and work reason', noting that it evoked both personal memories and professional insights. This viewer also valued that the production 'gave space for the audience to process after the show had finished', recognising the need for reflection to integrate emotional and cognitive responses. Other feedback showed that strong emotions did not prevent analysis. One audience member said they were 'doubting

[their] own knowledge of what [they] had consumed about DID', indicating that emotional impact prompted reconsideration of prior beliefs. Emotional immersion thus supported interpretive engagement, enabling spectators to reflect on their responses and consider the ambiguities of the protagonist's behaviour. In this way, emotional engagement enhanced the interpretive aims of the piece, fostering a balance of feeling and analysis.

Interpreting the ambiguous 'real' in performance

Audience responses often highlighted the challenge of discerning what felt 'real' in the performance, indicating active interpretation rather than passive viewing. One spectator described it as 'very 'real'', while another called it 'a fantastic, thought provoking, gritty piece of theatre that blurred the lines between what is real and what is acting'. The most detailed feedback emphasised authenticity, with one audience member writing, 'Everything about the piece was done with such authenticity that each character was believable. They were real people, not characatures and I bought every person on that stage… This is the hardest piece I've ever watched because of the authentic performance and the raw emotions felt by the cast at the same time as us'. This response is especially revealing, as the spectator moves between references to 'characters' and the 'cast', illustrating the intended oscillation between actor and role.

These reactions suggest that the performance's ambiguity led spectators to consider multiple interpretations, including clinical or diagnostic uncertainty. For example, one viewer noted that DID 'isn't a straightforward condition and hard to diagnose'. Another wondered 'whether Oliver's mother had a similar condition' and questioned whether DID might be hereditary. These comments show that audience members were testing hypotheses, weighing possibilities, and drawing on prior knowledge, reflecting the interpretive approach encouraged by the play.

Some audience members also recognised possible external motivations or gains. One spectator observed that 'the idea of celebrity at the very end was interesting but appeared as opposed to being tracked through the piece'. This insight highlights a key dramaturgical consideration for future development. While the performance encouraged reflection on malingering and self-presentation, cues for this theme may need to be integrated more consistently.

Insights into DID and trauma

Audience reflections showed strong engagement with the psychological aspects of DID, with several respondents reporting new insights into the condition. Some directly linked DID to childhood adversity, stating, 'DID can be linked to early childhood trauma'. A healthcare specialist noted that the play provided 'an understanding of multiple personalities and how that manifests from childhood trauma'. Others recognised the lasting impact of harm, observing that 'child abuse can affect some

people even later in life'. These comments indicate that the performance effectively highlighted trauma as a formative and ongoing influence, supporting the play's goal to deepen audience understanding of dissociation as an adaptive response.

For many spectators, the performance clarified previously unfamiliar aspects of DID. Several stated, 'I didn't know about DID' or 'I didn't realise DID was multiple personality disorder'. Others reflected on how the condition affects interpersonal relationships, noting, 'Yes I learnt about how DID affects romantic relationships'. One respondent admitted, 'I have never really took into consideration how this disorder affects other people aside from the one who has DID', showing increased awareness of the broader relational and ethical issues the play aimed to address.

Some responses showed active engagement with diagnostic ambiguity. The actor's rapid shifts led one viewer to note the 'performance was impressive with rapid changes between the personality', reflecting both symptom interpretation and theatrical recognition. These comments suggest that spectators were navigating the boundary between performance and potential symptoms, aligning with a central aim of the production.

These responses suggest the performance helped audiences develop a more grounded understanding of DID and its traumatic origins. Many demonstrated increased awareness of how dissociation emerges and affects relationships. Rather than showing confusion, these reflections indicate growing conceptual clarity, which is essential for engaging with the piece. By deepening understanding of the psychological and relational contexts of dissociation, the work fostered more thoughtful and informed interpretation.

Reception of aesthetic and dramaturgical strategies

Audience feedback provided clear insight into how the production's aesthetic and dramaturgical strategies influenced interpretation. Several spectators highlighted the symbolic and physical elements of the staging, with one stating they were 'moved by the performance especially the use of the paint and sheet in the rape scene and the use of the puppet to explore the past trauma'. This response aligns with the intention to make trauma visible without literal re-enactment and to use the puppet as a metaphor for the protagonist's fractured self. Others praised the piece's physical vocabulary, describing it as 'some really beautiful pieces of writing mixed with a fantastic physicality', and noting that the staging 'certainly emphasised the duality of the condition', especially in moments such as 'cleaning of Laura in [the] mirror'. These comments indicate that the physical and spatial strategies effectively communicated trauma and dissociation.

Spectators responded positively to stylised and postdramatic shifts, with one noting that 'the stylised moments were done beautifully and the scenes themselves took my breath away'. This suggests that

moments of heightened theatricality effectively generated the intended affective and interpretive impact, supporting the play's aim to model dissociative instability. The intertextual frame was also acknowledged, with one respondent stating they 'thought the Hamlet intertextuality was effective when exploring the ideas of feigned "illness" and how it can become real through trauma'. These remarks show that audiences used these devices as interpretive tools, reflecting the play's intention to encourage critical engagement. Even brief comments such as 'the props were amazing' demonstrate appreciation for the play's physical world and highlight the role of symbolic materials in supporting meaning-making.

Audience responses indicate that the performance created a reflective and ethically engaged space, consistent with the project's applied theatre goals. The combination of emotional intensity, dramaturgical ambiguity, and aesthetic disruption prompted several spectators to reconsider their assumptions about trauma, dissociation, and interpretation. Some reflected on the material's emotional complexity and noted that the piece encouraged them to rethink their understanding of DID. However, the findings also reveal limitations. The small sample size means the results are indicative rather than representative, and no respondent addressed a central provocation: the influence of social media and digital self-presentation on public perceptions of DID and malingering. While many described the piece as emotionally powerful, none considered how emotional displays might function as strategies in ambiguous or deceptive contexts, which is a key dramaturgical question. Although some comments suggested interpretive effort, the responses do not support a claim that audiences consistently adopted an IPA-like mode of spectatorship. Feedback from mental health specialists was positive, with one stating, 'Art/theatre for me is very much a healing tool. I really appreciate being able to go' and expressing interest in seeing the work further developed. Despite this positive impact and recognition of the project's potential, these responses did not provide detailed insight into how the performance might inform clinical reasoning or decision making.

Despite these limitations, the results are valuable within an R&D context. They show that the work generated emotional engagement, encouraged interpretive uncertainty, and highlighted trauma in ways that spectators found meaningful. The responses identify which dramaturgical elements were effective and where further development is needed to enhance applied outcomes. Overall, the findings affirm the potential of *The Art of Dissociation* and offer constructive guidance for its next stage of development.

Conclusion

The Art of Dissociation was developed with interconnected creative and applied goals. The project examined dissociative identity disorder, trauma, and possible malingering through a dramaturgical approach grounded in ambiguity and multiple perspectives. It aimed to engage spectators in

interpretive phenomenological analysis, encouraging close attention to shifting behaviours, uncertain viewpoints, and the ethical challenges of judgement when authenticity is uncertain. The project also explored the relationship between performance and authenticity, particularly how digital trauma narratives on platforms like YouTube influence public perceptions of credibility and self-presentation.

Audience feedback suggests that several project aims were achieved in this early draft. Viewers reported strong emotional engagement and empathy for both characters, indicating a willingness to engage with the material's complexity. Many described uncertainty that prompted active interpretation, showing that dramaturgical ambiguity fostered the intended reflective patience. Some noted the authenticity of the performances, the blurred line between actor and character, and the effectiveness of symbolic or stylised staging, all of which are central to the play's design. There was some evidence of changed perspectives, with respondents questioning previous assumptions about trauma, dissociation, or interpreting challenging behaviours.

However, some aims were only partially met. While ambiguity was effective as an aesthetic device, it was not always supported by sufficient contextual framing, and its purpose may not have been clear to all audiences. The interpretive goals were shaped mainly by textual research rather than collaboration with clinicians or individuals with lived experience, so the applied dimension was inferred rather than co-developed. Certain dramaturgical choices risked unintentionally reinforcing sensational tropes about DID, especially when emotional intensity or perceived danger overshadowed the intended interpretive focus. These findings highlight both the project's strengths and areas for further development as it moves toward a more refined applied-theatrical form.

Addressing gaps in applied theatre in health and care contexts

This case study's findings contribute to ongoing debates in applied theatre and health, especially regarding methodological scope and evidential depth. The small, single-site sample reflects limitations noted by Martí-Vilar et al. (2023, p. 10), who emphasise the need for more systematic, multi-site, and experimentally informed research to generate robust insights into theatre-based interventions. Similarly, the reliance on immediate post-show self-report aligns with concerns from Burns et al. (2024, p. 159), who advocate for mixed-methods and longitudinal approaches to better evaluate how theatrical experiences influence professional reasoning and behaviour over time.

Audience feedback for *The Art of Dissociation* rarely addressed structural or systemic issues in mental-health care or diagnostic cultures. This gap supports Prentki and Preston's (2020, pp. 182-183) argument that applied theatre should move beyond individual insight to address broader institutional structures. Similarly, the limited engagement with digital trauma cultures, despite the play's focus on YouTube and self-presentation, reveals a disconnect between the play's conceptual aims and its

execution. While the play references public visibility and commercialisation, these themes were not fully developed in performance and did not emerge in audience responses.

These gaps illustrate both the potential and limitations of this R&D phase. *The Art of Dissociation* offers insight into how audiences interpret ambiguous mental-health narratives. However, the findings also show that short-term, small-scale studies are limited in addressing broader methodological and conceptual challenges. This reflects the purpose of R&D: to test ideas, identify ethical and dramaturgical issues, and lay the groundwork for more extensive evaluation. The study provides a pilot framework to inform future versions of the play and support the development of a more comprehensive applied theatre research strategy.

Future revisions

The next phase of *The Art of Dissociation* will focus on refining the dramaturgy to better support its applied, interpretive, and ethical objectives. Audience feedback, personal reflection, and further research have identified key areas for improvement. A central priority is integrating YouTube-based material to highlight the protagonist's engagement with digital visibility and the commodification of trauma. Scenes featuring the protagonist's online channel will clarify questions of motivation, encouraging audiences to consider how digital cultures influence the portrayal of psychological distress. This approach supports the project's broader goal of examining how online trauma narratives shape public understanding of DID.

The current draft includes moments that suggest physical danger, which may unintentionally reinforce harmful stereotypes about mental illness. Future revisions will shift the emphasis from threat to interpretive ambiguity. Instead of portraying the protagonist as escalating toward violence, the revised structure will examine reasons individuals might appear to simulate dissociative symptoms, including economic incentives in digital contexts. This approach maintains dramaturgical uncertainty while avoiding narratives that could perpetuate stigma.

The play's structure will be reimagined as a series of art-therapy-based vignettes. Each section will focus on a different artistic medium, improvised music, puppetry and roleplay, or painting, each linked to a specific memory or embodied response. This restructuring will strengthen the relationship between trauma expression and aesthetic form, drawing on psychological theories of embodied memory and providing audiences with a clearer framework for understanding trauma processing. Expanding physical theatre will further support this goal, enabling the exploration of dissociation and trauma through movement and sensory experience rather than exposition.

Revisions will further blur the boundaries between performer, character, and persona. The next draft will introduce more moments of uncertainty, including a new opening sequence that immediately

engages the audience in interpreting whether the protagonist is exaggerating, genuinely struggling, or occupying an ambiguous space between these states. Direct address will shift from Laura to Oliver, creating intentional uncertainty about who is speaking and intensifying the interplay between actor, persona, and character. This will deepen the interpretive work central to the project.

Together, these revisions aim to deepen the play's emotional impact, sharpen its intellectual focus, and expand its exploration of dissociation and performative identity. By embedding ambiguity within a stronger dramaturgical structure, the next draft will provide a more rigorous and ethically informed examination of its core themes, enhancing both artistic integrity and applied theatre potential.

Practitioner collaboration and enhanced evaluation strategy

Further development of *The Art of Dissociation* will require closer collaboration with clinical practitioners to ensure the dramaturgical exploration of dissociation and potential malingering is informed by current professional insight, not just textual research. Although the first R&D phase received support from MIND and Arts Council England, it lacked sustained early dialogue with clinicians. Feedback from MIND's mental health specialists, who said, 'if there's a chance to watch again after they have developed it some more I'd love to hear about it and go support', highlights both the work's relevance and the need for deeper professional engagement. Their willingness to re-engage provides a foundation for collaborative relationships that can inform the next draft. Direct involvement of practitioners through script workshops or advisory discussions will help ensure the play resonates with real-world mental health contexts.

In addition to practitioner input, the evaluation strategy for the next phase will be expanded to address previously identified methodological limitations. The project will use mixed-methods research, including post-performance interviews, facilitated discussion groups, and written reflections from multiple venues. This approach will provide a more nuanced understanding of audience interpretations and whether spectators adopt the intended IPA-like interpretive stance. Longitudinal tracking through follow-up surveys or repeat-engagement studies will assess whether interpretive insights or changes in understanding persist beyond the immediate post-show period. Comparing responses across demographic and professional groups, especially among mental health practitioners, general theatre audiences, and younger spectators familiar with digital trauma cultures, will offer further insight into how outcomes vary by context.

Closing reflection

This case study demonstrates how *The Art of Dissociation* contributes to the thesis by showing that dramaturgical ambiguity, actor/character slippage, and aesthetic disruption foster reflective engagement. The interplay between emotion and interpretive uncertainty indicates that applied theatre

can address complex mental health presentations without relying on explanatory narratives. By layering identity, the piece shows that an IPA-influenced dramaturgy can prompt careful observation and analytical engagement from spectators.

This case study has significant limitations that affect the strength of its conclusions. The data comes from a single performance with a small, self-selecting sample, so findings are indicative rather than conclusive and do not show whether audiences adopted an IPA-like interpretive stance beyond the event. Although the play aimed to explore how digital cultures shape perceptions of trauma and authenticity, audience responses showed little engagement with YouTube or related online content, suggesting this aspect was not yet clear in performance. While reflections indicated substantial personal impact, they did not provide insight into clinical reasoning or applied decision-making. This is partly due to the lack of early collaboration with clinicians or lived-experience experts during script development, which led to applied aims being inferred from literature rather than co-created with practitioners. Some spectators also appeared to accept emotional authenticity at face value, with limited recognition that affective disclosure can be ambiguous or manipulative. This interpretive nuance, central to the project's aims, was not fully realised in the responses.

Ethical and methodological reflections from this case study highlight the need to clarify the framing of ambiguity. The emotional intensity reported by spectators demonstrates the effectiveness of the aesthetic approach, but this affect must be managed to support, not obscure, interpretive reasoning. Methodologically, the study reflects common gaps in applied theatre research, including reliance on self-report data, lack of longitudinal follow-up, and limited attention to structural or systemic aspects of mental health discourse. These constraints limit the interpretive potential of the work and underscore the need for a more integrated evaluative framework in future iterations.

Despite its limitations, the R&D process provided clear value by identifying which dramaturgical strategies best supported interpretive engagement and which require further refinement. The work also received positive feedback from mental health practitioners, who described the performance as meaningful and emotionally resonant, and expressed interest in further development. Their responses suggest that, even in its early form, the play was valuable in discussions of trauma and the representation of mental health. The findings clarified key priorities for the next phase, including more precise framing of ambiguity, more explicit cues about potential malingering, and better integration of digital trauma economies into the dramaturgy. While the current draft does not yet support concrete applications or dissemination, the data suggests preliminary conditions for these to develop as the work evolves. The study confirms that, when ethically and contextually framed, ambiguity can serve as a productive interpretive tool in applied theatre and provides a foundation for future iterations.

Placing this case study within the broader thesis shows how *The Art of Dissociation* supports the argument that combining aesthetic and conceptual strategies can foster reflective engagement with complex mental health presentations. The play offers an early model for staging contested psychological states through dramaturgical ambiguity, actor/character oscillation, and symbolic disruption. While still in development, it lays a foundation for future interdisciplinary collaboration and more robust evaluation, demonstrating how interpretive dramaturgy may support applied contexts as the piece evolves. In this way, the case study reinforces the thesis' central claim that theatre, when deliberately framed, can provide a meaningful reflective space to examine complex health and care scenarios involving potential deception.

The Art of Dissociation

Notes

This play is a work of fiction that has taken influence from many of the publicly documented cases of people who have been diagnosed with dissociative identity disorder (DID). It's worth noting that these high-profile cases likely received significant media attention due to the relatively dramatic nature of

their stories. The characters and events of the play are a composite of these cases, and purposefully do not represent any one individual. It is also important to add that this play explores the ambiguous concept that the protagonist may or may not be malingering.

Finally, '[m]ost people who experience traumatic events do not commit future acts of violence. Research strongly suggests, however, that for some people traumatic experiences are directly related to future perpetration of violence.'
Neller, D. & Fabian, J. (2006). *Trauma and its contribution to violent behaviour.* Criminal Justice Matters. 66. 6-7. 10.1080/09627250608553387.

The above statements should be made available in the programme notes.

Characters

This play should be performed by two actors.

Actor 1 plays:

Oliver - During the performance, Oliver (which is the character's birth name) should be referred to using the actor's name who is playing this role. In the script, this will be indicated using [Name]. Oliver has been diagnosed with DID, and so Actor 1 also performs the various personalities that manifest throughout the play, including:
Luke
Harold
Amy
Dave

Actor 2 plays:
Laura
Doctor
Mum
Stepdad

Each of the above characters should have a varied and detailed physicality, vocal quality and facial expressions. Actor 2 should change their costume as they switch between characters.

Staging

The performance space is engulfed within a huge, jagged, dome-like structure made of chicken wire.

Oliver's flat has a collection of paintings on display that reflect the nature of trauma and dissociation; a sombre picture of a weeping red rose with a black stalk; a mirror; a sculpture of a snake under a

beautiful flower; an easel and canvas; a guitar on its stand; a record player, a desk with two chairs; a sofa with a white cotton throw; a huge bookshelf overflowing with texts, and on one of the shelves there is a puppet of a little boy.

The Doctor's office should appear similar to Oliver's flat. The bookshelf, desk, chairs, should be moved to a slightly different position on stage. The artwork should be notably different and none of Oliver's works should be displayed, instead, there should be a large painting of, *A Clinical Lesson at the Salpêtrière*.
The snake-rose sculpture should also be replaced with a sculpture of Chiron.

An abstract space down centre stage should also be created with lights.
LEDs could be fixed in a triangle in the rig, facing off-centre stage, one red, one green, one blue, to create the dissociative lighting state as indicated in the script.

The set can be moved around by Actor 1 and Actor 2.

The intimate audience space could be circular, mirroring the dome-like structure of the set.

An art exhibition has been set up in the foyer. All of [Name's] artwork is on display, and the audience members are encouraged by the front of house staff to peruse the collection. Each of the artefacts are briefly titled and signed by [Name]. The audience is also asked to read the notes as indicated above. They are then directed into the performance space.

When the audience is seated, Actor 1 and Actor 2 enter, and stand centre stage. The house lights should remain on as the actors engage in a loosely structured conversation with the audience. While

the actors are speaking, the stagehands bring the artwork from the foyer into the performance space, and position the artefacts accordingly.

The following statements should feel very spontaneous. The scripted dialogue should be used as a guide, and the actors are encouraged to improvise around the content.

Actor 1: Hello!

Actor 2: Hi everyone, we just wanted to start off by saying a huge thank you to you all for coming along and supporting the show. We really appreciate it.
My name is [*Actor 2 states her name*] and I'll be playing Laura, but I will also be multi-roling as well. So, for those of you who don't know what multi-roling is, it's basically when you have to play more than one character in the performance. As an actor, you have to think very carefully about how to make all of these characters appear different from each other. You have to think about how to change your body, change your tone of voice, your facial expressions, and you have to think about all of the tiny little bits of details for each of the parts that you're representing.
So for me, as a performer, this role has been [*Actor 2 finishes this statement*].

Actor 1: Hi everyone, my name's [Name], and I'll be playing the character [Name]. So, you could say that I've got a slightly easier job, because I'm just playing the one part.

Actor 2: And basically I'm a better actor than he is…

Actor 1: No, yeah, she's right, it's true, however, [Name], not me [Name] but the character [Name] has been diagnosed with dissociative identity disorder, DID. Now, for those of you who haven't heard of this before, in the DSM-5, which is basically the medical bible that psychologists use to categorise mental illness, this book states that DID is, 'a disruption of identity characterized by two or more distinct personality states'. So essentially, [Name] will present with several different personalities, and each of these will look and sound a little bit different from each other. It's quite a complex character and so for me, as a performer, this role has been [*Actor 1 finishes this statement*].

Over Actor 1 finishing his final statement, Actor 2 puts on a dress.
She then changes into Laura.
Actor 1 looks at Laura and then leaves the stage.
The house lights come down, and the lights on stage change.

Laura steps forward into the spotlight that illuminates centre stage.
She addresses her monologue towards the imagined auditioners.

Laura: 'Not this by no means that I bid you do:
Let the bloat king tempt you again to bed,
Pinch wanton on your cheek, call you his mouse,
And let him for a pair of reechy kisses,
Or paddling in your neck with his damned fingers,
Make you to ravel all this matter out,
That I essentially am not in madness
But mad in craft.'

Pause
She shifts out of audition mode, and now addresses the audience directly.
Laura judders with a smile at the resonance of the speech.

Laura: Every syllable, every beat of this monologue is just so ugh; is he mad, is he not… For those of you not so familiar with Shakespeare, this is one of the most puzzled over speeches in *Hamlet*, it's just so exciting. This was the monologue I had to do for my audition for an upcoming all-female version of the play. I know, at first I was like, hmm, but then I thought, how amazing would it be to have the opportunity to take on one of the most prestigious roles in theatre history. And I know I would do it well because I'm a good actor.. I've trained at drama school, I'm a professional, well, I'm in-between work at the minute, but I know what I'm doing, and I live for Shakespeare, so there was no way I wasn't getting this part.

The thing is, I've been to a few auditions recently, well, over the last year or so, and I've not been cast in anything meaty, anything that I can really get my teeth stuck into.. or pay the bills with; so I've been doing a bit of gigging, singing in pubs and weddings, and that's great because it's really flexible.. Oh the last show I did, was alright but I couldn't really enjoy it because, my ex ruined it for me, he was like really jealous all the time, and he'd get mad if I had to do a "romantic" or "intimate" scene, and you know, I get that, I really do… but he just didn't understand that it wasn't me, it was just a character… He'd get so viscous sometimes and he'd make things difficult. At his worst he'd get wasted at mum's and then he'd.. I don't know.. So I was like, you know what, I don't need that in my life, I don't want to rely on someone who could just switch like that. So I left him…

Well, anyway, I got the part…

Classical music plays.
Laura exits

Lights change and we are now in Oliver's flat.
Oliver is sitting at his desk unenthused, typing on his laptop and looking through papers.
Oliver stops typing and sighs. He closes the laptop.

Pause
Oliver looks visibly stressed.
He stands and moves over to the bookshelf.
After flicking through, he takes a book on psychology.
He sits back down at his desk, takes out a bookmark, and starts reading.
After a moment he stops.

Oliver: Boring… it's not boring…

He closes the book, places it on the desk and then goes over to the record player and turns the classical music off.
Oliver considers what to do with his time. He goes over to the guitar on the stand, picks it up and sits on the sofa.
Oliver's demeanour subtly shifts to Amy, who sighs, and plays/sings the first verse of a popular sombre song.

Amy: My dad played that for me when I was little.

Pause, slightly different tone.

Amy: My dad played that for me when I was little.

Pause, slightly different tone.

Amy: My dad played that for me when I was little.

Amy smiles.

Amy: Yes he did.

The backing track of the same song plays, and Laura sings quietly in the dark.
Amy returns the guitar to the stand, puts a jacket on and leaves.

As the lights change, Laura steps forward and is now fully engaged with the song.
She is gigging at a bar and sings the chorus of the song that Amy was playing.
By this point, the desk from Oliver's flat has been brought forward centre stage and becomes the bar, with the two chairs placed in front. Oliver takes a seat.
As Laura's performance finishes, the lights change to include Oliver, who is applauding with genuine sentiment.

Laura: Okay ladies and gentlemen, I hope you've all had a fantastic evening, that was my last song of the night. Thank you for being such a great crowd as always! See you same time next week!

Laura steps away and seems to relax somewhat.

Oliver: Just brilliant, absolutely brilliant.

Laura: Aw thank you.

Oliver: You've got a really nice tone.

Laura: Nice?

Oliver: What I mean is, you're really brave to be able to stand up there and do that infront of all these people. I could never do that.

Laura: Have you ever tried? I can set you up on karaoke if you want?

Oliver: Oh no no no, absolutely not. That is terrifying.

Pause, smile.
Oliver goes to say something but can't find the words, then looks down.

Laura: You're a bit shy aren't you?

Oliver: A little bit, yeah, sorry.

Laura: You don't have to be sorry. It's nice actually. It makes a change from the *lad* lads that usually come in here.

Pause

Laura: I'm going to the bar. Do you want a drink?

Oliver: Oh no no, I'm fine.

Laura: Right, you're literally like my number one fan, you come in here every week to watch my set, so I'm going to get you a drink.

Oliver: Alright, thank you… Oh and it's not every week.

Laura: Pretty much every week.

Laura steps out of the light.
Oliver sits waiting. His eyes show that there are a million thoughts whizzing around his head.
Several moments pass like this.
Laura, who has found two (real) bottles of beer, stands behind the bar, and opens them.
There should be a cloth to hand in the event the beer fizzes over.

Oliver: They let you behind the bar?

Laura: Yeah of course; they love me here!

She slides Oliver's beer to him across the bar and picks up her own.
Then she walks back round and sits next to him.

Oliver: So it's Laura, yeah?

Laura: How do you know my name?

Oliver: Oh I erm, saw it on the poster outside, and I think you said it when you were up on the stage earlier.

Laura: Oh, for a minute there I thought you were stalking me.

Oliver: No, no I just remember it from-

Laura: Dude chill, I'm winding you up.

Oliver: Oh, no, yeah, I know.

Laura: So, what's your name?

Oliver: [Name].

Laura: Nice to meet you [Name]

Oliver: Nice to meet you Laura. You actually have the same name as my mum.

Laura: Do I?

Oliver: Yeah, she's called Laura too.

Laura: (*Laughing*) You're a bit weird, but in a good way.

Oliver: Weird in a good way. That's probably the nicest thing anyone has ever said to me.

Laura: Well, what can I say, I'm just a lovely person.

Oliver: I think so.

Pause

Laura: (*Smiling*) Shut up.

Oliver: So, how long have you been a singer?

Laura: Oh I've been gigging for a few years now but I'm an actor really. I just do this on the side for a bit of extra cash between work.

Oliver: Oh you're an actor.

Laura: As much as I can be.

Oliver: Have you been in anything that I might know?

Laura: Probably not, although I have just been offered the part of Hamlet.

Oliver: You mean like Ophelia or something?

Laura: No, Hamlet.

Oliver: But you're a girl?

Laura: Yeah, I'm also an actor.

Oliver: Yeah?

Laura: And my uncle never killed my dad, though sometimes I wish he did, but anyway, I can pretend. Actors are good at that.

Oliver: No, yeah, fair point.

Laura: Yeah, it's an all-female cast so it's quite exciting.

Oliver: Sounds interesting.

Laura: Do you like Shakespeare?

Oliver: I actually do, yeah. I love reading.

Laura: Yeah?

Oliver: Yeah, I can just sit for hours with a book.

Laura: What do you read?

Oliver: All sorts.

Laura: Yeah but, like, what's your favourite?

Oliver: I like reading about psychology, about people.

Laura: Umm very.. academic.

Oliver: And I love reading about Ancient Greece, and all the myths, and their way of life, and all that sort of thing.

Laura: What, like Medusa, and stuff like that?

Oliver: Yeah exactly that, yeah.

Laura: Well that's very.. niche.

Pause

Oliver: And I'm an artist.

Laura: What, like your job?

Oliver: Well, no, it's not my job, but I would like to be, literally more than anything. One day I think it will.

Laura: I like drawing.

Oliver: Do you?

Laura: Well I like colouring… Like those colouring books.

Oliver: Colouring? How old are you?

Laura: No, not the kid's ones, like the adult colouring books.

Oliver: Ohh those *adult* colouring books, oh yeah, I know what you mean… Do you go over the lines? Or?

Laura: (*Laughing)* They're actually really intricate and detailed and it's quite therapeutic.

Oliver: Uhum

Laura: So what's your excuse for not making it as a famous artist then?

Oliver: Oh good one… errm… no one's really seen me yet, seen my work. Not properly.

Laura: Sometimes, you just need to get yourself out there, and just go for it. Make people see you.

Oliver: I totally agree… but sometimes that can be easier said than done, but… How come you're not a world famous actor?

Laura: Well, we are really getting to know each other aren't we.

Oliver: You asked me about my art.

Laura: I did… I'm a carer for my mum.

Oliver: Are you?

Laura: Yeah, if I'm not at rehearsal or a gig, I'm at home with her, looking after her.

Oliver: Is she alright?

Laura: Oh yeah, she's fine, she just needs some help moving around the house and stuff.

Oliver: Does she help you do your colouring?

Laura: (*Laughing*) knobhead.

Oliver: Is there someone with her now?

Laura: Yeah, her friend comes round and stays with her every now and then.

Oliver: Right.

Laura: So, it's not often I get the chance to do something like this.

Oliver: Right. Well, I think that's very good of you.

Laura: Yeah?

Oliver: Yeah, mums are very important.

Laura: Yeah, I agree.

Oliver changes into Amy, who tilts her head.
Laura notices this.

Amy: You look really nice by the way.

Laura: Thanks… I don't really know how to take compliments.

Pause

Laura: They'll be kicking us out soon.

Amy: Well you can come back to mine for a drink, if you want?

Laura: I really shouldn't…

Lights change.
Amy changes the space back to Oliver's flat.

Laura stands and puts her coat on.
Then she pulls out a compact mirror and touches up her makeup over the following.

Laura: I shouldn't, but I kinda did. We just clicked. It was weird really, it was like we'd known each other for ages. He really listened, and it's hard to meet someone who just gets you. And it helps that he's absolutely gorgeous. I also liked that he was really nervous and kept saying weird things. It was like he was trying too hard, you know, and I know people say that's not a good thing, but after coming out of that vile relationship, I really didn't mind that he was bumbling to find the words to impress me, because he was at least trying to impress me. He didn't grab my arse or out, like most of the lads who bark for my attention. He was sensitive, and I could tell he liked me, so I thought I'd just go for it.

They walk into the flat.

Laura: Well, this is an interesting place. Where shall I put my coat?

Amy: Oh just throw it on the back of the sofa. Do you want a drink?

Laura: Yeah, go on then.

Laura throws her coat on the back of the sofa.
Amy pulls out two more beers and opens them, and hands one to Laura.

Laura: Thank you.

Laura wanders around the space looking at the various artworks, and the collection of texts on Oliver's bookshelf.

Laura: Wow, you do have a lot of books. Have you read them all?

Amy: Most of them, yeah.

Laura: You weren't kidding, you really do like psychology.

Amy: I find people fascinating, and I love figuring out why we do things.

Laura: I get that. As an actor, I'm always people-watching. (*Nodding at him*) There are some right weirdos out there. You know, I think that's why I started talking to you.

Amy: (*Smiling*) Oh thanks!

Laura: Oh look at this one.

Laura takes a book from the shelf.

Laura: 'The Psychology of the Actor', this looks interesting.

Amy: I've not actually had a chance to read that one yet… You can have it if you want.

Laura: Oh no, I can't-

Amy: Honestly, it's fine. I've had that for ages and I've never read it, and I probably won't to be fair, so go on, you have it.

Laura: Wow, thank you…

Amy: You're very welcome.

Laura puts the book near her coat, then notices the guitar on the stand.

Laura: (*Gesturing towards the guitar*) Do you play?

Amy: A little.

Laura: Are you any good?

Amy: Nrr not really.. Do you want to hear something?

Laura: Go on then, why not.

Amy: Okay, one sec.

Amy picks the guitar up off the stand and they both sit on the sofa.
Amy starts playing the same song from earlier.
After a line or two of the first verse, Laura joins in singing the harmonies.
They stop after one verse and one chorus. It sounds very polished.

Laura: Well that worked.

Amy: It really did. It sounded like we'd been rehearsing for ages.

Laura: You are good, you liar.

Pause.
Amy winces internally.

Amy: My dad played that for me when I was little.

Laura: Did he?

Amy tilts her head.

Amy: Yeah… He's not with me any more…

Laura: Sorry to hear.

Amy: No, it is what it is. But anyway, thank you for that, you are amazing. I actually think we sound really good together.

Laura: You should come and do a gig with me.

Amy: (*Laughing*) No chance!

Laura: Why not, you're really good.

Amy: I don't know, music is quite personal for me.

Laura: I get that. When you're gigging in the pub, it's not exactly about the love for it. Don't get me wrong, you still get a buzz every now and then but… I get what you're saying.

Laura stands back up and continues walking around looking at the artwork.
She reads one of the titles.

Laura: "Two souls, alas, dwell in my breast"… Did you do these?

Amy: Kind of. Yes.

Laura: Kind of?

Amy: I mean yes, yes I did.

Laura: Modest?

Pause

Laura: You're very talented, [Name]. You could sell these.

Amy: I have tried, but like I said, no one's interested.

Laura: What actually is your job?

Amy: I'm an accountant.

Laura: (*Laughing*) An accountant?

Amy: Yeah, why?

Laura: That's like the complete opposite of an artist.

Amy: Tell me about it.

Laura moves over to the snake and flower sculpture.

Laura: (*Reading the title of the sculpture*) “The Serpent Under the Innocent Flower”… Did you make this?

Amy: Yeah.

Laura: Wow, the detail is insane.

Pause

Laura: Would you teach me?

Amy: Teach you what?

Laura: How you do this.

Amy: Do what?

Laura: Your art.

Pause

Laura: Just show me how you do it.

Amy: Alright.

Amy walks over to the easel and places a new canvas.
She then pours two different coloured paints onto a pallet.

Amy: Okay, come over here?

Amy beckons Laura and she walks over.

Amy: Take this.

Amy hands Laura a paintbrush.

Amy: Close your eyes.

Laura: Really?

Amy: Yeah, close your eyes.

Laura closes her eyes and takes a breath.
Amy stands behind Laura, takes her hand and guides it towards the canvas.
Amy runs her fingers down Laura's arm. She responds and makes a mark on the canvas similar to automatic painting. Amy runs her hands through Laura's hair, holds her waist etc. each movement instructs a new mark on the canvas.
Amy gently removes the brush from Laura's hands and puts it down. Then Amy turns Laura to face her.
Amy takes Laura's hand, dips it in the paint and places it on the canvas, then does so with her own hand.
They kiss and their hands move across the canvas.
They stop.
Pause.

Laura: So that's how you do it.

Amy stares for a little too long.

Laura: [Name]?... [Name]?

Amy becomes aware of her surroundings.

Laura: [Name]?

Amy: Yes?

Laura: What was that?

Amy: What?

Laura: You just kind of blanked out there.

Amy: Oh I'm sorry. I'm a bit tired.

Amy picks up two rags, and hands one to Laura. They both wipe as much of the paint off their hands as they can.
Amy then takes the canvas from the stand, and places it somewhere significant.

Laura: Do you need me to go?

Amy: No, no sorry. I'm just not used to having people round that's all, I don't know if what I'm doing is, what I should be doing-

Laura: Just relax [Name]. Just be yourself.

Amy: Are you acting like yourself?

Laura: Yeah, I am. I mean, everyone puts their best face on when they first meet someone new, don't they?

Amy: Like on a date?

Laura: Yeah, yeah like on a date.

Amy: So, you are yourself on a date, but the best version of yourself?

Laura: I suppose, yeah.

Amy: Actually, I should just say, I do have something that, erm, I struggle to tell people because.. I worry that they'll think I'm.. I don't know..

Laura: What, what is it?

Amy: (*Embarrassed*) Erm, I have this thing, where sometimes I'm, like different, and, I don't really know how to explain it erm, I have different parts of, me, that express themselves differently. Sometimes I can seem not like myself.

Pause

Laura: (*Soothing*) Look, [Name] you're dealing with some things, and that's fine, you know, you're human. (*tone change*) We've all got shit… you should see me when I'm hungry.

Amy smiles.

Lights change.
Laura steps forward and addresses the audience.

Laura: I couldn't have been happier. I finally met someone who was sensitive, and expressive, and genuinely cared for me. That's all I ever really wanted. For years, I had to make too many sacrifices, too many compromises, and, well, [Name] wasn't perfect, he was a bit strange, but I didn't care, I didn't care because he made me happy. And I deserve that. We spent the next few months like this, me going round to his flat, and we'd have the most random, crazy nights. We made music together all the time, we'd have a few drinks, we just talked and talked and really got to know everything about each other, and he was always so gentle. I even thought he was starting to get my humour. And, you know, [Name] has gone through a lot with his family, I mean we both have, and we had that shared understanding of what that's like, and we're both trying to deal with that in a similar way; which is nice. I've finally met someone that I could… I don't know…

Lights change.
Oliver's flat.

Oliver is back at his laptop, typing and looking through papers.
He is becoming more and more agitated with the banality of the work.
Laura is sitting on the sofa with a script in her hand, learning lines, and trying not to get distracted by her mobile phone.
Oliver sighs.

Laura: What's up?

Oliver: One sec… I'm sick of this job. It does my head in.

Laura: Well, why don't you just take a quick break, you've been at it for ages.

Oliver: Yeah, I think I will.

Oliver closes the laptop and stands.

Oliver: How's the line learning going?

Laura: Meh.

Oliver: That good?

Laura: There's just so many of them.

Oliver: Do you want a hand? I could test you on them.

Laura: Go on then. If you don't mind.

Oliver: No course not. Give us your script.

Oliver sits on the sofa and Laura hands him the script.
A very small percentage of the audience might see that she hands over a script that was used to rehearse this play.

Oliver: Which bit are you up to?

Laura: Literally from the top of that page, there.

Oliver: Right okay, go on then.

Laura leaves her phone on the sofa, gets up, and paces as she tries to remember her lines.

Laura: 'Be not too tame neither, but let your own discretion be your tutor. Suit the action to the word, the word to the action, with this special observance, that you overstep not the modesty of nature. For anything so overdone is from the purpose of playing, whose end both at the first and now, was and is, to hold as 'twere the mirror up to nature; to show virtue her own feature, scorn her own image, and the very age and body of the time his form and pressure.'… That's all I've got up to at the minute.

Oliver: That was good, it was good.

Laura: I’m getting there.

Oliver: One tiny, tiny, pedantic thing.

Laura: Yeah? Go on.

Oliver: It’s o'erstep, not overstep. And the same with overdone, it’s o'erdone.

Laura: That’s what I said isn’t it?

Oliver: No, you said overstep and overdone.

Laura: Are you sure?

Oliver: Definitely sure.

Laura: Hmm.

Oliver: Oo she doesn’t like criticism.

Laura: No, no I can take feedback.

Oliver: I just thought it would help.

Laura: No no, I appreciate it, I do.

Oliver: Well, there was just one more thing.

Laura: Yeah?

Oliver: With your voice, it sounded a bit like… droney.

Laura: I wasn’t acting, I was just saying the lines.

Oliver: No, yeah, I know, I was just thinking, like, just to use your voice in a different way, like sell it to me.

Laura's phone rings.
She says the following whilst reaching for her mobile.

Laura: Oo look at you, you should go do some am-dram-

She sees who it is, cancels the call, and then sits back on the sofa.

Laura: Oh get lost.

Oliver: What? What's up?

Laura: Oh nothing, it doesn't matter.

Pause
Laura looks exasperated and Oliver is concerned.

Laura: I don't really want (*she sighs*)

Oliver: Go on. You can tell me.

Pause

Laura: Well, the director…

Oliver: Yeah?

Laura: He's being a bit funny with me.

Oliver: Right? I thought you said it was an all-female cast?

Laura: Yeah it is, but the director's a guy, and he's, well, he's a bit sleezy.

Pause

Laura: The money's good, and it's a dream role for me, but if it wasn't for that I would have left by now.

Oliver: Why? What's happened?

Laura: He's just too forward.

Oliver: What do you mean?

Laura: Honestly, it doesn't matter.

Oliver: No, go on, tell me.

Laura: Well he just doesn't leave me alone. Today at rehearsal, he said he only cast me because he thought I was available. And he keeps staring at me and he doesn't respect my boundaries.

Oliver: Okay..

Laura: He's like, always in my personal space, and, instead of directing me, he feels the need to physically move me and touch me, when it's just not necessary.

Pause
Oliver changes to Dave and stands up.

Dave: I'll kick his fucking head in.

Laura: You what?

Dave: What a fucking prick. Ugh I'm fuming.

Laura: [Name], calm down, it doesn't matter.

Dave: It does fucking matter, I'm not having it.

Laura: You're overreacting, it doesn't matter.

Dave: No, chance.

Laura: You are, he's just a stupid little boy and he's not worth getting upset over.

Dave: Don't be sticking up for him, I'm not having anyone touch you. I'm not having it, I'm not fucking having it. I'll kick his fucking head in.

He throws the script in a rage.
Pause
Laura looks terrified.
Dave changes to Amy.
Amy realises the damage that's been done to their relationship.

Amy: Laura…

Laura: What is wrong with you.

Amy: Laura…

Laura: I don't want to hear it [Name].

Amy: I am so sorry. I don't know why that happened.

Pause

Amy: That is not me, that is not who I am, I promise.

Laura: (*Tearful*) After everything I told you. After everything I told you about my ex and what I went through, you go and behave like that. Why would you do that?

Amy: That's not me, I promise, that's not me.

Laura: I can't do this. I said that I would never-

Amy: Listen, listen, I need to tell you something.

Laura: No [Name].

Amy: (*Emotional*) It's really hard for me to say because I've never really met anyone who accepts us and you do. I need you Laura. I need you. I admire you as an artist, I respect you. And you must have been terrified. And that awful person you saw then, that is not me, and I promise you, I promise you that that will never happen again. So please, please, don't walk away from this. Please don't walk away from me. And, I'm trying, I'm trying-

Laura: No, I'm sorry [Name]. I can't.

This breaks Amy, and she is significantly emotionally affected. After a moment of this, she just stops and stares blankly.

Laura: [Name]?... [Name]?

Pause

Laura: Right okay, I'm going.

Amy is present again.

Amy: Is it too much to ask, to want to be loved. To want to have somebody for you, just for you. And we finally get that chance and we've managed to fuck it up. As we always do with everything. Love is bittersweet. A thing so out of reach for us.

Laura: Look, I'm sorry. This is all a bit too much for me. I've got a lot going on at home with my mum and by the looks of it, you've got too much on yourself, so I think it's for the best that we don't do this anymore.

Amy: Please. Please.

Laura: Look [Name], Amy, whatever.. We've only been seeing each other for a few months and you're acting like this. And the whole different people inside you thing, I mean, I don't know… I just don't see this working.

Amy: Sit down please.

Laura: I can't-

Amy: (*Fierce*) Sit down!

Pause
She sits.
Amy goes over to the painting of the red rose.

Amy: This one was for my mum. You close your eyes, and just feel, and you pour it out on the canvas. She liked flowers.

Laura: It's sad.

Amy: It is… Love is sad… Is there anything I could do to make you stay?

Laura shakes her head.

Amy: I am ever so lonely. You see, we all have a purpose. My purpose is to find love.

Laura: [Name], that's not how love works.

Amy: Well how do you explain this burning ache that I have for you? You are beautiful, everything.

Pause
Lights become abstract.
The sound of percussion fills the space; the same as the childhood scene at the end of the play.
Laura stands.

Laura: Look, I really need to go now.

The dissociative lighting state becomes prominent.
Actor 2 looks uncomfortable, moves out of the stage lighting and stands directly in front of the first row of the audience, in their space.
Actor 1 looks confused and stares at Actor 2.

After a moment, Laura steps back into the dissociative lighting.
A physical theatre sequence ensues with movements that represents violence.
It is important that the movement is symbolic, rather than literal.
The percussive sound increases in volume as the struggle proceeds.
Amy takes the paint pallet from the previous scene and smears Laura's face and body with the two colours.
Amy then takes the white throw from the sofa and lays it on the floor.
Laura is then pressed into the white sheet during the movement sequence, which is now covered in the paint from Laura's body.
The struggle stops and Laura is moved from the sheet.
Amy picks the sheet up and walks over to the canvas that the two of them created earlier in the previous scene. Amy removes this canvas from the wall and replaces it with the sheet, as though the sheet is a work of art.
The percussive music slows, and then comes to a stop.
The lights change.
Laura is beyond distraught.
Amy stares.

Amy: Now they will see me.

Lights change and there is no longer any focus on Amy.

Laura continues crying for an uncomfortable period of time.
The director emerges from the audience, approaches Laura, uses her real name, and consoles her.
When Laura calms, the director returns to their seat.
Laura picks up the rag from the easel, and then sits in front of the large mirror. The mirror should be positioned in a way that the audience can clearly see most of Laura. She begins to wipe herself clean, though some remnants of paint should remain, even after she has finished. Laura says the following whilst cleaning herself up.

Laura: Time passes and it doesn't.. My logic has been replaced with impulsive urges.
I can't do anything.. I can't look after myself nevermind my poor mother.. Time passes and I think it's getting better, and it doesn't. The slightest thing sets me back, someone touches my arm, someone calls me beautiful. Books, music. I can't even listen to music.
I struggle to find the words to express how I feel and to explain what happened, my brain has literally lost that capacity. Instead, there's just this claustrophobic feeling of being mentally and physically

trapped, and flashes of sound and images that haunt me. My memory is not a linear narrative, it's just fragments of pain.
How can I be myself if I don't even know who that is? If I cannot verify my experiences or account for what is real. I cannot trust my memories or tell them apart from my imagination.
He didn't just take from this shell of a body, he murdered my soul. He took my ability to look around and know what I am experiencing is verifiably true.
The eroding of awareness after a tear so fucking deep in my existence, the eroding of knowing who I am, who I can trust.. For survival. I have survived, though I am changed. I cannot inhabit my own skin without being possessed by this huge wave of emotional numbing that cuts me off from everything good in this world. I am just completely disconnected with myself, my true and authentic self and I'm still fighting this threat that's not actually there.

Pause
Laura finishes cleaning off most of the paint.
She stares at the audience through the mirror.

Thank you for listening to me. Listening makes it a bit easier, some of the time.

Laura smiles.
She stands, turns, and addresses the audience directly.

Laura: He's pretending to be ill so he doesn't have to face the consequences of what he's done to me. I'm an actor, I know pretense when I see it. He's a liar.

Lights change.
Laura changes into the Doctor who puts a suit jacket on.
The space is changed to the Doctor's office.
The bookshelf, desk, chairs, should be moved to a slightly different position on stage. The artwork should be notably different and none of Oliver's work should be displayed, instead, there should be a large painting of 'A Clinical Lesson at the Salpêtrière'.
The snake-rose sculpture should also be replaced with a sculpture of Chiron.
A camera has been set up on a tripod and it is pointing at Luke, who appears childlike.

Doctor: So how old are you Luke?

Luke: (*Proud*) I'm nine.

Doctor: And what's happening at the moment?

Luke: Well at the minute I was just playing my games but then I got interrupted because you wanted to talk to me about something.

Doctor: Do you want to talk?

Luke shrugs his shoulders.

Luke: I don't mind.

Pause. Luke appears uncomfortable.

Doctor: What games do you play Luke?

Luke:: I like to play Batman.

Doctor: Batman?

Luke: Yeah, I like Batman.

Doctor: I don't know much about him to be honest.

Luke: You don't know Batman?!

Doctor: No.

Luke: (*Exasperated exhale*) I've got the Batmobile and everything, and you can put Batman in the Batmobile and just (*car whizzing gesture*) whizz him around, it's brilliant.

Doctor: He can't be beaten can he?

Luke: No course he can't, it's Batman. And he's just literally like, real powerful and he's got anything that he wants. He's my favourite superhero and that's why.

Doctor: Oh that's wonderful.

Luke: Yeah, he's good isn't he. And when I play, sometimes [Name] plays with me and I'd be Batman obviously and [Name] would be Robin, and we run around together and fight crime together. (*Laughing*) We have lots of fun.

Doctor: So, Luke and Batman are kind of the same person in a funny way.

Luke: Yeah, kind of.

Doctor: Maybe not in a funny way… maybe in an absolute way.

Luke: Maybe… you can call me Batman if you want.

Doctor: (*Internal*) Another part.

Luke looks oblivious to the previous statement.

Doctor: With all of them magical weapons of one kind or another?

Luke: (*Physically animated*) And the fact that he can just fly in the sky from building to building, and like, that would be cool wouldn't it? How cool would that be if you could fly (*optimistic sigh*) that would be awesome.

Pause

Doctor: So, Batman is powerful, but he's good isn't he as well; he does good things. He does good things and stops bad people.

Luke: Yeah he does stop bad people, he gets the Joker and that. And he gets the Joker because the Joker wants to hurt everyone, doesn't he, so, he's the one who actually… tries to stop him.

Doctor: What do you know about the Joker?

Luke: He's like… all he wants to do is blow everyone up and he just wants to hurt you. And I'm like, why would you want to do that? Why do you want to hurt people, so Batman comes along and just (*Luke kicks out*) just kicks his face in.

Doctor: Why do you think that.. I don't know why he'd want to hurt people. Any ideas, I don't know? I don't know much about the Joker you see, I mean, do you know?

Luke: Yeah, I know, I know everything, I know everything about him… He, erm, he had this bad accident or something when he was younger, and I think that made his face go all weird, and that's why he's always got this weird smile.

Doctor: So, he's not really smiling then?

Luke: Well, it's not a real smile is it, because it's a fake one, because of what happened to him with his accident, and ever since then he's just not been very nice.

Doctor: Oh I see, so he had this terrible thing happen to him, and now he's taking it out on other people? Sort of thing?

Luke: Yeah, and he needs stopping, doesn't he, and that's where Batman comes in, and stops him, so.

Doctor: Ah, it's like a balance then, between good and evil, or, between good and bad, and hopefully the good bits can win out.

Luke: Yeah yeah. Well the good guys always win don't they?

Doctor: Possibly… I suppose so.

Luke: The good guys always win.

Doctor: Yes, I think that's probably true. We have to hold on to that one don't we.

Luke: I think so.

Doctor: Well, Luke, thank you for speaking with me, I really enjoyed that chat.

Luke: It was alright.

Doctor: You are really grown up for your age aren't you?

Luke: You are quite nice to us. You look a bit like my mum.

Doctor writes a note.

Doctor: Do I?

Luke: Yeah, a bit.

Pause

Luke: Can I go play my games now?

Doctor: I think that's a really good idea. Can I speak to [Name] please?

Luke: Yeah.

Luke closes his eyes.
Luke changes into Oliver.

Doctor: How are you doing today [Name]?

Oliver: (*Sighs*) Not bad, I suppose.

Doctor: I've just been speaking with Luke; he's a lovely boy isn't he.

Pause

Doctor: Have you been for a walk in the garden today?

Oliver: Not today, no. I went yesterday.

Doctor: The weather is lovely, you should make time to go outside.

Oliver: I will.

Doctor: I've just seen you on the news.. you've caused quite the stir in the media. We've had journalists and whoever else calling non-stop. So, because of this, I think it's really important that you feel that you are supported-

Oliver: -Where am I?

Doctor: You're in my office [Name].

Oliver has a blank and confused expression.

Doctor: What were we just discussing?

Pause

Oliver: I don't know.

Doctor: We were talking about the weather… What do you think?

Oliver: Oh, yeah, it looks nice out.

Doctor: It does… So, in today's session, I thought we could talk about some of the things that make you feel anxious. Does that sound alright with you?

Oliver: I don't know.

Doctor: Well, it's completely up to you. I think it might help.

Oliver shrugs, then nods.

Doctor: Okay then… Before we carry on, I just wanted to remind you that this is being recorded. Okay?

Oliver nods.

Doctor: Good. Now, just try to relax.

Oliver: Are you going to ask me about that girl? Because I don't think I could handle that today. I'm not feeling strong enough.

Doctor: You mean Laura?

Oliver: Yes, Laura.

Doctor: Do you prefer not to use her name?

Oliver: Well, I don't know, I don't know-

Doctor: [Name], I know it's difficult for you but it might help if we just touch on it briefly.

Oliver is becoming emotional.

Oliver: I don't know. I don't mean to hurt people.

Doctor: I believe you [Name]. I do. What do you think that means, you don't want to hurt people?

Oliver: Sometimes I just wake up in the middle of doing something, and I don't know how I got there. I have no memory of things and time goes by and I just don't know what's happened to me or what I've done.

Doctor: I see. And how often does that happen?

Oliver: All the time. It's horrible… I just feel, shame.. Absolute burning shame.. I haven't got the words, Doctor, I haven't got the words. Just these images and sounds that haunt me.

Doctor: Images of Laura?

He breaks down emotionally and his distress is represented physically by shaking and scratching himself.

Oliver changes into Dave and stands up.

Dave: What the fuck do you think you're doing? With your fucking suit jacket, and your up your arse attitude.

Doctor: Would you please calm down.

Dave: Calm down, calm fucking down. I swear I'm gonna smash you in the fucking head in a minute. Why you upsetting us? Why you upsetting [Name]? Can't you see he's messed up, and you're supposed to be a doctor.

Doctor: Look, can you just take your seat?

Dave: You don't care about us, look at you. Look at you with your fucking degrees and your massive salary. Judging us? What? Are you actually having a laugh? I'm sick of people hurting us, and I'm not gonna fucking let you do it anymore. Just leave us alone.

Doctor: I am not trying to hurt you (Name), I'm trying to help you. And, if I'm honest, you're really not helping yourself at the minute… So, shall we sit down, and we can talk about this together.

He sits.

Dave: Sorry doctor… me head's gone at the minute.

Doctor: Yes, I can see you're in distress.

Dave: Mate, I'm stressed out to the max and everyone keeps saying we've done shit and we 'ant, and I'm not having it, I'm not fucking having it.

Pause
Dave blankly stares out.
Dave changes into Harold.

Harold: Terribly sorry about the outburst there doctor. Dave sometimes struggles to manage his emotions. I do assure you, he is not a bad person, he simply wants to look after us and the only way he knows how to do that is to fight, essentially.

Doctor: I see, and who am I speaking to now please?

Harold: Harold. Good to see you Doctor.

Doctor: Good to see you.

Pause

Harold: What are we discussing today then? The weather, how I'm settling in?

Doctor: We were talking about things that make you feel a bit anxious.

Pause

Harold: May I walk around?

Doctor: Please do.

Harold stands and surveys the room.

Harold: I see you've opted to decorate your office with some interesting artefacts.

Doctor: Umm, do you like them?

Harold: I do actually. They've got me thinking.

Doctor: And what are you thinking?

Harold: Correct me if I'm wrong.

Harold refers to the Chiron sculpture.

Harold: Chiron.

Doctor: Correct.

Harold: The wounded healer. Excellent at curing others. But could never quite heal himself.

Doctor: Also correct.

Harold: Do you see yourself as a Chiron, Doctor?

Doctor: Not necessarily… It's just a myth. I like his character.

Harold: Do you have a wound?

Pause

Doctor: I suppose we all carry something, don't we?

Harold: What is your wound? Or would you rather not say?

Doctor: I don't mind… If the analyst isn't changed, then the therapy isn't working.

Pause

Doctor: I've known loss, and grief.

Harold: Any mistakes?

Doctor: Too many to mention.

Harold: Anything dark?

Doctor: We all carry that as well. It's in our nature to have parts of ourselves in shadow.

Harold: Spoken like an artist.

Doctor: Well, we are talking about art. It would be rude not to.

Harold: And this is the bit that baffles me.

Doctor: Go on.

Harold: On the wall.

Doctor: Yes?

Harold: Charcot.

Doctor: Correct.

Harold: Some call him a charlatan.

Doctor: Maybe so.

Harold: Freud called him an artist.

Doctor: Did he?

Harold: He did…You see that lady there, swooning. Some people say she wasn't really ill, rather, she was simply a fantastic actress.

Doctor: They do.

Harold: When researching our.. situation, I found that there are lots of people, and in fact lots of professionals, who believe that we are like your friends in the painting. What are your thoughts on this Doctor?

Pause

Doctor: I think that… I think that that was a long time ago, and we have come a long way since then. We are in a much better position now to make those sorts of professional judgements.

Harold: Ohh what would we do without the MMPI tests and the Malingering Index.

Doctor: Now, I've shared quite a lot there.

Harold: And I do appreciate that.

Doctor: But it works both ways.

Harold: It does. But before we move on I have one last thing. There's something I've been meaning to ask since we arrived here.

Doctor: Okay?

Harold: I wondered if you would contact a dealer or a gallery on my behalf? See if there is any interest in my artwork?

Doctor: I can look into it for you.

Harold: Thank you. I was thinking, if there was interest, I could donate some of the money to a charity?

Doctor: We shall talk about that later Harold but we do need to press on with today's session.

Harold: But art is long and our life is fleeting, doctor.

Doctor: (*Firm*) Harold.

Pause

Harold: You look like her.

Doctor: Who?

Harold: Laura.

The Doctor makes a note.

Doctor: Why would you say that?

Harold: Just an observation. I assume you're going to ask me about her?

Doctor: Is there something that you want to tell me about Laura?

Harold: Hmm. Yes actually. Most of the time, it was Amy who was with her.

Doctor: Amy?

Harold: Yes, she loved spending time with her.

Doctor: So, what happened?

Harold: Honestly, I don't know. Which is very strange. Because generally I oversee everything, but not this. You see, I'm not particularly concerned with the intimate side of things. I actually found Laura to be quite time consuming, so it's very likely that I drifted off. Though it is odd that I cannot remember anything at all from that night.

Doctor: So maybe Amy might want to speak to me instead?

Harold: I'm afraid that won't be possible either Doctor. Amy has taken the break up quite badly, and has not spoken to any of us since. She is simply mute. It's like she's not there anymore.

The doctor makes notes.

Doctor: Okay, if we can't talk about Laura, there is something else that I would like to ask you.

Harold: What's that?

Doctor: What was it like growing up?

Harold: Please do be very careful when talking with [Name] about this. He is still very troubled by his past; we all are.

Doctor: Do you think you could tell me something?

Harold: Not really, no.

Doctor: I think you would really benefit from it.

Harold shakes his head.

Doctor: It would be very useful for me to know a little bit more about you if, if I'm going to be able to help you.

Harold: Look, I appreciate what you're trying to do, but there are some things that are just too painful to deal with, even for me.

Doctor: But if we just-

Harold: (*Very firm*) I said no.

Pause

Harold: Look, I apologise for being abrupt, I apologise for that but… I-

Doctor: You're not here to look after me.

Harold: No, no, I'm here to look after [Name].

Doctor: Hmm.

Pause

Harold: And he.. we have gone through a tremendous amount of hurt. And I just need to be sure that what's happening is the right thing for [Name].

Doctor: But would you say in some ways that, each of this, each of these parts of you, the common thread is that there's a sense of trauma. Previously you've talked about feelings of remorse, a sense of guilt, a sense of pain, a sense of injury from way back. So there's a thread, isn't there, it seems.

Harold: There is.

Doctor: When you've been hurt. And, hurting others hurts you, that's what you've said. And the memory of hurting others hurts you.

Harold: It does.

Doctor: So there is something common, in your experiences.

Harold: I suppose… But why? Why has this happened to us?

Doctor: And do you have an answer to that at the moment, or not?

Harold: I think… I think it very much does go back to… when [Name] was very young, and, you know, what [Name] had to go through. And, obviously, how he's dealt with it, has meant that we have had to… step in, and help him. I think it's entirely that; the beginning.

Doctor: Yeah. Yeah. So, without wanting to be too… definitive about it let's say, the we part, and the [Name], they are very connected, intimately connected, obviously because it's all part of you. And how might we.. bring these parts together?

Harold looks concerned and confused.

Doctor: In a way that-

Harold: Why would-

Doctor: Feels more helpful to you.

Harold: Why would we do that?

Doctor: Why would you want to bring those parts together? Well, because they are all in you anyway.

Harold: They are, they are all in me, we, are here, and we serve a very clear purpose, and we have this agreement, and without this without us, [Name] would be dead.

Doctor: [Name] would be dead?

Harold: [Name] would be dead.

Doctor: Yeah, that's true.

Harold: So, why would we want to, not be here?

Doctor: Absolutely, yeah, yeah, so I wasn't thinking that these parts should be gotten rid of at all. I think these parts are enormously valuable.

Harold: Yes.

Doctor: Because they look after [Name]. So, inevitably, they're valuable aren't they?

Harold: Yes.

Doctor: And you said there was something that happened to [Name], do you want to say more about that, or not? And I say you, but, wherever that's from, whichever part, does [Name] need to be spoken about? Or does [Name] want to speak directly? Or not, because the pain around that seems so profound.

Harold: I don't think I can.

Doctor: How about Luke?

Harold: Luke? He's a child.

Doctor: He is… Luke was the first one to join [Name] wasn't he?

Harold: Yes.

Doctor: And I think you mentioned before that the purpose for Luke was to take the place of [Name], whenever he was experiencing pain?

Harold: Yes.

Doctor: Well, surely then, he is more resilient than all of you?

Pause

Harold: I suppose he is.

Doctor: We will speak to each other through play. We can use a doll. To tell a story. You see?

Pause
Harold flickered his eyes closed.
Harold changes into Luke.

Doctor: Hello, is that you Luke?

Luke nods.

Luke: Harold said that you wanted to play a game with me?

Doctor: Well, I thought we could play a game. I thought we could tell a story.

Luke: Okay.

Doctor: One moment. You'll like this.

The Doctor fetches the boy puppet that has been sitting on the bookshelf.

Doctor: Would you like to hold him?

Luke: Yeah, go on then.

The Doctor hands Luke the puppet.

Luke: He's really cool.

Doctor: He's good isn't he?

Luke: (*Enthused*) Look I can make his mouth move.

Doctor: I was thinking he could be Robin.

Luke looks at the Doctor.

Doctor: And you could be Batman.

Pause

Doctor: I was thinking that, you could tell me a story about when [Name] was little, and how you two became friends?

Pause

Doctor: You can use all your superhero strength to tell me if you want?

Luke: All of it?

Doctor: All of it.

The lights change.
The Doctor changes into Mum.
The space is changed to represent Oliver's family home - the kitchen.
The puppet should be operated without concealing the intentionality and performative choices of Actor 1.

The puppet is sitting at the table with a basic meal in front of him.
Mum is also sitting at the table, staring blankly.
The puppet messes with his food.

Mum: What are you doing?

The puppet freezes.
Pause

Mum: Eat your tea.

The puppet picks up his fork and continues to eat carefully.
Mum becomes emotional.
She smiles at him.

Mum: Right, best get sorted.

She picks up a bag, rummages around and, using a small mirror, she removes any of the remaining paint from her face, and starts applying makeup.

Mum: Got to look beautiful haven't we.

Pause

Mum: We should go somewhere nice. Would you like that?

The puppet nods.

Mum: We should do that.

She becomes emotional again.
The puppet approaches Mum and puts his arms around her.
She hardly responds.

Mum: Don't.

The puppet goes over to a pile of toys. He picks up crayons and a piece of paper, and starts drawing a picture.

Mum: *(To herself)* Get looking beautiful, and then have a quick tidy up.

Mum continues to apply makeup.
The puppet stands up and takes his picture to Mum.
He holds it out to her.
She takes it off him and looks at it. She smiles.

Mum: You're quite the artist aren't you?

Pause

Mum: Such a happy picture. I love these flowers. I'll tell you what I'm going to do. I'm going to put this up on the wall, so everyone can see it.

She takes the picture to the position where the Weeping Red Rose was positioned in Oliver's flat, and hangs the picture there.

Mum: This makes mummy very happy… I'm very proud of you Oliver. I hope you always draw happy pictures. Promise me you'll always draw happy pictures.

The puppet nods.

Mum: Good boy.

The puppet goes back to drawing a new picture.
Mum begins to look anxious and starts tidying up the room.
Mum accidentally knocks over a bucket of Lego that has been left out.

Mum: (*Fierce*) What have I told you about putting your toys away after you?.. Hmm?

The puppet freezes.

Mum: What do you mean it was Luke? Whose Luke?! I'm sick to death of you lying all the time Oliver! Are you listening?

The puppet freezes.

Mum: I said, are you listening? Stop pretending like you can't hear me Oliver! You need to grow up and grow up quick. You can't just ignore things and hope they go away and hope someone else will come and sort your shit out for you because they won't… Stop pretending to be deaf, stop pretending to be a baby… just stop pretending that you're someone else. This is your life Oliver, yours. You have got to deal with it.

Mum composes herself.

Mum: Nobody likes a liar Oliver… Can you just put your toys away please?

The puppet places most of the toys in the toy box. Leaving the crayons and the paper out.
Mum opens a (real) bottle of wine and pours herself a glass.

Mum: Look, I'm sorry for shouting at you but your dad'll be back any minute now from work, and he doesn't need to come home to all this lying around, does he?

Puppet shakes his head.

Mum: Just, just be good.

Mum drinks her wine, then continues to tidy up.
We hear a door open and shut.
Mum quickly checks her mirror again, retrieves a (real) bottle of beer, and opens it.
She leaves it on the side.
She looks out towards the audience during the following interaction.

Mum: Hi baby, have you had a nice day? I thought it would be nice if we had a little drink tonight so I've got you a beer out... It's alright... You look knackered, been a long one? Bless you. You know, I've missed you today... Hm not much, just sorted a few things around the house... No, I've not been out today, I've… It's not that bad... No, I've had a good clean up and I've ironed your work clothes for tomorrow… No, I told you I haven't been out. Anyway so what if I did... Oh don't start that again.

Mum's head flings back as though he is pulling her hair.

Mum: Ow! I'm not lying! I've been in all day... It's not, it's just a few of Oliver's toys, and that's it.

He lets her go.

Mum: And I have makeup on because I wanted to look nice for you.

Pause

Mum: Please don't say that, you know I love you… It's alright, don't worry about it, you've had a stressful day haven't you? I can tell… Can we just have a nice night please… Yeah?... Well I'll just put Oliver to bed first.

She tilts her head and gently strokes her neck.
He kisses her.
She holds her stomach.

Mum: (*Smiling*) not yet, let me put Oliver to bed first.

She slowly, and reluctantly, pulls her top down over one shoulder.
She presses her hand at the top of her thigh.

Mum: Not in front of Oliver… No, I'm not saying no... No please don't. There's no need for that… Look at me, look at me.

She kisses him again.
She takes his hand, leads him upstairs, and the puppet watches them pass by.
The lights dissociate.
The same percussive music plays from the previous scene when Oliver assaults Laura.
The puppet holds his ears and looks down.
The percussion intensifies.
The song that Oliver played on guitar and sang with Laura starts playing over the percussion. This slowly increases in volume.
The puppet slowly lifts his head, and removes one hand.
The puppet is relaxed by the song.
He gets up and dances.
The lights change.
Stepdad is standing at the doorway.
Oliver takes the puppet's pants down a little.
Step dad pulls them down further.
Oliver's eyes blank as he dissociates and moves backwards.
Oliver places the puppet on the coffee table with his legs dangling down, leaving him unassisted.
Oliver stares blankly for a moment, and then steps back.
Stepdad stands behind the puppet and freezes.
The lights change. Music plays much quieter - like it's in the distance somewhere.

Oliver: Things can hurt you so much, until, actually, it doesn't hurt anymore. It's like, it's there, happening but it's kinda not at the same time. My stepdad would regularly beat me for little things, like, not eating my tea, or forgetting to brush my teeth. He had a pet snake, a boa constrictor, and he'd threaten me with it, telling me that his favourite food was little boys. He would rape me in the most spectacularly creative ways. Sometimes he would just piss on me; he thought it was hilarious. I could see in my mother's black and blue eyes that she knew. Maybe not the full extent, but, she knew. She would sob her heart out when he wasn't there. I used to think about killing him. I was too young to have those thoughts, but I became obsessed with the idea of it, thinking how I could do it; and I really wanted to. One night, I even got out of bed, early in the morning.. I got up, and went into the kitchen and got a knife, and I crept back up the stairs. We had loose floorboards and I froze after every step. I opened their bedroom door. It had like a funny smell. It was warm and muggy. I went inside, with my fist white, clenched around the knife and I looked up, and saw the snake in its cage. And I was absolutely terrified. I couldn't breathe, I couldn't move. I just wanted to cut its head off. I wanted to cut its head off so bad but I couldn't do it. I woke my mum up, she was a light sleeper. She picked me up and carried me out of the room and she looked at me and said, no baby, don't do that. Don't ever do that. He looks after us. We need him.

The stepdad picks the puppet up, holds him under his arm, and takes it offstage.
Music stops.
The lights change.
The space has changed back to the Doctor's office.
The Doctor has retaken their seat at the desk.
Oliver is crying uncontrollably.

Doctor: Thank you for that.

Oliver: I'm sorry, I'm so sorry…

Pause
Oliver calms, and takes a deep breath.

Doctor: Who did you talk to about this?

Oliver: No one. I didn't have anyone to tell. I was alone.

Doctor: And that's the trauma.

Oliver: I'm just so angry.

Doctor: And so you should, you should feel angry about that. But anger doesn't have to be destructive.

Oliver nods.
Pause

Doctor: Can I ask, who is Oliver?

Oliver: Please don't use that name.

Doctor: Okay, that's absolutely fine.

Pause

Doctor: I think you've done really well today [Name].

Oliver nods.

Doctor: So, I'm going to set you up with something else before we finish today's session.

The Doctor stands and brings forward an easel, blank canvas and paints.
The lights dissociate, illuminating the canvas.

Doctor: Think about how you are feeling right now, all those thoughts and energies inside you. I want you to use that, and paint for me, and express as much of that as you can. Is that okay?

Oliver nods.
The Doctor leaves.
Oliver approaches the easel. He uses his hands to apply paint to the canvas.
He creates, in real time, an original piece that represents dissociative identity disorder.
When Oliver finishes the piece, the Doctor returns.

Doctor: Wow, it's looking good.

Oliver: Thank you.

Doctor: What does that say at the bottom there?

Oliver: Oh, Amy added that. It just says: if we are to love, we must first be at peace with each part of ourselves.

Doctor: I see… I have some news.

Oliver: You do?

Doctor: I have just been on the phone to someone quite interesting.

Oliver: Who?

Doctor: I have just spoken to an art dealer in London, as you requested; apparently he's quite a big deal. I've shown him some photographs of your art.

Oliver: Really?

Doctor: Yes, he said that he'd seen your case on the news, and that your work could be quite valuable. He said he would be very interested in speaking with you to discuss potentially getting your work installed at an exhibition. Would you like me to arrange a call with him?

Oliver smiles.
The Doctor exits.
Oliver looks directly into the audience.

Oliver: Finally, they see me.

Oliver takes a slow bow.
Laura enters.
They look at each other.
Lights change.

Oliver changes into Actor 1.
Laura changes into Actor 2.
They both bow, though Actor 1 bows in the exact same way as he did as Oliver.
They exit.

All of Oliver's artwork, including the painting he has just done, is moved to the foyer, where the audience members are able to buy them. The sheet is also put up for sale.
The price for each artefact should be relatively high, and probably too expensive for the visitors to actually make a purchase - but they could, if they absolutely wanted to.

Conclusion: Theatre as Reflective Space

Revisiting the Aims, Objectives, and Research Question

This thesis examines how dramaturgical strategies developed through practice-as-research can represent contested health and care scenarios, including cases of fabrication or malingering. It argues that live performance provides a reflective space for health, social care, and education professionals, enabling new insights into complex cases. This approach informs the scope, development, staging, and analysis of *A Bitter Pill* and *The Art of Dissociation*, without imposing predetermined outcomes.

Through the creation and staging of performance texts and the collection of qualitative audience responses, the research shows how dramaturgical form and audience positioning influence reflective experiences among professionals. It highlights the roles of affective engagement, participatory strategies, and uncertainty in shaping this reflective space in live performance.

In addressing the central research question, the thesis shows how dramaturgical strategies support reflective engagement with potentially deceptive behaviours by shaping how professional audiences encounter and interpret material. Evidence from creative practice and audience feedback demonstrates that both case studies contributed to this inquiry in distinct yet complementary ways, offering practitioners opportunities to rehearse judgement and reflect on the interpretive demands of their own practice.

Synthesis of the central argument and main findings

This section synthesises the central argument and findings, demonstrating how the case studies collectively illustrate the creation of reflective space for professionals in complex health and care settings.

Mobilising reflective space through affect, participation, and uncertainty

The two case studies show that reflective space for professional audiences can be created through dramaturgical design that addresses emotional, perceptual, and interpretive demands in complex care. In both works, reflection emerges from audience positioning, active engagement, and participation in the face of uncertainty.

In *A Bitter Pill*, reflective space develops through sustained engagement with the child's perspective. Participatory strategies highlight safeguarding responsibilities. The dramaturgy presents events through Lucy's imaginative and emotional world, allowing audiences to experience fabricated or induced illness as lived experience rather than as an abstract category. Participation draws audiences into moments of hesitation, anticipation, and relief, reflecting real safeguarding pressures. Improvised music serves as an empathic device, translating the child's inner life into sound and emphasising the impact of silence and withdrawal. These strategies encourage professionals to reflect on care, responsibility, and the consequences of delayed action.

In *The Art of Dissociation*, reflective space is generated through sustained uncertainty about dissociative identity disorder and potential malingering. The dramaturgy requires continuous interpretation, exposing audiences to shifting behaviours, unstable identities, and conflicting cues of sincerity and performance. Techniques such as actor-character blending, stylised staging, and narrative ambiguity prompt attentive scrutiny. This uncertainty encourages reflection on how credibility is assessed and how assumptions about trauma and authenticity influence professional judgement, particularly when behaviour may seem genuine, performed, or ambiguous.

These case studies show that reflective space can be created through dramaturgical strategies tailored to the specific pressures of various health and care contexts. In *A Bitter Pill*, reflection results from affective engagement and participatory strategies that highlight care, responsibility, and safeguarding

judgement. In *The Art of Dissociation*, reflection stems from sustained uncertainty, requiring audiences to interpret behaviour and credibility without clear resolution. In both works, reflective engagement is shaped by the audience experience, encouraging professionals to navigate complex presentations that reflect the challenges of their own practice.

Implications for applied theatre and arts in health and care

This thesis demonstrates that dramaturgical form in applied theatre engages professionals in reflective encounters with care contexts marked by uncertainty. The case studies show that performance encourages professionals to examine behaviour and responsibility, addressing the interpretive and ethical demands of their practice through experiences that mirror real-world decision-making.

The findings indicate that applied theatre engages professionals by simulating the interpretive demands of real care practice. By presenting situations involving possible deception, the case studies show how theatre prompts professionals to reflect on their judgement in challenging conditions.

This research clarifies that applied theatre serves professionals in safeguarding, health, and care systems, not only service users. By presenting work directly to these audiences, the thesis responds to calls for applied theatre to engage those who influence practice and decision-making (Prentki & Preston, 2020, pp. 182-183). Applied theatre is shown to foster institutional responsibility and reflective dialogue within professional cultures.

Finally, the thesis demonstrates the value of addressing ethically complex subjects in applied theatre. By exploring contested situations involving potential deception and urging professionals to engage with discomfort and interpretation, the research positions applied theatre as a practice in which interpretation is a meaningful outcome. In health and care, the theatre's value lies in deepening professional reflection rather than providing solutions.

Limitations

This research has methodological and contextual limitations. Both case studies used small, self-selected samples from voluntary post-performance questionnaires. While this provided detailed qualitative insights, it limits the extent to which the findings can be generalised beyond these performances and professional groups.

The evaluation is based on immediate self-reported responses, capturing first impressions rather than long-term change. Without longitudinal follow-up or pre-performance measures, the research cannot demonstrate lasting impact or changes in professional practice. The findings indicate reflective engagement rather than long-term behavioural transformation.

The specific contexts of the performances influenced the conclusions. Both works occurred in particular institutional and professional settings, and the reflective space resulted from these conditions. This research demonstrates how performance can foster reflective engagement in these specific settings, not across all health and care contexts.

Future directions

This research identifies several opportunities for future development in performance and research, especially in creating and evaluating reflective space across various professional contexts.

A Bitter Pill is well-positioned for further testing through tours and presentations in professional and educational settings. Although the script is largely complete, future efforts will focus on expanding its reach to social work departments, safeguarding teams, and universities. The performance could serve as a stand-alone event or be integrated into workshops. By leveraging the network of care professionals established during the research, future iterations can assess how performance aligns with curriculum needs and training priorities, thereby enabling evaluation of its reflective potential across diverse audiences and institutions.

In contrast, *The Art of Dissociation* requires significant dramaturgical redevelopment before further public showing. Future efforts will clarify its conceptual goals and practical focus, particularly regarding dissociation, credibility, and malingering. Planned revisions include restructuring the play's interpretive challenge, addressing stereotypes, and deepening the exploration of digital self-presentation and performative identity. These changes aim to support sustained, ethically sensitive audience engagement and enhance the play's impact as an applied theatre intervention.

Future research should use more rigorous and diverse data-collection methods to gain deeper insights into how professionals experience reflective engagement. Longitudinal strategies, such as follow-up questionnaires, interviews, or reflective sessions at set intervals, help reveal how performance encounters are revisited or integrated into professional practice over time. Collaborating with social work, health, and education providers will ground this approach in practice and enable evaluations that reflect professional realities and clarify long-term impacts.

These directions highlight strong potential for further development beyond this study. While this thesis explores how reflective space can be created through performance, future work could deepen this inquiry through more comprehensive testing, ongoing collaboration, and systematic evaluation. This research provides a foundation for continued investigation into how theatre can support reflective professional practice in complex health and care contexts.

Closing reflection

This thesis shows how live performance addresses complex health and care situations to encourage reflective attention among professional audiences. Both case studies demonstrate that dramaturgical design creates conditions where uncertainty, emotional pressure, and ethical responsibility coexist. Instead of resolving these challenges, the work motivates audiences to confront them, prompting reflection on professional judgement in demanding circumstances.

The findings highlight the importance of aesthetic and emotional experience in encouraging reflection on professional practice. The performances influence the audience's sense of responsibility by engaging them emotionally and perceptually, supporting sustained attention in situations where information is partial or ambiguous. Emotional response is essential to reflective judgement, strengthening attentiveness and professional reasoning. The work prompts professionals to consider how best practice is negotiated under pressure through direct engagement with complexity.

This thesis provides a foundation for further research at the intersection of theatre, safeguarding, health, and care. Applied theatre is most valuable when professionals interpret experience rather than simply receive it, and when it addresses contested or uncomfortable topics. By showing how dramaturgical form and audience engagement shape reflective space, the thesis contributes to discussions about theatre's role in professional life and identifies opportunities for practice and research that address the ethical and practical complexities of care work.

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Appendix A: Selected Interview Excerpts

Consultant in Liaison Psychiatry: I mean, it's a very deviant way of getting attention. To do that with a young child. And that's why I think the people who do it are extreme. Yeah. Are extreme. You know. Their psychological makeup, _ knows more about this than me. But they have to be.

Interviewer: So, should they be presented as deviant and criminal?

Consultant: Well, that question's an interesting. Yeah. Well, I don't know. I think you'd have to present, looking through the case studies, because I suspect, you know, that, um, in I don't know, actually. Um,

Psychoanalyst: It depends who you are or what you're doing. If you're a lawyer, it's legal stuff. If you're a doctor, I guess it's medical stuff. I mean, there's I know.

Interviewer: Well, if you're a playwright.

Consultant: There, there is why it's interesting. If you're a playwright, yeah, what so where are you? Um, I, I want to, the objective is to show a truth. A truth without a stereotype that society might already hold, um, towards mental illness in general or or towards, um, these specific disorders. I mean, I think these disorders you're picking out, I mean, I absolutely agree that mental illness should not be stigmatized, that's what I've spent my life working on. But these people who do this, factitious disorder by proxy, to me, I mean, they are harming, they are abusing another person, a child.

…

this is criminal behavior and should be predominantly, nine times out of ten, be seen as this is just criminal, this is just, well, I think if they're deliberately harming the child, that that is, you know, that is harm, that is, yeah, I think it's criminal behavior. The motives for it, that is, you know, what's going on, and what it is. And I think there are people around who don't want to explore the motives as well, and that might be the dilemma that you can create. How much sympathy do we feel, you know, this woman has deliberately harmed a child, but actually she's had a terribly crap life, she's been abused, she's got an abusive partner, you know, how much, really, what could she do, how could she stand up to him, when he was encouraging her to, because it was his step-child, you know, how much could she stand up to him, what would have happened, would she have been killed herself, if she had stood up, you know, sympathy do we create for that character?

…

I have seen patients with Factitious Disorder quite a quite a number. But they don't present to psychiatry. They present to um, physicians and surgeons. Right. So, they present because they present with um, all sorts. I had, I've had patients who present with unusual skin problems and they've been pouring acid onto themselves. So, you know, they present, and or people present with falls in their hemoglobin. And what they're doing is they're letting their own blood out. Right. Um, and then they're taking litres. Yeah, yeah. And then they turn up at A&E or I've, you know, and they perhaps squirt the blood up the bottoms or in the vaginas or I've got this. I'm bleeding. So, do you think then, because I was thinking there's so many dimensions, because the other dimension to it is, when you're the psychiatrist doing that, it's horrible because nobody wants to view people like this. It's not an easy thing to do. And you always want to give people the benefit of the doubt really. Yeah. Yeah. And there are times when you think, I can't anymore. And then you're confronted with this horror really. It is it is horrible. Yeah. Which you know, But, but also you know you've got to break confidences because as a, you know, as a clinician, someone's come in. And if you then you say, well, actually, I'm not

believing what you're saying because the, where it taught, you know, we want to believe what our patients say. Right. But then, but there you stand. Yeah, I don't believe what you're telling me. You're packing a load of lies.

Interviewer: Would you say, would you say that to a patient?

Consultant: No. …. So, what you would say So, I've never had to confront anyone with Factitious Disorder by Proxy but Factitious Disorder patients, I have had to confront them. So, I've gone to say to them, [name], um, you know, I know you've come in with, you said you're bleeding from your bottom and we'd be very concerned and we've done a lot of tests but we can't understand um, our blood tests show that you haven't lost blood acutely and we, I can't work out how this has happened.

Interviewer: So, there's something wrong with your test.

Consultant: Well, we've rechecked, we've rechecked the tests three times and I've had my senior colleague look at the tests and I-

Interviewer: Why is it happening then?

Consultant: Well, sometimes we find that some patients that they're very upset about things and they can do this to themselves. They can harm themselves.

Interviewer: So, you think I'm doing this to myself?

Consultant: Well, that's my concern, [name]. Yes. You're doing this yourself.

Interviewer: Well, that's not, that's not true. Why would I do this to myself, actually?

Consultant: Well, sometimes some patients are very unhappy, very upset about things and we know, and I have seen patients with this where they do this to themselves and it's perhaps not looking after yourself properly, perhaps harming yourself. But that does happen and that's what I'm concerned is happening with you, [name].

…

Because what you would be doing there is really genuinely trying to be, well, being empathetic. You really would be trying to tune in in the hope that somebody thinks, actually, they do care about me. And there's more mileage in this than coming up with. Right. And I don't know whether And I can tell the truth. I can be honest. Yeah. But the um, so when we, what usually happens is that patients say, no, no, you're wrong, you're wrong. So, you end up, and you can say, well, I'm sorry, that's where I am.

Appendix B: Audience Feedback Data for the Live Performance of *A Bitter Pill* (2024)

The full anonymised dataset was collated using an online survey tool and exported for analysis. A working version of the dataset was maintained as a spreadsheet during the research process.

Quantitative Summary of Audience Responses

- 130 people attended the Hull Truck Theatre performance
- 110 people attended the Caxton Theatre performance
- 240 people attended in total
- 82 people gave feedback (approximately 34% response rate). This would have been higher, but the Wi-Fi signal at Hull Truck Theatre appeared to prevent many members of the audience from engaging.
- 8 social workers
- 21 medical professionals

- 32 worked in the care sector
- 41 worked with children
- 10 theatre professionals
- 73 already had prior knowledge of fabricated or induced illness

Selected Qualitative Excerpts Referenced in the Thesis

Did you learn anything new about Fabricated or Induced Illness? If so, what?

- I wasn't aware of the severity and never really thought about it. Really got across a really important
- It raised awareness
- No, familiar with it but extremely well portrayed
- How easy it is for others to be drawn in
- Others/staff don't always challenge parents information.
- the seriousness of the problem
- The intensity of the care provider and the desire for attention.
- How bad it was for the child
- That even the closest people should be checked more
- How this can be hidden easily particularly in single parent families
- How the child feels
- How underhanded the perpetrators are around other people. The social media bit was shocking.
- Yes, how it can develop over time and how not enough is known to spot the potential signs
- I learnt it can be more severe and dangerous to children.
- Yes, the different ways this can be done
- The modern day look - social media, go fund me
- Just how much it impacts the child
- Made me think more about the child's voice
- More awareness around the impact on the child.
- No but it's a subject that is quite personal to our family from experience
- Yes, pills without labels
- How manipulative the person can be
- Hearing it from Lucy's perspective was brilliant. I've had cases of suspected fabricated illness and seeing the holistic team around her fail the child was so powerful.
- Yes, I didn't realise how young of an age it happened and the extent to which it happens, e.g. having unnecessary operations, suffocating the child etc.
- Yes how it was not recognised and affected the child
- Easily to be taken in by lies
- How people are blind to the obviou[s]
- Voice of child very important
- Was surprised at the asphyxiation ..... didn't know it went that far
- The depth of how far people can go to make themselves look like a good person, even when they are actually quite evil!
- That the mother hid it well. This type of stuff happens alot . I find the rich people hid it well . I'm a cleaner and I see it . I should have also had social services help as my cries was undetected. I left home finally at 15 and half ,in the 1980s and social services tried to send me back ,cos I was strong, it didn't happen. She looked the part as a good mother ,as nice

clothes etc , she fooled alot of people. So I can totally relate to this story ! It was fab . I still really don't have a good relationship with my mum ,I don't trust her . In my adult life I gave trust issues.

- I already knew about fabrication and illnesses like Munchausen's by proxy, however I felt this play really reinforced it from the child's perspective. It hammered home the emotional and physical effects at the child's level.
- I knew about Fabricated/ Induced Illness through popular crime cases, however, this show reinforced that this is more common than we're aware. The abuse is a lot more subtle than we might think but the damage is the same.
- I couldn't believe anyone would actually go to suffocate their own child for attention. That was shocking but beautifully done.

If you were already familiar with Fabricated or Induced Illness in a professional capacity, do you think the play represents this well?

- Yes I think it was great job. I think using several illness worked well to show how things move on and this cause also mean illness fabrication is missed by professionals
- Yes, I think it was portrayed very well and sensitively
- In many ways. It's especially shows how people play the system for their own gains And Often at the expense of other people
- Yes I really do. So sad! But as much as the play ended pretty abruptly, I wish there was a part that actually rescued the little girl in the end. Someone in the audience might be struggling with their own inner child's lost innocence.. Can't it end somehow where the girls life is changing for the better? Or maybe even just ends up safe.. Rescued :(
- Yes, from the child's perspective
- Certainly. The flip from comical to hard hitting worked.
- Absolutely - I think it was an excellent exploration of the illness told from the perspective of the victim.
- Yes and definitely how easy it is to miss some of the signs
- Yes! Incredible! Very proud & I really want more social workers & our foster carers to see this play. Simples amazing.
- The play represented this well although it would be nice to see the mothers point of view more for a deeper understanding towards the characters.
- Yes it was an amazingly effective and humerus way of sharing a very important message
- I thought the play depicted it very well. I appreciated Lucy's experience growing subjected to her mum's issues.
- I think the show presents Fabricated/ Induced Illness well and highlights the importance of calling out neglect, physical abuse and manipulation.

Does the play make you want to be more proactive in the protection of children?
If so, how does the play achieve this?

- Just gonna make you take a second look
- Speaking out if needed
- Talking to the child involved.
- Awareness - showing the importance of proffesionals questioning parents/families.
- Question more about it when you have doubts about frequent illnes

- The balance of finding joy to playing with the audience. We are apart of this girls joy, and positive journey. However, right at the end, we become equally responsible for the detriments to her life too. We are blamed and left feeling guilty
- Highlighting how professionals did not raise or pass on concerns about the welfare of 'Lucy'
- Raising questions, making the audience consider if they could've should've seen and done something.
- It puts focus back on the child victim and their perspective, rather than the usual focus on the perpetrators
- Adults need to be the voice for children
- This was really power full. As a social worker we are often told children are unwell sometimes even just common illness and we just take this as truth. This play highlights the voice of the child.
- Showing that safeguarding is everyone's responsibility
- More safeguarding checks in school for absent children.
- Ask more questions , talk more to the child
- The ending especially makes you want to be more aware of children around you. It really makes you think and feel that you should always speak out if you get a bad feeling about something.
- It reminds you that it is always better to say something than not, even if it is the smallest thing
- The voice of the child was very powerful
- Listening to how important it is to gain the voice of the child.
- Will make me look more deeply
- Reconfirms the need to listen to the voice of the child, wether verbal or non verbal, to always, always follow your instincts
- The end where Lucy asked why didn't you do something why didn't you hear my voice
- Continue to promote best practice in social work
- The last scene / speech was quite cutting and painful. Our experience has been unfortunately that police and social services do not believe third party reporters.
- Connects with the audience, as if we were the people in her life with responsibility. Making you realise we do have responsibility.
- Voice of the child ,safeguarding is everyone responsibility
- You empathise with the child and want to give them a voice
- I am already proactive but this would make me be so if I wasn't
- It's certainly an awareness creator. I liked the line about not ignoring your gut when it tells you something isn't quite right and to call social services.
- I work with children and it made me think outside the box.

Were you invited on to the stage? If so, did you feel safe / comfortable participating with the activities?

- Thankfully I was not, but was concerned that I would be.
- Yes… extremely uncomfortable with it, public speaking/appearance terrifies me
- I was the teacher and yes it was very good
- No. I avoided looking at Lucy Most of the time just in case she picked on me.
- I was not but the "child" interacted with me at the beginning of the play and magiced me into a fairy.. It's was very engaging and drew you in to the character.
- I wasn't but I would've loved to have been called up
- I wasn't invited, my daughter was, d she enjoyed it

- No but I think the invitees felt safe
- No. Thank goodness aha

How did the improvised music impact the performance?

- The music was amazing and you could tell the musician was really invested in Lucy
- A little too loud, but impressive playing.
- Made it powerful and sad at the same time
- Fitting
- Good music slightly to loud
- Excellent, powerful and really brought emotion to the scenes
- It was done very well and I didn't even realise it was improvised
- Really good
- Set the tone
- Could have been a bit quieter at times
- Brilliant - helped to build mood and energy, as well as allowing us to connect better with Lucy as the music reflected her feelings
- Bloody brilliantly, without the music the story would be flat.
- It added a raw layer of emotion based upon the accompanist's feelings as he was watching the piece - every performance would be different.
- Added tension, excitement
- Added suspense
- Built suspense and emphasised the emotion
- Created atmosphere and connected with the audience
- The improvised music impacted me emotionally by sonically exporting the child's thought processes.
- Beautifully done and the use of music was really effective especially when the music stopped. I loved the "play rock music or Musical Theatre" you never knew what you would get from the audience and that reinforced that it was live music.

What was your biggest takeaway from the play?

- Involving the child more.
- Thinking about thinking about looking more and acting.
- That safeguarding is everyone's business!
- Will help me look differently at situations
- How complex these lives can be
- The voice of the child
- How sad I felt for Lucy
- That is EVERYBODYS responsibility to safeguard children
- I saw the situation through the eyes of an education provider, linking absence from school for fabricated illness and the potential for falsifying reasons for children being missing from school or absent for frequent and/or prolonged periods of time.
- "I am considering how individuals can help these cases because services often don't speak to one another or are not allowed to disclose information.
- Everything isn't always as it seems
- Although, my biggest takeaway was the joy of watching the actress play the young girl. I felt a real compassion for Lucy. "
- How easily it can happen

- That you should always follow your gut instinct with the use of professional curiosity.
- To be more aware of this with the young people I work with
- How manipulative people can be
- Upsetting
- Listen to the child!
- I want more and more people to see it
- How sad it made me deel
- Missed opportunities and spotting mum's behaviour
- Made me see it from the child's view
- Listen more
- Food for thought
- Think where has that child gone. Think why does this child look so well when the mother is describing so much illness
- To see beyond what is visible
- How sick some people are in the head that they would hurt thier own child which is after all, the point of the play to portray. The line about how they bring them (children) into the world only to bring them to the brink of death was heart wrenching and poignant. No one should be suffering this.
- Just heightened awareness of the issue
- That these things can, and do, happen, and that it can ruin a child's life. Be more vigilant.
- Sad at some parts of humanity
- I really enjoyed it. I came in not knowing anything, my friend got some spare tickets and I'm so glad I saw it. Really thought provoking, great story telling through using an adult playing a 6yr old and getting the audience to take part without it being panto-y. I loved the shaving of the dolls head, huge impact and the staging of the suffocation. I will take a chance with theatre more often. I will continue to think outside the box and question odd behaviour from parents and children.

What are your overall thoughts about the performance?

- Incredible, educational and emotional
- The performance was great and the actors were fantastic. Audience involvement was really well played and i could have watched it for longer.
- I was moved by the play. To say I enjoyed it would be a strange comment but I valued the message.
- Excellent. Especially with Gypsy Rose Blanchard‘s story being in the news so recently after her release from prison, it was good to see the performance tackle the same difficult subject matter in a far less sensationalised way than social media has. The sudden turnaround at the end to bring the onus back onto the audience was sobering and impactful, and the performances all round were great. Using audience interaction and music to connect with us worked well - altogether a very nice piece. Funny, heartfelt and moving.
- Really enjoyed it but felt nervous as didn't want to be picked to go on the stage.
- Serious topic but with humour
- I liked the link to different princesses throughout and the concluding discussion at the end.
- I felt this was a great performance and made light and dark of an awful reality, I think capturing the child's voice slightly more would improve things it felt it ended fast and that was the most powerful part of the play. Amazing job x

- Working in a school, I wish this was performed for many staff to show the effect on the child and because all safeguarding literature is based on a child centred approach.
- I think ‘Lucy’ portrayed the difference of her being in her own world and enjoying the innocence of being a child and the reality when she talked to the audience really well.
- Very good, the characters did really well especially Lucy engaging with audience as soon as they where sitting down. The play was about a sad topic but provide humour in parts too which balanced reality with theatre perfectly.
- Fantastic job and the audience interacting brings an extra dimension to the story. I just want to add.. The parts there the mum sat over the pillow and the doll hair scene.... God you could hear a pin drop. Well done for producing this tastefully guys..
- I enjoyed. I began to realise what was unfurling at mid point. Whether this was deliberate or intended to be masked a little longer. Made me conscious of the depths of deception. At times the 'flow' lost pace whilst Lucy performed actions on stage without dialogue. Dressing table could be set slightly on a diagonal so Lucy's back isnt full to the audience whilst looking in the mirror. Just minor feedback in a strong piece of theatre. Well done.
- I thought it had a serious meaning but got the point across in a child manner that all of us could understand.
- Amazing! Really good to get the message out there. Thank you for raising awareness of such a taboo topic.
- Show-stopping, riveting, and emotional.
- Fantastic, emotional, intense, funny and entertaining
- Amazing, well researched thank you
- it was really good. it was very captivating and the interaction activities and party bags were a really good idea. really good acting and highlights a real day issue. makes audience more aware. possibly could of been longer but still really good
- Well, I was crying by the end. Really pulled at my heart strings which I assume is the aim. It definitely increased my knowledge.
- A great and challenging peace of theatre. Moving and thought provoking language and performances from the cast. A professional ability to explore sensitive subject matter with an element of fun and excitement.
- I came unsure what to expect and am leaving flabbergasted. The manner inwhich such a heavy and emotive subject was delivered was both professional, delicate and quirky. The balance between serious and sad content with some light humour towards audience improv was very clever. I would like to see a little more about mum in this too, how might this have developed. I also feel the ending and Lucy dying could have had more emphasis. The father element was also very powerful, showing the impact an absent father can have on a child as an added cultural issue.
- Very good and very powerful. The crowd work was funny and powerful at the end, and the lead’s ability to straddle the seriousness of the issue and yet still come across convincingly as a child was excellent. A great vehicle for educating about these issues and providing a voice for the child to show us the struggles at their level.
- I loved the idea of using the audience, especially as friends and the party bag was a nice touch. No need for cake, balloon and popper is enough (my opinion)
- The live impro music was also a nice touch and loved that we were all in Lucy's imagination and the musician being Lucy's dad. The use of a hat for Lucy's shaved head was done nicely.

- Over all I really enjoyed my evening and huge congratulations to you all for creating such a thought provoking, not always done sort of play and excited to see what you do with it. Best of luck.

Appendix C: Audience Feedback Data for the Live Performance of *The Art of Dissociation* (2022)

The full anonymised dataset was collated using an online survey tool and exported for analysis. A working version of the dataset was maintained as a spreadsheet during the research process.

Quantitative Summary of Audience Responses

- 88 people attended the Hull Truck performance
- 31 people gave feedback (approximately 35%). This would have been higher, but the Wi-Fi signal at Hull Truck Theatre appeared to prevent many audience members from engaging.

- 6 under the age of 25
- 25 over the age of 25
- 9 theatre professionals
- 6 worked in medical / care / mental health / psychology
- 24 said the protagonist was genuinely ill, 4 not sure, 3 thought feigning
- 27 had sympathy for both characters, 4 said only for Laura

Selected Qualitative Excerpts Referenced in the Thesis

Did you learn something that you didn't already know? If yes, please explain

- I have never really took into consideration how this disorder affects other people aside from the one who has DID. I also got to see it from Jordan's own perspective and the trauma he was carrying whilst suffering
- I was definitely doubting my own knowledge of what I had consumed about DID. Seeing films or information about it and trying to work out what gaps I had. Certainly helped me question my experiences.
- DID can be linked to early childhood trauma
- Yes I didn't know about DID
- No but it was very 'real'
- I didn’t realise DID was multiple personality disorder
- Yes - the emotional toil on those who are harmed as a product of DID when feeling justice isn’t available to them.
- Yes I learnt about how DID affects romantic relationships
- Did isn't a straightforward condition and hard to diagnose
- An understanding of multiple personalities and how that manifests from childhood trauma
- Yes didn't know mich about DID, was very interesting.
- yes impact of DID on a person and the relationships within
- Yes didn't think they had multiple people
- How child abuse can affect some people even later in life

If you work in the care sector, with people struggling with their mental health, does this play provoke any questions / thoughts regarding your own practice?

- The importance and context around behaviour and actions.
- Have to keep being reminded that often how people present is from past trauma.
- No but it makes me realise the affects of trauma a little more because I fully felt everything on that stage.

What are your overall thoughts about the performance?

- A thought provoking piece that poses more questions than perhaps it is able to answer.
- I was blown away. Everything about the piece was done with such authenticity that each character was believable. They were real people, not characatures and I bought every person on that stage. The characters were played so successfully that the stage even seemed full when there were only 2 people on it. The stylised moments were done beautifully and the scenes themselves took my breath away. I felt the juxtaposition of completely loving a piece of theatre even though it was so difficult to watch. This is the hardest piece I've ever watched because of the authentic performance and the raw emotions felt by the cast at the same time as us was something I was particularly moved by. It is something that will stay with me for a while. I commend all involved in such a profound and deeply important story. Well done, it was excellent
- Really loved the staging and direction of certain parts. Certainly emphasised the duality of the condition - cleaning of Laura in mirror and the question asked of the actor after the physical aspects of the piece. I would have loved to see more of this. Especially if we were to question Jordan - could it be expanded to him being brought out of the confines of performance but the other actor still questioning who I'm he was talking to. I felt very much that it was Laura's story to begin with and then half way through flipped to Jordan. I wonder if there is a way for this to happen more smoothly so that we have a balanced view of both situations. Some really beautiful pieces of writing mixed with a fantastic physicality. The idea of celebrity at the very end was interesting but appeared as opposed to being tracked through the piece. I did question whether Oliver's mother had a similar condition and then wondered if my own understanding of whether DID was hereditary or not. Very intense but I liked that. Jumped more than once when other 'personalities' appeared
- It was a really moving performance, and conveyed emotional trauma, the causes and impact of this brilliantly. It captured the essence of developing empathy for both sides and the importance of humility and humanity.
- Intense
- It brought out a lot of emotions in me and touched on things Iv dealt with in my personal life and made me reflect on relationships and life in general. It also made me self analyse my self.
- The props were amazing
- I really enjoyed it - it explores the intricacy and threads of trauma and ignites a conversation on a multitude of topics from class to mental health.
- I was moved by the performance especially the use of the paint and sheet in the rape scene and the use of the puppet to explore the past trauma. I thought the Hamlet intertextuality was effective when exploring the ideas of feigned 'illness' and how it can become real through

trauma. The opening wasn't as effective in its early start (it felt stunted) and also the transition from the outburst into the physical theatre section felt like it didn't connect together.

- Jordans performance was impressive with rapid changes between the personality.
- A fantastic, thought provoking, gritty piece of theatre that blurred the lines between what is real and what is acting
- Outstanding and believable, very thought provoking
- "It was intense, powerful, emotional(I cried a little) and such amazing actors. Totally immersed myself into the story because the characters were portrayed so well. Huge well done, that can't have been easy to do but you did it so so well.
- Also the absolute quiet made it even more intense.
- Jordan was absolutely brilliant at portraying his characters DID and was very genuine. the sympathy for both characters was definitely conveyed. I personally loved it!!
- It was very emotional and touches on some serious issues.

Additional feedback from audience members employed by MIND was provided to me by the organisation via email following the event.

- 'Myself and two others from Mind had a fabulous night. Thanks for the tickets. Also saw a few others from Mind there!!
- It was so, so powerful. An amazing performance...a big well done to both of the actors. Who truly got into their characters.'
- 'I went to go see it and it was very emotional and hard hitting for personal reason and work reason. Mental health is such a rollercoaster and this message definitely came through in the play. I was thankful that they gave space for the audience to process after the show had finished and didn't rush people out as it felt necessary to have that time/space.
- When the main character was creating art it would have been nice to have a view of him doing it.
- The director said that they are continuing work on this so if there's a chance to watch again after they have developed it some more I'd love to hear about it and go support.
- Art/theatre for me is very much a healing tool. I really appreciate being able to go. Thank you to them and you for the tickets'