

Performance and Postmodernism

Developing News began in the wake of “Unscientific Psychology: Conversations With Other Voices,” a conference hosted by the East Side Institute in June 1997. The nearly 150 participants from all over the world were enthusiastic about having a way to keep in touch and expand the network of people with a postmodern sensibility. Many months later, the Institute launched the first issue, originally mailed to the conference attendees. Since then, readership has greatly expanded, and this month *Developing News* goes on line – at our web site www.EastSideInstitute.org.

In addition to *Developing News*, that conference sparked a forthcoming book entitled *Postmodern Psychologies, Societal Practice and Political Life*. Edited by the Institute's director of educational programs Lois Holzman and John Morss (until recently at the University of Otago in New Zealand) *Postmodern Psychologies* continues the conversation begun at the 1997 conference. The contributors, some of whom revised their presentations, others who wrote new essays and still others who were invited to comment, include: Harlene Anderson, Erica Burman, Lenora Fulani, Ken Gergen, Mary Gergen, Lois Holzman, Sheila McNamee, John Morss, Robert Neimeyer, Fred Newman, Vesna Ognjenovic, Ian Parker, and John Shotter. The book (published by Routledge) won't be out until Spring 2000, but here's a little preview from Holzman and Morss' commentary – which sets the stage for this issue's contributors. Weaving its way throughout the authors' discussions of psychology, society, culture and politics is the concept of performance, as a method for a new way of understanding/being/becoming, i.e., for transforming human social relations. At issue is: can we create new performances of our sexuality, our emotionality, our identities, our meaning-making, our politics, ourselves? Performance, the authors imply, becomes unstoppable.

Performance is not just the first night of the show, the polished (perhaps) and single-voiced human pyramid that is the orthodox western (and eastern) theatre. The stage lights show you what you are meant to see and how you are meant to see it, just like a conventional conference presentation. Performance in that sense – the performance of Cloud Nine at the Royal Court Theatre or of The Lion King on Broadway – official performance, performance as sanctified by the institution of the theatre, is no more than the tip of the iceberg. That kind of performance is essentially repetitive, even if it closes after the first night, and even if it's been arrived at through the actors improvising in a workshop.

Performance, we think, is better revealed by the rehearsal. Here the nuts and bolts are in clear sight, yet the performance aspects are just as much present as on opening night. Actors are working in rehearsal to collectively create something new, not to display a finished product. Rehearsals lurch awkwardly between technical precision and tedium. They may stop and start unexpectedly. At one and the same time some people are performing, some are chatting about the performance, the play, the director or the acting while others about where they will have dinner after the show.

This is the performance that our contributors find relevant – even essential – to the transition from (modernist) identity to (postmodern) relationally, from a psychology of adaptation to a psychology of transformation. Their essays can also be viewed as a rehearsed performance of the possibilities afforded by the postmodernization of psychology. The implication, the authors suggest (passionately), is that such a transformation of psychology is helping to make possible a social/political/cultural transformation that goes far beyond the borders of a particular discipline. Performance, as a method and as form of life, can restructure and rebuild how it is that we are together. (Lois Holzman and John Morss)

–Lois Holzman

Conversations on Health I

Susan Massad

The medical profession is just discovering what patients have known for years – physicians are not very good at communicating. Recent work by Roter, Tuckett, Cassells and many others have shown how doctors talk *at* patients, adhere steadfastly to their own agendas, don't listen very well and are not very collaborative in their interactions with patients. Studies have also shown that, with training, physicians can get better at interpersonal skills and, when they do, their patients are more satisfied, have better health outcomes and are less inclined to sue their doctors. Not surprisingly, medical communication is a hot issue.

I have taught in the arena of the doctor-patient relationship for over 30 years and for the past 20 years have worked with Fred Newman on different medical projects. During this time I have had extensive dialogues with him and the East Side Institute staff as to how the developmental cultural performatory approach of social therapy could be useful to my work as a clinician and trainer of physicians. Three years ago funding became available at Long Island College Hospital in Brooklyn (LICH), where I direct ambulatory medicine, to develop a communications/interpersonal skills (IPS) training program for our medical residents. I successfully bid for the program and used it as an opportunity to bring the performance work of Newman and his colleagues into the medical training arena. Working with the staff of Performance of a Lifetime (POAL), the performance school for nonperformers that was conceived by Newman and makes use of his discoveries about performance and development, a collaborative project was launched in the fall of 1997 to teach IPS to first year medical residents.

In bringing the POAL staff into my hospital I wanted to introduce a training approach that was entirely different from the cognitive, behavioral approach that is typically used to teach young physicians scientific medicine. Although science and its method have made enormous contributions to medicine, it has been my feeling for a long time that the extensive training that physicians-to-be get in the scientific method does not serve them well in acquiring the noncognitive skills of relationship building. As scientists they learn to abstract, to objectify and to generalize. Building a relationship and creating a conversation with a patient, however, is much closer to creating a play or a poem. I felt these skills could best be taught by using a cultural approach.

The training program for first year medical residents consists of eight weekly workshops where they are taught the language and skills of improvisation. All of the classes start with relaxation exercises and a series of improv games and listening exercises. Residents provide material for the improvisations which are directed and redirected by the POAL staff. For example, in one scene the residents played hospital administrators from all over the solar system who had come together to develop an intergalactic health care system. They were redirected to speak gibberish. The subsequent direction was to perform different emotions.

The final workshop is a performance created out of the improvised material that is held for other residents in the program.

We have found that performance training is effectively addressing issues that have been difficult to engage through other teaching methods, including teaching residents listening skills; addressing residents' concern with getting to the point of things, and helping residents to interact more effectively when there are issues of medical uncertainty.

Based on the success of the first year training, we initiated a performance based training project for second and third year residents. We videotape resident/patient interactions, and myself, a POAL trainer and the residents review them from a performance perspective.

Through this process, residents come to see themselves as engaged in a performatory activity with another person that can be directed, redirected and played a number of different ways. A recurring theme in our discussions is "accepting the patient's offer." In improv, you accept whatever your fellow performer gives you and create with it. Similarly in performing a conversation with patients, residents can accept their patient's offers and build with them. As creators of conversation they can break with the ritual of the medical script.

We are very enthusiastic about the strength of this training approach and are now going out to spread the word. I have presented at several academic conferences this past year, among them the International Conference on Medical Communication and a meeting of the Academy and the Doctor Patient Relationship. Additionally, with the help of the POAL staff, we have lined up ten speaking engagements to present our work to medical residents and faculty in different New York City hospitals.

Susan Massad, MD is the Director of Ambulatory Internal Medicine at Long Island College Hospital in Brooklyn.

Conversations on Health II

Tom Strong

Hi, I'm Tom Strong. Presently, I am a counselor-educator of graduate students at the University of Northern British Columbia (in Prince George, British Columbia, Canada), and have a part-time practice as a psychologist. Living in northern British Columbia, I have greatly benefited from exchanging ideas regarding the practice of postmodern psychotherapy, particularly on the listserv: Postmodern Therapies, where I first encountered the ideas of Lois Holzman and Fred Newman.

My shift to postmodern thought came while researching peoples' coping efforts with chronic illness while doing my doctorate in the late 80s. Postmodern thinking has helped me to focus on relationship conditions through which meanings are retained, reflected upon and altered. This thinking fits well with my efforts to practice and teach in a collaborative manner. In recent years I have focused on the constraints on meaning-making possibilities and action created by modern language systems such as the DSM-IV and other biomedical forms of discourse. I see discourse not so much as a medium for representing, or conversing about, experience, but as a way of relating to my experience of others and myself. I'm drawn to social therapy because it speaks of a world that goes beyond our discursive ways of justifying ourselves with truths (forms of "aboutness") external to our relationships. Collaboration is seriously constrained when one of the parties claims to hold (over the other) the trump card of REALITY.

Biomedical discourse has often sewed up the meaning-making and activity seemingly possible for sufferers and caregivers, thereby shutting down many potential areas of agency-promoting conversation. And this is for experiences of suffering that English scholar Elaine Scarry views as "language-shattering," experiences ripe for many meanings, but so often cast solely in a language of symptomatology. Alongside medical constructions, I try to bring forth the other possible meanings obscured or formerly inaccessible for describing illness, since a language of symptoms scarcely conveys the complex qualitative experiences and challenges involved in suffering and caregiving. In my experience, many interactions between sufferers and caregivers are unnecessarily atrophy or routinized, in ways that create chasms of misunderstanding that promote a sense of isolation and impotence. Should this occur, the influence of pain or illness can diminish each person's quality of life in more areas than might otherwise occur. My role as a therapist has been to invite people into conversations that explore possibilities for an improved quality of life that have been obscured by the usually reluctantly acquired understandings they have been working from. These efforts are intended to help people talk beyond the familiar ways of conversing that have not made a difference, to engage their subjective views about experiences usually spoken of in limiting forms of discourse, to look beyond symptoms to optimal ways that can continue beyond my office.

For more on my work in this regard, please check out: "Conversations about conversations on chronic pain and illness: Some questions and assumptions for a one day workshop," (in *Geeka: A Journal of Deconstruction and Narrative Ideas in Therapeutic Practice*, 2, 1997 45-63) and "Macro- and micro-conversation in conspiring with chronic pain (to be published in the Fall 1999 edition of *The Journal of Systemic Therapies*).

Building on the ideas in these articles, I intend to explore themes related to the performance of meaning as sufferers attempt to articulate their hurts with caregivers as they negotiate care. How, for example, does a person on chronic disability negotiate with his/her caregivers (professional or otherwise) the implications of a worsening of his/her condition – when all had hoped for improvements in that condition?

Tom Strong is a counselor-educator at the University of Northern British Columbia and a psychologist.

Conversations on Health III

Joan Fleischman

Madge came to me as a patient in an unusual way. I had been standing by the front desk and she was upset because of a mix-up with her appointment time. She needed some medications and there wasn't a doctor available to see her. I was drawn to her and liked her feistiness, and asked what she needed. She only needed a refill on her blood pressure medicine and said she would make another appointment.

She was an older West Indian woman, bright eyed and assertive. She was wearing a pink turban, with a large safety pin at the front. I loved the vibrancy of her striking white eyes against her dark skin, and her pronounced cheekbones. We went to a patient room. We said nothing to each other. She opened her bag, handed me her bottle of pills, hopped up on the examining table and held out her arm. I noted the medication in the chart. She was on the lowest dose prescribed.

As I measured her blood pressure at 170/110 I was thinking this was going to be more complicated than I'd bargained for. So much for a simple prescription refill. As if reading my thoughts, she snapped at me, announcing: "I've been with this problem for 20 years and I know how to handle it. I'm not changing my medicines".

I nodded.

"I'm going to show you something." At that point she took me by surprise as she lifted up her shirt. Underneath was hanging a big sign covered in plastic that said, DO NOT RESUSCITATE. "When the Lord thinks it's time for me to go, then it'll be time. It doesn't have anything to do with these medicines. I don't want to be a bother to nobody."

I nodded again. I wondered, though, why she came in at all if she felt that way. I refrained however from asking the question. It seemed something we would get to know over time. I felt a strong fondness toward her, and hoped she would come back to see me. I felt vulnerable in my desire to have her follow up with me.

"I'd like to talk more about this on another day. Do you want me to be your doctor?"

"Not if you're going to change my medicines. I know my pressure. Doctors don't understand these things."

"I can't agree to that, but I can promise we'll only do things you agree to do."

"That's a good start."

I gave her the prescription for the same dose of the same medicine, feeling it wasn't going to help her.

When she came back she started in immediately, explaining that she was different from all other people with high blood pressure. Hers developed when she was hit in the head at age 40. Until then her blood pressure had been completely normal. Because it started from a blow to the head, it didn't respond the same way to medicines. She had been to so many doctors and none of them understood that.

Everything was going bad in her life when the pressure started. She had an ovarian cyst taken out, then fibroids, then finally they did a hysterectomy. She was getting divorced and her son turned on her. He lived in California and they still didn't talk. "You know how you raise them and then they turn on you." She didn't care. She didn't have anybody in her life. "Just me, God, and now you." She said I had better not leave her now that she was attached to me.

She lived in the projects down the street. She didn't have any friends and kept to herself. At some point I asked if she was lonely or depressed. She looked at me, and laughed and laughed. "Oh no! I have a beautiful life; every minute I have that God gives me is precious. I love my life." She described her crafts. She made crafts out of beads and shells, beautiful shells. She would show me at our next visit.

"What are we going to do about the medicine for the blood pressure until then? It's 150/100 even on the medicine."

"I've been working on that. I'm taking these new herbs. I want to see how they'll work."

"It's certainly come down since our last visit, but I'm a little worried about it. I think you should continue with the herbs, but maybe you could try a higher dose. You're on the lowest dose possible. How about if we double it?"

"Oh no, no, no. That would make me dizzy."

"You're right. How about one and a half?"

"O.K."

She agreed, remarkably easily, as if there had never been an issue about it.

When I completed my residency training in family practice I felt something lacking in who I wanted to be as a physician. It wasn't that I was insensitive or unresponsive to my patients. Instead, it seemed that there was an artificial separation between what I was trained to do medically and the more human aspects of helping people with their health. I began the two-year training program in social therapy not knowing how much this would change my entire practice of medicine.

Early in the program I attended a workshop where Fred Newman, differentiated between *having* conversations and *creating* conversations. Conversations we "have" are automatic, reactive and based in social roles. Conversations we "create" have to do with actively listening to another person and stepping out of roles to develop a creative response. Created conversations are "purposeless" and are like the way children babble with each other. I was fascinated with this way of seeing how we talk with each other, and worked to see if I could bring created conversation into medical visits. What resulted challenged the major assumptions of the medical model. As I started to actively listen to all of what my patients said to me, it became obvious that I had been taught *directed listening* in medical school. I had learned that there were diseases, and that my job as a physician was to direct conversations in order to only understand what problems existed that I could fix. I had learned to listen for a purpose, rather than listening to people. I had learned that health was the absence of disease, rather than an activity or a process. Classifying symptoms into diseases, while useful, had also prevented me from seeing processes and the totality of people's health.

Giving up control of the visit and allowing people to play an active role in what we do together transformed medical conversation, and seems to have a direct impact on people's health. I see people take responsibility for their health in ways I hadn't seen before. The medical questions, while still tremendously useful, no longer drive the visit. And I, stepping out of the authoritarian role, have learned to simply be helpful in ways that I can.

Joan Fleischman M.D., is an attending physician in the Department of Family Medicine at Long Island College Hospital and is on the faculty of SUNY Downstate in Family Medicine. In Brooklyn.

My Journey to the Border

Ellen Peskin

I stumbled into becoming a therapist. The idea occurred to me over 20 years ago when I read a brochure about a Master's Program in Clinical Psychology. It was addressed to my ex-husband who had moved out months earlier. Totally at a loss for what to do with my life, the program sounded like perfect fit for me. I was quickly captivated by psycho-dynamic thinking. The idea that people's personalities "made sense" in a linear way – that their early experiences shaped them – was very intriguing and comforting to me. It assuaged my terror of chaos and eased the anxiety I felt when faced with my own or other's pain and confusion. I enjoyed the search to find the missing pieces of the puzzle that could help people make sense of their lives.

I became enamored and interested in one theory and approach after another. The different theories were like maps that identified the "terrain" and pointed towards specified goals. All of them focused on the individual. My own two therapists (Jungian) and a couple of admired supervisors were the strongest influences on how I was doing therapy.

I cannot separate the therapy I was doing from how I was living my life. My privilege, my narrow homogeneous world and Eurocentric lens made me blind to much of life. My "bubble" popped one miserably rainy night when I was having dinner with a friend. She looked disturbed as the waitress

brought the food to our table. I asked her if something was wrong. She apologized for what she was about to say, hoping it wouldn't ruin my dinner. She told me she couldn't stop thinking about a homeless man she had befriended. She wondered if he had shelter from the rain and warm food to eat. She told me about his life – how he was a gifted musician and had fallen on hard times. As she spoke, the savory food turned to dust in my mouth. Her compassion broke through the protective walls around my heart and I could no longer wall off my pleasure from her homeless friend's pain.

Later that night I tossed and turned in anguish and conflict about my privileged life and those whose suffering I had ignored. I remember asking myself, "How do you live when you let the world in as it really is for so many people who are suffering?" It was one of those pivotal moments. I had started my journey to the border, though I didn't know it at the time.

I did a lot of soul searching in the ensuing years and the therapy I was doing began to change. I was introduced to Narrative Therapy as practiced by David Epston and Michael White. I began to see my clients lives in class and cultural and gender contexts. I became more curious and playful and spontaneous in my work. A group of friends who were narrative therapists got together to be a reflecting team for each others clients. It was very liberating to break out of the isolation of private practice and to collaborate with each other. A Narrative Conference in Vancouver, B.C. in 1995 changed my life further. A small but passionate and vocal group of therapists of color challenged the leadership of the conference to make Narrative Therapy accessible to people. Their voices resounded throughout the conference. I left that conference shaken and inspired and scared, committed to find ways to address the issues of injustice my eyes had been opened to.

Three months later, I walked away from the life I had been living. The journey since then has been incredible challenging – full of conflict and learning, development and love.

I came upon social therapy after participating in a number of contexts where issues of diversity: class, race, homophobia, and gender had increasingly divided and paralyzed conversations. When I came upon the development community, of which social therapy is a major part, I was searching for a different approach to building bridges, not necessarily a new way of doing therapy.

I was powerfully effected by the first Life Performance Training I attended. The participants created a group therapy session and were directed to re-perform their roles with changes in their voices, gestures, manner etc. I was amazed at how a simple change in our performances changed everything! It was a powerful antidote to the feelings of helplessness and paralysis I experienced in the diversity forums I had been in. Since my introduction to Social Therapy, the therapy I am doing has continued to change a great deal – along with the way I am leading my life. I feel more openly expressive and human and closer to my clients which is allowing me to take more risks in confronting and challenging them. The transition has been rocky for me and for some of my clients. I often feel very awkward without the "protection" of knowing what to do. It has been humbling and strengthening to experience relationships continuing to grow, despite my mistakes, and to risk leading and directing without a map. It's ironic. Though I feel more insecure, I experience a deeper confidence in myself and others, trusting that we are creators and choice makers and that there are always moves to make.

Ellen Peskin has been a therapist in the San Francisco/Bay Area for the past 23 years. She has recently joined the staff of the West Coast Center for Social Therapy. Peskin brings to her current work a life-long interest in working with people to develop creative responses to what can seem like paralyzing problems.

Tool and Result Strategies in the Classroom: Benefits and Challenges

Patty Wilson

Imagine being myopic for your entire life, but not realizing it. I have lived as a professional secondary school teacher and counselor in the public school system for more than 20 years now. I have learned certain methods for teaching and conducting counseling sessions with youth. It's likely that I have done little harm and, in fact, may have had a positive impact on youth because I do care about them. But for two decades, I have maintained – as many people have done – that I am in charge and know what I am doing. I've continued to acquire knowledge and expertise using strategies ranging from psychodynamic to

systems approaches in the class and therapy room. I had accepted this methodology; there was nothing else available to me for many years.

The world continues to change, as young people know very well. Yet adults continue to forge ahead as if they know the way. I have done plenty of forging (and wondering why things were not going too well in my work). I held onto my methods which were comforting for short periods of time. Despite my myopic view and out of a compulsion to be creative, I have had periods of being willing to try something new. I returned to school several times, acquiring an MA in Clinical Psychology and other credentials – all of which offered methods that purported to transform the individual. The packaging was altered, but the methodology was basically the same; nothing had changed. I continued to interpret, analyze and provide the final word on how the classroom and therapy will function.

But it has not worked. I have remained at a loss while staying in the comfort zone to some degree, yet strangely compelled to continue my activity of seeking ways to improve upon the situation in today's world. They seem to know something(s) of which I have had not a clue. The rationalist, product focused, moralistic approaches just do not work.

A tool and result approach offers educators, therapists, parents and all people an opportunity to give. My vision is gradually improving. It's likely that I'll never have perfect vision, given my imperfections as a human being, but I now have additional tools to enhance the view. I have been given permission to create with others without knowing how it will develop. I don't need perfect vision after all.

There are challenges and benefits of practicing social therapeutic methodology. The challenges may look like this to a teacher: I have a choice. I can consider maintaining my role as the all-knowing teacher, dictating rules and correcting papers without creating with young people. Or I can consider strategies for teaching that focus on how my students will develop from childhood to adulthood in a rapidly changing world. The latter requires that I consider and work with young people on what it means to learn and develop in our classroom environment and in our world.

This conversation – which is not scripted, but improvisational – goes beyond products and content; it incorporates process and product as unified activity. Choosing to create an environment where I give what I have rather than getting what I can from children and teens is far more satisfying – it has the potential for growth for everyone involved, including me. If it sounds difficult, the alternative – teachers as all (seeing) knowing – is a defensive position in my view (myopic as it is) and usually yields strategies that assume a “getting” position of control or staying in the comfort zone as the knower.

A strategic perspective of giving what you have to youth rather than getting what you can from them is rare in our culture and vastly undervalued. It's probably only understood by actually engaging in this kind of activity. I myself speak from only limited experience, but I believe it's a strategic move worth trying, especially if you, too, consider that your vision is blurring as the world passes you by, and are motivated enough to consider a kind of radical laser surgery methodology. The revolutionary nature of tool and result method, where all concerned are challenged to go beyond themselves, has a powerful impact on people's lives. Likewise, the practical daily activity of creating with others couldn't – ironically – be more basic to our human need to do something with others in our life.

Patty Wilson is a secondary teacher and counselor in the San Francisco/Bay Area, and on staff as a developmental mentor at the West Coast Center for Social Therapy.