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Playback theatre and narrative therapy: introducing a new model

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This article explores a new synthesis between Playback Theatre and Michael White's narrative therapy. Through an exploration of the two methods the article elaborates how such integration can be achieved and how it can contribute to the process of narrative re-authoring. The discussion also includes the limitations and possible drawbacks of such integration, for both playback theatre and narrative therapy. Finally, a structured therapeutic model integrating White's approach to narrative change with Playback Theatre techniques is detailed.

Keywords: narrative dramatherapy; playback theatre; narrative therapy; Michael White; problem externalization

Introduction

Combining narrative therapy and dramatherapy is a widely accepted therapeutic practice. Narradrama, founded by Pamela Dunne (Dunne 2000, 2003) is a comprehensive approach that combines narrative therapy, drama, and other forms of creative arts. Dramatherapy techniques are also embedded in narrative therapy sessions and are accepted as having a valuable contribution to the field of practice (Novy, Ward, and Thomas 2005). Finally, dramatherapy has been shown to open up new possibilities within narrative therapy while remaining in line with its basic principles (Chan 2012). However, discussion of narrative-oriented dramatherapy models in the professional literature has been scarce and warrants further consideration. To address this knowledge gap I wish to suggest a new model for narrative dramatherapy. The model combines Playback theatre (PT) with Michael White's narrative therapy. I will begin by briefly describing both methods.

Playback theatre and narrative

PT (playback theatre) is a theatrical form that was founded by Jonathan Fox, his partner Jo Salas, and their group 'It's All Grace' during the 1970s (Salas 1996).

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In PT, a group of actors improvise short scenes as a response to real-life personal stories. The scenes give the storyteller a new perspective or insight, a sense of validation and affirmation to their feelings (Salas 2009), and a look into alternative options (Fox 1982). Personal stories in PT are always told voluntarily and always in front of an audience. The audience can be a small therapeutic group or ticket buyers in a performance context. Accordingly, a PT performance promotes community values of togetherness and connectedness (Fox 1982; Nash and Rowe 2000; Salas 1983).

The process of PT is rooted in a well-thought-out ritual. This ritual is composed of a set of rules that define the sequence of events and define the roles of its main participants: the teller, the audience, the actors and the conductor (Fox 1999). The ritual starts with the conductor inviting a teller to tell his story. The conductor interviews the teller, and instructs him to choose roles for the actors. After the interview is over, the actors improvise one or a few short scenes that are based on the story's materials. When the scenes conclude the actors stand still and symbolically bring the story back to the teller with a look of acknowledgment. The ritual ends as the teller comments and reflects upon what they have witnessed (Chesner 2002). While it serves as containment to the emotional and social experience of participants, the ritual also emphasizes the flow of theatrical event (Salas 1996).

Since its foundation, PT has become an important source for dramatherapists in therapeutic contexts (Landy 2006). However, most writings that address PT's therapeutic attributes avoid defining it as therapy and therefore do not supply the reader with a clear therapeutic route to follow (See for example, Nash and Rowe 2000; Hoesch 1999). When an explanation about PT as therapy is provided, it is usually coined in narrative terms. Salas, for example, describes playback as a process of rewriting and refining the teller's story. She explains how 'fragments of life, often chaotic, half understood by the teller' transform by a PT performance into 'crystallized, made clear and coherent' (1983, 18–19). She further explains that, during the process of acting, the teller can be invited to imagine a new outcome or to witness a transformation of his story 'that the actors bring to life' (2009, 446). Fox addresses the particular issue of narrative transformation. He explains that such a transformation can be achieved by changing of the ending of a story on stage. These transformed interpretations of personal events are based on the belief that 'individuals are responsible for their own alternatives' (Fox 1982, 300). Rowe emphasizes the connection between PT autobiographical narrative and memory work. He describes the interview of the teller in a playback session as a process of co-creating anew the teller's story (Rowe 2007). Finally, Moran and Alon (2011) argue that PT can promote the ability of tellers to re-author their story. This common use of narrative terminology points to PT's strong connection to narrative thinking, and hint to the possibilities of using PT techniques in a narrative dramatherapy session.

Michael White's narrative therapy

Michael White's therapeutic method plays a central role in the field of narrative therapy. White (1948–2008), a well-known Australian psychotherapist, was one of the 'narrative therapy' founders. He began his career as a social worker and a family therapist. Between the years 1983 and 2008, White and his wife Cheryl co-managed the Dulwich Centre in Adelaide, a family therapy center, and the Dulwich Centre Publications, the main publisher of his writings on narrative therapy. Throughout those productive years White explored therapeutic ideas that were influenced by post-modern philosophers, such as Michel Foucault, and led numerous international workshops to teach his methods (Speedy and Payne 2008). White collaborated with other family therapists to develop narrative therapy, mainly with David Epston with whom he wrote their well-known and influential narrative therapy book: *Narrative means to therapeutic ends* (1990).

At the root of his method, White identifies a specific type of personal story as a dominant story. A dominant story is a story that governs the life of people, as it defines issues of identity and life choices for them. Relying on a Foucaultian viewpoint, White argues that dominant stories are socially, politically, or culturally imposed on individuals and, therefore, not necessarily objectively true or false (Besley 2002; Madigan 1992). Hence, if a dominant story appears to have negative effects on its narrator, White suggests a therapeutic narrative reconstruction (Carr 1998; White 2007).

Re-authoring is the term White uses for changing a patient's story, and it is a fundamental feature in his narrative therapy (Epston, White, and Murray 1992). Re-authoring is achieved by two major practices. The first is the identification of unique outcomes, namely positive narratives that do not fit in the dominant story, and therefore, slip the client's awareness (Gonçalves, Matos, and Santos 2009). The second is the externalization of the problem. Externalization involves rejecting intra-psycho identification with the problem in favor of regarding it as exterior to the client (Tomm 1989; White 2007). It can be achieved by attributing a character to the problem (White 1984) or through a dialogue in which the client learns to use 'I have a problem' terminology, rather than 'I am the problem' (Bubbenzer, West, and Boughner 1994).

White's therapy contains within it a process of slow and thorough dialogue about externalized problems and unique outcomes. With regards to externalized problems, the therapist's role is to expand clients' awareness of the reciprocal 'relative influence' they have on each other – namely how the problem affects the client and vice versa (Carr 1998; White 1995, 2007; White and Epston 1990). This dialogue promotes the clients' awareness of their proactive ability to overcome their problems. With regards to unique outcomes, the therapist role is not only to identify them, but rather to expand their presence in the narrator's life by incorporating them into a story and thickening the new plot. This process further develops the client's capacity to regard unique outcomes as an opportunity to

change his dominant narratives and to create an improved and more personalized narrative (Draucker 2003; Moules and Streitberger 1997).

Finally, White emphasizes the role of providing a public place for new positive narratives that emerged in therapy. Accordingly, he encourages therapists to invite an audience to individual therapy sessions (Payne 2006). The outsider witness groups are guided to act as reflecting teams that share their thoughts and feelings about a client's narrative re-authoring, with the narrator and with each other (White 1995, 2007). In addition to reflecting teams, White encourages clients to tell their new stories to others. Such practices assist clients in maintaining their sense of change, along with helping witnesses to look differently at their own narratives.

Playback narrative therapy – a synthesis

As shown, White's therapeutic principles are not far from what constitutes PT's basic principles of narrative transformation. Both methods re-author narratives, in front of an audience, with the purpose of bringing a new and more adaptive coherence into them. Both methods look for possibilities to make use of a new imagined outcome, or an existing underappreciated unique outcome, in the process of narrative transformation. Hence, by combining the two methods, a powerful intervention technique can emerge.

Yet before we move further to explore a possible combination of PT and narrative therapy, it is important to critically examine the possible limitations of such a synthesis. The aesthetics of PT is based on a theatrical emphasis, rather than on a narrative-psychological one (Fox 2007b). Hence, while a theatrical emphasis may stress the flow and pace of a PT session, a narrative therapeutic emphasis would favor progress toward therapeutic goals. Accordingly, a true systematic use of narrative reconstruction within playback theatre may result in a possible loss of theatricality and artistry. As an alternative, I suggest using a well-defined contractual model that permits a slow and thorough narrative exploration within a closed therapeutic setting. This suggested synthesis is not a direct implementation of the originally conceived PT, but rather a model inspired by the method.

In narrative therapy, it is arguable that theatrical manifestations of narratives may, on one hand, enlarge and exaggerate them beyond their true proportion, or, on the other hand, simplify the complexity of stories to interactions between one-dimensional stage characters simply portrayed by group members. This can be caused, to some extent, by the medium of improvisational theatre, which does not allow extensive preparation before an enactment. Through a sensitive therapist-client dialogue, however, such exaggerations may illuminate new aspects of the teller's story, help them to identify those aspects, or reject the level at which they are exaggerated within their enacted scale. Identifying simplifications and striving for a more complex way of enacting and understanding narratives, offers a powerful therapeutic leverage for all sides involved. As a group becomes more learned and skilled in its practice, it is expected to find more accuracy and depth in its work.

Whilst taking into account possible barriers and limitations, I would like to suggest an integrative model of PT and narrative therapy and expand on its potential. The model draws from White's emphasis on key features of narrative therapy (1995) and uses Carr's detailed typological analysis of those features (1998). This model is best suited to a closed therapeutic setting, what Salas identifies as 'the workshop model' (2009, 446). It is based on PT as a comprehensive source of techniques and inspiration, but does not necessarily keep all of its original structure and goals. The new synthesized model is composed of five basic features: (a) establishing a dialogue of co-authoring and consultation, (b) validating the teller's story, (c) externalizing the problem, (d) identifying unique outcomes and thickening the plot, and (e) 'taking it back' to the group and to others.

The stages of the model are most clearly illustrated through a case study. The case study presented in this article describes a highly structured session, though the same process might leave room for more intuitive, less organized exploration of narrative-oriented issues in other circumstances.

Case study – re-authoring guilt

The narrative PT group has existed for about six years. The group operates once a week for a three-hour session. The meetings start with a one-hour workshop that contains drama exercises that help participants choose a personal story and explore different aspects of their story. The workshop ends with a group sharing. After the preliminary workshop, three tellers tell their story and watch it be performed on stage.

Establishing a dialogue of co-authoring and consultation

Tellers in therapeutic settings often bring stories that need to be opened up by an interview; the purpose of the interview is to give the teller and the actors a greater understanding of the original story. Using a playback narrative therapy approach, the conductor-therapist can choose one of two options: (a) to add a long therapeutic interview before the acting begins or (b) to perform an ongoing dialogue between the therapist and the teller throughout the session between acts. In the first case, a long interview between the conductor and the teller is initiated. During that interview, options for externalizing problems are suggested and unique outcomes are revealed and expanded. This process gives the trained group members rich material for performing according to White's outlines. In the second option, an ongoing dialogue between the therapist and the teller is established before, between and after the scenes are performed. This ongoing dialogue can act as a vehicle for a collaborative process of re-authoring, and serve as a means for representing more accurate and powerful scenes that will have a greater therapeutic effect on the teller. In both cases, I suggest extending the 'regular' PT session, and generating a process in which many scenes can be performed, according to the client's needs.

The story

Daniel is 36 years old. He came to our meeting after a two-day trip to the south of Israel that did not go well. He sat on the teller's chair and started to narrate. As he could not easily find words to describe his feelings, I interviewed him throughout the session. During the interview I used White's method of 'experience near language' when I asked questions or commented (1995). Whenever possible, I used the same words or phrases as Daniel did. Using experience near language is an essential step toward establishing a collaborating, co-authoring position of the therapist (Carr 1998). When the preliminary interview was over, the group better understood Daniel's story

Daniel and his cousin decided to go hiking once a month, so that they could eventually walk the entire Israel trail – a hiking trail that crosses the country from north to south. Both of them are very fit and exercise intensively. But as they started the joint venture many of their friends and family decided to join them. Soon the two cousins found themselves hiking with people who they love and respect, but could not share the same enthusiasm for physical strain.

During the weekend before the meeting, in the middle of the hike, when it was cold and raining, one member of the hiking group felt that he was not able to continue. He was too cold and tired. Since Daniel was the founder of the group, everyone looked to him for a decision. He did not know what to do: urge the group to continue; lead the group back to the camp; or carry on only with his cousin and let the others go back to camp by themselves. Since he felt responsible, he put his recreation and enjoyment on hold and took responsibility for leading everyone back to the camp. He felt miserable and angry for having to give up his plan. However, as he saw how wet and cold his partner was and how ill-equipped he was for winter hiking, Daniel felt guilty for even contemplating continuing the hike. Even after he returned to his apartment after the hike, Daniel still blamed himself for being insensitive and unaware of his companion's hardships.

Validating Daniel's story

A key healing feature in PT is the validation of subjective experience of a personal story through performance of the story (Salas 1996). This affirmation constitutes a basic condition for re-authoring. Thus, our sequence of enactments begins with a scene that validates the teller's perspective about his own story. Such a scene can be composed of a PT short form, like the chorus that echoes the story in sounds, words and gestures that are offered by shifting leaders and repeated by the other actors (Fox 2007a), tableau stories, a technique of retelling the story as a series of titles, with the actors freezing and forming a tableau as a response to each title (Sanders 2008), or a direct rendition of the plot. All three methods offer a retelling of the same story, using the story's vocabulary, without changing its basic content and structure. When the enactment is done, the conductor may

choose to ask the teller – was it your story? If the teller feels that the story was presented incorrectly, then the group tries again until it produces a successful performance. The next phase of the therapeutic process begins only after validation is accomplished.

In order to validate Daniel's story I asked the group to perform a validating scene, without directing them how to perform it. All group members went on stage and formed a structure made of people holding hands and hugging each other. They began walking together without unbinding the group. The actor playing the protagonist, Daniel, was in the middle. When some group members began to go back, he tried to separate himself from the group hug. The group did not permit Daniel to leave, but also did not allow him to stay at ease within the hug. This enactment reflects an interpretation of 'fluid sculptures', a PT short form. In fluid sculptures, actors collaborate to build a human sculpture that represents their reading of a told story. The sculptures are fluid, as they move to represent different stages and aspects of the narrative (Dennis 2004; Salas 1996). 'Does that look like your story?' I asked Daniel at the end. 'Yes', he replied. 'That's exactly how I feel'.

Looking for the right externalized problem

In the next stage of the process, the group offers several short interpretations of externalized problems; each problem is portrayed as a mythological fight between the protagonist and an opponent. The results of the match always are unclear and demonstrate that the fight can be won or lost. Considering this ambivalence, the conductor might ask questions, such as, would you like to say something to the problem? Would you like to help us identify key features in this hardship?

White (2001) entitled this type of interviewing as an 'externalizing conversation'. He argued that externalizing conversations often reveal negative conclusions that clients have about their own identity. 'Thin conclusions' is the term White gives to these negative, personal conclusions. 'Thin conclusions' are narrowly described and based on a small selective part of the complete story. Externalizing conversations can reveal thin conclusions and may further illuminate the relevant influence of the problem on the client and vice versa. In the model I use, the teller's answers are immediately implemented in further scenes. In Daniel's case, the interview helped him and the group to focus on the right externalized problem.

I asked Daniel: What do you identify as your problem? Danielle contemplated his inability to give up. 'I needed to notice how ill that guy was', he said. 'He was almost in a state of hypothermia. Sometimes I am just not flexible enough. I have to learn how to change my plans, if circumstances change'.

I asked the actors to externalize what Daniel identified as 'my inability to give up', so that Daniel could decide for himself about his relationship with that particular problem. In a second scene, the inability to give up was portrayed by an

actress who whipped the onstage Daniel and forced him to carry on with the hike, although the situation did not permit it. Whenever he tried to give up, for whatever good reasons he gave her, she insisted that he continue. 'Carry on', she demanded. 'You have to follow your plans'.

I asked: Is that what you identify as your problem?

Daniel was not satisfied. After seeing the externalized problem he realized that his problem was not being insistent, but rather being filled with guilt and not being able to pursue his own goals if the slightest inconvenience appeared. This feedback invited us to correct the scene, so that it would be more accurate for Daniel. Fox (1982) argued that 'a mistaken first interpretation will often help the teller reveal what is necessary for really capturing the experience' (11). While in many cases correcting a scene is achieved by redoing it with minor changes, it is also possible to offer a different more suitable scene.

The group returned to the stage to interpret an externalized problem that was defined as 'guilt'. An actor playing Daniel stood at the corner of the stage and made himself a big sandwich. He was planning to eat it when a beggar arrived and said that he was hungry. The Onstage Daniel really wanted to eat the sandwich but the beggar pleaded with him and looked really hungry. Eventually, Daniel agreed to give half of his sandwich to the beggar, saying, 'Here, take a half'. However, the beggar refused. As miserable as he was, he insisted on having the entire sandwich to himself. Meanwhile, another actress approached the scene slowly until she finally stood at Daniel's side. She confronted him for not giving up the sandwich, making him feel very guilty about it. Eventually, he gave it up. After the beggar ate it all, the 'guilt-giving' actress pointed to the floor and said in a soft voice, 'you can eat the crumbs'.

This scene metaphorically reflects the teller's basic conflict within an external, distanced context. Dramatic metaphors are a basic component of PT (Nash and Rowe 2000; Park-Fuller 2003). As the group moves deeper into the telling of Daniel's story, it is not surprising to find such a distancing mechanism at work; distancing through metaphors makes the onstage materials more accessible and less threatening for the teller and the group.

Identifying unique outcomes and thickening the plot

After the mythological fight between the protagonist and his externalized problem is demonstrated and is validated by the teller, the conductor can choose to interview the teller about unique outcomes. Possible questions to be asked during this stage might be: Do you remember an event when things were different from what you described in your story? Can you tell us a story about a time when you reacted differently? In order to thicken the plot, the therapist may encourage the client to make more connections from the unique outcome to the past and to the future. Accordingly, the conductor may ask questions like: if you could hold on to that feeling, in your opinion, how would that feeling affect your life in the future? Or, can you identify the roots of this story in your past? The answers to these questions are used to produce more scenes.

For example, in Daniel's case, I asked him, 'Can you remember a time when you did not abandon your plans? A story where you succeeded to follow your wishes, although there were objections?'

Daniel had an example. When he was 25, he was a player on a local amateur football league. He was asked to give up his place in the opening team for social reasons; another player had a brother on the team, and they wanted to play together. Daniel was offered a complex system of replacements that enabled the brothers to play together and that guaranteed all of the players an equal time to play, regardless of their performance level.

Daniel did not agree. Although it was hard, he did not give up his place on the team. He thought that only the players' ability was relevant, and he was one of the team's best players. Throughout the season, the situation became increasingly difficult as Daniel felt that he was not able to be 'the nice person' the team expected him to be.

I asked the group to comment on the football team story in relation to the original hiking story. An actor went to the stage to act out this unique outcome and to give it presence. He stood in the middle of the stage and marked an imaginary line that he refused to cross. The entire group approached him and tried to force him to move, but he refused. He looked stubborn, but happy to be able to stand in his place. Nothing the other group members did, including physically trying to move him, worked.

This performance portrayed an alternative ending to Daniel's story. In PT terminology, the scene can be defined as a transformed scene (Fox 1982). The conductor can suggest transforming a scene by asking the teller to imagine a different ending to his story. In Daniel's case, the group intuitively chose to portray a complementary transformative enactment to the initial validating enactment of the session. While at the first enactment the protagonist was physically forced by others to move along with their hug, this time he was able to escape despite their constraints.

I tried to make a connection between the football team story and an imagined future. If you were able to keep that strength and use it in other aspects of your life, can you imagine how it would influence you? Daniel replied, 'I would feel less guilty all the time'. I asked the actors to perform another scene about this possible future. Two actors went on stage: An actor representing Daniel, and an actress representing guilt. The actress begged Daniel to stay with her. She used all the excuses that Daniel previously had used, namely: loyalty and responsibility. She was clinging to him, trying to make him feel guilty. Eventually, he succeeded in persuading himself that no harm would occur if he left her.

Immediately after that scene, another actor went on stage; this actor dramatized a rewriting performance. He narrated the story as a dramatic monologue in which Daniel was able to follow his own desires. This is a short form we sometimes use in order to make a re-authored story imaginable and concrete. In this enactment, the actor took into account the fight against the problem of guilt and self-hatred and the option of overcoming them. His monologue was a

heroic monologue of victory over an externalized problem. It was a monologue of an alternative story in which Daniel is able to complete the hike he so carefully planned.

I ended the session by inviting Daniel to reflect upon an open-ended question during the upcoming week: Can you communicate with that 25-year-old boy that did not give up his place on that football team? And what would he advise you to do, if such a dialogue would be possible?

Taking it back

In the playback narrative therapy model, I use reflecting teams in between scenes or at the closing of an individual session. Using reflecting teams in the middle of session provides precious feedback and insight about the story as experienced by the peers. This feedback, consequently, can contribute to more enactments as well as to more accurate interpretations of the story told. Using reflecting teams at the end of the session can help group members connect to the original story, and can give the teller additional valuable feedback. I consider this personal sharing with outsiders to be a ritual in which new narratives are shared and validated.

I asked the group to reflect upon what they felt in relation to the story. Everyone commented how the story affected them. All participants shared a common feeling of frustration from the fact that Daniel could not find a way to satisfy his desires, without hurting others or feeling guilty. Some group members shared their own difficulties about not being able to do what they really want because they try to be nice to everyone.

Daniel summarized the discussion by stating that his relationship with his story had transformed. 'When I came to tell my story, I did not realize how deep my reflex of giving up my own desires for others was. I thought that I was to blame for even contemplating continuing when someone was having a hard time. I guess I have to think about how not to be selfish, but yet, make room for my desires and needs'.

Conclusion

PT techniques and conceptions can be incorporated into a narrative dramatherapy framework. This can be achieved well by identifying key features in White's theory and applying them in the practical field of performance. As PT deals with stories that are constructed and reconstructed onstage, it is important to have the opportunity for extended and ongoing dialogue between the teller and the conductor-therapist, and to allow the group members to select different roles according to different aspects of the story. Giving a reserved place to enacting externalized problems, to revealing unique outcomes, incorporating them into a story, and dramatically thickening the plot, may contribute to the process of re-authoring that might otherwise not be achieved. Engaging the group in practices of validation and reflection can be achieved by formulating reflecting teams in

the middle or end of the session. These basic features can be learned and practiced by PT practitioners interested in integrating narrative dramatherapy into their therapeutic practice.

Notes on contributor

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