ALTERNATIVE REPRESENTATION OF WOMEN AND MENTAL ILLNESS:

"IMPATIENTS" IN THE WAITING ROOM

by

Lee Anne Block

A thesis submitted in conformity with the requirements
for the degree of Master of Arts
Department of Curriculum, Teaching and Learning
Ontario Institute for Studies in Education of the
University of Toronto

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ABSTRACT

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Master of Arts, 1999
Lee Anne Block
Department of Curriculum, Teaching and Learning
Ontario Institute for Studies in Education of the University of Toronto

This thesis inquires into how popular theatre functions to create alternative representations to dominant discourse. It is contextualized in the writer’s work on a community-based play about women and mental illness, The Waiting Room. An analysis of how narratives function to resist socially constituted identities is central. The role of the teacher/facilitator in structuring storytelling and collective theatre is examined and the agency of participants is emphasized. The thesis proposes that representing illness and wellness on a continuum, rather than as a dualism, is important in reframing how mental illness is understood and experienced. The gendering of mental illness is considered as occurring at two levels: metaphorically in the connection made between passion or unreason and essentialist notions of the feminine; concretely in the differing experiences of women and men in the mental health care system. In performance, The Waiting Room suggested alternatives to stereotypical images of mentally ill women.
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This thesis is dedicated to the women of The Waiting Room.

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CHAPTER I - FRAMING *THE WAITING ROOM*

Galaxies of women, there
doing penance for impetuousness
ribs chilled
in those spaces of the mind

-Adrienne Rich, *Thinking of Caroline Herschel*

This thesis develops at the intersection of three aspects of my life experience: my work as an educator, my work in theatre and my work in living with mental illness. Broadly, I politicized my personal experience of mental illness through collective work with other women on a popular theatre piece about women and mental illness, *The Waiting Room* by Joy Beauchamp with Acting Out. This play was intended to serve as an educative experience for both participants and audience, who could also choose to participate in a workshop following the play. This thesis proposes that *The Waiting Room* was effective in resisting dominant representations of “madwomen” and performing an alternative representation which situated illness and health on a continuum. I believe its effectiveness was a function of the collective process of developing the play. The process situated women who had self-identified as consumers of mental health services as performers and co-authors. That process in turn penetrated the performance of *The Waiting Room*.

An analysis of the project’s effectiveness must address its scope and the gritty details of actualizing it. This analysis must situate “mental illness” within historical discourses while respecting its material manifestations in human lives. In this introduction I contextualize my experience of mental illness and outline the play’s content and development. I introduce the discourse of mental illness and suggest how the play challenged dominant discourse. Chapter II examines the discourse of mental illness more closely in relation to the construction of the bourgeois subject. The storytelling process in educational and popular theatre contexts is explored in Chapter III, with a focus on the role of
the facilitator in popular theatre. In Chapter IV that exploration is particularized in relation to *The Waiting Room* project and the transition from story-telling to playbuilding. The representation of women and mental illness that evolved from that playbuilding process is analyzed in Chapter V. The educational possibilities and limitations of a popular theatre project are suggested in Chapter VI, through examining the evaluations and reflections of participants in *The Waiting Room*. These reflections include material from interviews I conducted with Acting Out members in the summer of 1998.

**Contextualizing My Experience**

"Contextualizing my experience of mental illness" is not a simple straightforward task. What follows is just a version of the text and subtext of the experience. My experience of mental illness began twenty years ago, after the birth of my second child. I had a post-partum depression that lasted for seven years. That is, after the post-partum depression, I had recurring clinical depressions over a seven year period. In this period, I experienced a broad range of psychiatric interventions, including hospitalization. My understanding of mental illness, when I was twenty-five, was that it was something that happened to "other" people, not to people like me. My self-image included a strong sense of my own invulnerability, partially because I had never been seriously ill. When I became seriously ill with a depression, I did not have a repertoire of how to deal with illness. More significant was my refusal to identify depression as an illness when I first experienced it. I believed I was having an existential crisis and my failure to get past it was a failure of the will. I did not append any medical or biological label to what I was feeling. Another aspect of this refusal was my awareness of my privilege. I could not legitimate my dis-ease to myself. I did not believe I was entitled to an existential crisis of this ferocity because I perceived myself as fortunate and understood mental illness as attached to unfortunate people.

That dualistic conception of "fortunate" and "unfortunate" individuals can be reformulated as another dualism, "privileged" and "underprivileged". I would prefer to avoid dualisms and work with a concept of privilege as relative. This relativity does not prevent awareness of how privilege works to create or maintain dominance in specific sites and in
awareness of how privilege works to create or maintain dominance in specific sites and in specific historical periods. Subsequently, one's relative privilege can be reduced by circumstance. In my case, my middle-class privilege was reduced both internally and externally at the site of mental illness. Kathleen Rockhill describes privilege as the power to act, to exert the will. Insofar as it limits the power to act, disability is experienced as a loss of privilege. Sherene Razack distinguishes between theorizing that privilege is relative, that one is constituted as both dominant and subordinate, and working to address privilege in specific contexts: "Who is dominating whom is not a question I reply to with the answer that we are all constituted as simultaneously dominant and subordinate." In specific contexts of oppression, which Razack defines as "the consistent and organized domination of one group over another", the privilege and penalties ascribed to those involved produce hierarchies. Disrupting those hierarchies requires analysis of how privilege and penalty function.

Within the context of being a depressed person who was not functioning and then a mental patient, I experienced a loss of privilege that included the loss of basic human rights such as the right to refuse medical treatment. At the same time, the privilege attached to being white, middle-class and educated helped me to negotiate with the mental health care system, to maintain some "respectability" and eventually to reconstruct my life.

In the reconstruction phase, I moved quickly from being satisfied with being okay, that is not being ill and locked up, to desiring, as I wrote in my journal, "to get back my life", or to reclaim all my privilege. At the time, I experienced my privilege as embedded in how I was perceived by others, more than in my own power to act. I felt I had to appear twice as respectable to make up for the loss of respectability. I also felt I had to be twice as cheerful to make up for having been depressed and twice as responsive for having been unavailable. In part, it was this need to "make up" for lost time and respectability which fueled the cycle of depressions and led to a diagnosis that verged on manic-depressive. It "verged" because although the depressions were classic, there was no classic manic behaviour, insofar as there were no extremes of spending money, of pursuing sex or of self-aggrandizement. I believe gender and class functioned to limit "manic" behaviour on my part. Perhaps if I hadn't been a young mother of two in a marriage which left little space for self-aggrandizing and hadn't
been a person with a highly-developed need for bourgeois respectability, I might have been able to muster up a more classic mania. What Foucault termed “self-restraint” was functioning well in this particular subject both within the periods of mental illness and in the recovery periods. That self-surveillance which bounded my madness also reinforced my guilt for having crossed the boundaries of respectability.

My sense of failure at becoming a victim, someone who needed help rather than someone who gave help, was amplified by the systemic construction of mental illness. In the 1970's it was even more stigma-ridden than it is now. Initially, my illness was not identified in conversation with family and friends; rather, I was “having a hard time”, “going through a rough period” or “not feeling well”. There was a hushed tone that accompanied these euphemisms and a sense of embarrassment. Everyone more or less knew what was meant. At the same time, had it been named, the shame would have deepened. Due to the shame associated with mental illness, as well as a very legitimate fear of being in the hands of psychiatry, I resisted seeing a psychiatrist, I resisted taking drugs and I resisted being hospitalized. I was terrified of giving up control and of being labelled. I did lose control and I was labelled as a result of being psychiatrized.

Over the seven years my depressions became less debilitating as I and the people who supported me through them developed coping skills. In addition to practical medical interventions and therapy, there were important changes in my personal life. My marriage of nine years ended in the middle of this period. Subsequently, I went back to school and obtained an After-degree Bachelor of Education and began teaching in the public school system. I had formed a strong connection with a female psychiatrist whom I did therapy with. With her guidance, I was taking medications in a more managed way and somewhat less reluctantly. I had never bought into the medical model completely, neither intellectually nor emotionally. I had consulted some alternative therapies. Although I would not reduce my experience during my illnesses to simply “a chemical imbalance”, neither could I dismiss the evidence that some drugs helped my mind to work better. As well, I was beginning to understand mind and body differently.

In retrospect, I understand those early depressions partly as an expression of my
resistance to my body and the roles of wife and mother that came with it. I had come to understand the mind and the body as dichotomous. At the time, I felt I had to choose between living in my mind or in my body. Clearly, if I had to choose, I’d go for the mind part, which I understood as masculine and therefore powerful. Unfortunately, I found myself stuck in my mind going in circles. My will was frozen, lost somewhere in the space between my body and my mind. Yet, I experienced how my lack of will also functioned to structure activity around me. For example, if I didn’t make supper, someone else would have to. I wanted clarity and purity but experienced my life as a web of entanglement in which I could never come clean.

In that first depression I was insomniac and immobilized. I lay in bed for hours, playing and replaying my life and trying to figure out how to live it. As the depression deepened, the more impossible I found it to believe that I could reclaim the living time I had lost to it. Yet, I was convinced the only way out of it was through reason. That is, at first, I believed I could think through why I was so unhappy, figure out the reasons and then solve the problem. This strategy had been useful at other difficult periods in my life. It was the problem solving process I had grown up with. I trusted and valued my mind as rational and capable. It wasn’t working now. When my mind could not find either the problem or the solution at a personal level, I began to attach my experience of despair to universal despair. This was not a conscious decision nor was it a unique experience. It was a pattern of thinking I later met in many other patients on the ward. My perception, like theirs, was altered radically. I perceived absence more strongly than presence. For example, if I was reading to one child, what I experienced was my absence from the other. Words became heavily laden. I heard resonance, denotation and connotation alongside the words, particularly abstract words like “honest”. I couldn’t speak some of those words, like honest, because I wasn’t “honest”. I believed that if I wasn’t honest all the time, I wasn’t honest at all. My strong sense of morality became rigid, strictly either/or. I could not meet my standards. I could not, would not make decisions, as I felt the moral ground on which I made them no longer existed. I was not speaking and not acting and then not sleeping because I hadn’t spoken or acted meaningfully. I was dysfunctional. Others decided it was “time for professional help”. 
In my initial meetings with a psychiatrist (about six months after the birth), I was almost mute and he asked me to write out what I was feeling. I managed a few sentences. Of course, part of the reason I was mute was that I was afraid to betray myself and afraid to commit myself or be committed to treatment. All of which eventually transpired. Psychiatric hospitalization felt like being on exhibit as a totally incompetent human being to myself, my family and to a gaggle of medical students. I believed my respectability to be lost forever, but I still wanted out of the role of patient, the role of victim. I discovered that I was prepared to manage without respectability. However, getting out required, among other things, adorning oneself in compliant respectability as defined by the rulemakers on the ward, the orderlies, nurses and doctors. The process of socialization on a psych ward is paradigmatic of social restraints on a grander scale as Foucault has made clear in *Madness and Civilization*. I had to learn appropriate patient behaviour and learn to take my medicine, literally and figuratively. Once identified as a psychiatric patient (in contrast to being “in therapy”), there is a loss of privilege both materially and psychically. Privilege has another level of meaning on a psychiatric ward or in an institution. For a hospitalized psych patient, “privileges” as basic as wearing your own clothes are earned through compliant behaviour such as going to group meetings, making your bed or taking your meds nicely. The patient is being re-socialized into “the normal”, which provides access to privilege and potentially to reinstatement as a “functioning member of society.”

If I believed in “humility”, I would say I learned humility in hospital. Instead, I will say I learned to be much tougher and less judgemental. One event in particular marks that change. Through compliant behaviour, I had earned the privilege of leaving the psych ward at Health Sciences Centre for short walks. So had my room mate, who was also a young mother. We walked to Lizzie Park, a couple of blocks from the hospital. It was a sunny afternoon in late spring. We sat on a bench in the park, barely speaking, pretty drugged and I was so happy, just to be outside. Part of my mind also registered that I was doing nothing, that I was sitting in a park full of children without my children, without the excuse of my children, doing nothing. I was just like the old guys I used to see when I took my kids to the park. I’d see those old men and I’d think, how can they just sit and do nothing? From my
twenty-something arrogance about getting things done, producing dinners, ideas, articles, babies, social change, I would judge those men to be less alive than me. Sitting on that bench, I knew that if I had been me-then, I would be looking at me-now and, even if I couldn’t identify me-now as a psych patient, I would still judge this person who just sat on a bench as “less”. I have tried to remember what it is just to sit, just to be and not to judge.

“Breakdown” is one of the popular terms for mental illness in its milder forms. It makes sense in terms of my experience. There was a breaking down of beliefs, marriage, respectability and identity. It was and continues to be important to me to know I am the woman in Lizzie Park, even though I ran away from her as fast as I could. After the breakdown(s), a nice middle-class woman like me writes an article or a play or perhaps a thesis about her experience and “builds up” her artistic career, her profile, her resume. But it is about more than rebuilding - there is a need to make meaning. “What was the breakdown for ?” was a question I asked myself in different ways. I did not want to believe that things happen randomly, to no purpose. That didn’t fit with the rational humanistic values I’d grown up with. I tried to make “sense” of what had happened through a variety of means. One of these was my work on The Waiting Room, a community based popular theatre project, which made possible a politicization of the personal.

The Waiting Room: A chorus of women

Working on The Waiting Room contextualized my experiences within those of other women and that helped to make sense of them. It also made them less personal, intense or dramatic. It wasn’t all about “me”. In hospital, a young male doctor had said to me: “What makes you think you’re so special?” Years of psychoanalysis - a dialogue which resembles a monologue and was scripted by a bourgeois,Victorian male - might have helped me formulate an answer to that question. However, I preferred to act or perform within a chorus of women who could reformulate the question. Working in theatre has always been a powerful experience for me because it is where I have exerted my will, expressed my agency. What makes theatre powerful?

It is not fantasy, but alchemy. The substance of individual experience is transformed by
theatre into a substance that reflects or refracts or re-members multiple experiences in the observers, the audience. What interests me is the movement of contextualizing individual experience through cultural production which in turn may provoke individuals in the audience to contextualize their experience, to get beyond themselves and stretch some boundaries.

Popular theatre involves the creation and production of plays which are focused on social issues and directed to social change. Honor Ford Smith says of Sistren, a Jamaican collective engaged in cultural production, that it "defined itself as a group which confronts the public with issues about women which have been hidden or considered irrelevant." The issues may be identified by a community or by a company such as Popular Theatre Alliance of Manitoba (PTAM). The plays may be performed by theatre professionals, for example PTAM's production of Judith Thompson's *Lion in the Streets*, or by community members, PTAM's production of *How Do You Do* by Donna Lewis and the Dreamsharers, a group of recent immigrants. In the case of a community-based play, theatre professionals will serve as facilitators of the process, as directors or dramaturges.

*The Waiting Room* by Joy Beauchamp with Acting Out was community-based. I had believed that the issue of women and mental illness would be viable to develop as a community-based play, where consumers of the mental health care system would form the acting troupe. In 1992, I discussed the project with Margo Charlton, artistic director of PTAM, with whom I had worked previously. Preliminary community research indicated an interest in the topic and PTAM agreed to co-ordinate the project and to provide help in securing funding. Donna Huen, the community development director at PTAM, and I were co-facilitators of the project. Joy Beauchamp and myself were funded by the Manitoba Arts Council as playwright and director. Funding for the project as a whole came from Human Resources: Women's Program and from Manitoba Health.

*The Waiting Room* project was developed over two and a half years. This included research, application for funding, development of an ad hoc community advisory committee, development of the acting troupe and the script, rehearsal, production, promotion and performances, which most often were accompanied by workshops. Evaluations were done by
some of the agencies which sponsored the performances. Troupe members completed written evaluations of their experience shortly after the final performance. Ten performances took place in April, May and June of 1994 in a variety of community settings, ranging from community centres to the lecture hall of a teaching hospital. Seven of the ten were followed by participatory workshops. [see appendix A for locations]

In the late spring of 1993 a working group of women who were interested in a long-term commitment to building a play was formed. The group eventually named itself “Acting Out”. These women came into the group from the research workshops, from flyers posted in agencies or by word of mouth from other members. The focii of these early group meetings were trust building, personal narratives and an introduction to drama techniques. Working with a community group to develop a theatre piece involves maintaining a delicate balance between the needs of the project and the needs of the individual group members. Our community group consisted of members who had self-identified as having been consumers of mental health services and who had an interest in giving voice to that experience in a dramatic form which would address the stigma attached to mental illness. The make-up of the group thus constituted the potential for both coherence and conflict. The emotional investment in the project was high. Unlike professionals, who most often work in a short time-frame of a few weeks, community-based plays can take a year or more to develop, while participants continue with their work, schooling, families, moves. Participants who persevere have a high level of commitment. Members of Acting Out were asked in the fall of 1993 to commit to the end of June 1994, in which time period we would develop and workshop a script, build acting skills, rehearse and launch the play and perform it up to a dozen times, as well as videotape it in a studio for future use in that form.

The commitment to both the process and the product was engendered through the participants’ relationship to the issue of mental illness. Acting Out members were what Augusto Boal calls active participants.7 They were committed both out of their personal need to tell their stories and their belief in the social value of bringing those stories to public attention. It is this double focus on the individual and the social context which is the impetus of community-based popular theatre. Its impact on the audience is partly a function of the
actors' or participants' presence in the play they have created together out of their life experiences. Richard Tomlinson states that "performance gives the performer power" and explains how when the actor is disabled, her presence is doubly powerful as it resists the image of passivity attributed to the disabled. Acting Out members were prepared to act out their disability in order to contextualize it as part of continuum of illness and wellness, that we all participate in.

If health and illness are understood as on a continuum, then individuals cannot be limited to a singular state that defines them and/or their ability. This is in contrast to the medical model which is focused on diagnosing cause and effect and defining pathology. This model develops a perspective in which health is understood in terms of its opposite, illness or pathology. Similarly, sanity is defined in terms of insanity. These dualisms are based on one of the opposites being normed and the second being named as deviant from the norm. For example, if age and youth are opposed, then one is categorized as the norm. Depending on the culture, youth can be seen as the unripe precursor to the maturity of age (ie. being middle-aged is "normal") or as the pinnacle of energy from which one falls into the decay of age (ie. being young is "normal"). The dualisms of the medical model are used to categorize and label individuals. Those categories become powerful tools for regulation and for self-surveillance. It was important in our work on *The Waiting Room* project to resist this dualistic opposition of mental health/sanity and mental illness/craziness. The performance of the play had to represent that resistance. Chapter V explicates how that representation functioned.

Briefly, *The Waiting Room* relates the stories of several women who are all outpatients at a psychiatric clinic. In the context of their meetings in "the waiting room", a sense of community develops. Friendships form and the women are prepared to problem solve with each other. One character misses out on this connection, mostly as a factor of timing. All the characters in the play are female. [the scene synopsis in appendix B gives more details] To some extent the script of *The Waiting Room* mirrored the process of what actually occurred in the acting troupe. In the context of working on the project, the troupe members developed friendships and camaraderie which in turn supported our work on the
project. Some of the friendships were sustained after the project was completed. The community formed in the play and the community formed in the troupe are both communities of women. This gender specificity was deliberate.

The basic objective of the project was to explore the issue of women and mental illness, not mental illness in the general population. That choice was mine and evolved from my own experiences and my research which indicated that women’s experience in the mental health care system was significantly different from men’s. These differences derive in part from the medical and service models that too often reflect male bias: “It seems likely that when differences between men and women are not even examined [no gender breakdown of samples in many studies] the result is likely to be service models that are theoretically androgenous, but in actuality male-biased.”

Theoretically, I was coming from a feminist position and I wanted to work dramatically from that position. Practically, it made sense to narrow the topic and also to work with a more homogeneous group, although the group that emerged was heterogeneous in relation to everything but gender and mental health issues. Troupe members ranged in age from twenty-two to sixty-nine, with most being in their thirties. Some were working class, many were middle class. Some were originally from rural backgrounds. There was one Black woman, one Metis woman and one aboriginal woman (who was involved in the play development stage, but did not perform, as she had commitments to an aboriginal theatre company). The other troupe members were white from a variety of ethnic backgrounds. As well as the troupe, the facilitators, playwright, designer and production crew (with the exception of the video crew) were all women.

The cultural hush surrounding mental illness and the loss of privilege associated with it both function to silence women who have experienced mental illness. Depression, which is much more predominant among women than men, has been described by Dana Jack as “the silencing of the self” in her study by that title. Some of the women in the troupe evidenced that silencing; all had experienced it to some degree. To break the silence would require revisiting the silencing and other painful experiences. It was important to build a working relationship that would both facilitate that process and protect the group members. The
decision to have only women in the group was critical to creating an environment where it would be safe to encounter what Julie Salverson terms our “risky stories”11. That storytelling process is explored in Chapters III and IV with reference to feminist and popular theatre practices.

The decision to have only female characters in the play should be read as our effort to redress an imbalance in representation and to affirm women’s community and agency. In the play itself, the only male voices are those recalled by the female characters and the taped male voices of the psychiatrists. Elin Diamond describes Western theatre as “a cultural site where the gender models against which women and men struggle are systematically and profitably imitated.”12 Feminist theatre rejects that mimesis of dominant culture and presents alternative forms of representation. The very limited presence of male voices in The Waiting Room may not have impacted greatly on phallocentric discourse, but it did facilitate hearing female consumer voices in conversation with each other. In her introduction to Getting a Life: Everyday Uses of Autobiography, Sidonie Smith describes narratives of mental illness as among the “culturally unspeakable” and states that their unspeakability sustains privileged cultural narratives. On the other hand: “In citing new, formerly unspeakable stories, narrators become cultural witnesses insisting on memory as agency in its power to intervene in imposed systems of meaning. These witnesses also participate in the cultural work of reframing the meanings of the speakable, of voicing the speakable differently.”13 To voice the speakable differently in The Waiting Room required that the female voice dominate.

The Waiting Room also challenged dominant discourse of mental illness. That discourse utilizes a scientific medical model of pathology, diagnosis and cure to deal with behaviours and experiences that in other times and places would be described as idiocy or prophecy or possession. Suman Fernando, who writes on and practises trans-cultural psychiatry, warns of the dangers of imposing the medical model indiscriminantly and emphasizes the importance of attending to cultural contexts, including the effects of racism. He does, however, attest to the cross-cultural existence of “distress”, which I would call suffering, and thus believes there can be “a universal criteria for the need for coping [with distress], notwithstanding the lack of universal criteria for mental illness or psycho-pathology
noted earlier. The distress Fernando refers to does defy cultural differences. It is experienced across cultures. However, that distress is also culturally produced, amplified or attended to.

Disability is experienced concretely in the limitations of one's body and mind. It is also produced socially by a disabling society which fails to provide for those it does not name "normal", those who are Other. Recent work in disability studies has questioned the opposition of normal and abnormal, of abled and disabled. It examines how disability is constructed, within the disabling society. In *Enforcing Normalcy*, Lennard Davis positions the construction of disability historically, in relation to industrialization and the rise of the bourgeoisie and the development of "norms" for human bodies and behaviours. Rosemary Garland Thomson’s work on disability utilizes poststructuralist feminist theory which understands identity as generated by difference: "Representation thus simultaneously buttresses an embodied version of normative identity and shapes a narrative of corporeal difference that excludes those whose bodies or behaviours do not conform." Certain identities are maintained at the expense of marginalizing others that do not conform.

Representations created in the media and attached to actual bodies are used to reinforce the discourse of normal and abnormal. The process of understanding physical disability as historically situated and constituted through power structures can be applied to mental illness.

"Mental illness" is a twentieth century term reflective of the dominant scientific discourse of this century. "Madness", a term of older origin, is still powerful today as a signifier of both a romantic sensibility and a degenerate one. Sander Gilman states that psychopathology is greatly feared and experienced as highly degenerate, as a loss of "self":

> Of all the models of pathology, one of the most powerful is mental illness. For the most elementally frightening possibility is loss of control over the self, and loss of control is associated with the loss of language and thought perhaps even more than with physical illness...the mad are perceived as the antithesis to the control and reason that define the [bourgeois]self.\(^\text{16}\)

I explore the linkages between the construction of the bourgeois self and the loss of
that self to mental illness in relation to interlocking oppressions in Chapter II. My position is that in modern Canadian society, mental illness creates a particular identification which, at times, may collapse other categories of identification - gender, race, class, sexuality - under its weight: "There is a fundamental truth that must be acknowledged in order to consider the reality of mental illness - that mental illness and the associated stigma are great equalizers. Once people have a psychiatric label, they are generally relegated to a separate, genderless, asexual subspecies of ‘CRAZY ITS’." However encompassing is the psychiatric label, race, gender, class and sexuality do not disappear once that label has been attached to a person. Rather, these social constructions are pivotal. They are interlocking sites of oppression which may lead to distress and to psychiatristizing and they are factors in the access to and efficacy of mental health services. I feel it is important to address the specificity of the stigma attached to mental illness and so return to Gilman’s statement that mental illness is particularly frightening because of the “loss of control over the self.” Fernando would suggest that this too is a culture-bound statement and that in some non-Western cultures, control of the self is valued differently. Nonetheless, Fernando acknowledges the universal need to relieve the distress experienced by individuals who have mental illnesses. This relief must be formulated with reference to both the socio-cultural and the intra-psychic. That is, intervention must take place both at the social level and with the individual and such intervention must be cognizant of the how the two are articulated and interwoven.

Garland Thomson’s warning about the limitations of deconstructing identities is relevant: "Thus, the post-structuralist logic that destabilizes identity can free marginalized people from the narrative of essential inadequacy, but at the same time it risks denying the particularity of their experiences." Garland Thomson advocates for a feminist disability politics that allows women to define their physical differences and their femininity for themselves rather than conforming to the representations and regulations of dominant discourses. The Waiting Room project can be understood as working within such a framework. Its dramatic narrative worked to voice both individual or particular stories and collective experience. In performance, the play resisted much of the dominant discourses of women with mental health issues. Augusto Boal, a practitioner and theorist of popular
theatre, declares that: "The Theatre of the Oppressed is the theatre of the first person plural." He also affirms that it is vital to begin with an individual narrative. The individual narratives are contextualized within the collective experience. In The Waiting Room, the focus on the community of women is thematic and also reflects the position of the community troupe. In addition, it reinforces the construction of an alternative position to the "madwoman" as isolated.

If identity, a sense of self, is inevitably a hugely important compartment of the bourgeois subject's baggage, then the loss of identity or being re-identified by oneself and others as "mentally ill" is very unbalancing. This re-identification is cemented by "diagnosis" of a medical professional into a specific category of the mentally ill, such as schizophrenic. As a person in a wheelchair becomes "the wheelchair", so a person who hears voices becomes 'the schizophrenic'. This representation by others can become how one represents oneself, i.e "believing in your diagnosis is big-time trouble". The Acting Out troupe and the script were deliberate in refusing to label individuals or characters by their diagnosis.

The Waiting Room's representation of women and mental illness is embedded in the agency of the women who developed it, who refused to identify only with a diagnosis. Their self-identification as consumers of mental health services was in itself an act of resistance to the stigma attached to mental illness. Their collective agency is an alternative representation which speaks to their impatience/ "im-patients" with the passive role as patients or victims of disease. This alternative representation also spoke powerfully to general audiences, service providers and consumer groups, as the discussion in Chapters V and VI delineates.

In exploring the development of the project, how this alternative representation evolved, and how it was received, this thesis may shed some light on experiences which have been characterized as obscure, murky and dark.
ENDNOTES

1. Beauchamp, Joy, with Acting Out, *The Waiting Room* (copyright Popular Theatre Alliance of Manitoba, 1994). All quotations from the script will be followed by the page no. in brackets [ ].


4. Ibid., p.33.


CHAPTER II - MADNESS, THE MEDICAL MODEL: WHO IS A “PATIENT?”

The category of “woman” is a social construction, and the visible ruptures of women’s narratives are expressive of ruptures in social experience. Narrative differences are eloquent not of anatomical destiny and design but of the daily difficulties women experience in negotiating their lives around the magisterial forms of male selfhood.”

“Mental illness” is neither a neutral nor descriptive term. Rather, it is a twentieth century term which invokes a medical model that must be analyzed as dominant discourse. My analysis will be framed with reference to the construction of normalcy in the bourgeois subject. Within that construction, occurs the normalization and the concomitant pathologization of Western femininity. The links between those constructions will be explored, as will the implications of those links on the lives of women categorized as mentally ill.

Resistance to dominant discourse can take the form of creating alternative representation. Theatrical representation is experienced as embodied by both the performer and the audience. As such, it is potentially a site of transformation. In this thesis’ discussion of alternative representation of women with mental illness, I am working from within an understanding of identities as socially constructed and therefore relational. That construction occurs within and not outside of representation. The focus of my analysis is on Canadian women today who are consumers of mental health services and on how alternative representation can impact on their experience as consumers. Secondarily, I consider the impact of alternative representation more generally. Central to my argument is my theory that mental illness is experienced and regarded as “degenerate” and so is instrumental in lowering the privilege of any person, regardless of their relative privilege. To understand why mental illness is constructed in this manner, I explore how and why it is seen as Other. By examining its construction, I can explore the potential for de-construction through resistance to the dominant discourse.

Discourse creates meaning and within those meanings identities are formed, resisted, transformed. Stuart Hall’s understanding of identity includes both the social and the psychic.
He suggests that subjects both do and do not identify with the position to which they are summoned or interpellated by discourses. They also negotiate with and resist those interpellations. Therefore identity is not static but is in process, constituted and reconstituted. "The notion that an effective suturing of the subject to a subject-position requires, not only that the subject is 'hailed', but that the subject invests in that position, means that suturing has to be thought of as an articulation, rather than a one-sided process..." 2 Hall’s theory of articulation affirms the active role of the subject in creating linkages between ideologies and experience in particular historical situations: "Thus, a theory of articulation is both a way of understanding how ideological elements come, under certain conditions, to cohere together within a discourse, and a way of asking how they do or do not become articulated, at specific conjunctures, to certain political subjects." 3

The construction of the bourgeois subject is the product of particular discourses and historical practices evolving from and into particular power relations. Those power relations and that way of understanding identity framed and continue to frame contemporary discourse and identity formation. Central to this discourse are the concepts of normalcy and abjection, evolution and degeneration. I examine these concepts in relation to the construction of mental illness.

Madness: Regulation and Self-Surveillance

Michel Foucault’s *Madness and Civilization* reveals the regulation of madness and the development of psychiatry as a function of the construction of the bourgeois subject. Foucault traces how the understanding of madness in the West changes from 1500 to 1800 by delineating its social construction as expressed in social and medical practices and in art. Foucault’s work focuses on the development of “self-surveillance”, that is internalized regulation. Madness, which prior to the Renaissance had been understood in relation to “imaginary transcendancies”, is now understood as a form of “uselessness”, which is in opposition to the bourgeois value of labour, productivity.

Foucault’s history suggests that mad people were always excluded or marginalized, even in Medieval times when madness itself was less negatively constructed and was related
to divine or diabolical presences. However as the age of reason took hold, mad people were both shunned and confined. Foucault proposes that with the Renaissance there developed a new understanding of madness as coming from *within* human beings, as opposed to a visitation on human beings, by God or Evil or Folly personified. In this situation there "is no madness but that which is in every man, since it is man who constitutes madness in the attachment he bears for himself and by the illusions he entertains." Yet this self-absorption is celebrated in the literature of the period, a period in which the birth of humanism provides for a different construction of the subject. The subject is more individuated than in Medieval times. Cervantes and Shakespeare both write of madmen who see more clearly than do the sane. This view of madness was short-lived. In the classical period, the age of reason, madness would be contained, both literally and figuratively.

If there is in classical madness, something which refers elsewhere, and to *other things*, it is no longer because the madman comes from the world of the irrational and bears its stigmata; rather, it is because he crosses the frontiers of bourgeois order of his own accord and alienates himself outside the sacred limits of its ethic.  

Foucault characterizes the classical period as the period of "The Great Confinement". City governments chose to buttress social order by confining those who were disorderly - the beggars, the poor, occasionally the dissolute members of the upper classes, the criminal and the insane - in institutions like the Hopital General in Paris, created by royal edict in 1656. These institutions were also organized in relation to economic factors. Inmates were a source of free labour, although this did not always balance the cost of their keep. However, it was believed that the social cost of including them in the life of the city outweighed the cost of their keep. Foucault states that the "house of confinement in the classical age constitutes the densest symbol of that 'police' which conceived of itself as the civil equivalent of religion for the edification of a perfect city." It is significant that these houses of confinement were not intended to cure the conditions of those detained, but merely to contain them.

It is in the nineteenth century that the house of confinement was transformed into the insane asylum. The mad were no longer placed in the same category as the destitute or the criminal. Instead they were housed separately in the insane asylum, where the search for a
cure for madness and the development of a medical model of treatment began. Foucault argues that this development cannot be construed simply as "progress". Although the relative absence of physical restraint in the asylums was significant, Foucault argues that the moral restraint which followed upon it is ultimately more encompassing: "The absence of constraint in the nineteenth century asylum is not reason liberated, but madness long since mastered."  

What were the tools by which madness was mastered? In the new asylums, for example Tuke's Quaker Retreat, reason or madness was not engaged with. Rather, there was a conviction that through living in a milieu of reason circumscribed by occupation with work and prayer, the mad would improve. If they did not improve, silence and observation by the reasonable would serve as chastisement to curb unreasonable behaviour. If necessary, cold showers and physical restraint were resorted to. Most significant to Foucault was the strategy of training the mad to observe themselves, their madness: "We see that at the Retreat the partial suppression of physical constraint was part of a system whose essential element was the constitution of a 'self-restraint' in which the patient's freedom, engaged by work and the observation of others, was ceaselessly threatened by the recognition of guilt."  

Within the asylum, treatment is termed "moral management". This management is centred on developing the internalized policing of the subject. The project of taming unreason flourishes: "Now madness would never -could never- cause fear again; it would be afraid, without recourse or return, thus entirely in the hands of the pedagogy of good sense, of truth, and of morality." The bourgeois morality which had broken the chains of Bedlam, the Bicetre and the Salpetriere, would attempt to confine madness by internal policing.

The madmen "delivered" by Pinel and, after him, the madmen of modern confinement are under arraignment; if they have the privilege of no longer being associated or identified with convicts, they are condemned at every moment, to be subject to an accusation whose text is never given, for it is their entire life in the asylum which constitutes it... Madness will be punished in the asylum, even if it is innocent outside of it. For a long time to come, and to our own day at least, it is imprisoned in a moral world.

In this moral world, madness is constructed as disorder and order is constructed as
social usefulness. Although the parameters of social usefulness will vary from place to place, in different times and according to the current hegemony, the premise of utility will not be challenged. In the eighteenth century, the parameters of social usefulness had begun to be measured by mathematical and scientific tools. The bourgeois value of utility was augmented by the concept of normalcy.

**Normalcy and The Family of Man**

In *Enforcing Normalcy*, Lennard Davis examines the construction of normalcy. He argues that the "normal" is part of "a notion of progress, of industrialization and of ideological consolidation on the part of the bourgeoisie". He traces the roots of the term in the mathematical "norm" and in statistics, which appear in the mid-eighteenth century for the purpose of collecting information to improve the state. Nation and empire building are central to this period. However, a nation is comprised of and is as good as its citizens, the individual bodies who make up the body politic. Therefore the regulation of those bodies is important. Thus the mathematical norm is translated into the behavioural norm. It was a French statistician, Adolphe Quetelet [1796-1847] who coined the terms "l'homme moyen physique and l'homme moyen morale". The quantification of human physical attributes is in itself dangerous in terms of what is attended to and what is quantified. There is an even more dangerous move in the quantification of human moral capacity.

Davis contrasts the concept of the norm with the earlier Platonic concept of the "ideal". No person can match the ideal, only aspire to it or reject in the form of the grotesque. An ideal is not a moral imperative, but a norm becomes one. Davis argues that the norm is established in order to secure power relations, in this case the power of the "middle" or moyen class, the bourgeoisie. It functions to regulate both its members and members of other classes. Any person can be seen to deviate from the norm. The extreme of this regulatory function was the science of eugenics, a movement based on the use of the norm to improve the body politic by perfecting the individual bodies that form it and controlling deviations from the norm:

An important consequence of the idea of the norm is that it divides the total
population into standard and non-standard subpopulations. The next step in conceiving of the population as norm and non-norm is for the state to attempt to norm the non-standard. Of course such an activity is profoundly paradoxical since the inviolable rule of statistics is that all phenomenon will always conform to a bell curve. 12

Davis links the standardizing of the body to the establishment of identity through the body (as done through fingerprinting, also an invention of this period): “By this logic, the person enters into an identical relation with the body, the body forms the identity and the identity is unchangeable and indelible as one’s place on the normal curve.” 13 The consequences of this discourse for the physically disabled are clear; their identities are attached to a body that will be perceived as deviant or substandard. Davis points out that the disabled, the poor and the criminal were all grouped together as undesirable, as deviations from the norm, as were racial and ethnic groups. In this period, the discourse of “scientific” racism is established, linking the different races in relation to the norm of whiteness. This discourse defines a hierarchy of races using evolutionary theory and statistics as its scientific basis. European and American scientists measured and mapped bodies to “prove” the validity of the hierarchy: “Anatomical criteria were sought for proving the relative positions of races in the human series.” 14

The hierarchy of evolutionary progress is understood in terms of its limits, its lower ranks, the undesirables. In some instances it is precisely desirability which is categorized as undesirable by the makers of the norms. Who are these makers? They are men who mask their limitations behind their mathematical objectivity and their scientific discourse that maps, explains and controls natural phenomena and gets things done. They have the power to determine what and who is undesirable. This category can include anyone who is perceived as getting in the way of getting things done. Let us begin with anyone who is not “un homme” and therefore is desirable from a male heterosexual viewpoint. What is desired is also feared. For desire is not understood as “good” from within the Christian worldview nor as “reasonable”, which is the secular version of the “good”. Quetelet did not discuss “le person moyen”; rather, as in Shakespeare’s or Da Vinci’s time, man not woman continues to be the measure. An analysis of the construction of the bourgeois subject must acknowledge
that the norm is framed as male. This has implications for the construction of mental illness.

In her introduction to Imperial Leather, Anne McClintock affirms that dynamics of
gender are prior to the discourse of colonialism, as well as entrenched within colonial
practices: “The histories of these male policies [among her examples are gendered
malnutrition and sexual violence], while deeply implicated in colonialism, are not reducible
to colonialism and cannot be understood without distinct theories of gender power.”15 Thus,
although McClintock emphasizes the articulation of race, class and gender, she rigorously
inspects their distinctions as well as their connections at the sites she analyzes.

Inderpal Grewal, like McClintock, refuses to work within essentialized binaries such
as dominant and dominated. Rather she examines how discourses interpellate subjects in
specific contexts in ways which complicate the binarisms: “Feminist work that attends to
issues of class, caste and sexuality interrupts such binarism, working against the hegemonic
formations that occur within both sides. However, by paying rigorous attention to
multileveled power relations created within such binaries, I want to dissipate any notion of a
relativist approach in which all forms of domination are equated or nullified.”16 In Looking
White People in the Eye, Sherene Razack asserts that systems of oppression are interlocking.
Thus one is complicit in the oppression of others despite or in relation to relative privilege
and penalty. Razack insists on accountability, “a process that begins with a recognition that
we are all implicated in systems of oppression that profoundly structure our understanding of
one another.”17 She also insists that such accountability be site specific, that is related to the
historical and material context.

McClintock’s exploration of the historical and material image of the “Family of
Man” develops the categories of desirable and undesirable in more detail, indicating how
gender factors in. The image is an extension of the theory of evolution. Darwin’s Origin of
the Species, published in 1859, was important in establishing another layer of domination for
the mapmakers: “Now not only natural space but also historical time could be collected,
assembled and mapped onto a global science of the surface.”18 Just as biological Darwinism
had opened the natural world to scientific categorization, Social Darwinism secularized time
or history, replacing the hand of God with the hand of Man. Through science, the hand of
man could trace the evolution of man over time. Two icons were central images created to do this, the tree of life figure (borrowed from the Bible) and the "Family of Man". Both trace the evolution of the races, as progressing "naturally" from the "childlike" native at the lowest level of humanity to European white men as the pinnacle of evolution. McClintock focuses on the regulatory function of the image of the "Family of Man". The family was understood as the "natural" order of relations. Within that natural order women and children were subordinate to men. The naturalness of their subordinate position was extended to the childlike or feminized races of the colonies, who also were deemed naturally subordinate: "The trope of the organic family became invaluable in its capacity to give state and imperial intervention the alibi of nature." 19

McClintock emphasizes that family tree is gendered as well as raced: "There is a problem here, however, for the family Tree represents evolutionary time as time without women.... From the outset, the idea of racial progress was gendered but in such a way as to render women invisible as historical agents." 20 Women are literally not pictured in the Family of Man. They were not understood as having a part to play in evolutionary progress. Rather, women belonged to the muddied pre-historical time from which evolution is born. McClintock documents how European explorers characterized the lands they encountered as female bodies to be mastered. In the late Victorian period, the conquest of these desirable spaces was extended into the mastery of time. McClintock describes this version of time as one which labelled the colonies as a- or pre- historical and which defined history as the movement of time which formed European civilization. As a result, "the agency of women, the colonized and the industrialized working class are disavowed and projected onto anachronistic space: prehistoric, atavistic and irrational, inherently out of place in the historical time of modernity." 21 The irrational conflates with madness which inhabits that anachronistic space at the margin.

**Degeneracy and Madness**

It is not a huge leap from the "atavistic and irrational" space to the degenerate space. The parallel trope to evolutionary development and the progress of man is degeneracy.
Degeneracy is the antithesis of evolution and was an equally central theory and image of the nineteenth century. It was understood as a reduction or dilution of the physical and moral fibre which impelled the imperial project. It was categorized as abnormality. Degeneration is tied to racism and the fear of "corrupting" blood lines as Ann Stoler explains: "That 'vast theoretical and legislative edifice' that was the theory of degeneracy secured the relationship between racism and sexuality. It conferred abnormality on individual bodies, casting certain deviations as both internal dangers to the body politic and as inheritable legacies that threatened the well-being of the race."22

McClintock draws on the connection between degeneracy and contagion of disease to account for how the late Victorians used this concept of degeneracy to police both physical and social boundaries: "The poetics of contagion justified a politics of exclusion and gave social sanction to the middle-class fixation with boundary sanitation, in particular the sanitation of sexual boundaries. Body boundaries were felt to be dangerously permeable and demanding continual purification, so that sexuality, in particular women's sexuality, was cordoned off as the central transmitter of racial and hence cultural contagion."23 Degeneracy must be contained by keeping the boundaries clear. Degeneracy also functions to identify what is not degenerate. Thus the marking of certain classes, races or even an entire gender as degenerate, will affirm the position of others as superior: "Normality thus emerged as a product of deviance, and the baroque invention of clusters of degenerate types highlighted the boundaries of the normal."24

Sander Gilman links sexuality, race and madness in *Difference and Pathology*. In his introduction, Gilman asserts that there are three basic categories through which the identity of both self and Other is framed. They are: illness or pathology, sexuality and race. He notes that in all cultures there are laws, taboos or diagnoses which distinguish the "healthy" from the "sick" and that "[t]he very concept of pathology is a line drawn between the 'good' and the 'bad'."25 Gilman notes that if illness is "bad", i.e. destructive of self, mental illness is particularly "bad", as the loss of reason and language associated with mental illness signify a deeper loss of self. Degeneracy is the pull towards the irrational, the sexual, the primitive, which overlay each other. They also delineate the nineteenth century stereotype of the Black,
which represented the loss of control:

Blacks, if both Hegel and Schopenhauer are to be believed, remained at this most primitive stage, and their presence in the contemporary world served as an indicator of how far humanity had come in establishing control over the world and itself. The loss of control was marked by a regression into this dark past, a degeneracy into the primitive expression of emotions, in the form of either madness or unbridled sexuality. Such a loss of control was, of course, viewed as pathological and thus fell into the domain of the medical model.  

Pathologizing that which threatened the construction of the bourgeois subject provides a measure of control. Gilman examines the intersection of psychopathology and race in the association of the Black and the Jew with mental illness. He emphasizes that creating difference defines the self: “The Other is always ‘mad.’ Insanity is not merely a label (any more than is geography or skin color). It exists in reality. But the Other’s ‘madness’ is what defines the sanity of the defining group.” Gilman’s assertion that insanity is more than a label recognizes the experience as painful for individuals, while affirming its social construction and its function in norming the dominant group.

A Deeper Level of Abjection

The abject provides another level from which to differentiate normalcy. Like Gilman, Stuart Hall emphasizes how identities are constructed through difference: “throughout their careers, identities can function as points of identification and attachment only because of their capacity to exclude, to leave out, to render ‘outside’, abjected.” The realm of the abject can be understood as that which is refused. When one can no longer sustain the myth that degeneracy is only “out there” - in the working class, in the colony, in the prostitute, in the madwoman- then one must recognize that degeneracy is within, is the abject, one’s own blood and excrement. However to sustain one’s identity as a bourgeois subject, the abject must be expelled:

...[T]he realms of the universal subject and the socially abject mutually constitute each other. To secure the universality of the self, cultural practices set various limits, and these limits are normative limits of race, gender, sexuality, and class
identifications. A scrupulous classification of the shades of difference establishes clear boundaries around the neutral self. That which is expelled through classification becomes the socially abject, a cultural gesture that installs itself psychologically in the founding identifications of the universal subject.29

The normative limits of race, gender, sexuality and class are limited further when complicated by the classification of madness, which constitutes a deeper level of abjection.

McClintock describes the double nature of the abject, as developed in Julia Kristeva’s work: “The abject is everything that the subject seeks to expunge in order to become social; it is also a symptom of the failure of this ambition.”30 McClintock sees abjection as a formative aspect of modern imperialism which expels certain populations from the body politic. She believes that abjection provides a meeting place for psychoanalysis and material history. Abjection is “that liminal state that hovers on the threshold of body and body politic - and thus on the boundary between psychoanalysis and material history.”31 The social subject is formed, in part, through the abjection of the psychic self. This leakage of the psyche’s abjected self into the social self is one form of madness. The madman, and more often the madwoman, serve to represent the loss of the universal bourgeois self or the abjected self.

In Western art, madness is often represented as a female figure. Mad female literary characters are manifestations of the loss of the bourgeois self. A particularly rich example is Bertha Mason in Bronte’s Jane Eyre. Bertha is Rochester’s mad wife who is hidden away in the attic under the care of Grace Poole. Bertha can be read as the abjected self of both Rochester and the governess, Jane Eyre, who becomes his “true” life partner. Bertha comes from and longs to return to the West Indies, a degenerate colonial site where the borders between races are less carefully policed. She is passionate, i.e. untameable by the lord and master, in sharp contrast to Jane who is self-sufficient and respectable. When the abject is released, when Bertha escapes from the attic, destruction of the bourgeois mansion and its master is the result. That destruction is redeemed through Jane’s “goodness” and respectability. In the novel, Bertha is heard of more than heard from, a typical fate of
madwomen. Jean Rhys’ retelling of Bertha’s story in the novel *Wide Sargasso Sea* is a powerful reinterpretation and an alternative representation of madness, which situates it in a social context.

In summary, the construction of the bourgeois self is predicated on the construction of the Other as degenerate, abjected. The category of the Other is inhabited by those who are different than the norm. Difference is constructed through gender, race, class, sexuality and disability. Difference is equated with pathology and psychopathology, madness, is an extreme form of difference. The regulation of psychopathology and pathology is conducted by doctors within the defined power relations of a scientific profession that is itself produced socially: “What we call psychiatric practice is a certain moral tactic contemporary with the end of the eighteenth century, preserved in the rites of asylum life, and overlaid with the myths of positivism.”  

I am particularly interested in how gender complicates our understanding of the complex power structures for containing madness.

**Gender and Mental Illness**

An understanding of how mental illness is constructed through gender requires an understanding of how femininity is normalized. It is my contention that the normalization of femininity predicates the construction of the madwoman. Stoler’s argument that women were collapsed with non-Europeans into a category of passion or unreason by the discourse which constructed the bourgeois subject provides a significant starting point for understanding how femininity was normalized in the modern age and points to the connection between the “normal” and the “mad” woman. I would argue that the characteristics Gilman attaches to the nineteenth century stereotype of the Black - the irrational, the sexual and the primitive - are also attached to women in that period (and for some time before and after that period). Certainly women were placed in a subjugated position in the hierarchy of the Family of Man. At the same time, the companion discourse for bourgeois women constructed them as the (irrational) keepers of morality and respectability in the family. The contradictions inherent in these discourses are mind-boggling, literally and metaphorically. Bourgeois women were denied agency in society but were responsible for policing the borders of respectability in that
society. Responsibility without power is difficult to support.

The same scientific discourse which measured and weighed the "natural" differences between the races pronounced on the "natural" differences between the sexes. Darwin's theories about the differing natures of men and women supported the Victorian construction of women's roles:

Theories of biological sexual difference generated by Darwin and his disciples gave the full weight of scientific confirmation to narrow Victorian ideals of femininity. Female intellectual inferiority could be understood as the result of reproductive specialization and the 'womanly' traits of self-sacrifice and service so convenient for the comfort of a patriarchal society could be defended in evolutionary terms as essential for the survival of the race.33

In discussing how madness/mental illness is constructed through gender, I do not want to essentialize woman nor disregard the interlocking oppressions of race, class, sexuality and disability. However, I argue that women's experiences in the mental health care system are complicated by gender. For example, the effects of many anti-psychotic drugs include reduced fertility in women. Until recently these effects were not public knowledge as there was an assumption in the medical profession that reduced fertility in female schizophrenics was a socially useful side-effect34. In addition, many pharmaceutical studies do not differentiate the gender of the subjects and are then applied identically to both men and women. Male and female biological systems are different and therefore handle psychotropic medications differently. Learning to take these biological differences into account is easier for a mental health system still dominated by the medical biological model, than it is to take into account the social and power differences that accompany gendered roles in the planning and delivery of mental health services.

In a Manitoba Health report on a survey of women consumers, recommendations from the consumers for improved mental health services to women included: a "home assessment" which would determine whether factors in the home contribute to the illness; better transition from hospitals to home via halfway houses or support of home care staff; reducing the stigma associated with mental illness through public education. All these recommendations speak to the consumers' understanding that illness and health are
embedded in social relations. I would suggest that the medical model which reduces mental illness to chemistry results from discourse produced by power structures which function to maintain existing oppressive social relations. As much as I believe that mental illness is a sickness, not a sin nor a testimony to lack of moral fibre; I also believe it is more than an individual biological problem to be treated with site-specific or mind-numbing drugs.

Gender is more than a factor to be considered in the development of mental health services. It must also be considered as constitutive of mental illness in social systems which devalue and delimit the agency of women. Psychiatry has served to regulate the lives of people and in particular the lives of women. In the modern period, women who have rebelled against their social positions as wives, mothers or mistresses have been diagnosed, treated and incarcerated as hysterical or schizophrenic or manic-depressive. The specific forms taken by the psychiatric regulation of women are determined by culture, race, class and sexuality.

As Western medicine became a global phenomena, so psychiatry’s regulatory powers function globally to differentiate the sane from the insane and to provide treatment. Suman Fernando, a psychiatrist who is a participant in the trans-cultural psychiatry movement and practices in social psychiatry in Britain has argued convincingly about the cultural specificity of psychiatry and its endemic racism:

The position, at present, is that psychiatry functions as an imperial force imposing its views and exerting its power, confident in assumptions of its own superiority, not just of its presumed scientific methods but of the Western culture that underlies it - a culture that promotes a materialistic, non-religious standpoint and deep-seated presumptions about race.35

Fernando recommends developing practices and service-delivery systems that are culturally appropriate and do not disempower the client. To do this, practitioners need to be able to question assumptions and make paradigmatic shifts “from ‘symptoms-thinking’ to ‘needs thinking’, from looking for illness to promoting health.”36 The female consumers who participated in the Manitoba government survey above also recommended that clients be empowered: “We need to be fully informed, have honest choices, and have someone to work along with us rather than lord it over us.”37 In general, empowerment is an objective of
consumer or psychiatric survivor groups in Canada. Proactive groups undertake dismantling of the power structures that support psychiatry's regulatory functions through changes in legislation. Other groups are focused on support to consumers and their families and public education. In "Empowerment and Women's Mental Health Services" Coni Kalinowski and Darby Penney highlight the complexity of empowerment: "... the goal of supporting empowerment in women psychiatric survivors requires that both the provider and the recipient commit to an ongoing examination of power issues in all their manifestations, including gender, psychiatric diagnosis, socioeconomic group, and ethnicity." Kalinowski and Penney point out that service providers are inevitably uncomfortable with such an examination of power issues as they are both reluctant to see themselves in the role of oppressor and fearful of losing power. They advocate for creating "a work environment in which it is acceptable and safe to discuss issues of power and discrimination and in which the examination of these issues is an organizational priority."39

Psychiatry and Regulation

To provide mental health services to women that are gender-sensitive and that operate within an environment which is open to discussion of power issues requires that the medical model of mental illness be dethroned. The medical model presupposes the Cartesian division between body and mind. Behaviour which in the past would have been deemed mad, possessed or irrational is, under the medical model, diagnosed as an illness of the mind. The illnesses of the mind, like the illnesses of the body, may be treatable if diagnosed correctly. The profession of "mad doctors" or psychiatry was born in the eighteenth century. As scientific technology was integrated into medicine, the biological model of madness became dominant. This model, like any, is both useful and limiting. Its limitations have been critiqued from within by individuals such as Szasz or Breggin and by the trans-cultural psychiatry movement and from without by consumer networks such as MIND. Professionals in mental health services are struggling to balance the biological model with awareness of the impact of social situations: "...mental health problems that result from violence and discrimination do not fit neatly into the biologically based explanatory frameworks that
currently dominate our thinking.”

Despite the critiques, the biological model continues to dominate. Suman Fernando provides a succinct overview of the traditional “illness” based psychiatric process:

In Western culture today, the theme of ‘illness’ is consistently used in evaluating certain human problems. These are problems where individuals (1) present with distress (2) are presented as disturbing other people, that is causing distress, or (3) are designated as behaving in ways that society sees as deviant and irrational. The basic contention that influences theorising in these instances is that of a personal disturbance seen as a ‘problem’ in the mind associated with a biological change which is then conceived of as a mental disorder or ‘mental illness’. In other words, the process of psychiatry is to evaluate certain types of human problems in terms of illness by identifying a ‘change’ (from a hypothesized norm), giving it a name (‘diagnosis’), evaluating the causation (‘aetiology’), and finally making a judgement on interventions (‘treatment’) that are likely to counteract or alleviate the ‘condition’. 

In describing how psychiatry treats certain human problems as illnesses, Fernando is echoing one of the earliest critiques of psychiatry by a psychiatrist, Thomas Szasz’, *The Myth of Mental Illness*. Szasz’ characterization of mental illness as myth was not meant to suggest that the distress of people characterized as mentally ill did not exist: “When I assert that mental illness is a myth, I am not saying that personal unhappiness and socially deviant behaviour do not exist. What I am saying is that we categorize them as diseases at our own peril.” Szasz argues that such categorization is a highly effective form of social control, limiting individual freedom. Szasz delineates psychiatry’s regulatory role and its failure to critically reflect on that role: “The language of psychiatry thus de-ethicizes and de-politicizes human relations and personal conduct.” While the profession of psychiatry is concerned, as are medical doctors, with alleviating distress or treating illness, it also had, from its inception a regulatory function. Psychiatry not only polices the “normal”, it helps to define it.

Psychiatry has re-defined itself in part through its *Diagnostic and Statistical Manuals (DSM I - IV)*. The *DSM III*, published in 1980, legitimizes psychiatry’s regulatory function by affirming psychiatry’s scientific basis: “Because *DSM-III* serves the mental health profession as a charter document, it places the biomedical model...at the center of the textual web of mental health. It thus redefines psychiatry as a high-status profession built upon
investigatory science rather than a heterodox set of practices with no secure theoretical and empirical knowledge base. The categories of mental illnesses in the manual are applied globally.

Psychiatry’s regulatory function is hegemonic. The power of individual psychiatrists over individual lives is huge and the checks and balances on the profession imperfect. The Waiting Room project was constructed to reveal the regulatory power of psychiatry in some individual female consumers’ lives. However, it also presents an alternative representation of women with mental illnesses. This representation resists the medical model which would reduce the women to patients awaiting medical attention or to victims of disease. Alternative forms of representation can function to disrupt “normal” images. Feminist theatre calls into question modernist assumptions about the individual and society. In the following chapters I explore how alternative representations can be elicited from and performed by women who have been marginalized as a result of mental illness.
ENDNOTES


5. Ibid. p.58.

6. Ibid. p.63.

7. Ibid. p.252.

8. Ibid. p.250.

9. Ibid. p.245.

10. Ibid. p.269, italics inserted.


12. Ibid. p.31.

13. Ibid. p.31.


18. McClintock, p.36.

19. Ibid.p.45.
20. Ibid. p39.


23. McClintock, p.47.

24. Ibid. p.46.


27. Ibid. p.129.


31. Ibid. p.72.


34. Dr. Ruth Dickson, University of Calgary, speech, Manitoba Schizophrenia Society, Oct. 7, 1998.


39. Ibid. p.139.

40. Blanch, Andrea K. and Cynthia Feidan-Warsh, "Women's Mental Health Services - The Need for Women in Mental Health Leadership" in Journal of Mental Health Administration (Fall 1994, Vol.21 no. 4), p.335.

41. Fernando, Mental Health in a Multi-Ethnic Society, p.14.


CHAPTER III - STORYTELLING:
LISTENING & SPEAKING WITH “IM-PATIENTS”

A story is not just a story. Once the forces have been aroused and set into motion, they can’t simply be stopped at someone’s request. Once told, the story is bound to circulate; humanized, it may have a temporary end, but its effects linger on and its end is never truly an end.1

_The Waiting Room_ was developed from the stories of women who had experienced mental illness. This technique for creating a script is common to popular and educational theatre projects. In this chapter I examine the storytelling process specifically with reference to its use in popular education and theatre. Like any educational process, storytelling must be used in a reflective and critical manner. The use of stories in educational settings can become exploitive rather than empowering. When storytelling is being used to produce a collective story or script, the process becomes more complex and ownership or authority over the story can become problematic, as it did in the development of _The Waiting Room_. Exploring the complexities of the storytelling process helps in understanding the greater complexity of collective script-building.

Part of what makes a story more than “just a story” is that it is more than the words, more than the context, more than the teller or the listener. It is all these things and more, the whole being greater than the sum of its parts. My focus here is on a particular kind of story, personal narratives or stories told within and for an educational and/or popular theatre context. It is important to contextualize the storytelling for the context is part of the process. Part of what makes a story powerful, more than just a story, is its mutability. The educational and popular theatre contexts are focused on that mutability. In changing the story, we may be changing whose story is told, how and why it is told and who gets to tell it and who gets to hear it. In changing the story, we are working to change ourselves and each other.

Within the context of education and theatre for social change, storytelling has multiple functions. I understand its central function as inscribing the political with the personal. Stories are valued for precisely this function of being oppositional to a reductive rationalism and its call for objectivity. Stories break the rules, written and unwritten, that
educational discourse is restricted to the reasonable and impersonal. Storytelling can function in a variety of ways, directed towards creating change in the teller, the hearer or both. For the teller, these ways include: describing or reinscribing the self through the testimonial, witnessing which integrates the past and the present, the manifesto which reclaims agency. For the listener, a story can create connections, make the unfamiliar recognizable, suggest possibilities that might not have been available. Storytelling can also work against social change. It can exoticize the teller or the tale and thus contribute to the Other remaining othered. It can foster facile empathy which camouflages the need to critically reflect. It can exploit the teller or the listener or both.

How the story will function is related to the context developed by the group and its teacher/facilitator. In contrast to a confessional, therapeutic or performance setting, when the storytelling process occurs in an activist or educational setting, the group itself must discuss and determine the function and the parameters of the exchange. Both the nature of storytelling and the nature of group dynamics preclude fixing the boundaries of function or process. Nonetheless, group agreements can provide a baseline which can support the storytelling process. There are inherent contradictions in trying to create a safe environment for storytelling and for self-revelation. Taking risks safely is one of them.

In a popular theatre project, such as The Waiting Room, the goal is the delivery of the stories to the audience in the form of a collectively developed drama. Therefore the context for the storytelling includes a direction outside the group, an orientation to the public. This orientation outside the group itself adds another level of complexity to group process, which is explored in more detail in chapters IV and V. Initially, I will examine the functions of storytelling in an educational setting that is not directed to public performance. This examination is structured around the roles of the teller, listener and facilitator/teacher.

I want to attend to the issues that complicate the storytelling process in an educational setting. I begin by imagining a neo-conservative response to the topic of this paper: “Why are stories told in educational settings? What’s the use of it? What kind of settings are they, besides primary school? Whose stories are being told and why aren’t my culture’s stories being ‘shared’? How effective is storytelling at making better citizens? What has theatre got
to do with education?!?" At some level these are a practical set of questions which I hope to address with attention to complexity and nuance.

### The Teller: Re-creating the Self

Why do we tell stories? From nursery rhymes to the Bhagavadgita, stories answer questions about 'how' and 'why'. Some stories complicate the questions rather than answering them. The telling of stories not only explains creation, but is an act of creation. Potentially, the teller re-creates the self through the telling.

What kind of self is re-created through the telling? If the sense of self is understood as socially constructed through discourses of power and knowledge, then identity is not fixed but is found temporarily in the articulation of subjects to subject positions. A subject’s conscious participation in the production of discourse, whether it is a political campaign or a re-storying of a life, is part of the active role in articulation. The subject’s position in relation to gender, race, class, sexuality, disability will form, but not determine, the shape of that participation. Sidonie Smith’s *Subjectivity, Identity, and the Body: Women’s Autobiographical Practises in the Twentieth Century* includes a consideration of how feminist writing can alter the sense of self. Smith suggests that: “Autobiographical practices become the occasions for restaging subjectivity and autobiographical strategies become occasions for the restaging of resistance.” There is an absence of female biography or autobiography in Western literary tradition. Before this century there is very little such writing to be found. The questions must be asked: Were there no women’s lives worth writing about? Were there no women who wanted to write about their lives? Perhaps there were, but obviously the discourse was highly regulated. Telling one’s story, which is sustained by the belief that one’s story is worth telling, is a preliminary step to writing the story of oneself, autobiography. Smith’s analysis of contemporary writers like Gloria Anzaldúa, Cherie Moraga and Donna Haraway, posits they are reclaiming the territory of autobiography and transforming it as they do so, entwining the personal and the political and re-configuring the representation of self. This reconfiguration of the self can take place within the oral tradition as well as the written.
Storytelling and theatre are sites where the representation of self can be re-configured. Trinh T. Minh-ha's work reclaims storytelling as a source of wisdom as well as a source of subjectivity. Her argument is that such subjectivity creates wisdom, when embedded in a collective tradition. Trinh writes of how the storyteller is “the living memory of her time, her people.” 3 Trinh refuses a schema that positions the oral tradition in opposition to the written. Trinh celebrates speech as story and story as transformative: “[s]peech, that active agent in our Mothers’ magic...”4 When the story becomes “just a story” or is reduced to an invention, a lie, then its power to transform has been limited: “Men appropriate women’s power of ‘making material’ to themselves and, not infrequently corrupt it out of ignorance. The story then becomes just a story.”5

Here is a piece of a story, an autobiographical story that helps me understand the power in storytelling: My experience of feminism began in the late seventies in a small city on the prairies. Most of my women friends were in grad school or working. I had two babies. There was stuff in the media about women’s liberation, but who had time to read Maclean’s, never mind Germaine Greer. Besides, when I did have time to read seriously, I would delve into the philosophers (all dead white men) whom I had so recently abandoned for real life. When my sister returned from Boston U. that spring she was on fire about the women’s movement. She wanted to create a discussion group a.k.a. consciousness raising group. So we did, meeting in the evenings on my front porch or living room, because I lived centrally and if it was at my place I wouldn’t need a sitter. I remember very little of the content or the process of those meetings. I do remember how exciting those evenings were; how we told our stories; how we pushed each others’ paradigms. I believe we sometimes used an article or poem to focus our discussion. We had no manual for what we were doing, only my sister’s sensibilities, honed in Boston, and our own desires to be there. For me that desire was formed around the novel possibility that women could come together to learn without men, without a rabbi or a [male] professor to set the parameters of the exchange and to validate the story of our learning. In retrospect, I understand that part of what we were doing was learning to tell the story differently from before. We were re-forming our story of how we could learn.

Over time, such collections of women learning to tell the story differently helped to
frame a series of social changes, ranging from access to daycare to access to the chairing of reactionary corporations. I find it interesting that storytelling in a circle of women has become again a powerful event. Magda Gere Lewis addresses the feminist focus on experience, on story:

I understand that the transformative power and social significance of feminism lies in the coherence of a process that articulates a politic out of the personal. The importance of the feminist focus on experience is not to prompt a vacuous, gratuitous telling of our intimate stories as a cathartic moment, but indeed to emphasize the political meaning of our personal reality; that subordinate groups live subordination and marginality through our subjectivity.  

Stories of our experiences have the potential to alter our own and others’ understanding. When the storytelling takes place in a context which addresses their political as well as their personal meanings, that potential is greater. If the stories are translated from the relatively private realm of the group or class to a more public domain such as a performance or autobiographical writing, they are changed by that process. The public setting for the personal story can be very powerful. Such a story is C. Carr’s “An American Tale: A Lynching and the Legacies Left Behind”. Elizabeth Ellsworth’s analysis characterizes Carr’s use of story and autobiography within an historical and cultural context as powerful social, cultural and educational work. Part of its power lies in breaking the rules of how the story has been told in Carr’s family and culture in the past. Part of its power is that the form of the telling of the story changes the rules for defining whiteness: “Instead of defining whiteness as a fixed locatable identity, ethnicity, or even social positioning, Carr addresses whiteness as a dynamic of cultural production and interrelation. By telling the lynching story differently than the way she heard it told for years growing up’ she breaks the rules of her family’s relating to each other as white and understanding each other as white through this story.”

If one understands identity as culturally produced and developed in relation to others, then understanding that process as dynamic expands the range of possible identities and the possibility for social change. Dominant stories are not immutable. They must also be
reasserted dynamically; thus they are also subject to change. Those stories that challenge, question or even nudge the dominant stories can create a some tension which can be productive for an individual or a group engaged in resisting the dominant stories. I will consider how storytelling is used to resist dominant stories in therapy and in conflict resolution as examples of this "productivity".

In *Narrative Means to Therapeutic Ends*, Michael White and David Epston examine how storytelling shapes experience and how it can be used to reshape problematic stories in a therapeutic setting. A story may be problematic when the person performing it finds it unhelpful or contradictory or feels coerced into its performance by others. The authors contextualize what is "problematic" by placing it within a Foucauldian understanding of how power operates sociopolitically through truth discourses. Thus a person's story may be problematic as a result of a disjunction between social narratives and/or family narratives and personal narrative. Carr's work "An American Tale" is produced by that disjunction. In turn it produces a re-generation of the story, one that challenges the dominant mode. White and Epston contend that therapy is a political activity: "This is not a political activity that involves the proposal of an alternative ideology, but one that challenges the techniques that subjugate persons to a dominant ideology." Narrative techniques are a means for making that challenge.

In an article on storytelling as a tool for conflict resolution, Michelle Lebaron Duryea states that narratives function in a variety of ways. They "engage others and communicate values using familiar language, thus translating unfamiliar concepts onto frames that can be understood by those of a different culture or value system." They may provide access to community beliefs about conflict. Intervenors can use narrative to encapsulate the perspectives of the parties or to create a story which presents an alternative to the adversarial story presented for intervention.

In conflict resolution, as in therapy, narratives can be re-formed in order to facilitate change. However those engaged in therapy, conflict resolution or a popular theatre project must develop and/or access theory that will facilitate defining what constitutes re-forming the story. Such theory must also connect that re-formation of the story with who gives and
who receives the privilege of intervention or facilitation.

The power of storytelling is its rootedness in subjective experience. In an educational setting, the act of honouring subjective experience is in itself an act of resistance to a power/knowledge system which valorizes objectivity. However, storytelling as an educational tool demands attention to its process. That process will have a focus or direction, such as challenging stereotypical representation of mental illness, as it did in *The Waiting Room* project. Paying attention to subjective experience does not mean abandoning theory:

What can we learn from the stories we have lived? Locating our experiences in the materiality of our everyday lives is not the same as “telling all”.... As much as they serve a clearly articulated political agenda, theoretical frames are crucially important to how we assign meaning to the specificities of personal experience across all the social disjunctures that divide us. Yet the politics of ‘storytelling’ like the politics of teaching and learning must be directed toward a particular and explicit project.  

What Gere terms “social disjunctures that divide us”, must be inspected as part of the process for storytelling directed to social change. Those differences frame how we hear each others’ stories. The mutability of narrative is dependent not only on the story being told but on how the story is heard, on what is attended to. When a series of stories is being shaped into a collective book such as *Lionheart Gal* or a collective script such as *The Waiting Room*, there are different layers of listening which must come into play. How the collective listens to each others’ stories is one layer. The second layer is how the facilitator hears the stories and groups or orders them. The third layer is how the facilitator and the collective imagine or desire their stories to be heard. These layers do not build on each other in a linear manner, rather they interpenetrate.

**The Listener: Attending to Difference**

Listening to stories requires that we listen for difference as well as for connections. We must also attend to the different positions of the teller and the listener, as Sherene Razack makes clear: “When we depend on story telling, either to reach across differences or to resist patriarchal and racist constructs, we must overcome at least one difficulty: the difference in position between the teller and the listener, between telling the tale and hearing it.” How
we listen cannot be separated from the power structures which create the context in which the story is told. Elizabeth Ellsworth’s analysis of her work in Curriculum and Instruction 607, “Media and Anti-Racist Pedagogies” is revealing of the impact of context on process. Ellsworth demands of herself and of other educators to “be accountable for naming the political agenda” that underpins what and how we teach. In naming her agenda, anti-racism, Ellsworth also creates a context which she describes and affirms as “partial” to particular stories:

Students’ and my own narratives about experiences of racism, ableism, elitism, fat oppression, sexism, anti-Semitism, heterosexism, and so on are partial - partial in the sense that they are unfinished, imperfect, limited; and partial in the sense that they project the interests of ‘one side’ over others. Because these voices are partial and partisan, they must be made problematic, but not because they have broken the rules of thought of the ideal rational person by grounding their knowledge in immediate emotional, social, and psychic experiences of oppression or are somehow lacking or too narrowly circumscribed. Rather they must be critiqued because they hold implications for other social movements and their struggles for self-definition.13

Both Ellsworth and Razack advocate for a different kind of listening to the voices and stories of marginalized or oppressed people. Both are cognizant of the difficulties of this position. These include competing marginalities and an uncritical assumption that all suppressed knowledge is valuable by virtue of having been suppressed. I believe that privileging these stories is critically important work. I see this privileging metaphorically as making room in the community, in the classroom, in the discourse itself. If so, it must be acknowledged that the teacher/facilitator has the privilege to re-arrange the furniture. Once the room is rearranged, however, that privilege may be reduced: “In fact, I brought into the classroom privileges and interests that were put at risk in fundamental ways by the demands and defiances of student voices.”14 Ellsworth had made room to hear those voices. Making that room requires very tangible work within the educational institution and the less tangible work of interrogating one's own position.

Imperative to meaningful listening is consideration of how the listeners themselves make meaning, using what Razack calls “...interpretive structures that underpin how we hear
and take up the stories of oppressed groups." A critical awareness of our own narrative and interpretive structures, how they are constituted, and how they in turn constitute our reception of others’ stories, is necessary - in order to avoid storytelling becoming the audio equivalent of voyeurism. "Sharing your story" has become almost a plague in bourgeois culture in the '90s. Numerous talk shows are now built around the "true confessions of ordinary people", as well as the continued presence of celebrity revelations in the media. Although analysis of these confessional yet celebratory events is not the focus here, the cultural environment they create can effect how we listen to stories in other contexts. I believe this listening environment increases the possibility both for avid listening for consumption, "eating the other", and for facile empathetic listening which reduces or trivializes another's experience.

Pearl M. Rosenberg's discussion of the "Politics of Empathy" is very useful in examining how some ways of listening can reduce another's experience. She describes her work on racism with primarily female, white, bourgeois preservice teachers in New Hampshire. These students read and hear the stories of inner city students of colour. In response, they empathize and identify with those lives and problems. Although this empathy may be an important first step in awareness, Rosenberg states that it is also a dangerous step because it can create a false sense of involvement. It is false because it reduces the inner city students' experiences to what the preservice teachers can relate or connect to. This false sense of involvement can prevent a meaningful response to differences in the lives of the two groups. Without an understanding of difference, there can be no understanding of complicity in the production of difference: "In the case of my white students it is not that there has been no recognition of the pain and anger of the "other"; rather, the pain and anger of the other has been reduced to what they know. Unfortunately, what they know is limited and does not reflect back on their privilege."16

In order to move beyond a politics of empathy there must be critical reflection on differences in privilege. Teaching and facilitating can set up the means for this reflection. However, this itself reflects the privileged position of the teacher/facilitator. In "And Still I Fight", Kathleen Rockhill grapples with the concept of privilege in relation to disability:

I am troubled by this concept of privilege. I want to stop attaching privilege
to individuals, as though it’s a state of being or a commodity that one does or does not have, and to think instead of acts, of what it is that one can do, in varying situations, and in relation to whom. Privilege is about power, the power to affect the actions of others, the power to exert some control over one’s life, to know the possibility of choice and rights that are inscribed by ‘the normal’.  

I believe it is important not to attach privilege to individuals without relation to context. However in the case of Rosenberg’s education students, their context, that is where and how they listen to the stories of oppressed students, resonates with their privilege. Their response to those stories must attend to their privilege. Shame might be more useful a jumping off point than empathy, simply because shame can be attached to one’s privilege. Shame can then be deconstructed by situating the privilege within the context of power, what Rockhill terms the power to act. Razack distinguishes between theorizing that privilege is relative, that one is constituted as both dominant and subordinate, and working to address privilege in specific contexts. “While we are all simultaneously dominant and subordinate, and have varying degrees of privilege and penalty, this insight is not the most relevant when we are seeking to end specific hierarchies at specific sites.”

When, as teacher/facilitators, we are engaged in specific hierarchies at specific sites, we are being accountable for our political agenda. This accountability must inspect our subjectivity and its contextualization in the role of facilitator/teacher. I want to explore issues of power and privilege for facilitators of popular theatre. I situate that exploration on the impact of the facilitators on the storytelling process in *The Waiting Room* project in Chapter IV.

**The Facilitator in Popular Theatre: Doubly Privileged**

In a popular theatre setting, the role of the facilitator or animator is central to the translation of the group’s personal stories into the public performance of those stories as a play. Sometimes there may be more than one facilitator. (I will use the term “facilitator”, as that is my practice, using “animator” only with reference to another speaker who prefers that term.) Broadly, the facilitator’s role is to aid the community in expressing the stories of their experience through a collectively created dramatic piece. The facilitator is expected to have
skills or expertise in theatre, as well as a politicized understanding of group process and of the issue or issues which the community group is addressing.

The facilitator may or may not be part of the community creating the work. For example, Headlines Theatre in Vancouver is the resident theatre company for the Vancouver School District and is available to facilitate “Power Plays” on race relations in high schools. This company has facilitated plays with activists, unions, women’s groups and Native communities across Canada. Obviously, Headlines is not part of all these communities. Headlines artistic director, David Diamond, describes the community which he is part of as newly formed, multicultural, and transitory. He explains that he feels part of many groups, but he is also aware of the danger of appropriation: “Not wanting to appropriate, ... at Headlines we established some basic personal rules. We work only with people who have invited us to work with them. We never tell them who they are, but instead allow the process of their telling the group who they are to guide how we facilitate the workshop.”

I would suggest that such “rules” are a necessary but not sufficient condition for avoiding appropriation. Facilitators who are not part of the community developing a play are often parachuted into a community by the vagaries of the grant process or at the invitation of privileged community members. They can easily be identified as strangers to the community or just plain strange. At the same time, they can be identified as fixers with powerful and practical tools which they bring into the community and with charismatic appeal. What is needed is a system of checks and balances for the group process. Otherwise the facilitators’ expertise can distort the balance of power which is necessary to build respect for differences and to create integrity in the theatrical work.

Julie Salverson distinguishes between facilitators who are members of a community and facilitators who see themselves as “serving” a community. These she terms “enablers”. They are “largely white, middle-class artists or activists” working with a variety of communities in both salaried and volunteer capacities. For Salverson, the enablers themselves form a community, a community she understands herself to be part of. Playing Boal: Theatre, Therapy, Activism is an anthology of writing about Augusto Boal’s work and popular theatre. Much of it is written by facilitators like Salverson. In “The Mask of
Salverson raises some of the issues enablers must deal with. Salverson is concerned that through their work with others, enablers are avoiding their own life experiences, particularly pain or oppression. This avoidance leads to wearing the mask of solidarity, as a protective cover which inhibits the work of building true solidarity.

With no identity of our own we cannot allow someone else to be different or separate; our whole sense of self is bound up with theirs. I am not suggesting activists contact their own oppression because it is the same as that of others. Quite the contrary. By feeling and knowing our particular life structures and experiences, both as recipients and perpetrators of violence, we can then become visible ourselves and enter honestly into relationship and solidarity with others.¹¹

Salverson’s distinction between being aware of one’s own oppression and equating it with others’ oppression is important in avoiding the “politics of empathy”. Salverson advocates that popular theatre work provide a balance between the emotional engagement of theatre and the reflective analysis necessary for political response and action. In “Feminist Acts”, another essay in Playing Boal, Berenice Fisher raises her concerns with Boal’s methods. Like Salverson, she is concerned that reflection be part of the process and that Boal’s methods do not make enough room for reflection. I myself have experienced Theatre of the Oppressed [TO] workshops as having too much cowboy energy: “Let’s corral the oppressors and shoot it out in our white hats while they wear black ones.” Fisher is also concerned that “... TO runs the risk of reproducing rather than representing oppression”.¹² Fisher sees the facilitator as integral to avoiding the reproduction of oppression. The facilitator must direct the process: “Not letting stereotyped portrayals go unchallenged, and holding students accountable for the images they project, creates room for reflection on these questions.” ¹³ Much of Fisher’s work takes place in educational settings where the facilitator’s role can be more structured than some community settings would permit.

Popular theatre practitioners differ in their approaches to the role of facilitator, as is apparent in the roundtable of Canadian practitioners moderated by Mady Schutzman and included in the anthology. A central concern is the facilitator’s level of control of a workshop or theatre piece and to what extent the facilitators’ political convictions and
artistic vision will shape the community’s work. Privilege and power come into play, affecting the facilitator’s ability to hear stories and to translate them into theatre with the group.

All the participants in the roundtable agreed that they had “skills” which were useful and which place them in a different position than other participants in the community theatre project. Eleanor Crowder frames the dilemma: “There is a place for consensus in TO work but there is also a place to exercise the skill of the animator. Right now we’re trying to figure out the lines between the approaches.” Rhonda Payne differentiates between using those skills to frame or explore a problem and using those skills to “fix” the problem:

If I’m working with a union going on strike, I can use my skills as a theatre artist and performer to tell the story. But the telling of the story does not in itself solve the problem or fix whatever the problem is in the community. It is always fundamental to me to do that in conjunction with community organizers or therapists. What worries me about Theatre of the Oppressed, and about various concepts of facilitators and jokers, is that we’re starting assume the role of fixers.

The concern with differentiating between the role of the facilitator and the role of therapist surfaces throughout the discussion and in several essays in the collection. Boal’s most recent work has focused on the application of his techniques to therapeutic settings. In community settings, popular theatre facilitators may be involved in conjuring up or extracting painful experiences, what Salverson terms “risky stories”, which include and embody acts of violence. Ultimately these are the kinds of experiences called up by the popular theatre process, which has a political focus on oppression and a dramatic focus on conflict. This is why facilitators are concerned with creating a safe environment, so that participants can call up these difficult stories and not feel they or their stories are being used or trivialized. The facilitator is responsible for creating both the possibility for risky stories to be revealed and the support for those who reveal them. Sometimes these are perceived as conflicting demands. Crowder is concerned with “... how much control by the animator is necessary for the safety of the participants.” Salverson cautions against an overly protective approach on the part of the facilitator: “...if we start saying we have to ‘look after’ these people, it’s colonialist in a way. People have lived through all this trauma, and our drama exercises are
not all that shattering."

Salverson’s thesis, *The Unimaginable Occurrence: Storytelling, Popular Theatre and Risk*, offers the image of the container and the gap to structure the development of a popular theatre project. Salverson stresses that theatre, unlike therapy, is a public, not a private event. People who choose to work on a popular theatre project have chosen to engage with their personal experiences in a community and/or public context, in performance. The performance creates a context which is a different and more risky form of engagement. The stories will be performed face-to-face with an audience and the stories performed are not billed as fiction but as a representation of the lives of the performers. Performing is itself a risk that not all of those concerned about an issue are willing to take. For example, of the dozens of women who were generous and shared with me stories of their experiences during the research phase of *The Waiting Room* project, only twelve chose to develop and perform the play, that is to enter into a public context. That choice to perform the story, which entailed a greater risk than telling it to an individual or a group, had to be respected.

The process for developing a community play must focus on the agency of the participants, recognize them as actors in the story, not victims of it. I believe that the facilitator’s role is to support that agency. Salverson calls that support the “container”: “For a popular theatre project, the strength of the group, the container, is built slowly from the images and practices which truly exist there among its members, including of course, the artist/educator.” Although Salverson recognizes the specific role of the facilitator in designing the container, she is very clear about distinguishing that role from the role of therapist/hero, which she rejects. Like Fisher, she is concerned that the popular theatre process not reinscribe oppression. Fisher fears this will occur due to inadequate intervention on the part of the facilitator. Salverson’s concern is with inappropriate intervention: “As listeners and translators within a society that grants considerable currency to the protector role of the confessor, artists and educators need to consider where our actions may reinscribe the very roles we wish to dismantle.”

Salverson suggests some guidelines for structuring the container. These include: Setting a time and place for the work. Finding and articulating the group’s common
investment. Naming the power differences among the participants. As well, the group will develop “a structure of relations that includes a space for what no one knows how to name”.

This space refers to “the gap” in the container through which Salverson recognizes and affirms the limitations of any structure.

I find Salverson’s metaphor of the container a very useful guide to the storytelling phase of popular theatre work. In my own work I have struggled with the power and the privilege of shaping the container. In the next chapter, I want to examine that work on The Waiting Room more closely, focusing on the transition from storytelling to playbuilding. This involves examining the group process and the role of the facilitators and the playwright in building that process. Before situating the theory I have discussed in my work on The Waiting Room, I want to summarize this chapter’s more general discussion of storytelling in an educational and/or popular theatre context. If a story is produced or constructed for educational purposes, then the facilitator/educator has specific responsibilities. Those responsibilities include an awareness that a story must be considered contextually in relation to the teller and to the listener(s) and that the context is both political and personal. This storytelling process is directed to transformation, to social change. The facilitator must hold herself accountable to her own political agenda in her structuring of the process. That process must be respectful of differences among the group and must not slide into the politics of empathy or the mask of solidarity in which differences are collapsed before being named or problematized. Rather, as Trinh suggests, difference must be attended to as “that which undermines the very idea of identity, deferring to infinity the layers whose totality forms ‘I’.”

If the storytelling is produced collectively in order to create a performance, a representation to the public, then there are additional complications for the facilitator. Such a story becomes a popular theatre piece or play, like The Waiting Room. The popular theatre process involves the translation of individual stories into a collective story. Potentially, participants have greater agency in a popular theatre project, insofar as they perform collectively for others the individual stories they have told. That potential agency can be lost or mangled if the group process is mismanaged. Facilitators have a doubly privileged position in the group process in that they are the gatekeepers to the required drama skills, as well as
having the role of facilitator. This privilege must be named, although the naming will not prevent the difficulties that arise from the privilege. If, however, the delicate balance among group members is maintained, then their differences and their different stories will indicate the “infinite layers” of difference, the possibility in fragmentation and the power of collective energy.


3. Trinh, p. 125.

4. Ibid. p. 129.

5. Ibid. p. 129.


14. Ibid. p. 309


23. Ibid. p.195.


27. Ibid. p.207.

28. Ibid. p.204.

29. Ibid. p.46.

30. Ibid. p.61

31. Ibid. p.51

32. Trinh, p.96.
CHAPTER IV - AGENCY: HOW TO PERFORM “IM-PATIENTS”

Autobiographical narrators become agents in and of the story.... Seizing the occasion of telling the story turns speakers into subjects of narrative who can exercise some control over their “lives”. This assertion of agency is particularly compelling for those whose personal histories include stories that have been culturally unspeakable, for instance child abuse and spouse battery, interracial marriage, homosexuality, mental illness and disability.¹

I have suggested that for participants in a popular theatre project, agency develops from the performance of the collective story. It is a particular form of agency, in that the individual’s agency is produced through the collective agency. Those whose “personal histories include stories that have been culturally unspeakable”, are very often isolated by the unspeakability of their lives. Certainly this was my own experience and it was echoed by many of the women I interviewed in the research for The Waiting Room project and by the members of Acting Out. The project’s mandate to educate both consumers and the general public about the experiences of women in the mental health care system could not be realized without the agency of the community troupe members. That agency was formed in the context of creating community.

One objective of The Waiting Room project was to: “serve as a catalyst to encourage women who are and have been consumers of the mental health care system to work together in a supportive atmosphere on a common issue... This process will assist them in developing independence, assertiveness, self-confidence, and self expression.”² I think it is important to note that the expectations for the participants were that their personal growth would develop through the educational work which they had chosen to be engaged in. That growth is produced through their agency, not through therapy. From its conception, the project was directed to giving voice to the culturally unspeakable stories of women who had experienced mental illness. That voice would be a collective voice, not a monologue.

My research on the project began with listening to and telling stories with individual women and small groups of women. Through several networks I was able to make contact with consumers. It was the possibility of a play which created the stepping-stone for the
storytelling sessions with them. I would explain the project and that I was collecting material for a play. For the majority of the women I contacted, there was a strong interest in the possibility of making the personal political or at least public. Over and over I was told that "people just don’t understand what it's like" or "other people should know that...". In the storytelling, both the specificity of individual experiences and their commonality were stressed. There is a culture of those who have lived with mental illness, a culture that includes its own rules of speech and gesture, codes of behaviour. This culture can bridge differences. I had been part of this culture and it was from that position that I was accepted by the women I spoke with, as much as from the legitimized position of directing the project.

These initial storytelling sessions were relatively informal. Once the project was funded, we needed to develop a community group committed to the process of creating and performing the play. Members came into the group in several ways: some came from participatory research workshops held early in the spring of '93, some responded to flyers posted at agencies and in newsletters, some came through word of mouth from friends or service providers. By September of '93, the group was formed and soon after named itself Acting Out.

This chapter will trace the development of the group process for storytelling and the transition from storytelling to playbuilding. Data I have used includes the planning sheets the facilitators prepared for group meetings as, well as the weekly mailings to members which summarized the previous week's work and laid out plans. There are also documents generated for the group, such as group agreements. Some of these documents are included in the appendix. In addition to written data, there are my reflections on the process in the context of my studies. Those reflections have also had the benefit of occurring in the context of recent discussions with group members. In the summer of 1998, I was able to arrange interviews with four of the members of Acting Out, as well as with Huen and Beauchamp. I wanted to hear their reflections on the project now that four years had passed. Each of the women I was able to reach was interested in doing an interview. They were eager to support my work and enthusiastic about the project. Six interviews were held, with Huen’s occurring over two different dates. The interviews were informal and open-ended [see appendix for
questions and consent form]. Some of those interviewed requested anonymity. Therefore I have used first-name pseudonyms for all the actors’ comments, although not for the facilitators’ or playwright’s. I am most appreciative of the time and energy the interviewees gave me. It reminded me of the spirit with which they had approached the work on The Waiting Room project. Their reflections helped me formulate my conclusions about the playbuilding process and about how the play functions as representation. However, those conclusions are my own and do not necessarily reflect others’ convictions.

The discussion which follows reviews two stages of The Waiting Room project: the first was group building and storytelling; the second was playbuilding. The transition from storytelling to playbuilding was very difficult, partly because of the shift from the individual to the collective voice. The subsequent transition from playbuilding to the rehearsal phase was much easier. Examining the group process and the role of the facilitators in shaping that process and in shaping the script itself is the focus of this chapter.

**Groupbuilding and Difference**

Once the acting troupe was formed, the facilitators’ first priority was to develop the group process. It was a Catch-22 situation in that we had to create an environment which would both provide safety and promote risk-taking. A strong shared sense of purpose around creating a play contributed to that environment. A carefully developed structure of agreements for group meetings and for the storytelling process was also important. [see appendix F. It is interesting that these agreements parallel the conditions Salverson outlines for the container.] In addition, it was significant that one of the facilitators, myself, had, like the participants, self-identified as a consumer. This resonated through the work we did together. Huen and Beauchamp were able to identify experiences they shared with female consumers while respecting difference.

If self-identification as consumers was an initial political act for troupe members, choosing the term “consumer” was another political decision. Although there are many terms used to refer to people with mental illness, “consumer” of mental health services was chosen as the least disempowering, perhaps because it was in use by the Canadian Mental Health
Association and other national groups. Equally important was the troupe’s refusal to name individuals by their diagnosis, as in “she’s a manic-depressive.” This decision was carried through into the script where no character identifies herself or is identified by a diagnosis.

The project required that a very clear distinction be made between theatre and therapy, partly because therapy, its uses and abuses, was one of the topics under consideration. [see appendix D for the list of issues] At the same time, our community group consisted of women who had self-identified as being or as having been “at-risk” in relation to mental health. Some members were more at-risk than others. While not engaging in therapy, the facilitators were concerned with maintaining the health of the group as a whole and its individual members. There would be such concern in working with any community group, but this group was more volatile. On the other hand, group members generally were very clear about identifying their individual issues, needs and volatility to the group as a whole.

In the storytelling phase, participants were working directly out of their experiences, finding stories which exposed the “violence, betrayal, revictimization...not listening” [from appendix D]. These stories were often traumatic for the teller to re-visit and also traumatic to listen to. Many were stories about not being heard or understood. Thus it was important to listen carefully. Yet each participant had learned through experience how necessary it was to protect herself from too much input, lest she be thrown off balance. Meeting in the whole group created safety in numbers. That is, one could tune out if necessary and count on others’ listening. The energy created by the group could support variations in the energy of its members. The facilitators’ role was to maintain balance between individual and group needs.

Early in the storytelling Huen, the co-facilitator, introduced two aboriginal traditions to guide our process: the use of a talking stone and the image of the medicine wheel. We positioned our storytelling sessions around the quadrants of the medicine wheel: first body, then mind, then heart and finally, spirit. These aspects were also the focus of drama and movement exercises. The talking stone was used in storytelling sessions to ensure the teller was central. We also used it to help focus and balance discussion and to aid in conflict resolution. In interviews, several participants mentioned the talking stone and how it helped
with the storytelling. Deb explained that the speaking stone “gave me a chance to have a turn when I wanted a turn; to be able to listen when I first came in and to see what other people had to say.” There was also a circle at the beginning of each meeting and sometimes at the end, to help “check-in” and “check-out” of the group experience.

The group was diverse in age, education, sexual orientation, class and race. What its members had in common was gender and a desire to perform the experiences of consumers in the mental health care system in order to educate others. Of course those consumer experiences reflected the group’s diversity as well as its commonalities. One member, Carli referred to the “the common ground” [25/8/98] we shared, the experience of mental illness. Having “walked the same path” did bond the group members, create a significant meeting place. But to push a limited metaphor a little further, not everyone had walked that path in the same footwear, with the same pack or in the same season. As a result, there were differences in health and self-sufficiency among members of the group. These differences were reflected in their housing situations. Many were living independently, while some were in various stages of supported housing. These differences mirrored not only various levels of wellness, but also the financial resources and the support from family and friends available to different women.

In retrospect, I regret that, as facilitators, we did not explore these differences as part of the group building process. Our focus was on developing cohesiveness, a “container” in which to develop the project. Our initial workshops were built around naming blocks and supports to mental health. Differences in participants’ health were attended to by the facilitators and the group members. They were also related to socio-economic factors. Nonetheless, the group did not name the fragility of some individuals’ health relative to the others. Nor were the economic or class disparities named directly. Difference in race was not addressed directly, although early in the storytelling phase racist language had surfaced and been addressed [see appendix F, agreements 9 and 10 which were the outcome of the process ] There was an overlay of middle-class politeness that was part of our way of working together. I believe that it came about in part as a protective device to contain the content we were dealing with. By joining the group, we had announced to each other that we were
consumers/ had been Crazy/ had survived psychiatry. As a group we were getting ready to make that same announcement publicly in the performance of the play. Having taken that risk, we needed also to affirm that despite being crazy, we were still respectable, i.e. polite and middle-class.

I have described in chapter II how mental illness is constructed as degenerate. All the members of the troupe had experienced marginalization as result of this construction, which they named “stigma”. The content of our work, the content we would perform, encompassed that marginalization and included the experiences of abuse and suicide. These “unspeakable” stories become more unspeakable when spoken by a voice which has been labelled mentally ill, because that voice has been defined as unreasonable or untrue. This is why psychiatry is so often a catch-22 experience- where the patient is required to “honestly” reveal herself and then those revelations become the basis for restraint of the patient and for the professional labelling which defines the patient as unreliable and dishonest. Once labelled, one is no longer a “reliable witness”. This doubting of one’s voice, by oneself and by others, is what complicates self-advocacy for people with mental health problems. This is why it was easier to speak about these experiences from within the construction of the play, than to directly address professionals or lay people as individuals. The collective voice of the performers in a play, a narrative, may be more believable, may be listened to more readily.

In the storytelling sessions participants had expressed passionately the dissonance between how they lived their lives as consumers and how they were perceived by others. They wanted urgently to bridge that gap through the performance of The Waiting Room. To do that they had to “confess” to not being respectable, that is self-identify as consumers. At the same time, they had preserve some respectability, in order to be credible, to be listened to. That respectability had to be maintained within the troupe, as well as in its representations to the public.

Respectability, like health, is relative. Differences among group members were experienced and sometimes identified as strengths. More often, those differences were glossed over as part of the process of maintaining respectability. For example, differences in sexuality were never addressed within the group nor was the experience of lesbians raised in
the script. Nor were experiences of racism discussed in the group or found in the script. The script had to limit its focus on mental illness and could not take up all related issues. Other issues that the script did not take up included the experience of having mental illness while raising children. Although this issue was discussed within the group, the majority of women in the group did not have children and did not relate to the issue. Therefore it was not included in the script. In contrast, sexuality and racism were not raised sufficiently enough to conclude that the group had discussed these issues, but had chosen not to include them within the scope of the play. I believe that some differences were too “scary” to address while we were struggling to keep our respectability. Confronting racism or sexuality might have threatened the cohesion of the group or its tentative sense of its toehold on respectability. I believe that as a facilitator, I had limited skills with which to address racism or heterosexism. Huen had more experience in working with these issues. However, we were both concerned about not adding complexity to an already complex group. We tended to address what came up from the group, rather than creating an agenda beyond the work on the play. The atmosphere was tolerant of differences, but was not critically reflective on race or sexuality. This same “tolerance” also glossed over differences in class and in health among group members. The lack of critical reflection on differences was detrimental to our work.

Over time within the group process, members learned to access their own and others’ strengths. Part of facilitating the group was creating structures to facilitate that access. The group agreements were part of that structure. Almost as soon as the group was established, Huen had discussed and drafted, with the group’s active participation, the set of agreements [appendix F], which were then reviewed and revised as necessary. The agreements did not prevent conflicts, nor were they meant to, but they did provide a set of parameters to guide our process. For example, one agreement read: “We will not interrupt or judge one another while sharing our stories.” The agreement about confidentiality and the conviction that it was being sustained were most important, particularly in the earlier phase of the project when membership in the group was more transient. The agreements also provided a sense of security through including basic courtesies like starting and ending on time. Punctuality is most important to people with anxiety disorders who need to know that order is being kept.
Other accommodations to disability included choosing what was perceived as a safe location for our rehearsal hall and arranging for transportation. Drama exercises had to be planned and carried out with respect to persons' physical boundaries and abilities. At the same time, as facilitator of those exercises, I also encouraged group members to stretch their boundaries.

The first phase for the community group, storytelling and group building, took place from May to October 1993. In these early group meetings, spontaneity and playfulness were encouraged through drama games which usually followed the more deliberate and heavy storytelling sessions. These games were grounded in the bodywork, were physical. Working with gesture and movement creates an alternative to imposing words on experience. The initial drama exercises were designed to build trust, physical and emotional awareness and interaction. Later there was focus on improvisation skills and characterization which were necessary for the play building and performance phases.

By the fall of 1993, when the group had formed and committed itself to the longer term goal of making a play, there were thirteen members. The group had closed itself to new members, although it later added one more member to replace a woman who left to do other theatre work. Two other members dropped out of the project later in the fall, one directly as a result of her discomfort with the group process and one for personal reasons. Choosing a name for the group had been discussed and many names suggested. This name would be used in crediting the play and in promotion. On October 6, 1993 the name "Acting Out" was chosen.

Playbuilding, Narrative Structure and the Collective

The trust developed through this first phase was tested in the transition from the storytelling and group building to the playbuilding phase. For the facilitators this was also a difficult transition. Our objectives shifted from helping the group to form itself and function, to making sure the play happened, as well as helping the group function. As facilitators /coordinators we were responsible to the group, to PTAM, to our ad hoc steering committee and to the funders. We had worked to develop in the troupe a sense of ownership over the process of sharing the stories. This sharing was directed towards a larger purpose, creating a
play together. The story of that play would have to communicate to a broad audience. Thus there needed to be a translation from individual experiences to collective experience to a theatrical representation that would be engaging. Creating that translation belonged in the territory of "artistic vision". This is a term I am hesitant about using, but it came up in the interviews and I understand it as part of the process of creating the play. I understand artistic vision as what propelled the project into being, what directed its development and what framed the structure of the play itself with respect to that development.

By the end of October 1993, the playwright, Joy Beauchamp, had developed the structure of the play and the first scenes were presented to the troupe. Both the structure and the content were problematic. In terms of the structure, there were concerns among the facilitators that it was too demanding for the troupe. In terms of content, troupe members had to adjust to the translation of their stories into scenes with characters. Many members had a play in their minds that did not resemble the script in their hands.

Beauchamp had participated in the group storytelling sessions from late spring of 1993. She believed her writing must respect the experiences of the participants and the issues they wished to address in the play: "I think they had suffered and they had a piece of wisdom and I think that the most important thing we had to do in the project was honour that wisdom. Because otherwise we weren’t honouring their suffering or experience or any thing else.” [13/8/98] Her writing would also have to honor her artistic vision, which saw the play in a narrative structure. The structure of the play and its embedding in the metaphor of the waiting room had come to Beauchamp after weeks of working with the group, when she was ill with the flu. Once she had that structure, it was a question of attaching the individual stories to it: “I took the germ of what she said was happening and played with it...” [13/8/98]

The power to frame and connect everyone’s stories was problematic. In the interview Beauchamp commented several times about being isolated or at odds with the troupe: “Whose story is it? became a constant theme for some very strange conflicts and undertones.” [13/8/98] The initial conflict over “ownership” of the stories occurred when the first draft scenes were presented. One participant felt her story (most of it written in her own words from a taped group session) was being mis-used, trivialized by its context. At the following
meeting she broke down. She decided to leave the project soon after, but she asked to have that scene with her story included in the play and it was included. Huen’s interpretation was that the participant “wanted her story to be heard, but didn’t have enough distance from it to be there while it happened.” [20/8/98] It was a painful event that highlighted the more general dis-ease of making the transition from storytelling to play building.

Those tensions pervaded the next few weeks of meetings. Huen, Beauchamp and I were strategizing for, rather than planning, the group meetings, as we struggled with the transition in the month of November. I personally was struggling to acknowledge that there were power differences within the group and that as a facilitator, I had a different role and more power. In addition, I knew I would have to distance myself from the group a little as it moved into the rehearsal phase. In the role of director I would have to make demands of the actors and guide them through the rehearsal process in a more rigorous manner than I had used for group facilitation. Huen and I had discussed this step months previously and agreed that she would maintain her role as group facilitator. I also believed strongly that the group had to achieve some distance on their individual stories in order to work collectively to build the play. At the group meeting on November 24, 1993, the group came to terms with being in a new phase, playbuilding, and accepted the facilitators’ guidelines for feedback to the playwright as part of the amended group agreements. Beauchamp suggests that one of the difficulties of this period was that “we had a lot of people wanting to write that play.”[13/8/9/8]

I believe that at one level each of us did want to write the play of our own story. I also believe we each wanted more than that. We wanted the strength of our collective experience. We also wanted someone to write the play for us because most of us weren’t writers. In many popular theatre pieces there is no playwright; the piece is constructed collectively. This eliminates one level of traditional theatrical hierarchy. Many community-based popular theatre plays are also collective creations, shaped by the facilitator and/or director, such as PTAM’s Beyond the Punchline. The structure of this play about family violence was what Huen describes as “a series of vignettes”, common to community plays. It was episodic and did not work within a theatrical timeframe of beginning, middle, end. In August, 1993, many
group members had seen the videotape of *Beyond the Punchline*. Subsequently, in discussions about our play, the group had agreed to have a more traditional play structure than that found in *Beyond the Punchline*. Such a structure would require more control by the playwright than would a series of vignettes. It would also involve creating a longer piece and the length itself would increase pressure on the participants. Huen explains: “We ended up with a play that was an hour long when traditionally we were doing thirty-minute community based plays which is... a more attainable goal for a community based group....We put a lot on the group. Now, that had to be weighed against artistic integrity and the feelings of the group...” [20/8/98]

The questions which I must address are: Whose artistic integrity was involved? That is, to what extent did the facilitators’ artistic vision direct the group? Huen suggested that there were some members of the group who had theatrical experience and strong desires to perform. Their energy was taken up by the director and the writer. It was that combined energy which created the group’s decision to do a play, not a collective.[see appendix G which documents that decision] Those in the group who had less experience in theatre and/or less strong a voice were caught up in the energy and excitement of doing a “real” play, rather than a series of sketches. Another factor was that for most participants, the narrative structure was more recognizable and familiar than the vignette structure of a collective. That familiarity of narrative structure created accessibility for the participants and for the audience. It also privileged certain characters’ stories.

A narrative structure includes a protagonist, a hero/heroine. A collective piece does not usually have one central character. The narrative structure of *The Waiting Room* was focused through one character, Kristen. Kristen’s story is central in creating the tone of the play, in exposing issues and in creating the isolated counterpoint to the community developed by the other characters. Kristen is a protagonist and as such, she dominates the stage for much of the play. Huen, Beauchamp and myself were aware of the demands of the role and cast it accordingly.

Boal’s theory is that all participants become the protagonist through the work of Theatre of the Oppressed. In our work with Acting Out that was our goal for all members-
agency, being the protagonist. Yet the structure and performance of *The Waiting Room* did not demonstrate agency in the way that a more collective piece, a series of vignettes with no central protagonist, might have done. In the translation from sharing stories with each other to performing a play for the public, some members came to have more power than others. An awareness of that difference in power came through in my interviews with participants. Sometimes it was expressed as simply as having less stage time or less to do than others. Huen commented: “I think the structure of the play sort of set up a bit of elitism within the group ... and if I have any regrets, it is about that.... If we had gone along with a series of vignettes then we could have been more inclusive.... I mean I’m not saying it wasn’t an ensemble cast, but it could have been more of one, it could have been more equal.”

Whose story was told by the performance of the play? My perception was that the play told our story, a collective story that was inclusive of the experience of many women, particularized in the characters performed by the members of Acting Out. In their self-identification as consumers, those women gave an embodied performance of their agency and their resistance to dominant representations of mental illness. The experiences I shared with troupe members during the development of the play, evaluations done after the performances were completed in the summer of 1994, and the interviews conducted in the summer of 98 demonstrated a strong sense of accomplishment in the troupe members. They knew they had touched their audience, had made people laugh and cry and also, perhaps, helped them to think about mental illness differently.

Questions of how the process could have worked better persist for me. Could the play have challenged the “master narrative” more thoroughly if it had not been in narrative structure? Could the troupe members have been given more equal access to telling the story? Would that have changed how the story was told and heard? The following excerpts from the interviews speak to these questions.

In the interview, Deb made clear her conviction that she had told her story and had contributed to making the play. She mentioned that she was still getting comments from people who recognized her from the play. She continues to lend out the videotape of the play, most recently to staff at the Crisis Stabilization Unit and also to friends. As a member
of the Manitoba Society for Depression and Manic Depression, Deb has spoken to both consumers and service providers. She saw the work of the play "as a training session to try and get some stigma out of society...and help educate." [31/8/98] When asked if her story was told by the play, Deb replied:

Oh actually it did. I was happy that I kind of got picked to do the role of my illness. I don't know if it was - I don't know how they did the picking of who did what - but it was my illness and I did the acting for it. I got up on the stage and I was talking really fast and I know that's a manic-depressive aspect and I remember talking about it. I was given the opportunity to do that role and I noticed Carli was given the opportunity to do some abuse issues, which was what she was talking about. I was disappointed that I didn't get to do more onstage because my role was short. Plus I got caught short at the end [of the play]; I didn't get to go onstage in the end [final scene]. [31/8/98]

Picking up on her comment about not doing enough onstage, I asked Deb if some of the actors had too much to do. With no hesitation she responded:

Oh yes. I think the lead role [Kristen] she had way too much I was just - but she did it so well - I'm not saying there's anything wrong with what she did. But she took such a big part in the beginning and then a big part in the end ...So many lives floating in and out of the play and there wasn't as much story line to everybody else's.... it was based around her specifically. And she had a lot of big long speeches to say and things to say. And I thought oh, I couldn't have handled that and she did it really well. and I'm not complaining but I thought, well I wish I could have had time to do that and have some songs myself...... [31/8/98]

Deb's comment speaks directly to what Huen called "a bit of elitism" in the group. Some actors had and were perceived to have more lines, more time on stage, more of the story line. They were thus perceived as more important to the play. On the whole, group members had a good sense of what they individually could handle in terms of memorizing and cues. Still, there was some frustration with the fact that others had the "big parts". This also penetrated the off stage relationships to an extent. Actors identified very strongly with their characters, so much so that initially no one wanted to play the nasty nurse, because no one wanted to identify with her or be identified by her. The actor who played the nurse told
me in her interview that some people who saw her perform gave her a hard time about playing the “enemy”.

Although some actors had bigger parts, the group functioned onstage and off as an ensemble, with a sense of community built around what they accomplished together, their collective agency. Brenda remembers that “there was mutual support and understanding”. [24/8/98] Working with the other women affirmed she was not alone in her experience and not “a lesser person” [24/8/98]. She is very active in consumer groups, including liaison with the police on consumer needs, and feels her work on the project helped her to advocate better.

Carli had joined the group after most of the story sharing had been done. For her the experience was more about listening than telling: “...it was about listening with your inner being and inner voices allowing me to ...sort of understand...The whole project made me more empathetic. Plus I could also relate and I had stories of my own that were quite similar.”[24/8/98] Carli felt she could not have contributed any more had she told her own stories. She noted that the issue of abuse, which was important to her, was dealt with in the script.

For Anna the group was a place where her experiences, her story, was validated:“ I needed a place where I could feel I was believed and affirmed.” She added that it was also important to hear others: “It wasn’t just the sharing of my story, but being in a place where stories are shared. That was important; it was affirming and it confirmed certain things...It confirmed that my experiences might be real and not imagined or paranoia.” The central story for Anna was “the web of psychiatry”. That web included the relationship between the psychiatrist and the patient and the “power struggle” that goes with it. She saw that relationship represented meaningfully in the play. In addition, she noted that in one of the scenes with a psychiatrist, “quite a bit of what I had said in my personal narrative did get included.” Anna experienced mental illness as “isolation from the community” [11/8/98, all quotes in this paragraph] because it isn’t talked about, admitted or recognized. Being able to hear from other women in the group about their experiences was very meaningful.

Carli too valued her interaction with other group members: “I wasn’t alone. There were people in the same situation dealing with the same problems.... [I had felt] I had no
options. They [group members] discovered a way that there were options for them. ....What really stuck out is they had all these options, which I could see....They had a mental illness, were a consumer, plus they had personal lives.” [24/8/98] Carli explained that having options meant not being defined only by your illness. The options she noted in her fellow troupe members were that some worked and some did volunteer work, some were on disability, some weren’t. Some were in relationships; others weren’t. Some were in heterosexual relationships; others were in lesbian relationships. Working with Acting Out developed her sense of her own agency:

It’s kinda nice to get together with a bunch of women who have something in common with you. But also have very different social lives and personal lives and things like that, and to talk about it. And to say, I’ve experienced this. And it made you think: What kind of personal life could I have? I mean I wouldn’t want to copycat anybody’s personal life, but it’s to take different parts from people’s lives and sort of incorporate them into yours. And to say this is what I can do or this is what they’ve done, so maybe I can do kind of the same thing, but in my own way. [24/8/98]

I have suggested that, in creating a collective theatre piece, several layers of listening come into play. The piece created wears the layers of telling and listening that formed it. The collective is the story within which individual stories meet and shape each other. In the collective process, the individual stories change. The individuals telling them may be changed as well. It needs a very delicate sense of balance to facilitate that meeting and shaping of stories. It demands some artistic vision. It requires that the facilitator critique the process as it is created and attend to how privilege functions in its creation. Honor Ford Smith describes the collective process as one which does not “...deny the special skills of individuals or their need at times to work alone. Rather it aims to place that individual within a community which will lay bare the contribution of social processes to his or her way of thinking and to his or her final product.” 5 The collective process of The Waiting Room project was concerned with a feminist contextualization of women’s experiences as consumers in the mental health care system. The central focus was to develop the agency of its members through the work of developing and performing the play and to communicate that agency, their power to act, to the audiences, collectively.
In this chapter I have focused on the play development stage in *The Waiting Room* project. I have considered how the facilitators shaped the storytelling and playbuilding process and how that process both fostered and limited the agency of the troupe members. I have suggested that had the facilitators worked more directly with differences among the troupe members, there might have been more clarity and agency available to individuals. I have concluded that the narrative structure of the play was problematic insofar as it led to some characters being privileged over others. This impinged on the troupe’s functioning as an ensemble. However, the narrative structure did make the play more accessible to audiences. The next chapter is focused on the play in performance. I argue that the agency of the troupe members penetrated the performance and must be considered in assessing its impact as an alternative form of representation.
ENDNOTES


3. from an interview transcript, dated 31/8/98. All further quotations from the interviews will indicate the pseudonym of the actor and the name of the facilitator and will be followed by the date of the interview in [ ].

4. My use of the term “respectability” is in the sense used by Razack, see chapter 5 in Looking White People In The Eye.

CHAPTER V - REPRESENTATION : PERFORMANCE AND AUTHORITY

{WAITING ROOM. KRISTIN AND MARNIE ARE WAITING QUIETLY}
MARSHA: (enters, loudly) Hi!
MARNIE: Hi Marsha! How are you doing?
MARSHA: Would you like the real answer or a reasonable facsimile?

Representation is a pervasive aspect of our experience. We represent ourselves to ourselves and to others in public and in private spaces in a variety of roles. Art is a particular form of representation and theatre is a particular art form. In its mimetic function theatre both represents life and is alive: "Representation has a dual nature that is coreflexive and coproductive. It is at once a thing in and of itself, a place of disclosure, and a referant to something outside its frame."1 Like dance, theatre uses the human body directly in creating a representation of experience. Unlike film or video, the representation occurs live and thus the participation of the audience is immediate and may directly affect the performance. Elin Diamond describes that vitality: "Theatre itself may be understood as the drama’s unruly body, its material other, a site where the performer’s and spectator’s desire may resignify elements of a constrictive social script."2 I would like to consider The Waiting Room as such a site of resignification in its representation of women with mental illness.

This chapter will focus on the script and the play in performance and on responses to the performance as evidence of alternative representation. To consider what made The Waiting Room counter-hegemonic in its representation of women and mental illness, initially I will explore feminist theory of representation, mimesis and the role of theatre in challenging dominant discourse. I will discuss popular theatre theory with particular reference to the work of Augusto Boal and focusing on embodiment and empathy. I will relate feminist and popular theatre practices to the possibility of cultural transformation as Stuart Hall defines it. Then I will consider the factors which made the performance of The Waiting Room function as an alternative form of representation of women and mental illness. These factors include: the performers’ authority as consumers, dominance of female voice, use of modified realism, use of fantasy and song and the theme of community reflected in the collective work of the
troupe. I will consider how the use of traditional narrative structure in an alternative piece functioned and to what extent it reproduced dominant discourse.

**Feminist Theatre and Alternative Representation**

My understanding of representation is based on feminist theatre theorists. In *Unmaking Mimesis* Elin Diamond examines how a feminist postmodern formulation of mimesis and representation differs from Western tradition. That tradition, in relation to theatre, is rooted in the Greek plays and in the aesthetics and metaphysics of Plato and Aristotle. That tradition is one in which art is understood as an imitation of the Real. If one’s metaphysics no longer require a “Real”; that is, if the real is understood as contingent on historical materiality and its production in discourse, then art is also understood differently. Art no longer functions as a pointer referring to the transcendant eternal Real. Rather art produces meaning through its relationship to the real. Diamond defines this difference: “A feminist mimesis, if there is such a thing, would take the relation to the real as productive, not referential, geared to change, not reproducing the same.” A feminist poetics values the imagination as a way of knowing. Through the performance of theatre, an imagined experience is materialized in the aesthetic space, in the bodies of the actors which communicate with the audience: “Her [the actor’s] desire, because it is aesthetic, transforms itself into an object which is observable by herself and others.” The audience’s reception of that experience is mediated through its desires, which are produced, in part, through the actors’ performance. In order to evoke a self-conscious response from the audience, a response which approaches a critique of dominant discourse, the play must be self-conscious, aware of its own theatricality. Feminist theatre is aware of its own theatricality and thus creates an alternative theatre in form and content.

In considering how theatre functions as representation, Alisa Solomon’s discussion of its fluidity and self-consciousness is useful:

> As the quintessential mimetic art...theater can question the very means of its production, call attention to its own processes and limits, and, as a result, raise questions about the images and ideologies it may give stage and voice to. It
can self-reflexively consider its own embeddedness in cultural institutions and historical moments. When it does so, theater— in Stuart Hall’s terms— “negotiates” dominant culture, at once reproducing and resisting it: self-conscious theater self-deconstructs. ⁶

Historically, theatre has functioned both to disrupt and to affirm dominant discourses. The carnival aspect of theatre celebrates what Bakhtin terms “the grotesque” and inverts the social order. This questioning of authority may be direct or indirect in relation to the self-consciousness of the artistic process. Solomon suggests that the obsession with gender conflict in the ancient Greek theatre may be an indirect acknowledgment of that culture’s misogyny. Ibsen’s work in The Doll’s House and Hedda Gabler is a deliberate questioning of the dominant construction of the roles of women. Many critics and audiences of his time found his representations of women very uncomfortable. Yet Ibsenite realism, so radical a departure from the melodrama which preceded it, became the repressive style to depart from within thirty years. That realism is firmly rooted in the bourgeois subject’s drawing room and Freudian analysis.⁷ Bertolt Brecht refused such “realism”. His epic theatre takes self-conscious theatre to another level as it draws attention to the theatricality of theatre in order to engage the audience more directly in a critique of power structures. Brecht’s characters are drawn as the objects of social and economic forces and are performed with intent to represent those forces, rather than representing psychological forces.

The self-consciousness of a theatre piece is developed through script, direction, design and performance. Performance includes an audience, which is engaged in the performance. The performance can be structured consciously so as to engage the audience in specific ways. However the actual engagement of the audience is unpredictable: “... a feminist, more phenomenological theater criticism doesn’t assume that every single spectator has the same experience, or interprets his or her experience in precisely the same way. Rather, it looks at how performance produces itself in the temporal event of theater, all the while instructing its audience in a means of regarding it...That doesn’t mean that the spectator must follow the instructions.” ⁸ This unpredictability of response is part of the dynamic of theatrical performance. The audience or spectator may also refuse to engage or respond only partially:
In the theatre one can say, “this is just an act” and de-realize that act, make acting into something quite distinct from what is real. Because of this distinction one can maintain one’s sense of reality in the face of this temporary challenge to our existing ontological assumptions about gender arrangements.  

The audience may choose to “de-realize” what is represented in a theatre piece as being “just an act”. However, an act is never just an act, in the same sense in which Trinh reminds us that a story is never just a story. The story or the act points at, connects to, reverberates with human experience, as it provides an interpretation of it. The interpretation of experience that happens in theatre can challenge assumptions and be counter-hegemonic or can reinforce dominant discourse. In developing The Waiting Room it was our intention to disrupt, to create a “temporary challenge” to existing assumptions about women and mental illness. The play and its performance was structured accordingly.

The performances of The Waiting Room were interactive experiences which cannot be directly accessed on paper. However, in analyzing the impact of the project as a representation of women and mental illness, aspects of the performance of the play must be taken into consideration. Those performances were bound up in the popular theatre process of creating the play which includes the agency of the community troupe. Jill Dolan affirms the centrality of performance to theorizing theatre: “Feminist poststructuralist theories...simply enlarge the consideration of texts to take into account the meanings that are constructed in performance as well as on the page.” One very significant aspect of the performance of The Waiting Room was that the performers had self-identified as consumers and as co-authors of the piece. Therefore their presence was received by the audience differently than had they been professional actors playing the same script. The making of the play cannot be fully abstracted out of its performance. Its theatrical power evolved from that process, which inhabited the meaning of the performance and its reception. An example of this is a comment from an audience member who also participated in the workshop following the performance: “It was strange how in the workshop I immediately forgot the actors were also consumers. I turned them into ‘experts’ outside the experience, and then realized how wrong that was. But it was also a validation of their strength.” This comment indicates that the speaker is
struggling with an assumption that expert and consumer roles are mutually exclusive. The performance of the play and the workshop provided an alternative experience to the participant, one in which an individual can be a consumer and can also be strong, be productive and be expert. The representation of "consumers" in *The Waiting Room* stimulated this spectator's questioning of her own assumptions.

**Popular Theatre, Boal and Active Participants**

*The Waiting Room* belongs to a genre of theatre, popular theatre. Popular theatre is theorized as resistance to hegemonic discourse. Popular theatre is theatre for social change. It requires a sensibility of how social conditions shape identity and a belief in the possibility of agency or resistance on the part of subjects. Augusto Boal's *Theatre of the Oppressed* is central to popular theatre theory. Boal, as well as working with his own company in South America, conducts workshops and events internationally. Boal's theory grew out of his work with peasants and working people in his native Brazil and in Argentina and Peru and was influenced by Paolo Freire. Boal's theatre work is premised on its participants being actively engaged and thus the people becoming protagonists, not spectators. His work is directed towards transformation both in the individual and in society: "One of the hypotheses of the Theatre of the Oppressed is that knowledge acquired aesthetically is already, in itself, the beginning of transformation."12

Boal's theory is based on the premise that we learn from art experiences and more specifically that such learning is developed more fully when it is embodied in action as well as observation. Knowledge acquired aesthetically is created in the aesthetic space and is integrated in the body as well as the mind of the participant. From a post-Foucauldian perspective, "the body, always already ideological, can never escape its ideological encoding; it exists only insofar as it is 'structured' through discourses."13 Boal's understanding of the body includes this structuring by discourse, but also includes the potential to restructure, to resist. Boal's conviction that this re-structuring happens on the site of the material body as it works through the images of oppression is at the heart of his theory.
and practice. His techniques offer participants possibilities for paying attention to and re-
structuring the body's gestures and movements. For Boal, working with physical images
created by individuals and groups is central: "It is often in movements that the rituals of
oppression are most embedded." By witnessing and/or creating these physical images or
statues, the participants experience the oppression in an embodied fashion. In re-fashioning
or sculpting the statues, the participants exercise their wills and desires as embodied in the
work they do with other participants. The abstract becomes specific and alternatives are
actualized.

It should be noted that Boal's techniques are non-gendered and non-raced. The
dualism of oppressor and oppressed which he works within can be effective, but is also
limited to working with a unified subject. The limitations of this way of working have been
identified by feminist practitioners. For example, they have questioned the appropriateness
or usefulness of the intense bodywork in mixed gender groups. In The Waiting Room project,
working in an all female group, this was not a concern. Our focus in bodywork was on
developing awareness and strengthening the repertoire of posture and movement in the
participants. One troupe member described it as making her feel whole: "Instead of being out
in left field, it made me feel more connected. You had to concentrate really hard...I could feel
my body weight. Instead of floating, I was standing." [25/8/98] When working with
community groups, the physical work needs to be modified in relation to the specifics of the
group, which may include people with physical disabilities or cultural and personal taboos
around touch. In the case of Acting Out, there were older and/or less fit members in the
group. There were also issues around boundaries and safety which had to be negotiated
before intense physical work could happen. One solution was to agree that anyone could "opt
out" of any activity. This agreement helped to create emotional safety for the group.

In Boal's work, the protagonist is shaped by social and economic forces but is also a
subject who resists such forces. Philip Auslander contrasts Boal and Brecht: "What Boal
seems to be after in his work with the spect-actor, however, is not so much a Brechtian gestic
body educated and shaped by the experience of class struggle, as a body that can step aside
momentarily from its particular ideological regimens to try on others for size." This
flexible body opens the actor, develops the protagonist. Transformation becomes possible. Not all popular theatre work is directed to creating a performance piece. Both activists and therapists have made use of Boal’s techniques (which he has called “games for actors and non-actors”) in facilitating change in communities and individuals. This work involves representation, but not performance.

Popular education techniques include a deliberate engagement of the participants in activities which are directed to developing awareness of one’s subject position and of alternatives to that position. These techniques are functional, directed to working with groups of people over short periods of time on an agenda created or approved by the group. This functionalism can result in an oversimplification of the issues and/or can foster a dualistic notion of oppressor and oppressed which does not recognize complicity in systems of oppression. The facilitator has great impact on the group process, as was discussed in Chapter III. Razack provides direction to the facilitator: “...education for social change is not so much about new information as it is about disrupting the hegemonic ways of seeing through which subjects make themselves dominant.” Popular theatre exercises are a useful tool for this disruption, as through the activities the embodied gaze may be embodied differently and may be received differently. These exercises are performed by the participants. They may also observe each others’ work. However the work becomes a “performance” only when there is an external audience. In this case the exercises may be formalised, to greater or lesser degree, into a script. In The Waiting Room project, it was our intention that the material generated from storytelling and popular theatre activities would be formalised into a script by a writer and would then be performed for the public.

When a group takes its analysis, no matter how simple or complex, and works with it to create a performance for others, then the analysis may have to be reduced further in order to translate it for an audience. The artistic and didactic aspects of the piece need to be in balance for a popular theatre piece to work. Humour can be an important technique in creating that balance. Throughout the play development process of The Waiting Room, the participants had insisted that the play have a sense of humour which would reflect how humour had been a saving grace in their lives. They also insisted that without humour the
play would depress and bore the audience! Beauchamp was able to incorporate the humour of the storytellers as well as her own dry tone into the script.

**Popular Theatre and Transformation**

A popular theatre piece is performed with the intention to engage its audience in the possibility of cultural transformation. In “On postmodernism and articulation”, Hall discusses cultural transformation as neither something totally new nor something fully continuous with the past. Rather, it is a “reorganization of the elements of a cultural practice. elements which do not themselves have any necessary political connotations.” That reorganization develops from subjects and social groups that are articulated to and by discourses. Understanding that cultural practices function discursively, like languages, generates possibilities for transformation: “The discursive metaphor is thus extraordinarily rich and has massive political consequences. For instance, it has enabled cultural theorists to realize that what we call the ‘self’ is constituted out of and by difference, and remains contradictory, and that cultural forms are similarly, in that way, never whole, never fully ‘sutured’.”

If cultural forms are never fully closed, then cultural transformation is possible through the engagement or articulation of subjects to alternative forms of representation.

The Theatre of the Oppressed is more concerned with the engagement of the participants or “spect-actors” than with the audience. Boal posits that as culture and theatre developed, the space between players and participants grew larger, eventually resulting in a passive bourgeois audience which lived vicariously through the actors. Today in traditional theatrical performances the audience is engaged passively in relation to the performers. In contrast, Boal constructs performance situations which engage the audience more actively, such as Forum Theatre where the audience intervenes to propose alternatives to the protagonists or Invisible Theatre where the actors perform in public settings without declaring their performance.

Boal contrasts the empathy experienced in traditional theatre with the sympathy produced in his Theatre of the Oppressed. Empathy with the character occurs in a one-way transmission of experience from the stage to the audience. Boal argues that the catharsis
experienced in traditional theatre can be another form of social control because the spectator is purified of the desire for transformation as a result of the vicarious experience of the transformation of the protagonist. In Theatre of the Oppressed catharsis develops from action, not from observing others’ actions. In a workshop, even if a participant is not directly involved in an exercise or scene, the potential for involvement is present. That action or agency be available to the participant is central. The goal of Boal’s theatre work is that “the people reassume their protagonistic function in the theatre and in society.”\(^9\) This is why the bulk of Boal’s work takes place in workshop settings, in communities and in the street, not in formal theatres.

_The Waiting Room_ project was not designed to model Boal’s Theatre of the Oppressed. However, the project was designed to be potentially transformative for troupe members, workshop participants and audience members. We utilized popular theatre techniques to develop the troupe’s awareness and skills and to develop material for the script. Performances in community settings allowed the play to communicate with a wider audience. That audience would have the option to become active participants in the facilitated workshops which followed the performances. As I have explained, the project had a double focus: to create a play which would challenge assumptions about women and mental illness and to provide individual troupe members with a setting in which to develop self expression. Work with troupe members was focused in three areas: communication skills, group skills and politicization around mental health issues.

Facilitation was directed at developing the abilities and strength of the group and its individual members in relation to the undertaking of creating _The Waiting Room_. Longer term goals for the individual members were not directly addressed as that was not the mandate for our work. Yet there was a belief on the part of the participants and the facilitators that our work would set up some positive spin offs for group members in relation to confidence, concentration, presentation of self and group skills. At another level, the experience of working together on the play would break down the alienation that living with mental illness often creates. One troupe member described it: “I was interested in what other women had to say because with mental illness there is (and I felt it at the time) this sense of isolation from
the community, from various communities, even in the mental health system where people who have shared experience of psychiatry can’t or don’t get together.” [11/8/98]

The third aspect of work with the group members was politicization around mental health issues or refining their current politicization of mental illness. Although the facilitators did not use the term “oppression” directly in workshops, we did work with participants to identify “blocks” and “supports” to mental health. These were explored in drawings, in movement and through improvisation. Drama exercises were directed towards opening the body as well as the mind to trying on possibilities outside the familiar “regimens”. After the community tour, Acting Out members were asked to complete a written evaluation of the project [see appendix I for the evaluation form] One of the questions troupe members were asked was: “Did your perception of the issues relating to women and mental health and your personal experiences change?” One troupe member’s response to the question is indicative of her exploration:

Yes. I think the song “Secrets” sums it up. So many people still regard it as a taboo subject; a secret. I regard the medical profession with even more cynicism now and feel women should be more empowered and self-directed. I realized my abuse was not an isolated incident. I also heard that there were some good therapists. However I would like to see another play called Revenge of The Waiting Room exploring the societal basis for much of women’s pain and alternate ways of coping or seeing one’s “Madness”. I would also like to see an exploration of how other cultures handle “mental illness”, a phrase I find repugnant.

Another participant responded to the same question with a different political awareness: “...felt a bit “lucky” to be able to challenge the [mental health] system because of who I am. Still feel a lot of women are unable to do this because of their emotional, social and economic state. It’s not fair to them.” She is addressing her middle class privilege in the context of her work on the project. A third participant stated that there had been no change in her perceptions: “No, I understood what was going on from the beginning. Stigma still out there.”

Once the troupe was formed, negotiations around the politics of mental illness, as well as group politics, had to take place. For example, there was one troupe member who
was very opposed to the use of psychotropic drugs. There were others who believed their survival depended on such drugs and others who had little experience of psychotropic drugs. In constructing the play, we had to negotiate what its stand on drugs would be. Marsha's speech about valium in scene ten reflects the point of view of the group member who was anti-drug. Other characters speak of how drugs helped them. The troupe had agreed to disagree on this topic and this structured the writing. On other issues, such as difficulties with employers, it was easier to reach consensus on how the script would deal with the issue.

Performing Authority

There was no difficulty in establishing consensus about the purpose of the project as a whole. In developing *The Waiting Room*, there was self-conscious intention on the part of the community troupe, the facilitators and the theatre company to disrupt conventional representation of mentally ill women. Both the process of creating the piece as described above and the structure of the play itself speak to that intention. Research participants and troupe members had reiterated the importance of telling the story from their point of view, from within their experiences. In performing as well as recounting their stories, the actors themselves represent an alternative to the passive victim of mental illness.

The play had introduced that passive image of the mental patient waiting for direction or salvation in the doctor's hands in its first scene. However, as the image was introduced, it was also deconstructed in the song fantasy sequence which is part of that first scene. The song questions medical authority. It is an intial step for the “patients” in claiming authority, the right to author one's narrative, rather than be narrated and prescribed to. As such it is mirrored in the actors who perform it, who have co-authored the play. Thus the agency of the actors is instrumental in creating alternative representation.

Another example of a community group co-authoring an alternative representation is *Looking at Teen Motherhood: The Fantastic Moms Video*. Salome Chasnoff, who directed it, describes the video as counterdiscourse. The young women she worked with at a transitional learning centre in Evanston, Illinois were angry about the dominant discourse of distress and disaster in the lives of teen mothers and their children. Chasnoff expicates how in the
process of making their video, these women became the authorities on the topic of themselves and each other. The video they created (with the support of Chasnoff and Dalida Maria Benfield as producer) is the material manifestation of their agency. Chasnoff argues that "...agency, like identity, is enacted in material forms, in time with material means. Subjectivity, at the 'margins' or at the 'centre' is performed through narrative agency." Similarly, the performances and videotape of The Waiting Room manifest the agency of Acting Out members. Both videotapes are in use as teaching tools, for teen mother and consumer groups respectively. Both have also been used in training with service providers to break down stereotypical representations.

The public arena for the autobiographical narratives of Acting Out members and the Fantastic Moms shaped the process of their telling: "By publicly narrating and interpreting these personal and hitherto 'private' matters in the context of stereotype, the Fantastic Moms politicized without essentializing themselves, and rendered their tale eminently tellable. They demanded an audience for its subtext of rebellion against the normalizing force of the dominant voice." "Demanding" an audience is different than "getting" one. Chasnoff emphasizes the agency of her group. She affirms their performance as positioning and defining themselves or as taking the centre, as Gayatri Chakavorty Spivak advises: "... in terms of the hegemonic historical narrative, certain peoples have been asked to cathect the margins so others can be defined as central....In that kind of situation the only strategic thing to do is to absolutely present oneself at the centre." For the brief periods of its performances, The Waiting Room presents "life on the edge" at centre stage.

**The Waiting Room - Form and Content**

A closer examination of The Waiting Room's structure will reveal its intent to disrupt conventional representation. Tools for that disruption include the female voice, the plot which foregrounds consumer experience, the use of fantasy and song, the use of realism and the theme of community. The play is marked by the predominance of female voices, the absence of male voices. All the characters in the play are female. Two of the three psychiatrists' voices are male. However, all the psychiatrists' voices are taped, thus only two disembodied
male voices are heard. The decision to tape the psychiatrists’ voices was made in order to reflect both the power of the doctor and the alienation of the patient commonly experienced in therapy. (It also reflected the gender makeup of the acting troupe, all female, in relation to the gender makeup of the psychiatric profession, predominantly male.) One other male voice is ‘heard’, secondarily, in Kristin’s telephone conversation with her husband in scene fifteen. Although we do not literally hear his voice, we understand both his words and tone from her responses.

The world of the play is dominated by female voices. Not all the female voices belong to those classified as mentally ill. There are three characters who are not so identified: the nurse at the clinic, Kristin’s mother and Mrs. Whitehead, an employer. All three function as antagonists, whose version of “reality” is questionable. The dueling monologue between Darcy and Mrs. Whitehead of scene seven contrasts the limitations of conventionality, exemplified by Mrs. Whitehead’s “What would people think?” [p.15], with Darcy’s eloquence and honesty. In scene eleven, Ma’s reality cannot encompass a daughter who has “brains and looks and savvy” [p.29] and also has a mental illness. At the end of their meeting, Kristin declares ironically: “Well, I see I’ve got a long way to go before I’m as sane as you are, Ma.” [p.29]. In scene thirteen, Nurse Hook is temporarily disrupted in her role as gatekeeper by Kristin’s commandeering of the intercom, her trespass on the time and authority of the doctor and the doctor’s minion (a theatrical moment that audiences often greeted with glee).

Thus the “normal” characters in the play function to pinpoint the hypocrisy of the social conventions that circumscribe the lives of the women of the waiting room. An example of this is Marsha’s boisterousness which offends the Nurse as it doesn’t match the tone appropriate to a waiting room. At the same time, Marsha is aware that she exceeds what is socially appropriate: “Damn, I gotta watch this...take up too much space some time.” [p.11] Marsha balances on a tightrope of “nice” behaviour which does not always carry the weight of her emotional needs. In the opening scene of the play, Kristin’s explication of the “rules” of the waiting room is interrupted by a fantasy sequence in song which punctures the niceties and plays out the anxieties of the “patients”, as well as their desire to resist the “finishing
schools of life” [p.2]

The play contains three fantasy scenes, all of which are built around a song. In these scenes Kristin’s imagination, personified in the actor playing the inner voice, leads her to reveal the undercurrents of the surface she presents. The audience may follow her to this deeper level of experience. The second fantasy sequence occurs in scene nine and interrupts her session with her doctor (who is the one psychiatrist portrayed sympathetically). The song, Secrets, resonates with the story of Kristin’s beating on the psych ward, a story which she has just told her doctor. The song suggests how many “secrets” there are in polite society and in our lives and how revealing them can be dangerous. The song sequence self-consciously mirrors the therapeutic process, where the patient is both required to reveal herself and at the same time is vulnerable to psychiatric sanctions, such as committal, on the basis of those revelations. The final fantasy, scene twelve, is the Orderly Song, which speaks in the voice of the committed. It occurs after Kristin’s meeting with her mother where she is encouraged to “own her anger” (p.28). Kristin’s anger is not just about herself or the abuses she has experienced. She is angry for all of those “huddled in the hallways/ outside lock-up/just to see/ all of the order provided instantly by orderly” [p.30]. The anger is modulated by the country western style of the song, which also dresses the orderly as a cowboy, who rides “off into the sunset with the very best of me” [p.30]. The women of the waiting room, of the hospital corridors, have a disjunctive image of the cowboy/hero. They know neither he nor the patriarchal authorities he represents can be trusted. In the song, Kristin affirms that there is an order that can’t be provided by the orderly and that she has to seek it out, recreate meaning for herself. Following orders, playing the role of the good patient or even the role of the bad patient, is too limiting.

These three fantasy scenes are distinct from the modified realism of the rest of the play. In addition to the fantasy scenes, the realism is modified by Kristin’s monologues addressed to the audience, the dueling monologue and by the three interviews with invisible psychiatrists, all of which break the fourth wall of conventional stage realism. However, aside from the monologues and songs, the audience is presented with characters who speak in an everyday fashion about events in their lives and behave in a fairly conventional manner.
The play invokes the ordinary in the lives of its characters while recounting their extraordinary experiences. This approach is set forth in the opening monologue when Kristin, while describing the niceties of normal waiting room behaviour, admits “this is no ordinary doctor’s office” [p.1] while insisting that her feelings are pretty ordinary. She addresses the audience directly with: “And even if you think you are above all this, well I know you have waited in a doctor’s office...” [p.1]. Thus, from the outset the play asserts that the extraordinary, mental illness, is not a totally foreign experience and suggests to the audience spaces of commonality, for waiting rooms are “the true equalizers in life”. [p.1]

It is in this common space that some of the characters in the play meet and connect to each other beyond the social niceties. Although the meetings in the play are driven by the dramatic structure and thus somewhat forced, similar meetings were recounted in the stories collected during the research for the play. In addition, the community that had developed among the actors as they worked together on the project was recreated in the script. In the play, what evolves out of the chance meetings in the waiting room is a sense of community among Marnie, Darcy, Marsha, Tillie and Joan. Kristin misses out on the community, partially due to gratuitous events and timing. Portraying this element of chance in a person’s life was truthful to the many stories which had conveyed that chanciness as part of the fabric of any life and more so in lives lived “on the edge”. At the margins of respectability there is less “cover”, less camouflage to conceal the element of chance. Mental illness both results from and is experienced as a loss of control. That loss of control makes room for the workings of chance.

However, it is not merely chance which prevents Kristin from being part of the community. It is also due to who she is, how she, as a character, constructs her identity. Throughout the play Kristin has insisted on being recognized, by the nurse, by her mother, by her husband and her therapist. She has a strong belief in her right to be heard. Yet in the waiting room, which she has described as muffled in social niceties, Kristin can not cut through the silence between herself and the other women. The gaze she gives her co-inhabitants of the waiting room is wary and judgemental: “Kristen looks interested in the conversation. She observes them with scientific interest.” [p.17, stage directions]
The character of Marnie is central to the community building. Unlike Kristin, when Marnie looks at the other women, she sees potential allies. It is she who engages the others and she who first offers to extend the meetings beyond the waiting room. When Marnie recognizes Tillie in the waiting room, her demanding cheerfulness is somewhat threatening to Tillie. The gap between them is bridged by what, in other circumstances, might be a throwaway witticism:

TILLIE: You mean you haven’t seen me since I was bald?
MARNIE: Bald? No. the last time I saw you, you had hair. it was spiked, and the colour was purple with blue highlights.
TILLIE: Oh yeah. Those highlights weren’t highlights really. they were just mistakes.
MARNIE: Yeah well, some of my biggest highlights have been mistakes, if you know what I mean.
TILLIE: I can relate.... [p.7]

In the context of women who are consumers in the mental health care system, Marnie’s remark about “mistakes” resonates for Tillie, who can now “relate” to Marnie on the common ground that acknowledges both of their departures from the norm.

Later in scene ten, Tillie faces another kind of demand from the character Joan, who urges her to fill in a government form about sexual abuse by therapists. Here the demand is less willingly met, despite the fact that Tillie’s relationship to Joan is an established one. Tillie is skeptical about activism and is also afraid to relive a painful experience. None of the characters except Joan are politicized around mental health issues in a direct way. They all question the doctors’ authority at times, but they do not take action.

The women’s agency is limited by their position as mental health patients. The disability and the stigma attached to it penetrates several levels of their social beings, including the economic. Tillie and Joan are underemployed and Marsha and Darcy are unemployed. Marnie, more than the other characters, is maintaining “respectability” or is “passing”. She has a full-time job as an administrative assistant and hides her weekly appointment with the doctor by having her co-workers assume she is taking early lunch to go to aerobics. When Darcy challenges her to tell the truth instead of continuing the gym bag masquerade, Marnie replies: “...it’s just that when it comes to dealing with people who are
supposedly sane, it can get pretty damn crazy sometimes. I’m not saying that I don’t work with some pretty nice people...but I don’t want to be a crusader for a cause.” [p.10] Marnie is not willing to risk her respectability by admitting her illness publicly and with good reason. The scene with Mrs. Whitehead demonstrates the danger of doing that when Darcy loses the job as a result of admitting she was “sick”.

Sexuality and reproductive rights is another site where mental illness complicates an already complex issue. It was explored most directly in scene six where Marnie discusses wanting to have a baby with her therapist. He is not at all supportive. The drugs she is taking cannot be taken during pregnancy. Marnie is caught between her dependency on the doctor and her desires. She wants to have a baby but she also wants the doctor’s approval of her desire. The women of the waiting room are often tentative in taking action or expressing their desires as they have to “toe the line” of respectability. They know they are being watched for slippage. Desire can lead to slippage. Foucault’s “self-surveillance” comes into play to police desire. As Marnie explains in scene ten: “It was when I learned about being a good patient, learning the system.” [p.23]

Marnie’s acknowledgement of how she learned to be a good patient is understood by the other characters. It resonates with their own experiences, their own skills at learning the system. Surviving the mental health system (which is theoretically there to help), dealing with the stigma associated with mental illness and retaining some measure of control in one’s life requires complex skills. Consumers who have the support of other consumers, who can pool their expertise, are more capable of managing all this. The characters of The Waiting Room demonstrate the need for and the value of community. Similarly, in their performance, the actors demonstrated the agency that is possible through collective work.

The play was constructed around issues which had been identified by research participants and troupe members. However, unlike many popular theatre community-based plays, The Waiting Room was character driven as well as issue driven. The intention in developing individual characters, who had a throughline and who were identifiable from scene to scene, was to allow the audience to identify with those characters. Thus the gap between “crazy” and “sane”, between self and other, would be narrowed. We believed that
the narrative structure and the character or bourgeois subject that accompanies that structure would be useful in communicating the experiences of women and mental illness to ourselves and to the audiences. I still believe that structure and those characters were useful in bridging the gap. However, in the process of creating those characters, we also created a protagonist, Kristin. Although the focus had been intended to emphasize the community of women, Kristin dominates the text, both on the page and in performance. Her agency limits the range of the other characters. As I have suggested in the discussion of the playbuilding process, once a community group elects to develop a play with characters and narrative structure, a mirroring of hierarchical social relations can occur. It occurred in The Waiting Room. There is a sense in which the play celebrates Kristin’s individualism and rebellion, those qualities which alienate her from society, from her family and finally from herself. In her final scene, the suicide attempt, Kristin becomes a victim. In the play’s final scene, the women of the waiting room mock the authorities and celebrate their friendship.

The narrative structure of the play evolved from the need to construct an accessible alternative to conventional representations of women with mental illness. Those representations use conventional narrative structures and characters. In The Waiting Room, the audiences were able to identify with the characters’ individual and collective concerns, which were expressed through narrative structure. The characters were situated in contexts that appeared “normal”, even though they (and the actors) had self-identified and had been labelled as “crazy”, as “abnormal”. The character of Darcy can speak of the “worlds upon worlds which are my mind” in one moment and organize a potluck dinner in another. The play presented a continuum of illness and wellness as opposed to a binary opposition which norms one of the opposites: “‘Normal’ no longer has meaning. Who is sane anyway and why?” was the response of one workshop participant.

At the beginning of the chapter I suggested that feminist theatre works against dominant discourse, in part by working through it. In Solomon’s words, such theatre “negotiates dominant culture, at once reproducing and resisting it”. I have delineated how the form and content of The Waiting Room in performance both reproduced and resisted dominant discourse of women and mental illness. In positioning its characters on a
continuum of illness and health, the play refused to engage with the romantic image of the 
"madwoman". In summary, the authority of the performers/characters contradicted the 
conventional representation of the "crazy lady" as a passive victim of disease and 
circumstance.
ENDNOTES

1. Beauchamp, Joy, with Acting Out, The Waiting Room, p.17. Quotations from the script will be followed by the page number in brackets [1].


4. Ibid. p.xvi.


7. See Diamond’s Unmaking Mimesis for a discussion of Freudian influence on drama.


18. Ibid. p.145.


20. All three responses are from three individual evaluations stored in PTAM archives.


22. Ibid. p.129.


24. This moment addresses the experience of the women who chose to develop and perform the play. It also respects the choices of the women who limited their involvement in the project.

25. PTAM, “Final Report”, appendix III.
CHAPTER VI - RESIGNIFICATION: *THE WAITING ROOM* on a CONTINUUM

We privatize the social construction of disability when we focus on the vulnerability and incapacity of individual women and not on the social relations that transform a physical or mental condition into a condition of great vulnerability.¹

*The Waiting Room*, as representation, presented individual women, characters, in a context which acknowledged that social relations render disability into vulnerability. In particular, the play drew attention to the power structures of the patient/doctor relationship which abused, demeaned and controlled the consumer. The play also focused on the stigma associated with mental illness and how that is played out in social relations and in employment situations. However, the characters caught up in these social relations were not depicted as victims. Rather they were individuals with humour, fears and desires. Some of the characters exhibited their capacity for agency. All of the actors exhibited that agency is achievable for a “consumer” and, as I have described, the performers’ subjectivities interpellated the performance. My thesis that *The Waiting Room* provides an alternative representation of women and mental illness is centred on the agency of the performers/characters and on the performance of that agency on a continuum of health and illness. I consider the conceptualization of a continuum of health and illness as central to the alternative representation. This concept was pivotal in the development of the workshops which followed the performances. In this chapter, I analyze the workshop process and consider the impact of the project on the troupe members and in the community. I argue that the impact of the project is bound up in the interweaving of the troupe members’ subjectivities and their delivery of the representation of women and mental illness in *The Waiting Room*. I consider some of the implications of the project for other community-based educational theatre work.

Moving from understanding health and illness as opposites, to seeing a continuum of illness and wellness, requires a paradigm shift which is difficult to make. As representation, *The Waiting Room* was directed towards that shift, to presenting an alternative to dualisms. The waiting room itself can be understood as a location representing a borderland where the
division between health and illness is unclear. Although there are no statistics available on how many paradigms shifted as a result of seeing *The Waiting Room*, there are some indicators of the impact of the project available from the evaluations done by group members, sponsors of performances and workshop participants. As well there is material from interviews I conducted in the summer of 1998. I will consider this data together with my experiences as facilitator and director of the project in assessing the impact of the project as alternative representation. Having examined the performance of the play in Chapter V, in this conclusion I will focus on the responses of troupe members and workshop participants to ground my reflections.

The project was to serve as an educative experience for both participants and audience. The reflections of the participants I interviewed address the quality of that experience. In the interview with Donna Huen, the project co-ordinator, she reiterated what she had written in the final report, that the major impact of the project was on the lives of the women who participated and that its impact on the broader community was secondary:

...the project had a lasting, positive impact on the participants. Troupe members expressed, shared and broadened their varying degrees of awareness of the issues facing consumers, and learned strategies for coping with problems. Further, they carried this empowerment with them into their homes and communities, educating countless others.2

Two of the troupe members that I interviewed have done direct educational work in the community, one working with The Manitoba Network for Mental Health and with the Winnipeg Police Force, the other working with the Society for Depression and Manic Depression. Both indicated that their experience in the project had increased their confidence in communicating. Less formally, members have helped circulate the videotape of *The Waiting Room* to consumer advocacy groups and to services such as the Salvation Army's Crisis Stabilization Unit, as well as to family and friends. Three of the four troupe members I interviewed had recently been “recognized” as having been in the play. They are still identified with and identified by that experience. That identification is positive. It is connected by other consumers to doing something that was putting the experience of mental illness “out there” where it was noticeable.
The video is "out there" on an ongoing basis. The videotaping of the play was professional. Although the videotape does not have the energy and immediacy of a live performance, it does communicate the issues, the characters and the humour. It also identifies the process of creating the play and that the performers are consumers. The video is available for purchase or for loan with a guide for a follow-up workshop and continues to be used as a resource by the Mental Health Branch. *Towards Gender-Sensitive Mental Health Services for Women Consumers* is a 1996 report from the Women and Mental Health Working Group of the Manitoba Health Department. The Working Group conducted a survey, held focus groups and ran a round table discussion to gain an understanding of the needs and concerns of Manitoba women consumers of mental health services. *The Waiting Room* video was viewed by round table participants. The report is remarkable for the presence of consumer voices, including two of the eleven members of the Working Group identified as consumer consultants. The use of *The Waiting Room* video amplifies the consumer voices.

Among consumers, service providers and the public in Manitoba, *The Waiting Room* project gave women and mental health issues some air time, literally and figuratively. I believe that in the nature of its representation, the play made re-thinking the issues possible. Anna, a participant, described it this way:

... there was excitement at the end of the play. Maybe I'm projecting but - people really had an experience. And perhaps they hadn't thought of certain issues, certain aspects of issues, certainly not about women [separately] and mental health...People who are in the system often buy into stereotypes, maybe not consciously. Because I've worked with various mental health professionals over the years as a patient, or client or whatever and I think that they - we've talked about power before [earlier in the interview] - I think that they, as I said, buy into the stereotypes and seem to think: I'M THE WELL PERSON. YOU'RE THE SICK PERSON. AND SICK PEOPLE ACT LIKE THIS. AND THEY DON'T ACT LIKE THAT AND THAT AND THAT. [11/8/98]

Anna explained how people had questioned her ability to take on the work of the play. She affirmed her right to perform in the play and in her life and to demonstrate that an illness does not define her identity. I want to return to Richard Tomlinson's statement that
"performance gives the performer power" and that the disabled performer breaks dominant discourse which attributes passivity to the disabled. I am convinced that the performances of Acting Out members were powerful in disrupting stereotypes of mental illness. I believe those performances portrayed illness and health on a continuum. I believe that the experience of creating and performing the piece impacted positively on the actors’ sense of identity, insofar as identity is attached to one’s ability to perform.

The project was intended to reach beyond its members and into the community. It connected to the public in two ways, through performances and through participatory workshops. Having considered the performance in Chapter V, I focus here on those workshops. The workshops which followed the performances were a very significant part of the educational work of The Waiting Room project. They provided the audience the possibility of becoming actively engaged in the issues, of being participants in the process of challenging assumptions about mental illness. Those who chose to participate had an experience in which they could work to modify images of oppression. The workshops used the representation of women and mental illness in the play as springboard to connect to the experiences of audience members.

Seven of the ten performances were followed by facilitated workshops. [see appendix A] Not all audience members stayed for the workshops; it was always voluntary. The workshops had a very similar structure to the workshops used in the early stage of play development. The focus in both was on “blocks” and “supports” to mental health. Workshop participants were asked to draw a representation of something that supported their sense of well-being and also to draw something that got in the way or blocked it. We used drawing to create images instead of drama activities because the timeframe of the workshop was too short to introduce drama. Of course, there were people who insisted that they couldn’t draw, but they were encouraged to make the attempt by the milieu we had created. These drawings, which could be stick figures and could include some text, were then discussed in the whole group and lists of blocks and supports were compiled.

Consistently there was crossover on those lists of blocks and supports: family helped and family made you crazy; religion was the source of pain and religion was inspiration.
There were a couple places most everyone could agree on - fresh air and walking were generally seen as a supportive activities! The dialogue around the crossover was very valuable as it encompassed differences and refused essentialism. Participants had to come to terms with each other’s different needs and different perceptions of what causes suffering. One participant commented: “Others’ sharing really helped. People you see as competent may feel inadequate. Don’t judge a book by its cover. We all need to review what we already know.” The exercise refused to name or label any individual’s block or support as essentially or innately “good” or “bad”. The exercise paralleled the performance’s emphasis on a continuum of health and illness as opposed to a dualistic vision, which norms and pronounces deviance.

The research workshops which had been held during the play development stage consisted of fairly homogeneous groups. They were for women only, women who had self-identified as having mental health problems or having been a caregiver to someone with such problem. In contrast, the workshops after the performances were mixed gender and often included a mix of consumers, service providers, family members and general public. The structure of the workshops was non-hierarchical; there were no “experts”. Thus in the workshops, service-providers and consumers met as equals, outside the hierarchical structures they usually function within. In most cases participants did not identify themselves with a role, only by their names. The workshop structure facilitated a direct exchange of experience. Like the waiting room, the workshop space was potentially a “true equalizer” [p.1] The evaluation from Winnipeg Region: Health and Family Services, one of the co-sponsors of a performance, included the following comments:

The opportunity for our regional employees and clients to participate in this presentation and workshop was a valuable learning and entertaining experience. It accorded us the environment in which we could share our ideas, beliefs and fears about women and mental health issues amongst ourselves, other program workers, and consumers. The mediums of theatre and workshops are excellent and entertaining tools. As professionals in the field we were introduced to a different and participatory focus on some grassroots issues.  

Not all workshops were heterogeneous. The workshop following the performance at
the Selkirk Mental Health Centre was composed exclusively of patients in the long term facility. Being “sent to Selkirk” was a bogeyman threat that kids in Manitoba hurled at each other. Among consumers, Selkirk marks the end of the line for treatment; once admitted there is very limited hope of release. Even a visit to “Selkirk Mental Hospital “ (its original name) is intimidating, perhaps because both consumers and non-consumers are aware of how tenuous is the hold on what is deemed “sanity”. The performance that evening in Selkirk had a Marat-Sade quality. Many of the audience were resisting or unaware of the rules of being spectators. They were moving in and out of the auditorium to smoke or wander or cough and were calling out encouragement, concerns or nonsense to the actors and to each other. I was relieved that the auditorium had a raised proscenium stage and stage lights which kept the activity in the audience at a distance from my troupe. After the show, the actors told me that they had been aware it was a restless audience, but they hadn’t had the full picture, which was a good thing.

The Selkirk workshop was a unique and powerful experience. About half of the audience stayed and we split them into three groups, one of which I facilitated. What I remember is sensing the stretch and the risk the participants were involving themselves in. I also understood their desire to communicate and how important it was that the workshop was inviting them to express their opinions. I followed the basic workshop format, but with a different pace and also with a willingness to move indirectly or to follow a side road. When the nurse co-ordinating our visit mailed in her evaluation, she wrote that one woman who hadn’t spoken for years spoke up at the workshop and had continued to speak.

That evening of the community tour stands out. Several of the troupe had been anxious about visiting the site of so much despair. All had believed that this was one of the most important locations in which to perform. This belief was affirmed by the evening itself, as well as the feedback from the institution, which was considering starting drama activities for patients. The performance in the Grand Rounds lecture hall at Health Sciences Centre bookended the evening at Selkirk. That hall was filled with medical professionals. They listened; they laughed; they paid attention. I like to imagine that for one psychiatrist who hadn’t “listened” to a patient for years, the potential to listen was reawakened. Of course
there’s no documentation on that since psychiatrists are less closely supervised by their nurses than are the patients.

As valuable as these workshops were, they were also embedded in existing power structures. They could not lead to direct action nor fully explore the issues. An hour long workshop could only skim the surface of the responses the play evoked. It could access only a limited amount of the resources in any group. Within those limitations, the workshops functioned well. The function of the workshops was to engage the participants with the problems and to engage them through connection to their own experiences, a basic popular theatre education technique. To engage more deeply with the problems was the responsibility of the sponsoring group or the individual. Nonetheless, the workshops extended the ability of the project to expose the social construction of mental illness. At times, workshop participants experienced their own agency through the exercises. That experience mirrored on a smaller scale the experiences of the troupe members in their collective work on the project.

In summary, I believe that The Waiting Room project was effective in creating alternative representations of women and mental illness. I have argued that the agency of the performers, who had self-identified as consumers, was a critical factor in disrupting the conventional image of the madwoman as passive victim. Their self-discipline in creating and performing the play challenged stereotypical images of loss of control associated with madness/mental illness. The focus and control of Acting Out members was manifested in performance. That performance also addressed the loss of control and lack of clarity in the lives of consumers, but refused to perform it as either tragedy or victimization and maintained a sense of humour. As well as disrupting stereotypes, the project presented alternatives. The collective agency of the company, mirrored in the agency of the community of characters, suggested to the audience the potential within community to disrupt the status quo and to resist dominant constructions. The performers were not “professionals”, neither professional helpers nor professional actors. Therefore the agency they manifested was potentially accessible to the consumer in the audience. The play’s focus on a continuum of illness and wellness and the related refusal to adopt a diagnosis as definitive also modelled
alternative representation of mental illness.

The Waiting Room’s disruption of conventional representation was incomplete. It was limited by a variety of factors. These included: the narrative structure of the play and its protagonist, the limitations on audience participation, the desire for respectability which both animated and limited the agency of the troupe members. I want to examine these factors and how they connect to each other and to the process of representation.

The traditional narrative structure of the play included a story with a beginning, middle and end, characters, conflicts and a throughline. All this occurred within a modified realism. The realism was embedded in the source of the plot, the stories of the lives of the actors and of other women, and was expressed through the settings and characters. It was disrupted by the surrealism of the song sequences and by Kristin’s monologues to the audience and the dialogues with invisible psychiatrists which broke the fourth wall. These interruptions of realism were integral to telling the stories that play had promised to tell. Those stories were replete with disruption, dislocation and a questioning of what experiences can or should be defined as real, as Darcy does in scene two: “The last doctor was only concerned with getting me back out to my profession...the exact words were to the effect that ‘I was different, I had been in the real world.’...And all I could think was...different than what? And what the hell is realer than this?” [p.5] A play which addressed those experiences had to modify theatrical realism.

In my early imaginings of the piece, it had been more surrealistic, fragmented and tortured. Those imaginings were abandoned fairly readily in the context of working with the troupe and within the parameters of community-based popular theatre. I believe each troupe member, to greater or lesser degree, had to abandon her fantasy version of The Waiting Room. This was painful but productive. Coming to an informed and collective decision about using narrative structure for the play was very difficult, as I have described in Chapter IV in relation to how the facilitators and playwright influenced the processing of that decision. Another important influence in choosing narrative structure was the group’s desire to communicate to the audience, to make the material of our stories accessible [see appendix G]. I believe the narrative structure did assist in making the material accessible. It also
reproduced elitism, by creating a setting where one character was more valued than the others. Can one do narrative structure without a protagonist? Can one do a protagonist without elitism? I cannot fully address such questions. In *The Waiting Room*, the character of Kristin was clearly privileged. However, I also witnessed the impact of other characters on the audience. Similarly, although the performance of the actor who played Kristin stood out, the collective performance of the troupe as a whole was also noted. The performance failed to be counter-hegemonic insofar as it reproduced elitism, but it also represented community and collective agency.

The structure and style of the play evolved out of its function which the troupe members had defined as breaking down the stigma attached to mental illness. They understood clearly that their agency moving through the vehicle of the play was instrumental in disrupting stereotypes. PTAM articulated the function of the project as using “theatre as an innovative educational tool in developing an original community-based play which will focus on the issue of women and mental illness in our society.” The project would provide public education that “would be accessible in terms of subject matter, location and cost.” The variety of venues in which the play was performed speaks to its accessibility [see appendix A] Most sponsoring groups did not charge for the performance or workshop and this made the play more accessible. PTAM’s publicist worked independently and with sponsoring groups to get the word out. Consumer groups also spread the word. A resource information sheet was available at performances and audience members were encouraged to stay for the workshop after the performance. Evaluation forms were given to audience members as well as sponsors to encourage feedback. Thus the performances had structures built around them to increase accessibility. The audience was invited to engage actively through the workshops. However, those workshops were limited to an hour and thus audience participation was limited. There were also structures internal to the play and its performance which created accessibility. The characters and the narrative structure provided familiar hooks to which to attach the unfamiliar. What was unfamiliar in the play was speaking aloud about mental illness, identifying oneself as mentally ill and refusing to be victimized by that identification.
I remember vividly the first time I found myself doing that unfamiliar task. I was working with the Manitoba Network for Mental Health and had volunteered to speak with two other consumers to a meeting of the CMHA in Swan River, a small town. One woman did most of the speaking and the other man and I responded to questions from the audience. At that time it was very difficult for me to identify myself publicly as having been mentally ill. I had never done it before. I still find it difficult to do, although less so. Yet it was liberating to take that step. The liberation was experienced not as confession, but through refusing to accept that the identification defined me. The context for my self-identification was very important in shaping it as an affirmation and not a confession. I was talking to people who had asked for understanding and information about mental illness. Some had experienced it directly; others through family members. Our revelations were for an educational purpose and not for entertainment or titillation. There was an integrity of purpose shared by the speakers and the audience. That sense of shared purpose is not available in the context of presenting a play to a large audience. Without the shared purpose, the performance can be received voyeuristically. At that point, The Waiting Room does not create alternative representation, but instead can become a freak show which invites a marginalizing gaze.

Obviously the company and the troupe could not control the audience response. We could have controlled the kind of people and limited the number of people who came. However, our mandate was to be accessible. Perhaps how we defined that accessibility should have been problematized. Whom we wanted our audience to be and how best we could connect to them was raised, but not inspected in the way I would consider necessary now. Playing for the public was different than playing for inmates and staff at Selkirk Hospital, which was different again than playing for an audience where the majority were mental health professionals. Should we have chosen to work with such disparate audiences? Would a tighter focus on particular audiences have been more useful in terms of education? For example, had we chosen to do a shorter piece, a series of vignettes, it would have been more accessible to certain consumers who had limited concentration. Representation which is constructed as an alternative to dominant discourse has to consider carefully whom it is being
directed to, its audience.

Those who facilitate and participate in the construction of alternative representation have to be critically reflective of their own narrative and interpretive structures and how those structures impact on the political agenda of the group. Ellsworth and Razack give concrete examples of this process which I explored in Chapter III in the discussion of storytelling and popular education. In Chapter IV I discussed how the desire for respectability and group cohesion limited that critical reflection in our work on *The Waiting Room*. As members of a marginalized and isolated group, the women of Acting Out needed to protect themselves with a cloak of respectability. Having taken the risk of publicly self-identifying as consumers in order to represent an alternative to dominant discourse of mental illness, it was critical to perform the alternative successfully. To perform collectively required cohesion. In the facilitators' attempt to preserve that cohesion, differences among group members of Acting Out were not addressed critically enough.

Working to create a performance piece collectively shapes the product. It is always more than personal, arcs to the political in the form it takes. That form is inclusive and respects differences among the collective's members. In order to work artistically those differences need to be articulated. However, there is the tendency in any group to homogenize in order to produce the shared work. That tendency needs to be resisted. Like myself, Donna Huen regrets that, as facilitators of *The Waiting Room*, we did not "name directly" those differences in race, class, sexuality and wellness. I know this naming might have been uncomfortable for some group members who were, as consumers, angry and hurt about being defined by labels. Nonetheless, I believe this particular labelling could have clarified our work as a collective. That naming might have strengthened our articulation of what grounds health and breeds illness.

What are some of the implications of the work on *The Waiting Room* for other community educational theatre work? What are the problems I would address in facilitating such work? I would begin with a focus on what Ellsworth called "partial knowledge". This would include respecting that the knowledge the group has is partial, that is, it is both profound and incomplete. Discovering and communicating that knowledge through cultural
production requires critical reflection on the narrative structures and political agenda of group members and the facilitator(s) and on differences among them. Such critical reflection can be impeded by the group’s desire for cohesiveness or solidarity. It can also be impeded by a lack of solidarity where individual concerns overwhelm the project. Group agreements provide a structure from which these problems can be addressed. Group process needs to be attended to.

Cultural production by the group must be inspected in terms of its form and its intended audience in relation to the group’s objectives. The cultural product needs to reflect the agency and voice of the participants. The group’s collective voice can lend legitimacy to voices which have been defined by dominant culture as illegitimate. However, if the group chooses to communicate to a broad audience, it needs to negotiate with dominant culture and decide to what extent it can compromise in terms of form and content of its cultural production.

Finally, it is as the double movement of recognizing social construction and discovering one’s agency within that construction that I understand the work of The Waiting Room project as alternative representation. Holding that double movement is a possibility created by a collective theatre piece which connects the individual stories within a collective construction. The form of the work reaches mimetically towards its content. In a collective, the performers are focused on more than words, more than movement, more than words and movement together. It is more than one person’s story or the combined directions of different stories. It is the living breathing entity that the performers have collectively given birth to and that they let out to play with the audience. In that play is the potential to disrupt the usual, to resist oppression, to re-negotiate identities.
ENDNOTES


3. Ibid. appendix III.

4. Ibid. appendix IV.

5. Ibid.p.6.

6. Ibid.p.6.
BIBLIOGRAPHY


Blanch, Andrea K. and Cynthia Feiden-Warsh. “Women’s Mental Health Services- The Need for Women in Mental Health Leadership”. *Journal of Mental Health Administration* (Fall, 1994, Vol.21 No.4). (Special Issue: Women’s Mental Health Services).


Kalinowski, Coni and Darby Penney, “Empowerment and Women’s Mental Health Services”. *Journal of Mental Health Administration* (Fall, 1994 vol.21 No.4)


October 10, 1995.


Schutzman, Mady and Jan Cohen-Cruz, eds. Playing Boal: Theatre, Therapy, Activism.


Minneapolis: University of Minnesota Press, 1996.

Solomon, Alisa. Re-Dressing the Canon: essays on theater and gender.


APPENDIX A.

The Waiting Room - Performance Dates, Locations and Audience Statistics

-from PTAM's Final Report
Appendix I - Performance Dates, Locations and Audience Statistics

In total, there were nine performances of *The Waiting Room* between April 26 and June 29, 1994. Seven of these performances were held at various locations throughout Winnipeg and two in Selkirk. The total number of audience reached was 805.

<table>
<thead>
<tr>
<th>DATE:</th>
<th>ORGANIZATION BOOKING THE PLAY:</th>
<th>AUDIENCE:</th>
<th>WORKSHOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 26/94</td>
<td>LAUNCH OF THE PLAY St. Stephen's-Broadway United Church</td>
<td>206</td>
<td>N/A</td>
</tr>
<tr>
<td>June 5/94</td>
<td>NORTH YM-YWCA Seven Oaks Hospital</td>
<td>22</td>
<td>8</td>
</tr>
<tr>
<td>June 10/94</td>
<td>CATHOLIC WOMEN'S LEAGUE Lord Selkirk High School Selkirk MB</td>
<td>48</td>
<td>23</td>
</tr>
<tr>
<td>June 21/94</td>
<td>HEALTH SCIENCES CENTRE Dept. of Psychiatry</td>
<td>200</td>
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</tr>
<tr>
<td>June 23/94</td>
<td>ADAM/SDMD/MSS Gordon Bell High School</td>
<td>43</td>
<td>11</td>
</tr>
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<td>PTAM COMMUNITY SHOWCASE Gas Station Theatre</td>
<td>98</td>
<td>N/A</td>
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</tr>
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<td>June 28/94</td>
<td>COMMUNITY MENTAL HEALTH WORKERS Young United Church</td>
<td>60</td>
<td>26</td>
</tr>
<tr>
<td>June 29/94</td>
<td>MB HUMAN RIGHTS COMMISSION/MNMH/SSCOPE/CMHA Deaf Centre Manitoba Forrest Nickerson Auditorium</td>
<td>88</td>
<td>33</td>
</tr>
</tbody>
</table>

**TOTAL AUDIENCE** 825  
**TOTAL WORKSHOP ATTENDANCE** 136
APPENDIX B.

*The Waiting Room* - Scene Summary
Scene 1

In the waiting room, a woman (the central character) waiting to see her doctor talks about the Rules and Etiquette of Waiting Rooms. A song emphasizes her points. The central character is then taken to see her doctor, and the remaining women in the waiting room begin to get to know one another.

Scene 2

In the doctor’s office, a woman and her psychiatrist discuss her mind, which, because she is multiple personality, is very complex.

Scene 3

One of the women from the waiting room is on the phone with a prospective employer. She tries to convince the employer that she really does want the job, but couldn’t come to an interview when the employer wants her, due to a previous appointment. She tries another advertisement.

Scene 4

In the waiting room, the women we met earlier in Scene 1 are discussing finding work and, if you have a job, how to fit appointments with therapists in without your employer knowing what kind of appointment it is.

Scene 5

In the doctor’s office, a woman wishes to discuss her wish to have a child, while the psychiatrist tries to divert her from her goal in session.

Scene 6

A dualing monologue between the woman we met in Scene 3 and the prospective employer. The employer believes it is too risky to offer her a job, because of her mental illness history. The woman applying for the job has been honest about her past, and now she has been labelled and rejected for her honesty.
Scene 7

In the doctor's office, the central character we met in scene 1 again avoids meeting the others in the waiting room. She is in session with her psychiatrist and talks about the abuse she has suffered by mental health care workers, a secret she doesn't think the doctor will believe, but he does. A song about keeping secrets is interspersed with mini-monologues on the topic.

Scene 8

In the cafeteria, the four women from the waiting room discuss their hospital experiences. A potluck dinner is planned amongst them.

Scene 9

In a restaurant, a mother and her daughter, the central character, discuss the daughter's illness, and the mother's denial of her illness. Her advice to her daughter is 'Just go country for awhile.' Later, in the daughter's apartment, she sings a country song, and we see her demise into the world of madness.

Scene 10

The central character calls her psychiatrist, who is unavailable, and then goes to the office, demanding to see him. The doctor is busy, but agrees to see her for five minutes. She reveals that her husband did not visit her in hospital, and will not go with her for counselling. He agrees to speak with her husband.

Scene 11

Potluck dinner preparations at the home of one of the women.

Scene 12

The central character is on the phone with her husband. He wants to break up with her. She wants to work things out.
Scene 13
At the potluck dinner. The women are gathered and share stories about the food they have brought.

Scene 14
The central character, alone in her apartment, begins drinking and taking an assortment of pills.

Scene 15
After the potluck dinner, the women are cleaning up and reflecting on the moon. One of the women shares a story about incest and betrayal. The women share a toast to their new found friendship with one another.
Notes to the Scene Summary:

1. The summary was written before the final draft of the play and before the title was chosen, to function as a plot summary.

2. Scene 1 - The “central character” refers to Kristin. The “remaining women” are Marnie, Darcy, Tillie and Marsha. The nurse is present in all the scenes in the waiting room.

3. Scene 3 - The character looking for work is Darcy.

4. Scene 5 - The character wanting a baby is Marnie.

5. Scene 8 - Joan, Tillie’s friend, a new character is introduced. The potluck is a celebration of Darcy getting work.

6. Scene 14 - There is no dialogue in the scene.

7. Scene 14 - The characters at the potluck at Darcy’s home are Marnie, Tillie and Joan,
APPENDIX C.

"A Woman's Place is...." 

promotional flyer for participatory research workshops
A Woman's Place Is...

In the community, at work, at play, in the home...

There are times when her mental health is endangered such as when she is recovering from past abuses, at risk physically, or is coping with unresolved stress. A woman's mental health, or lack thereof, needs to be understood in terms of her role in the community, including her roles as worker and caregiver.

The Popular Theatre Alliance of Manitoba is currently researching a community-based play project on the topic of women & mental illness. The play will evolve from the stories of women who have been consumers of the mental health care system both directly as patients and clients, and indirectly, as caregivers.

These stories will be related in the context of how social and political factors impact on women's lives. Are you and/or your group interested in participating in a research workshop?

Come and share with us in a friendly atmosphere. All stories will be treated confidentially.

Monday, May 10th, 7:30 P.M.
Room 3M61
(Room 361, Manitoba Hall)
at the University of Winnipeg,

please contact Donna or Lee Anne at 589-8408.

PLEASE POST
APPENDIX D.

Women and Mental Illness Drama Troupe

summary sheet of material generated in the first meeting of the troupe
re: blocks and supports to mental health
Women & Mental Illness Drama Troupe

Week 1 - April 26, 1993

Blocks/Supports

Blocks

- ridicule
- lock up
- family
- paternalism
- Christianity/martyrdom
- heterosexual stereotypes
- psychiatrists
- hospital policies
- church
- not listening
- professionals
- medications
- inequities
- lack of awareness
- lack of money
- stigma: verbal
  - snowballs
- bad weather/spring/
  - change of seasons
- isolation
- juggling multiple roles
- gender stereotypes
- lack of self-knowledge:
  - inner centre
- hypocrisy/bullshit
- labelling

Supports

- being heard/sharing
- children
- inner child
- exercise
- hobbies/interests
- higher power
- mothering children
- friends
- groups
- counselling
- music
- calming, creative
  - activities
- time
- knowledge, education
- nature
- nurturing family
- home

What happens when you have been labelled? How do you get out of the role?

Victim, inferior
Trouble trusting own judgements
Lack of boundaries
People feel fear: negativism
People label you because it's easier for them, excuses them from facing up to
  own weaknesses, fear, etc.
People project onto others in order to control, to get needs met
See fear on others' faces helps to nullify own fear
Fear and ignorance
APPENDIX E.

PTAM - Women and Mental Illness Drama Project
Form re: commitment to playbuilding and performance
Popular Theatre Alliance of Manitoba

Women & Mental Illness Drama Project

This group will be meeting weekly beginning in September 1993 to continue the process of developing a play on the topic of women & mental illness. The storytelling process we began in June is nearly completed. Through a process of improvisation and using our shared stories, we will build the script, which is expected to be completed in January 1994. We will then continue to meet weekly to rehearse the play, with performances expected to begin in March or April 1994. The play will then be performed approximately 10 times to community audiences until June 1994.

Please take a few moments to reflect upon your commitment to the project.

Please answer the following questions and return this form to Lee Anne or Donna on or before September 8th.

Name: ___________________________ Phone: ____________

1) Count me in! I am willing to commit to building the script, rehearsing and performing in the play.
   _____ YES    _____ NO

2) I am willing to work on the process of building the script, but rather than acting, I wish to be involved by:
   (check one)
   _____ assisting backstage during rehearsals and performances
   _____ facilitating participatory workshops which will follow play performances
   _____ assisting with the promotion of the play

3) I feel I have given all I can to this project, and will not continue my involvement once the personal story-telling stage has been completed.
   _____ YES    _____ NO

Thank you. If you are unable to attend the meeting on the 8th, please return this form to:

   Donna Huen
   Popular Theatre Alliance of Manitoba
   2nd floor, 413 Selkirk Ave.
   Winnipeg, Manitoba R2W 2M4
This group has agreed that:

1) We have a right to confidentiality;

2. We have the right to 'opt out' of any activity and to observe;

3) We have the right to take 'time out' when needed, in order to be alone;

4) We will not interrupt or judge one another when we are sharing our stories;

5) Each member's feelings and opinions are valid;

6) We speak one at a time, or request the use of the talking stone;

7) We make 'I' statements, not 'you';

8) We do not make personal attacks;

9) We may 'call' (challenge) one another on our use of language in order that our process be mutually respectful and educational;

10) Each member has the right to suspend an activity by stating "I'm not comfortable with this" and explain why.

11) Our meetings begin at 7:00 P.M. and close at 9:00 P.M.
APPENDIX G.

documents produced by the facilitators for the group meeting of November 24, 1993 relating to the choice of doing a play, not a collective creation
Where We Came From

1. Research and goodwill
   Meetings with women to determine need for play project and to collect stories;
2. Community-Building
   Drawing upon our resources so that we have the strength and material to build a play.
3. Play Development

What is a Play?

A play is heightened reality

1. Metaphor - In our play the waiting room is the symbol of the place (interval) between illness and health;
   - It is the vehicle we are using to connect the stories.

2. Character Development - **Fictional** characters are followed.

3. Conflict - These fictional charaters encounter **conflict**;
   - There is no play with conflict.
   Conflict can be:
   human vs. human
   human vs. self
   human vs. society
   human vs. nature

5. Plot (Through-line of action) - All parts of the play further the whole, the through line of action, or the plot.
   - All plays have a beginning, middle and end.
   - We have decided on a clear ending which is unresolved.
What is a Collective Creation?

1. Performance piece
2. Mirrors reality without a clear through-line
3. Series of vignettes
4. May have some characters to a through-line, but the piece does NOT have a through-line
5. Group consensus is reached (by majority) on:
   i) all scenes
   ii) themes
   iii) order of scenes
   iv) characters
6. Creative collections explore either:
   a) one topic, or
   b) many generally

We are at a crossroads

Group consensus on all things

Community-Building

Informal research: Is there a need?

GOAL!
A PLAY
Why a Play?

1. Target Audience
   Our target is people who don't have a clue about mental illness, and mental health care professionals who may be biased or supportive. We will play to both audiences.

2. Entertaining
   A play will entertain as it educates.

3. Workshop
   The follow-up workshop plays an important role in our work, but it is separate from the play.

4. Communication
   A play is an effective means of communication. It will communicate the needs expressed in Phase 1.

5. Vision
   When this group watched the 'Beyond the punchline' video, it was expressed that a play was our goal, and this affirmed our vision as to what the project is about.

6. Time-Line
   The time-line expressed to this group and our funders can best be accomplished by the production of a play.

Your Script Should Look Like This

Do you mean gave birth to?

Mary had a little lamb.

I think, this sounds like a sacrificial lamb. I thought we had discussed the goat as the central animal image.

I am glad she is doing this because this character is young and might make these choices.
APPENDIX H.

Program - *The Waiting Room*
 Popular Theatre Alliance of Manitoba staff

These awards for their support in Women's Programs, Artist in Residence, and the Manitoba Arts Council. We thank Funding assistance for the project was received from Human Resources:

FUNDING:

Acknowledgments

Marina Kershman, Canadian Mental Health Assoc. Manitoba
Keith Lumsden, University of Winnipeg
Beanie Block, Popular Theatre Alliance of Manitoba
Donna Hugen, Popular Theatre Alliance of Manitoba

THE WAITING ROOM-AHOC PLANNING COMMITTEE

Date with the Room composed and performed by Chris Kola

Pramodhos Assistant:

Video Producer:

Production Manager:

Graphic Design:

Music Arrangement:

Lyrics and Music:

Musical Director:

Set Designer:

Lighting Consultant:

Project Co-ordinator:

Director:

Playwright:

Playwright:

Marine Vieno

Megan James, Robyn, Michael, Delight Tucher

Karen Kuhns, Voice is Heard is Kristin's Doctor

Megan Gessner's voice is heard as Melanie's Doctor

Victor Dodds's voice is heard as Dave's Doctor

Nurse's voice: Woman on the Bus in Secrets: Christine Vieno

Title: The Delight Tucher

Name: Megan James

Kris: Mike

Date: Michael

Friend: Michael

Voice: Megan James

Kris: Michael

Kris is Voice: Woman on the Phone in Secrets: Christine Vieno

Keith is Voice: Woman on the Phone in Secrets: Christine Vieno

Martha's Mother: Bequia Dwyk

Martha's Mother: Dawn Blames

The Case:

By Joy Beauchamp with Acting Out

THE WAITING ROOM

Present

Popular Theatre Alliance of Manitoba
APPENDIX I.

Audience Survey Form - blank
sample of comments from audience survey forms
AUDIENCE SURVEY

Please take a few minutes to help carry out an audience survey. This information will help us to evaluate The Waiting Room.

1. Female _______ Male _______
   Age Group: under 18 ____ 26 - 40 ____ 41 - 50 ____ 50 - 65 ____ over 65 ______

2. Do you live in: a city _______ a small town _______ a rural area _______
   Did you grow up in: a city _______ a small town _______ a rural area _______

3. Would you identify yourself as a (check one):
   consumer _______ service provider _______
   related to a consumer _______ related to a service provider _______
   other: ________________________________

4. Annual Income:
   Do you consider yourself financially secure? Yes _______ No _______
   Are You: Employed _______ Unemployed _______ Under employed _______ Student _______

   Do you consider that you are able to provide for your:
   needs & comforts _______ needs alone _______
   not able to provide for needs _______

   Do you financially support others in addition to yourself? Yes _______ No _______
   If yes, how many? ______________

5. How have we done?

   The Waiting Room looks at a number of issues facing mental health care consumers. Check those issues in which you think we did a good job.

<table>
<thead>
<tr>
<th>Thought-Provoking</th>
<th>Educational</th>
<th>Entertaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family responses to mental illness</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>Stigma experienced by consumers</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>Service provider/consumer relationship</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>Concerns specific to female consumers</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>Economic concerns of consumers</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>The importance of a supportive community</td>
<td>_______</td>
<td>_______</td>
</tr>
</tbody>
</table>

   Would you recommend The Waiting Room to others? Yes _______ No _______

   Comments: __________________________________________________________

   __________________________________________________________

   Thank you for your time and assistance.
The Waiting Room - Audience Survey
June 23/95  ADAM/MSS/SDMD Gordon Bell School

26 Respondents - 18 female, 6 male, 2 unknown

Comments:

As a mental health patient I found the play to be very real to life. Keep up the work and education. We need greater awareness of mental health issues.

It's great to see a play like this from the client's point of view. Thanx for the great work.

Excellent.

This is the second time I've seen it. And I enjoyed it just as much the second time. Could have used some air-conditioning though!

Great production - I could identify strongly.

Issues were very well presented. I enjoyed the musical presentations and the stark forceful way you got your points across.

An excellent performance! We are not alone in our struggles!

A bit slow. Boring but brave.

Excellent play!!

Well done! Could develop the last 3 components somewhat.

This play covers the importance of a support group, and the lack of certainty in patient therapy.

Thank you. Excellent play, good topic. Could have maybe been a break in the play for 10 mins.
APPENDIX J.

Acting Out: Evaluation of the Project Process
dform distributed to all troupe members
Acting Out: Evaluation of the Project Process

Note: Your responses to the following questions will be kept confidential. They will be used in the Final Report to funders, but your comments will remain anonymous.

1. How did you find out about the Women & Mental Illness Drama Project?

________________________________________________________________________
________________________________________________________________________

2. Why did you decide to become involved in the project/acting troupe?

________________________________________________________________________
________________________________________________________________________

3. Please respond to the following questions under each of the project's stages below:
   a) What did you learn?
   b) What difficulties did you experience?
   c) What helped you? Commendations.
   d) How could we/PTAM have done it better? Recommendations.

I. Workshop & Script Development Stage (March - Dec. 1993)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

II. Rehearsal Stage (January - April 1994)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
III. Performance/Community Tour Stage (April - June 1994)

4. General comments in relation to your involvement in the project:
   a) Did your perception of the issues relating to women and mental health change? If so, how?

   b) Did your perception of your personal experiences in the mental health care system change? If so, how?

   c) Further comments:

Thank you. Please return to Popular Theatre Alliance of Manitoba in the enclosed stamped envelope.
APPENDIX K.

Interview Consent Form and Questions
CONSENT FORM

You are asked to give consent for Lee Anne Block to tape record an extended interview with you. Material from the interview may be included in the production of a Master's Thesis on popular theatre and education. The thesis will propose that a community-based theatre education project, *The Waiting Room* by Joy Beauchamp with Acting Out, was effective in resisting stereotypical representations of “madwomen” and in presenting alternative representations. The thesis will be submitted to the Department of Curriculum, The Ontario Institute for Studies in Education, University of Toronto.

You have the right to read a transcript of your interview and to request material to be taken out of the transcript if you believe such material to be damaging in any way. Any material you have deleted from your transcribed interview will not be used in the thesis or any subsequent publications. The final thesis or subsequent publications will be available for you to read.

Your name will not be used if you request anonymity.

I REQUEST ANONYMITY

YES

NO

I HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE AND I HEREBY GIVE MY CONSENT.

INTERVIEWEE--------------------------------------------------------DATE--------

INTERVIEWER--------------------------------------------------------DATE--------
INTERVIEW QUESTIONS

1. How did you become part of The Waiting Room Project?

2. What are your feelings about your part in the project now that four years have gone by?

3. a) Did you have a story of your own to tell that you brought to the work we did?
   b) To what extent did your story get told by the play?
   c) How do the stories of the characters in The Waiting Room reflect your own story or experiences?

4. When you reflect on it, what impact did the project have for you personally? What impact might it have had on the community? What can people learn from watching a play like ours?

5. In my thesis, I describe the work we did as being “inscribed on our bodies, literally and figuratively.” Does this describe your experience?