ETHNODRAMA - ANALYSIS IN ACTION[1]

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Abstract

Qualitative research reports containing dramatic demonstrations or performances of elements of qualitative data - that is, ethnodrama - may have import for audiences beyond those more commonly experienced in the realm of traditional modes of data analysis and transmission. Referring to this specialised form of qualitative, ethnographic research in health and education, this chapter uncovers disturbing potentials inherent in newer tropes of data portrayal (Morgan, Mienczakowski & King, 1999) whereby the misguided (albeit well-intentioned) use of performed health education research can be seen to have potentially deleterious effects on vulnerable informant collaborators and/or audients.

Introduction

Located in what Denzin (1997) has previously described as that space in which resides a variety of forms of improvisational, critical theatre (Morgan, Mienczakowski & Smith, 2000, pp. 165), ethnodrama is derived from (and is consequential to) our quest for a textual mode of analytical qualitative reporting which synchronously provides accountability to and autonomy for its informants. As an emancipatory form of qualitative analysis, ethnodrama typically synthesises classic forms of qualitative research methodologies with aspects of ethnography, action research

and symbolic interactionism in the field of health theatre / education research. It symbolises the co-production of a report script detailing authenticated qualitative research data performed for health care recipients, their caregivers, health care professionals, school students, government and non-government agencies by student actors and student nurses. In short, ethnodrama combines emancipatory agendas with constructed (staged) cathartic approaches to produce experiential revelation and (potentially) deep emotional location for audiences and subjects. In so doing, we now realise that some are carried further on these 'ethnodrama' journeys than others.

In our conception of this emancipatory form of educative health theatre, those who have contributed data may also be the audients of such works. In this way, previously marginalised informants are given an authorised public voice through which they are able to relate their lived experience of health consumption ranging from mental psychosis, suicide related behaviors, rape, drug and alcohol abuse to cosmetic surgery. To our chagrin however, in the course of reflecting upon our own on-going research and through our appointed roles as consultants to government and non-government agencies, we have observed that ethnodrama is open to exploitation with, on occasion, little or no consideration given to the impact of portraying socially sensitive subject matter such as drug abuse, youth suicide or sexual abuse on vulnerable audiences.

Bauman (2000, p. 41) observed that: '*if the old objective of critical theory - human emancipation - means anything today, it means to reconnect the two edges of the abyss which has opened between the reality of the individual* de jure *and the prospects of the individual* de facto. *And individuals who relearned forgotten citizen skills and reappropriated lost citizen tools are the only builders up to the task of this particular bridge building.* Our research team, in collaboration with informant participants

and utilising the methodological process of the ethnodrama, has attempted to bridge the chasm that separates the 'parvenu' (Beilharz, 2001, pp. 218-221) or marginalised members within the health care system from wider society. Yet it was the subsequent attempted hijacking of this endeavour to provide access to public acceptance and understanding that has given us cause for concern as some (health) theatre groups, apparently more focused upon securing a share of lucrative public monies than presenting acceptable lived representations of their informants lives have, at times and perhaps unwittingly, exposed their fragile collaborators to performed scenes which may have precipitated copy-cat syndrome suicides in some, or set back the recuperation from drug and/or alcohol abuse in others.

Public voice / public space / private sphere

Ethnodrama (Mienczakowski, 1992/1994) may be considered a precursor to Bauman's (2000) theories around what constitutes public issues and space, and private issues or space and the ways in which forms of analytical qualitative research have been transposed in academia. Popular culture's very public demonstration of how themes gain vogue and/or notoriety through the public confessional of 'live-chat shows' on television or 'talk-back' radio exemplify Bauman's notions around liquid modernity (2000) and Mienczakowski's original conception and intention for the ethnodrama: public voice for previously private issues. Consequently as we explore the increasingly flexible and traversable borders of public space, we inevitably draw parallels between which sectors within the public are given voice and notions of privilege echoing the old emancipatory paradigms. Of course, as the late Basil Bernstein notes, the voicing of individual narratives in the public sphere may be no more meaningful than the echoing of voices in an auditorium. Not everyone, individual or otherwise, is privileged to speak – ever.

Why then the trope of ethnodrama?

Geertz's (1973) '*thick description*', as Bauman (1992) and others have previously confirmed (Mienczakowski, Morgan, & Rolfe, 1993), allows the observer to assimilate the unfamiliar into a personally visceral and enriching experience through grasping, translating and/or deciphering (the concept of) the previously inexplicable and rendering it personally meaningful (Bauman, 1992, pp. 106). Extending Geertz's thick description, Mienczakowski (1996, 1997, 1999) and Singer et al (2001) have concluded that the autonarratives of, for example, medical patients are effectively their individualised and uniquely reconstructed understanding of themselves.

Through autonarratives, health consumers are able integrate their experiential knowledge of the sequences of events in their medical history into this new portrayal or vision of self. Thus health care recipients reshape their identification of 'self' incorporating such terms as 'mental health client' or 'rape survivor' to embody those visceral incidences which have polarised their lives. In this manner, our informants are able to give credence and significance to the various interventions that occurred and their own unique responses to them – that is, their understanding of self has layered or multiple meanings that are 'thick' with interpretative possibilities.

It is this experiential understanding and evolving construction of 'self' that the ethnodrama draws on in its immersion into the various phases of qualitative data collection and analysis, collaborative script writing and validation. This cooperative process is followed by the public performance of ethnodrama which means that researchers and actors - guided by their health care informants - inevitably become progressively more exposed to some of the harsher aspects of the lived realities of their collaborators. And, as we have recounted at some length

elsewhere (Mienczakowski & Morgan, 1999; Morgan, Rolfe, & Mienczakowski, 1999; Mienczakowski, Morgan, & Smith, 2000) impromptu events or extensions to our research scripts have alerted us to the potential harm of performed health research on unsuspecting or uninformed audiences or actors.

For instance during a performance of *Syncing Out Loud* (1992/1994), a piece that articulates schizophrenia from the perspectives of both the afflicted and their caregivers at a 'secure' psychiatric hospital, a female student (whose suppressed fundamentalist religious beliefs equated psychosis as being actual possession by the Devil) was 'accosted' on stage by an inmate who truly believed her to be a psychiatrist and wanted to have 'his say'. Her departure from the stage was emotional, abrupt and traumatic to say the least. In another example, during the validation performance of a script we were alarmed by the spontaneous response of a number of our informed audience members to an unintended expansion on the scene they were watching. Set in a detoxification process in a rehab unit, our audience was made up of recovering drug abusers in varying stages of detoxification. Several of them leapt to their feet all too graphically displaying the symbolic 'needle fixation' behaviour common to many drug addicts when several syringes rolled across the stage after a 'nurse' accidentally spilt the 'sharps' container. And we were consequently forced to ask ourselves what impact has this event had on their recovery? (Mienczakowski & Morgan, 1998).

For those of us engaged in 'serious' research regularly hypothesising about real people going about their daily lives Bauman's (2000) humorous quip to Baudrillard that '... *it becomes a philosopher and an analyst of his time to go out and use his feet now and again. Strolling has its uses.*' (pp. 154-155) is a non-too-subtle reminder of the need for researchers to remain in tune with (cognisant of) the multi-voiced lived actualities

of those we describe (Geertz, 1973; and Clifford, 1986). Bauman's telling gibe reminds us that we academics are not external observers but rather collaborative participants performing lived data - complete with its component emotional, physical, social and pathogenic features - to and on behalf of those who have intimate and firsthand knowledge of it every moment of their lives and that this carries ethical responsibilities.

In health education research for instance, our informants include those who have lived with schizophrenia; or who daily struggle with the imposed invisibilities of public condemnation for being alcohol dependent women; or who battle ideation of self-harm, or all of the above. Informed collaborators day after day endure the experience of that which we present as a performed snapshot in our reports, and consequently as researchers we seek to ensure that what we recommend is neither untenable nor impractical with respect to policy formulation. In our portrayal of the qualitative data we analyse we remain sensitive to the *people* that we observe.

As academic investigators we do indeed need to stretch the limits of our personal comfort zones by undertaking regular descents from the sanctuary of our textual selves to the realms of life on the street. Yet we should seek to do so without impinging on the equally important rights and aspirations of those being observed and critiqued. In our work as qualitative researchers ought we also be cognisant of the potential damage our research may cause to those being reported on? What do we do to test the import and impact of our researches on our audiences and informants? How much do we assume rather than know? Ethnodramatic presentation of data is intended to be a mode of reflexive, collaborative response by informants and audiences. However, the mode of data presentation is not without ethical dilemmas of its own.

On the culture of the nightworkers and marginalised health care recipients

Cohen (1993) describes culture as being all about political expediency – the myth of what is worth preserving and what should be allowed to disappear - particularly when speaking of the cultural worth of 'others'. Culture, in western terms, is most frequently about power, usually synonymous with economic and social status – the haves and the have nots or what might also be termed dominant and sub-dominant cultures (Schafer, 1998; Cohen, 1998, and Braidotti, 1994). If we transpose this to the scenarios of less glamorous areas of health education and health care (and its associated research in say addictive behaviours and mental health), it becomes evident that both the patients and their caregivers occupy a space which is invisible, marginalised and other. Likewise, due to the associated stigma, those employed within such fields as mental health or drug and alcohol rehabilitation are often reluctant to reveal what it is that they 'do'.

Prior to the production of the ethnodrama *Busting: The Challenge of the Drought Spirit* (Mienczakowski & Morgan, 1993) our team, in an endeavour to more fully appreciate the culture and marginalisation of those working in the health care sphere of drug and substance abuse, undertook extensive field research at a local urban drug and alcohol detoxification unit. For these health care professionals the marginalisation and muting of their public voice has meant that the plight of women alcoholics, for instance, has been afforded less voice than those of their male counterparts. However, this particular unit, which provides free rehabilitation treatment (lasting some 10 days) to victims of drug and alcohol abuse, recognised this gap in health services and was particularly attentive to the curative needs of women from within the local street and red light communities:

Consequently, as one follows the evolution of postmodern cultures, figures, and personalities (Beilharz, 2001, pp. viii) one cannot help but query the potentially damaging features of the new public status on ethnodrama's parvenu. For despite their elevation into 'public space' our research partners are still denied access to the prestige or power usually afforded the politically, socially and/or economically privileged. Their space remains firmly located in that of the marginalised undesirable 'other' peering out at those who in turn peer in (on them) and there it sadly seems to remain.

Altruism, funding and youth suicide

It is particularly within the sphere of suicide prevention that we have witnessed the most visible movement of a once marginalised sector of health care into public space. Like many western nations, Australia has experienced an alarming increase in the numbers of its young people who are attempting suicide, or have succeeded in their suicide bids, in recent decades. Between 1996 – 1997 $AUS 31 million was pumped by the federal government into the development of preventative strategies and policy initiatives. This provided government and non-government agencies with access to not inconsiderable sums of money to fund innovative educational programmes and research, many of which were located within the realms of health theatre. Unfortunately this increase in funding opportunities spawned a corresponding escalation in the numbers of theatre groups *purporting* to have an health theatre research agenda some for altruistic purposes and others apparently only intent on acquiring money regardless of or oblivious to the emotional and/or psychological cost to their audiences or casts.

Through the advocacy of ethnodrama research we have undertaken, members of our team have been asked to act as advisers to a number of national organisations involved with the development and implementation of youth suicide

intervention strategies and programmes and to provide independent evaluations on a number of self-professed ethnodrama performances. These appraisals provided us with the opportunity to assess what was being offered in the name of youth suicide health preventative measures. This form of peer review of critical health theatre enabled us to further reflect upon the potentially damaging ramifications of a mode of qualitative research which is inextricably bound in carthartic empowerment through the emotional emancipation of its informants (Mienczakowski & Morgan, 2001, and Morgan, Rolfe & Mienczakowski, 1999).

Our evaluations of health theatre performances such as Jeanne Mazure's *And I'll Give You All The Diamonds in My Teeth* (unpublished play, 1993), the Warren Street Theatre Group's *Tears in the Shadows* (unpublished play, 1999) and David Brown's ethnodrama, *Kill Everything You Love* (1999) later renamed *Keep Everything You Love* exemplified for us some of the highly emotive and ethical issues which intertwine portrayals of youth suicide and mental illness. We witnessed within the 55 minute performance of one of these plays the graphic representation of child abuse, a stylised rape scene and a very explicit suicide by hanging on stage. And learnt, post-performance of the cataclysmic conclusion – that the young man who had conceived the play's music hanged himself at the rear of the theatre during the post-performance party, followed by the suicide one week later by a friend of the group although no link has been established nor is inferred between the play's graphic content and these tragic events (Mienczakowski & Morgan, 2001).

Similarly when we were asked to evaluate an ethnographic performance supposedly located in the experiences of its former psychiatric nurse author we observed that the cast made up of young university students were subject to a great deal of criticism from an increasingly hostile audience. To those whose reality this play purported

to represent, what they were watching was nothing more than a pseudo-educational and stereotypical farce – a reinforcement of what Hollywood usually portrays as mental illness and treatment – they perceived it as ill-advised and sensationalist, judging that it denied them (and less well informed others) the validity of their lived knowledge. Rather than a traditional, research based piece of work they recognised and exposed it as yet another attempt to denigrate them and to take away their right to autonomously articulate their needs - they left the theatre in protest. Mistakenly, the play had been performed to an informed and expert audience made up of mental health patients and their professional carers who were very vocal in their criticism of the play's credibility and validity (unpublished play, Mazure, 1993).

Exemplars such as these helped to reinforce for us the legitimacy and great significance of our fundamental requirement that the ethnodrama methodological processes include continual cross-validation and collaboration of data and scripts throughout the writing process. Given the concerns for establishing validatory, determining co-factors which often precipitate suicide or copy-cat episodes as eloquently expressed by Schmidtke & Haffner (1989) we believe that it is essential that those involved in ethnodrama and performed critical health theatre research make good use of the Guidelines we developed in response to the ethical and moral dilemmas exposed in the performance and post-performance experiences that we have evaluated (Morgan, Mienczakowski, & King, 1999). We proposed these Guidelines, not to limit or censure art, but to better guide those undertaking health performance construction such as David Brown, an award winning Queensland author. Brown's ethnodrama, *Kill Everything You Love* (1999) later renamed *Keep Everything You Love* was critiqued by State Health Agencies and Schooling Authorities as not meeting these Guidelines and quickly closed due to lack of patronage.

We believe that firm adherence to such processes enables our informants to assist us in the creation of an accurate and emotively sensitive glimpse of their lives. Critical health theatre that claims research foundations is no longer fiction in the minds of many audients. It becomes performed facts – not stories. The consequences of providing self-harm ideation to vulnerable and sensitive health audiences via ethno-performances may, at the very least, carry consequences such as associated actual injury amongst audients or even litigation for producers.

Conclusion

Since ethnodramatic performance clearly has the potential to either empower through carthartic experience or to have an adverse effect upon (particularly vulnerable, uninformed or naïve) audiences and health care informants it seems critical that researchers in the guise of directors, writers and/or performers act in total collaboration with their informants to provide ethnodrama founded in authentic and collectively validated data. It is also imperative that there are appropriate post-performance debriefing activities and health care professionals on hand to counsel audience members when and if required. The ethical dilemma then becomes whose responsibility it is for harm and distress provoked or produced through constructed catharsis? Still very much committed to the emancipatory promise and potential of ethnodrama's performed report, this email extract between two members of our research team eloquently sums up our concerns for future ethnodrama performances:

> *J: But as the constructors of cathartic encounters, as educators we surely are responsible for the morality and ethics of what we produce. We seek catharsis as a catalyst for therapeutic encounters, therefore we must also take ownership of its implications? ... look at Carolyn Ellis' work on the emotional quagmires of returning to the field ... (and other evidence) of how researchers are impacted*

by their emotional responses to, basically, working with other human beings. I understood our aim to be the construction of a form of cathartic encounter which has implications for specific audiences ...' and since '... we do all of this with the validation and good will of our informants' we acknowledge that '.. we are not alone in creating these consensual representations.'

– email discussion concerning the scene 'Talking with the Devil' in the ethnodrama *Syncing Out Loud* (Mienczakowski, 1992/1994).

Endnotes:

1. Based on a Paper presented at the 18th Qualitative Analysis Conference, Hamilton, Ontario, Canada, 17-19th May, 2001
2. In the sense used here, we refer to those health care clients and their professional carers occupying the marginalised or invisible sectors of the health care system whose needs are finally beginning to be articulated and made public, yet who nevertheless are not considered socially acceptable

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