Manipulating practices

A critical physiotherapy reader

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Performative acts of physiotherapy

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Abstract

There are elements of performance and acting techniques that are relevant and applicable to the (physio)therapeutic encounter. Specifically, we consider Keith Johnstone's heuristic framework of theatrical improvisation around which performers can create interesting narratives and relationships. The concepts of "status" and "blocking" seem particularly pertinent to the therapeutic interaction. Much has been written about the power differential in a variety of healthcare encounters, including physiotherapeutic ones. Collaborative interactions in healthcare are considered favourable, yet physiotherapists have been criticised for continuing to engage in predominantly therapist-centred models of communication. We extend some of Johnstone's theatrical constructs with the theories of feminist post-structuralist Judith Butler to consider how they might be useful in understanding physiotherapists' clinical interactions. For Butler, there is little distinction between personal and political, where even the most mundane-seeming acts are scripted by (and script) hegemonic belief systems. She outlines how identities are formed through

repetition of certain "speech acts", postures and movements. Butler's theories of performativity can help physiotherapists understand how they (re)produce patterns of interaction in clinical encounters that (re)inforce therapist-centred interactions. Understanding these interactions using a Butlerian reading of Johnstone's techniques can provide physiotherapists tools for recognising, and resisting hegemonic physiotherapy practices.

Introduction

As this chapter introduces elements of acting and performance techniques and considers their relevance and applicability to the therapeutic encounter, we thought it relevant to introduce the theatrical aspects of ourselves to provide some context. Before retraining as a physiotherapist, Blaise Doran was a professional theatre actor for 10 years, working in a variety of styles, predominantly modern classics and Shakespeare. Improvisation was one of the foundations of his training, and it was used variously to develop scripts, the emotional tone of a scene and occasionally in performance. In his experience, parallels between physiotherapy and acting exist in the interactive nature of physiotherapeutic encounters, and this nourished his approach to such interactions, particularly in his current work with children and adolescents experiencing chronic pain. A clinical physiotherapist – now an academic – Jenny Setchell also had a career as a physical theatre/acrobatic performer. Her performance work was primarily physical – i.e. she embodied meaning through acro-balance, aerials, and dance. For Jenny, improvisation was a core part of devising new work. The content of her performance focussed primarily on (deconstructing/queering) gender: in many ways a physicalisation of some of Judith Butler's concepts of performativity that we employ in this chapter. We hope to be able to share

some of our insights from our performative worlds with other physiotherapists.

The idea for this chapter came about during a conversation over a beer at a conference. We realised that we both use aspects of what we have learnt as performers to inform how we relate to patients (we use "patient" in its clinical sense, as the recipient of care but acknowledge that the use of the term has been criticised elsewhere [e.g., Langer & Abelson, 1974]). We discussed a number of ideas relating to performance, including that of *status transactions*. The study of status in theatre relates to the idea of a constant, and sometimes subtle, interplay between supremacy and obedience (power relationships) occurring in human interaction. We speculated whether physiotherapists adjust their interpersonal communications, including status transactions, intuitively to address these relationships. Our initial discussion extended to include Judith Butler's concept of *performativity*. Butler (1999) applied her ideas specifically to gender, proposing that gender identities conform to societal expectations as they are continuously replicated/ created through the repetition of particular physical and verbal actions. Gender is not innate, she asserted, but created to society's specification through continual performance (ibid). We suggest this concept of gender performativity may be extended to other forms of identity construction, including "physiotherapist". What constitutes a physiotherapist is not pre-existing: through repetition of particular bodily gestures, attitudes and acts of speech, the recognisable identity of a "physiotherapist" is formed. As we discuss, this recognisable identity also includes certain "status" positioning(s).

While acknowledging that there may be more than one manifestation of this recognisable physiotherapist identity, continuously repeated elements coalesce to produce a kind of normative template. We propose that there is, professionally and socio-culturally,

a collective idea of "a physiotherapist". In keeping with the theatrical theme, we will call this collective idea of a physiotherapist an "archetype". We will delve into the physiotherapy archetype more comprehensively below, highlighting how it is both productive and limiting for the profession, and in turn has implications in terms of physiotherapists' power to regulate, constrain or work to liberate others. We argue that developing an understanding of this physiotherapist archetype presents opportunities to work in ways that subvert problematic power differentials that can exist in physiotherapeutic interactions (see, Harrison & Williams, 2000; Potter, Gordon & Hamer, 2003). To our knowledge, there has been no previous discussion (in physiotherapy or similar health professions) on status, improvisation and performativity in therapeutic encounters.

What we present is an interactional framework, and we argue that awareness of factors such as status can be helpful, particularly when therapeutic encounters become challenging. We acknowledge that this is one way to approach interpersonal communication, not the only way, and that the perspective we present is skewed towards Western cultures, as we predominantly discuss our own experiences – primarily within the United Kingdom and Australia. Nonetheless, we aim to provide an innovative analysis of the physiotherapist's "performance" as informed by established techniques used in theatrical improvisation that should, with considerations of nuance, have relevance across numerous contexts.

Keith Johnstone's "Impro"

Performance training is not a homogenous entity – there are plentiful (sometimes competing) schools of thought and approaches to training. While acknowledging this, we choose to focus on just

one – best known as improvisation, or more commonly, "impro". A consideration of what impro might bring to physiotherapy would be incomplete without exploring Keith Johnstone's pioneering work on theatrical improvisation, which was influential in Blaise's actor training and Jenny's performance devising process. Johnstone had a varied career as an educator, writer, script reader, theatre director and drama teacher. In his monograph, *Impro: Improvisation and the Theatre* (1979; hereafter *Impro*), Johnstone outlines a heuristic framework around which performers can create interesting narratives and relationships. Johnstone likes to simplify, and a superficial reading of *Impro* may leave the reader with the impression that his approach is one-dimensional, and uncritically favours action over thought. However, his work is a complex synthesis of his observations on the processes involved in improvised performance, and diverse conceptual influences drawn from his experiences in education and theatre, which concludes that the creative process (dramatic or otherwise) should be less about thinking and discussion, and more about doing. Johnstone emphasises the process of improvisation is founded on an ability to be aware of, and use, openness and vulnerability. Being comfortable with failure is an important component of this, and we will revisit the concept in the context of clinical interactions. Taking the risk to move away from reproducing the conventional, and embracing difference and newness underpins Johnstone's approach, because (as with critical perspectives in healthcare) the novelty of making "the familiar strange" (Kumagai & Wear, 2014) can be interesting and enlightening. While critical approaches are far from homogeneous, they arguably share with Johnstone a drive to shift customary thinking and established practices.

Johnstone peppers *Impro* with autobiographical details, and his approach to pedagogy is particularly interesting. He describes

working against his formative experiences of school which, as he describes them, were oppressive (involving power and status). He maintains that this constraining type of education stunted his creativity for many years. Johnstone's approach to teaching bears comparison with the methods described by one of the founding thinkers of critical pedagogy, Paolo Friere. Friere (2000) is celebrated for his censure of traditional pedagogic approaches, and what he called "the 'banking' concept of education" (p. 72) where students are conceptualised as empty vessels to be filled with information as if making deposits into a bank account. For Friere, to view the learner as a passive receptacle is a form of oppression that promotes conformity to the *status quo*, rather than a liberating process of dynamic and creative knowledge discovery (for a discussion of this in relation to health profession education, see Halman, Baker and Ng, 2017). While teaching in a working-class area of South London, Johnstone subverted the traditional teaching methods that he experienced as a student (particularly: conforming to rigid strictures, focus on end results, and shunning failure) in order to creatively engage his pupils. It is possible to make connections between traditional teaching methods and the teleological focus (and repudiation of failure) in rehabilitation. Teaching, for Johnstone, is a creative act, and these experiences feed the epistemological stance of *Impro*. Rehabilitation can and should be a similarly creative act; an important factor in our reflections on therapeutic interactions below.

Next, we elaborate on Johnstone's concept of *status*, which we propose forms an important and influential part of therapeutic interactions, and to the performative "physiotherapist archetype". We then extend these concepts further through Judith Butler's (1999) theories of performativity and highlight the relevance to the therapeutic interaction.
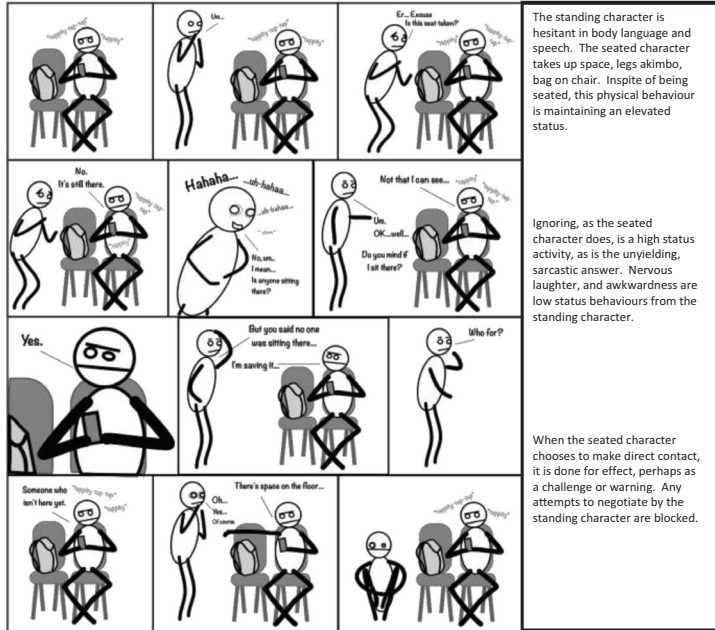
Johnstone's concept of status

"*Status is a confusing term unless it's understood as something one does. You may be low in social status, but play high, and vice versa.*"
Johnstone (1979, p. 36)

Bringing to mind status may evoke thoughts of an individual's social standing and even her/his lineage, conjuring notions of hierarchy. Johnstone (1979), as illustrated by the above quotation, clearly uses the term "status" to describe what one *does* (how one behaves), rather than what one *is* (socially oriented concepts of self). At the core of his interpretation are the concepts of dominance and submission. Working with a group of actors in the 1960s, he struggled to get them to improvise naturalistic dialogue without sounding stilted or dull. His pragmatic solution was inspired by some diverse reading, including Konrad Lorenz's (1952) treatise on animal behaviour; particularly the pecking order of birds. He used "pecking order" within improvisation exercises and, assuming he would be met with resistance if he called it "dominance and submission", he coined the term "status" (Robbins Dudeck, 2013). Johnstone discovered that getting actors to raise their status (dominate) or lower it (submit), even subtly, facilitated remarkable changes in the quality of the dialogue, and physical communication (e.g., Figure 5.1).

He emphasises that the taking of higher or lower status has little to do with an individual's putative social standing. The process is rarely in stasis, as it needs to be continuously verbally and physically modulated. Johnstone believes we all have a preferred status, our default starting point within any given interaction. While he gives little elaboration as to what may influence this (other than it being based on his own observations). Some readers may recognise that there are others who have written about preferred status, and how status may be socially – indeed performatively – created

The standing character is hesitant in body language and speech. The seated character takes up space, legs akimbo, bag on chair. Inspite of being seated, this physical behaviour is maintaining an elevated status.

Ignoring, as the seated character does, is a high status activity, as is the unyielding, sarcastic answer. Nervous laughter, and awkwardness are low status behaviours from the standing character.

When the seated character chooses to make direct contact, it is done for effect, perhaps as a challenge or warning. Any attempts to negotiate by the standing character are blocked.

Figure 5.1: "Is this seat taken?" An illustrated example of how status may work in an improvised performance (source: the authors)

(e.g. Bourdieu, 1977). While we recognise the importance of these perspectives, it is beyond the scope of this text to include them.

Status and performativity

To an extent, Johnstone's interpretation of status resonates with the Butlerian view of performativity, where behaviours, speech and physical actions, continually repeated (something one does) consolidate an identity (the performative self), rather than it being an internalised reality (something one is). Using Butler's perspective, it is possible to consider the identities adopted in different contexts (for our purposes, "the patient" and "the physiotherapist") as conforming to particular kinds of repeated actions, gestures, behaviours and speech. This connects well with the *status* concept (Johnstone, 1979) where

performing particular actions, physical and verbal behaviours, and vocal qualities produce high or low status.

"Performativity" and "performance" have clear similarities – both involve language and vocal tone, physicality and movement, behaviour and affect. In this chapter, we will use the common understanding of "performance" to refer to both the representation of artistic works, and (more subtly) the expression of a tacit agreement between individuals wherein one "acts" a role in an everyday context (i.e. acting offended over something that is said). To understand how performativity is different from performance it is worth looking to the former's original use in relation to speech. Austin (1962) introduced the concept of performativity in relation to the performative nature of certain phrases. Other than what is being spoken (i.e. the words used) Austin (1962) put forward two further elements: The "illocutionary act", which is the speaker's intended purpose behind the words, and the "perlocutionary effect", which is the actual effect the person speaking has on the person they are speaking to. Performativity thus recognizes that speaking involves more than simply the production of words. Butler (1999) goes further, acknowledging the repressive power of language, particularly the elements that are repeated in societal and legal credos, and extending the concept of performativity to non-verbal acts. Performativity, then, for Butler, is the cyclical reproduction through speech, action, physical displays, and so on, that consolidate an identity, and that are validated (or censured) by others.

Butler (1999) is renowned for applying the concept of performativity to gender and, in doing so, extending understandings of the productive power of performativity beyond that of Austin (1962). She deconstructs the idea that gender is a stable or predetermined inherent feature of the individual, refuting the notion that it is something individuals are born with. Instead Butler proposed that through repeated actions of speech, behaviour and mannerisms

(something which we learn, or receive) gender is consolidated, as (for example) masculinity or femininity. As Karen Barad (2007) succinctly depicts, Butler describes gender as an "iterated doing through which [gendered] subjects are brought into being" (p. 57, parentheses added by the authors). Gender is thus understood as perpetually reproduced through physical and verbal actions that constitute subjects through performative acts, and are policed by the expectations of others. There are multiple masculinities and femininities, however dominant forms of gender identities can be restrictive and coercive to those who fall outside of these putative "norms". Butlerian performativity can be extended beyond considerations of gender (e.g., Larsson, 2012), to describe the speech, behaviour, mannerisms and actions that contribute to the formation of other identities. While recognising that (like with gender) there is no single physiotherapist subject identity, we consider the dominant archetype of "the physiotherapist" below.

One way to discuss "the physiotherapist" using Butler's concept of performativity through the work of Johnstone (1979) is to return to our notion of an *archetype*. We will draw primarily on Frye's (1957) understanding of the notion. Importantly, Frye acknowledges Greco-Roman and Judeo-Christian cultural influences on western notions of archetype, and emphasising the quintessential qualities of characters as being recognisable in spite of the differing detail of the narrative (e.g., the hero, the villain, the mentor, the wise woman), particularly if one stands back to see the (mythopoeic) design. This cultural influence is significant for our interpretation, as it opens up the possibility of archetypes being performatively reinforced by the culture from which they emanate. The archetype, then, is the recognisable "normative template" that Butler (1999) might argue is (re)produced through performativity. To use a theatrical example, in *Commedia dell'Arte* (a form of Italian improvisational theatre dating back to the 16th Century), there are four main

archetypes: *Zanni* (servants), *Vecchi* (old men), *Innamorati* (lovers), and *Capitani* (captains), (Chaffee & Crick, 2015). A 16th century audience attending a performance by a *Commedia* troupe would expect to see such stock characters, and expect them to behave in certain ways. They are the genotype to the phenotype of the individual actor's improvised performances - the inscribed model from which all others are made, and are usually strong enough to withstand whatever personal interpretation the actor brings.

To apply the concept of an archetype to physiotherapy, one might perform a simple thought experiment: You are a casting director for a film or television show that is to have a physiotherapist as one of the characters. You must decide what type of actor you would cast so s/he will be easily recognised as a physiotherapist: you will need to make decisions about gender; ethnicity; body shape; mannerisms; and vocal quality. Note that this "archetypal physiotherapist" does not necessarily reflect what you actually see in your workplace but rather the dominant societal concept of a physiotherapist. We created Figure 5.2, below, to show some

Figure 5.2: Possible descriptors of the archetypal physiotherapist (source: the authors)

possible descriptors associated with physiotherapists in Western healthcare settings.

Reflecting upon the elements that you decided formed an "archetypal physiotherapist" may be a revealing process. Physiotherapy (perhaps wishfully) likes to portray itself as a diverse profession, but it is worth considering whether the idea of diversity stays at the forefront of your mind when imagining a physiotherapist and if your first imprint, reflecting a "normative template", suggests something more like the descriptors shown in Figure 5. 2, above.

Because we suggest that the archetype is culturally embedded, something reinforced performatively and reflecting the concepts of Butler (1999), a possible challenge arises: How does the physiotherapy profession encode a different archetype that reflects the constative desire of the profession to be inclusive and diverse? Evolving from this archetype of the physiotherapist may be difficult, because it is mediated by sociocultural expectations from within the profession as well as broader society (Hammond, 2013; Dahl-Michelsen, 2014). Mediators such as training syllabuses, colleague practices and behaviours, patient expectations, professional codes of conduct, and juridical foundations of our scopes of practice (amongst other things) delineate how physiotherapists think, look and act. Thus, Butler's (1999) performativity can be applied to physiotherapy "as set of repeated acts within a highly rigid regulatory frame that congeal over time to produce the appearance of substance, a natural sort of being" (pp. 43-44). The performative view of physiotherapy (as expressed through the archetypal "physiotherapist"), then, is that it is not so much what one *is*, but what one *does.* As a profession, or at least in professional contexts, we collude in this performative act by continuing to embody it. Central to Johnstone's conception of improvisation is the notion that creative risks need to be taken and that failure is expected, even necessary at times, to produce more interesting work. The physiotherapy

profession may need to consider how playful or creative subversions of our established archetype may benefit us, and acknowledge that there may be failures along the way.

The verbal and physical actions that constitute a physiotherapist (e.g., observing bodies move, measuring joint range, interacting with patients, using outcome measures) form a state of doing rather than being. Such constraints exist before one enters the profession, and while individual *acts* of physiotherapy remain unscripted and can be subjectively (i.e. individually) interpreted, once the designation is assumed it becomes difficult to shift or subvert the physiotherapist identity too far out of its relatively fixed framework without consequences. We invite the reader to consider further what constitutes "the physiotherapist" as a performative identity (Butler, 1999). An identity that requires the tacit agreement and observance of received expectations that (taking a Foucauldian perspective) form a kind of carceral system, with its associated network of panoptic resources to ensure compliance, with judgements passed and punishments meted out for those who do not conform (Foucault, 1975; Eisenberg, 2012). As we propose in the next section, this physiotherapist archetype has the capacity to constrain or to liberate through the use of *status* in its performative acts.

The fundamental components of status transactions

While by no means comprehensive, we have emphasised and extended aspects of Johnstone's (1979) concepts of status to consider contexts familiar to physiotherapists. It is probable that many physiotherapists already use parts of these concepts within their work (consciously or unconsciously). Based on our own clinical practice experiences, we suggest that through conscious awareness of therapist's and patient's status behaviours (as will be

outlined below), a greater appreciation of how they influence clinical interactions can be developed. We hope that an exploration of status presents opportunities for physiotherapists to recognise and modulate their own status behaviours in any given context, and to strengthen the therapeutic alliance. It is our reflection that such explicit consideration fosters more positive interactions, particularly when therapeutic relationships become challenging.

There are some fundamental tenets in performed improvisation that are transactional components of status. Perhaps the foremost of these is the *offer*: indeed Johnstone (1979) suggests that anything an actor does is an offer that can be either accepted or blocked. An offer is usually a clear, brief interaction (verbal or non-verbal) that sparks the improvised narrative. In order for any action to advance, the other performer needs to *accept*. If the performer avoids, repudiates, or contradicts the offer this is a *block*. Blocking kills the action, and distracts from the original offer (and performer who offered) shifting the focus to the blocker. However, there are more subtle ways in which blocking is used that feed into status. These do not wholly negate the offer, but alter the status between the two actors as the offer is not fully accepted by one party. Such behaviour is considered by Johnstone to be adopting a high status position. We created a fictitious example (Figure 5.3) to show how this may apply to someone experiencing low back pain who is referred to a physiotherapist by an orthopaedic surgeon.

There is a creative way to prevent "blocking" speech behaviour (both in impro, and everyday interactions) and that is to use "*Yes, and…*" as an answer to patient offers. "*Yes, and…*" is an improvisational concept that allows the action to keep flowing, and it is almost impossible to block another person's offer when it is used. There are clearly other ways to maintain "flow" in an interaction, as we briefly illustrate below (Figure 5.4):

Person with back pain: I'm in terrible pain all the time. I've been told my spine is crumbling, and it's bone-on-bone in parts of it…	[Offer] The person seeking treatment offers their narrative.
Physiotherapist: I see. Who did you hear that from?	[Block] Although apparently accepting, it is non-committal. There is a wariness that the lay interpretation of facts may require correcting with expert knowledge makes it a block, albeit a partial one. This sets up a status differential, so that the therapist takes high status.
Person with back pain: The orthopaedic surgeon told me. I've had an MRI, and…	[Offer] While this appears to try to block the therapist, the person seeking treatment is actually trying to offer their narrative again, but ups the ante to raise their status, by mentioning significant players, and imaging as "proof".
Physiotherapist: I don't think that's what he meant. Can you remember what he told you?	[Block] This is a clear negation of the second attempted offer, then cross-examination. Again, Johnstone would consider this taking high-status.
Person with back pain: Degeneration… or … I don't know… something…	[Offer] Although an offer, the answer is essentially coerced. Status is lowered, verbal qualities start to change (hesitation, loss of confidence).
Physiotherapist: You're probably thinking of degenerative joint disease. That doesn't mean your spine is crumbling. Let me explain it to you…	[Block] The physiotherapist continues to block, through correcting the person seeking treatment, even though the answer was coerced from them. The physiotherapists then goes on to further negate the original narrative; "trumping" the offer maintains the higher status.

Figure 5.3: Example of a physiotherapist-patient encounter to demonstrate offers and blocking (source: the authors)

Person with back pain:I'm in terrible pain all the time. I've been told my spine is crumbling, and it's bone-on-bone in parts of it…	[Offer] The person seeking treatment offers their narrative.
Physiotherapist:Yes, and the way you describe it sounds distressing. Can you tell me what that means to you?	[Accept] Instead of blocking, an affirmative response indicates acceptance of what has been offered. Furthermore, following up with an open question that solicits information maintains "flow".

Figure 5.4: "Maintaining Flow": An example of a physiotherapist-patient encounter to demonstrate offer and acceptance (source: the authors)

Obvious discrepancies in status do appear in clinical interactions, but commonly much subtler status transactions occur. The "see-saw principle" is a term used by Johnstone (1979, p. 37) to

convey the constant give-and-take exchange in status transactions that, in a performance context, are reflective of relatively balanced power interactions in real life. More successful clinical interactions likely rely on the consistent give-and-take of high and low status where both (or all) parties alternate positions; as if on a see-saw (Baker et al., 2011). While eliminating all power differentials may be a challenge, alternating status positions in physiotherapist-patient interactions is a possible way to dynamically share power and promote collaborative practices such as shared decision making (Joseph-Williams et al., 2014). The notion of the expert physiotherapist has been part of modern developments in the profession, with specialisation pathways in Australia, and consultant physiotherapists in the UK as two examples. This is not problematic *per se*, but an awareness of our actions (what we *do*) in relation to use of status might need to be factored in. As physiotherapists, our desire to educate those who come to see us, where people are referred to us for our *expertise*, may end up blocking patient offers with the unintended effect of creating therapist-centred interactions (e.g., Hiller, Guillemin & Delany. 2015) thereby giving higher status to the therapist. Following is a précis of information contained within Johnstone's *Impro* that he suggests are manifestations of high and low status behaviours.

Physical control

Physical control equates to "body language" or physicality. Physicality that creates high status includes enacting precise, efficient and confident movements. High status posture, depending on context, can be relaxed, open and changing fluidly between postural sets (dominating postures), or can be upright and still (intimidating postures). Self-interaction is limited, and often used for a desired effect (such as superciliously holding on to one's chin while

listening to what others are saying). Thus, movement and posture in those claiming high status exudes control. Movements used to create low status are effectively the opposite. Moving tentatively, with twitches, or with poor coordination – or those who move with unusually stiff and awkward physicality enact low status. Johnstone suggests that in adopting low status, the body may be stooped, or internally directed (as if folding in on oneself) or low tone and slack (acquiescent). Low status is also enacted through frequent head movement, and self-interaction that is influenced by the level of nervousness (e.g. covering one's mouth with one's hand, fidgeting with clothing, etc.). As might be expected, in physical terms, those displaying low status exude a lack of confidence.

It should be easy to recall or imagine scenarios in which, purely in terms of physicality, a physiotherapist behaved in a high status manner and the person seeking treatment displayed low status behaviour, according to the above indicators. Certainly, people referred for physiotherapy treatment may be moving awkwardly, stiffly, and so on; the semaphore of "low status". What may be potentially missed from this is that in contrast, the physiotherapist (though their physicality) is likely to enact high status – placing themselves in the "higher" position of the status see-saw from the moment an individual comes to see them. While we re-iterate that this does not apply to all physiotherapists at all times, to conform to archetypes, competence and confidence in movement are part of the stock-in-trade of physiotherapy. However, it is informative that a typical physiotherapist posture (likely created through a continual rehearsal of "good posture" or through conveying a "sporty" image: see Dahl-Michelsen, 2014), can be perceived as high status and potentially intimidating. From a performative perspective, the fit and physically confident archetype of *the physiotherapist* pitted against the patient whose movement has been labelled as "pathological" or "incompetent" creates a status differential. Physiotherapists

see patient physicalities as movement compensations, or as part of psychologically-informed diagnoses like *fear-avoidance*, or *kinesiophobia*, but may neglect to consider the status or performative implications of such physicality. To our knowledge, physiotherapists rarely receive training in these types of broader, sociocultural implications of movement/posture in therapeutic encounters (for an informative discussion see Larsson & Quennerstedt, 2012).

Knowing that particular physical expressions create different status positions might help physiotherapists choose when to change their physicality from their archetypal "correct" posture and movement. The purpose would be to see if such an *offer* is accepted by the patient and if so, to observe if their physicality alters. For example, when a physiotherapist wants to hear a patient's perspective, they might choose to temporarily slouch a little. Try it! We have both found that changing our physicality to claim lower status at times appeared to help create a more two-way interaction with patients. Be aware, that choosing to subvert the physiotherapist archetype (e.g. by slouching) may have any number of other consequences (i.e. a risk that the subversion may fail). There is the possibility, for example, that a patient may perceive a therapist to be less "trustworthy", "competent" or "professional". However, it can be powerful to creatively subvert the archetype, and while both patients and physiotherapists may find it challenging, it is not necessarily negative.

Vocal and verbal control

Physical control theoretically goes in tandem with vocal and/or verbal control. As might be predicted, people adopt high status positions by speaking in a volume "suitable" to the context, modulating pitch and tone accordingly, with fluidity, and accepted prosody. Vocal and verbal behaviours that enact low status might

include speaking in a voice that is quiet and/or monotonous or a volume that is considered inappropriately loud for the context. The speech may have an overly rapid, blurting quality, or may equally be hesitant and mumbling, and there are likely to be fillers ("*um*", "*er*", "*ah*", "*like*", etc.). On the last point, Johnstone (1979) makes a distinction between how fillers may be used differently to create high or low status. Vocal fillers generally transmit hesitation and lack of confidence (low status), but high status behaviour may be to extend those sounds to take up aural space so that others cannot interrupt.

It is likely that physiotherapists moderate their vocal quality to suit various patient situations. When considering that around half the physiotherapeutic encounter may be verbal (Roberts & Bucksey, 2007; Roberts, Whittle, Cleland & Wald, 2012), both vocal quality and verbal content are bound to be influential. To our knowledge, there is no physiotherapy-specific examination of vocal quality. However, within medicine, some researchers discuss an association between affect conveyed by vocal tone and malpractice litigation against surgeons (Amabady, LaPlante, Nguyen, Rosenthal, Chaumeton & Levinson, 2002). There may also be a long-lasting negative influence from what clinicians say to people experiencing low back pain (Darlow, Dowell, Baxter, Mathieson, Perry & Dean, 2013), and a need to recognise the emotive nature of orthopaedic vocabulary (Vrancenu, Elbon & Ring, 2011). Physiotherapists may wish to consider their own vocal qualities, reflecting upon the contexts in which they use high or low status vocal qualities with patients. For example, a physiotherapist might use confident-sounding, high status speech when disagreeing with a patient on a diagnosis. This could be problematic if the patient consequently feels less comfortable about raising doubts. A greater awareness of the effects of vocal quality, and acknowledging the possibilities for disrupting usual performative physiotherapist voice, might help provide physiotherapists with options to work differently.

Touch

Johnstone makes surprisingly little of the use of interpersonal physical contact in *Impro*. The clearest examples he provides relate to the crossing into someone else's peri-personal space intentionally (in order to make them uncomfortable, creating high status) or as a gaffe (creating low status). These examples are, however, simplistic; the nuance of interpersonal touch, and the myriad contextual factors that influence it have been stripped away (likely to gain more comedic effect).

The question of touch in a physiotherapeutic context (and how it relates to status) is difficult to establish, as touch has a host of factors that influence it. Nonetheless, considering the importance of touch in physiotherapy it is worthy of reflection. In a physiotherapeutic context, touch is often expected/desired (Nicholls & Holmes, 2012) and thus may not be experienced as an invasion of personal space. Because touch is a foundational element of physiotherapy, there is an expectation that it forms part of treatment, so it may or may not produce the high status often produced by touching someone in other contexts (for example: guiding someone by the elbow as they walk, or patting someone on the back or head often generate high status). On the other hand, relevant positions of high (therapist) and low (patient) status may be reinforced with patients who fear pain associated with touch, are uncomfortable with a stranger touching them, or simply dislike it. Physiotherapists have only just begun to explore such elements of "doing" physiotherapy. Notably, in a study of physiotherapist-patient interactions, Hiller et al. (2015) observed that while dialogue was often practitioner-centred (i.e. the physiotherapist adopted high status) this was frequently tempered by the use of touch and casual conversation, which these authors argued produced more balanced status interactions. There is considerable nuance to discussions of the status produced from touch in

a physiotherapy setting – individual contexts are important to consider in any given interaction.

Status as communicated by the environment

The relationship between environment and status is something Johnstone addresses only briefly. He suggests that status transactions are not exclusively with another individual, but can be with the environment itself, and dominance and submission (status) can be seen in the context of territoriality. Referring to *space*, he proposes that environments and objects can influence whether an individual takes high or low status; the socio-cultural meaning of which is explored in more depth by social theorists such as Ahmed (2006), and Bourdieu (1977). Thus, the status of a physiotherapist (and the individuals using physiotherapy services) is likely to vary if their environment changes. For example, when a primarily outpatient-based physiotherapist is required to work on an inpatient ward, or an inpatient therapist is required to work in domiciliary rehabilitation, there are likely effects of the different status of different work environments as well as a possible drop in status due to reduced familiarity with surroundings. Regardless, in all these scenarios, the physiotherapist usually leads (adopts high status) and the individual seeking treatment acquiesces (adopts low status). When in the rehabilitation gym, the physiotherapist is in a familiar environment, moves comfortably and confidently, knows what the equipment is called and how to use it. A patient unfamiliar with this environment must conform in order to interact, and it is likely that conformity will mean deference (lowered status). The environment, then, can influence status transactions and identity formation of the physiotherapist and patient through the trappings of the physiotherapy workplace, such as plinths, parallel bars, training equipment (Nicholls, 2012). They are an intrinsic part of the performativity of physiotherapy.

Conclusions

Becoming aware of what occurs in status transactions might assist physiotherapists in forming more helpful therapeutic alliances with patients. The contextual identities we inhabit (our performative selves) tether us to unconscious subroutines of behaviour, which in turn serve to reify a particular type of physiotherapist. Status is an inherent part of performing "the physiotherapist". The physiotherapist may be seen, through repetitions of various actions, behaviours and speech acts to be at once an arbiter, a sage, and a master of their craft; granting permissions, imparting knowledge; dexterous and restorative in their handling. The client seeking treatment may likewise be perceived as the vessel (perhaps vassal) that is the receiver of this combined acumen, but who is also asking for help. For this to be the case, the hierarchical nature of the relationship as described requires conformity to the model it puts forward, which is why it may be described as performative. Reflecting on this, someone labelled by a physiotherapist as *an engaged patient* may be conforming to the status that his/her performative identity allows: an identity that has been constructed, reproduced and internalised by patient and physiotherapist alike and which manifests in their behaviour and judgments. Conversely, the *challenging patient* may resist this construction, perceiving herself to be of equal or higher status than the physiotherapist, and conflict arises from each agent constantly vying for high status. Neither of these scenarios is necessarily helpful for achieving what is arguably the ultimate goal of physiotherapy – meaningfully improving the lives of those who seek care. A power difference tipped towards the physiotherapist is likely to reduce the ability for patients to bring their own needs and meanings into physiotherapy encounters. With a greater awareness of the performative nature of enacting "the physiotherapist",

and its status implications, we may be able to contribute to addressing power discrepancies, and subvert our entrenched performative identities. Doing so should open up opportunities to act and speak in ways that creatively play with what it means to be "a physiotherapist" and "a patient" – providing more options for agile, tailored care for those who seek it. Furthermore, in the spirit of *Impro* we should not be afraid to fail at doing so, or at least become more comfortable with it. Understanding physiotherapy through theatre and performance techniques offers a way to scrutinise what we do as physiotherapists. Exploring status and performativity offers specific "thinking and doing" approaches that are not usually part of physiotherapy training.

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