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Clowning Within Drama Therapy Group Sessions: A Case Study of a Unique Recovery Journey in a Psychiatric Hospital

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Abstract

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A Case Study of a Unique Recovery Journey in a Psychiatric Hospital

Johanne Roy

This qualitative research delineates the recovery journey of four persons with severe mental illness that experiment, from within, with the healing potential of creating, playing and acting a clown character in a context of ten drama therapy group sessions. The analysis of the therapeutic process of the group is viewed through the lens of Renee Emunah's Integrative Five Phase Model while each participant's journey is analysed by using the Recovery Model in Mental Health proposed by Nora Jacobson and Dorothy Greenley. The results reveal that playing and acting as a clown character enabled participants to laugh at themselves and, together, express significant issues from the personal struggle of living with a mental illness. The results also expose the beneficial effects of the intervention on each individual's recovery journey, highlighting the fact that drama therapy is a recovery-oriented approach as it can enhance hope, healing, empowerment and connection. Despite the limitations of this qualitative case study, the author believes that the drama therapist should embrace the Recovery Model in Mental Health. Supported by the use of humor in research, joy and laughter as an applied therapeutic intervention has shown cognitive, physiologic, social and emotional benefits; since clown figures have long been associated with psychological healing, the author argues that therapeutic clown training should be included in the drama therapy university curriculum.

Acknowledgements

This research project is the final act of a long epic performance! Now that the curtains are closing as I am writing this final note, I would like to dedicate a standing ovation to the entire cast that supported and inspired this creative process.

Thank you to Stephen Snow, who was perfect in his supervisor / stage director role. Stephen was an inspiring guide as he listened, encouraged and challenged my thoughts along this path. Thank you Stephen, it was a real pleasure working with you.

Thank you to all the supporting actors which include managers and colleagues from the psychiatric hospital where I held the drama therapy group sessions. *Un gros merci à* Hélène R., Sandra C., Annie G., André T., Nelson V., Mike C. and Claudine A. *Un merci tout particulier à* Michel L., who was the first one to believe that this clowning experience would be beneficial for people struggling with psychiatric illness. Thank you so much Michel.

A very special thanks for Luc, my life companion. You were always by my side in this journey of hope, healing, empowerment and connection.

I am also grateful to Patch Adams and Kathy Blomquist for the inspiring journey I experienced in Virginia.

Finally, I would like to praise the best guides of all, the clown participants of the drama therapy group sessions with whom I shared unforgettable moments on the paths of their recovery journey.

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Introduction

Health is based on happiness – from hugging and clowning around
to finding joy in family and friends, satisfaction in work, and ecstasy in nature and arts.

As a doctor, I believe that *it does matter to your health to be happy.*
It may be the most important health factor in your life.
(Patch Adams, M.D.)

Patch Adams: The Recovery Journey of a Clown

After a suicide attempt, Patch Adams, was admitted to a psychiatric hospital. He declared that the greatest impacts on his recovery were not doctors but his family and friends, his roommate and other patients' stories (1998). Adams was astonished that patients' stories all shared similar threads of loneliness and lost dreams. He claimed that his hospitalization forced him to formulate a philosophy about happiness and love and, like a scientist, he applied his own medicine and started to examine its impact on his life. "Nurtured by levity and love, I blossomed. I defeated all my demons and became the person I am today. My self-confident, love of wisdom, and desire to change the world were rooted in that brief period, when I climbed out of despair to rebirth" (Adams, 1998, p. 9). Adams has certainly found a way to connect to the world. By becoming a famous mental health provider and advocate, he is a living example of the possibility of recovery. Patch Adams has become a celebrity in medical circles. Doctor, clown and social activist, he is still pursuing his dream: to build a holistic rural hospital and health care community based on his healthcare vision. Adams' recovery journey and philosophy on human care were the first building block of this research project.

During my training as a drama therapist, I had the opportunity to attend a seminar with Patch Adams, members of the Gesundheit Institute and the School for Designing a

Society. I will never forget this amazing adventure where I had the chance to reflect exchange and create a project based on Adams' philosophy with other health care professionals from around the world. I also experienced being a "caring clown" and realized the amazing power of "being happy and offering joy" to others, but mostly to myself. This clown experience was amazingly nourishing and rejuvenating especially for a nurse recovering from burnout!

After the completion of my second year in the Drama Therapy Masters programs, I accepted a position as a clinical nurse specialist in a Psychiatric Hospital in Montreal. My first assignment was to follow a "training for trainer" seminar on the Recovery Model in mental health offered by David Stawner and Dietra Hawkins, from Yale University. I soon discovered how similar the Recovery Model in mental health was with the Patch Adams philosophy of care as both visions shared similar core concepts based primarily on hope and being able to live a meaningful life despite a person's illness. Therefore, Patch Adams' philosophy, the recovery vision in mental health and my own experience are the guiding path of this research project.

Finally, in preparation for this research project, I felt the need to personally complete a clown workshop as such training is not part of the drama therapy curriculum. This workshop was a rewarding and enjoyable experience which provided me with new skills and insights. It helped me integrate a few basic principles of the clown's work within the drama therapy session. After the encounter with my clown character I felt somehow ready to start this "red nose" adventure.

The Story of this Research Project

The project of clowning with psychiatric patients seemed to be, at first, an unreachable endeavor as I was anticipating major resistances from health care professionals on the field. But, an unexpected event opened the path of this research journey. On October 17, 2007, on a short notice, I was asked to present a conference to the nursing staff by the Director of nursing at the psychiatric hospital where I just started working. I decided to offer the Patch Adams presentation that I previously prepared as an assignment for a university course in my Masters program. The conference was a success. I gave the same presentation on other occasions at the hospital for audiences made up of health care professionals and patients. The evaluations of my presentation revealed that participants were touched by the human and caring message I delivered and many of them reflected on the lack of joy and laughter in their personal and professional life.

> Health education does little to develop the skills of levity. On the contrary, hospitals are notorious for their somber atmosphere. Although hospital staff members may enjoy camaraderie among themselves, with patients their goal seems to be to fight suffering with suffering. What little humor there is occurs during visiting hours. (Adams, 1983, p. 66)

While professionals and patients are suffering form the lack of this fundamental human experience, activities that promote and instill joy and happiness are not part of the "Patient Care Plan."

I believe that humor and laughter are a universal medicine. Clowning as an art form invites play, interaction, and above all laughter. Therefore, I thought that clowning

as a component of a drama therapy group process could facilitate the recovery journey of a group of person with severe mental illness.

Recovery Model in Mental Health

Psychosis: Nature versus Nurture

Two central opposing theses are offering explanation for the understanding of mental illness: the 'nature' and the 'nurture' standpoint. The nature view offers a biophysiological explanation which attributes mental illness to chemical imbalance while the nurture thesis suggests that psychological, social, cultural, environmental, biological, and experience-based problems are actually the root of mental illness (Wheeler, 2008; Raingruber, 2003).

In the first thesis, nature is held responsible. Wheeler (2008) specified that the cause of mental illness is correlated to an imbalance of neurotransmitters in the brain as such; the answer lies in correcting the imbalance largely through medication. This new understanding has revolutionized psychiatry and is dominant since 1950s, especially with the discovery of a new promising medication for the treatment of those with chronic mental illness or psychosis (p. 17). On the other hand, as cure relies mostly on focusing exclusively on pharmacology treatment, Wheeler argues that the vast majority of nurses disapproved having to be relegated to a "spectator observation" role on psychiatric unit and they questioned whether if such an approach would reinforce the barrier between "caregiver and recipient" and that a focus on "genetic determinism could lead to greater marginalization of the mentally ill" (Raingruber, 2003, p. 108).

Thus the second thesis argues that there is more than nature in the explanation of mental illness. Consequently, mental health nurses claim a healthy respect for patient individual story and they advocate for "a place for in depth processing of confusion and longing for connection" (p. 109). The author maintains that even if patients feel that their

needs for safety, structure, and medication have been met, they "express a longing for a deeper connection with staff and more intensive insight oriented therapies" (p. 109). Finally, like Patch Adams, Raingruber (2003) argued that the lack of human interchange between patients and nurses explains the high level of burnout experienced by mental health staff. "It is not standardized interventions but rather caring, individualized ones that build on client strengths and provide mental health nurses with a source of joy, job satisfaction, and enthusiasm in their practice" (p. 109). She added that in 1999 Van Manen, cautioned the mental health field about the "medicalization of life."

> There is a "defying difference" about being human. Free will, volition, and one's uniqueness as a person influence health outcomes. This is not to say that humans have unlimited freedom. Rather, humans exist in a world of situated freedom and choice – a world that is bounded by their culture, experience, past history and biology, and hopes for the future. (Heidegger, 1962, cited in Raingruber, 2003, p. 111)

New Paradigm in Mental Health

Despite long held assumptions about the chronic and deteriorating nature of serious mental illness, a new paradigm has emerged in the field of mental health. Jacobson and Greenley (2001) asserted that the publication of a major study conducted by Harding, Brooks and Ashikaga in 1987 of first-person accounts describing their experience and how they managed to recover, had a major impact on the mental health field. The result of this study revealed that "the course of severe mental illness was not an inevitable deterioration" (Jacobson and Greenley, p. 482). This new story about recovering from a severe mental illness included voices of organized advocacy groups of

consumers[1] started to create a wind of change in the field of mental health around the world.

Consumers brought forth the fact that the process of recovery involves more than recovering from the illness itself.

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of a new meaning and purpose in one's life as one grows beyond catastrophic effects of mental illness. (Anthony, 1993, p. 15)

Consequently, Onken, Dumont, Ridgway, Dornan and Ralph (2002) asserted that recovery services should be person-oriented, respect people's life experience and expertise, address people's needs holistically and contend with more than their symptoms.

Recovery Conceptual Model

Lester and Gask (2006) specified that few conceptual models have been developed to capture the basic elements of recovery. Nevertheless, the model created by Jacobson and Greenley (2001) had the advantages of synthesizing and simplifying the basic characteristics of this human journey without losing its essence. In order to create their model, the authors analyzed numerous accounts from people describing themselves as being on a journey of recovery. Based on their findings, their model is constructed on internal and external conditions. They discovered that the internal key conditions in this process are hope, healing, empowerment and connection. On the other hand, human

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[1] Widely used in Mental Health Recovery literature, the term *consumers* describes any individual who does or could receive health care or services. The definition comes from the Mental Health Dictionary, US Department of Health & Human Services, Substances Abuse & Mental Health Services (SAMSA), retrieved on August 21, 2009 from http://mentalhealth.samhsa.gov/resources/dictionary.aspx#C

rights, a positive culture of healing and recovery-oriented services were identified as being the key components of the external conditions. All of these conditions have a reciprocal effect as they all influence each other. For example, Jacobson and Greenley (2001) explained that reducing social stigma eases the internalized stigma that impedes the ability for some people to define a self apart from their psychiatric diagnosis. As for collaborative relationships between health professionals and people in recovery, the author believed that it empowers both parties, by allowing meaningful power sharing and more mutual assumption of responsibility. However, in the context of this research, only the internal conditions will be considered and, therefore, discussed.

Hope

Hope is the essential component of recovery. "It lays the groundwork for healing to begin" (p. 483). At the most basic level, it is the belief that recovery is possible. Jacobson and Greenley also specified that the attitudinal components of hope are:

> recognizing and accepting that there is a problem, committing to change, focusing on strengths rather that on weaknesses or the possibility of failure, looking forward rather than ruminating the past, celebrating small steps rather than expecting seismic shifts in a short time, reordering priorities, and cultivating optimism. (p. 482)

They explained that for people in recovery, gaining hope has a transcendent effect and that its source could be different for each individual. For some, it might be through a spiritual connection with God or nature; for others, it could be through an artistic process.

Healing

Jacobson and Greenley (2001) emphasized the importance of remembering that healing is not synonymous with cure. They explained that in fact, the healing notion of recovery in mental health is a process that has two components "defining the self apart from the illness and control" (p. 483). As Estroff as noted in 1989 in a study on the self, identity and subjective experiences of schizophrenia, people who have psychiatric disabilities often find that they lose their "selves" inside mental illness.

> Recovery is in part the process of "recovering" the self by reconceptualizing illness as only a part of the self, not as a definition of the whole. As consumers reconnect with their selves, they begin to experience a sense of self-esteem and self-respect that allows them to confront and overcome the stigma against persons with mental illness that they may have internalized, thus allowing further connection with the self .(Jacobson and Greenley, 2001, p. 483)

The second healing process is control. The author specified that control has a double meaning. Firstly, it refers to finding ways to relieve the symptoms of the illness or reduce the social and psychological effects of stress by adopting diverse strategies (i.e. medications, self-care practices, etc.). Secondly, control refers to the locus of control. They stated that on a recovery journey, the person has to take control by becoming an active agent of his or her own life.

Empowerment

Simply stated, empowerment can be understood as "a corrective for the lack of control, sense of helplessness, and dependency that many consumers develop after long-term interactions with mental health system" (Jacobson and Greenley, p. 483). The sense

of empowerment may be facilitated by external conditions but it emerges from inside one's self. For Jacobson and Greenley (2001), empowerment has three components: autonomy, courage and responsibility. In order to develop autonomy, or the ability to act as an independent agent, the tools needed are knowledge, self-confidence and the availability of meaningful choices. In this model, courage refers to the willingness to take risks by stepping outside of safe routines. Finally, responsibility stands for the person's obligation in his own recovery, because "full recovery requires that consumers live with the consequences of their choices" (p. 483).

Connection

Connection is a way of being in company of others and is a crucial component of the recovery process. This internal condition captures the aspect of reintegrating the community and has to do with what some consumers have called "getting a life." The authors asserted that "to connect is to find roles to play in the world" and they reported that for some consumers this means "becoming a mental health provider or advocate" as for others, "it means bearing witness, or telling their own stories in public arenas" (p. 483).

> In all these capacities, consumers increase the general understanding of what it is like to live with a mental illness. They find ways to validate and reconcile their own experiences, and by standing as living exemplars of the possibility of recovery, they serve as role models for others. (p. 483)

In sum, the recovery model proposed by Jacobson and Greenley offers a solid and valid framework for drama therapist working with people with severe mental illness. It is a guiding vision for drama therapist who wishes to assist people recovering from

psychiatric disabilities in their recovery journey. The Recovery Model is consistent with the values of the drama therapy field, which is committed to help people achieve psychological change and growth.

Clowning and Drama Therapy

Drama Therapy

Drama therapy is a recovery-oriented approach with the focal point being the potential for growth and change. Simply stated, it is a form of therapy that uses techniques derived from drama and theater and applies them to the process of healing. Drama therapy is an active and creative form of psychotherapy that engages the person's strengths and potentialities (Emunah, 1996, p. 31). Based on humanistic psychology, drama therapy "elicits and expands the healthfulness of the person" (Emunah, 2000, p. 71). Consequently, the healing potential of this approach relies on the process of creating, playing and acting, thereby offering a more holistic experience for healing.

Drama therapists believe that the healing process is enhanced by the shift from fictional work to spontaneous personal connection. Indeed, Jones (2005) specified that change occurred through drama processes when "a connection is made between the client's inner world, problematic situation or life experience and the activity in the drama therapy session" (p.41). For Emunah (1996) "the use of drama as therapy fosters liberation, expansion and perspective". She explained that drama therapy "invites us to uncover and integrate dormant aspects of ourselves, to stretch our conception of who we are, and to experience our intrinsic connection with others" (p. xvii).

Emunah, as many other drama therapists, who have worked with psychiatric patients (Johnson, 1980; Emunah & Johnson, 1983; Schnee, 1996; Grainger, 1992; Snow 2000, Casson, 2004), agrees on the beneficial aspects of the drama therapy process. In fact, Grainger (1992) stated that drama therapy is an appropriate form of psychotherapy for people diagnosed with schizophrenia because it provided the following: "a secured,

boundaried, structured yet free, playful space where there is relaxation, rehearsal and validation" and he added that "drama is a playground for the release of interpersonal tension and a laboratory for the safe anticipation of events" (Grainger, 1992, p. 165).

While drama therapy techniques may differ from one therapist to another, there are concepts that are common to all forms. To illustrate how the healing potentials of drama and theatre are realized through drama therapy, Jones (1996) has determined nine core concepts. In the context of this research, I have restricted my choice to four of these therapeutic factors for their apparent compatibility to the therapeutic goal of this research project.

Dramatic Projection

A fundamental concept in drama therapy is the process of dramatic projection. From a psychological standpoint, projection is defined as a defense mechanism unconsciously used by individual displacing unwanted feelings onto another person or things. Jones (1996) considered that this mental process is often the inspiration of a creative activity (p. 129). As such, drama therapy encourages this mental phenomenon and uses this process to therapeutic ends. In drama therapy, projection becomes an expressive tool rather than being exclusively a defensive reaction. By projecting their problems out into dramatic material, it creates a means to both express and explore the participant's difficulties (Jones, 1996, p. 132). Many projective techniques can be used in the course of drama therapy group sessions, such as play with objects, improvisation and creation of characters.

For instance, in the context of a therapeutic process, a clown character can provide a creative and projective tool through which participants can discover and work unconscious contents.

> I created my first clown character as a teenager. As a cool and rebellious young woman, it was difficult for me to express my childlike feelings. My clown character provided an outlet for me to experience the world with the wonder, love and joy of a child. As an adolescent, I refused to admit theses qualities into my persona. However, I maintained them and even shared them with others through my clown character. (Carp, 1998, p. 249)

Empathy and Distancing

Jones considered that empathy and distance are two processes that are closely linked within the context of drama therapy. Using theatrical method of working characters, Jones explained that empathy refers to the created bond between actor and audience which relies upon the audience capacity to "identify with and engage in the characters portrayed" (p. 104). On the other hand, distancing is viewed as a process in which the "actor does not allow himself to become completely transformed on the stage into the character he is playing" (p. 104).

In order to explain the close relationship between those two concepts, Casson (2004) specified that "the more we are distanced from the other the less empathy we may have" moreover, "the less distance we have from the other the more likely we are able to be overwhelmed, be a victim if the other has no empathy"(p. 122). The concept of distancing has two polarities: undersdistance and overdistance. Therefore, in order to

achieve a healthy psychological balance, one has to be able to vary the distance between oneself and others according to the circumstances and one's needs.

Casson (2004) noticed that many people with psychotic disorder did not have "sufficient experience of an empathic career" (p. 122). He believes that the lack of empathy of the professional heath providers might originated by their fear of being "flooded by the needs and feelings of the psychotic patient" (p. 122). As such, they professionally overdistance themselves. Like Casson, I believe that drama therapy can offers way to provide safe distance when needed.

> To discover a balanced, middle distance and healthy relationship of self and other, the person needs a holding where this is modeled and enabled. The person may go from overdistance to underdistance and needs to discover a middle ground, like Winnicott's potential space, where play and creativity are possible, where it is possible to voice feelings and grow as a whole person. (Casson, 2004, p. 123)

Interactive Audience and Witnessing

For Jones (1996), witnessing "is the act of being an audience to others or to oneself" (p. 112) and both aspects have equivalent importance within the process of therapy. Jones explained that "the degree of consciousness of the role of audience can vary greatly" but "alternatively the role of the audience member can be clearly delineated" (p. 111). In the context of this research, I chose to create such a clear distinction for the play space, the area to engage in enactment, and the audience, an area where participants had the opportunity to witness without actively playing. This way of working created more distance between one state and the other and the act of witnessing was made more visible. This clear distinction can serve a number of purposes:

> the creation of safety, the enhancement of boundaries concerning being in an out of role or the enactment, to heighten focus on concentration, to heighten the theatricality of a piece of work. The shift from audience to actor can act as a pivot for change, enabling perspective and insight. (Jones, 1996. p. 111-112)

For the purpose of this research, the use of the "audience chairs", as suggested by Casson (2004), was offered to participants in order to give them the opportunity to say "no" and withdrawing without prejudice from any activity if they needed to distance themselves and observe. This strategy also "reduces the likelihood of a client dissociating to escape overwhelming materiel" (Landy, cited in Casson, 2004, p. 244).

Furthermore, the relationship between the therapist and the client being an essential component of any therapeutic process, "the therapist acts as a witness for the emerging clown character and as a guide for the client's psychotherapeutic process" (Carp, 1998, p. 249). "In this way, the therapist's witnessing stance helps the client invite new aspects of the psyche to emerge through movement in the form of a clown" (p. 250).

Playing

> Psychotherapy has to do with people playing together. The corollary of this is that where playing is not possible then the work of the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play (Winnicott, 1991, cited in Casson, 2004, p. 213).

For Winnicott, it is only through playing that a person, adult or child, is able to be creative and use its whole personality and by doing so, discover their self.

Drama therapists recognize the healing potential of playing. As such, the therapeutic process encourages playfulness, uses play as an expressive form, adopts a

developmental model of play within the process of therapeutic change and finally, facilitates the healing process by creating a play space (Jones, 1996, p. 115). In order to create a state of playfulness, the initial stages of sessions invited participants to play. First sessions are important, because, as Emunah (1994) stated, they are the foundation of the work that will follow.

But most importantly, drama therapy is fun. John Casson (2004), a drama therapist who completed his doctoral research working with people who hear voices and had psychotic experiences, discovered that "participants regarded fun as the single most helpful element in drama therapy and psychodrama" (p. 212). Casson, who views the role of therapist as a playmate, makes the point that the fun and play components of drama therapy helped people with psychosis in the healing process of recovering their sense of self.

For Casson, it is "through play, spontaneity and creativity that the self is rediscovered, reclaimed, reborn" (p. 212). Lack of spontaneity is a common symptom in psychiatric disorder as such; according to Emunah (1983), improvisation is an ideal modality for the development of spontaneity:

> Spontaneity entails a degree of imagination and inventiveness. The development of imagination helps psychiatric client to achieve a sense of humor and perspective, to see beyond the present reality, to discover options and the capacity of transformation. (p. 80)

As mentioned earlier, I considered clowning as an art form that invites play, interaction, an above all laughter. Therefore, I thought that clowning as component of a drama therapy group process would facilitate the recovery journey of a group of person

with severe mental illness. Consequently, in the context of this research, I invited participants to play as clown character in the first stage of the drama therapy session.

Clowning

Therapeutic Humor

Humor is a universal phenomenon that occurs in all culture. Much has been said about the healing power of humor and laughter, and many studies in healthcare recognized the beneficial effect of humor (Heather, 2002; Chirstie & Moore, 2005; Adamle & Turkoski, 2006). The Association for Applied and Therapeutic Humor (2000) defines therapeutic humor as "an intervention that promotes health and wellness by stimulating a playful discovery, expression, or appreciation of the absurdity or incongruity of life's situations." Benner (as cited in Harrington, 2009, p. 33) asserted that "laughter, among other remedies, can help us sleep better and bring a more positive, joyful attitude to our lives. It can help us think better, get out of emotional ruts, connect with other people, and release emotional pain."

Although research about the use of humor, joy and laughter as an applied therapeutic intervention has showed cognitive, physiologic, social and emotional benefits, Harrington (2009) specified that there is still a lack of empirical research on the subject. Still, he stated that recent studies have revealed that humor and laughter have been especially helpful with depression and obsessive-compulsive disorders. Regarding people with psychiatric disorders, the benefits include "boots in hope and self-worth, as laughter can replace negative thoughts with positive ones" (p. 34).

Another potential advantage of the use of humor in therapy was related to the improvement of counseling sessions, "as shared laughter between counselor and client can foster trust, rapport and reduced defensiveness" (Harrington, 2009, p. 34).

And, with regard to the ability to laugh about ourselves, Beverly Bender, a trained laugh leader specified that:

> People who are able to make fun of themselves display high self-esteem. They are secure in themselves and don't take themselves so seriously. It also builds resilience. Being able to laugh at ourselves can help us when we face difficult situations in our lives. (as cited in Harrington, 2009, p. 35)

As such, she added that self-deprecating humor, in which we make fun of our own faults and shortcomings, can be especially powerful for persons with psychotic disorders. Indeed, Granirer (2007) based his intervention on teaching comedy to people with mental illness as a way of building confidence, fighting stigma, and coping with stress and adversity.

Yet, even with all its apparent and recognizable benefits, therapeutic humor must be handled with care. Indeed, during a psychiatry-humor workshop held at APA's annual meeting, advice was given by psychologist Ed Dunkelblau to psychiatrists on the use of humor in a therapeutic context. Dunkelblau advised psychiatrists to: "avoid sarcasm, sardonic humor or humor directed at their patients and instead use humor directed at themselves." Aside from using the right kind of humor at the right time, he added that "it is also crucial to use it only with certain patients." For example, humor is often a good way to handle patients' delusions, but with paranoid patients, first "you put a couple of

toes in and see how the patients respond" (Dunkelblau cited by Arehart-Treichel, 2008, p. 5).

Therapeutic Clowning

Many scholars, such as Miller Van Blerkom (1995), Ott (2007) and Koller and Gryski (2007) have stated that clowns have been around in one form or other in every civilization. Based on her literature review, Miller Van Blerkom has determined that clowning originated with shamanistic performances. The author explained that both clowns and shamans "mediate between order and chaos, sacred and profaned, real and supranatural, culture and anticulture, or nature"(p. 463). She also highlighted the fact that "in the language of semiotics, clown performances are metacultural texts, acts of communication about culture that invert cultural rules, thereby provoking emotional responses" (p. 463). Therefore, while she asserted that clown figures have long been associated with psychological healing, Ott (2007) specified that clowns use interactive performance to "focus on developing new perspectives, insights, and discoveries for those with whom they interact" (p. 314).

The use of therapeutic or caring clowns in health care facilities originates from the belief that humor has a salutary and healing potential (Cohn Jones, 2000; Miden, 2002; Patenaude & Brabant, 2006). Clowns in a hospital setting have been around for some time and their role have generally been to bring play, humor, and laughter into the facility for the benefit of the patient, family members, and staff (Cohn Jones, 2000; Spitzer, 2006; Koller & Gryski, 2007). Koller and Gryski (2007) explained that in the last decade, there was a rapid expansion of clowns in health care settings around the world, which resulted in different levels of professionalism and accountability. In Canada,

organizations such as Dr Clown (Montreal) and Fools for Health (Windsor) follow the steps of Patch Adams and the Big Apple Circus Clown Care (New York), by offering clown-doctor performances with specially trained professional artists providing therapeutic humor to patients.

Despite the growing number of clown programs around the world in hospital setting mostly within the pediatric population, Koller & Gryski (2007) stated that there is a paucity of research on therapeutic clowning, and added that they have not been widely disseminated. However, these few results have shown that "therapeutic clowns are most effective when they are specially trained to work in health care setting, and when they function as members of the health care team" (p. 9). As a next step for future research and practice, the authors proposed a model of therapeutic clowning which is based on three key concepts: 1) empowerment, 2) play and humor and 3) supportive relationship, which can be adapted to a variety of settings for children's care.

Although the field of therapeutic clowning with sick children is growing, Patch Adams (2002) deplored the fact that clown programs are mainly offered to children bedside care when he expressed the view that: "hospital clowns have spent most of their time in pediatrics, and I have from the beginning encouraged clowns to go to the adult wards as well. I actually prefer clowning with adults because they have a much broader life experience" (p. 447). Even though, Koller and Gryski reported that volunteer caring clowns visit countless hospitals and nursing homes in United States and Canada, no evidence has been found yet that clown intervention programs are also offered to adult psychiatric population. After a reasonable in dept exploration, only one pilot project conducted in a psychiatric clinic in Germany was found (Wild, Wetzel, Gottwald,

Buchkremer and Wormstall, 2007). In the context of their pilot study, the researchers examined if a weekly visit of a specially trained clown, as established in pediatrics services, would also be beneficial in a psychiatric service. After an experiment period of 6 weeks, they discovered that patients had more positive attitudes. As such, the authors argued that since positive effects have been demonstrated, there is sufficient reason to initiate similar projects in the future.

However, in the context of therapeutic clown works, Koller and Gryski (2007) specified that it is important to keep in mind that some children, young people and adults are afraid of clowns, "whether because of the unfamiliarity of the make-up and costuming, because of unfortunate incidents with unskilled and insensitive clowns or because of the fairly recent appearance of 'evil clowns' in the media" (p. 5). The authors explained that in order to deal with some of these issues, well trained therapeutic clowns tend to represent their character with minimal make-up and costuming, as she alleged that "a red nose and a hat, and a visually pleasing costume are enough to communicate the clown's identity" (p. 5). Consequently, in the context of this research project, clown noses, hospital gowns (Johnny shirt) and white hospital lab coat (doctor lab coat) were the basic props that participants used as dramatic material, in order to play as a clown character.

The Beneficial Effects of Being a Clown

Carp (1998), who studied the connection between clown and psychology, integrated the creation of a clown character as a treatment intervention in her clinical work. She claimed that this type of intervention involves the use of improvisation, movement, drama and character clown techniques in order to facilitate "the emergence of

a unique part of the psyche that may be call the individual's trickster, fool or clown character" (p. 246).

> The theory is that the integration of this unique character into consciousness and daily life is psychotherapeutic, brings about change and is of value to the individual. The use of the clown character in individual or group psychotherapy is important because of the relationship between these archetypal images of the Self. (Carp, 1998, p. 246)

Oswald (1985) claimed that the value of being a clown is high within the clown world, as he argued that most clown performers declared that they receive more than they give. The opportunity to give is one of the great needs throughout our lives and it has been identified as an important component of the recovery process from mental illness (Jacobson and Greenley, 2001). Trapped in their sick role, individuals with mental illness are often stigmatized and relegated to the set role of receiver of care and being told what to do. As such, playing a clown character could be an empowering experience. Carp (1998) explained that "clown's ability to poke fun at positions of power is a useful tool in psychotherapy" (p. 247) as this playful character can be used to "counteract the power differential between client and therapist" which enhance, according to the author, their empathic relationship. Furthermore, she asserts that:

> The clown provides a creative outlet through which to discover and work with unconscious contents. (...) The red nose or make-up of the clown, like theatrical role or character, is both protective and liberating, enabling the expression of what lies buried beneath our real life roles. (p. 249)

Therefore, I thought that in the context of a drama therapy group, clowning might offer the opportunity for a group of persons in recovery to experiment, from within, the healing potential of creating, playing and acting.

Basic Principles of Clowning

Ott (2007) specified that "while each clown tradition has idiosyncrasies," they all share three common elements. First, all clown characters aim to make people laugh and they do so by verbal and/or physical skills. Secondly, they usually invert power structures and social norms; finally, clown characters and acts are developed through makeup, colorful costumes, exaggerated mannerisms and practiced performance.

Those principles represent a valid foundation, but on the other hand, I felt that my personal experience as a clown was not enough. Therefore, I took an intensive workshop with Francine Côté, a clowning trainer of international repute and the artistic director of Dr Clown, who had developed a method of the Art of Clown. According to Côté, there are five guiding principle to a clown's work: 1) simplicity, 2) honesty of emotion, 3) joy, 4) openness 5) keeping it light.

Simplicity. Keep it simple, be yourself by playing "who you are" is enough to be funny, play one emotion at the time and "keep it as long as you can" are the main advices given by Francine Côté that I integrated and offered as guidelines to participants.

Honesty of Emotion. For the clown, the main objective is to show and accept the real emotion that he feels in the "here and now". For Côté, the art of clown demands that the actor commits emotionally to what they feel.

Joy. Clown gives joy, pleasure and laughter. The clown character enjoys being looked at, as his main source of happiness is rejuvenated by the joy he gives to other.

Openness. The clown character is always doing the best he can to make people laugh. Therefore, he stays emotionally open to the reaction of the audience and adjusts his own performance accordingly.

Keeping it Light. The clown is always ready to laugh, about himself or a problem that he cannot resolve. The play is spontaneous and light. For a clown, a problem is a gift, a way to reach success.

Methodology

Research Questions

I thought that clowning as component of a drama therapy group process would facilitate the recovery journey of a group of person with severe mental illness. It was my assumption that the fun and play component of drama therapy would help people with psychiatric disorders in the healing process of recovering their sense of self. I believed that playing a clown would help them to define a self apart from their psychiatric illness. More specifically the primary question investigated in this study is: How can humor, playing and acting a clown character in the context of 10 drama therapy sessions enhance the recovery process of a group of persons with severe mental illness?

As clown training is not part of the drama therapy university program, a corollary question was justifiably added: How does clowning integrate within drama therapy sessions?

To answer those questions, I will use a descriptive case study approach which is, according to Jones (2005), a form of qualitative methodology that offers the advantages being inclusive and containing the voices of both participants and therapist.

Collected Data

Data was gathered using multiple methods, including the following: personal field notes observation; participant's hospital records; meetings with professionals of the residential service; pre, during and post-session notes; artwork; participant's final interviews; and, photography documentation. Also, a Mental Health Nurse participated, observed and took notes along this process, as the sessions were not videotaped or recorded as the majority of participants refused these data recording methods.

Description of Setting

This research project was offered in the context of 10 drama therapy group sessions from March 28 to May 23, 2008, including the final closing group session held on May 30, 2008. Those sessions were offered to a group a persons living in a treatment and rehabilitation residential service part of the Psychotic Disorders Program division of a psychiatric hospital in Montreal. This residential service is a community-oriented treatment and rehabilitation in-patient unit. Its multidisciplinary team helps residents improve their level of functioning by offering individualized and group learning program. Residents participate and practice newly-acquired knowledge and skills, in order to prepare for community living. The multidisciplinary team is composed of a psychiatrist, nursing staff, behavior modification agents, a rehabilitation assistant, a social worker and a psychologist. Residents usually stay from five months to a year, depending on their needs and individual recovery progress.

Sampling and Recruitment

This qualitative case study used a quota sampling method composed of specific characteristics and criteria. A recruitment strategy was planned and used in order to find people who fit these criteria and prescribed quotas. Characteristics and criteria included that potential participant:1) was an adult, male of female, aged between 18 and 65 years old; 2) had been diagnosed with a psychotic disorder; 3) had experienced at least one hospitalization in a mental health hospital; 4) and would agree to be involved, once a week, in ten drama therapy group sessions and one individual closing interview. The subset population was delimitated to a small group of individuals (quota sampling: 5 to 8 participants).

I presented my research project to the Director of Nursing in order to get her approval. She consulted all the research documents related to my research project (research protocol, summary protocol form (SPF), information letters and consent form) before endorsing this project. Then, I met the Psychotic Disorders Program Managers and Service Coordinators of the targeted service to explain and describe, in details, this research study.

After receiving the managers agreement and support, I visited the residential service to present this project directly to professional caregivers of the multidisciplinary team. I discovered that staff members and some patients had heard about my previous Patch Adams presentation. Therefore, many were curious and interested to hear more about this "clowning project." In order to choose the best recruitment strategy, I followed the team members suggestion and I met all 18 residents during their "Friday community meeting" on March 14, 2008, to present my research project using a power point presentation (Appendix A). Those who voluntarily accepted to join the drama therapy group were interviewed by the therapist-researcher on March 21, 2008, and were given a thorough explanation of the drama therapy group process, research purpose, procedures, and ethical considerations.

Participants

The group initially consisted of seven participants, three men and four women, aged between 19 to 45 years old. The participants included one East Indian, one Greek, three English and two French Canadians. As showed in the following table, all participants had been diagnosed with a psychotic disorder and all, except one, had more

than one mental health diagnosis. In order to protect confidentiality, names have been changed.

Table 1
Participants' clinical profile

Name	Gender	Age	Admission	Diagnosis
Bianca	F	19	18/09/2007	Mild mental retardation Attention-deficit/hyperactivity disorder (ADHD) Psychotic disorder NOS
Emily	F	32	10/01/2008	Undifferentiated schizophrenia Schizoid personality traits
Hugues	M	45	10/12/2007	Major depression with psychotic features Psychotic disorder NOS Delusion disorder: persecutory type
Jim	M	38	3/3/2008	Major depression with psychotic features Paranoid schizophrenia
Karim	M	44	21/03/2007	Paranoid schizophrenia
Louise	F	26	5/2/2008	Schizoaffective disorder Borderline personality disorder
Paul	M	28	3/12/2007	Undifferentiated schizophrenia Substance abuse (drug and alcohol)

Their length of stay in the residence ranged from between 25 to 373 days, for an average of 140 days. All participants attended to psycho educational groups on social

skills, medication and symptoms management, but they did not benefit from group psychotherapy. Participation in this drama therapy group was very high, as five of seven members of this group attended all sessions. All participants read the research information and signed the consent form (Appendix B) and the consent for the use of images and/or other media (Appendix C).

By the third session, Paul stopped coming. Then, Karim was discharged and transferred to a supervised apartment in the community during the week of the forth session. Although Jim attended to every session, he eventually changed his mind and decided to withdraw from the research project during the final individual interview. In respect for his decision, I will not disclose any of Jim's personal material.

Description of Group Session

The drama therapy group sessions were held in a large room equipped with a stage, located outside their residential unit, from 10 to 11:30, every Friday morning. Every group session was conducted according to drama therapy key principles, which consist of the following: opening ritual, warm-up, core activities, a de-roling and debriefing period, and closing ritual. In the context of a drama therapy session, it is important to offer familiar ritual and safe structure, especially when working with person with severe psychopathologies as it helps contain anxiety (Casson, 2004) and gives participants a sense of security (Snow, 2000).

Even if the drama therapy group had a predictable structure, on the other hand, the therapeutic creative process remained fluid and organic, in order to enhance and generate new discoveries. This process aimed to engage participants in the fictional realm of the play space where fictional scenes and role play based on real life issues could be

produced. This fictional realm is protective, yet, at the same time it enables self-revelation in a safe and distanced manner (Emunah, 2000, p. 72).

The main focus of the therapeutic work was based on a "here-and-now" approach, while clowning was used as a dramatic projection device to engender joy and laughter, playfulness, empathy, safe distance and connection with the self and with others. For warm up and core activities, I chose various techniques mainly inspired by the work of Emunah (1994), combined with experiential activities from my own training as a student in the Creative Art Therapies Program, the Patch Adams seminar and the Art of Clown workshop of Francine Côté.

Theoretical Frameworks

This case study is using two theoretical frameworks. The experience of clowning within the drama therapy group session is viewed through the lens of 1) Emunah's Five Phase Integrative Model and 2) the Recovery Model in Mental Health proposed by Jacobson and Greenley (2001).

In order to analyze the process of the group, I will use the Five Integrative Model of drama therapy framework developed by Rene Emunah (1994). This model offers a guideline to analyze the gradual unfolding of the therapeutic process. In brief, the five phases are: 1) Dramatic play, 2) Scenework, 3) Role play, 4) Culminating enactments and 5) Dramatic ritual. Not every drama therapy group works its way through all of those phases. Emunah specified that factors such as the length of therapy or therapist style have to be considered. Futhermore, she added that "some population may be best served by an emphasis on a particular phase" (Emunah, 1994, p. 45). Therefore, the aim of this drama therapy group was not to reach the Culminating enactment stage where personal issues

are acted out directly through psychodrama or self-revelatory performance. In the context of this research project, the therapeutic work that could be achieved in phase three was most suitable; the main focus being to use the dramatic medium to explore participants' recovery journey.

Finally, participants' material and experience will be viewed through the lens of the Recovery Model. The analysis will be based on the four internal conditions of this model and linked to participant's personal objectives.

The Drama Therapy Clowning Recovery Group

Main Objective of the Drama Therapy Group

The main objective of this therapeutic process was to create a safe and nurturing environment within the drama therapy sessions in order to explore the beneficial effect of the clown character on the internal conditions of recovery, such as hope, healing, empowerment and connection for a group of person with severe mental illness.

Participants' Objectives

Participants' personal objectives were transcribed on a Therapy Agreement Form (Appendix D) that was kept, with all copies of progress notes, process notes, field texts and any other data collection, in a locked filing cabinet in the researcher's office, until the completion of the final version of the research paper. The table below presented the transcription of participants' therapeutic objectives.

Table 2

Participants' personal therapeutic objectives

Name	Therapeutic objectives
Louise	• "to become more active as in – doing this group will add more activities and pleasure to my schedule." • "to express my "excitability" side, appropriately." • "to try and concentrate on each activity while at the same time having fun."
Hugues	• "de me sentir à l'aise (to feel more at ease)."
Emily	• "to be less fearful and more confident when dealing with an audience or a large group of people."
Bianca	• "to be more a better person to myself and others."

Collective Group Contract

During the first session, I invited participants to create a collective group contract where they had to decide on group norms. I believe that this collective activity allowed participants to engage in an empowering process. In accordance with the recovery model, I constantly valued their rights to choose and helped them to become active agents in this therapeutic process.

> The person is empowered by the process: to choose, to change, to decide the direction of therapy session to stop any activity. Clients need to find that the locus of control is substantially in their own hands, not only in those of the therapist (...). This can be done by the therapist offering clients a choice of several activities and the right to refuse any of the choices offered. (Casson, 2004, p. 245)

From the first session onward, all participants arrived half an hour before the beginning of the group. After the second group session, I explored this issue with them and they declared that they were happy to have the opportunity to get out of the residential facility and expressed the need to socialize in a relaxed and fun atmosphere. Coming from a rehabilitation program based on a rigid privilege system, I understood and respected their needs. It was mutually decided to modify the contract by adding half an hour of "free social time" before the beginning of the group. I felt that this free social time became their "own check-in ritual" as it eventually evolved into a period rich with sharing and laughter.

The Audience Chairs

To ensure a feeling of safety, I introduced the use of the "audience chairs" in order to represent the right to say "no" or withdraw. The audience chairs enabled

participants to distance themselves from the group when required and allowed users to stay in the room rather than leave, because they felt overwhelmed. As explained by Casson: "from this place the observer ego is still engaged and the person need not flee or dissociate" (p. 165). I highlighted the importance of the audience chairs by explaining how they could also gain some therapeutic benefit from being in a witness role. During the process, Louise and Hugues, but mostly Jim, used the audience chairs while remaining engaged to share with the group what they had witnessed.

Analysis of Therapeutic Process

Group Process

The following analysis of the group process, from stage one to stage three, will be based on the therapeutic framework of Emunah's Five Phase Integrative Model. Participants' *verbatim* originated from the collected notes taken by the mental health nurse during group sessions and are also extracted from the results of the recorded participants' final interviews (Appendix E).

Dramatic Play

During the first three weeks of this process, my goal was to establish the foundation of this group and to build a safe play space, enhance trust and connection by generating joy and laughter through play. The nurse assistant and I became playmates, as we participated in every warm-up exercises of this phase. Like Casson, Emunah (1983) believes that "the leader must actively demonstrate that s/he is 'doing drama' with the group members, rather than for them" (p. 82). Before introducing the "clown nose" prop enabling them to play a clown character, I slowly introduced playful and interactive exercises. Spontaneity being a key component of drama therapy, I carefully invited participants to engage in simple dramatic games in the play space. As noted by Chadwick (1997) in Casson (2004), I was able to observe that some participants had difficulties to engage in dramatic play, especially individuals with paranoid traits. "People who are paranoid are also more likely to be rigid and less able to be creative: progress may be slow and the therapist must be creative in finding small, safe steps a person can take" (p. 245). I nurtured participant's progress and praised their efforts as they attempted to be playful, spontaneous and funny.

During this phase, I was able to observe the detrimental effects of the positive symptoms (hallucinations, delusions, disorganized thoughts and behaviors) and negative symptoms of their illness. At different levels, the seven participants were struggling with various negative symptoms such as affective flattening (difficulty communicating or expressing emotion), inexpressive faces, blank looks, alogia (slowness to respond and not much to say), monotone and monosyllabic speech, few gestures, avolition (little motivation), anhedonia (unable to get pleasure from anything), lack of interest in the world and other people, inability to act spontaneously and social withdrawal. In addition, attention deficit, like poor concentration or poor memory, were also affecting their ability to play. Emily explained that playing and acting were difficult for her at first because "*sometimes it was hard for me to remember certain things but... it was fun!*"

At the end of the third week, I gave them their "clown nose". I felt that it was a pivotal moment for the group. They all worked so hard to rediscover the pleasure of playing and being spontaneous. The first participant, who put his nose on, was Hugues. This man, afflicted with affective flattening, inexpressive faces and blank looks, was the first participant that proudly presented his "clown face" to the rest of the group. We all gazed at him. He smiled. Then, spontaneously, everyone else put their clown nose on. This witnessing experience was amazing. Alternatively looking at each other and at themselves in a mirror generated a joyful moment for the group. Their clown nose "first encounter" was a seminal and rewarding moment, as participants seemed proud of what they had accomplish so far.

Scenework

As the group evolved, participants were able to transit from dramatic play to sustain dramatic scenes as I invited them to improvise, compose and develop their clown character. Emunah (1994) clarified that the acting component of this phase cannot be compared to psychodrama, in which protagonists play roles of themselves in a variety of situations. Instead, scenework involved playing roles other than those reflecting one's own life, which allowed greater role distance and less immediate self-disclosure. Emunah (1994) explained that "stepping outside oneself and into a role is freeing; it provides relief and release from the constraints, both internally and externally induced that are experienced in everyday life" (p. 37). As such, within the context of the play, aspects of the self can emerge, and suppressed emotions can be expressed. Hence, I encouraged participants to share and express their opinion, thoughts and feelings on what happened in the play space. At first, participants did not share much about the enactment experience. They were mostly talking about their lack of energy, concentration, acting skills and creativity. I noticed that participants were still mostly attuned with the symptoms related to their illness. Positive symptoms were affecting some participants, which could explain their difficulty to play. During the final interview Emily, who has schizoid personality traits, explained how difficult it was for her at first to embody a clown, as she was associating this character to a malicious figure: *"... well it was a bit weird to put together a clown, it was kind of after seeing a scary movie sometimes it's a bit evil.."*.

But as the group progressed, participants slowly made connections between the improvised scene and their own life experience, which, I thought, marked the transition to the following phase.

Role Play

According to Emunah (1994) the primary process of this phase is to engage participants in role play, as they shift from imaginary play to exploring situations in their own lives (p.39). During this period, participants used their clown nose, "Johnny shirts" and doctor "lab coat" to enact different psychiatric hospital scenes (e.g.: emergency room, psychiatrist and patient interview, etc.). They did not use those enactments as a laboratory to try new options or prepare for real-life events. Instead, participants used self-deprecating humor as a mean to express significant issues from their personal experiences with the health care system. The enacted scenes generated a lot of discussion, as personal "funny stories" and issues from their hospitalization experiences were shared. Many stories highlighted the incongruity of particular situations and revolved around themes such as the lack of awareness and/or empathy from the health care professionals. Participants of the group particularly laughed at a group member's story where she related to being in the emergency room, watching a horror movie while suffering from visual hallucinations. "*The staff was all sitting at the nursing station while I was watching monsters coming out of the screen. That didn't help my hallucinations!*" The lack of intimacy related to sexual needs was also an emerging theme as any form of contact between patients is forbidden in a psychiatric ward. "*One time, I was caught having sex with another resident in the stock room. You should have seen the face of the nurse!*" Keeping secrets or lying on symptoms in order to protect staff's "well being" was another theme revealed by stories. This strategy seemed to be used especially with "new comers" on the professional team. "*This nurse stagiaire was so cute and nice with me. She tried so hard to make me feel good. So I pretended that I was getting better and*

that I had less hallucination. She seemed really proud. I even went to tell her teacher how good this girl was so she would have a good score for her stage!" Dealing with auditory and visual hallucinations was also a source of laughter and connection amongst participants, as they were comparing their behavior related to those negative symptoms. *"I was on a bus answering my voices. People were staring at me but I continued talking loudly like I didn't care. I did not know at that time that the voices were not real. I must have looked like a real psychiatric patient!"* Humor and empathy were used to connect and understand each other. One of the group member who noticed the lack of concentration of Louise one day, asked her: *"Are you OK? Do you see monsters? What kind? Do you see them now? Where?"* Embarrassed at first by his spontaneous question, she slowly described the monster characters that haunted her mind. Then, little by little, encouraged by the naïve and non-judgmental reaction of her interrogator, Louise started to overstate and really exaggerate the fear components of her hallucination in order to scare him until he and the group burst out laughing. It was a powerfully bounding moment.

Participants' Recovery Process

The participants' recovery process is view through the lens of the Recovery Model in Mental Health proposed by Jacobson and Greenley (2001). Participants' *verbatim* originated from the collected notes taken by the mental health nurse during group sessions and are also extracted from the results of the recorded participants' final interviews (Appendix E).

Louise

Amongst the group, Louise had the longest history with the health care system. She cumulated seven hospitalizations between the age of 14 and 18 years old, and committed her first suicide attempts at the age of 15. She had a long list of diagnoses including anorexia, bulimia, depression, anxiety disorder, and bipolar disease that have been frequently revised and adjusted over the course of her "psychiatric career." Louise was raised in a violent family and has experienced severe physical and psychological abuses in her childhood. She is heavily medicated and her recovery journey included many relapses where she had to be admitted to the hospital, mainly because she had stopped taking her medication. She completed one year of college in specialized education, has a real talent for writing and a great sense of humor.

Hope: When she started the group, Louise did not believe that recovery was possible. She claimed that she joined the drama therapy group mainly because she saw the Patch Adams' presentation, and thought that the "love and caring approach" I was promoting could help her.

> *"I really think that drama therapy is definitely... well, I don't know about recovery but drama therapy is right there you know. There's a big link. I don't know... because it's so compassionate and I don't know if it just you or all the drama therapists but you're very patient and very kind and loving and so it makes it... it's like you're helping us with recovery..."*

By focusing on her strengths, I nurtured every effort she made in her attempt to reconnect with the joy of playing. It finally paid off. For Louise, the pivotal point of the

session was when she played as a psychiatrist with her clown nose. During her final interview, Louise explained the benefit of drama therapy as followed:

> *"It made me a good doctor (laugh)!... No!... it helps because when I was a teenager I was really silly... I was laughing a lot... and I kind of just lost that past life for 7-8 years you know... I lost all that so this was a way to like be really silly and at the same time not be super inappropriate super like... manic you know... it helps."*

Healing: Louise had difficulty to see herself as a whole, as a person apart from her mental illness, but it seemed that through drama therapy, she was able to reconnect with a healthy part of herself. It also gave her a sense of control, a way to alleviate symptoms associated with her illness. *"It's just a time to be silly and forget about everything else in the world. Just forget about the stress that you have and just transform in another... thing! (laugh)"*

Empowerment: L ouise's long-term interactions with the mental health system seem to have created and maintained a lack of autonomy and sense of dependency towards the system. Interestingly, during role play, she always chose the Doctor Clown character, and usually took the leading role during enactments. Throughout the sessions, she was also very keen to share, communicate and exchange stories with other participants. Her energy and sense of empowerment constantly increased as the sessions progressed; unfortunately, she could not transpose to real life these newly acquired skills that she discovered within herself. During the final interview, she stated that her expectation was "*to be fixed*", choosing words that betray a lack of responsibility in her own recovery. Indeed, instead of acting as an independent agent, I believe that her multi

pronged struggle against psychotic negative symptoms, drug side effects and her non-acceptance of her Axis II diagnosis meant that she was constantly fighting an inward battle.

Connection: Louise seemed to enjoy being in company with others. She demonstrated a friendly attitude and great ability as storyteller. About the created connection amongst the group, she stated: "*The relationship we formed with the group and with you and it just all fit you know...Like everything, it runs smoothly.*" Louise has an intimate connection with the hospital it is a safe place, it's home. Ergo, connecting with the "real world" and "getting a life" represent distant goals whose paths to achievement are fraught with obstacles. Referring to her present life, she states: "*...it's kind of like the hospital maybe, where everybody else thinks it's weird to be here and when you are here you form relationships with bodies that are very intense.*" On the other hand, her testimony about her new life in an apartment demonstrates, her helplessness: "*I feel isolated. I feel lonely... I feel unable to keep up with my routine and stuff...*"

Hugues

Hugues never knew his father, and his mother was unable to take care of him. Consequently, from the age of three months until he was ten, he lived in different foster homes, where he was subjected to physical and psychological abuses. As a teenager, he alternatively lived with his mother or as a boarder in a college. He dropped out of school after grade eleven, and had many job experiences, but none that ever lasted. He experienced difficulties to connect and establish any form of trusting relationship with either his mother or anyone else. When admitted, he was single, unemployed, had no

support network, and no friends. He had experienced depressive episodes since the age of forty, and for some years, lived on the street and had developed delusional paranoid ideas. The residential clinical staff, as well as the psychiatric resident, described Hugues as a reserved and devoted person, always ready to lend a helping hand and accomplish miscellaneous domestic tasks around the residential house.

Hope: At the beginning of the group, Hugues clearly expressed his hope to get a job and be autonomous. He knew that his hospitalization was coming to an end and he was motivated to try any treatment available in order to help his recovery. Nevertheless, acting, creating and playing a clown character in a context of a drama therapy group represented a real challenge for this reserved and solitary person. But step by step, with genuine attention and encouragement from the therapist and his peers, Hugues was able to play his clown character with honesty and simplicity. He was able to sustain his flat affect in the "here-and-now" by creating a "neutral clown." His touching performance was acknowledged and valued by the group. For Hugues, this experience conveyed a hopeful meaning.

> *"Well.. I saw that with all kind of people we can... we can create a kind of consensus... we can do something... we can do something with all kinds of people. Yes, that's it...that's it... and we can even do surprising things!"*

Healing: The clown experience seemed to have enhanced Hugues' self-esteem and self-confidence. I was able to observe, as the group progressed, that Hugues was becoming more at ease with himself and with his peers.

> *"What the clown character represents for me? Well.. the clown is someone... it's like someone neutral... hum...how can I explain that? It's someone neutral who*

just by the fact that he is neutral it makes him funny... Yes, I would explain it like this... it is somebody without prejudice..."

It seemed that playing and acting with others as a clown had helped him accept the internalized stigma associate to mental illness that impedes his ability to relate to others. Throughout this process, trust in others was slowly coming to light. His clown character has taught him also, to have faith in the creative flow of the moment, to "let it go". *"Yes, that's it, I was letting it go... I did not have any preconceived ideas to what I had to do... I was just doing it... I improvised."*

Empowering: During the final interview, Huges admitted that he didn't like to act and improvise or share his feelings with others during the opening and closing rituals. Yet, throughout the sessions, Hugues never used the audience chairs and bravely participated in all exercises that were proposed and chosen by the group. His statements clearly demonstrated his willingness to take risk by stepping outside the safety of his usual withdrawal which is, in my opinion, all the more admirable.

Connection: For Hugues, connecting and trusting others is a lifetime struggle. Commenting on his experience on acting, playing and creating a clown character within the drama therapy group, he stated: *"Well, in general... I learned that with different people we can achieve something and without...well if we don't have prejudice, if we take people as they are... and let events unfold..."*

Bianca

Bianca was the youngest participant of the group. At the age of seven, following her parent's divorce, she was diagnosed with Attention-deficit/hyperactivity disorder (ADHD) and started to take medication. Life has been a struggle for Bianca as she has,

over the years, been diagnosed with mild intellectual retardation, anxiety and more recently, psychotic disorder NOS. She was living at home with her mother and step-father, where she was in constant conflict with her mother, herself diagnosed with major depression. Family conflict, psychological and physical abuses have been major stressors in her life. In the fall of 2006, she committed four suicide attempts, by which time she was finally admitted in the rehabilitation residential service. Bianca is recognized as being very energetic and bubbly, and she is always ready to help the residential team as well as her peers.

Hope: While a member of drama therapy group, Bianca was discharged and admitted to a supervised group home in the community. *"I am now out of the hospital and now I am in a group home and then in actually 2 years I can start looking for an apartment..."* Bianca wishes to be free and live with her boyfriend. She believed that she is living a *"happy ending story"* because *"I am young so I try to experience life and try to go step by step and try to see what is after for me..."* In sum, for Bianca, recovery is possible and is associated with living an independent life in the community.

Healing: Bianca clearly aspires to take an active role in her life. She understands that healing is not synonymous with cure and accepts the fact that she will have to take her medications and live with the limitations of her illnesses. During the final interview, she claimed that her clown character helped her discover a new side of herself.

> *"I am more happy. I laugh. I joke. I am the new clown of the class in school now... they laugh when I do something in the clown... I never knew about... I never knew that I had a funny personality. I make people laugh by telling them jokes. That's good. I discovered something that I never new about myself. Since*

the group... I find stuff I did not know about myself...that I was a funny person like people likes jokes! I tried my best!"

From the drama therapy group, she seemed to have integrated two basic principles of clowning into her own life: joy and openness.

Empowerment: Bianca is investing her energy and effort in developing her autonomy. The dramatic projective techniques used in drama therapy sessions helped her reflect on her own difficulties:

"It's like my mom. She puts me in a dog leash. I had... I have to get out of there...I had to get out of my mom skirt. It's like the control of everybody. And so, I had to leave the control all behind and start a life."

As for the acting, playing and the creative parts of this process seemed to have helped her be more assertive and confident in herself.

"I learned to live my own life without no one telling me what to do... yeah it's basic... being that character it helped me to express and see... I need to look free and to live my own life without everybody telling me what to do."

Connection: Bianca had the tendency to treat everybody in her surroundings as friends or family members. She needed to learn to accept and better manage the distance between herself and others. Her clown character helped her realize that not everybody will be able to accept the joy and happiness that a clown character is always ready to give. *"People are strange... people are after the money, wanting cigarettes. What's going on in this world? There is fight, there is war. I kind of figure it out... life... the world."* It seemed that her hospitalization and the drama therapy group experience

provided some new insight that would to enhance her social skills and ability to relate to others.

Emily

Emily lived with her mother and sister with whom she had problematic relationship. She started experiencing psychotic symptoms during her first year of college. She began having paranoid thoughts and wishes to leave the country which lead her to run away from home. She claimed that she was treated against her will. In reality, her mother obtained a strict hospital confinement order from the Court to treat her daughter who refused any type of treatment. We do not know much about Emily as she usually keeps to herself. She did not claim any physical or psychological abuses. A story in her file indicated that she had to go to Court to obtain the right to have her own passport against her mother's will. Her new diagnosis seemed to be difficult to accept by herself and her family members. Emily is a sweet, reserved and bright young woman. Her dream was to be an actress.

Hope: Finding that you have a mental health disease such as schizophrenia must be a devastating experience. But for Emily it appears that the rejection of her sickness and by extension herself, by her mother, is even worse. When Emily started the group, she was still hearing voices and had to manage with the detrimental effects of many symptoms. But on many occasions throughout dramatic enactments and scenework, Emily expressed her needs to find love and be loved, as she claimed that her life struggle is her inability to distinguish between "*true love*" and "*false love.*" I believe that there might be a link between her struggle and her mother's perceived rejection. For Emily, recovery seems intimately tied with resolving this issue.

Healing: Emily is still adapting to the burden of living with the detrimental effects of a psychotic disease. At the beginning of the sessions, she mostly remained in a witness role, while choosing the patient clown character during enactment. She never used the audience chair, but had difficulties sharing her thoughts and feelings outside the play space. *"The most difficult? Maybe the magic box every session... Not uncomfortable but... hum...I guess talking about what you have inside... like I know why you did it, but sometimes, I felt like I didn't want to talk about it."*

Empowerment: It took Emily a lot of courage to come to drama therapy sessions. *"I was a bit scared at first... shy... well more shy to come out, but I thought that the experience was nice."* As time passed, she dared to step out of her shell and experience more fully the joy of acting, progressing from being in a supporting role to being in a leading role. In doing so, she earned the praise of her peers. She claimed that the clowning experience was inspiring by giving her the permission to laugh and have fun. *"I like to act different roles... I do... I find it fun, but I'm still shy..."* She claimed that putting on her nose and costume really helped her.

Connection: In the beginning, Emily had difficulties trusting and being at ease with others. In this, the experience of the drama therapy group appeared to be beneficial for this young woman, who used to be socially withdrawn from the rest of the residents. Indeed, she has been able to connect with the other participants and during the last session, she even performed in front of a live audience, thereby establishing a connection with the outside world on top of the one she had from within her therapeutic circle. Reflecting about her "live" performance, she was able to laugh about her mistakes caused by her lack of memory and concentration, by using self-deprecating humor.

Discussion

> In lands more familiar with oppression, a joke is necessary for one's self-esteem. Laughter is the only weapon the oppressed can use against the oppressor.
>
> (George Mikes cited in Granirer, 2007)
>
> In clown therapy, participants find joy and laughter in the midst of pain.
>
> (Cheryl E. Carp, 1998)

Clowning, Recovery and Drama Therapy

The premise of this research was the belief I had that clowning, as component of a drama therapy group process, would facilitate the recovery journey of a group of persons with severe mental illness. More specifically the primary question investigated in this study was to find out the following: how can humor, playing and acting a clown character in the context of ten drama therapy sessions enhance the recovery process of a group of person with severe mental illness? I believe that playing and acting a clown character helped participants develop the ability to laugh about themselves, provided relief and release from the constraints of the experience of being "psychiatric patients". Emunah (1983) stated that Maslow explained that people with schizophrenia "experience many insights and yet do not often make therapeutic use of them because they are too immersed in 'experiencing' and cannot sufficiently self-observe and evaluate." As such, she claimed that "drama therapy group tends to reduce inhibitions and resistances, at the same time fostering the distance necessary for the development of the self-observing ego" (p. 79). As the sessions progressed, I realized that the clown characters offered safety and role distance while the "de-role and debriefing" part of the session was used for self-disclosure, sharing and connection.

Depth exploration of the enacted scenes focusing on behavioral change was not in line with this therapeutic process. Participants played their clown-doctor or clown-patient roles, keeping in mind that the goal was to have fun. After enacting, participants seemed rejuvenated and I could observe a boost in their energy level, which facilitated discussion and therapeutic work with emerging themes.

During their final individual interview, all participants declared that they mostly appreciated the "fun" element of this approach. As such, the clown character was directly linked to "having fun", which enabled participants to develop and use self-deprecating humor. This type of humor allowed participants to reveal themselves and connect with one another by disclosing and sharing "funny stories" about themselves.

Casson (2004) and Bender (cited in Harrington, 2009) both claimed that the fun and play components of therapy help people with psychosis in their healing process. For Casson, it enhances the recovering of their sense of self, whereas for Bender, the use of self-deprecating humor can be especially powerful for persons with psychotic disorders, as it helps them build resilience. Finally, Granirer (2007), who teaches stand-up comedy to people with mental illness, recognized that humor is a powerful tool, as he claimed that it helps people in accepting their dysfunctions.

With regards to the recovery process of the participants, I believe that this analysis demonstrates the beneficial effects of the intervention as it relates to hope, healing, empowerment and connection, although each story and healing journey presented in this study is unique. It seemed that the "red nose" character provided a protective and liberating experience for the participants, enabling the free expression of their day to day struggles. Gold (2007) stated that "empathic healing from psychosis

happens in support groups and family meetings as well as through creative writing or other art" (p.1272). Therefore, I believe that the holistic experience of clowning in a context of this drama therapy group has definitively helped Louise, Hugues, Bianca and Emily, by enhancing different aspects of their own recovery journey.

Clowning Within Drama Therapy

As clown training is not part of the drama therapy university program, a corollary question was justifiably added to this study: How does clowning integrate within drama therapy sessions? The main focus of this therapeutic work was based on a "here-and-now" approach, while clowning was used as a dramatic projection device to engender joy and laughter, playfulness, empathy, safe distance and connection with the self and with others. I believe that the use of the clown character facilitated the process of bonding, connecting and creating empathy amongst participants.

As stated earlier, it has been shown that clowns use interactive performance to develop new perspectives, insights, and discoveries for those with whom they interact and also, within themselves. Along this journey, I knew that clown figures had long been associated with psychological healing. Still, before my own encounter with the many aspects of clowning, I realized that I underestimated the powerful healing potential of this archetypal character.

> Obviously clown therapy is interconnected with other creative arts therapies. However, the introduction of the clown character to psychotherapy offers a unique opportunity for clients and therapists. The clown with its archetypal power, multicultural history, crazy wisdom, hilarious antics and paradoxical

nature is the quintessential character to guide the individual on a healing journey. (Carp, 1998, p. 254)

Therefore, I claim that it would be beneficial to have a clowning training course as part of the drama therapy curriculum, in order to better prepare drama therapists for their future therapeutic work.

Research Limitations

Although it appears that the experience of playing a clown character in the context of ten drama therapy group sessions had an enhancing effect on the recovery process of a group of people with severe mental illness, there are several limitations to this research that need to be addressed. First, these results cannot be generalized or replicated to a wider population of people with severe mental illness, because they only reflect the experience of the four participants of this study. Second, the case study method has another downside, since the experience under study takes place in an open and uncontrolled environment; therefore the research results do not represent useful cause and effect indicators. Finally, the case study has the advantage of providing lots of data, indeed too much data for easy analysis, and like many case study researchers, I felt overwhelmed by the sheer amount of information. As such, other interesting and rich materials were created during the course of these drama therapy group sessions, such as a collective fairy tale story, which could also have been used and analyzed. However such data would have led this research on another path. Regretfully, I decided to select only the findings related to my research questions. Two theoretical frameworks were used to help organize the results of this research. The goal was not to test Emunah's framework

or the conceptual theory of the Recovery Model, but to help me organize and make sense of the amount of research data I collected over ten weeks.

Nevertheless, I believe that the case study method is a very intimate and valuable means of understanding individuals living with mental illness. Thus, despite the limitations of case studies, they stand as an extremely useful method within the field of drama therapy research.

Other than the research method I used, I found that my own clowning experience was quite limited. I believe that if I had been more confident about my own clown character and training, I probably would have been able to carry much further the therapeutic process of this group. Although, this research has demonstrated the benefit of playing a clown in the context of a short-term group therapy, the time limitation precluded reaching the depth and breadth of psychological work potentially realized in a long-term group.

Conclusion

> Recovery-focused psychotherapy calls for a nonhierarchical dialogue in which clients are not supplied with a narrative but assisted in creating their own.
> (Elizabeth Gold, 2007)

This research project represents a long journey. It started with my own recovery process and my deep belief in the potential for healing via human creativity. The road I travelled in order to become a drama therapist had many obstacles, but was also filled with magical moments. Within my personal quest, I encountered many guides, such as Patch Adams, David Stawner and Dietra Hawkins, inspiring faculty teachers, co-workers and other creative art therapists but mostly, I was moved by the stories of people recovering from mental illness.

After my own clowning experience with Patch Adams, I was convinced that this human caring experience had to be shared, in order to enhance the recovery process of people admitted in a psychiatric hospital, a milieu that still today, is generally not based on a recovery-oriented model. "Recovery is a natural process that can occur gently in a sane, healthy environment and can be fostered through authentic relationships. Recovery is facilitated only when a genuine sense of friendship is fostered among caring people, both staff and clients" (Gold, 2007, p. 1272).

Many aspects of illness can be known only from direct experience, and narratives of those who have recovered from psychosis come from voices not often heard. Like chronic pain, psychosis is often a silent, inner, and invisible experience. I believe that the experience of playing a clown character in the context of ten drama therapy session in the environment of a psychiatric hospital offered the opportunity for the research participants to voice some aspects of the unique experience of living with a psychotic disease.

Clowns universally address issues through humor, which, in itself can be cathartic. As stated earlier, comparing clowns and shamans is not new. Miller Van Blerkom (1995) alleged that clowning originated with shamanistic performances, leading to psychological reactions such as transference and catharsis. Snow (2000) also believes that drama therapy is based on "the essential structures of shamanic rituals". As he was working with psychotic population, he observed that:

> The contact with and embodiement of the "archetypal affect-images" appear to guide these patients towards decreasing social isolation, better communication, increased reality testing and improvement of self-image through the completion of the task of performing what they have created. (p. 233)

Furthermore, he added that for individuals struggling with psychotic disorders who have their self-image wounded by social stigmatization, "the contact with the powerful archetypal symbols, especially when contained in the performance of a role, can lift them up and empower them" (p. 233).

In light of the results of this case study, I endorse Snow's observations and hope for further research and clinical work along this path. More empirical research is needed in the drama therapy field, as it a therapeutic modality most advantageous for people struggling with severe mental illnesses, and a effective recovery-oriented form of psychotherapy. It is person-oriented, respects people's life experience and addresses people's needs, holistically.

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Appendix A

Présentation du projet de groupe de drama thérapie

«À la découverte de mon personnage de clown !»

Johanne Roy inf. M. Sc.
Maîrise en thérapie par les arts de création
Université Concordia

Mars 2008

Qu'est-ce que la drama thérapie ?

- Forme de psychothérapie qui utilise des exercices de base issus du théâtre pour faciliter l'expression d'émotions, de difficultés et d'expériences vécues
- Exemples de méthodes utilisées en dramathérapie : jeux de rôle, improvisation, construction de personnages, masques, contes, collages, etc.

2

À qui s'adresse la drama thérapie ?

- Aucune expérience théâtrale n'est requise !
- À toute personne souhaitant entreprendre une démarche de croissance personnelle.
- C'est une approche dynamique qui favorise l'éveil du potentiel créatif, l'affirmation de soi et qui entraîne souvent un sentiment de bien-être, d'autonomie et de liberté.

Intérêt pour le personnage de clown

- Rencontre avec Patch Adams
- Expérience personnelle de *«Caring clown»*

Intérêt pour le personnage de clown

" When a dream takes hold of you, what can you do ? You can run with it, let it run your life, or let it go and think for the rest of your life about what might have been ".

5

Intérêt pour le personnage de clown

"The clown provides a creative outlet through which to discover and work with unconscious contents. [...] The red nose or make-up of the clown, like theatrical role or character, is both protective and liberating, enabling the expression of what lies buried beneath our real life roles (Carp. 1998. p.249)".

6

Le personnage de clown

Francine Côté

Le travail du clown est basé sur 5 points : la simplicité du jeu, la vérité du jeu, le plaisir, l'ouverture et la légèreté.

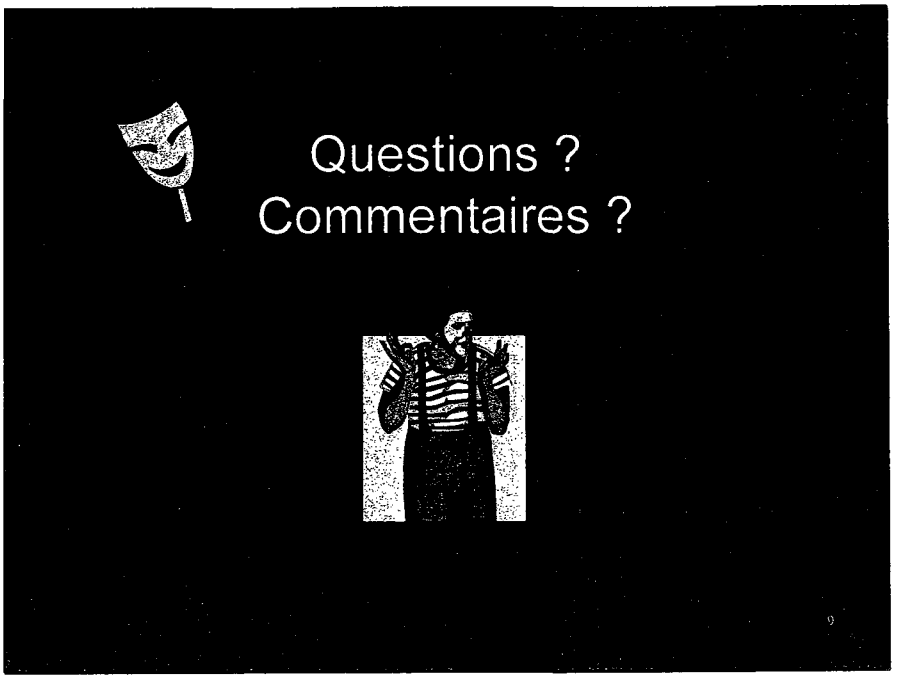
L'équipe du Dr Clown

7

Le groupe de drama thérapie

- 1 fois /semaine, le vendredi matin
- Groupe de 8 personnes
- Durée de 1h30
- 10 rencontres (9 session de groupe + 1 entrevue individuelle)
- Pavillon Newman
- Début : 28 mars

8


Questions ?
Commentaires ?

Appendix B

INFORMATION AND CONSENT FORM

Uncovering the clown, Rediscovering the self: An exploratory research about the experience of a group of people with chronic mental illness within dramatherapy sessions

Drama therapy Student : Johanne Roy inf. M.Sc.

Research Supervisors: Stephen Snow PhD RDT-BCT
Concordia University

You are invited to participate in this research project. The goal of this study is to explore your experience about being part of a drama therapy group which aimed to help you discover the joy of playing a clown, create personal and group stories and develop your own character.

WHAT IS DRAMA THERAPY?

Drama therapy is a form of therapy that employs techniques used in theater, and applies them to the process of healing. The focus in drama therapy is to help individuals grow and heal by taking on and practicing new roles.

WHY ROLE PLAYING A CLOWN CHARACTER?

A clown is a character that invites play, interaction, an above all laughter. The researcher (drama therapy student) believes that by playing a clown role, you will discover the healing power of laughers and as a result, you will be able to feel better about yourself. You will also discover that improvisation and acting a role offer the opportunity to express yourself in a creative way.

IF YOU DECIDE TO PARTICIPATE, WHAT WILL YOU HAVE TO DO?

If you volunteer for this project, you will have to come once a week to ten drama therapy group sessions, animated by the researcher, Johanne Roy. This group will include around six participants and a mental health nurse as a researcher's assistant. At the end of the sessions, you will meet the researcher for an individual closing interview. This interview will be audiotape and the therapist will ask you questions about the experience you had in the drama therapy group sessions.

WHAT ARE THE ADVANTAGES OF PARTICIPATING IN THIS RESEARCH?

The introduction of the clown character within drama therapy sessions offers an innovative opportunity for both you and the drama therapist, to discover the healing power of this specific character. Your input in this research will help in the development of this new therapeutic approach. It will also give you a chance to voice your opinion about this new form of group therapy.

WHAT ARE THE RISKS?

It is not anticipated that participation in drama therapy sessions could be risky. However, certain persons could find that they may have strong and/or unexpected

reactions or feelings related to this new exploration of the self. In such a case, the researcher's assistant will provide immediate counseling. If needed, and with your permission, your case manager will be contacted.

As for the interview, you are free to answer or not answer, to the researcher questions. It is your choice to reveal what you feel confortable to share about your experience.

WILL THERE BE MONEY INVOLVED?

No. You will not have to pay for any of the therapy sessions, art materials and costumes; as well, you will not be paid for the personal interview.

WHAT ABOUT CONFIDENTIALITY?

All information disclosed during the individual interview will remain confidential and will not be transcribed on your hospital file. Also, in order to further protect your anonymity, a "fake name" (pseudonym) will be chosen to conceal your identity. After completion of the research paper, all audio recording will be destroyed.

WHAT HAPPENS IF YOU DECIDE TO WITHDRAW?

You can withdraw your consent at any moment, which means that you do not want to participate in the research anymore. Whatever choice you make, your stories and the content of your personal interview will then not be used for this research.

WHY DO YOU HAVE TO SIGN THIS DOCUMENT?

If you decide to participate in this research, you will be given a copy of this consent form, which you will need to sign. Before signing it, make sure that I have answered all of your questions, and that you thoroughly understand this research project.

For more information about this study, you can communicate with me: **Johanne Roy** (Researcher), [redacted].

In signing the consent form, you accept to participate in this research project and you give your consent to audiotape the personal interview.

If you have any question about your rights as research subject, or for any ethical problem concerning the conditions of your participation in this research project, you can communicate with: **Adela Reid**, Research Ethics and Compliance Officer, Concordia University, at (514) 848-2424 ext. 7481 or by email at areid@alcor.concordia.ca.

Participant / research subject signature	Print name	Date
Researcher signature	Print name	Date
Witness signature	Print name	Date

Appendix C

CONSENT USE OF IMAGES AND/OR OTHER MEDIA

I, _____ authorize the

student researcher and drama therapist: _____ to

take or do:

- ❑ Photographs
- ❑ Tape recordings
- ❑ Video recording

and to use the above-mentioned material for therapeutic use and educational purposes, in the context of the research project on clowning and drama therapy.

However, I express the following restrictions:

_____

_____

_____

Signature of participant: _____ Date: _____

Signature of dramatherapist
student researcher: _____ Date: _____

Witness signature: _____ Date: _____

Appendix D

THERAPY AGREEMENT

For the drama therapy group entitle: *DISCOVERING MY CLOWN CHARACTER*

Date: _____ day of _____ 2008.

Between: Name of therapist:_____
(Master Degree student in Creative Art Therapies at Concordia University)

And: Name of participant:_____

The drama therapy approach has been explained to me by the therapist of this group therapy. I was able to ask all the questions I needed in order to fully understand this group process and I feel that I was well informed.

Therefore, I accept to participate in this group therapy entitled: "*Discovering my clown character*" which will be offered over a 10 weeks period for _____ hours per week, starting on _____ (day) of the month of _____ 2008 and ending on _____ (day) of the month of _____ 2008. This group therapy will be offered every _____ from _____ to _____.

- During this period, my personal therapeutic objective will be:

_____

_____

_____

_____

I accept to respect the terms and condition of the group contract which will be discussed and decided by all participants during the first session.

I also understand that the therapist is bound by confidentiality rules, by ethics principles and values of her Order and professional association (OIIQ, AATQ).

I understand that once signed, this document will constitute a binding agreement between myself and the therapist, and will indicate that I have given my informed consent to begin treatment.

Participant's Signature : _____Date :_____

Therapist's Signature : _____Date : _____

Appendix E

Individual Final Interview Script
For The Participants of the Drama Therapy Group

Name of participant: _____

Date and time of interview: _____

Theme: Drama Therapy Group Sessions

1. What are your general impressions after having participated in 10 sessions of drama therapy? How was the experience for you?
2. Did you have any expectations before starting this group? Is this group similar to what you were expected?
3. What do you appreciate the most in this group? What do you appreciate the least?

Theme: Therapeutic Objective

4. Your personal therapeutic objective was (read their personal objective). Is this group therapy helped you in working toward your therapeutic goal?

Theme: Clown Character

5. Let's talk about the clown character. Following your drama therapy experience, what does the clown character represent for you? How can you describe your clown character?
6. Referring to the activities where we used the clown character, can you tell me if this character helped you learn something about yourself?

End of Interview Session

7. Do you have any other comments or any suggestions about this drama therapy group experience?