Giving Life to the Greyness: The Effects of Clowning in an Elderly Care Home in South Africa

An exploration of therapeutic clowning as part of a drama therapy study

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A Research Report

Masters in Drama Therapy (MADT)

Wits School of the Arts (WSOA)

June 2020

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University of the Witwatersrand, Johannesburg

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Abstract

Therapeutic clowns practice in a number of healthcare settings worldwide, most predominantly in paediatric settings. Therapeutic clowns have been known to cultivate positive feelings in adverse environments; they support patients undergoing care and treatment, as well as their families and the surrounding staff. More recently, therapeutic clowning has developed in elderly care, with clowns working in geriatric wards and residential care homes. Therapeutic clowns that work with the elderly are referred to as elder clowns. Elder clowns attempt to meet some of the needs of the elderly, particularly those with dementia.

Research pertaining to elder clowns in a South African context was, at the time of writing, limited. This study, as part of a Drama Therapy MA degree, sought to explore therapeutic clowning in the context of an elderly care home in South Africa, to ascertain whether therapeutic, or more specifically elder clowning, could, in the form of an intervention, benefit the elderly and support existing elderly care. This was a piece of qualitative research that captured the experiences of participants in relation to the intervention. Participants included elderly residents, staff and social workers on duty, as well as the researcher-therapist/clown.

The results revealed that therapeutic clowning cultivated positive affect, in the form of upliftment, in both elderly residents and staff on duty. It also resulted in experiences of positive human social connection, which appeared to be of particular benefit to a residential facility that catered to elderly abandoned and destitute. Therapeutic clowning had also positively changed the atmosphere of the home, and was even recognised as a form of staff support. As this research formed part of a drama therapy study, the study also observed a relationship between therapeutic clowning and drama therapy, and, while the scope of this study prevented a more in-depth analysis, the study encourages more research integrating the two schools of thought in theory and practice.

Key words: Clown; Elder Clowns; Therapeutic Clowning; Drama Therapy; Elderly Care, Complimentary Care

Acknowledgements

A sincere and heartfelt thank you must be made to the elderly home which, despite having no prior knowledge of therapeutic clowning, accepted this project openly and supportively. It is thanks to the home, the staff, and most importantly, the elderly participants, that this research could be achieved. This research was an enriching and profoundly learning experience, both academically and personally as a clown. I am incredibly grateful.

Thank you to Warren Nebe for your in-depth knowledge, guidance and insight, and to Sue Van Zyl for offering your expertise.

Thank you to my fellow master's classmates - how fortunate I am to be a part of such a supportive and knowledgeable group.

Thank you to Helen Donnelly and Olivier-Hugues Terreault for sharing your knowledge, clown stories and support.

To my partner, Antonio, and my family, your patience, love and unwavering support carried me through.

To WITS and WITS Drama for Life thank you for your support, especially in completing and handing in during the Covid-19 pandemic. A special mention must be made to Sao Mendes for being so dedicated to helping students.

A final acknowledgment, thank you and dedication must be made to my late paternal grandmother, Lily Owen, who, despite no longer being with us, inspired this research.

Thank you.

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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.) (Roy, 2009:1).*

In the last few decades, the presence of clowns in healthcare settings has both increased and evolved. Therapeutic clowns, also called clown-doctors, medical clowns, or hospital clowns, have predominantly worked in hospitals, and in particular, paediatric settings, to improve the mood of patients in a therapeutic context (Warren and Spitzer, 2011). The occurrence of these clowns has ranged in varying levels of professionalism and accountability – from the general volunteer, who, though well-intentioned, may simply dress-up like a clown with little training, and little to no understanding of the role and potential of therapeutic clowning, to those working as respected complementary care providers, able to articulate their role in the care of the patients and within the healthcare team itself (Koller and Gryski, 2008). While clowns have presumably entertained patients for years, the birth of therapeutic clowning, also called medical clowning or healthcare clowning, as a formalised profession is, however, recent (Pendzik and Raviv, 2011). "Prompted by the revolutionary work of Patch Adams in the 1970s, [where] medical clowning gained public recognition, first through the publication of Adams and Mylander's (1993) Gesundheit!, and later, thanks to the movie Patch Adams (1998), in which the actor Robin Williams takes the role of the red-nosed, legendary doctor" (Pendzik and Raviv, 2011: 268). As both a doctor and clown, his work highlighted the potential for healthcare clowning as an artistic, patient-centred, holistic, body-and-mind-centred approach aimed at maintaining and/or improving well-being in patients. At the core of his work, Adams (2002) believed in a *love strategy* - "reconnect[ing] the delivery of care to compassion, joy, love, and humour" (2002: 447).

Although therapeutic clowns practice in a number of healthcare settings worldwide, most predominantly in paediatric settings, it has evolved to include working with those undergoing dialysis, as well as supporting patients in oncology wards, burn units, emergency units, infertility and IVF units, palliative care and surgery (Warren and Spitzer, 2011). In this capacity, therapeutic clowns aim to cultivate positive feelings in adverse environments (Auerbach et al., 2016). They aim to reduce patient stress, and support them, their families, and staff, "to develop positive attitudes, coping mechanisms, and resilience in the face of illness, tragedy, and catastrophic health events" (Warren and Spitzer, 2011: 562). It does so mainly through clown skills, sensitive interaction, positive distraction and, more specifically, "by means of humour, laughter, fantasy and empathy" (Pendzik and Raviv, 2011).

More recently, therapeutic clowning has developed in elderly care – clowns working with older persons in geriatric wards, residential care, and other healthcare settings such as frail care (Warren and Spitzer, 2011). Therapeutic clowns that work with the elderly are specifically referred to as *elder clowns*. While hospital-based therapeutic clowns visit patients in their ward or hospital rooms, elder clowns specifically engage the elderly in the place that they call home and a space where most residents are not bedridden (Warren and Spitzer, 2011). Bernie Warren, clown and founder of *Fools for Health* (Ontario-based therapeutic clown program), and Peter Spitzer, the co-founder and Medical Director of the *Humour Foundation* (Australian-based therapeutic clown organisation), explain that:

> *"The residents of care facilities for older people are often afforded few choices about their lives. Many do not have a key to their front door, they cannot choose their home furnishings or what colour to paint their walls. This loss of control and independence tends to exacerbate negative feelings that may already be present as a result of the loss of old friends and a diminution in physical abilities and, for some, mental acuity. Recent research has suggested that some older people who use humour as a way of coping with the challenges of ageing might be more likely to live longer, age well, and be more satisfied with their physical health and experience a better quality of life. However, opportunities to experience humour and laughter can be hard to come by for residents of residential care facilities" (Warren and Spitzer, 2011: 562).*

In this way, therapeutic clowning, and specifically elder clown programs, may assist in meeting some of the needs of seniors, especially those with dementia (Warren and Spitzer, 2011). These may include providing clown-based engagements and scenarios ('clown plays') that give the elderly a sense of control and choice, as well as creating opportunity for them to experience joy, humour, laughter, connection and company, which, as mentioned above, may assist with developing, or enriching, coping mechanisms and overall quality-of-life.

Chapter 1

Aims and Rationale

Dionigi and Canestrari (2016) highlight that research in the field of therapeutic clowning is still very young; the first published article evaluating the efficacy of clowning was with pre-operative children released in 2005 (Vagnoli et al., 2005). Whilst studies within this field have largely focused on children, there have since been several studies conducted in various healthcare settings with different population groups, all of which suggest a general effectiveness of therapeutic clowns (Dionigi and Canestrari, 2016). With this said, Dionigi and Canestrari (2016), suggest how further research should focus more on adult patients, such as the elderly, "where clowns have proven to be effective in inducing positive emotions, as well as on the [positive] perception of relatives and healthcare staff" (Dionigi and Canestrari, 2016: 485).

The elderly are an often forgotten population group – they are a people often dismissed as already having lived their lives and, when placed in a care home, become, quite literally, out of sight and out of mind. Comedian Ricky Gervais - whose series *Derek (2013)* explores life in an elderly residence - pointed out that the elderly are forgotten by society, not because people are cruel, but because the elderly remind us of our own mortality (Hall, 2013). In other words, many fear the idea of getting old; concerns may include a probable mental and physical health decline, increased need for medical attention, and an increased reliance on others, as well as losing one's independence and freedom, and the ever nearing eventuality of death. In South Africa, there are various concerns surrounding elderly quality of life and elderly care: systemic and financial difficulties, racial tension, access to healthcare, access to *quality* healthcare, and unreliable family support due to economic pressures, all of which add to a need for more short and long-term elderly care facilities, as well as psychosocial support (Makiwane et al., 2004).

The life expectancy of the elderly are rising worldwide; 80% of whom will be living in low-to-middle income countries (Gerber et al., 2016). In Sub-Saharan Africa alone, the elderly population will increase from 36.6 million to 141 million by 2050 (Gerber et al., 2016). Troisi (2004) says that "[t]he significant increase in life expectancy unavoidably implies not only heightened demand for existing services but also new services and alternative approaches to meet varied and specific needs of older persons" (Triosi, 2004, cited in Makiwane et al., 2004: 9).

A South African study by Hao et al. (2017) showed a direct relationship between a lack of social participation and increased depression and loneliness amongst the elderly. This included a lack of community activities, as well as relationships (friends and family). They advocate for increased social participation as a means to reduce depression and loneliness amongst the local elderly population. In addition to benefits of humour, therapeutic clowning, as a form of social engagement, may be a means of supporting and contributing to existing elderly care. Clown interventions with the elderly are considered a promising practice for improving elderly quality of life (Dionigi and Canestrari, 2016: 484).

In South Africa, therapeutic clowning, and in particular, elder clowning, is in its infancy; with this said, there is growing interest - Dr. Amnon Raviv, an Israeli-based clown, recently visited South Africa to launch his book and hold various workshops. Local companies that focus on clown-based psychosocial support include Clowns Without Borders South Africa (CWBSA), founded by Jamie Lachman, and The Upliftment Program (The UP), started by Nicola Jackman and Lucille Greeff. The UP specifically train volunteer care clowns to be able to visit and offer joy in hospitals. I have trained and worked with both of these companies; I have witnessed the positive impact clowning can have on others, and the positive responses it can elicit. There is, however, little therapeutic clowning research within the context of South Africa, and even less around clowning with the elderly. McMahan (2008)'s *Infinite Possibility: Clowning With Elderly People*, documents her experience of clowning within an elderly home in Ficksburg, South Africa, as part of the 2006 *Clowns Without Borders Project Njabulo* expedition to Lesotho. Her paper, along with the largely positive international studies, suggests that there may be therapeutic potential for this work within local elderly homes, providing not only the possibility for joy and laughter, but also *a compassionate communicative connection*, giving agency to those often powerless (McMahan, 2008: 24). Existing research effectively encourages further inquiry into the potential efficacy of this work both locally and specifically with the elderly. How, and in what ways therapeutic clowning may be considered effective, are explored within this practice-based and practice-led research.

This study aimed to explore therapeutic clowning in the context of an elderly home in South Africa. It focused on capturing the experiences of the elderly in relation to a therapeutic clown intervention. Additionally, it captured the experiences of the staff and social workers on duty, as well as my own experience as both the research-therapist and the clown. In this way, it aimed to reveal possible (positive) effects of therapeutic clowning on the elderly and staff, and how these might contribute towards existing elderly care.

Research Questions

1) In an effort to understand if, and in what ways, clowning might benefit an elderly group in South Africa, as well as potentially support and enhance existing elderly care, this study unpacked the experiences of those who observed and/or participated in the therapeutic clown intervention, by asking:
   - What was the experience of the participants and observers of the therapeutic clown sessions?
     - What did the elderly experience and learn?
     - What did the staff experience and learn?
     - What did the social-workers experience and learn?
     - What did the researcher-therapist experience and learn?

By understanding these experiences, this study revealed what may or may not have been effective, and how clowning might contribute towards elderly care by asking:

- To what extent was this intervention effective?

And,

- Based on this intervention, what could therapeutic clowning offer existing elderly care in the context of an elderly home in South Africa?

2) As this study formed part of a Masters in Drama Therapy, I approached the work as both a drama therapist and a therapeutic clown. In this way, it further asked:
   - In what ways can drama therapy inform this practice?

And,

- In what ways can this study engage and probe discussion around the relationship between drama therapy and therapeutic clowning?

In order to answer these questions, a descriptive case study approach was used. This qualitative methodology has the advantage of including and containing the voices of the participants, including that of the research-therapist/clown (Jones, 2005).

Definitions - A Brief Classification of Key Terms Pertinent to this Study

The words 'healing', 'well-being', 'quality of life' and 'health' are often loosely referred to in the writing of therapeutic clowning, as well as drama therapy. This section aims to provide clarity of these terms in relation to how they are used in this study:

Healing – "Healing may be operationally defined as the personal experience of the transcendence of suffering" (Egnew, 2005: cited from the abstract). This paper defines healing as the personal experience of *feeling better*. This can also include the visible presentation and/or observational judgment of feeling better – in other words, a nurse seeing an improvement in a patient's mood or physical well-being.

Well-being – "[W]ell-being is when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge" (Dodge et al., 2012).

Well-being and quality of life are often used interchangeably thus making defining them "conceptually muddy" (Dodge et al., 2012). Whilst well-being can be used in isolation with reference to psychological, social or physical levels of comfort, health or happiness, for example, my mental well-being, as opposed to my physical well-being, 'quality of life' is far a more over-arching a concept:

Quality of Life (QoL) – refers to "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment" (WHO, 1997). It is thus the "extent to which pleasure and satisfaction characterize the human experience" (Farquhar, 1995: 1440). Health within the elderly has been shown "to be a vital part of [their experience of] quality of life; decline in health was associated with a decline in other activities, loneliness and a greater reliance on others" (Farquhar, 1995: 1440).

Health - The World Health Organisation define 'health' as inclusive of physical, mental and social well-being – not merely the absence of disease (WHO, 1997).

Chapter 2

Literature Review

This chapter will look at the evolution of the clown into healthcare, specifically elder care, and its relationship to the healing arts. It also serves as a means to understand and unpack therapeutic clowning in relation to drama therapy, as forms of creative and expressive arts therapies. Before moving into the method, this chapter ends with a look at the research paradigms that informed this study.

The Clown as Healer

One might not ordinarily associate a clown with well-being or healing. Many might have the image of a birthday or circus clown typically in mind - the clown with a bright curly-haired wig, oversized shoes, and garish make-up – and wonder how the two might relate. Based on scary depictions in horror films, such as Stephen King's *IT*, some might even fear clowns – 'coulrophobia' – further distancing the possible consideration for such a relationship. And "yet the relationship between clowns and those in need of healing should not be so surprising" (Koller and Gryski, 2008: 18).

The clown – also known as the fool, buffoon, jester, etc. - is an archetypical figure that has always existed, making people laugh because of its accidents, failures and faults (Miller, 2006, Warren and Spitzer, 2013). According to Cotlov (1999), the hospital of Hippocrates on Kos island kept players and clowns in the quadruple "in the belief that mood influenced healing and that convalescents ought to be kept happy and amused" (Warren and Spitzer, 2013: 7, Cotlov, 1999). Medieval court jesters were used to improve the mood of kings, clergy and the common people (Warren and Spitzer, 2013). Court jesters were often used to help monarchs and nobles when they felt melancholic, in fact, it was one of their primary functions (Warren and Spitzer, 2013), for example, *Il Matello* helped Alfonso D'Este, Duke of Ferrara, in forgetting about his serious illness (Warren and Spitzer, 2013). Clowns have also appeared in some First Nations as Sacred, such as the sacred clowns of the Hopi which serve as jesters, priests and shamans (Koller and Gryski, 2008, Cline, 1983). Clowns have, historically and culturally, been associated with the well-being of society and the healing arts (Koller and Gryski, 2008), but "because they [clowns] were [often] seen as simple entertainment, [they] were not studied seriously for many decades" (Christen, 1998: xi).

"Whether selling burgers, challenging religious truths, saving lives or seemingly just entertaining us, the clown… [has] performed many functions for his culture" (Bala, 2010: 50). Clowns, and it's archetypal trickster, "…reverse order, invoke chaos, and epitomize unpredictability" (Christen, 1998: xi). Clowns are not representative of a perfect ideal; they are flawed and vulnerable, and yet their messiness, their dualism and paradoxical nature allows for "pure possibility" (Babcock-Abrahams, 1975). Clowns are "the embodiment of hope in the face of hopelessness, and possibility in the face of impossible" (Henderson, 2005, cited in Koller and Gryski, 2008). Cline (1983) describes the essence of the clown:

> *"[The clown] is our scapegoat, "he who gets slapped," suffering every indignity that the human mind can conceive. He is our alter-ego, vicariously acting out the unspoken desires that we could never hope to act on in reality. He is our critic, piercing through our cultural hypocrisies with well-aimed barbs. And he is our healer, enabling us to laugh at the realities that could too easily make us weep" (Cline, 1983, cited in, Koller and Gryski, 2008).*

From a modern and performative perspective, author, clown and clown-teacher Jon Davison explains that:

> *"…[C]lowning gives us strange, odd, and generally "wrong" behaviour: mishaps, failures, surprises, misunderstandings and mistakes. Some clowns speak, others are silent, some participate themselves into physical danger, others reflect leisurely upon the situation" (Davison, 2013: 131). And yet, "[d]espite the recurrence of slips, falls, mistakes, errors and mishaps, the result is not tragedy but joy" (Davison, 2013: 15)*

It is through the clown's vulnerability, through its tragedy, that it becomes comical and even endearing. The clown, in many ways, holds up a mirror to its audience. As the audience, we know about mistakes and failures, we laugh because they are familiar - we recognise them in society and ourselves, and because we know them (quite personally), there is a shared human experience. It is the shared experience of these shortfalls that allow us to laugh. The clown reminds us "about our imperfection and disorder and chaos and, eventually death, in a way which is based on humour…" (Miller, 2006: 1). Thus, "the use of the clown is to process, with humour, the tragedy of life…" (Miller, 2006: 1).

Therapeutic clowning

Towards the end of the 19th Century, *The Fratellini Brothers* (a famous clown trio) began visiting hospitals (Warren and Spitzer, 2013). "From 1908 onwards, regular reports beg[a]n of other circus clowns performing occasional clown rounds, predominantly in children's wards" (Warren and Spitzer, 2013: 7). Modern and professional hospital clowning is recognised as having formally begun in 1986 with the independent clown-doctor programs of Karen Reidd (as *Robo the Clown*) in Winnipeg, Canada, and Michael Christensen (as *Dr.Snubbs*) and Jeff Gordon (as *Disorderly Gordoon*) in New York, USA (Warren and Spitzer, 2013, Dionigi et al., 2012).

Pendzik and Raviv (2011) offer the following working definition for therapeutic clowning:

> *"[T]herapeutic or medical clowns (also called clown doctors), are clown therapists who work in hospitals and other healthcare settings. The goal of the medical clown is to provide support for the sick and their families, promote their recovery process, and minimize stress in every possible way – including the healthcare setting itself. The medical clown achieves these goals through the use of clown's skills, and by sensitively interacting with patients, families, and staff by means of humo[u]r and laughter, fantasy and empathy" (Pendzik and Raviv, 2011: 268).*

This definition lists a number of alternative terms that can be used to describe these clowns – namely, clown doctors, medical clowns, as well as healthcare clowns, etc., all of which "donate a difference between being a clown in healthcare and being a clown in [, for example,] theatre" (Donnelly, 2019: 6). This study uses the preferred term 'therapeutic clown' as a more encompassing term to refer to clowns that ultimately work within a therapeutic context (Warren and Spitzer, 2011). The term therapeutic clown has also been used to describe clowns that specifically work alone (solo) (Pendzik and Raviv, 2011). Whilst this definition is befitting for this study which only used one clown in practice, it is not a standardised definition. This study recognises solo, duo or group clowns as 'therapeutic clowns'. In addition, 'therapeutic clowning' is referred to as the general therapeutic clown profession.

Therapeutic clowns "are not medical doctors, [nor psychotherapists, or psychiatrists], they are professional artists specially trained to work in hospital[s] and other healthcare settings" (Warren and Spitzer, 2013: 7). This does not mean that they are mere entertainers; they harness the innate capability of the artform to intentionally and thoughtfully bring about distraction, laughter and joy in a way that promotes healing and well-being:

> *"Their work is not mere entertainment. They interact with patients, their families and the healthcare team seeking to promote wellness and to improve quality of life through the use of artistry that includes music, improvisational play, magic and humour" (Warren and Spitzer, 2013).*

The founding programmes of Ridd and Christensen also represent two main ways in which therapeutic clowns can work – as a solo clown or working in pairs (Dionigi et al., 2012). The stylistic choice to work in pairs has been said to allow clowns the opportunity to support and engage each other, potentially relieving the client from feeling any pressure to participate (Pendzik and Raviv, 2011). On the other hand, those that work alone may promote a sense of intimacy and collaboration with the direct environment, as well as offering vulnerability which may mirror the experience of the client: feeling out of place in an otherwise adverse environment (Pendzik and Raviv, 2011).

Elder Clowns

Elder clowns denote the therapeutic clowns that specifically work with the elderly and in elder care (Warren and Spitzer, 2011). Elder clowns work with the elderly in geriatric wards and in residential care homes, the latter being a space often recognised as their last home (Warren and Spitzer, 2011).

Warren and Spitzer (2011) highlight various elder clown programmes around the world that use a range of approaches and clown-based techniques to support elderly care, for example:

> *"Hearts&Minds, based in Edinburgh, UK, uses clown-based techniques to encourage communication, interaction, and laughter in hospice, residential, or respite care, while in the Netherlands, the Mikkus Foundation uses clowns for sensory work and non-verbal communication with patients with dementia care in health-care settings. In Chicago, USA, The Big Apple Circus, Vaudeville Caravan works in residential nursing care facilities and uses a repertoire of recognisable songs, puppetry, dance and magic to help empower older people to take part in the action and express positive emotions" (Warren and Spitzer, 2011: 563).*

Multiple skills and artistic tools are incorporated into the clowning routines and engagements in order to connect with the elderly and meet their various needs. This includes offering artistic, entertaining, healing, communal and personal forms of engagement (Warren and Spitzer, 2011). Warren and Spitzer (2011) were involved in *Fools For Health Canada* and *The Australian Humour Foundation,* whose elder clown programmes sought to promote well-being and improve quality of life of the elderly using humour, music, and more specifically improvised play. The choice of clown material depends on the elderly present and what healthcare concerns there may be, as well as what the clown, or clown company - in accordance with the professionals on-site - feel might work best - for example, choosing more sensory and non-verbal communication for dementia care, or more lively and participatory interactions for more abled residents (Warren and Spitzer, 2011). Therapeutic clowns engage intuitively in the spaces they work in, listening and exploring creative possibilities together with the residents and staff, rather than imposing activities upon them (Warren and Spitzer, 2011). Unlike clowns that work in theatre or in the circus – therapeutic and elder clowns use gentle play, (appropriate) humour and therapeutic relationships to foster supportive environments (Warren and Spitzer, 2011).

The work of therapeutic clowns is intimate (Warren and Spitzer, 2011). An elder clown's costume is considerate of this close encounter. It is not a stage or circus that requires one to "play-big", nor does it require larger-than-life make-up or over-sized clothing in order to be seen or identified as a clown (Warren and Spitzer, 2011). Unlike the therapeutic clowns working in hospitals who play on the doctor's coat, many elder clowns use period inspiration when deriving their clown costumes, dressing in styles that draw from, and resonate with, an era, or decades, that many of the elderly may recognise (Warren and Spitzer, 2011). Not using a play on the doctor's coat also ensures that the clown does not confuse the elderly, particularly for those with dementia (there is a clear distinction between clown and doctor) (Warren and Spitzer, 2011). In addition, the intimate engagement means that elder clowns will perform more subtly than, for example, stage or circus environments. Elder clowns "rely on character-based idiosyncrasies to create humorous moments and relationships in their interactions with other people" (Warren and Spitzer, 2011: 563). Relationship is key to these interactions – this is further discussed under 'the therapeutic relationship'.

Elder clowns aim to visit and engage residents on a personal level (Warren and Spitzer, 2011). With this said, there are also opportunities for communal, or group, moments. Therapeutic clown visits can take place regularly, "however, frequency and duration of visits vary for each programme and can range from three times a week to once a month, with each visit usually lasting 2 to 4 hours" (Warren and Spitzer, 2011: 563).

Elder clowns also work with the healthcare team. Prior to a shift commencing, elder clowns typically "meet and interact with staff and receive notes about each resident's psychosocial and medical conditions. Elder clowns keep notes after the visit and share their observations with the health-care team" (Warren and Spitzer, 2011: 563). Elder clowns will use the information shared with them to help inform their work and approach.

> *"Elder clowns are improvisors who use staff information about a resident's abilities, previous history, and interests combined with their own experience and intuition to create tailored, [thoughtful] interactions, or "plays", with each resident" (Warren and Spitzer, 2011: 563).*

Clowns will then adopt various strategies in order to engage, connect and develop relationship and play. Other than the use of humour, music, and improvised play, clowns may ask stimulating questions to begin a conversation, asking residents to tell them a story, or asking for a piece of advice. "Elder clowns may encourage residents to take the lead in interactions" (Warren and Spitzer, 2011: 563). Through the clown's failures, intentional misunderstanding of instructions, and/or general foolishness, residents are given the opportunity to help the clown or to tell the clown what to do – "the clown's ability to evoke feelings of superiority in the spectator plays a hidden role in all clowning" (Towsen, 1976: 206) . In this way, the elderly residents may be given a chance to take on a (higher status) role that they may not usually experience in an elderly care facility; roles outside of the patient-nurse dynamic, and experiences outside of typical routines (Warren and Spitzer, 2011). These clown strategies "may return a sense of autonomy to individuals who may have little control over their lives" (Warren and Spitzer, 2011: 563). Warren and Spitzer (2011) highlight, in particular, the importance this may bear to those who do not receive many, or any, visitors. The visit of an elder clown, in this case, could be quite surprising, and possibly even touching and meaningful.

"The intention of elder clowns is to positively change the atmosphere of the facility" (Warren and Spitzer, 2011: 563); by positively affecting the atmosphere, the idea is that they will positively affect the emotional well-being, or mood, of those within the space. In terms of the potential benefits of elder clowns, elder clown research has shown that clowns can help the elderly in residential facilities to: “connect to their immediate surroundings; recognise family members; remember the past; improve cognitive functioning and communication skills, [improve their mood]; and increase quality of life in the elderly, their families and the healthcare staff that work with them” (Warren and Spitzer, 2013, Warren and Spitzer, 2011).

> *“Although more research is needed, our first decade of work as elder clowns suggests that a playful, improvisational, and light-hearted approach to psychosocial health may have beneficial effects on the lives of elderly residents, their families, and the staff who care for them. For older people who have experienced so many losses, the work of the elder clowns can return humour, playfulness, music and joy to their lives” (Warren and Spitzer, 2011: 563).*

Patch Adams argues that it can also bring a sense of love. Adams (2002) love strategy suggests that a therapeutic clown, or a clowning intervention, ultimately provides humour and love. The following sections will explore this further.

Humour, Laughter and Joy

The affective response to humorous stimuli is described as amusement (or exhilaration) (Auerbach et al., 2016, Ruch et al., 2009). “Amusement is displayed on a behavioural (e.g., smiling and laughter), physiological (e.g., changes in heart rate and skin conductance), and experiential level (e.g., changes in emotional state of mind)” (Auerbach et al., 2016: 15).

> *“In his 1927 paper entitled “Humour,” Freud tells us there is dignity in humor. “Humor fends off the possibility of suffering . . . ,” which, he says, “. . . places it among the great series of methods which the human mind has constructed in order to evade the compulsion to suffer”... Humor “. . . is a rare and precious gift . . .”... Freud views humor as a defence mechanism, in which the superego functions in a “friendlier” manner, a process of gaining mastery of one’s imperfections through a lighter touch. Of imperfection, Jung writes in Answer to Job, “imperfectum carries with it the seeds of its own improvement…” (Bala, 2010: 51-52).*

Clowns often elicit laughter and joy as a response due to comical, and, as mentioned, typically ‘wrong’ behaviour, as well as comedic material (humour), including silly songs and jokes. “Laughter is an observable reaction to a humorous situation in which physiologically, “muscles are activated; heart rate is increased; respiration is amplified, with increase in oxygen exchange” (Fry, 1971)” (Adams and McGuire, 1986: 157). Laughter is inconsistent with anger and depression (Adams and McGuire, 1986); in other words, laughter can assist in alleviating these experiences. Whilst amusement and joy are manifested through laughter, the expression and communication of joy can be noted in other forms, e.g. smiling and bright eyes (Kontos et al., 2017).

> *"Medical research supports our human instinct that people who smile and laugh are [usually more] happy, whereas those who are inexpressive are usually not happy. Behaviour markers for depression include social inactivity, nonspecific gaze, no mouth-or-eye-region movements, and[/or] withdrawal. Behaviour markers for recovery of depression include social smiles, raised or wrinkled eyebrows, social laughter, gesticulation, pointing, help, and social interest" (Williams & Wilkins, 1998, cited inMcMahan, 2008: 23).*

Humour has been understood to pervade "all aspects of human behaviour, thinking and sociocultural reality" (Apte, 1988, cited in Dean and Gregory, 2005). Dean and Gregory (2005) examined the phenomenon of laughter and humour in the palliative setting, and by doing so highlighted the important role that appropriate humour and laughter can have in improving quality of life in difficult scenarios and settings. They concluded that humour, in combination with care and sensitivity, can be a powerful therapeutic tool and one that should not be taken for granted, nor considered trivial.

There is a plenitude of research documenting the health benefits of humour (McMahan, 2008, Rosner, 2002). Humour has been shown to reduce "anxiety, tension, stress, depression, and loneliness; improv[e] self-esteem; it restores hope and energy; provides a sense of empowerment and control" (McMahan, 2008: 23). Laughter has also been shown to increase oxygen levels in the blood, enhance the immune system, ease muscle tension, reduce vascular stasis, and release endorphins, as well as counter depression, anxiety, psychosomatic symptoms and improve quality of sleep (McMahan, 2008, Berk, 2001, Rosner, 2002). Laughter has been shown to "improve overall mental functioning and increases interpersonal responsiveness, alertness and memory" (McMahan, 2008: 24). Humour and laughter can have a direct positive effect on emotional and physiological processes, as well as on pain tolerances (Warren & Spitzer, 2013).

In terms of the elderly, humour and laughter have been found to affect how the elderly experience and perceive pain (Adams and McGuire, 1986). In their mixed methods study titled *Is Laughter the Best Medicine? A study of the effects of Humor on Perceived Pain and Affect*, Adams and McGuire (1986) found humour to have significant benefits for the elderly. Their study used films, one which could be perceived as funny and another as not, which were shown to two different elderly groups. Differences in their perceived pain and affect were observed. The group exposed to humour, were shown to have increased reduction in perceived pain as opposed to those not exposed to humour. The first group also experienced an improvement in affect, defined as "a global feeling toward life in the present" (Adams and McGuire, 1986: 162). In other words, whilst the elderly may have been experiencing pain, they felt better or were distracted enough not to perceive the pain to be as grave, or even present, during those moments of joy. "The fact that laughter makes people feel better can be verified by many nurses in long-term care facilities" (Adams and McGuire, 1986: 157).

Humour, laughter and joy are not solely applicable to the care and well-being of patients and clients. Many nurses have been found to " feel disconnected from their organizations, morale is plummeting, and employee mistrust and cynicism are growing" (Manion, 2003). Whilst Manion's study is from 2003, it's important to note that "serious financial difficulties, declining employee commitment, and escalating patient and family demands, as well as new crises every day" (Manion, 2003: 652), are factors that lead to feeling less joy in the (health care) workplace.

> *"How we feel about and enjoy our work is crucial to how we perceive the quality of our lives. However, loss of joy is more than a personal issue; it is also an organizational issue. Positive mood has been directly linked to linked to a range of performance-related behaviours including greater helping behaviour, enhanced creativity, integrative thinking, inductive reasoning, more efficient decision making, greater cooperation, and the use of more successful negotiation strategies. Positive emotions, such as joy, have the potential of making the workplace a much more pleasant and appealing environment. Joyful people are inviting to others, which positively affects the quality of relationships in the workplace. Engagement and commitment of employees is related to their attitude about their work and influences retention rates" (Manion, 2003: 652).*

From this, one can deduce that joy can have a positive effect on staff and their general working environment, which the elderly form part of. In this way it can thus additionally and inadvertently benefit the elderly; as mentioned, a positive environment can lead to positive emotions: "[p]eople's mood are often affected by the moods of the people around them" (Manion, 2003: 658).

Positive feelings from engaging with a "loving" clown can also *transcend* the humour response (Auerbach et al., 2016). This *transcendence* includes feelings of attachment, as well as "the feeling of being uplifted and surpassing the ordinary, for example, feeling elevated, privileged, appreciated by, and associated with the clown" (Auerbach et al., 2016: 15). In other words, these feelings are related to relationship and connection.

Whilst humour and laughter are important aspects of therapeutic clowning, McMahan (2008) argues that clowning with the elderly brings far more benefits than laughter alone – rather, clowns create *compassionate communicative connection*. Patch Adams (1998; 2002) highlighted the value of relationship, largely in the form of friendship, in both therapeutic clowning and in healthcare. In my separate interviews with professional therapeutic clowns Helen Donnelly (2019, Appendix A) and Olivier-Hugues Terreault (2019, Appendix B), they both described the importance of relationship development in therapeutic clowning. For Terreault (2019, Appendix B), the aim and skill of the therapeutic clown is trust development; he refers to therapeutic clowns as "trust-based accelerators" – using clown skills to enhance immediate connection.

Terreault (2019, Appendix B) explains that in therapeutic clowning, "the first stage would [be to] develop a trust-based relationship with someone in a vulnerable state…We [often] have 20 seconds to 2 minutes to be able to develop a trust-based relationship. So, we come into the room, we do not know each other… and in that short space of time we need to develop this powerful trust-based relationship" (Terreault, 2019, Appendix B: 5). The clown meets this vulnerability by being vulnerable themselves; an act of meeting and mirroring each other. Terreault (2019, Appendix B) goes on to explain that the clown in essence 'seduces' the person they are working with using artistic skills; Adams (2002) refers to compassion and generosity as a means of seduction. You want the elderly to feel like "wow, I really like this person [this clown], I want to be closer to that person, I want to invite that person into my world" (Terreault, 2019, Appendix B: 5). The point is to develop trust so that you can get to place where you can play together, sing together, dance together etc., and not feel embarrassed. You want to create a safe space for possibility. At first, the clown may do a lot of this initial work, prompting while the elderly observe, but as time goes on and as the trust develops between them, the elderly may join in and even instigate the interaction/s. Terreault (2019) describes how making the elderly feel as though they can help the clown is one way to achieve this. The clown is vulnerable, and clumsy, and in need of their assistance. The clown is not presented as the expert, the elderly are; they are on a journey together. As described before, this is a form of role reversal, but also seduction – giving people the opportunity to help others who suffer is what Adams (2002) deems the strongest transforming mechanism. Giving "agency to [an often] powerless individual does wonders to that person's emotional state. An interaction that is shaped entirely around specific individuals changes their entire reality" (McMahan, 2008: 24).

Relationship is a core feature of most therapies. In drama therapy it is noted that "the use of drama in and as therapy leads to a process that emphasizes relationship…" (Emunah, 1994: 33); a process that appears to resonate with therapeutic clowning. Like most therapies, the therapist and client are fellow travellers, "both simply human, all too human" (Yalom, 2010: 10); they are both *wounded healers* that meet and journey together, sharing the way forward (Yalom, 2010). *The Gift of Therapy* (2010) is psychiatrist Irvin Yalom's culmination of thirty-five years in clinical practice presented in bound tips and insights. As a psychiatrist, Yalom (2010) draws on a variety of methods from Freud, Jung, Perls' Gestalt Therapy, as well as a Roger's humanistic approach, all of which inform tailored practice, based on the individual and the situation. At the book's core is the relationship between therapist and client, which can, in and of itself, be considered healing:

> *"A great many of our patients have conflicts in the realm of intimacy, and obtain help in therapy sheerly through experiencing an intimate relationship with the therapist. Some fear intimacy because they believe there is something basically unacceptable about them, something repugnant and unforgivable. Given this, the act of revealing oneself fully to another and still being accepted may be the major vehicle of therapeutic help. Others may avoid intimacy because of fears of exploitation, colonization or abandonment; for them, too, the intimate and caring therapeutic relationship that does not result in the anticipated catastrophe becomes a corrective emotional experience" (Yalom, 2010: 11).*

According to Yalom (2010), the care and maintenance of the client-therapist relationship is key and for many therapeutic clowns, this can be considered even more important than laughter (Adams, 1998, 2002; Terreault, 2019, Appendix B). Yalom (2010) tells the reader (the therapist) to let the patient matter to them (Yalom, 2010). He explains that the task of the therapist is to "establish a relationship with the patient characterized by genuineness, positive unconditional regard and spontaneity" (Yalom, 2010: 34). Like with therapeutic clowning, Yalom (2010) explains that:

> *"At its very core, the flow of therapy should be spontaneous, forever following unanticipated riverbeds… One of the true abominations spawned by the managed-care movement is the ever greater reliance on protocol therapy in which therapists are required to adhere to a prescribed sequence, a schedule of topics and exercises to be followed each week" (Yalom, 2010: 34).*

What Yalom (2010) highlights is that each client and situation is unique, and thus requires a unique therapy – not a one size-fits-all approach. Meet the person and adapt accordingly. The "task is to build a relationship together that will itself become the agent of change" (Yalom, 2010: 35). Therapeutic clowning is social and spontaneous. Spontaneity is used as a means to create and navigate connections; spontaneity is to work with what is present in the 'here and now'; it is to intuitively engage – to trust, to listen, to learn, and to play, all while respecting and serving the client.

> *"The here-and-now refers to the immediate events of the therapeutic hour, to what is happening here (in this office, in this relationship, in the in-betweenness – the space between you and me) and now, in this immediate hour" (Jones, 2007: 47).*

All we have is the present; this is where the therapeutic exchange occurs (Jones, 2007; Yalom, 2010). The clown does not deal with the end result, it deals with the present; it functions in the 'here and now', with current emotions. The clown's presence mirrors the way we subsequently deal with emotions. We can only heal in the present; you cannot change feelings that are in the past, nor those unknown in the future. The 'here and now' offers the possibility for some kind of therapeutic engagement. This is what probably makes the clown 'therapeutic' to a large degree: the clown's presence or ability to make present ('presence-ing'). This echoes Gestalt therapy which facilitates an "awareness of behavioural and emotional experiences in the present" (Sue and Sue, 2007: 152) The 'here and now' becomes key to how a person interacts with the world and their process of healing (Sue and Sue, 2007). Yalom (2010) adds to this by suggesting that "the rationale for using the here-and-now rests upon… 1) the importance of interpersonal relationships and 2) the idea of therapy as a social microcosm" (Yalom, 2010: 48). As human beings we are social, relational beings. Human problems are often relational and an individual's interpersonal problems will ultimately manifest in the here-and-now of the therapy encounter (Yalom, 2010). They may also enter the relationship with the therapist giving opportunity to explore and reimagine them.

Connection is nuanced and complex. Whilst the therapeutic relationship is key, connection can happen in a number of ways. Observing, or witnessing, an interaction is a form of connection that results in its own affect:

> *"observers [may] experience different emotions than participants of clown interventions. For example, being involved in the clown's jokes and tricks may result in feelings of amusement and playfulness, whereas observing it might result in a feeling of elevation, touch, or gratitude" (Auerbach et al., 2016: 16).*

Over and above the described humour (amusement) and love (transcendent) responses to the clown, there can also be the experience of "high (e.g., feeling overexcited) versus low (e.g., feeling speechless), as well as arousal, and uneasiness… (e.g., fearful, threatened)" (Auerbach et al., 2016: 15).

Song and Dance

Warren and Spitzer (2011) highlighted music and dancing as two specific elder clown tools used with residents. Music is increasingly being used as a therapeutic tool for the elderly, and more specifically, for people with dementia (Brancatisano et al., 2019). The therapeutic value of music is attributed to it being "persuasive, engaging, emotional, personal, physical, and social, and it affords synchronization" (Brancatisano et al., 2019: 1435). Music, whether playing it or listening to it, engages the brain. It can support, stimulate, enhance, and stabilise cognitive functioning (Brancatisano et al., 2019). It can stimulate memory and reinforce neural scaffolding (Brancatisano et al., 2019).

> *"In the last decade, music-based activities have been implemented as a way of alleviating negative symptomology associated with dementia (primarily AD), such as agitation, anxiety… and depression" (Brancatisano et al., 2019: 2).*

Music can capture our attention. It has a strong correlation with emotion. It can reduce apathy and increase smiling behaviours (Brancatisano et al., 2019). It can be used to reminisce and to awaken memories; "the effects of music can benefit people with AD [Alzheimer's Dementia] not only by eliciting memories but also by inducing a positive state of mind" (Brancatisano et al., 2019: 4). Some musical functions and musical memory are spared in people with Alzheimer's dementia, for example, the ability to learn new songs and the ability to detect emotional meaning in music (Brancatisano et al., 2019), thus enhancing the possibility for its use as therapy in dementia care.

The adverse side effects of incorporating music into therapeutic interventions are rare (Brancatisano et al., 2019). With this said, negative experiences can manifest if the music is intrusive, unappealing, or happens to reinforce depressive tendencies (Brancatisano et al., 2019). Careful choice of music and paying attention to the client/s during music use are important. Gibbons (1977) highlights how adults typically prefer the music of their young adult lives.

Combining music and movement can encourage "exercise and [can] subsequently benefi[t] cognition, mood and behaviour" (Brancatisano et al., 2019: 1435). Exercise can decrease depression, and has even been shown to decrease depression in those with dementia (Brancatisano et al., 2019). Inactivity can result in "greater percentages of body fat; poor cardiac conditioning, reduction in muscle mass; less body strength, endurance, and balance; consequently, these physiological limitations subject older adults to less than optimal quality of life (Alpert, 2011). Hui et al. (2009) and Hopkins et al. (1990) found that dancing had both physical and psychological benefits on the elderly. Dance has been to shown to improve memory and attention (Alpert, 2011). In a more recent pilot Masters Dissertation study by Choo (2018), the use of reminiscent music and movement with elderly with dementia, as part of a particular curated program and methodology, "provided a sense of aliveness, fun, humour, playfulness and imagery that motivated the study participants to dance and interact with joy" (2018: ii).

> *"Dance is a mind-body experience that increases blood supply to the brain, provides an outlet for releasing emotional expression, allows for creativity, and the socialization aspect lowers stress, depression, and loneliness" (Alpert, 2011: 156).*

Whilst music and dance have been shown to be effective in reducing anxiety, the use of humour has, however, been shown to have greater anxiety-reducing results than that of music and aerobics (McMahan, 2008). Thus, therapeutic clowning, that uses a combination of these experiences (humour, music and dance), could arguably offer a greater range of anxiety-reduction and positive effects.

Drama Therapy and Therapeutic Clowning

Whilst the above literature pinnacles the clown, it is drama therapy that formed the foundation upon which this intervention was ultimately understood and constructed. Drama therapy is the "involvement in drama with a healing intention" (Jones, 1996: 6). Both drama therapy and therapeutic clowning appreciate the dramatic arts as a means to facilitate therapeutic change.

> *"Drama therapy is the intentional and systemic use of drama/theatre processes to achieve psychological growth and change" (Emunah, 1994: 3).*

These *processes* include, among others, "creativity, playing and acting" (Jones, 1996: 8). In drama therapy, the therapeutic "tools are derived from theatre, [and] the goals are rooted in psychotherapy" (Emunah, 1994: 3). It "uses the potential of drama to [explore], reflect and transform life experiences to enable clients to express and work through problems they are encountering or to maintain a client's well-being and health" (Jones, 1996: 8). It does not require the client/s to be versed in acting or theatre.

Drama therapy is conducted by a (trained and registered) drama therapist within a series of sessions (appointments). Session goals are often co-formed with client/s. There is no one particular technique and/or structure when it comes to drama therapy; some are more specific and structured than others.

> *"A drama therapist first assesses a client's needs and then considers approaches that might best meet those needs. Drama therapy can take many forms depending on individual and group needs, skill and ability levels, interests, and therapeutic goals. Processes and techniques may include improvisations, theatre games, storytelling, and enactment. Many drama therapists make use of text, performance, or ritual to enrich the therapeutic and creative process. The theoretical foundation of drama therapy lies in drama, theatre, psychology, psychotherapy, anthropology, play, and interactive and creative processes" (North American Drama Therapy Association, 2019).*

In this way, one might argue that (therapeutic) clowning could be a form of, or even a means – a process/technique – of carrying out drama therapy. As both a drama therapist and clown, I am in favour of this argument, or, at the very least, appreciate the possibilities of thinking in this way. Whilst drama therapy and therapeutic clowning share the dramatic tradition, they are, however, fundamentally perceived as two distinct professions, with their own unique practices.

The perceived relationship between drama therapy and therapeutic clowning is described by Pendzik and Raviv (2011) as *a family resemblance*. Pendzik and Raviv (2011) point out how, despite a number of similarities, and the fact they are both interested in the therapeutic value of performance, the disciplines have, for the most part, failed to really acknowledge and incorporate each other, for example, there is no mention of therapeutic clowning in latest edition of the book *Current approaches in drama therapy* (Johnson and Emunah, 2009) – a comprehensive collection of essays surrounding drama therapy methods and techniques, particularly those used in the US and Canada (Pendzik and Raviv, 2011). Drama therapy and therapeutic clowning have developed separately as professions (Pendzik and Raviv, 2011).

Key distinctions within the disciplines include *role* and *audience/client perception*. According Pendzik and Raviv (2011), the role of the drama therapist represents the 'real world', versus the clown who is always in role and represents the 'imaginary world'. It is the drama therapist who walks into the room before engaging the artform, or undertaking various characters or roles, versus the clown who arrives and leaves in character/role. More so, the clown is not seen by the audience/client as a therapist but rather as a character from the imaginary realm (Pendzik and Raviv, 2011). In addition, there is an arguable distinction in engaging in 'therapy' (attending therapy with a therapist), as opposed to experiencing something that is/can be 'therapeutic'.

With this said, Pendzik and Raviv (2011) "paper shows that the clown's working techniques can be conceptualized using drama therapeutic models and theory, and that using this approach as a method of analysis can serve to enhance the body of knowledge of the rapidly growing profession of therapeutic clowning" (Pendzik and Raviv, 2011: 267). More importantly, their paper cites the work of Grinberg (2009) who highlights how the therapeutic aspects of the clown, over and above humour and joy (or even love), "are related to [the] dramatic tools (or more specifically *drama therapy* tools) utilized by clowns. These include the facilitation of an encounter with the patient in the realm of imagination, and the variety of roles that the clown [and patient/s] plays" (Pendzik and Raviv, 2011: 268). In utilising the imagination:

> *"The great joy of play, fantasy and the imagination is that for a time we are utterly spontaneous, free to imagine anything. In such a state of pure being, no thought is "unthinkable." Nothing is "unimaginable." (1997, 5, cited in (Chodorow, 1997, 5, cited in Bala, 2010: 52).*

The world of imagination is a realm of possibility, which can be experienced almost as *real* (Pendzik and Raviv, 2011). Drama therapists use dramatic reality as a *complimentary dimension* offering clients a space to actively imagine and play in a physical, present and tangible space. In this way, imagination can be "legitimized, explored, mastered and transformed" (Pendzik and Raviv, 2011: 259). Research supports how the imagination can be used as a tool to improve physical and emotional well-being, as well as facilitate therapeutic change (Pendzik and Raviv, 2011, Lahad, 2019, Karpelowsky and Edwards, 2005, Lahad et al., 2010, Sabatinelli et al., 2006, Sheikh, 2003). Imagination can be a means to both cope and grow (Lahad, 2019, Lahad et al., 2010).

> *"Drama therapy uses human imagination as a healthy psychological strength. It works by helping people put their imagination into action in ways that activate positive attitudes and outcomes" (Pendzik and Raviv, 2011: 269).*

Pendzik and Raviv (2011) go on to discuss the clown as symbolic of this world of imagination, "a distinctive representative of this realm" (Pendzik and Raviv, 2011: 269). When the clown enters the room, they offer those they encounter an immediate connection to imagination. As imagination is already innate in human beings, the idea is that the clown reminds those they engage with of a tool that can be accessed within, and more importantly, over and above sessions (Pendzik and Raviv, 2011).

Drama therapy and therapeutic clowning "make therapeutic interventions from within dramatic reality" (Pendzik and Raviv, 2011). Within the drama therapy session, drama therapists can become performers, stepping in and out of various roles. Some, like David Reid Johnson, spend most of the session in the *play space,* within which they offer their client/s an "empathetic feedback in embodied, imaginal form" (Johnson, 2009: 96, cited in Pendzik and Raviv, 2011: 269). Therapeutic clowns, however, are always in role; much like the patient (Pendzik and Raviv, 2011), or a resident in an elderly home.

> *"… [And yet,] within this fixed role, a sense of flexibility may emerge as the clown approaches, as he or she represents someone who defies the role's very structure, plays with it, and expands its variations, shifting from one aspect to another, introducing paradox, and moving within the role with the freedom that only the Fool and the Trickster archetypes can offer… " (Pendzik and Raviv, 2011: 269).*

Thus,

> *"…in its archetypal strata the clown is a symbolic type that has the capacity to move above context and therefore, to disintegrate the framework of the hospital [or elderly residence, or any space for that matter], keep its boundaries flexible and fluid, and establish its own prerogatives as a way of life" (Grinberg, 2011 :49).*

Grinberg et al. (2011) approach an understanding of the clown and the patient/client through the concept 'role perspective'. As described, the clown and its fellow participants can assume a variety of roles. Role theory is primarily located within Robert Landy's (1994, 1993) 'role theory' and 'role method'. According to Landy (1994, 1993), people play multiple roles, and the relationship between these roles and their interaction with the external social environment (other people), each person will subsequently develop a personal role system (Grinberg et al., 2011). Personality is, therefore, a construct; "a dynamic system of roles" (Grinberg et al., 2011: 43). The more a person can grow their personal role system, by engaging with a variety of roles, the more balanced and thus healthier they become (Landy, 1994, Landy 1993, Grinberg et al.,, 2011). Landy's (1994, 1993) method of drama therapy encourages us to engage with our 'counter roles'. These are not necessarily opposites or negatives, but perhaps denied or avoided sides to the roles we play. Within the dramatic reality, the clown and patient can take on several roles, e.g. doctor, nurse, pilot, etc., whatever the fantasy presents. In addition, patients, or the elderly in a care home, are usually of lower status compared to the staff, and not having as much independence and freedom can remove their agency. Roles can be linked to status (Johnstone, 2012, Landy, 1993, Landy, 1994, Grinberg et al., 2011). The clown, who fumbles and falls, presents a low status, requiring the assistance of a patient or elderly resident, thus giving them higher status (Terreault, 2019, Appendix B). This role play, and status play, can uplift, transform and allow for an experience that may not always be possible in reality, but it most definitely possible in dramatic reality (Landy 1994, Landy 1993, Terreault, 2019, Appendix B).

Phil Jones (2007; 1996) compiled, reflected on, and thus created a body of knowledge and a corresponding set of core therapeutic processes that form the thread, or the umbrella, for understanding drama therapy. He claims that drama therapy is effective and its' effectiveness is identified by, and highlighted in, different elements that combine in drama therapy work, like those mentioned above. These are not specific techniques, instead they are the fundamental/core processes within all drama therapy and they describe the nature of change in drama therapy. In other words, these key processes "are the main ways in which therapeutic change occurs” (Jones, 1996: 7). Over and above those already mentioned, these include: *dramatic projection* (projecting experiences into theatrical forms and externalising inner conflicts); *playing* (a playing state has a unique relationship to time, space, everyday rules and boundaries); *drama therapeutic empathy and distancing* (dramatic work can encourage empathy; distancing encourages thought, reflection, perspective); *active witnessing* (seeing and being seen, this involves witnessing oneself or others and/or being witnessed by the therapist, the group or family present); *embodiment* (physically expressing and encountering material in the ‘here and now’ or dramatic presentation); *the life-drama connection* (bringing life into contact with drama; how the work affects real-life); *transformation* (the experienced changes in state; how drama can transform what we perceive and feel; as well as changes in role, moving from audience to actor etc.); *the therapeutic performance process* (the structure – the process of identifying a problem and expressing it using drama in some way); and the *triangular relationship* (though Jones (2007; 1996) does not express this specifically, it refers to the significant relationship between the client, therapist and the drama).

From these brief explanations, one might see how many of these *processes* apply to therapeutic clowning, how they are fundamentally being used (even if not directly described or recognised as such) and in so doing, may suggest why therapeutic clowning could be considered potentially (therapeutically) effective or observed and/or experienced as ‘therapeutic’, or even as a form of (drama) therapy. I suggest that we cannot fully separate drama therapy and therapeutic clowning, regardless of their notable differences. In relation to Grinberg (2011), the above drama therapeutic processes form a kind of conceptual framework within which one can further understand the inherent processes and thus the possible corresponding effects of therapeutic clowning.

What this drama therapy section, and literature, ultimately acknowledges is that there is potential for increased overlap between the professions, and whilst in its apparent infancy, the work appears to be more closely related than is often acknowledged and documented. Whilst the scope of this paper does not allow for a detailed investigation into this relationship, it recognises, values and explores the relationship none-the-less.

Research Paradigms

As a precursor to the following method chapter, this section introduces the literature concerning practice as a means of research. While this paper culminated into a descriptive case study report, it was based in practice, using performance as a means to evoke change. Practice-based research is research undertaken in order to gain knowledge by means of both practice and the outcomes of that practice (Candy, 2006). Performance-as-research is a model of knowledge-making located in an exploration of Praxis; emphasising practiced embodiment (Fleishman, 2012), and embracing physical intelligence as a valid form of knowledge. Here, research is derived from performance, and the research output can also be presented through performance, either partially or in full (Fleishman, 2012). Performance here being “close, active, immediate, on the move, embodied, sensual, fluid, interactional and affectively engaged” (Fleishman, 2012: 30). Praxis, in the context of this study, defines itself as being placed at the juncture of knowledge-making, as well as research conducted with that of theoretical compilation and analysis.

Therapeutic clowning and drama therapy are embodied practices; understanding how and why, largely requires doing and experiencing. Conquergood (2002) and Nelson (2006) discuss dominant (text, seeing, writing) and subjugated (masked, embedded, hidden) forms of knowledge and knowledge-making in academia. They suggest a collapse between theory and practice, as well as a hybridity, “a commingling of analytical and artistic ways of knowing” (2002: 151), within which, Maksimović (2015) highlights the importance of process and the place of researcher as participant. The researcher-as-participant supports an approach that embraces and draws from the subjective, adding personal enquiry into how we may understand an engagement that is in and of itself, personal, subjective, and based on experience.

Whilst practice-based and practice-led research are often used interchangeably, the latter refers to research which leads towards a new and/or added understanding about that practice, much like action research (Candy, 2006). A performance-based intervention, especially one where the performer is also the researcher, may include aspects and qualities of both; where information regarding experience (physical intelligence), ultimately contributes to understanding more about what a particular practice can do and offer. With practice-led research, “[t]he primary focus of the research is to advance knowledge about practice, or to advance knowledge within practice” (Candy, 2006: 3).

Practice-led research falls within the general domain of action research. Action research is ultimately concerned with changing a practice. An intervention, such as the one in this study, seeks to change and develop (socially situated) practice through a mode of reflective inquiry, action and re-action (Townsend, 2013: 7). It uses a cycle of planning, acting, observing, reflecting, and adjusting/changing, and so on, as described in the action research spiral of Kemmis and MacTaggart (1982) (Townsend, 2013). Whilst this may be the core of an intervention, this cycle is a natural part of spontaneous forms of performance, such as clowning, or specifically therapeutic clowning, and even therapy itself; they are (or at least should be) adaptive. Whilst a therapeutic clown may have various ideas, skills, possibly a repertoire of songs or even a bag of props (Warren and Spitzer, 2011), it is ultimately the client/s, as well as the situation, that will inform the engagement. Whilst one can prepare for sessions, sessions are never static and rigid. It is the client, the relationship with that client, and the circumstances that will directly inform the encounter and what transpires within and from it. This is what it means to be actively listening, present and working in the 'here-and-now' as both a clown and therapist. As the therapeutic clown learns what is being positively responded to, or negatively responded to, so they will adapt their performance (their practice) accordingly. This is done in an effort to provide a more positive, embodied and potentially therapeutic exchange between performer and participant/s within that specific context.

Chapter 3

Method

This section will focus on the specific procedures and techniques associated with the research as a whole, but more specifically the operationalisation of the therapeutic clowning intervention, how participants were chosen for the intervention and interviews, and how the subsequent data was collected, processed and analysed. This includes an understanding of the site (where the intervention took place) and the creation and operationalisation of the clown – namely, Miss. Whoopsie Daisy – the primary vehicle used to try and achieve elderly support, growth and/or change. This section also covers the study's design and a description of sessions.

The Site

The intervention took place at an elderly care home situated in the West Rand of Johannesburg, South Africa. The suburb has long been characterised as a low-income area. The home is a non-profit organisation that positions itself as a safe haven for the elderly and older destitute persons. Whilst it began as a support for those within the immediate area, it has since catered to elderly from across Gauteng. The home has both an elderly residence and a frail care unit catering to various stages and needs of elderly care. This study took place within the residential section of the home, in line with the non-medical ethics attained for this research (Appendix H). This research project was presented to the board of the home, which included the General Manager, in order to attain permission and approval for the study. All the necessary documentation was overseen with the support and approval of the WITS School of Arts and WITS Ethics.

At the time of this research, the home had approximately eighty-one (81) elderly residents – with some new members joining the home during the research process. Approximately fifty-five (55) of the residents belonged to the residence, the remainder of which were in frail care and thus fully dependant on caretakers and nurses. The age of the residents ranged between sixty (60) and ninety-four (94) years old; a gentleman aged one-hundred-and-seven (107) years old had passed shortly before sessions commenced. At the time of this study, the home had permanent and intern staff. The intern nurses would work shift; they were not always present for each session but rather intermittent sessions. The home's permanent social worker (Faye) and auxiliary social worker (Veronica) oversaw the intervention.

Prior to commencing the intervention, I conducted preparatory research in the form of visiting and touring the site, as well as a pre-interview with the home's general manager. This formed part of evidence gathering in order to implement a more considered and thoughtful intervention. My initial impression of the home was that it was a caring environment; the staff felt very hands-on. During one of my visits, the home's general manager, pseudonymised Berta, sourced for clothing for a new resident who appeared to not have any warm clothing upon arrival, and on Valentines the staff had put up some red and white banting and handed out wrapped chocolates. The home was also installing new curtains and blankets, and the walls were being painted lime green; Berta had researched this colour and had found it to be effective for those with Alzheimer's and dementia. With this said, I don't think one could easily ignore the almost embedded uneasiness or loneliness often associated with a care home. Residents could be seen knitting, reading, watching TV, smoking outside, and playing cards and dominoes. Some were sitting alone, others in groups, many asleep, other's falling asleep. I could imagine how difficult it could be adjusting to this new home; residents could not leave; they often shared rooms; there were specific routines, and of course, the typical struggles of mental and physical decline.

Of the eighty-one (81) residents, approximately thirty (30) to thirty-five (35) were reported as abandoned and destitute (General Manager, 2019, Appendix C). According to Berta, families have been known to drop elderly members off, some only visiting once or twice, then providing the home with incorrect contact details and never returning again. Berta described how in many of these circumstances, elderly who pass-on would be subject to a pauper's funeral by the State, which Berta sadly described as a kind of mass burial (General Manager, 2019, Appendix C). These were some of the very grim realities facing residents. These descriptions alone gave an idea into the possible loneliness and trauma that many of the residents may experience, including abandonment, depression, anger, betrayal and grief.

Berta also described how many elderly resist coming to the home; "they don't know what to expect and anticipate" (General Manager, Appendix C: 11). She described how some may not feel like they belong there and that it takes adjustment. Many of the elderly go from working all their lives, "to sitting and doing nothing" (General Manager, Appendix C: 11). Over time, some of the elderly may even get despondent, depressed or feel like 'giving up':

> *"…some of them [the elderly], actually said 'no I wish I could die tomorrow'. And they have, you know…they get to a point where [they say], 'no I'm not going to breakfast. I'm done with this now. I don't need this anymore'" (General Manager, Appendix C: 11).*

The general mood of the elderly was described as fluctuating: it's "different everyday… you never know what to expect" (General Manager, Appendix C: 11). In terms of rapport between the elderly, Berta explained that:

> *"[t]hey [the elderly] [are] always fighting… sometimes it gets quite serious but…look it's part of… getting old, you know? So, something small will just irritate somebody and there's a whole fight" (General Manager, Appendix C: 8-9).*

In terms of routine, Berta described:

> *"…before breakfast they have a cup of tea or coffee and then they start getting ready to come down to breakfast. But it's dependent on how many care workers we've got to bath them, get them ready, bed bath them or wash them, help them get dressed and get them downstairs. So, it's quite a busy time in the morning. And then of course once they finished eating they'll go and find their little seat where they go either to watch TV or to go outside to the smokers' balcony or to go to their rooms again and just relax again. So, ya, they, they actually just free to do as they please" (General Manager, Appendix C: 8).*

In terms of working with the elderly, Berta acknowledged some of the challenges in caring for the elderly:

> *"[T]he staff have a roster [within] which they actually get 10 days or 15 days [off] between working and not working. So yes, it is…pressurised. They start at seven and they finish at six. It's an eleven-hour day and that's picking people up, moving them, ... taking them, washing them, bathing them, making their beds. It's quite...busy" (General Manager, Appendix C: 9).*

She explained that working with Alzheimer's and dementia patients in particular requires a level of calm; some of the elderly might ask the same question ten times. Berta described the staff rapport as generally quite good, but like everyone, they also have their days.

Over and above the other (more personal) activities mentioned, the home offers (when possible): occasional singing engagements/choir and "sports" (physical activity), often led by the social workers. For the elderly who are mobile, the home takes the residents out to the mall on Wednesdays, as well as occasional visits to the hair salon. The home also has a small church and offers sermons for those religious and interested. They offer monthly bingo, as well as outings if they are invited by companies, schools and/or churches. Berta explained that the elderly loved these activities because they offered different experiences to their daily routines. The home has also had a previous visit from another master's student from WITS Drama for Life who did Applied Theatre activities.

When asked what might benefit the home and the elderly, Berta felt entertainment and increased social engagement would do so. A consolidation of some of the things Berta felt the elderly enjoyed: the pre-school next door (possibly seeing or hearing the children play); activities that added to or changed the resident's general routine, including going out - Berta had mentioned that even attending a funeral was, for some, a treat, because of the cake and tea; and finally, Berta mentioned that the residents appreciated music the most. Music apparently enlivened them; it made them want to dance and smile and laugh. She also mentioned specifically music of the 40's and 50's.

Additionally, when asked about the clown, Berta shared her personal feeling of clowns, which included hesitancy: that with the clown, there might be an element of hiding or disguise. Rather, she prefers people to be who they are (what you see is what you get). She also felt there could be an element of shock or surprise.

Becoming Miss. Whoospie Daisy, aka 'Daisy' (The Clown)

This intervention was informed by my background, training, and work experiences as a professional performer and clown[1], as well as a drama therapist in training. My experience of clowning is rooted in a theatrical and stage tradition, largely informed by the work of Lecoq. I trained and worked with Clowns Without Borders South Africa (CWBSA), and The Upliftment Program (The UP); thus, I had experience of the clown's application in a psychosocial context. I went on to attend the Healthcare Clowning International Meeting (HCIM) conference held in Vienna in 2018, which saw four-hundred (400) clowns and healthcare professionals engage regarding the profession. This gave me the opportunity to meet professional therapeutic clowns

[1] I completed a bachelor's degree in dramatic arts (BADA honours equivalent) at WITS University, within which I studied clowning. These extended into workshops with local clowns Slyvaine Stike, Andrew Buckland, Daniel Buckland, Jayne Batzofin (who was the creative director of CWBSA), and international clown, Jon Davison.

from around the world, as well as attend practical and research-based workshops related to the field.

Whilst I had experience clowning with children and adults, as well as general audiences, I had no direct experience of clowning with the elderly in a care home. My relationship with my grandparents, and in particular my paternal grandmother, as well as her and my family's experience of her being in a care home, provided a working frame and inspiration for my clown.

As mentioned, I had conducted two separate interviews with professional therapeutic clowns, Helen Donnelly (2019, Appendix A) and Olivier-Hugues Terreault (2019, Appendix B), both of whom I met at the Healthcare Clowning International Meeting (HCIM 2018). These conversational-style interviews allowed for greater understanding and consideration. In addition, both offered to stay in touch during the intervention.

Clown identity: Clowns often refer to 'their clown' – speaking back to a persona and character developed over time; this is not to say it cannot change or develop. This clown often extends, opposes, and/or heightens aspects of oneself; good or bad. For this study, I wanted to tailor my clown to be more in line with what I understood to be an 'elder clown' – therapeutic clowns that specifically work with the elderly. This informed my name, clown-style and clown appearance.

The name Miss. Whoopsie Daisy came from the old phrases 'whoops-a-daisy' or 'oopsie-daisy' - an old exclamation when someone stumbles or makes a mistake; this felt fitting for a clown, and specially a clown in an elderly care home. I happen to say, 'whoopsie-daisy', and so this version 'Miss. Whoopsie Daisy' emerged, a name that made me laugh when I first heard it and instinctively stuck.

Clown style: Miss. Whoopsie Daisy can be described as clumsy, naïve, curious, and someone that falls in love very easily. She's high energy and charming. Whilst Daisy can, and does speak, my preference, as the performer, is silent-physical humour and/or sound effects (not relying on speech). The choice to use one or the other, or a combination, would depend on each encounter. I chose to perform the intervention as a solo-clown, as opposed to pairs or a group. Pairs or groups should be carefully put together and developed over time, this was not possible for this study. At the same time, a solo-clown, as noted earlier, "may promote intimacy and sense of collaboration with the environment, and that the single clown's vulnerability may act as a mirror to the patient's feeling *out of place*" (Pendzik and Raviv, 2011: 268). This, however, meant bearing in mind not to pressure people into participating. As I approached this work as a drama therapist-clown, I was interested in this relationship. Most importantly, I felt comfortable and excited to work as a solo-clown for this study.

Clown costume: My costume was mostly sourced from vintage thrift stores. My costume consisted of a red fluffy hat with a pink flower broach, a pink floral long sleeve shirt, a short-sleeve brown waistcoat knit with yellow embroidered flowers, a multi-coloured floral mis-matched skirt, and black and white polka-dot stockings paired with black and white two-toned tango-style shoes; the outfit was mismatched. I accessorised with my late grandmother's pearl necklace, Chanel no.5 perfume, a pair of (fake) pearl earrings and a red plastic basket-bag that had the name 'Daisy' written on it. I wore a more subtle-style make-up (as opposed to stage or circus make up): mascara, a bright pink blush, a few drawn-on freckles and a baby pink lip. All of these choices supported close-contact work – they were not garish or over-the top. In addition, I wore a small rubber red nose. The nose was chosen for performative and symbolic relevance. The nose signified being a clown. It was also the object and symbol to show the staff in particular, when I was in character, for example, if I needed to let the social worker know I was ready, I would not have the nose on, but once the nose was on I became Miss. Whoopsie Daisy and engaged with others as Miss. Whoopsie Daisy. This setup allowed the staff to experience and understand this difference (the difference between Emilie and Daisy; reality and fantasy/performance), thus allowing them to know when and how to engage with Daisy.

Clown props (select props were brought into different sessions): A large suitcase, balloons, bubbles, brightly coloured feather dusters, wash-sponges, an umbrella, blow up beach ball, shakers, and a small speaker-set which connected to my phone (hidden in a wallet) with music playlist compiled largely of old classics and music generally from the 40s, 50s, and 60s – this included music from The Crew Cuts, Bobby Darin, Elvis Presley, Little Richard, The Penguins, The Dell Vikings, Chubby Checker, Frank Sinatra, Nat King Cole, to name a few, and local music artists such as Sipho Mabuse and Dorathy Masuka.

Clown Intention: My goal as Daisy was to have (or create opportunity for) fun, to be loving, to be interested, and to be in a state of service. Relationship development would be key. The goal was to create positive experiences as per each individual or group; or to meet and explore a particular participant's wants, needs or desires in the moment. Daisy's look, high energy, joy, curiosity and mishaps would be used to attract attention. Engagements, as far as possible, would position participants as the catalysts for engagement; as far as possible they would be given the agency to dictate the engagements; whilst engagements could be playful and funny, they were grounded in kindness and respect.

Design

This study was practice-based research in so far as it primarily involved practice as a primary means of research. It drew on performance-as-research in so far as the primary mode of research and method of inquiry happened through, and by means of, performance (Fleishman, 2012: 28). It also drew on the broader aspects of practice-led and action research in so far as it involved exploring, changing and contributing to a practice. This particular study resulted in a descriptive case study research report.

The design of this study included: 1) preliminary research and data-gathering; 2) the intervention; and 3) the collection and analysis of data.

As a piece of qualitative research interested in the (potential positive) effects of therapeutic clowning for participants, this study would capture and focus on both observational cues and verbal feedback from the participants during and post-sessions. Whilst the interviews/focus groups would provide the direct feedback from the elderly and staff participants, as the researcher-therapist, my journal would capture the details of each session: what had happened, and in particular, reactions and responses expressed, both physically and verbally, towards *Daisy* and the intervention. For example, emotional states: if participants smiled and laughed, if they were withdrawn, if they were angry etc and any changes in states, moving from one state, e.g. looking sad/withdrawn, and then smiling, laughing and looking happier etc. It would also observe whether participants became more social with *Daisy*, interested or engaged, or physical participation, for example, if they danced or not, or whether they joined in activities or not. My journal would be used to see the intersectional work between feedback and experience.

Data Collection

Data was collected using multiple qualitative methods: a pre-interview with the home's general manager; pre-interviews with professional therapeutic clowns; regular post-session journaling;

and then, post the intervention, focus groups held with the elderly residents, the staff and the social workers to discuss their experiences of Daisy and intervention.

The post-performance focus groups, with the elderly and staff, were facilitated by an external moderator, Dr. Cameron Harris (professor at WITS University). A moderator was used to ensure that the elderly and staff participants could answer honestly, without bias or hesitation. For the elderly residents, a moderator also meant that the fantasy of 'Daisy' would not be broken. Breaking character could have been jarring, potentially confusing, upsetting and/or even distressing.

The (three) post-intervention semi-structured focus group interviews ranged from thirty (30) to forty-five (45) minutes in length. Questions were pre-determined and open-ended, covering feedback towards the intervention and, in particular, participant experiences of both *Daisy* and the intervention in relation to what they thought and felt. Questions began more broadly, what they thought of intervention as a whole, what they liked or disliked, what they thought stood out, and then focused 'feelings', in particular, the potential emotional impact *Daisy* and the intervention may have had on them. The transcribed data used pseudonyms for the participants in order to provide anonymity.

Participant Choice & Recruitment

Sessions

The intervention engaged male and female elderly residents aged sixty (60) years or older, as well as any staff and visitors present during the sessions. This study engaged participants that were both available and willing; participants could refuse to engage. As Daisy, I used my subjective interpretation of participants' verbal and/or physical reactions and responses to determine levels of comfort or discomfort in order to inform my approach and contact. Initiating contact and connection would depend on each individual or group.

As mentioned, this study was restricted to participants in the residence, as per the non-medical ethics attained for this study (appendix H). Engagements and sessions were limited to common areas, including those within the admin block, the residence foyer/passages, the lounge/dining room (open plan), and at times, the patio, which extended off the lounge. These areas were chosen for consistency, practicality, and time-constraints. The number of participants would vary per session depending on those present at the time of sessions; staff could vary depending on shift and day; elderly could vary depending on whether they remembered, their mood, their choice to be present or their general health – some could be in their rooms, seeing the social worker or visiting the hospital etc.

Residents varied in mental and physical abilities. A number of residents had dementia and Alzheimer's in various stages. Residents ranged in their mobility: some had pain and difficulty moving (most likely associated with physical decline associated with old age), some were wheelchair bound, some had canes, some had walkers, some had amputations, others were fully mobile. Selection of participants was non-discriminatory.

Focus Groups

The social worker, Faye, assisted in recruiting elderly residents for the focus group. The criteria for their participation in the focus group was based on: 1) being present and willing, and 2), if they were cognitively sound. In other words, they would be able understand and respond respectively. This excluded elderly with advanced stages of Alzheimer's and dementia.

The focus group with the residents took place in the dining room. Residents were introduced to the facilitator, Dr. Cameron Harris, by Daisy. Daisy then left the room, allowing the focus group to take place. Dr. Harris briefed the elderly prior to commencing. The elderly participants were asked to speak back their experience of Daisy and the intervention. Dr. Harris' interview style was semi-formal and conversational, allowing a sense of ease and comfort.

Dr. Harris then facilitated a focus group with some of the staff. This focus group was held in the boardroom in the administration block. The staff were chosen based on the staff who were present, available and willing. The staff had been informed about the focus group a week prior in order to allow time to read and sign the participant information sheets (appendix I). These documents were collected by Dr. Harris prior to commencing the focus group. The staff were also briefed accordingly.

As the social workers had to leave to tend to an emergency during the staff focus group, Dr. Harris facilitated a separate focus group with them.

Description of Sessions

This study took the form of nine (9) therapeutic clown sessions. The clowning sessions began on Friday the 12th of March 2019 and ended on Tuesday the 9th of April 2019. Sessions took place twice a week for a period of five (5) weeks. Sessions were held from 1:30pm to 2:30pm on Tuesdays, and 3pm to 4pm Fridays. Sessions were initially planned to be shorter (approximately 20min), but it became apparent in the first session that more time was needed in order to engage with both the staff and residents. Sessions ranged between one-hour (1 hr) and one hour thirty minutes (1hr 30).

The intervention included: arriving at the home, checking in with the social workers (discussing the intervention or any relevant information pertaining to residents), changing into costume, letting the social workers know I was ready, and then commencing the session. It was typically the auxiliary social worker who oversaw the sessions. The sessions began in the administration block, where I engaged with the staff on duty; this included two or three of the administrative staff, as well the receptionist and any elderly residents in this space. I then made my way towards the residence a few meters away. Sometimes residents would be sitting or walking outside the residence. I would engage with them briefly. I would make my way through the entrance and passageways towards the common area, namely the lounge and dining room, engaging any residents along the way. The lounge and dining room were an open plan format; they were fairly large spaces. I typically began engaging with residents and staff in the lounge area (first point of contact), which had several couches and a TV. I then made my ways towards those within the dining area, which had a series of chairs and tables. Residents were dispersed among these spaces; many in what I began to know as their 'usual spots'. Depending on time, I sometimes engaged with residents on the patio, directly off the lounge – this usually comprised of the smokers, and residents that played dominos on the patio table.

The first few sessions were used as, 1) a familiarisation phase; getting to know the space and the residents and staff; and 2) as an assessment phase; as with drama therapy, taking into account the mood, the body language, and atmosphere in the space, and starting to see what residents responded to when it came to Daisy and the sessions; what she did and how they reacted and responded to her (North American Drama Therapy Association, 2019, Jones, 2007). This included physical comedy, conversation, jokes, as well as reactions to props or activities e.g. balloons, blowing bubbles, dancing, singing etc. As I began to notice what elicited more positive responses, the sessions and engagements became more personalised.

Sessions concluded with characteristic “goodbyes”, “see you next time”, mixed with blowing kisses, and hand waving. I then made my way back to the administration block, where I changed out of Daisy, concluded with the social workers and left.

The final three sessions required more planning. This included the use of a made-up scenario, where Daisy would be leaving to join a traveling show around the country. This was used as a means of closing the sessions in a non-abrupt and harsh way by using the creative form to contain and create closure. This narrative ending was introduced over the final three sessions in order for the residents to prepare for an ending, rather than it being abrupt.

Resident well-being was a priority. I used my knowledge and discretion as therapist-clown to decide if and when to move on from a resident, walk away, and/or, if necessary, break-character. The latter is something I tried to avoid at all costs; the therapeutic medium is the role of the clown; breaking character would break the imagination and the fantasy, and could impact how residents respond and relate to Daisy. In the case of those with memory loss, this could also cause confusion and distress.

Data Analysis

The method of analysis used for this research was thematic analysis, as guided by Braun and Clarke (2006). This method was chosen to identify and analyse the most prominent and recurring themes/patterns of meaning within and across the data sets, comprising of:

1) A focus group with the elderly residents of the home (Appendix D),
2) A focus group with the staff members of the home (Appendix E) and,
3) A focus group with the social workers who operated within the home (Appendix F),
4) As well as the researcher’s journals which acted as researcher notes and supporting session documentation (a summary of the journals attached as Appendix G).

Key themes were first identified according to each data set. Each data set represented a particular group or individual’s perspective and experience. A final set of key themes were then ascertained across the four (4) data sets; key themes emerging from the data sets when considered together. The themes would be acknowledged for their relevance in accordance with the research intervention, existing literature and research question/s.

Thematic analysis involved a six-phase system. The first step required the transcriptions of data (the focus groups and journal entries). The second step was to familiarise oneself with the data (reading and re-reading). Following the familiarisation, was the creation of codes. This process allowed for the grouping of relevant and meaningful data (Braun and Clarke, 2006). Once the codes had been identified and collected, the themes were then established, refined, defined and named (Braun and Clarke, 2006).

This method of analysis proved to be an effective means of making sense of, and filtering, rich and revealing data. Even though there were many relevant topics/moments of reflection, the very form of this method of analysis allowed for a focus on the most common arising themes, thus provided direction and a container/limit to what could be a larger scope of work.

Chapter 4

Presentation of Findings

This section will present the findings in two parts: first, by presenting the key themes per data set, and second, by presenting the key themes emerging from the data sets when considered together.

Some language discrepancies were noted in the verbatim transcriptions of the elderly and staff. This could be attributed to fact that English is often not one's first language in South Africa - a country that boasts eleven official languages. This may or may not affect one's use of English grammar, sentence structure and/or one's ability to express and/or articulate oneself clearly in English. This is not to say that one cannot ascertain meaning – but this should be kept in mind. Accents, spoken word, colloquialisms, use of gestures instead of/in place of verbal text etc may or may not have also affected the transcription process itself. In the case of the elderly, old age may or may not effect one's clarity or audibility, as well as how information is processed and/or relayed. For the purposes of clarity, supporting words were added where necessary, in the form of square brackets, to assist reading, while being wary not to change meaning.

Part 1: Key Themes per Data Set

Each data set represented the perspective, opinions and experiences of the participants and/or observers involved in the intervention. Data was both rich and overwhelmingly positive. Whilst broader themes could be attained from the data sets as a whole, each specific data set offers an understanding of the intervention from a particular perspective, and from a different role within the home e.g. the residents, the staff and research-therapist. Part 1 of results also speaks back to the question - what was the experience of participants and observers of the intervention? - in order to ultimately reveal what may or may not have been effective and beneficial. These are the key themes per data set:

Focus Group 1: Elderly Residents

Key themes identified within the elderly participant feedback (Appendix D) included: 1) upliftment (positive affect); 2) Daisy (as a unique artform); and 3) music & dance. Other themes included witnessing and staff support.

Upliftment (Positive Affect)

The theme of upliftment refers to the positive emotional affect as a response to Daisy and the intervention. Upliftment has been described as the "improvement of a person's moral or spiritual condition" (Cambridge Dictionary, 2020b) and uplifting with "making someone feel better" (Cambridge Dictionary, 2020a), it is "positive in a way that encourages the improvement of a person's mood or spirit" (Cambridge Dictionary, 2020a).Upliftment is "something that makes a person feel more cheerful, positive or optimistic" (Lexico, 2020).

Upliftment relates to improvement (Lexico, 2020). I use 'upliftment' to describe and encompass many aspects of amusement and transcendence, two forms of emotional affect described by Auerbach et al. (2016) in accordance to a therapeutic clown/clown intervention. "Amusement is displayed on a behavioural (e.g., smiling and laughter), physiological (e.g., changes in heart rate and skin conductance), and experiential level (e.g., changes in emotional state of mind)" (Auerbach et al., 2016: 15). Transcendence includes feelings of attachment, as well as "the feeling of being uplifted and surpassing the ordinary, for example, feeling elevated, privileged, appreciated by, and associated with the clown" (Auerbach et al., 2016: 15).

In their feedback, the elderly residents expressed general positivity when describing how the sessions and Daisy (the clown) made them feel. The residents described Daisy as someone who "*is putting life into us and we feel happy" (p.10)*, and as someone who *"makes such a difference" (p.10)* by making them feel *"brightened up" (p.13)* and *"energised" (p. 6; 9; 15)*, as well as *"released" (p.10)* and relaxed *("it's relaxing" p.14).* Daisy was perceived as someone who had the *"ability to share her happiness… with others" (p.13).* Daisy was described as someone who was able to make them *"smile" (p.13)* and *"laugh" (p. 2,14, 15, 16)* (examples of behavioural humour stimuli), an often described catalyst for the positive feelings they experienced. Daisy, and the laughter she elicited, were described (by 4 participants) as a form of positive distraction. Daisy was described as someone who is *"ready to make you laugh" (p.2)* and someone who *"makes you forget your troubles" (p.2), "even forget your aches and pains" (p.2).* Harry, one of the residents who was wheelchair bound, emphasised: *"…you completely forget about them" (p. 2).* Resident Violet further confirmed:

> *Violet: "I am in aches and pains but as soon as Daisy stands in front of me it is gone" (p. 14).*

The residents appeared to experience a physiological, or rather, psychosomatic response to Daisy. In line with existing research (Warren and Spitzer, 2013, Adams and McGuire, 1986), Daisy, the intervention, and most likely the laughter associated with Daisy, appeared to affect the perception of pain and pain tolerance in the elderly (3 participants). Laughter also appeared to have helped relax them, as resident Jim describes:

> *Jim: "…when you laugh and that, you get rid of all that [tension], and actually it's relaxing" (p. 14).*

Whilst the experiences described by the elderly were overwhelmingly positive, this was not to say that some of the residents did not feel some level of hesitancy, or as Auerbach et al. (2016) describes, *uneasiness*, in the beginning of the intervention. Violet, one of the residents, describes:

> *Violet: "We weren't so impressed until we found out, this person [Daisy] she is putting life into us and we feel happy…" (P.10).*

Once residents (3 participants) felt like they knew or could trust Daisy, they began looking forward to her visits, and even longed for her:

> *Violet: "I was longing [for] her until when I saw her coming in now. I was so happy and I felt released" (p.10).*

Taking into consideration possible language errors (she spoke Afrikaans), Violet's use of the word 'released' in this instance could have meant one of two things. Either she meant to say *relieved*, or she meant *released*. To be 'released' gives the impression of being given some kind of freedom from either the space or the emotional state she may have been in, for example, possible release from sadness, depression, loneliness etc. To support this, resident Janet did describe how she felt residents, particularly those with Alzheimer's, were lonely and that Daisy (and the interactions with her) relieved this *(p. 4) – "I think she helps them* [to feel less lonely*]" (p.4)*. Daisy appeared to bring Violet, and other residents – like Janet and those Janet describes – enjoyment and happiness. In Violet's feedback, there is a clearly described shift in emotional state related to Daisy. Resident Jim elaborated on this - Jim, although one of the residents, often spoke as an observer and commentator, most likely because he mainly occupied that role in the space, and because he also helped the staff at reception (in some way distancing/separating him from the intervention). He thus gave opinions on what he saw, and why he felt it worked:

> *Jim: "They [the elderly are] actually happy. Just as Daisy approaches her [Violet], she is already [happy]. Before she [Daisy] starts playing…" (P. 15).*

In this way, it's not just the engagements, but Daisy simply visiting, that provides the residents (Violet) with joy. This speaks back to feelings of attachment, and thus 'transcendence' (Auerbach et al., 2016) that supersedes a humour response. The other reasoning behind feelings of happiness was largely attributed to a transference of *"energy" (p.6; 9; 15)* – what could also be understood as a kind of 'high' (being excited) (Auerbach et al., 2016), and continuing with this motif of 'transcendence', in the way residents (Violet) longed for Daisy (as described above), as well as described experiences of *"love" (p.10)* and *"genuine[ness]" (p.15)* that came up in relation to her.

Upliftment was also noted in relation to energy (vitality). Residents (2 participants) described Daisy as having *"surplus energy" (p.6)* – like a child – and, an *"energy that rubs off"* on them *(p. 6; 9; 15).* Jim explains:

> *Jim: "Like she's entertaining. Next thing [Violet] will be getting that energy from her, from Daisy…" (P.6).*

By engaging with Daisy, residents felt like she energised them. For Violet, however, this energy, or the 'high', is perceived as having been experienced before the interaction with Daisy (before the play), as described above. As she saw Daisy, she felt happy. The interaction and positive experience can be understood as having commenced in Daisy's arrival and/or even in the anticipation *("looking forward to" (p. 11))* thereof.

Energy also appeared to be linked to laughter (laughter as an energiser). Jim described how Daisy made one gentleman, Stewart, aged 90, laugh so hard that he could hardly believe what he was seeing:

> *JIM: Ya, Stewart, I mean he doesn't always laugh like that. He was killing himself over there…we are not talking about a person who is always laughing… Usually he is quiet and sitting. And she [Daisy] was busy with him there. He was down like this [mimicking the action], I'm telling you!*
>
> *VIOLET (Resident): Yes!*
>
> *JIM: He was laughing! I couldn't believe it! He was a changed person. First time I've ever seen him like that (p. 15, 16).*

Jim, with the support of Violet, described his observation of Daisy eliciting an uncharacteristic behavioural response (laughter) from someone, Stewart, typically described as both *"quiet" (p. 16)* and *"not exactly a guy that's outgoing" (p. 6)*. With Daisy, however, Stewart was perceived as a ‘changed person’ - different from how he usually is. When Dr. Cameron Harris asked if this was an example of energy transference, Jim agreed. It is Daisy - her humour, her energy, her silliness – that ultimately provoked behavioural responses in the form of smiling and (fits of) laughter. There was a level of transformation being witnessed – in this case, one could say due to the use of humour associated with the clown (with Daisy).

In terms of ‘transcendence’ (Auerbach et al., 2016) residents, over and above their experience of humour, described love and genuineness in relation to Daisy, emphasising feelings of attachment and an association with the clown. Residents (1 participant) professed their love for Daisy - *“I love her so much”(p.13)* – but, residents equally felt as if Daisy loved them - *“she puts in a lot of effort. She really love’s the people… it’s not just a job” (p.12).* Jim described how it was this effort that they felt Daisy had put into them and the intervention that made them feel loved and cared for. He went onto elaborate:

> *“…not everyone can do this… they see it as false…[But] She [Daisy] does her thing and she is genuine you see. People can pick up on that. Anyone can just say they I’ll come and dance and stuff…she makes the people happy…” (p. 15).*

The residents, over and above thinking she was funny, felt Daisy was being loving and genuine with them. This gives a more nuanced and complex understanding of their positive affect experienced, and ultimately contributes to a nuanced and overall feeling of upliftment. For the residents, it was more than experiencing amusement and happiness, it was relationship – love – and feelings of connection. They felt like Daisy had their *“well-being at heart” (p.13)*. At the end of the day, Daisy’s (perceived humorous, loving, and effort filled) *“actions stole our hearts” (p.11).* This experience was extended to include the staff:

> *Jill: “Even the staff… She captured the hearts of the staff because this time of day they [get] tired. A young person gets tired too…She brightens us up [both the staff and elderly residents] … you can smile no matter what pain you have, or what adversity” (p.13).*

Jill was empathetic to the staff’s cause, and felt Daisy made them all (staff and residents), to some extent, brighter, uplifted and possibly even feel better. When asked about this feeling of ‘upliftment’ and ‘buoyancy’ they appeared to have experienced, and, in particular, how long it lasted for them, the residents [2 participants] said that it lasted up to *“two or three days” (p.11)*:

> *Jim: "…When she is finished after an hour, we have forgotten our troubles... and we think about her the next day, and the next day until she's here again, and then it carries on" (p.11).*

Daisy's positive affect was experienced both in the moment, in the form of reactions, but also in more long-term responses which superseded a single session. This appeared to be related to both how they felt at the time, as well as in the idea, or the ongoing thought, of Daisy visiting them.

Daisy

Daisy, as the clown, appeared to be perceived as the vehicle and catalyst for the described positive experiences (upliftment) mentioned above. Daisy appeared to be appreciated as a unique form of entertainment: *"a solo-act" (p.2)* that was described as *"impressive" (p.10)*. Daisy, and the intervention, were identified, by the residents, as being different from other activities/engagements that they had previously experienced in the home. She differed from other *"musical" (p. 1)* group-like engagements they had, like *"karaoke" (p.1)*, as well as *"preachers" (p.1)*. It was also acknowledged as being different to another University of the Witwatersrand MA student, who was described as a *"storyteller" (p.5)*. Overall, they were *"not like Daisy" (p.1)*.

At first, the residents (1 participant) thought Daisy would be a form of mere entertainment for them, something not to be taken too seriously:

> *Harry: "It was unfamiliar and a surprise yes… then I didn't take it too seriously. I just thought it was somebody who came to… entertain the residents."*

This changed when (as described by Violet) they felt like Daisy had a positive emotional impact on them. It should be noted that the residents were never formally introduced to Daisy as 'a clown' – this might account for the reason why they don't describe her as such. The clown might not have been familiar, or perhaps understood differently - for example, when Dr. Cameron Harris had asked if they felt the description of the 'clown' was suitable for Daisy, Violet appeared to think of this as a bad thing, citing, *"no, that did not disturb us at all" (p.11)*. When Jim felt that Violet did not quite understand what Dr. Cameron Harris had meant, he reframed the question to Violet, trying to ask her if she felt Daisy being dressed as clown made a difference to their engagement. Violet did not seem to think so, feeling the intervention would have worked with or without it because it more about what Daisy did with them – *"her actions stole our hearts" (p. 11).*

Rather, the elderly used descriptors such as 'actress' and an 'entertainer' when speaking about Daisy. Even more so, they appreciated her as a "*real actress" (p. 11)* and a *"real entertainer"* (p. 15). The emphasis on *real* could be a means to describe Daisy as someone who does their job very well and/or someone who fulfils their idea of what an entertainer should be. The elderly residents described Daisy as someone who *"entertains each and every one according to who you are and what you like" (p.6).* Someone attuned to their preferences, who *"knows what to bring, [and] what to play*" *(p.6)*, and who knows how *"passion[ate] to be" (p. 6)* in order to capture their attention (and their hearts). In other words, they liked the fact that *"she [Daisy] catered for each one [of them as residents]" (p. 4).*

The residents appreciated the *"one-on-one" (p.3)* encounter which spoke to the *"tailored" (p.3)* and personalised aspect of *Daisy's* interactions (Warren and Spitzer, 2011). This was particularly referenced in relation to Daisy's use of music and dance. They felt like Daisy *"pleased each and everyone, regardless of what nationality you are" (p.4)*. Residents (7 participants) appreciated that Daisy would *"go out of her way" (p.3)* to tailor the experiences, such as finding specific music they liked or requested - 'music and dance' were prolific and will be discussed as their own theme next.

The elderly residents also referred to how *"Daisy likes to play tricks" (p.7*) and is someone who has *"a wonderful sense of humour" (p.7).* They also spoke of other small acts, for example, *"you get a balloon and then blow the balloon up" (p.7).* These seemed to be of particular appeal to a resident named Janet. What Janet represents is that while most of this particular chosen group of elderly residents enjoyed the music and dance aspect of the intervention, others, like Janet, may have appreciated other aspects of the routines (or, as 'clown-plays', as Warren and Spitzer (2011) describe).

Whilst the residents liked that engagements were *"one-on-one" (p.3),* they also appreciated the fact that Daisy *"involves everyone" (p.3)* – Daisy was inclusive. Residents appreciated the fact that engagements were not forced upon them, rather Daisy would *"ask you" (p.3)*, as Violet describes:

> *Violet: "If you want to join, fine, if you don't want to… join her, no problem" (p.3).*

In other words, the elderly residents appreciated being given the choice [and agency] to engage. With this said, some of the residents (2 participants) also appeared to feel like Daisy just had a way to 'get them' *(p.7)* involved – she had a way to capture their attention and get them to feel as if they wanted to participate. Violet describes:

> *Violet: "…if she sees you sitting there... [and] you don't want to be involved. She will get you! She will! She gets each and every one of us" (p.7).*

Harry reinforces this by explaining that this was done without manipulation, nor with flattery:

> *"She will catch your attention! Without coercion! Without coercion! Just by coming to you… you know? Like, she's not even flattering you… but man, you… [laughing]" (p.7).*

In Harry's case, his tone of voice in the recording and his laugh suggests that he was easily charmed and captured by Daisy, but it appears he tried to ensure Daisy did not sound manipulative or bad. The way the residents describe Daisy is like she just had a way about her, perhaps even, as previously suggested, a skillset or an energy, or a joyful spirit, that appeared to make her quite irresistible to the residents – for some, like alluded by Harry, perhaps a form of arousal, one of the described possible affects linked to therapeutic clowns (Auerbach et al., 2016). Daisy was a young, *"beautiful" (p.2)*, woman, so this could have been something Harry, and others, experienced. Daisy may have also learnt to earn their trust, thus making them feel more inclined to participate. The idea of *"she will get you" (p.7)*, implies that it's something that could happen over time/over the course of a few sessions. Violet seems to have alluded to the fact that this happened in her case, whereas Harry appears to have described an engagement that was more instantaneous for him.

Music and Dance

Music and dance, often featured together, were prominently referred to in the elderly feedback. References to music and dance featured on almost every transcribed page *(p. 2, 3, 4, 6, 7, 8, 9, 10, 12, 13, 14, 15)*. When asked what stood out the most, or what the most memorable, this particular group of residents (which did not include all of those engaged with during the intervention) said *"dancing" (p.12)* with musical accompaniment. The residents felt like Daisy was a *"fantastic" (p.12)* dancer. The residents, in particular, appeared to respond to Daisy's choice, and use, of familiar music and accompanying familiar dance styles. Jim, as usual, helped to explain:

> *Jim: "…they [the elderly residents] know the 50's and the 60's, all these people here. That's what brings out a response from the people, because she's talking about Frank Sinatra" (p.8).*

The residents were surprised that Daisy *"knows the 50's music" (p.8);* clearly acknowledging an age difference with her. They (4 participants) felt like Daisy *"does the dancing so good, you would think she was born in those days" (p.8).* Jim described how *"the dance would be applicable to different kinds of music. If it's Jazz, it's this, if it's Zulu [music], it's that… she would play the song and dance accordingly" (p. 9).* In this way she appealed to a wide variety of musical tastes.

As mentioned in upliftment, the fact that Daisy *"goes out of her way" (p.3)* to find the music they like was appreciated. Daisy knowing their music *"brightens us up" (p.13)* - *"she [Daisy] tells me she remembers the song too and you can smile, no matter what pain you have, or what adversity" (p.13)*. Music appeared to elicit smiling behaviours in the residents (Brancatisano et al., 2019), as well as a state of happiness. The residents also appeared to connect to Daisy through her use of music and dance. The use of familiar music appeared to have a nostalgic effect, in accordance with Brancatisano et al. (2019), it appeared to elicit memories:

> *"We appreciate her very much because she takes us down memory lane… with music. With Songs. Like Frank Sinatra songs. Frank Sinatra, Dean Martin, Engelbert Humperdinck" (p.8).*

The significance of music choice in an intervention is demonstrated in the resident's overall feedback and response to it. It also appeared to prompt their engagement, as they, for the most part, appeared to always be ready to sing and dance with Daisy *(p.2)*, something they appeared to *"enjoy" (p.2).*

Other themes:

Other themes that emerged included appreciation, witnessing and staff support, many of which were referenced within above themes.

Appreciation

Appreciation was strongly felt and mentioned in the elderly resident's feedback. Residents were recorded saying, *"I appreciate her [Daisy] very much" (p.7)* and *"we appreciate her very* *much" (p.7).* The residents generally appreciated the music, and they appreciated and acknowledged the effort Daisy put into the intervention and into them. They appreciated her visiting them *(p.13)*. Whilst appreciation does form part of a transcendent experience, it felt strong enough to mention alone.

Witnessing

In terms of witnessing, residents often referred to what they observed in others. These mainly included the visible and positive effects (emotional affect) that Daisy appeared to have elicited in others, for example, in Jim observing Stewart uncharacteristically laughing at Daisy, which amazed him, or how the residents generally saw how Daisy involved everyone and tailored the experiences for them. It also includes them seeing how tired the staff can get and how this helped them, which leads to the next theme. Observation, as described here, has been known to have its own benefits: "observers of clown interventions [may] experience different emotions than participants of clown interventions. For example… observing might result in a feeling of elevation, touch and gratitude" (Auerbach et al., 2016: 16). These can be observed in the described feelings of upliftment and general accounts of appreciation.

Staff Support

The residents recognised the staff's challenges, and how Daisy appeared to benefit them as well - in what appears to be as a form of staff support. Whilst this theme may not have featured as prolifically, it appears to be significant to their overall experience and how they perceive themselves and the staff in relation to elderly care.

Focus Group 2: Staff

Key themes identified in the staff feedback (Appendix E) included: 1) upliftment (positive affect); 2) staff support; and, 3) music & dance (nostalgia). Other themes included witnessing (seeing and being seen) and inclusivity.

Upliftment (Positive Affect)

In their feedback, the staff spoke of Daisy having a positive emotional impact on the elderly residents, on themselves as the staff and on the home's general environment (the atmosphere and mood of the home):

> *Martha: "She [Daisy] was giving life to the greyness. You know, she can come here and maybe we are busy and in some kind of a mood [but] when she come[s] here, you can see, here is life. Everybody is alive. And the residents they start laughing and we all start dancing. I leave my job and we go out and we dance. That was nice. That was really good for the home" (p.1).*

What the staff, and in particular Martha from administration, described was an overall impact on the home and those within it. The staff felt like the elderly residents had generally shown excitement towards Daisy and the intervention. They described it as "*that little something that they [the elderly] needed…to be cheerful" (p.1*). The staff described Daisy as making *"everybody… happy" (p. 10)* and keeping them *"entertained" (p. 5,10)*. She was also described as someone who *"captures everyone's attention" (p. 10)* and *"puts smiles on people's faces" (p.9)*.

The staff expressed general surprise at the positive impact they saw that Daisy had on the elderly:

> *"The ones [residents that] normally you see sitting down. They enjoy standing up and dancing and that was really…amazing…" (p.2).*

Daisy was observed as being able to get participants, including those typically seen to be sitting, to stand up, engage, move and even dance with her. Dancing was described by the staff as a way to make residents happy. In addition, the movement that Daisy initiated through dance, was recognised as having a physiological impact on the residents:

> *"…most of the residents they just sit and watch TV, but when she [Daisy] comes, they will stand up and dance with her… [T]his movement… encourages circulation of the blood… [A]s time goes on, they would feel better than when they [were] just seated" (p.6).*

This is in line with existing research which shows how movement and exercise can "subsequently benefi[t] cognition, mood and behaviour" (Brancatisano et al., 2019: 1435).

In addition, the staff observed the, again, surprising behavioural impact that Daisy had on the residents. In particular, the staff described an elderly *"woman that we have been watching in particular... she did not want to talk to anybody, but… immediately [when] she [Daisy] came in and did what she did and put the music [on]… or [when she] just [started] dancing around the lady… she [the lady; the elderly woman] started laughing. I was like 'ha! Come and see* *[to other staff], she's now laughing! What's happening?" (p.4).* The staff recounted visible shifts in behaviour and emotional state in residents when they engaged with Daisy.

The staff appeared to have likened laughter to a form of emotional relief, or as Violet had described, 'release', for the elderly residents:

> *"…a lot of residents here, some of them have got problems…they do not want to smile, laugh, you understand? So, when they see such funny things, you understand. They laugh out their sorrows" (p.4).*

The staff appeared to be very understanding and empathetic of the elderly. Over and above the described emotional impact that Daisy had on the elderly, the staff described the emotional impact that Daisy, and the overall intervention, had on them. The staff equally appeared to feel *"happy…and entertained" (p.5)* by Daisy. Daisy was described as making everyone, staff and residents included, feel *"alive" (p.1).* This is an extension of what Martha described as Daisy *"giving life to the greyness" (p.1)*. What these descriptions infer is that they, and the home, generally felt quite grey, solemn and lifeless, and that Daisy brought or (re)imbued them with a sense of life. The staff described how *"…having her around here, around us, was… like a reviving of the spirit" (p.5).* In many ways, it felt like it was something that they, and not just the elderly, needed to be cheerful.

Whilst the positive impact they described appeared to be quite obvious to them, one staff member described a more subtle or, in the moment, unconscious affect that Daisy had had on them:

> *"…a lot of people do not realise the impact that she is making… until then, you like oh, really, I smiled when she was dancing" (p.9).*

In this instance, we have a described observational effect (Brancatisano et al., 2019) – observing Daisy dance and have fun made her smile.

The staff generally felt that Daisy had *"a huge impact" (p.9)* on them, the residents and the home in a very short space of time. It is for this reason that they felt sessions could be extended further.

In terms of feelings of transcendence, the staff appeared to feel very comfortable around Daisy and appeared to connect with her over and above an experience of amusement. They described Daisy as *"a good person" (p.9)*, who was *"easily approachable" (p.5)* and *"very* *accommodating" (p.5)*. This could have also been their referring to Emilie, as the researcher-therapist (referring to a kind of appreciated personhood behind the clown). They appreciated the work and skill involved: *"you must remember it is not just about dancing. A lot of people can do that…" (p.9). "You can give me the same job but I do not think I can do it the way she does it" (p.9).* They felt this came down to Daisy's *"energy" (p.9)*, *"emotions" (p.9)* and overall *"attitude" (p.9)*.

Staff Support

Over and above the positive affect described above, the staff felt that the intervention supported their work (as carers of the elderly). As described by Manion (2003), the staff spoke of the challenges of working with the elderly, and how Daisy helped to create a positive work environment for them:

> *"The work that we do here becomes a lot sometimes and becomes draining, so having her around would like calm us down and it would be cheerful and that sort of thing. It creates a positive environment" (p.5).*

The intervention was described as "*mak[ing] our work easier" (p. 7)* because it kept the elderly *"happy" (p.4, 5, 10)*, *"entertained" (p.5)*, busy, *"focus[e]d" (p.5)* and *"calm" (p.6)*. One of the staff members (respondent 4) described how, during the intervention, they would not need to chase after residents who may typically wonder off *(p.7).*

The intervention also allowed the staff moments of fun – moments of pause – where they could *"leave my job and go out and we dance" (p.1).* Daisy also appeared to help to develop rapport between them as the staff and between them and the residents:

> *Martha: "…when she comes here you will forget about everything and then we are one team. We are the family and then we start dancing and even the residents they start standing up" (p.1-2).*

The intervention appeared to have created new opportunities to engage with, and relate to, each other. These are described as positive connections and relationships.

Music and Dance

The staff also acknowledged music and dance as something that both they and residents enjoyed. Music and dance appeared to pull focus away from any negative emotions and experiences:

> *Respondent 10: "I think even with the workers, because sometimes you find that the resident they are just taking to another mood but when they hear the music or when she's dancing you take your concentration on what she is doing and off you let go of whatever bad thing …So it has been helping basically who has been around her" (p.8).*

Music and dance appeared to be a form of positive distraction. The staff also recognised the relationship between music and memory on the elderly:

> *Respondent 10: "Even the type of music that she was using because she would use this old African music, so it reminds them of the old days. It was helping them" (p.7).*

Song choice was thus recognised as stimulating the memory of the elderly. As described in upliftment, movement and dance were appreciated as a likely means of increasing blood circulation which would have had a likely positive effect on their overall emotional and physical well-being.

Other themes:

Other themes noted in the staff's feedback were inclusivity and witnessing (seeing and being seen), both touched on in the above themes.

Inclusivity

The staff spoke of how Daisy actively included both them and residents: "*She [Daisy] will go to the admin, will go to the residents…and she will also come to us, as the students. She will also go to them. She will entertain everybody" (p.10).* The staff also acknowledged, and appeared to appreciate, how Daisy included residents of different mental abilities, such as Alzheimer's and dementia, and different physical abilities, *"…even those who can't walk, she goes to them" (p.10).*

Witnessing

The staff were primarily in positions of observation, noticing many positive effects on the elderly, but also, noticing the effects on themselves as the staff. The staff were often surprised by the way Daisy was able to elicit certain emotions and behaviours from the elderly, which appeared to positively affect the way they viewed the overall intervention - something they saw value in and something they felt could have been extended and/or included in the home in the future. By creating opportunity for the staff to participate, they also got to have fun and engage with the elderly, and with each other as staff, in different ways and in different roles, making them see themselves more as a family, and most likely, giving the elderly and staff potentially new ways to see them and their relationship (not just a staff and elderly dynamic, but as family, friends, a team, dancers, and even as people, as equals etc).

Focus Group 3: Social Workers

Key themes identified in the social worker's feedback (Appendix F) included: 1) upliftment (positive affect); and 2) Daisy. Other themes included teamwork and visually recognising Daisy.

Upliftment (Positive affect)

The social workers felt that they had seen a *"big change in the residents" (p.1)*, particularly those who directly engaged with Daisy. *"She [Daisy] changed everything" (p.4)*. In the *"time she [Daisy] comes… she lifts up their moods"* and makes them *"happy" (p.5).* According to them, it gave both the staff and the residents something to look forward to *(p.2).*

The social workers also acknowledged how residents, who seemed withdrawn and unwilling to do anything, appeared to change and become more responsive when Daisy was with them:

> *Victoria: "…some they do not even want to talk, they do not want to do anything, but, when Daisy comes, we have seen them react, we have seen them laughing" (p.4).*

In this way, they observed a clear shift in behavioural and emotional responses in the elderly residents as they engaged with Daisy. The social workers also referred to what Hatfield et al. (1994) call *emotional contagion*. The "tendency to automatically mimic and synchronize expressions, vocalisations, postures, and movements with those of another person, and, consequently, to converge emotionally" (Hatfield et al., 1994, cited in, Auerbach et al., 2016: 16). Faye, the social worker, said that *"people started…acting like [a clown]" (p.2).* They *"joined in to be that clown…[and] in that mood that Daisy brought" (p.2).* In the case of a resident Mary, someone who was often quite angry and withdrawn, Daisy *"was doing the way* *she was doing and reacting" (p.3)*, like mimicking her, which would prompt Mary to *"laugh out so loud" (p.3)*, they then *"they laughed" (p.3)* together. This was a (clown) technique that Faye felt she identified that prompted behaviour and emotional responses from those Daisy engaged with.

The social workers, like the rest of the staff, felt like Daisy created a sense of excitement in the home *(p.2)*. Faye described how Janet, one of the residents, enjoyed engaging with Daisy and her walker, Janet seen pushing Daisy around the home:

> *"…it was lovely and exciting, and she [Janet] really enjoyed it, so I think that is… the mood that she brought to all of us" (p.3).*

Faye described how Daisy could be heard from afar, created a sense of anticipation amongst them:

> *"…you will hear noise when she comes in [laughing]. Like people are excited saying yes, okay, she is here! So, she will just have that change of mood in everything else. That seriousness, it will just fade away, like when she comes" (p.2).*

Daisy appeared to be able to permeate and transform an otherwise described serious atmosphere in the home. Daisy appeared to invite fun, excitement and joy into their lives. The social workers felt that the work *"was really therapeutic to the residents" (p.5)* and hoped to continue including this type of intervention in the home going forward, or at least aspects of it. They felt that Daisy coming back *"will make them [the residents] happy again" (p.5)*.

Daisy

The social workers also described Daisy as a kind of catalyst for the general sense of upliftment that those within the home experienced. In the beginning, the social workers weren't sure how the intervention would be carried out on a practical level, nor what impact it could have *(p.1)*. Like the residents, the social workers recognised Daisy and the intervention as something very *"different" (p.1)* from the types of activities that they offered the residents:

> *"…it was more like being fun, changing the mood into like being fun and entertaining uhm, it was just a difference approach like from what we are doing because like we do like sometimes exercises, theses board games and so it was totally like different and funny and entertaining way of approach…" (p.1).*

The social workers felt Daisy created *"a play therapy-like…environment" (p.5)*; they appeared to recognise it's therapeutic value by likening it to other therapies. The social workers highlighted the intervention as *"fun" (p.1)*, *"funny" (p.1)*, *"entertaining" (p.1, 3)* and something that was able to affect the general mood of the home and those within it. The social workers felt like when Daisy came it was *"not boring" (p.4)*. According to them, *"[t]hey [the residents] loved it. It was fun and they appreciated it" (p.1).* The social workers felt that the intervention offered the elderly *"...something more fun and more engaging… rather than just playing the cards, playing dominoes…[etc]" (p.6).* They felt like the intervention had an all-in-one quality*; "including everything but in one thing" (p.6)*, for example*, "fun" (p.1), "music" (p.1), "singing" (p.6) and "dancing" (p.1).* The sessions appeared to encompass many activities, engagements and positive experiences into one. The social workers also liked that Daisy *"involve[d] everyone, including the staff members" (p.3)*. The social workers felt they had *"learnt something from her project" (p.5);* there was an exchange of knowledge.

Other themes:

Other themes observed in the social worker's feedback included teamwork and Daisy's costume as a means for the elderly to visually recognise Daisy.

Teamwork

The social workers appeared to recognise and appreciate teamwork and a collaborative approach. They appreciated the regular check-ins, which consisted of information sharing, prior to the commencement of sessions:

> *"The other thing also what helped, is she [as Emilie, not in the role of the clown] would ask and say, 'is there anyone maybe with a particular behaviour', to say, 'if I do this, they will maybe react in a different way'. So… she…did, like consulting. It helped in a way… she would know…what to expect and what to do" (p.4).*

The social workers appreciated being consulted and felt it helped to contribute towards the intervention and Daisy's overall engagement with the elderly. By doing this, they felt Daisy would know what to expect and thus how to adapt accordingly.

Visually Recognising Daisy

The social workers explained that for many of the residents, Daisy would have been their first encounter with a clown; "*…it is their first time to experience somebody like Daisy" (p.4),* although the clown may have been something *"seen… [or only previously recognised] in a*

TV" (p.4). The social workers spoke about Daisy's appearance, and how her costume, with particular emphasis on her red nose and (black and white) shoes, would help the residents to recognise, remember and identify, as well as identify 'with', Daisy - "*For them to see the nose it was like "Wow! Look at that now!"" (p.4)*. Many of the residents *"said they liked her shoes, we like those shoes because they are old stylish ones" (p.4). "[T]hey even identify with her shoes. They say oh, there's Daisy with the black and white shoes… and the red nose" (p.4).* This supports the ways in which elder-clown costumes can be effective in creating connection and in creating generally memorable characters (Warren and Spitzer, 2011).

Journal Entries

Key themes from the journal entries (Appendix G) included: 1) upliftment (positive affect) & connection; 2) Daisy; and, 3) music and dance. Other themes included teamwork, a humanistic approach and the (elderly's) fear of being forgotten.

Upliftment (Positive Affect) & Connection

In line with the feedback from the elderly, staff and social workers, the journals documented positive affect in the form of upliftment, in both the elderly and staff in relation to Daisy and the intervention. The experience of upliftment, however, appeared to correlate more strongly to connection and relationship development.

In line with Auerbach et al. (2016), both feelings of amusement and transcendence were observed in the elderly and staff over the course of the sessions. There were also accounts of hesitancy (particularly when first meeting Daisy), variations of highs (excitement/high energy) and lows (speechlessness), and aspects of arousal (charm and innocent flirtatiousness, particularly with some of the elderly gentleman).

In terms of amusement (Auerbach et al., 2016), the journal described experiences of happiness and excitement. Daisy appeared to be well received by the residents and staff from the start *(Session 1)*, with curiosity developing into visible expressions of excitement and joy. Levels of comfort and excitement could be seen to happen either in a single session, or over the course of a few sessions - for example, Janet, aged 88, appeared to be immediately affected by, and interested in, Daisy. This is an account of when Daisy first stepped into the lounge/dining room area:

> *"… an elderly woman sitting on the front couch caught my attention immediately as she appeared completely awe struck by my sudden appearance; her eyes were wide, she was looking directly at me, her posture was up, and she was smiling with the same open-mouthed 'wow' as I had entered with. She seemed excited to see me and eager to know who I was. She was sitting with her walker next to her. She was gentle looking, she appeared kind, with white hair, a soft wrinkled face, older looking than many of the elderly near her and quite small - short, slightly hunched over…We held eye-contact. As I breathed her in (as if amazed that I was meeting her) she appeared to mimic me – breathing in at the same time, still with a big smile…" (session 1).*

In this engagement, the connection between Daisy and Janet was immediate. The mere presence of Daisy appeared to elicit curiosity and excitement from her. At the same time, Daisy expressed an equal amount of curiosity and excitement towards Janet. Daisy had stepped into the space with a high *"energy" (session 1)* which Janet appeared to match/mimic. In Daisy's engagements with Janet, *"we [often] bounced off each other's energy" (session 2)*. In the description of this engagement, I had used the word *"synchronised" (session 1)* to describe what was happening between us. This speaks back to (gentle) mimicking as a possible technique used to connect with residents.

Using Janet as an extended example: she appeared to consistently express joy and excitement towards Daisy in the following sessions. As the relationship developed, so did Janet's apparent levels of comfort and confidence with Daisy. Janet started to lead engagements, pushing Daisy around on her walker as if it were a car (much to the amusement of those watching) – this appeared to bring her much joy she would *"smile"* and *"laugh" (session 3).*

Janet expressed both amusement and transcendence in the sessions. Feelings of love and transcendence appeared to be, for her and many of the residents, important (Donnelly, 2019). Janet and Daisy's relationship began from that very moment Daisy stepped in. She appeared very trusting of Daisy and was very affectionate towards her – happy to touch, hug and kiss Daisy (on the hands or cheek), all of which was appropriately (and lovingly) returned. She, and many other residents in due course, began calling Daisy a *"friend" (session 3-9)*. It appeared that Daisy, and Emilie, as the researcher therapist, cared for the residents. As much as Daisy appeared to emotionally move some of the residents, they appeared to move Daisy. Engagements come across as real and genuine.

Trust development appeared to enhance the level of playfulness between Daisy and the residents and staff. Comfort levels also appeared to make room for the use of more personalised forms of humour and subsequent reactions of laughter.

In terms of feelings of transcendence, the attachment experienced by residents towards Daisy can best captured in the expression of love. Janet, along with three other residents, namely Harry, Violet and Mary, all expressed their love for Daisy: *"I love you" (session 9)*. As their confidence increased with Daisy, so they began calling Daisy over, or in their telling her what to do, all of which appeared to make them happy.

Participants often *"smiled" (Sessions 1-9)* and *"laughed" (Sessions 1-9)* in their engagements with Daisy, or whilst watching her engage with others. Daisy often engaged with one person, or two people at a time. Excitement could be seen to build up in those watching Daisy engage with others before Daisy approached them. Some, like Violet, were happy to simply watch. Daisy's relationship with Violet was one that began more distanced. She usually sat in the furthermost point of the dining room, not wanting to really participate much, until finally in the later sessions, appearing more comfortable and playful with Daisy. Whilst Violet wasn't interested in dancing, she made sure Daisy would see and greet her - *"Hello Daisy"*, followed by a little smile. It is actually quite surprising to see how much feedback Violet gave in the focus group as she was experienced as being a lot more distant. It appears clear from both accounts, that Daisy made Violet, and many others, happy. This happiness, however, appeared to be rooted in their relationship development.

There were many relational narratives and emotional arcs documented in the journals, all of which cannot be mentioned in the scope of this paper, however, what was clear, is that residents generally appeared to appreciate Daisy's visits, and experience joy in the presence of Daisy. Upliftment appeared to be present in the simplest act of someone visiting them or giving them attention, but also, in the play, silliness, music and dance that Daisy brought and shared with them.

It must be noted that while positive reactions and responses make up the majority of the responses experienced and observed, there were a range of responses. Some residents were hesitant, and, as mentioned, this intervention did not force engagements on anyone but used a variety of clown skills to create opportunities to connect. One resident appeared more nervous on day one – he seem quite surprised and taken aback when he first saw Daisy, he was walking towards to entrance within which Daisy was standing. Upon seeing Daisy, he retracted behind someone (as if slightly fearful). In response, Daisy tried to mirror the nervousness and make herself appear very small and shy (trying to appear harmless). This made him smile and laugh (though nervously).

> *"He stepped forward a bit, perhaps still aiming to pass. This time, however, his move prompted me to retract; I jumped back. Suddenly, a big burst of laughter came from the elderly lady on the couch…The gentleman smiled and giggled a bit as they laughed. He looked at them, and me, and them again. He may have been using them as a kind of gauge to see how they felt about me. He moved forward again, though still behind his friend, as if using her as a bit of a shield. This time, the move forward prompted me to retract further, jumping onto the chair near me and crouching. This was both a reaction to his move, but it was also a strategy on my part to clear the doorway for him to pass… He giggled as I jumped, though still appeared nervous. As he came closer, I looked away as if pretending not to see him. He approached, then stopped, I looked at him, he smiled, and then quickly slipped passed through the doorway with a chuckle…I leaned over and looked through the door and he turned back to look at me. I waved goodbye. He smiled, waved and then moved out of sight" (Session 1).*

In residents that appeared more hesitant to engage with Daisy- like the above gentleman or with Mary, who was often observed as being angry and who was even seen fighting with other residents - Daisy found ways to connect. Over the course of the sessions, the gentleman and Mary appeared more interested in and thus more at ease around Daisy. In one example with Mary, Daisy had kicked her toe and Mary, who saw this, laughed in reaction. From here, there appeared to be a turn in the relationship, with Mary a lot more curious in and observant of Daisy. A second turning point was a moment where Daisy saw Martha looking at her from across the room and, while dancing for others, tried to make her laugh with silly dance moves. Mary burst out laughing. From then onwards, Mary appeared to show enjoyment, in the form of smiling, laughing and increased discussion, in Daisy's visits and eventually verbally expressed her affection for her. In the case of the gentleman, he never expressed affection, but he did seem to enjoy Daisy's presence, laughing and smiling when she came around, but appeared to prefer some distance, and this was respected.

Harry, who was wheelchair bound, was, as Violet described, a *"praying man" (p.7).* Harry was often seen alone and busy praying during sessions, and so Daisy had not really engaged with him in the initial sessions. When Harry finally observed Daisy dancing, he appeared to express much interest (he stopped, observed, asked for her name etc.). He was very willing to engage. Daisy had found ways to dance with him in his wheelchair, which made him smile and laugh. From then on onwards, he started to call Daisy over:

> *"As I made my way to him he exclaimed, 'Daisy!", with a big smile. He was sitting in his wheelchair in his usual spot with a magazine in the sun. I told him I was pleased to see him. I told him looked particularly good today. He said, "yes I feel better now that you are here"" (session 9).*

Here, Harry expressed feeling better in the presence of Daisy. Harry had also told Daisy: *"Before you [Daisy] came, I was sad. You make me happy. You are a light for me" (session 8).* For him, and others, music and dance appeared to have elicited positive affect from both the residents and staff.

The combination of both amusement and transcendence could also be observed in a particular musical encounter with Janet. Janet, from the very first session, often mumbled a song "Daisy… Daisy". When I finally realised (with much joy) that Janet could have been attempting to sing Nat King Cole's "Bicycle built for two", I decided to learn it and surprise her with it. Presenting her the song, and her hearing it, appeared to have moved her:

> *"The music intro at first didn't seem [to be] familiar [to her], and then suddenly as the song started and I sang with it… "Daisy! Daisy! Give me your answer do!" ... Her eyes completely lit up… She immediately started singing along even if she was getting some of the lyrics wrong. She sang loudly and passionately…. As we sang, I noticed her eyes beginning to well up, she seemed very moved and overwhelmed by this song…When the song ended she said, "thank you". She had tears in her eyes. It was a heartfelt thank you and I recognised this. I thanked her and told her that I hoped it brought her as much joy as it did I. She said, "Oh yes… (pause) Oh yes!".*

Whilst Daisy elicited these emotions in others, they equally moved Daisy. Upliftment, in all its forms, was very much documented as a shared experience.

In line with what the participants recounted, the journals also described the positive effect that Daisy had on both the staff as well as the general atmosphere of the home. This could be seen in a group engagement that included staff and residents:

> *"They [the staff] laughed throughout this interaction. I said, "come on ladies, who is going to dance with me?". Some seemed very keen but a bit shy, others just looked tired. I put my music on and decided to dance for them. They cheered as I pulled some moves. Petunia [one of the residents] came back up to dance – she never missed an opportunity to dance. I noticed one care worker dancing [whilst sitting] on her chair. I cheered for her, she got up and danced a bit. Next thing Veronica had joined and started dancing with me, and another staff member joined. [Next,] Two elderly members, a gentleman and other lady joined, even Loraine [a resident with Alzheimer's dementia] joined in. We had*

> *a full group dancing. It was a wonderful atmosphere and [a wonderful] moment" (Session 5).*

In one particular engagement with an elderly woman, she had a sore arm that she didn't want to dance with. I had told her that she didn't need to move it, and used the other arm and leg movements instead. During the engagement, however, she seemed to forget she had a sore arm, and started moving both arms. She appeared to feel better once we started dancing and having fun, as if Daisy provided a form of positive distraction. The engagement may have also affected how she perceived pain (Warren and Spitzer, 2013, Adams and McGuire, 1986).

Daisy

In the journals, Daisy was also positioned as a catalyst for upliftment and connection. Through the use of humour, clown skills and clown plays, Daisy elicited amusement and transcendence, amongst other forms of affect. Some of the props that were used that appeared to be effective were bubbles, feather dusters, balloons and flowers. Playful banter and jokes were part of most of the engagements, for example:

> *"He [Andy, a resident] told me about how he could only walk to a certain point and then he would need a Grandpa (a local pain killer). I said, "aha! A grandpa that needs a grandpa!". He laughed and put his arm around me and gave me a squeeze. He said, "you are funny"" (Session 5).*

Imagination was also used in the case of Janet, where she told Daisy to sit on her walker (which had wheels) and to push her around the home as if it were a car. Daisy pretended that they were going super-fast which made Janet, and those observing, laugh. We pretended to hoot and Daisy played music as if it were the radio. Another instance was with a resident named Pam:

> *"Pam said, "well aren't you going to throw me your ball". I said, "Of course". I tossed the ball to her". I told her that this was my beach ball. She said "I love the beach". I told her "well then let's be at the beach". She seemed thrilled by this. "Yes! We are at the beach", "she said. I told her that the sand was hot, it was a sunny day. She agreed. I told her to smell the sea. We threw the ball for a while together before she stopped and asked me where I was from, how old I was, and if I had been to other countries and which ones" (Session 5).*

Pam enjoyed asking questions and imagining the places she, and Daisy, had been to, or where they could go. Daisy appeared to be someone to speak to, imagine with, and play with.

Daisy often created opportunity for the elderly residents to help her. One instance was when Daisy kept sliding off the couch. Stewart quickly caught Daisy's arm.

In many of the sessions, participants (elderly residents and staff) often copied or mimicked Daisy- particularly when dancing *(session 1, 2).*

> *"I began to shoulder pulse/bounce (like a shoulder shuffle). Janet immediately began copying the movement… I had pulled a bit of a silly face while doing this…Janet just copied this face. The staff were laughing. Janet burst out laughing, which made me laugh too" (session 2).*

Being high energy appeared to capture people's attention *(session 3)* and encourage a sense of excitement *(session 1, 3)* and a willingness to participate *(sessions 1-9).*

Music and Dance

Although there were many types of props used and various forms of engagement, music and dance appeared to be the most broadly liked and enjoyed aspects of the intervention. Both the staff and residents responded immediately with interest, smiling and laughter when music and dance happened.

Residents appeared to resonate well with the choice of music used – this was music that corresponded to their youth. Residents and staff often appeared to get energised by the music. Some would sing and dance, others would clap or watch Daisy singing and dancing. Music appeared to create an instant mood of upliftment in the home; it set a tone. The music was upbeat and appeared to encourage individual and group participation. It equally encouraged movement, as well as smiling and laughter. Music encouraged staff participation. When some of the residents appeared to be slightly shy, the staff dancing appeared to prompt these residents to engage. Resident Petunia loved to dance. I first met Petunia whilst dancing. She came up behind me, tapped me on the shoulder and extended her hands out as if to ask to dance. Most of my and Petunia's engagements were centred around dance. She is an example of how some of the residents mainly engaged through music and dance.

Music and dance appeared to improve the emotional states of the elderly:

> *"Harry started singing. His mood was changing. He was brighter and more cheerful. I turned and I took his hand and started singing with him. From someone who was not feeling OK and refused to dance, he was now suddenly singing and "dancing" (and fully participating) – it was quite an immediate*

> *change of mood. I would say the music definitely affected his mood" (Session 5).*

In this example, Harry was not feeling very well and was not in the mood to dance that day. As soon as the music started playing behind him, he turned and started engaging and singing. I took his hand and next thing he was dancing. Music appeared to promote well-being – it appeared to have had the ability to change how an elderly resident was feeling and quite instantaneously.

As mentioned, music seemed to distract the elderly residents from negative thoughts and experiences of aches and pains:

> *"I asked how she was, and she told me she was OK but a bit sore. I put on a song: 'Jive Soweto'. Whilst the aim was for me to dance for her, she immediately started moving in the chair. This song had a knack for just getting people in a good mood…She started singing with me – she got all the lyrics correct which allowed me to follow her. I sat on the couch and moved my legs from a seated position. Next thing her legs were moving in synch. I found that often there was this 'pain' or inability that some of the elderly would discuss, but as the music started much of what they had mentioned was an inconvenience seemed to disappear" (Session 5).*

For residents who were physically compromised, such as Harry in his wheelchair, Daisy became a kind of extension of movement when they danced:

> *"There was a different gentleman in a wheelchair. I played music and offered to dance with him. I danced with him in the wheelchair. In these circumstances I would often hold their hand and I would be the one to move near and far, twirling, moving around them, leaning on the wheelchair. He laughed as I danced away. He said to me "lovely!"" (Session 3).*

Music was a great way to get the staff to stop work for a moment and come out and dance – in these engagements, it gave the staff opportunity to see and engage with each other differently, for example, the administrator dancing with the general manager:

> *"As I started dancing, Martha came around and joined me instantly… Whilst dancing, Martha would cheer and laugh… She appeared to be really enjoying herself…It also made me aware that the staff were clearly eager to participate – they wanted to be included. This was as important to them as the elderly. Martha would often say things like 'you crazy, but I love it… Berta, the general manager, made her way to see what was going on… I asked her "Would you like to show us your moves Berta?". She smiled and agreed…Berta appeared*

> *completely willing to participate and play along, in fact she was leading some of the play by offering her own moves. She seemed interested in participating and having some fun with me and the staff in the workday. It was wonderful to see the staff witness and cheer Berta on…The staff really seemed to loosen up in these moments. They appeared to want to get involved. As the focus was on the elderly, it seemed they felt no pressure to participate, but just wanted to do so on their own accord" (Session 3).*

Other themes:

Other themes that were noted in the journal entries included teamwork, a humanistic approach and the (elderly's) fear of being forgotten.

Teamwork

The staff were noted as being very supportive of the intervention. The social workers were happy to check in and oversee the process. The staff in general were open to participating or providing assistance. The staff even started playing tricks on Daisy, hiding her bag while she was busy. They appeared very comfortable in her presence. Veronica, the auxiliary worker, came to almost every session (baring one or two when she was busy but had someone else stand in her place). Some of the staff, such as Vernonia (auxiliary social worker) and Martha (from admin), referred to Daisy as a "friend". They, as well as other staff, appeared to appreciate Daisy's visits. The general experienced support and teamwork appeared to make the intervention flow smoothly. As Daisy and the researcher-therapist I felt I could always approach the staff if need be. The social worker's feedback and willingness to discuss sessions was seen as having contributed to the overall experienced (and apparent) positive impact and success of the work.

In terms of teamwork during a session, the staff were also present to assist. On one occasion, a session was unable to commence on time due to the home having organised an outing for the elderly and bad weather delaying their return and thus delaying the usual session start time. In an effort to maintain the session – largely because I knew the elderly looked forward to Daisy and in effort to show I had come - I chose to do a short session instead of cancelling/rescheduling it. This led to the session ending when the elderly and staff were preparing for dinner. Dinner was a chaotic time, with the elderly becoming tired and the staff very busy. During this time, an elderly member, Petunia, had hoped to escape the home with Daisy - *"I want to go wherever you [Daisy] go…just please take me with you" (session 8).*

As Daisy, I worked with a staff member who helped to take Petunia back to dinner, allowing me to leave, and her to eat.

> *"Petunia appeared quite desperate, and I felt her deep desire to go; to escape. But I also felt her trust in me as Daisy. It's with this trust, and the support of the nurse, that we could come to a peaceful resolve" (session 8).*

Time constraints left little flexibility to explore the 'escape' further with her or resolve it more creatively. Given the time, the staff support and team effort here was appreciated. This case did however show that keeping routine was key.

Humanistic Approach

The journals highlight an overall humanistic approach. The work appeared to be client-centred and the accounts of the interactions show a sense of warmth, genuineness and optimism towards participants:

> *"She started waving her hands in the air with me. I eventually made my way to Mary… "Hello, Mary, my friend". Mary told me that I was very sweet. This felt like a genuine compliment and coming from Mary it meant even more. Mary had slowly over the sessions really softened with me. She did not appear as grumpy to me – and it was lovely to see her this way [less upset, frustrated and angered]" (Session 6).*

In the space, Daisy was on the same playing field as the participants. From the journal it's clear she did not assume a position of the expert (high status), but rather, journeyed with the participants. Both Emilie (out of character) and Daisy (clown character) showed care, love and respect for those she engaged with, and this too appeared to have contributed to the overall positive reception of the work, and positive affect elicited. The genuine experience of excitement, affection and sincerity as Daisy were visible in the writing of the journal. As Miss. Whoopsie Daisy I looked forward to the sessions and I had such fun being in the space. I put in a lot of effort because I was passionate about the work and I wanted to provide fun and meaningful experiences. It was an honour to be there. It was an honour to meet the elderly and staff. It was wonderful to be trusted and allowed to connect, play, witness and share an emotional experience with them. I appreciated the nuances of each session and the different types of relationships formed. Each had their own quirks and developments. Whilst the elderly expressed their gratitude, I felt an immense gratitude towards them and the home in general.

These feelings, reflections and descriptions highlighted in the journal support an ultimately humanistic, and person-centred approach.

Fear of being forgotten

In the final session in particular, some of the residents, like Mary, had expressed concern around being forgotten:

> *"I told Mary about my travels. I told her I would miss seeing her, but that she would always be with me. As we were talking, she told me "I love you" …I told her that I loved her too…I gave her a big hug… She told me to enjoy myself. She said to me, "you won't forget me?". I told her "never, how could I forget her" …She smiled" (Session 9).*

As many of the residents were destitute and abandoned, endings were more prone to fragility. Instead of asking if Daisy would remember her, Mary used the "forget her". Being previously forgotten may have been a reality for her. Asking to be remembered by Daisy may have been linked to feelings of worthiness - was she worthy of being remembered? Daisy seeing, engaging and remembering the elderly may have been a form of comfort and even validation for the elderly. Harry also expressed concerns around Daisy leaving:

> *"[Harry] asked when I would come back and see him…I told him about my travels…He then asked me quite abruptly, "what about me?" He said, "you know you make me happy. You make my heart happy". It was clear my leaving was difficult for him to process… I told him that what we had was special, and that we would be connected no matter where we were. That this was real, and fun, and glorious! He teared up…I wiped his tear… I told him to dance with me. He laughed" (Session 9).*

The relationships *Daisy* had developed with the elderly were particularly evident in the end session. Daisy often validated their experience and connection with Daisy by acknowledging that it was real and fun for her too. In order to leave on a high, Daisy tried to bring back a sense of joy and amusement before finally leaving. Using the narrative that Daisy would be joining a traveling performance group appeared to help the elderly adjust better. Many wished Daisy well. Daisy expressed nerves to travel, and they would try comfort her, thus changing the engagement around rather than Daisy comforting them, they comforted her, they were able to help Daisy. This is the kind of relationship that both Terreault (2019, Appendix B) and Donnelly (2019, Appendix A) said empowered the elderly.

Other examples of this theme include one of the elderly residents, Petunia, who wanted to escape the home with Daisy. Petunia did not want Daisy to leave without her– *"I want to go wherever you [Daisy] go…just please take me with you" (session 8).* Lorraine, who had dementia, had told Daisy that her family was coming to visit, which made her very happy, but I later found out that she was abandoned and had no family who would visit. She just kept thinking that they were coming, either due to dementia, or in hope that they would eventually come.

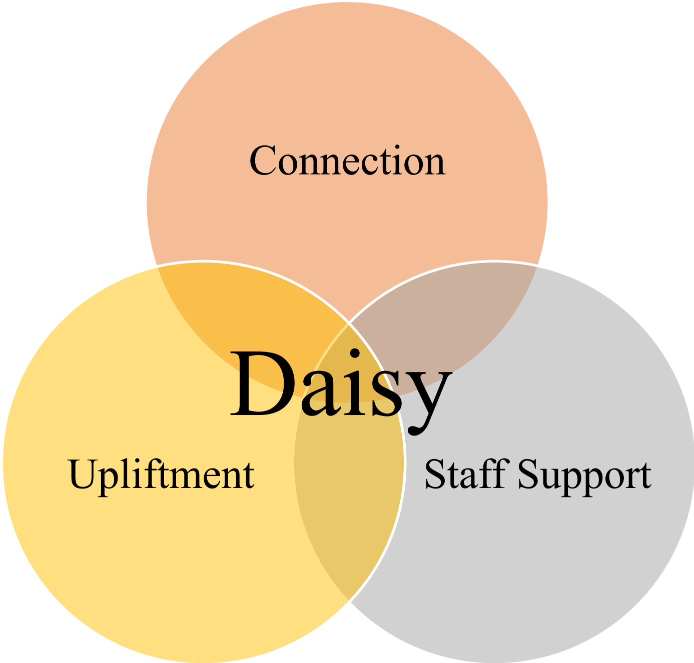
Part 2: Key Themes Emerging from Data Sets

After the initial mapping of the themes per data set as seen in Part 1, further analysis was done to consolidate and refine the themes when considered together. A consolidated set of themes is a means to provide a holistic view of the intervention in relation to elderly care (which includes the elderly, the staff, the social workers and researcher-therapist/clown).While there were many themes identified, a set of core themes, consistent within all data sets, were extrapolated. This resulted in the following key themes:

- Connection – Relationship development and friendship
- Upliftment – The primary positive outcome experienced by the participants
- Staff Support – The intervention appeared to support the staff and work environment
- Daisy – The medium through which upliftment and connection were achieved & Daisy as an intervention strategy (therapeutic clowning)

All of the themes are interconnected; they do not exist in isolation; they form a single experience.

The following Venn diagram illustrates the relationship between these key themes:



Connection – The different methods of creating connection with participants.

This theme permeated all of the themes listed in the separate data sets. Nurturing trust and developing relationship appeared to be key in creating a positive and meaningful experience for both the elderly residents and staff (Donnelly, 2019: Appendix A, Terreault, 2019, Appendix B). The elderly appeared willing and interested in connecting with Daisy. Connections between Daisy and participants were often immediate. Relationships developed over the course of sessions, and were often experienced/described by the residents, staff and researcher-therapist/clown as *friendships*. Connections were perceived as genuine from both the residents and Daisy/the researcher-therapist. Connections happened through clowning, via the medium of Daisy, and the various use of props and activities and specifically, music and dance. Humour was also used to build relationships (Dean and Gregory, 2005). There was an overall sense of teamwork and support evident with the staff which clearly had a positive effect on the way in which the intervention ran. In this way, "“clowning around” with elderly people [was seen to] bring more benefit than laughter alone" (McMahan, 2008: 24). Therapeutic clowning encouraged compassionate communicative connections (McMahan, 2008). In many ways Daisy appeared to encapsulate and encourage a sense of *ubuntu* – an African word and concept referring to "communality, oneness, co-operation and sharing" (Nefale and Van Dyk, 2003: 7). Daisy was described as someone who made them feel like family, and as someone who was able to share their happiness with others.

Upliftment – The primary positive outcome experienced by the participants.

The trick about clowning is that there is no trick – the emotions experienced are real. The participants "encounter actual feeling states. They [laugh], cry, feel anger, [joy], hope – these are not experienced as fictional. Real tears are wept. Real anger is vented. [Real joy is experienced]… [like with drama therapy there is]…the paradox that what is fictional is also real… this is crucial to… [therapeutic clowning and drama therapy's] efficacy as therapy" (Jones, 1996: 10).

The theme of 'upliftment' encompassed the positive affect described and observed within the intervention. This included the positive and improved emotional states of both the elderly and staff, as well the positive atmosphere (mood) created in the home. Participants witnessed and/or described positive emotions and experiences during, and after, engaging with Daisy. These included feeling happy, brighter, cheerful, excited, and generally feeling better in the presence of Daisy. The staff also reported feeling happy and in higher spirits around *Daisy*. The residents, staff and the researcher-therapist observed positive changes in the residents, staff and general atmosphere of the home. The staff noticed visible behavioural and mood changes or positive affect in both residents and staff. In the residents themselves this included accounts of uncharacteristic laughter, moving from a quieter and more withdrawn space to one of increased engagement, excitement and joy. Residents began looking forward to Daisy because she appeared to make them feel happier and more alive. The staff observed how residents - who were usually seen sitting – were standing up and dancing because of Daisy. The residents, staff and the therapist-researcher also noted positive psychosomatic responses – where positive distraction and feelings of happiness appeared to make some of the residents forget their aches and pains, as well as their troubles. The residents also appeared to feel uplifted for up to two to three days post-sessions.

Over and above accounts of amusement displayed "on a behavioural (e.g., smiling and laughter), physiological (e.g., [increased blood circulation, pain tolerance]), and experiential level (e.g., changes in emotional state of mind)" (Auerbach et al., 2016: 15). Daisy, and the intervention as a whole, evoked positive feelings from engaging with a loving clown that transcended the humour response. In this way, as can be observed in the theme of connection, participants expressed "feelings of attachment" [, such as love,] as well as the feeling of being uplifted and surpassing the ordinary, for example, feeling elevated, privileged, appreciated by, and associated with the clown" (Auerbach et al., 2016: 15). There were also accounts of hesitancy (uneasiness) which were seen to develop into upliftment over the course of the sessions in combination with relationship development. The journal entries encompassed the diversity of responses, recognising hesitancy and even some cases of nervousness towards Daisy in first encounters, all of which appeared to settle, and even progress into curiosity and upliftment, over the course of the sessions.

Overall, upliftment was recognised in the feelings associated with humour and love, as encompassed in Patch Adams' love strategy (Adams, 2002).

Staff support- The ways in which Daisy assisted the staff at the home

Daisy, and the overall intervention, appeared to contribute to a positive working environment. Staff appeared to appreciate participating. They appeared to appreciate the way Daisy kept residents entertained, busy, and in higher spirits. They appeared to equally benefit emotionally from the intervention. The staff also appreciated the way in which the intervention was carried out. In particular, they appreciated the check-ins that allowed for a sharing of information. There was a sense of teamwork and collaboration. These all appeared to contribute to the overall running of the intervention and its described effectiveness.

<u>Daisy</u> – The medium for upliftment and connection with participants.

Daisy was the clown which served as the "fun" and "funny" medium, or vehicle, in which connection, upliftment and staff support were achieved. Daisy, as representative of therapeutic clowning, stood out as something very different to the types of activities that the home had previously offered. Daisy was appreciated as a "solo-act", and as someone who was able to make participants feel happy and loved. She prompted smiles and laughter. Like theatre and drama therapy, therapeutic clowning created "a special world where people can make the rules, rearrange time, assign special values to things and work for pleasure" (Jones, 1996). When Daisy arrived, a sense of play was encouraged, and possibility opened-up. Daisy used a number of props to prompt and facilitate playful and loving interactions. Daisy invited participation – "participation [in drama, theatre and, in this case, therapeutic clowning as a form of drama and theatre" is seen to satisfy human needs to play and create" (Jones, 1996). It "allow[ed] [for] connections to unconscious and emotional processes to be made" (Jones, 1996). Daisy invited role and status play – participants could help Daisy or even lead the activities, that appeared to give them a sense of control and agency within the sessions.

An overall humanistic approach appeared to facilitate working with the elderly and staff in an elderly home. The participants felt a sense of warmth and genuineness about Daisy that appeared to make them feel comfortable around her, as well as appreciated, cared for, loved, and connected with her. As Miss. Whoopsie Daisy, I was genuinely excited about the sessions - I was eager, I had fun, I felt like I learnt so much from the elderly and the staff, and I felt very honoured to be welcomed into the space and into the participants lives. I think this excitement, vulnerability and sincerity as a clown made an impact. It contributed to how the clown was positively perceived. Whilst the work was respectful and professional, it was intimate and personal. It was a shared experience; we shared the joy, the laughter, and the tears.

The social worker, Faye, described Daisy and the intervention as "therapeutic" and an "all-in-one" – encompassing various activities to elicit overall positive affective responses. Daisy was appreciated for tailoring the experiences and for bringing in familiar music and dance. Music and dance were highlighted in all the data sets as something that was enjoyed and as something that, in and of itself, prompted positive affect (upliftment) as well as nostalgia.

Chapter 5

This chapter will further discuss and elaborate on the presented findings, it will also present concluding statements, raise the limitations of this study and provide recommendations. The questions raised in this study will be addressed more broadly within the chapter and sub-sections.

Discussion of Findings

The intervention was premised on a belief that therapeutic clowning could prove beneficial to an elderly home in South Africa. This premise was based on exisiting literature and research which supported and promoted therapeutic clowning in relation to elderly well-being and quality of life (QoL) (Dionigi and Canestrari, 2016, Warren and Spitzer, 2011, McMahan, 2008, Adams and McGuire, 1986). Studies also highlighted the positive effects that therapeutic clowning could have on the surrounding family and staff, and/or those who observed the interaction (Pendzik and Raviv, 2011, Auerbach et al., 2016). This study thus asked, if, and in what ways, therapeutic clowning, in the context of nine sessions, could support existing elderly care in an elderly home in South Africa.

Overall, the elderly residents and staff appreciated this intervention, and thus therapeutic clowning, as a unique form of entertainment and psychosocial support. As something new to them, it generally surprised and impressed them. They appreciated the fact that Daisy worked alone (solo), that the intervention was inclusive (including the elderly and staff, as well as various mentally and physically abled participants), and that it provided tailored, one-on-one experiences, as well as group engagements. Overall, the intervention was appreciated for yeilding positive results in a short period of time.

The feedback received by the elderly residents and staff was overwhelmingly positive, with the described positive experiences correlating across the data sets (elderly residents, staff, social workers and the therapist-researcher/clown). Based on the findings, and in line with exisiting research (and postulation), this study suggests that therapeutic clowning, as a vehicle for humour, upliftment, connection and staff support, can support and extend existing elderly care (Warren and Spitzer, 2011, Pendzik and Raviv, 2011, Dionigi and Canestrari, 2016, Auerbach et al., 2016).

In line with current research findings, the intervention appeared to be successful in inducing positive emotions in the elderly residents, as well as the staff (Dionigi and Canestrari, 2016, Warren and Spitzer, 2011, Auerbach et al., 2016). The therapeutic clown was observed as being “an instrument of joy, love and humour” (Adams, 2002: 448). This intervention primarily elicted feelings of upliftment, although a diverse range of responses, partiuclarly from the researcher-therapist/clown, were acknowlegded. Whilst upliftment generally includes feeling better, more cheerful and, feeling morally and spitually lifted (Cambridge Dictionary, 2020b), upliftment, in this study, also included feelings of amusement (responses to humour stimuli) and transcendence (responses to love stimuli), responses shown to manifest as a result of engaging with a humourous and loving clown (Auerbach et al., 2016). In particular, feelings of amusment accounted for happiness, cheerfulness, excitement, anticipation, release and relaxation, as well as transendent feelings of attachment, love and general appreciation. This is not to say some participants did not also experience feelings of hesitency, and even uneasiness, but these were often experienced in the beginning of the intervention (when first seeing Daisy) and were short-lived. The elderly residents also described feeling enlivened (feeling more alive) because of Daisy, and the staff as if their spirits had been revived. Over and above eliciting these emotions, it also prompted smiling and laughing behaviours, as well as increased movement (such as dancing) and even (happy) tears, for example, when being emotionally touched/moved by Daisy or music, responding to acts of kindness, or when feeling a sense of deep appreciation. Physiologically, the movement (and dance) encouraged by the clown – Daisy – was, in the intervention, suggested by the staff to have probably increased blood circulation in the elderly residents, and thus would have most likely contributed towards their generally feeling better (Alpert, 2011).

Participants also described the ways in which the clown – Daisy - and the intervention facilitated behavioural, emotional and physiological changes in participants (moving from one state to another). In particular, how residents, who were were described as being withdrawn and unwilling to engage in conversation, would burst into laughter because of the clown - Daisy. Whilst the intervention energised participants, it also appeared to reduce levels of aggression and agitation in some residents (Warren and Spitzer, 2011), making them appear calmer. The intervention, in what appeared to be predominantly through positive distraction, humour, music and dance, appeared to support exisiting research that therapeutic clowning can alleviate the experience and/or perception of pain in the elderly (Adams and McGuire, 1986, Warren and Spitzer, 2011, McMahan, 2008); the clowning was shown to have helped the residents forget and divert their attention away from their aches, pains and troubles (Donnelly, 2019, Appendix A: 4).

In terms of the possible long-term effects, the elderly residents described feeling uplifted for up to three days post a session. Here, they spoke of how they would think of Daisy (the clown), and anticipate her return. This gives some insight into possible post-session (and long-term) effects of therapeutic clowning, and encourages further research into the long-term effects.

By bringing in a sense of fun and creating opportunity for light-hearted, social, and, often times, communal interaction, the intervention appeared "to positively change the atmosphere of the home" (Warren and Spitzer, 2011: 563). Daisy, as the therapeutic clown, was understood as, and encapsulated in, the metaphor "giving life to the greyness". Sounds of laughter and music were described as filling the space during sessions, and were attributed to creating and contributing towards an overall sense of anticiption and excitement in the home. Participants percieved the intervention as creating an overall positive environment in which to both live and work (Warren and Spitzer, 2011, Adams, 2002).

As a form of staff support, the staff described how challenging and demanding working with the elderly could be, and how the intervention elicited positive emotions from both them and the elderly residents; it created an equal opportunity for them to have fun too; it it made them feel like they were a team and a family (suggested as both a staff body and between them and the residents); and, on a practical level, the intervention kept the elderly residents busy, entertained and focused, particularly when they (as the staff and social workers) did not have any other activities on offer, ultimately alieviating the elderly's boredom. It also appeared to offer them opportunity to momentarily step out of the role of general manager, or admin, or even just staff, like the elderly, stepping out of the possible role of Alzheimer's patient or resident, to meet each other in a different way, as people (outside of typical roles and statuses).

The social workers appreciated how therapeutic clowns can work with the onsite healthcare team (Warren and Spitzer, 2011). They valued being consulted during the intervention, and, more specifically, the process of checking-in and sharing notes prior to each session (Warren and Spitzer, 2011). As the researcher-therapist and clown working as a temporary presence in the space, knowledge sharing allowed me to know what was happening in the home or with partiuclar patients/residents, what participants were experiencing and sharing about the intervention outside of sessions, and, more specifically to thoughtfully tailor the experiences for the participants (Warren and Spitzer, 2011). For the social workers, sharing patient information made them feel as though I, as both the therapist-researcher and clown (Daisy), knew better what to expect. In this way, knowledge sharing appeared to give the social workers, and staff, a sense of ease and comfort over the intervention as a whole, especially as it was new to them. It also appeared to give them more incentive to support the work as a whole; they were more inclined towards, and available to, assist when and where necessary. Working closely with the staff appeared to faciliate a more positive and team-like work environment. It also appeared to promote the overall smooth running of the intervention, supporting how and why elder clowns should work with the healthcare team (Donnelly, 2019, Appendix A, Warren and Spitzer, 2011).

Whilst the overall experience was described as fun, funny and entertaining, the research findings indicated the importance of connection and relationship development in this intervention and, more broadly, in therapeutic clowning, in order to establish a playful, caring and interactive environment that could lead to increased participation and feelings of upliftment in those who participated and/or watched (Donnelly, 2019, Appendix A, Terreault, 2019, Appendix B, Adams, 2002, Auerbach et al., 2016, Yalom, 2010). The intervention's overall humanistic approach, and an approach that utilised both humour and love in the clown engagements, as per Adams (2002) 'love strategy', appeared valuable in creating authentic person-to-person connectedness. "From the dawn of modern psychology, psychological therorists have emphasised the importance of positive human social connection for health, well-being and survival" (Seppala et al., 2013). The experience of positive relationships is a primary psychological need (Seppala et al., 2013). Social connection is an established determinant of well-being (Seppala et al., 2013). A "[l]ack of social connection, on the other hand, is linked to psychological distress, dysfunctional interpersonal behaviour, accelerated mortality, and antisocial tendencies in a deleterious and mutually reinforcing set of variables" (Seppala et al., 2013: 430). Therapeutic clowning is, at its core, relational and social, and thus, by creating opportunity for positive human social connection, appeared to encourage well-being and thus contribute towards improved quality of life, particularly in an elderly group within which many had experienced abandonment, and who were described, and observed, as experiencing loneliness.

> *Being unwanted, unloved, uncared for, forgotten by everybody—I think that is a much greater hunger, a much greater poverty than the person who has nothing to eat.—Mother Theresa (Costello, 2008: 14).*

Some of the elderly hoped, in the end, that Daisy would not forget them. For these, and other residents, experiencing a positive, intimate and caring relationship with the therapeutic clown seemed to be meaningful and of benefit to them (Yalom, 2010). Being seen and heard, feeling loved and appreciated, and experiencing a relationship - a friendship (Adams, 1998) - characterised by genuineness, positive unconditional regard and spontineity appeared to offer both the residents and staff comfort and a form of validation (Yalom, 2010). An atmosphere of love and friendship, as experienced in this intervention, appeared to be, in and of itself, therapeutic and healing (Adams, 1998). As human beings, we need positive connected experiences in order to maintain a healthy psyche (Yalom, 2010). The value of therapeutic clowning, over and above humour, appeared to be in its social aspect (McMahan, 2008, Donnelly, 2019). Therapeutic clowning, in this intervention, appeared to offer love and emotional connection, as well as physical connection (in the form of touch, hugs, and appropiate hand or cheek kisses) to participants, providing experiences that did not appear to be common, nor necessarily easily attainable in the home. In this way, therapeutic clowning did not just offer participants entertainment, rather, they had connected and empathetic entertainment.

Connection was also facilitated by choice and agency; participants appreciated not being forced to engage in the intervention. Participants were also able to prompt and lead activities; giving them a sense of control over the engagements (Warren and Spitzer, 2011, Terreault, 2019, Appendix B, Donnelly, 2019, Appendix A). Due to the clown's general clumsiness and silliness, opportunities were created for the residents to help Daisy, rather than Daisy help them (Warren and Spitzer, 2011). This is something that Terreault (2019, Appendix B) highlighted as an important part of therapeutic clowning; reversing roles, playing with status and ultimately giving power over to the elderly.

Music and dance were often referred to when discussing Daisy and the intervention as a whole. The use of music appeared successful in setting an immediately positive atmosphere in the space. The use of familiar music and dance appeared to enourage participation, as well as feelings of upliftment and nostalgia (Warren and Spitzer, 2011). Music and dance also promoted connection – connecting via music and dance. Participants could express themselves through music and dance (Terreault, 2019, Appendix B). Whilst the music was light-hearted and upbeat, some participants were touched, and even moved to tears by their apparent connection to the music and memories associated with it.

This study was embodied - it revolved around practice and ultimately Daisy as the vehicle for therapeutic change. In this way, I believe the experience of Daisy faciliates a more in-depth knowledge into the approach. The research was done with her, through her. It highlighted the power of working in this way – working in role, in clown - even though there was a dance between the clown, drama therpaist, and researcher. The clown embodied vulnerability and sincerity. It embodied fun and play. It provided opportunity and possibility. The clown was not presented as the expert, or as the therapist. Rather the clown was an unsuspecting visitor, someone who appeared to be another form of entertainment, and yet quickly became a friend, a friend who who could make them feel uplifted. The challenges of old age, and of living in an assisted facility, can create a lack of agency in the elderly; the elderly are cared for and told what to do. I do think that the work was, to a large degree, effective because it was not the therapist or nurse bringing them in, asking them to speak and get involved etc. It was not another explicit 'carer'. Rather, it was the clown. Miss. Whoopsie Daisy appeared to be very left of field/our of the ordinary. She was odd, silly, and vulnerable. She subtly encouraged agency because she was vulnerable herself – and by being vulnerable she allowed vulnerablity and encouraged agency in those she encountered. She was interested in connecting with participants on their terms and (purposefully) from a similar status position, or lower. She was there to have fun, to play, to explore. Clowning presents a very different dynamic to a therapist in the space; in this way, I do not think the same results would have been achieved in a closed therapeutic circle with myself as the drama therapist. This is not to claim that one is more effective than the other, but clowning offered a unique and positive way to engage, with all permisions and consents, the elderly. As a therapeutic clown, as opposed to other clowns such as those on stage or in a circus, I also had to work within the limits of the space, with frail audiences in an open space where they can come and go. I also has to always consider the well-being of the elderly rather than it being a performance in isolation. As the drama therapist and clown, it was about maintainng awareness at all times – awareness of what was happening around me – for example, where and what the elderly and staff were doing, various repsonses and reactions, time, etc.

Conclusion & Recommendations

This study supports the implementation of clown visits as a strategy to promote positive feelings and positive social connections in both elderly residents and the staff of care homes (Auerbach et al., 2016). Whilst this may be applicable to family as well, no family were present during this partiuclar intervention and thus this cannot be concluded in this study. Therapeutic clowning, and more specifically elder clowning, particularly those rooted in what Adams (2002) calls a 'love strategy' (using both humour and love in the therapeutic clowning approach), was shown to be effective in eliciting feelings of upliftment in both elderly residents and the staff who engaged and watched in this particular facility. In accordance with existing research, this study "suggests that a playful, improvisational, and light-hearted approach to psychosocial health can have beneficial effects on the lives of elderly residents… and the staff who care for them. For older people who have experienced so many losses, the work of the elder clowns can return humour, [love,] playfulness, music and joy to their lives" (Warren and Spitzer, 2011: 563). Therapeutic clowning appeared to offer positive experiences of human social connection (Seppala et al., 2013, Warren and Spitzer, 2011). This appeared to be of particular relevance and benefit to a home for abandoned and destitute elderly residents. Therapeutic clowning, particularly when employing music and dance, was shown to positively affect the atmosphere of the home, contributing to both a positive living and work environment (Warren and Spitzer, 2011). In addition to their seeing the positive affect on the elderly, the staff in this study perceived the intervention as both supportive of their work as carers of the elderly, and of elderly care in general. Overall, this study argues that therapeutic clowning could contribute towards the well-being and quality of life of South African elderly residents in care homes, as well as towards elderly care, which includs the staff and their well-being.

Although therapeutic clowning appears to have had an enhancing effect on the elderly and staff of the care home within this study, there were also limitations to this research that must be taken into consideration. Whilst the findings suggest therapeutic clowning could be effective in supporting elderly care in South Africa, results in this study cannot be generalised or replicated across a wider population; this study only reflected the experiences of the participants in this home and context. Whilst measures were taken to allow for unbiased participant feedback (namely, the use of an external moderator), the study presented largely positive results. One cannot discount the possibility that the elderly and/or staff could have provided overwhelmingly positive feedback in the hopes of continued visits/support. The study also recognises that observation is, in and of itself, limited. Experiences exist beyond the bounds of what both the researcher and staff directly observe, and limited to what all participants disclose. The study took place in an open and uncontrolled environment; results do not necessarily represent useful cause and effect indicators. The study yielded rich data; other themes could have been explored; information was ultimately analysed in accordance to, and influenced by, my questions. This study reared limitations with regards to qualitative data; the reader unable to verify the results objectively against the experiences described by participants. My experience in elder clowning was limited; level of experience may or may not affect the overall approach and/or outcomes, as well as my decision to use a solo clown, as opposed to a duo. This was a short-term intervention, eliminating any of the potential psychological results that could have been realised in a long-term intervention. This study did not include a follow up in the home. This could have given impressions of what the elderly gained post the intervention, or the extent to which it had affected their lives post-the-fact. A follow up could have given some indication of lasting effects and perceptions of the intervention. Future research should consider the inclusion of local (therapeutic) clown interviews to enhance the research and strengthen the approach contextually.

In this study, I learnt that it was important to keep routine. The elderly would anticipate sessions. Keeping to set time slots was also important. Time slots were set with the social workers, in consideration of the elderly residents and their existing routines. The staff who wanted to, and looked forward to participating, had mentioned that it would have been easier for them if the sessions took place at times that also considered their schedules, and not just the elderly. I also learnt that keeping to the dedicated time slots was important. If, for example, a session cannot be done when planned, delaying, instead of cancelling/rescheduling a session, could lead to an overap with another set activity or schedule. In this study, one session was delayed due to an outing that was planned by the home for the elderly and bad weather preventing them from returning in time for the set session. In an effort to maintain the session and show-up for the elderly, I chose to conduct a shorter session upon their return. However, this still meant the session ended while the residents settled for dinner. Dinner time was a chaotic time. The elderly appeared tired and the staff were very busy. One elderly member hoped to escape with Daisy. Whilst this was calmly resolved with the support of staff, it meant she (the elderly woman) was more interested in Daisy than in settling for dinner. In this way, this could have ended negatively. It also meant that the session had little time flexibility to be able to explore her desire to escape further and more creatively.

With this said, the findings are promising and encourage further implementation and research of elder clowning in elderly care settings. In line with the feedback of the staff, a long-term intervention might yield different results (Appendix E). This study recommends that interventions work closely with the home and its staff to ensure a smooth and potentially more effective implementation. Staff participation should not be discouraged; this appeared to add to the depth and breadth of the intervention as a whole.

Whilst the intervention ultimately assumed the form of therapeutic clowning, I approached the work as a drama therapist, clown, performer and researcher. Like the resulting themes, these were inextricably linked. In this study, I drew specifically on the drama therapy stucture in the form of the check-in with staff in order to help inform and frame engagements. I also used the first few sessions to assess how best to engage and move forward. In this intervention, the clown, as an art form, was percieved and appreciated as the vehicle for humour, upliftment, connection, and even staff support, as well as being the main tool/catalyst in providing a therapeutic encounter and experience. The themes - presented in the findings - all revolved around that which was intrinsicly theatrical and dramatic. The clowning itself, as part of ‘drama’, was percieved as being the therapy (Jones, 1996). It was through the artistic medium of the clown that emotional and behavioural transformations occurred. With this said, the intervention was informed by the dramatic tools and processes ultimately outlined within drama therapy – these included play, embodiment, witnessing, dramatic imagination and fantasy, amoung others (Jones, 2007). The apparent therapeutic aspects of therapeutic clowning were not solely related to humour and joy, but also to theatre – which is social - , and drama therapy tools, like the therapeutic relationship, engaging patients in the realm of imagination and play, as well as role (and status) play (Pendzik and Raviv, 2011, Grinberg, 2009). Whilst this paper’s scope did not permit an in-depth look at these, they were still acknlowledged factors.

There are observed similarities and differences between the fields of drama therapy and therapeutic clowning (Pendzik and Raviv, 2011). The apparent separation of the fields for generally may perhaps be linked to the way drama therapy tried to develop a separate identity from other therapeutic uses of drama and theatre, including an identity distinct from arts in hospital and other care settings (Jones, 2007). This study, however, found value in not only drawing from each practice, but viewing and treating this therapeutic clowning intervention as an extension of, and even form of, drama therapy. As a drama therapist, I approached this work with a respect for therapeutic clowning as the artistic medium and process within which to maintain or achieve psychological growth and change (Emunah, 1994). Whilst there are certain nuances and technical variances within the practices, as described by Pendzik and Raviv (2011), so are there variances within various drama therapy approaches and practices. Drama therapy can take many forms (North American Drama Therapy Association, 2019). As *Current approaches in drama therapy* (Johnson and Emunah, 2009) does not include clowning in drama therapy, it highlights a gap in the literature and in the considered space of research. This study sought to begin to address this gap in a meaningful and comprehensive way; or at the very least contribute towards bridging it. Overall, drama therapy and therapeutic clowning concern themselves with the therapeutic aspects of performance (Pendzik and Raviv, 2011). In agreement with Pendzik and Raviv (2011), it is "odd" that the professions are not more closely related (Pendzik and Raviv, 2011), certainly in the literature. Fundamentally, they use the same dramatic toolbox in order to support their clients whilst they navigate challenging topics and experiences (Grinberg et al., 2011, Pendzik and Raviv, 2011). In this way, it may prove more useful to see the fields as more connected than separate.

As opposed to necessarily answering the proposed field related questions – this study continues to ask how the fields might be able to learn from and enhance each other, as well as how they might be able to integrate each other's theory and practice in a way that serves the therapeutic encounter. The work of Pendzik and Raviv (2011), who discussed the relationship and observed drama therapy models and theory as a means to analyse therapeutic clowning, the work of Grinberg et al. (2011), who used Robert Landy's Role Theory as a context for understanding therpaeutic clowning, and the work of Roy (2009), using clown character development within drama theapy sessions, are encouraging examples for this crossover. The use of humour, the clown, role and imagination are key to these studies. Based on this study, there appears to be more opportunity for how drama therapy might be able to support and extend both the implementation and analysis of a therapeutic clowning intervention (Pendzik and Raviv, 2011, Grinberg et al., 2011). Though beyond the scope of this current study, a question raised from this study was how the training of a drama therapist might impede or inform the work of therapeutic clown.

Whilst therapeutic clowning alone is not a panacea, combined with existing (medical) care, it appears it can support a holistic (elderly) care model (Adams, 2002), which "puts a patient's perceived needs first and offers care not only for the body but also for the human spirit" (Romeo, 2000).

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APPENDIX A

TOPTranscriptions
we play with words

CERTIFICATE OF VERACITY

We, hereby certify that in as far as it's audible the aforegoing is a true and correct transcript of the recording provided by you in the matter:

(NAME OF AUDIO: INTERVIEW WITH HELEN DONNELLY 11 03 2019)

DATE COMPLETED	:	04/05/2019
NUMBER OF PAGES	:	29

EMILIE: Thank you very much for agreeing to an interview, and uhm, …

HELEN DONNELLY: You are welcome.

EMILIE: … yes, so I will start you know quite in general and then we can move towards things and I know I gave you just a few questions as the possibilities but wherever it goes is wherever it goes.

HELEN DONNELLY: Great…and you got my signed Consent form?

EMILIE: Yes, perfect.

HELEN DONNELLY: Okay, great.

EMILIE: Thank you very much for that, and maybe before we begin, …

HELEN DONNELLY: Ah-ha.

EMILIE: … I can just give you just a little bit uhm, more of a background of me. Uhm, just so that you know.

HELEN DONNELLY: That's great.

EMILIE: … So, I am currently studying my Masters in Drama Therapy and I started this uhm, particular course not because I was necessarily interested in being a drama therapist but because uhm, I was very interested in the Arts having a therapeutic uhm, effect, and uhm, yeah, so my background is in theatre and then I joined Clowns without Borders. I had done some clowning at Varsity uhm, and then obviously moved it into that region so uhm, there is a bit of a background of clowning uhm, and …

HELEN DONNELLY: Yeah.

EMILIE: … then I started investigating it here with a company called The Upliftment Program in the hospitals and so forth but I am a very new clown to necessarily this uhm, type of work so most of my Masters research is obviously a discovery of something like that, and that is mainly because uhm, there is very little of the work being done here locally in South Africa.

HELEN DONNELLY: Yes…I see…

EMILIE: And so that is what this is all about it's just wanting to discover a little bit more uhm, about what it can do and what it feels like as a performer and so forth [laughing…]

HELEN DONNELLY: Yeah.

EMILIE: … Just so you know…So, maybe uhm, I think a great start for the interview would just be to know a little bit more about your uhm, background and uhm, what has drawn …

HELEN DONNELLY: Yeah.

EMILIE: … uhm, you specifically to therapeutic clowning?

HELEN DONNELLY: Yeah, so my background is quite typical like you know went to theatre school, I became a professional actor, just did a lot of shows and a lot of independent stuff uhm, live theatre mostly, uhm, some chill man TV but mostly like live theatre was really where it was at for me but uhm, I was really drawing towards uhm, more physical theatre uhm, approach uhm, so that led me to the art of clowns. Uhm, fortunately at that time in the early nineties uhm, there was a physical theatre uhm, school uhm, which we did not join and then there was a theatrical clown uhm, uhm, uhm, training uhm, that began with Richard Pochinko uhm, that is sometimes call the Pochinko method but anyway, that is another conversation but it's sometimes called Baby Clown or Clown Through Mask uhm, but there are many levels that you can dive into uhm, kind of culminating in duo dynamics and uhm, and the building of your own clown shows. So, I went through that training with two different teachers uhm, and that was really my first uhm, formative uhm, training in the art of clown even though we touched upon it in theatre school like so many do, it's a minor degree and I was craving more so that was kind of good to dive in and I stuck with that so called method for about ten years. Uhm, produced shows under that kind of banner and then uhm, by that time now we're at the late nineties, uhm, I was scouted by Cirque du Soleil and asked to audition and got a job within two years.

Uhm, my first job was touring with Dralion and uhm, I was with Cirque on and off for about like an eight-year period but mostly off like it was uhm, special events after the tour. Uhm, I toured for almost two years and there were special events worldwide for about two or three years and then I was cast for Cusa uhm, did not make it to the actual show. During the lions' den they cut a lot of the show, the show was four and a half hours long, and uhm, so I was part of the cats and so uhm, at that point I returned to Toronto. I had already started working as a therapeutic clown at Sick Kids Hospital here in Toronto uhm, but I did not desire to go back to that same position because theirs is a solo model clowning and I was really enamoured with a duo partly because I know it was the most popular model and uhm, there was a lot of artistry involved in duo clowning which I really was jazzed about uhm, through working with clown partners and in theatre so I really wanted to continue that uhm, structure so when I came back from Cirque the last time- that was about 2007- I was hired at my current position at Holland Bloorview Kids Rehabilitation Hospital which is Canada's largest rehab hospital for children with disabilities and I have been there for eleven years and uhm, sprinkled between that I was also uhm, recruited to work with elders with Dementia uhm, through a different company. So I had about three years working with that company, worked with that population so it has been a really well rounded approach I find you know, between working with Paediatrics and both the trauma and the rehab sites and then also with elders largely with Dementia and uhm, and a bit of palliative care as well, uhm, so yes that is a bit of my background. So, it's circus, theatre and healthcare clowning, but clowning is all I do in those three, uhm, I don't know, 'genres'.

EMILIE: Yeah…[laughing] and what is it about the therapeutic or the healthcare clowning that, uhm, yeah that you think is special that drew you or that makes you so passionate about it?

HELEN DONNELLY: Uhm, well I think that uhm, I was always drawn to healthcare so I think you know from a very early age I was uhm, a child in hospital at the age of five through a trauma, and uhm, and I had to undergo many surgeries and my hospital experience was really really positive uhm, so I…I guess I had a lot of empathy for children who had to undergo a dramatic change in their lives especially at a young age and uhm, when I was in high school, I … they used to call us candy stripers but I was a volunteer in a hospital, in that same hospital as a way of giving back and uhm, I did that for a few years and then later on I was working with uhm, with the blind at the CNIB, uhm, you know, reading out the news and sort of just accompanying them so I have always been sort of uhm, very, very, engaged in healthcare uhm, whether it was through personal experience or volunteer experience later on, and so, it just seemed like a really comfortable place for me to linger [laughing…]. I was just really drawn to it and uhm, and I guess I learned early on once I had grown some chops in the clown world, I could really easily see the application to healthcare, because by that time I had already made some in roads and some connections with healthcare clowns and therapeutic clowns or whatever you want to call them. Largely, first of all in Quebec, that was my biggest connection and uhm, and then to have your eyes opened and realise wow, this is a global movement and uhm, something that I wanted to be a part of so it's just a way to bring my desire together to be in the healthcare environment and then my love for the art of clown. It just seemed like a really good personal fit for me.

EMILIE: Yes, what have you seen that, what is it that the clown specifically offers in a way to, to those that you engage with?

HELEN DONNELLY: Uhm, well, you know just like other arts and health practices that offers clients a rest bed, you know an emotional break in their day. Uhm, it's an alternative way to express themselves and to share their feelings and to enhance their coping mechanisms. Uhm, we know it reduces anxiety and boredom and offers uhm, alternative ways to divert their attention away from you know, pain and other unpleasantries; uhm, we know that it can really go a long way to restore dignity that is often lost and personhood uhm, [pause 4 seconds]

EMILIE: Yeah…

HELEN DONNELLY: And you know therapeutic clowning in this context is unique in that failure is at the core of who and what we are. Meaning everybody else in healthcare space will inevitably feel innately superior to us. They may not know how or why; they just know that they are in control. Uhm, and that we're supposed to fail [laughing]

EMILIE: Yeah…

HELEN DONNELLY: And that is why it's very different from a drama therapist. Drama therapists are not supposed to fail uhm, in my estimation, in my, in my limited understanding of what other therapists offer.

EMILIE: Yeah…

HELEN DONNELLY: They're seen as another healthcare worker as a clinician…

EMILIE: Ah beautiful…

HELEN DONNELLY: Uhm, but therapeutic clowns are not viewed as that. We are the idiot, we are she who gets you know kicked down and is resilient and rises up again so we're that doll that can't get knocked down, that gets knocked down, but is resilient; that figure of resiliency is something very unique to therapeutic clowning in that separates us from other clinicians.

EMILIE: Yes, and uhm, well there's a few things that I have picked up with that but the first one that I am just responding to is that you know there is the sense that you say we and so there's this deep sense of community, this deep sense of like we the clowns. Uhm, I don't know it's just something that I am hearing and that I pick up on and it feels like uhm, yes, like just a network and a similar understanding uhm, and I know that a lot of this work is happening all over and I guess something else that you then followed with was like you know healthcare clowns or therapeutic clowns or whatever we call them and I suppose there are a couple of terms there is therapeutic clown, there is a medical clown, there is a care clown, there is an elder clown but essentially there's something that's pretty binding between them. Uhm, yeah, I am just picking up on that and if you have anything to kind of comment on that.

HELEN DONNELLY: Yeah…[laughing] I think that there, you're right. I think that we share a lot of the same philosophies and approaches uhm, and then there is this line, this line in the sand that is very uncomfortable, it's an uncomfortable line and a lot of people don't like to name it. Uhm, but I would say that uhm, there is quite a difference between caring clowns which you know who, in Canada at least, and in the States caring clowns are defined as volunteer clowns who don't necessarily have, some might, but most don't have formative theatrical or circus or movement skills. They've never specialised in the art of clown under an approved teacher uhm, they are, they are lovely people who, who, who love the idea of giving back to society but I, I myself don't align myself with…I don't recognise my practice in that umbrella.

EMILIE: Yeah.

HELEN DONNELLY: To be frank…uhm, and so for medical clowning it's a very interesting, it's a very interesting and recent thing so it was coined by uhm, The Dream Doctors in Israel and uhm, the purpose of calling it medical clowning is their aim was to become a paramedical uhm, therapeutic actually a paramedical practice and they claim they are therapists so this launched them into a trajectory that, again that I don't align myself with I don't believe we're therapists first of all. Therapeutic is an adjective, and not something that we are; uhm, what we do has a therapeutic merit but we do not…I do not approach things the way a therapist would approach things and I think that is a really, really, important point so paramedical clowns they participate in actual, you know, medical interventions with other medical staff; they will hold instruments, they will assist with dressings, like this is something that I don't do and I would argue most healthcare clowns or therapeutic clowns do not do, we do not engage with that aspect. We see this as a very different model so it's, it's tricky. So, we, we, uhm, the model that I…

EMILIE: Yes, I was about to say, what is your approach? [laughing]

HELEN DONNELLY: No, it's the approach that I would argue the majority of the world is following which is the healthcare clown approach uhm, often called therapeutic clowning uhm, so therapeutic clowning is a title that originally came from Canada uhm, but it's been picked up by uhm, by Scotland now and uhm, there are parts of the States that are picking it up uhm, and it just denotes a difference between being a clown in healthcare and being a clown in theatre. Uhm, the other thing too is that therapeutic clowns you can be a therapeutic clown not in the healthcare environment i.e. serving in a jail for instance. I would not necessarily call a jail a healthcare setting.

EMILIE: Yeah…

HELEN DONNELLY: But what we do there is, is the work of a therapeutic clown not the work of a Clowns without Borders clown, not the work of a theatre or circus clown.

What we do and the code of ethics that we follow mimics that of a therapeutic clown, so that is why for me healthcare clowning, as much as I love that term and 99% of the time it totally fits with what I do, it aligns with what I do, what I espouse, it doesn't tell the whole story about where we are so you know, is the healthcare setting a community centre for kids with disabilities that like a drop-in centre, I wouldn't necessarily call that a healthcare centre.

EMILIE: Yeah.

HELEN DONNELLY: So, that is why I like that more umbrella term therapeutic clowning.

EMILIE: And what is the intention behind the therapeutic clowning, what is the intention?

HELEN DONNELLY: [clearing throat…] uhm,

EMILIE: Sorry, that was quite tricky…[laughing], sorry.

HELEN DONNELLY: No, that is okay but are you talking about the benefits or…?

EMILIE: No, just…because you know you've specifically gone you know like the therapeutic clown is a very particular type of approach in a way; it's like more broadly applied but it's just you know easy to explain or understand the paramedical clowning kind of thing like okay so they're specifically aiming to do you know this and that. But what is the therapeutic clowning or the therapeutic clown specifically aiming to do; what is the intention when you go into the room or into the space?

HELEN DONNELLY: Uhm, [clearing throat] yeah, I think it's accompaniment; I think it's uhm, an opportunity like an invitation to join in a, like engage in an alternative uhm, an alternative reality if that's where it goes, uhm, you know sparking the imagination, sparking creativity uhm, and some of the things that I expressed earlier so things like you know, an opportunity to share feelings, offering an emotional break uhm, …

EMILIE: Yeah.

HELEN DONNELLY: … you know our work involves well, a lot of what we're doing especially for rehab hospitals is we're in the gyms working alongside other clinicians, other you know, therapists like physiotherapists, occupational therapists and speech therapists. So, we'll be on hand and we can be paged or to be at the side of our client and uhm, assist, assit with goals. These are not our goals but they are the team's goals and we're aligning ourselves with the teams uhm, and with the client's own you know, therapy goals, …

EMILIE: Yeah.

HELEN DONNELLY: … so our job description says well, really in any healthcare setting, it just depends on what part of the hospital you happen to be in. So, if I'm working very differently in a gym with my partner, with my client and the other clinician. Then I am with a teenager who is self-isolating and he is in his room and Amber accusing him of stealing at our office. Now there's a very different way that we can approach and I think what we offer is a really uhm, profoundly personalised approach uhm, that is age appropriate that is non-specific to their desires and likes and agree with their dislikes and sort of aligning ourselves and being uhm, yeah being a catalyst for their, for their, whatever it is that they're needing in the moment. Uhm, …

EMILIE: Yeah…is that alignment happening in the moment, is that alignment happening like prior, prior research…uhm, you know?

HELEN DONNELLY: Yes, there's a lot of prep like for instance in a seven-and-a-half-hour day that I have at my hospital, that we're having at my hospital, uhm, three hours of that is like about an hour and a half of looking up clients on the electronic medical record. Uhm, we're seeking out things like uhm, if is it a new client we need to know their diagnosis, we need to know their age, their family situation, uhm, their uhm, triggers, their likes and dislikes. You know anything that will give us uhm, a better idea of who they are, so that when we meet them, we're not surprised uhm, and were not taken aback and we're prepared to ... It's just really important to know yeah you know in there is communication styles too. Yeah…we need to know how they communicate; we need to know uhm, [laughing] there is an awful lot that we need to know before we go out, and then at the end of our shift, we spend an hour debriefing and then uhm, documenting electronically. We're the first clowns in the world to electronically document in the permanent health care record of our clients uhm, and the benefit of that is that all other clinicians can access our records and just as, our notetaking, just as we can access all of their notes about the clients ...

EMILIE: Wow.

HELEN DONNELLY: … so, that it creates a real uhm, collaborative inter-professional approach and we're all on the same page about our client and how best to serve them. So, out of that seven-and-a-half-hour day there is three hours that we're spending at the desk and about three hours that we're spending clowning.

EMILIE: Wow, and what would some of those notes be? Is it like something you have noticed just in the relations so like a client who is really open today or uhm, you know is really down but uhm, you know after some clowning felt like you know…what are that kind of notes?

HELEN DONNELLY: Yeah, it's those kinds of things so it's factual uhm, notes it's not, it's not, it seems they were open it's you know what actually happened.

EMILIE: Okay.

HELEN DONNELLY: So, what is it that we did …

EMILIE: Yes.

HELEN DONNELLY: … and then how did they react. Like what physically and vocally did they, how did they respond.

EMILIE: Beautiful…

HELEN DONNELLY: So, we'll be really accurate uhm, and just dispassionate about our notetaking.

EMILIE: Interesting…

HELEN DONNELLY: There's no, there's no, uhm, personal hopes or dreams inserted in there; it's just facts only. Uhm, sometimes we will quote what they say uhm, good, bad or ugly we will quote them accurately uhm, that sometimes is really, really, important for the team to know and we'll rate the level of reaction uhm, and this rating system was coined by Doctor Clown in Montreal so we have borrowed their system and it's just really simple, it's just anything from an R meaning reaction, neg meaning negative, R0 no reaction, R1, 2 and 3. So, R3 reaction would be a client who is helplessly laughing, giggling you know jumping up and down. R1 would be like a slight smile and some eye contact. You get the idea.

EMILIE: Wow, that's fantastic. I never even knew there was a rating system for therapeutic clowning [laughing].

HELEN DONNELLY: Yeah…it's something that we hope is gonna catch on because it's really easy to…it's an elegant system and it really, really, brings to life what happened at the, at that intervention and then we can track our progress. We can go back and we can go… and we can say to ourselves wow, look at that. It did take about a month you know from the time that this lad arrived to the time he…you know, to the present day and he went from an R0 to an R3 …

EMILIE: Yeah.

HELEN DONNELLY: … and there's been a steady progress in socialisation, he's now socialising with other kids…

EMILIE: Yeah, it's a fantastic assessment tool.

HELEN DONNELLY: Yes.

EMILIE: Wow, that is fantastic, I never really knew about that, so I am like pretty amazed. [laughing] Uhm, but now, so, uhm, maybe where we can go from there as it's maybe a personal thing so you uhm, you have your clown character uhm, and you obviously work in pairs as a preference as you have mentioned and so uhm, I suppose it would just be interesting to know like your experience uhm, yes, with the elderly specifically? Uhm, and what your approach is?

HELEN DONNELLY: Sure, uhm, …

EMILIE: Unless it does not differ much, I mean from other population groups I mean so…

HELEN DONNELLY: It does…so you know in general it's those, you know those same aims right, for socialisation, the you know, the alternative approach, uhm, you know the invitation into the imagination and the creativity level, all those things remain the same. Uhm, as you noted, uhm, as you noted we do have a different approach in terms of our outfits uhm, which we will get to, but uhm, basically the big differences for me uhm, in my experience and what I'm training my students to adhere to, is that the pace in general is much slower. Uhm, it almost kind of mimics the kind of pace that you would have with children with a brain injury. So, uhm, making sure that you're not talking at the same time, making sure that you leave space in between the dialogue, uhm, physically uhm, taking time to create what I call 'the drawing' which is you know is a sort of a suspension in your movement so that an elder has time to really take you in and observe you and have that time to just breathe you in. Uhm, when we move too fast all of that is lost and it seizes to become an art. So, the pace is much slower, uhm, physical comedy is still used but it's in different ways. It's age appropriate; it's slower uhm, a big thing as a starting point in order to build repour …

EMILIE: Yeah.

HELEN DONNELLY: … is that you know we're really focussing in on dignity and good manners which is that yeah, that root to connection that is going to be born out of those mannerisms. Your speech must be really clear and loud enough. A lot of people forget that even though there are uhm, some elders with great hearing, a lot of them use hearing aids and sometimes their hearing aid is on their bed table and we don't know where it's or it might be in their ear and it's not turned up enough, so uhm, so very clear speech and matched with the physical uhm, …

EMILIE: Sorry your physical? There was just a break ...

HELEN DONNELLY: … and also concepts of what you are … sorry?

EMILIE: Uhm so you said…sorry, there was just a break in the video. Uhm, so you said uhm, sorry, I just lost that part. But it just broke up uhm, instantaneously, sorry. Uhm, there we go I think it's back now.

HELEN DONNELLY: Okay.

EMILIE: Sorry, yes…

HELEN DONNELLY: I think I was just saying that the speech must be clear and loud enough…Sorry, go ahead?

EMILIE: Yeah…for the hearing aids is where I last got it.

HELEN DONNELLY: Okay…yeah and so that the speech should also be matching your physicality so that they have two different ways of taking you in, audibly and visually. Uhm, the concepts of what you are engaging with should be simpler in general so we're looking at less, abstract ideas, less flights of fancy, especially when it comes with people with Dementia. So, you know really concrete, familiar themes to start, and then see how that goes. Uhm, without losing the clownishness which is a really, ah, such a delicate line uhm, the focus, on the yes and no questions, or offering choices, versus open ended questions that is very different ...

EMILIE: Yeah.

HELEN DONNELLY: … uhm, and that is something that all clowns need to be grilled on uhm, and then the demeanour of the clowns, especially their facial expressions, need to be open and friendly and warm. Uhm, people who have Dementia often all the information that they are mostly going off of is our physicality and in our facial expressions because not a lot of things make sense otherwise so if you are frowning for some comedic reason, uhm, they are just gonna see a frown and they will worry about that. They will think something is wrong and a lot of the times they will think they did something wrong. So, it's really keeping in mind all of those I would say equally important factors to set up a very, very, good successful meet.

EMILIE: Yes, and so there, I suppose the building relationship with the elderly or I suppose in general with clowning is quite essential uhm, to how these progresses and moves and yeah, but …

HELEN DONNELLY: Yeah, we follow the courtship and it just takes the time that it takes.

EMILIE: Okay, and so have you noticed before that it might not or has it not necessarily developed in one instance before or it happens over a couple of sessions over weeks or is it quite instantaneous? Because I know with children it can be quite instantaneous, yeah?

HELEN DONNELLY: And for some kids they might play shy for the first couple of weeks and then it's a slow grow. It is all over the map I mean I am finding that uhm, yeah it's in general my experience is, uhm, in the elder population that I am currently serving at Sunnybrook Hospitals Veterans Centre, uhm, it's 99% pure joy right from the get go, like we have an end. Just as soon as they see us, they, they, you know even if it's a first time meeting us, it's instant and that is pretty generous of them and it's a very joyous thing to experience. I am finding that children uhm, depending on their age, if like I say the shy ones or the sardonic teenagers, these might take a while to, to, uhm, to create a, a relationship with, and then there are about two thirds of, of the children and the teenagers who are really open and it's instant so, there are really no stats out there, that's just from my own experiences. But in general, for elders it's pretty instant. Uhm, which really makes me wonder about their, like what is behind that. You know I think there is a lot of loneliness and I think that there is a lot of … like their days are very long uhm, compared to kids who go to school and then they have therapy and they're rushing around and there's hardly a time where they get to just chill out. Whereas elders they're lingering in healthcare largely alone and its uhm, I think we need to look at that.

EMILIE: Yeah…it's interesting you say that uhm, because yes I guess I am starting to see that or I'm definitely being told about that and yes, I guess it's that is why it's such an interesting relationship with the clown because I suppose you develop that relationship and so I mean I know I'm just going with the flow of these questions but I suppose how to close those relationships with elderly, how to leave the space is obviously also something that's different.

HELEN DONNELLY: It can be and a lot of the time it's very similar it's just you know, it's lots of gratitude, lots of you know, air kissing and lots of waving goodbye and we never say goodbye because a lot of these people are in their their lives so [laughing…] we say thank you …

EMILIE: Okay.

HELEN DONNELLY: … we'll see you soon. Uhm, thank you for sharing this time with us. Uhm, we have different exit strategies that mimic those of the kids. Sometimes it's a musical exit with some dancing uhm, but we enter and we leave very artistically; we have lots of different approaches of how to do it according to what we have learnt about the client or what we know about the client.

EMILIE: Okay.

HELEN DONNELLY: So, those entrances and exits are really carefully uhm, examined and there is a lot of attention paid to about how we enter and leave a room. Does that go off on a tangent?

EMILIE: No, that's absolutely perfect …

HELEN DONNELLY: Okay.
EMILIE: … and then uhm, what about outfits, what about outfits. Yes, I suppose there is general outfit but of course it always also brings up the nose and uhm, yes, I mean I suppose choosing to have the red nose and I have seen your clown specifically does keep the red and then you have the white uhm, medical coat. I'm not sure if that is something you keep in the elderly spaces or not but yeah just what about outfit?
HELEN DONNELLY: Yeah, so familiar images are really comforting for elders especially for those with Dementia. Their clearest memories are from when they were in their twenties. So, currently that puts us in the thirties to fifties era outfits.
EMILIE: Yeah.
HELEN DONNELLY: So, this was when they were young, romantic, adventurous, sexual beings who want to spark their memories from this time. This time when they were young and adventurous and strong uhm, and you know, for those reasons we really pay attention to, to what we wear and also what I've been doing is…I will just give you the example of my students. So, I've invited them in the Fall to start designing an outfit from the thirties, forties or fifties and they could choose to emulate uhm, either an iconic performer from that era whether it's a movie star or a famous singer uhm, or an iconic trade you know whether it's housewife, carpenter…uhm, you know…whatever right?
EMILIE: Yeah.
HELEN DONNELLY: So, most went the iconic star route and some went for a trade. So, in my class I have uhm, yeah I have a housewife, I have a woman who works for a newspaper [laughing] so she's very forties and you know I have Rosy The Riveter so it was someone whose, her name is Rose but you know someone who you know works in mechanics and has really got that feminist vibe so uhm, we're really paying attention to lots of different things. Where how, first of all, how does the artist become attracted to a certain figure. So, we always start with the artist themselves so it's not, it's never a random choice, it's never…Uhm, I don't know I think that a clown is kind of like a flower arranger. It's not about that at all; it's about who you are as a human first. Are you a leader, a follower and then we narrow it down to like what kind of, how do you take the space? How do you share yourself with the world? Uhm, what do you dream about? And all of these things uhm, it's in order for your clown persona to uhm, be almost mirroring big aspects about your own personality. So, for instance, you are getting to know me now, clearly, I am a leader, clearly, I am not too shy, clearly, I love to chat. So, I am not gonna be if you know me at all I'm not, I don't love to be in

dresses and …

EMILIE: [laughs]

HELEN DONNELLY: … I don't have curly hair you know so I am not gonna, I'm not gonna end up being like an older Shirley Temple or something. So, I'm you know, so I went with Katherine Hepburn. You know uhm, she wears slacks. She has a lower voice. Uhm, I am not imitating her but I am being inspired by her, uhm, and in this way, you know people can tell it's like yeah, this is very close to who and what you are so we paid a lot of attention uhm, and there was a lot of methodology behind uhm, behind choosing that, that look, and then once we have this look, we pay attention to things like footwear. Uhm, elders really, really, notice footwear a lot of the times they're looking down so [laughing] so, they're gonna see your feet. Uhm, they comment about it. Where did you get those shoes and oh your shoelaces are becoming undone or oh, I really like the heels and oh, they make a clappy sound and males like to wear things like suspenders and ties and belts. These are the things that get attention. We once had a gentleman who we were meeting for the first time and one of my clown students had a pair of suspenders and up to that point this gentleman had not really connected with any of us uhm, but on this day this clown student was serving him with his partner and the man immediately lit up and started [laughing] if you could run in your wheelchair he did, like he just animatedly went, follow me, and he rushed into his room and he said, pull the bottom drawer! And uhm, so, my clown student opened the drawer and there in the drawer were about a dozen different uhm, suspenders, …

EMILIE: Wow.

HELEN DONNELLY: … and for the next twenty minutes they went through every suspender and they talked about where did you get it, when did you wear it, did you ever date a lady in this suspender like you know. So, it's really, really, important. Uhm, hats too are also really important both for females and males. For female clowns we like to showcase hairstyles, hats may be involved or not but jewellery, shoes.

EMILIE: Hmmm.

HELEN DONNELLY: These things stand out perhaps a brooch or a badge.

EMILIE: Yeah…

HELEN DONNELLY: Or fancy buttons, things that bling. Things that get commented on and, and become often a main jumping off point to making a connection. Uhm, you mentioned the red nose, and it's, I love this topic because I'm really passionate about it. Uhm, For me it's vital. It's a signifier that something fun is about to happen …

EMILIE: Wow.

HELEN DONNELLY: … and in my personal experience this is something uhm, that they remember best. This is how they remember us best.
EMILIE: Yes.
HELEN DONNELLY: They may remember something about our outfits but all of them remember the red nose. We're often referred to as the Red Noses. 'Oh…you Red Noses are coming again oh!'
EMILIE: [laughing]
HELEN DONNELLY: You know, since our names will often be forgotten it's their noses that they will remember with fondness and they'll talk about us with other clinicians long after we're gone, days afterwards, and the clinicians will say they were asking about the Red Noses and they were wondering when the Red Noses would come back again. So, you know, you take that away, uhm, I would say you know what if you know me at all two of my clown personas out of five, are nose-less clowns and then the big believer in you can be just as clownish without a nose …
EMILIE: Yeah.
HELEN DONNELLY: … but when we're talking about healthcare and we're talking about uhm, clarity and we're talking about you know people with cognitive disabilities, …
EMILIE: Hmmm.
HELEN DONNELLY: … I think that we need to uhm, kind of like get out of our precious brains a little bit and cater to who it is that we're serving and I think you know the amount of clowns that are using noses very, very, successfully with elders with Dementia in particular would say the same thing and uhm, so yeah, I mean I understand and I, and I hear all the arguments for losing the nose. I get where that comes from but I am just not buying it.
EMILIE: Yeah…It is like you say context is uhm, important I guess in making those decisions.
HELEN DONNELLY: It is and it's clarity it's almost like being really proud and out about who or what you are. We are clowns and this is what we're uhm, giving them a non-verbal heads up about what is on offer and I think that that is part of respect. You know when we talk about respecting our clients, I think a big part of that is being really, really, clear and not being deliberately uhm, subtle.
EMILIE: Yeah, uhm, do you find that uhm, some people are fearful of the clown in like spaces that you've had or in the elderly spaces, have you ever been met with that opposite side?

HELEN DONNELLY: Not fearful, elders I mean, elders I mean with children it's about 5% right and most of those 5% get over it like after the first visit because the kids are jealous [laughing] that the rest of their friends are having fun and they're not. [laughing] so they get over it in a hurry. Uhm, …

EMILIE: Yeah.

HELEN DONNELLY: … with elders I have never experienced real coulrophobia, I've never experienced that.

EMILIE: Yeah…

HELEN DONNELLY: At all…uhm, some are, some are, yeah, there had been times where there's been a hesitation because uhm, whether it's a fear of infantilization which to be honest with you if I were them, I would, I would hesitate until I've vetted my fools [laughing], and you know, assessed with some deep means you know what your chops are like because there are a lot of practitioners that frankly, do infantilise; I have seen it and it's uhm, they may not be professional clowns but you know you really, really, need to know what you're doing and uhm, yeah, infantilizing is… infantilization within our profession is something that we all need to be vigilant uhm, about. We need to be on the lookout for. So discomfort around us might come from a fear of them being viewed as being silly if they participate uhm, or, or just confusion depending on where they are in their healthcare journey and if they, if they are diagnosed with Dementia and depending on the type of Dementia and what stage it's at. It can be very confusing and uhm, a little unsettling. Uhm, so, lots of different approaches that we use to reassure or to disengage or to, yeah, there's lots of things…But honestly it does not really happen very often. I would say like 2% of the time if that. It is very rare.

EMILIE: Yeah, in those interactions or in interactions with the elderly if someone asks like who you are or something like that do you ever refer to yourself as I am a clown or is it just like always ending at your name?

HELEN DONNELLY: I just, I stay in character the whole time and I just say, you know, you know, in my character voice I would say you know my name is uhm, Kat Jester and this is my cousin Yoke Jester and we're here to uhm, visit you if you have the time and uhm, you may not know this and I will share some personal anecdote about ourselves just to see if there is a bit of an interest.

EMILIE: Yeah…But you never self-refer as a clown?

HELEN DONNELLY: Never, no, they'll come and touch our noses sometime and ask why is your nose like that and we will say you know 'we were born like this' and…

EMILIE: [laughing]

HELEN DONNELLY: It is very, very, confusing sometimes or we will say…'Yeah, it's a big nose but you know everybody is very different' and they'll agree, or we will say…Oh, sometimes some people say 'I have a big nose' and we'll connect on a big nose front, yeah…

EMILIE: Oh yeah, okay, and I suppose that is important for not breaking the imaginative world, right? Not breaking that space from an artistic point of view?

HELEN DONNELLY: Yeah, I mean it's so important to not burst that creative bubble because you know there are very few times where I would legitimately say yeah, I can, for the safety of the client or for clarity or something yeah, I can totally see why you broke but I am a big believer in if you really commit, and you are very open and sincere in, in your language then they will be on board and they know that something silly is going on and if you're wishy washy then you can really easily slide out of character and then it takes that much longer to build it up again for the next resident and it's never worth it.

EMILIE: Uhm, and what about the staff, what about the relationship with the staff? Does this I mean obviously you've been in spaces where you've developed that relationship uhm, over many years and many months and many weeks? But how is it certainly in the beginning you know?

HELEN DONNELLY: Yeah, so if it's a new space, I do a lot of staff-prep. I am adamant that a lot of information gets to them before we ever arrive you know on the units. I will meet with them out of nose, as Helen, twe meet several times because everyone is on shift work and you are gonna catch different people at different times. I will leave a trail of, of how to get in touch with me you know there is email blasts, there's usually a live meeting that they can join. So, I do a lot of, a lot of, that stuff and that's really key. By the time then that we have reached the units, they're hopefully at that point after all that work [laughing]. Uhm, the majority of them are quite familiar with what is about to happen …

EMILIE: Yeah.

HELEN DONNELLY: … and they're very playful and I have to say they're, where we're serving right now which is Sunnybrook Veteran Centre where the average age is 97 uhm, …

EMILIE: Wow.

HELEN DONNELLY: … the staff there are just incredible people and they are funny and playful. Uhm, they're nursing students that come in and out and they're just equally delighted. They may not know about us but they are taking their cues from the staff that do know about us and uhm, and it's just, is really the key component to a successful program. You need to have your staff on your side and you need to convince them that this is interprofessional, that we're not …

<u>EMILIE</u>: Yeah.

<u>HELEN DONNELLY</u>: … entertainers flying-in willy-nilly you know, entertaining the troops and then leaving. We are a core part of the team and we're all working toward very similar goals uhm, so you know, it's important too to ensure that you are doing your documentation uhm, so like Holland Bloorview at Sunnybrook we electronically document there as well so the same thing is happening where I get to read updates about their clients and they get to read updates about the clients that we're serving and we get to know each other's practice through that exchange but yeah I actually have been criticised by, in the past, by a uhm, company that I will not name [laughing] who shattered us many years ago at Holland Bloorview and took me aside and said you guys spend quite a bit of time with your staff and this is time that would have been so much better spent on children who needs you the most.

<u>EMILIE</u>: Wow…

<u>HELEN DONNELLY</u>: And what, I was really baffled because I remembered engaging with staff as we normally do on route to our clients uhm, you know you might spend a minute here, two minutes there maybe making up a song about someone's pregnancy leave or welcoming someone back after they got their Masters, or whatever it's right but uhm, but to me that is just part and parcel of our practice. You got to look after your people and we know that well we were fortunate to belong to a study that did categorically prove that there is a residual effect, a physiological effect, a positive physiological effect of clowns as if they work with and interact with staff and that feeling doesn't go away for at least 15 minutes so we know that good care trickles down and so if we're looking after our front liners then it's going to have benefits for our clients so it's an odd thing when people are either surprised or criticise about the amount of time that we spend with staff but I think it's vital and I wouldn't have it any other way.

<u>EMILIE</u>: Yeah…agreed. Uhm, so yeah maybe coming towards the end of this I guess…uhm, would just be I guess to know uhm, what maybe before that is just have you clowned in many different countries or is it only in Canada or just to have some of an idea?

<u>HELEN DONNELLY</u>: Yeah, so, uhm, because of the healthcare clowning international meetings uhm, the first one being in Israel, the second one in Portugal and

the third being in Vienna uhm, I did shadow and clown with uhm, The Dream Doctors uhm, back in 2011, uhm, in Portugal in 2014, and this past year uhm, with the Le Rire Medecin in France.

EMILIE: Yeah.

HELEN DONNELLY: Uhm, I did shadow in Germany uhm, the Elder Clowns …

EMILIE: Yeah.

HELEN DONNELLY: … in Germany and uhm, yeah, it's been amazing to experience how other people operate and how they go about their day and yeah, just aside from Toronto in Canada I've also shadowed elsewhere in Canada and in Quebec is you know who we at Holland Bloorview try are trying to emulate the most and that's in a really big influence on how I built my school, they're one of the big influences.

EMILIE: And have you found that no matter uhm who you're meeting to clown with whether it's kids, whether it's different countries, whether it's adults, are you finding that there is a certain commonality or is it just wildly different every time you go to a different…yeah, it's like?

HELEN DONNELLY: Well, in general you are taking into account you know the different types of spaces and the different cultures, generally lots of things are very similar that is what I found.

EMILIE: Yeah…interesting…and yet, I am always asking have you also by any chance come to Africa [laughing…]

HELEN DONNELLY: No, not yet; I cannot wait to go.

EMILIE: Okay…good [laughing] Okay, we will stay in touch, okay no great! Yes, because it's something that's different for me going into this and yes, I guess not everyone is familiar with the clown. Yes, so that's been interesting. So, just to know if you had instances or spaces were people are not familiar to the clown the way you do and if that does not matter you just come in and this is the first time, they are experiencing it and so I guess you are that first experience.

HELEN DONNELLY: Yes, it's an interesting thing because you know the people are so glib and they just assume well everybody knows clown, well that is just not true. As you were noting, there's a lot of places in Africa that don't have clown. There's a lot of places in Polynesia and Malaysia that, you know there, clowning is a very new concept and in China it's usually through opera like the Tsao Chou and it's just, it's not a part of everyone's cultures so it's irritating to hear these sweeping statements about clown. The figure of a Jester, the figure of the Trickster, that is universal. Everyone has an animal trickster somewhere in their mythologies, right. It is found everywhere.

EMILIE: Absolutely.

HELEN DONNELLY: Uhm, but a clown with a nose no, that's a very Eurocentric concept so, yeah, it's an interesting thing and it gives me pause about introducing it, not to a huge degree but it just makes me …

EMILIE: Think?

HELEN DONNELLY: … philosophise a little bit about it and I think it's good to examine…

EMILIE: For sure, for sure …

HELEN DONNELLY: Like, and to see other approaches, I don't know.

EMILIE: Yeah, but I suppose there is something at the core of this which you mentioned which you know, I suppose, also offers something which is that this specific clown that you're referring to, this kind of therapeutic clown form, clearly has an underpinning of uhm, of curiosity, of openness, of generally a will to do well right, not a malice right?

HELEN DONNELLY: Absolutely, yeah it's a vulnerability and as you say this kind of earnest, we'll make good even though they often fail so the fad is the template I think everybody would do well if that were to be followed …

EMILIE: Yeah.

HELEN DONNELLY: … as opposed to you know there's a lot of concentration on skits you know and lutsy …

EMILIE: Yeah.

HELEN DONNELLY: … and tricks and I think these are the things that I think, matter the least. I think it's relational and I think …

EMILIE: Yeah.

HELEN DONNELLY: … it's uhm, physical and emotional. Uhm, it has to embrace clown logic, an alternative logic that uhm, you know it cannot just…I think it becomes stagnant when we get a lot of uhm, ideas around 'it's entertaining', 'let me entertain you' or 'let me teach you a trick' …

EMILIE: Yeah.

HELEN DONNELLY: … these are things that can go against the philosophy of serving. You know?

EMILIE: Agreed…and I suppose it's because uhm, yes, again, it's the particular role uhm, so yes, again like and openness with the clown right like a, and maybe that's where the therapeutic comes in, it's about the development of the relationship and that's never forced right. That has to be earned.

HELEN DONNELLY: That has to be earned yeah…

EMILIE: Well, it's amazing and I really look forward to uhm, watching your film I aim to buy [laughing] and download your digital copy of your documentary and uhm, yeah I look forward in just learning more through that and perhaps maybe one thing to just be left with is just as someone who is yeah, beginning and enquiring and yeah, just interested in stepping into this space. Just what is some of your veteran tips that you would advise you know, just going into this project.

HELEN DONNELLY: Yeah, I guess, like I've been hearing what the aim is but I need more information about like how many clown artists are involved, do they all have…

EMILIE: Just me, Helen … just solo for now, yeah…

HELEN DONNELLY: Just you?

EMILIE: Just because this is really new to this space and I considered two and I totally uhm, have come to understand why two is so beautiful and important in that dynamic but uhm, because I haven't necessarily been able to develop that kind of relationship with someone yet necessarily in this kind of context and uhm, yeah, you know, this being a first for both the home, for me uhm, that one feels like a manageable scope at this stage.

HELEN DONNELLY: Hmmm…okay…right.

EMILIE: [laughing] but perhaps you have comments on that as well.

HELEN DONNELLY: [laughing] Yeah, I'm quite firm on the duo being the model to follow …

EMILIE: Yeah.

HELEN DONNELLY: … uhm, not just because I mean I am not saying that it's impossible. I have done solo in the past; I am just speaking of experience. Uhm, it's not a sustainable thing because it does really take a toll on the artist.

EMILIE: Yeah…

HELEN DONNELLY: The other part is that uhm, it's to do with ethics a bit because when two clowns appear in a doorway ah, they can amuse themselves …

EMILIE: Yes.

HELEN DONNELLY: … and there is automatically not an implied expectation …

EMILIE: Totally.

HELEN DONNELLY: … for anyone to engage with these two idiots in the hallway.

EMILIE: Hmmm.

HELEN DONNELLY: … whereas if a single clown knocks at the door no matter who you are as a resident, you are gonna feel obligated to invite them in. No matter how you feel about them or how you're doing right now. There is an implied obligation because you are alone uhm, but you just cannot get away from that…

EMILIE: Helen, …

HELEN DONNELLY: I struggle with that.

EMILIE: … what if I tell you that the space is specifically not knocking or going into resident's rooms? This is the, more of like …uhm, what do you call…the communal area? Those who are present are present and those and it's not necessarily needing to force it on, it's like having the kind of job in the space that might…you know so very aware of that uhm, philosophy of imposing on but it's a communal space, yeah…

HELEN DONNELLY: Oh okay…that is a bit better uhm,

EMILIE: [laughing] It's good just hearing your…I mean I have not had anybody to converse in this way with so it's really lovely to be able to bounce that although I am sure it's not what you were aiming for but thank you regardless [laughing].

HELEN DONNELLY: Well, and you know the other thing too is that as a single artist everything's on you …

EMILIE: For sure.

HELEN DONNELLY: … so, what are the skills that you can bring to this? Like what are some of the approaches like you're aiming to employ?

EMILIE: Yeah, for sure. Are you asking me that really?

HELEN DONNELLY: Yeah…

EMILIE: Yeah? Great…uhm, so I suppose there's two things. One, obviously my theatrical background and uhm, yeah, I suppose my training as a clown, my engagements as a clown uhm, I suppose the application of it in a Clowns Without Borders setting as well although that is on a much grander scale. Yeah, …

HELEN DONNELLY: Sure.

EMILIE: … and then obviously starting a few experiences of doing it in a hospital space. I think uhm, one of my deep skills at the moment is obviously now and just recently and through the masters being privy to the therapeutic element and the therapeutic self and what developing relationship and the importance of uhm, yeah, of listening, being present have really kind of illuminated for me and I suppose in that regard I have a very humanistic approach yeah, that I believe that the answers or the path forward or a path for transformation for change because essentially therapeutic or the word therapy to me means some form of change, some form of transformation, yeah. It does not necessarily mean to be healed, whatever that means. Uhm, but to have some change, some transformation and so that kind of…that background that way of I guess understanding is certainly what is permeating this experience. I suppose also my own…I guess there is a personal side as well of me having experienced my own grandmother in elderly care and so that space uhm, yeah, just how I witnessed that how …yeah that space and so these are all culminating in something that is yes, of interest and of playfulness of course I have spoken to the home, I have presented and I have spoken to the staff and you know a lot of what you discussed of really speaking to and engaging to and engaging with the staff and ensuring there is some kind of understanding some kind of presence there; of course that has been really important and so now what I have decided on is very short installations of this work so at 20 minute cycles if it grows, if it gets shorter you know that is fine but because it's a start to see and engage. Uhm, something you should know is already just kind of like going into the space, meeting the staff and just kind of meandering through and so the minute there is a smile it's interesting that you discussed previously of you know the face yeah…the facial expressions.

HELEN DONNELLY: Aha….

EMILIE: Because already just coming in with that and an openness and a genuine willingness to just be present and be a part of just seems to really be very welcomed in yeah, and so I am obviously holding a bit of that openness but also the respect for the space, respect of my role, the respect of touch. I don't just go forward and just grab people I don't just touch. I always expect first and you know and there is a lot of that coming through and I am obviously aware that I have limitations in terms of uhm, my general experience, I mean I am honoured to be speaking to you and it's strictly speaking to someone with such a phenomenal uhm, past and background and uhm, and you know this is the beginning of those things but they are humble beginnings that I hope are located in the space that is of deep respect and dignity and I aim to just step in a space and you know just to be quite honest with you, my approach is to be the one who learns, yes, the one who enters, the one who steps in and has something to be taught from others. So, I am the fool, I am the one who fails and I am the one struggling and so you know, even if it's a need to learn how to do a dance, I am pretty certain the elderly can teach me more than I certainly have to offer and that is where the fun comes in. That is where the joy and the relationship comes in and it might mean that I have to stay at the door for a good entire 20 minutes before I am allowed to fully come in because there is a comfort of oh, is it like better here you know and changing; so I am aware of that there could be set …

HELEN DONNELLY: Sure.

EMILIE: … relations but I am very eager to explore that dynamic and I am equally intrigued with uhm, the elderly that might perhaps present in anger you know and what kind of game might emerge with that. Obviously, delicately, obviously, considerately. Uhm but yes, I mean I am yet to truly know and uhm, understand that and maybe I will…I don't know Helen, maybe I will land on my arse onetime and I will send you an email like holy crap [laughing] for lack of a better word but, …

HELEN DONNELLY: [laughing] Well we all fail and we all fail as artists too…you know, like I'm constantly you know, getting, giving and receiving notes with my partner.

EMILIE: Yeah.

HELEN DONNELLY: You know the learning never stops uhm, I did have a question around music because music is a proven…

EMILIE: Yes…absolutely. Yes, I've absolutely engaged in, I've downloaded…I don't play 'uke' (ukulele) but I play a little bit of the guitar but I am a singer so uhm, I hold the singing side. But I'm a phenomenal shaker [laughing]

HELEN DONNELLY: Okay…great!

EMILIE: I say that very sarcastically but yes, I am not necessarily too proficient in uhm, musical instruments uhm, other than my voice, holding rhythms uhm, in instances like that. But I do hope to have as well uhm, music in the space literally, music of the forties, fifties, etcetera, uhm, ...

HELEN DONNELLY: What do you mean to sing it?

EMILIE: No, to actually play it like through a little speaker through something like that.

HELEN DONNELLY: Oh, I see what you are saying. Right.

EMILIE: Feel free to bomb that if that is a terrible [laughing]

HELEN DONNELLY: It is not terrible it's fine I mean…you know we have clowned on top of canned music where we come into commune rooms at the odd time. It is just it does mean that there can be a lot of difficulties with elders to hear what is being …

EMILIE: Absolutely.

HELEN DONNELLY: … said when there are two things going on. There is canned music and then there is you and your speaking and their speaking and it's a lot. Uhm, often I ask the staff when we enter to turn off the canned music …

EMILIE: Yeah.

HELEN DONNELLY: … because we do play the 'uke' and we, all of us do uhm, and even if it's a shaker and singing thirties, forties, fifties songs I would say that is a bit more 'clownesque' uhm, but you know I experiment. You might find it's a great fit. Again, I have never clowned solo like I haven't done that in 13 years …

EMILIE: Wow.

HELEN DONNELLY: … and never with elders. I have always been in duo with elders so I don't, I can't really speak to what would work uhm, I can't imagine it so I would say yeah like try stuff out. Try it one way and one shift and then different way another shift …

EMILIE: Another shift, yeah.

HELEN DONNELLY: … and you can make a note for yourself …

EMILIE: Sure.

HELEN DONNELLY: … and the other thing too is that I would really encourage you to have a third eye, you know someone that you trust who has a similar background to you.

EMILIE: Yes…

HELEN DONNELLY: Who can be in the space and take notes and uhm, it's impossible to give yourself notes. Like that is the other thing it's like …

EMILIE: Yeah, for sure.

HELEN DONNELLY: … I don't even know if it's possible even to video tape…

EMILIE: Unfortunately, the home has not particularly agreed to that, they don't necessarily feel comfortable with uhm, the video camera…I did offer that uhm, as an approach but I will be journaling quite uhm, profoundly and uhm, I am hoping that also because it's a shorter time period that there would be something with that and hopefully able to remember some of the nuances, although it's not uhm, as revealing as video, I do have to respect the homes' wishes at this stage you know.

HELEN DONNELLY: Yeah…but I would say if you can get a third eye just like any theatre director would do, like just someone who can be in the space with you just for the first say three sessions …

EMILIE: Okay, yeah.

HELEN DONNELLY: … and sit down unobtrusively in that commune room and just take notes, lots of notes …

EMILIE: Cool.

HELEN DONNELLY: … and between their notes and your own reflection you can then decide what are some trends that are working, what are some things that you need to let go of…Because I really have to say…

EMILIE: Yeah…that is beautiful…

HELEN DONNELLY: You're working solo and so…

EMILIE: Yeah so you need that…

HELEN DONNELLY: And to have no outside eye, because we do double that so we do…we have an outside eye in our partner but that can only go so far because we both are in it…

EMILIE: Yeah, for sure.

HELEN DONNELLY: So, I can feedback to her about when she's talking over me or when there are two games proposed at the same time …

EMILIE: Yeah.

HELEN DONNELLY: … and we can talk a lot about okay, well, clearly we need to slow down. Or we often get an outside eye to come and shadow us and give us feedback …

EMILIE: Beautiful.

HELEN DONNELLY: … and ask questions about why we decided to go a certain route when other things were right there in front of us and what brought us to that decision, and yeah, like

EMILIE: I like that.

HELEN DONNELLY: … noting things that we can't possibly see when we're on the units. It is just not possible.

EMILIE: Agreed.

HELEN DONNELLY: So, I always say for a new program it's three. It's three shadowing opportunities uhm, …

EMILIE: Yeah.

HELEN DONNELLY: … minimum.

EMILIE: Perfect. I'll definitely take that into consideration so thank you very much for that and I think that has a lot value, I think that it's true that there is the outside eye which is essential I mean we require it when we create clown shows, we require it when we do anything.

HELEN DONNELLY: Yeah, why should this be any different and then the other piece is to make sure that you have some way of uhm, sharing your information with the rest of the staff.

EMILIE: Oh yes, for sure. That I plan to do just so that you know…so it will be over four weeks right, with two visits per week right, so it's a short intervention because it's the beginning …

HELEN DONNELLY: Yeah.

EMILIE: …and then it will end with an external person uhm, who will come in and who will do the uhm, interviews uhm, with the staff of just going okay, you can now tell me a little bit about your experience and so forth, as well as with some of the elderly which allows them to not necessarily feedback to me, which could be quite biased in not wanting to hurt me or offend me.

HELEN DONNELLY: Sure…yeah it has to be not you yeah…

EMILIE: So, someone else will be holding that. There will also be that and I suppose once that is there, well through the data, through everything, also feeding back and I have also developed a way to try and set in place at this stage uhm, yeah, quite a dynamic relationship with the staff anyway. They do have a social worker who is present who does a lot of the games and activities and experiences anyway with the staff, and uhm, so, they will be present through this as well and watching and being a part of and so they have been quite open to that kind of uhm, relationship and uhm, you know I have told them if there are any concerns or anything you're noticing, or something you're liking please feedback through the process. But obviously I have not started yet so we will see how that manifests throughout. But of course, there is allowing that space to be open and allowing that dialogue to be present.

HELEN DONNELLY: Yeah, I guess also I meant your own documentation to show to the staff.

EMILIE: Yes, for sure.

HELEN DONNELLY: What does that look like? Is it platonic, is it a binder?

EMILIE: Well, for now uhm, I have not quite decided yet as I will remain journalising on paper or if it will be as on my computer. But uhm, for the most part it's sounding like probably a computer entry just so I can legibly read and remember whatever is happening and the flow of thoughts. But I've never up until now really considered like if there was an assessment. I mean I am going to be uhm, looking at responses yeah, so what I'm documenting and what I'm making note of is what I can physically see in the space yeah, so I am feeling in the beginning there were a few people who were withdrawn or I am seeing a bit of laughter emerge or curiosity like I'm taking note of the responses. What is slightly different that I'm adding from necessarily your assessment is also what I'm experiencing as myself in these spaces as a second observation level and that is because uhm, it's just important for me to note and take track of that on what that might be feeding in the space, and yes, that's just something more from my therapeutic background of what am I transferring in this space …

HELEN DONNELLY: It's important.

EMILIE: … so it's really important for me just to make notes of those things as I journey through. But yes, that is what that document will look like.

HELEN DONNELLY: So, yeah, and that to me is in your own realm of your own personal reflections …

EMILIE: Yeah.

HELEN DONNELLY: … and your own notations. What I'm referring to is how does staff see it when you are there on Tuesday and you are there on Thursday. How does staff who works on Tuesday and Thursday ah, read your notes on, on, on Tuesday and then gets to see how things develop on Thursday. Like how do they map your progress?

EMILIE: Yes, so I haven't planned on sharing that during the uhm, the process to be really honest with you just because this is unique for them as well and this is something that they're observing and kind of going into and I am more offered the platform afterwards to go you know and had your experience from the clown different from the first one to the last one.

HELEN DONNELLY: A summary reflection, yeah …

EMILIE: Yeah, more of a summary of the reflection not necessarily during just I suppose as well to not overwhelm the staff it's already fear of like something that I am offering that's different and so just not putting too much necessarily responsibility on them for this research if that makes sense? Uhm, it just was not something that was discussed and I am interested in it and I am definitely going to keep it in mind but it really was not something considered until now, to be honest.

HELEN DONNELLY: Okay, well think about it because you know it will be up to them but at least it's something like to me uhm, you know kind of going back to ethics.

EMILIE: It's more open.

HELEN DONNELLY: Yeah, it's important I think for uhm, our practice to be really transparent and accessible to all so even if it's not even an obligation but it's a binder very clearly labelled that lives on the units you know lockbox or in a, you know behind the desk of a manager or whatever.

EMILIE: Yeah.

HELEN DONNELLY: Because if I'm a social worker and I didn't work with you Tuesday and I'm there on Thursday and I want to know how are my clients reacting to the clowns I have no way of getting to that information. Because the next time I see you is when you're actually working and I don't have a moment to connect with you so as part of my prep I would want to know…

EMILIE: Yes, what has been done. Even if that social worker is uhm, present…is observing…
HELEN DONNELLY: For anybody like for I don't know, for the night manager, for the CEO, I don't know [laughing] I just think it's important for anybody …
EMILIE: For transparency …
HELEN DONNELLY: working with hands on the client, they need to have access just like you need to have access to their notes. They would need to be able to look up things about your clients that might be written by a psychologist or actually physical therapist…
EMILIE: I actually have not even considered to do that anyway because I uhm, similarly in that therapeutic approach that I have usually the first time I hope to meet someone at this stage it's my early phase in the career and I am speaking like I am some veteran but anyway. But uhm, just even in the early stages I would just like to meet the person prior to making an assessment or a judgement of who they are and what they are because sometimes the person that I meet is certainly very different to that that which is written in the file and that is really important so I just bear that judgement and of course if they would like to meet things would have to be understood and discovered and that is fine. But certainly, in my initial meetings as to just meet and work with that which is being gifted in the moment, that which is being gifted there.
HELEN DONNELLY: Sure, and this is an argument I hear a lot uhm, I am looking at the time I have got to go…
EMILIE: Sorry. Thank you so much.
HELEN DONNELLY: … but I hear this a lot you know. Oh, it might bias the therapeutic relationship I might have, oh, I am going to be really distracted by knowing that they have violent tendencies, oh, it just goes on and on. The fact of the matter is how would you feel if in your uhm, refusal is too strong a word but if in your decision to not look up say, information about a communication style or behaviours…that you don't know for instance that you should never ever bring up cars ever, …
EMILIE: Yeah.
HELEN DONNELLY: … and then you just stumble into a conversation and the conversation takes you to cars in an in prob situation and they go ballistic so how do you justify? Not what I would call our due diligence and also what makes clowns so special? A being uhm, to not do the basic work that every other clinician is supposed to do i.e. looking up triggers, communication styles, the diagnosis, the family situation if that is relevant. Like, these are really core uhm, things to have in your back pocket

and for me they never interfere ever and they can be in the therapeutic relationship. They never cause me to hesitate or what to, what it does is to make me…it gives me lots of positive uhm, courage and confidence. It is confidence but I have done my due diligence and I am ready to reap them now. Uhm, I know what to steer away from. I know that they tire easily so I am going to be on the lookout for that. How would I know otherwise?

EMILIE: Yeah.

HELEN DONNELLY: How would I know that they are constipated and that they're really crabby because of that? Like, you know what I'm saying? I will never buy that argument that it's gonna somehow you know poison the well of the relationship or however people want to put it but I strenuously object to that argument, I really do, and I hear it all the fucking time [laughing] I hear it all the time and it's just, it's not true.

EMILIE: No, and I absolutely hear and you know, value your perspective and view and yes, it's really useful and particularly thought provoking you know.

HELEN DONNELLY: Sure, with that anyway because I yeah…anyway.

EMILIE: You know it's interesting because even with this space and shame I will close up now.

HELEN DONNELLY: Yeah.

EMILIE: But with this space as well you know a lot of…so this is a residence it's an elderly residence and there is a frail care section but I'm not engaging in the frail care section and this residence is largely where people uhm, live and they and they have a large component of people who are abandoned with very little family history necessarily or inability to access those families. I mean there is the staff and you know and there's a non-profit organisation uhm, and they get through it and sometimes there is not necessarily as much information available uhm, as one would like or hope for. Uhm, but there are definitely things that I am sure the staff note on each person that I am sure can be tapped into and be heard and listened to and engaged with so, yeah.

HELEN DONNELLY: Social workers would be my go-to. Social workers need to know all of those things.

EMILIE: Yeah, and I've already heard her approach, …

HELEN DONNELLY: They're my number one.

EMILIE: Okay great. Yeah, and that's the one person I spoke to funny enough today, so ...

HELEN DONNELLY: Seems like you already have a good repour and if you were to just say I don't need to know everything but I do need to know what their diagnosis is, what their family situation is. I mean how would you feel if uhm, if you've asked about the kids assuming they had kids and you did not know they always wanted to have a child and they could never have a child or they did have children, you read that in the medical records but you did not move on to see that they are estranged from their family, and how would you feel if you stumbled into a conversation around, so have you heard from your daughter lately…

EMILIE: I am hoping I veer away from questions like that in general, I mean my aim is to not anyway have such specificities you know, if that makes sense.

HELEN DONNELLY: I know but things can get very personal and very real and before you know they might start the ball rolling…and then you just avoid that. You would shy away from that and it would be very natural for you to exchange in kind but and then that could send you back. Uhm, so, the social worker would be the gate keeper of the information. Just for me it's diagnosis, family situation, medication styles, triggers. They always have a lot of information about what they did, what was their trade. You know any hobbies they had.

EMILIE: Yeah.

HELEN DONNELLY: These are really great things.

EMILIE: Thank you and that's yeah, fantastic advice and I really look forward to yeah, moving forward with this kind of knowledge and help inform the work you know.

HELEN DONNELLY: Yeah, and just lean on me if there is anything else, I can do for you or if you just want to give me updates from time to time; I would be very happy to hear them.

EMILIE: Thank you, I really appreciate that and yeah, I would love to stay in touch if you are offering that would be really appreciated.

HELEN DONNELLY: Yes, totally.

EMILIE: Obviously, I would not abuse the privilege [laughing].

HELEN DONNELLY: I know you won't, I know.

EMILIE: [laughing] but thank you, I really appreciate that.

HELEN DONNELLY: Yeah…pleasure.

EMILIE: Thank you and yeah…sorry I know that the interview had moved into a slightly different angle, are you happy for me to still include some of this or…

HELEN DONNELLY: Oh sure…

EMILIE: Okay great, maybe what I can do as well and it's up to you and you can let me know if you're comfortable enough with that but once I've transcribed I am also happy to uhm, give you that transcription, if you would like to read it, see if you're happy with it and I can always move from that point it's up to you.

HELEN DONNELLY: Yes, I would love to do that. That would be great.

EMILIE: Perfect, then I shall definitely do so. [laughing]

HELEN DONNELLY: Cool.

EMILIE: Thank you so much for your time and just engaging in this way and so in depth and so generously.

HELEN DONNELLY: No problem [inaudible 1:35:07]. Thank you and take care.

EMILIE: Thank you and have a wonderful rest of your day, you're at the beginning and I'm at the end.

HELEN DONNELLY: Thank you. Take care now.

EMILIE: Thank you Helen, bye.

HELEN DONNELLY: Good bye, Ciao…

APPENDIX B

CERTIFICATE OF VERACITY

We, hereby certify that in as far as it is audible the aforegoing is a true and correct transcript of the recording provided by you in the matter:

(NAME OF AUDIO: INTERVIEW WITH OLIVIER 08 03 19)

DATE COMPLETED	:	01/05/2019
NUMBER OF PAGES	:	24

DAISY: Perhaps we can start the interview with me just wanting to know a little bit about your background and what has specifically drawn you to uhm, therapeutic clowning?

OLIVIER: Right.

DAISY: If that is a good place to start.

OLIVIER: Uhm, …no that is perfect. So, I am coming from a theatre background, not a circus background. Uhm, so, I've got more, I have been trained in contemporary dance and theatre and as a story teller and so all my training in clowning has always been theatrical clowning and kind of like more European kind of style about the notion of this is your own vulnerability, your own clumsiness; it is not a comical actor that you are creating…

DAISY: Yes…

OLIVIER: But it is really about your own uhm, shadow that you are making fun of so that people can uhm, reach out to you even if they are in a state of vulnerability.

DAISY: Yes.

OLIVIER: Uhm, …so, twenty years ago in 1999 I worked on a project on the borders in Montreal. They were not uhm, going into the hospitals in Montreal…uhm, I kind of just discovered uhm, therapeutic clowning through a radio program on national radio and I heard [inaudible 0:01:38:0] Simons uhm, speaking and also an important therapeutic clown in Canada Paul Hoosen from Vancouver…

DAISY: Yes.

OLIVIER: And then I discovered that wow, that existed and I needed to do that so I called Combat on Borders to know you know what they were doing in hospitals and they were just telling me that they would like to do it but they were just busy with the mission in other countries so if I was interested and then I went and started and discovered uhm, that this turned out to be a passion.

DAISY: What was it about wanting to go into the hospitals?

OLIVIER: Uhm, …[inaudible 02:23 – 02:31] what could be [inaudible 02:33] one side uhm, I've got uhm, true lives that for me are going together uhm, and on one side a clown and a theatre person and the other side I am a Buddhist Meditation teacher.

DAISY: Wow.

OLIVIER: Uhm, …so for me that was already a moment that I started to feel a contradiction between all the stress and all the pride and all the attachment linked to trying to develop theatre career and how much I was suffering. Out of it to try to be on stage and be known and everything. Uhm, …and not feeling well anymore with my other side about uhm, Buddhist Meditation Practice and my teacher at the top uhm, because I did stop theatre at a certain point and she suggested maybe if I could do some more community work so I could be more linked actually really to people in their suffering and aging and sickness and so on, and at that moment I discovered therapeutic clowning and then it was like this is it! I need to do that and to be there I want to be you know…

DAISY: Yes.

OLIVIER: Uhm, in these extreme conditions and bringing my art and feeling that every time I was like uhm…as clown with the surgeons, with the nurses, with the psychologists, with the social worker and so on and while there is a clown in the team, I just felt just so great. This is so meaningful; this is such an amazing way to integrate arts as a way of social changes you know in the community. So, uhm, I guess this is really what uhm, drove me personally.

DAISY: Wow, and uhm, …

OLIVIER: … so, as what, yes …

DAISY: What about the, so … What is clowning for Healthcare for you then and uhm, what does this, what does this art form offer? And I see you have done it in multiple scenarios. You do it in hospitals, you do it with children, you do it in elderly spaces, so what is clowning for Healthcare?

OLIVIER: So, uhm, in that understanding that uhm, your clown persona is not simply a funny character or a funny way to dress up. Uhm, a fun … you know, a kind of a soothing way to entertain. Uhm, it is about you being the courage and the silliness and just show to people your shadow, your vulnerability, your stupidness, your clumsiness, in a way that is artistically adapted to your context to the people who's gonna interact with you. Uhm, …so this is for me the first base as that people can finally meet someone uhm, who is not them uhm, to take … to care for them. To take good care of them.

DAISY: Yes.

OLIVIER: They are there because they need help in such a funny and poetic, moving whatever ways you are using it but it is such a beautiful, delightful uhm, charming way where the person is just I want to play, even if it is kind of play funny or play sad or play you know whatever it is but I want to play in a position where I'm helping creation, uhm, the clown, and then we build from this a relationship, a playful relationship where we're both totally celebrating our vulnerability, our clumsiness and from this naturally uhm, if the game is well established, the other person will want to go and explore uhm, what is worrying them, what is missing for them at the moment, what is bothering them in a playful manner, in a secure space of playing and then a healing metaphor will naturally come out from the game …

DAISY: Yeah.

OLIVIER: … and so, we are simply guiding their own imagination uhm, so this is for me uhm…

DAISY: How it works?

OLIVIER: … therapeutic clowning is working and has just been taking me to amazing places and I have been shadowing and contributing amazing clowns in so many different countries and cultures and race and I could always find back this pattern [inaudible 0:07:40:9] when you know it is an amazing story of transformation …

DAISY: So, no matter …

OLIVIER: … the way you connect.

DAISY: So, no matter where you go you are finding that you come with the intention of helping, of healing uhm, in a way that is community based that you explore this together with the person that you are with and you do this by finding the games that you offer and how they are received. Is that a good way to kind of put it?

OLIVIER: Uhm, as a practitioner I could say yes, as the clown I would say definitely no …

DAISY: [laughs]

OLIVIER: … because as a clown …

DAISY: [laughs]

OLIVIER: … I am just there with a problem and then that person so, I'm bringing such a playful…

DAISY: It is your problem correct?

OLIVIER: It's my problem, it is me who is in the shit, …

DAISY: [laughs]

OLIVIER: … and so I am making them understand that it is no more about them being a patient. Now, you know, they are the expert, I need their help and they need you know to move on quickly because I am raining the shit and so they totally forget that you know they are patients and then they show their compassion for me and they are playfully trying to help me so this why as a clown naturally, and this is why for example I love it to be a clown doctor in Paediatrics and so I can really come and help them and make them feel better but it is really know that I am coming and it is such a crises and so they need to help me and so just for a child to be helping a doctor, automatically is changing the notion of herself but now wow I am someone who can take care of someone else and so psychologically it is changing completely the notion of healing and just in the same way that I was hearing young children with cancer telling their mother, I need to cure mom because I need to be back home because my pup is waiting for me or my kitty is waiting for me. So, they know the moment a human being is responsible for other living beings, automatically there is a healing process that starts.

DAISY: Yes.

OLIVIER: There is a notion of resiliency and we are tapping into human compassion and so for me this is what I want to be, I want to be the puppy they will take care of, the kitty they will take care of and they will be so happy so now they start to identify with someone you know who can help others.

DAISY: Yes, so you are shifting the roles and place basically?

OLIVIER: Exactly, it is exactly and even if the outcome is that the kid will die or of course the seniors of course they will die but then you know there has been a feeling that wow, I had a meaningful life because I lived truly what it is to be a human, it is to be compassionate.

DAISY: Yes.

OLIVIER: To love.

DAISY: So, it is …

OLIVIER: [inaudible 11:09]

DAISY: So, you're instilling compassion. You are instilling the compassion; you're allowing an opportunity for people to be empathetic.

OLIVIER: Exactly, exactly that is for me and so the moment that uhm, it is about my true weaknesses and clumsiness and the challenges so they can feel the truth of it and so they allow themselves to be true …

DAISY: Yeah.

OLIVIER: … and the relationship of it so if you are free and because I am celebrating in such playful artistic way, that clumsiness, so they can relax about their own problems so someone with Dementia is all trying to find back words and memories and ways to reach out and to feel at ease oh and for that person there is no problem. That person has no problem and would by clumsy and vulnerable and the opposite, that person is celebrating this and having so much fun with it. They can relax but more than that, that person needs my help.

DAISY: Yeah.

OLIVIER: And there is not going to be bridges of communication where I can be active and I can impact on that person and get feedback and we can [inaudible 12:25] action.

DAISY: How is it specifically with elderly? How does this work shift with elderly or if there is a shift anyway?

OLIVIER: Uhm, in the theory underneath no, it is the same thing. Of course, uhm, the way we adapt so for me uhm, the first stage would develop a trust-based relationship with someone in a vulnerable state and for me this little bit is what we…well the skill as to a therapeutic clown I call it that we are trust based accelerators. We have 20 seconds to 2 minutes to be able to establish a trust-based relationship. So, we just come into the room, we do not know each other …

DAISY: Yeah.

OLIVIER: … and in that very short time we need to establish this powerful trust-based relationship, uhm, and so the first thing is that we totally seduce the person to our artistic skills and we make the person feel wow, really I like this person; I want to be closer to that person, I want to invite that person into my world; uhm, which is sort of the first step and then from that we start the notion of wow, that person needs me and that person is creating a way where we are playing together, dancing together, singing together so that at the beginning of the game maybe the clown is doing a lot of the work and the patient is more observing and then the middle of the game now, we are dancing together, playing together…

DAISY: [laughing…]

OLIVIER: And then gradually the imagination of the patient kicks in and now the patient is taking all the decisions and the clown is just the avatar making it possible, making it bigger, making is seem able and becoming an amplifier of the body of the voice so the imagination of the patient, …

DAISY: Yeah.

OLIVIER: … and so ...

DAISY: So you start out offering and then you land up receiving?

OLIVIER: Yes, uhm, but then even it is the way that we were going with accompanying the patient and there is our own imagination …

DAISY: Yeah.

OLIVIER: … and just through our skills we are able to amplify that, so that they can see it, and they can have a slow playfulness that allows their imagination to really go into what are their fear, and to exploring their fears in a playful manner and in a compassionate manner then they can find a feeling metaphor that brings back some balance, bring back meaning. We train what was an object of fear now an object [inaudible 15:30] of growing up.

DAISY: And do you find the elderly are very playful like most of the other people?

OLIVIER: Towards the end of seduction part there is a little bit different from children than seniors, so uhm, one important element uhm, in general are meeting children in the hospital and I am meeting seniors in a senior's residence. So, it is not the same context. Uhm, for the children in the hospital one of the things that seduce more for a child in general, not for all of them is that uhm, because we are bringing uhm, disorders, [inaudible 16:18] were taking down the structure and they are kind of like what is that? The creator is making noise, this creating is making everything dirty and that wow they are breaking all the rules of the hospital…I like that. This is so fun! And then gradually they will open up personally, emotionally and start again to trust and get closer. Of course, sometimes we have to come and very quietly with some [silence 4 seconds] …we are good? [Laughing…]

DAISY: Yes, we are good. [Laughing…] Someone just walked in.

OLIVIER: With some children we need to come in a quiet way and that they will like us and everything is going to be more relational first and then we bring out the craziness. But in general, I can observe but they are first going to enjoy the craziness and that give them the trust to then be more emotional …

DAISY: Yes.

OLIVIER: … ensuing the relationship. Uhm, with seniors, in general, they kind of like that we played well, music first. They are elegant, we do things properly. If it is a home then we respect the rules of the home and so on and then we gain their trust and then they can allow themselves to be much more emotional and can bo going crazy.

DAISY: Oh, …

OLIVIER: So, it is all about this notion how do you get their trust and how do you seduce them …

DAISY: Yes.

OLIVIER: … so that you can dance together and then go wild. Uhm, and so in that role and so because it is a senior's residence and it is not a hospital in general so for me that was the [inaudible 17:57] to come dressed as a [inaudible 0:17:59] doctor that was something that was not so relevant on children, where I felt it was very relevant for them to finally see a stupid clumsy doctor that they can make fun of …

DAISY: Yes.

OLIVIER: … instead of taken care of. Uhm, so, in the senior's residence and especially people with Dementia I just felt it was creating a lot of confusion and it did not have so much meaning because it is not a hospital and the people with Dementia will sometimes get confused and think I am real doctor.

DAISY: Oh, …

OLIVIER: They get playful while what I was observing is that it didn't really care about the white coat, what they were really interested in was the relationship between the two clowns, and you know and asking me why were you with another woman last week…

DAISY: [laughing…]

OLIVIER: And then I will be in the shit and all the others look at me and say…What, he was with another woman? [laughing…] and then something would happen you know, and then the senior will say…oh, they want the alliance with me to cover me, to protect me from the alliance with the women and the clown and so they put me through the shit and so now we are having a game and so I saw it was much more trusting for them and they were more trying to know what was our relationship and if we were married, if we were a couple, if we were brothers and sisters, and you know what was going . So, it was very clear and much more interesting for them. Uhm, so what came out uhm, talking with Mixizum Sean Berger from Hearts and Minds at that time it is gradually [inaudible 0:19:41:1] the notion to families and what came to me was the notion that in the hospital the doctor is God, is a supreme figure and this is why it is so funny to have a supreme figure being so clumsy and vulnerable and the child will take care of that God of the hospital that [inaudible 20:06] the child, uhm…so I was trying to find out what could be a figure of the era that could have that power for the senior, and this is where the notion of the Hollywood star kind of like were not impersonating Hollywood stars. It is our own stupidness that all of us wish to be Hollywood stars and wish to be beautiful and perfect. The white clown, the high-status clown, that notion. You know in a circus I saw this clown, the white clown how gorgeous and beautiful and shiny and totally Hollywood and so to adopt that notion it will be like this beautiful Clark Gable all perfectly dressed, a small moustache and everything, and coming to their door and then they feel wow, that person came to visit me. So, well dressed but in a playful manner so there is no problem. The person with Dementia does not feel [inaudible 21:23] I am not good enough or something for such a visit but nobody can feel okay, because it is [inaudible 21:26], so playful and it is okay, and gradually they understand that with all their life maturity, knowledge and experience, now they can help emotionally, that Hollywood star is having lots of emotional problems.

DAISY: Yes.

OLIVIER: So, again, I have, finally taking care of us …

DAISY: I've noticed that uhm, a lot of people who engage with the elderly, who are uhm, therapeutic clowns often wear clothing of the Epoch anyway so …

OLIVIER: Yes.

DAISY: … it seems to be something that uhm, is used specifically with the elderly because it evokes memory, it evokes something that is familiar uhm, so I see that as almost a tactic with the elderly.

OLIVIER: Definitely that is so important uhm, and with Marbella now, we've been working so hard for people to stop uhm, being just dressing like crazy multicolours way or even using the same things for children with seniors …

DAISY: Yes.

OLIVIER: … and to really, really go and challenge them and uhm, what was very, very interesting is that uhm, the [inaudible 0:22:50:6] rehab I have been working with in Rio who is one of the experts in Dementia in all of South America, uhm, found out research from the University of California to demonstrate that the perception of the self, for the person with

Dementia, especially with Alzheimer disease in general they perceive themselves that they are 20 to 25 years old.

DAISY: Oh, …

OLIVIER: And so, they relate reality with that frame that they are 20 or 25 years old and that explains a lot of confusion uhm, on our side when relating to people with Dementia, and so that notion that we can recreate the era when they were 20 or 25 years old give them something very strong that they can relate with and it could be subdued so that they can trust so they can engage in the present moment and finally they can take care of us and feel totally empowered, so now we're able to use all their life experience of someone of 85, 90, 95 or a 100 years old but at the same time with deferring of their understanding that they are 20 or 25 years old.

DAISY: Yes, is the…what is the relationship like with the staff in an old age home when you're coming in?

OLIVIER: When we were dressed up as uhm, clown doctors in more of the same way we would work in Paediatrics and we're more like clowns then uhm, the people would naturally be much merrier and having fun and playing games but really, really love us, but many of the staff was puzzled and really afraid that we would [inaudible 24:50] the seniors and some people would just simply hate us. At the moment that we arrive very beautiful singing clowns, playing loud music, charming and using the codes of seduction of the era, we then flirt with the staff and be welcoming to the family then all this tension kind of went down …

DAISY: Hmmm.

OLIVIER: ... so much and then people would just like maybe uhm, a question like why do you use a big nose and then we even start to use leather nose and no more plastic noses, and it's already giving something more adult, and so, … and then we just have to explain the family what is the core of clowning and why it's an invitation to play and an invitation to form mobility and that it would be okay, even about the nose that it would be the last resistance because they are just gonna be like wow, this is making so much sense.

DAISY: Yeah, so the nose, do you find the nose very important uhm, in your work? Do you find it like differentiates you and is there some significance with that that you feel like…even if the rest of the outfit is more uhm, part of the Epoch etcetera but the nose just offers you something that says play or I do not know?

OLIVIER: On one side, because the nose is a leather nose and it is very small, and brings the notion of a family that we are all sharing the same nose, and uhm, so it doesn't clash with the era costume at all.

DAISY: Yeah.

OLIVIER: And it does function as once someone wears a red nose, he looks a bit more vulnerable, he doesn't look as perfect as normal, and at the same time, uhm, it is an invitation and more so the culture, to play.

DAISY: Yes.

OLIVIER: And for people with Dementia that was a very simple visual thing that they can relate to. They would start to talk about the red nose and the people with the red nose and you can see that they emotionally remember and some of the staff were noticing this importance of the nose and uhm, Magdelina has been, she told me she's been kind of almost forced by one institution where they were starting [inaudible 27:19] and they did not want the nose at all, and normally she was always the nose, the nose, the nose, and then you know she wanted to challenge herself and she said okay, let's try three months without the nose and see what's gonna happen. You know maybe you are right, maybe we don't need the nose and uhm, being dressed uhm, not in a clown way but something that…you know some people could dressed up like the era in their life …

DAISY: Hmmm.

OLIVIER: … and so, it is difficult to know if that person is in playful mode or not.

DAISY: Ah, yeah.

OLIVIER: So, then the staff and the family would arrive and see someone kind of dressed normally standing up on a chair in front of a senior. What is that? What's going on? And it would create finally more confusion for staff and family and for seniors because there wasn't a code.

DAISY: Yeah.

OLIVIER: Oh, no, we work here to play.

DAISY: Yeah.

OLIVIER: It's okay.

DAISY: So, it’s a signifier that says I am here to do this, to be different, you can play with me in this way, maybe not the staff in this way, don’t worry this is part of the plan, this is normal, this is part of the situation.

OLIVIER: Exactly, so it does explain that, there is the memory, the emotional memoir …

DAISY: Yes, the emotional memory.

OLIVIER: … and also there’s an invitation to vulnerability which you know a music therapist would come and can dress up beautifully from the era with music from the era and so he does not need a red nose.

DAISY: Yeah.

OLIVIER: But because this is not about the shadow, the vulnerability of that person.

DAISY: Yeah.

OLIVIER: It’s about that person having an amazing skill and profession and being a music therapist, which is great, …

DAISY: Yeah.

OLIVIER: … and they will play music of the era and they will manage like this to get back memories and mental uhm, abilities and this is fantastic. But uhm, maybe you know through relationship, vulnerability will develop and the senior will start to care naturally for their friend, the music therapist, and want to know you know if he or she is happy and in a relationship, and what’s going on, and all this. But it’s not gonna be set up in a playful …

DAISY: Environment.

OLIVIER: … well, and so it’s not gonna bring the seniors who want to play their own fear and explore that.

DAISY: Yeah, and so you do play music. Is this also music from the era? Have you found that music helps the scenario, does it bring out the play? What is it about the music?

OLIVIER: So, everything that uhm, is non-communicative uhm, and can activate the senses uhm, to bring back any familiarity of the era is such a plus.

DAISY: Okay.

<u>OLIVIER</u>: … so, using scents, perfumes, soap of the era that are still available so the the textures, the purses, the dresses, the clothing, the … a scarf. Anything that they can touch that will hit back memories of the era.

<u>DAISY</u>: Why? Why the era?

<u>OLIVIER</u>: Okay, so what we wanna do with the question of Dementia is that uhm, …[4 seconds] Dementia is uhm, stopping various synoptic connections and so their most common roots are being blocked and so the person cannot access that memory or that mental ability and so cannot speak for example, so now, we see this beautiful uhm, documentary music therapy and it started and everybody is lonely and they are inside their mind and they don't communicate and they don't relate to people. They've got the music of their youth and 10 minutes later they start talking again and they have memory again and it just seems like what was that miracle and then the same thing with the clown and so on. So, what's happening is that all these memories of when they were 20 or 25 years old are so emotionally charged, there's so many roots of you know uhm, for example, how many times uhm, many women called me mother. What would be my reaction? I would just continue like everybody else because I mean, I am not your mother. Your mother died thirty years ago, stop repeating this. I am not your mother; I need to bring you back to reality you know which is, I don't know why people are doing that. That's weird, when she just wanna tell me, I am feeling so safe with you. I love you, and so, the word to express this is the word mother and the word mother has been the first word in every languages. It's so charged of so many concepts, so many memories, so many emotions. We hated with her, we loved her, we had everything. So, there is so many synoptic root to get to that word, so the moment you find that even Dementia creates a block that stop it, the common root there's so many other ways to quickly get back to that word, so in that way we're putting the music of the era. So, many memories, so many challenges, so many fears, so many conquests and so long they remember uhm, home coming, party, they remember uhm, their wedding, they remember so many things that can come back. They remember when, you know, they had such a fight, so many things are coming back and so the synoptic connection can fire up and find another root and then the memory is accessed again. The mental ability that has not been destroyed and be accessed again and so they can speak.

<u>DAISY</u>: So, that's what …

<u>OLIVIER</u>: This is how we …

DAISY: … that's what the music, what the clothing, that's what that is offering. That era is offering access into memory, into past.

OLIVIER: Exactly because in general the people who will develop Dementia are people that, uhm, because not everybody with Dementia has the symptoms of Dementia, and the people who has the symptoms of Dementia, are people who are in general, uhm, putting themselves to repeat the same uhm, thinking patterns, emotional patterns and behavioural patterns, and so, they're just using the same synaptic root all the time. So, that's why when they have Dementia, they're losing the other possibilities.

DAISY: Yeah.

OLIVIER: While someone who is always challenging themselves, is able to access self the abilities with a difference. So, what we do with people with Dementia, more and more we're gonna put them into an institution where everything is about patterns. So, in some ways it's so counterproductive and so they will degenerate from phase II Dementia to phase III very quickly sadly and the family just want to do everything for them, and so that's emotionally, there's gonna be no challenges and kinetically there's gonna be no challenges and physically there's gonna be no challenges.

DAISY: So, the clown offers challenges?

OLIVIER: Exactly, because [inaudible 35:20] you know, I'm so clumsy, and I'm a mess and I need your help, so you're gonna do something about it. So, this is this notion that this is the art of failure, we're bringing failure, because true failure we need to change the way we thing, we need to change the way we relate to others and we need to be creative, because we felt it, and so, this is forcing new synaptic connections …

DAISY: And is this beneficial even for some of the elderly who do not have Dementia, so sometimes you have a group of people, many of the residents are still quite sound of mind? Uhm, some of the residents obviously are not, well yeah, that is certainly what I am seeing in my current site, is probably a bit of a combination. So, is it still beneficial to have that even in that space because like you said before there's still empathy and so forth or it keeps the mind fresh so even if you do not have Dementia it's still good?

OLIVIER: Definitely, we experimented uhm, right from the beginning there was a big challenge, there was a woman of 96 years old, we were seeing her [inaudible 0:36:37:9] and uhm, she's here…

DAISY: Wow, there's a photo. [laughs]

OLIVIER: And she didn't have Dementia at all, she had all her marbles, no problem uhm, and so that was a very, very nice thing to okay, see how she will react to clowns and uhm, she hated us in such a playful manner, she was so delighted to hate us and we're just so delighted that she would hate us …

DAISY: [laughs]

OLIVIER: … that we developed an amazing relationship with her and finally she was hating us because she was so uhm, angry and bitter and she was depressed and she just wanted to die and we tried everything to kill her …

DAISY: [laughs]

OLIVIER: … and it was so much fun every which to try to kill her finally and wow, we spent a year and a half and you know and finally we did it and the family was so thrilled and embodied us to be general …

DAISY: [Ugh]

OLIVIER: … because you know it was such a playful celebration and we were just saying yes to her needs, you know, naturally. So, that was very, very, nice.

DAISY: So, that's interesting, so the clown offers you in a way permission to do things that are quite taboo. Yeah, flirting with the elderly, killing the elderly, so forth you know…If you just told the general person on the street this it might you know, sound quite shocking. But in this space, it's actually the relationship that's playful, it's you know…

OLIVIER: Exactly, it's totally healthy and wonderful so yes, amazing and she managed to uhm, save our program in that institution.

DAISY: Wow.

OLIVIER: And she felt completely empowered.

DAISY: Wow, and do you find uhm, that the staff are quite supportive of this work or do they feel like you interrupt the work or just wondering about that relationship as well.

OLIVIER: For us it's really, really, important the relationship with the staff. Uhm, so, to really uhm, come and explain what we will do, tell them that we're not there to do something because they are not good, they are not human enough and so on. That we're not doing a good job and leaving them the bad job that there is nothing to do. But they are amazing and we're just here because we are bad and clumsy and stupid so this is why, you know, there is no competition and you know work. You know they need to continue to do amazing work that they're doing and we're bringing that vulnerability and stupidness that is lacking so the senior will take care of us; so to make it very, very, clear and being sure that you know all that seduction is also offered to them so they can enjoy also the core of the flirting and the music and the dancing and so on. They know that we're, that you know we're creating time for them too and so on.

DAISY: Yes, so you incorporate them.

OLIVIER: Exactly we incorporate them and we offer them…

DAISY: So, you incorporate them; you bring them into the play sometimes.

OLIVIER: Yes, and every time, then we can build up between family including the staff into the relationship knowing that they will continue afterwards and at least now they are starting to understand the keys of that non-infinitive communication.

DAISY: Yes, and uhm, is it fine to have one clown in the space, uhm, two clowns in the space uhm, what are your thoughts around how many clowns are in the space?

OLIVIER: So, uhm, I work uhm, with two clowns and I'm a big supporter even if I'm training and shadowing so many groups who are working solo, two, three, five, twelve and so on. Uhm, but my personal choice is two. Uhm, with people with cumulative impairments and challenges yes, two clowns can be a lot of information.

DAISY: Okay.

OLIVIER: So, with multiple kids and people with Dementia uhm, and even with seniors who you know are mentally still fine but visually and the hearing is impaired, and so it's still a lot of information to be able to work with two clowns. So, this is why it's very, very, important that we feel from the beginning how to facilitate the seduction phase, the clown is making alliance with which of the two clowns. So, that we understand okay, now that one will reflect the mirror emotion of that person and if we need uhm, an antagonist, then the other clown will be there to create a contrast and if for the moment we're still into seduction phase, then in relation the other one is just putting music, putting something over to just help out or to be the guard to, guardian to protect that game from the other clowns and the confusion from the staff or from the family who would insist too much and so the other clowns can be there to protect what's going on, the beautiful relationship and people will not come, then maybe reframe it, then okay now see it that way, come. So, one thing that is important for me into the concept of being two, of course there is all the emotional support, of course there is status quo status of red and white clown work and so on. But there is also this notion that for a moment there is an alliance. Once we get into the therapeutic game; the other clown would come …

DAISY: The support …

OLIVIER: … and be the object of fear that's gonna need to be killed for the qualities of that fear to be integrated. Like in any therapeutic game, you know, with imagination. So, for children, so of course, the child would become Batman and so the alliance clown would become Robin the sidekick and then we have a [inaudible 0:43:12:2] automatically which has all the qualities of what that child is afraid of at the moment. So, he is afraid of the doctor, of the hospital, …

DAISY: Yeah.

OLIVIER: … of the cancer, of his mother and of course that villain is with these qualities and in some way for the kid to be about I don't need to be so afraid of that villain and even they can integrate the quality of that villain in some way,…

DAISY: Yeah. It makes sense.

OLIVIER: … which is where they are taking that game with the help of the sidekick of the alliance and then the kid will make you feel okay, I want that clown to be in alliance with me and I want that clown to be allianced with, low or high status and so you need to feel that and then the villain, the [inaudible 43:56], would have to be then the opposite of low status or high status. So, there's like, the child wants to be rebellious so he needs an alliance with the rebellious red clown and then we're gonna attack the high-status white clown and we're gonna kill with our water gun and that's gonna be funny or the opposite. I wanna be the [inaudible 44:16] I wanna torture the low status clown, so I make alliance with the white like status clown that's gonna help me affirm this energy, and now we're gonna having so much fun torturing that other clown until we can kill him and then save his life and be a good uhm, [inaudible 0:44:37:1]

DAISY: [laughing…]

OLIVIER: … at the end, so you know, so the same way I observe the same things with seniors when we have established gradually the game and they're making the alliance but then it will become for example it's gonna be a couple and …

DAISY: Yes.

OLIVIER: … maybe the woman will take the woman's side and then you know the idea is to hit the poor husband and this is how we you know then this is the same thing the same game of high status where the low status would be antagonist or the opposite; we're gonna be very rebellious and then the other clown you know we're gonna insult and say very bad words and so on and then it's so much fun and we're both rebellious and the other one is all shocked and oh…

DAISY: Yes.

OLIVIER: … you cannot say this and…oh, and it's so much fun so like this it's important for me because in a very good game we need an antagonist and what normally I see uhm, the solo therapeutic clown is that at that moment of the game even if the trust based relationship is so quickly intensively developed, uhm, but after that when they need the villain then they need to use a nurse, they need to use a mother, and then it's not working as well because it's someone who is not trying to be a bad person.

DAISY: Yes, a bad person …

OLIVIER: … n that situation and sometimes also if for example it's what the child wants to project is his fear of his mother then if it's his mother who is playing the villain it does not have the same impact.

DAISY: Yes, so then what advice do you have uhm, because this is the first time going in uhm, for myself going into that mode I would most likely probably go in solo in this experience just because it's the first time and they've never…two clowns feels like it might be overwhelming at this stage just because already just me wanting to come in is quite daunting yes…[laughing…] so…

OLIVIER: It depends if you have a very good clown partner, and you have a very good connection and you work …

DAISY: Yes.

OLIVIER: … with each other, you can play music together and then it's support and supporting one another then it's so much less stress for you and then for the environment and then if you can bring a male figure, so there is even something you know for everybody, then we can pick up and choose what they prefer, then of course, if you know about these conditions at the moment then of course you need to come and you need to make it very, very, clear uhm, why you're coming, what you're needing, and what you're offering. So, let us make it very, very, clear so for me the basic notion that this is a Sunday visit and this is why I'm so nicely dressed to come and see you and you know and to build up on this and make it gradually clear you know what the person likes and what they can offer to please a person and gradually reverse the game …

DAISY: Yes.

OLIVIER: … so that person can help you.

DAISY: Help you, okay. That's very important. Okay, and uhm, maybe just to come bring it to a bit of a close, would be just be to know that you've travelled uhm, many different countries and you've done a lot of this work in many different spaces, different environments, different contexts essentially ...

OLIVIER: Yes.

DAISY: … so, what have you noticed moving? Are there similarities, do things change quite drastically in the different countries that you are going to? You know I'm, yeah, just interested in knowing in the broad reach of your contexts that you've engaged in, if you always find something similar to kind of, that it's still easy for you to engage in the environment because you are true to some kind of essence of the clown or if something is quite different when going into every space or how you deal with different spaces.

OLIVIER: It is both. Uhm, the playful vulnerability is working everywhere. The stages of seduction, alliance and then uhm, empowerment are applied everywhere in all the contexts, I have seen it, doing it and shadowing it uhm, so this is the same. Then the notion of how do you build a trust-based relationship like the steps are the same but how do you seduce someone? It is not the same in every culture, you don't flirt the same way in every culture. So, of course when I'm with Brazilian women, it's very different than with a city Jew woman. It is a completely different relationship and with New York women it's gonna be very different at the same time than French women. They're all very different in their relationship to men and in seduction and so on. So, I will view major self, trust and the person want to open and so this is where we need to be vary, very, adapted and so the costumes and the music and the games and everything, the approach is very, very, different.

DAISY: Yeah.

OLIVIER: You know how people will approach uhm, vulnerability and intimacy and trusting and empathy is very different you know.

DAISY: Yes, and also the clown?

OLIVIER: In Brazil someone fall in the street and you know everybody just come and help you automatically. In New York City you fall in the street and people just …

DAISY: Yes.

OLIVIER: … move away from you so it's very different, the relationship. So, how do you approach vulnerability and then you know how do you approach imagination of every culture as a different relationship and imagination, do we like to play games, do we like to play but you know that we are thing, or no, and so, how do you gradually set up …

DAISY: Yeah.

OLIVIER: … these few moments.

DAISY: Do you research that prior or do you discover that in the moment?

OLIVIER: Both.

DAISY: Okay.

OLIVIER: So, you know, I encourage people for example, when I go visit in every different city so okay let us go to the archive of the city to see how it was in the thirties, forties, fifties. We get pictures, we get, and then we go on You tube and we find videos and we get all the music and you know, we interview and we get as much information we can, and in the workshop we work into being much more … to develop our emotional intelligence, to transform that into creative intelligence, and so we get as many hints from the person in the moment to discover if that person you know if that person wants me to have the high status or low status. How can I feel that in that moment and that change every time? I can never just say oh that child loves us when I'm in high status. We know in that moment …

DAISY: Yeah.

OLIVIER: … that the same thing can happen with the person with Dementia. So, that's why we need both levels of information at the same time just like it's good to know that that person is reacting to medication. Okay that's maybe why, I'm just able to know, or the person has difficulty to hear, and so we need to speak louder or just sometime you know uhm, I'm three feet away from the person and why is that person not reacting, normally she is just so warm with me? And then I just think okay once I get closer…Whoa…. Magic! She was able to see me. That was as simple as that and I just need to remember yeah, of course with her I need to be two feet away from her face and not three and so on, and so just, so we need to know all this background in terms of their physical state and education and their life story if we can. Also, it's just amazing to know and then in the moment we will discover …

DAISY: Amazing.

OLIVIER: … because of course, sometimes they tell us that that person is so aggressive, and because we're vulnerable people-people, she is not a person at all, …

DAISY: Yeah.

OLIVIER: … and so, what can we trust and not trust and the like stories and sometime you know that person what is true emotionally in the moment is not uhm, what is recorded as their life story? But it's completely making sense just like the woman who is calling me mother, she is totally right. This is true. She is totally right to call me mother. So, I don't need to be bothered by her life story saying no I'm not your mother. It doesn't make any sense. She is right, she can call me mother.

DAISY: So, you've just got to be very present for clowning, for this kind of work.

OLIVIER: Yes, so that's why in the work show, that's why to be able to talk about the unstinted intelligence and emotional intelligence and created intelligence so I translate into clown language that uhm, we have an inner puppy in our belly and this is just our hah, curiosity who wants to play and it's so joyful and excited and just wow, someone and I just like wanna sniff the person and play around the person and just bring him back to the scenery of Dementia…wow…and then also there is a hummingbird in the heart who is able to feel every detail and every subtle emotional changes and then finally all this information is brought to an eagle in our head who can have very, very, large vision and can integrate everything into the play and bring it back to imagination, all this information at the same time.

DAISY: Wow…

OLIVIER: So, that's why we bring forth the puppy, the hummingbird and the eagle and …

DAISY: That's amazing ...

OLIVIER: … we bring them all together.

DAISY: … and so, do you think uhm, you know someone like myself who's fairly new to it all, uhm, what…I guess sometimes there is a feeling of am I skilled enough at this stage, am I, I mean you know there are people with many years of experience and so on and you know I'm just starting and so uhm, I just, yeah, I just wonder what if you've got any thoughts about that or any tips or just advice or …? I mean I suppose we all started somewhere but uhm, it's …

OLIVIER: Exactly all these people and me you know I just went to the hospital, had no notion…

DAISY: Wow…

OLIVIER: And I just went to play and connect and you know, and then I learned, and learned, and learned, outside and doing it, I learnt so much so you know your inner puppy needs to be completely free you know and really, I want to play with you, and to trust completely you know, I'm not here to succeed, I'm not here to help you, I'm not here to do a good job you know. People are observing me; I need to kind of ignore that they are observing me; they're just as a puppy, how possible it is to play and so you just need to come and with that then you knowing that okay, I'm going into a vulnerable place and I love it. You know this is, I'm not there to be careful, and you know taking care of everybody. No, I love this agility of life because this is what make us connect to each other.

DAISY: Yeah.

OLIVIER: Life is a catastrophe. We're all gonna die.

DAISY: [laughing…]

OLIVIER: It is horrible. It's not about, you know, making that disappear, it will never disappear. This is what make us connect and brings us the essential part of being human, being compassionate. Without failure and catastrophe there would be no compassion or empathy in the world. So, just determination and competition. So, that would be horrible and this is great and we're so happy that people end up here and people have disasters and people, you know, have Dementia you know and to forget that all this is terrible and so on…no, this is what make us connecting.

DAISY: Yeah.

OLIVIER: There is no problem and nobody is wrong, nobody you know, and integrate like this, so the staff is never wrong, we just say yes as a clown. Yes…we have that idea and yes, and the family yes, and the person with Dementia is saying yes, both as a puppy and as a hummingbird, and then you will trust your eagle with whatever, you know, the skills you have, your eagle will manage to make the best show possible, with whatever you know, you have and what the environment is bringing you and the client in front of you, is bringing you. Your creativity, well, you know, and if you are setup well with your puppy and your hummingbird then your eagle will fly.

DAISY: Yeah.

OLIVIER: But if you are just concerned, oh, is my eagle willing to fly, is people gonna be impressed by the flight of my eagle, then of course your eagle will never fly, we all know that. So, that's why just breeze, you know. You will go and just say yes, and wanna play with everybody because you're a clown.

DAISY: Brilliant! Thank you. One quick last question. Have you ever worked in Africa? Have you ever done any missions any trips to Africa, no, hey?

OLIVIER: Sadly no, not yet.

DAISY: Olivier…[laughing…]

OLIVIER: [laughing…] No, I have been wanting to go to South Africa many, many, times, and a great friend in South Africa sadly she died when uhm, she was doing, she was a meditation teacher and she was going to the Zulu communities to teach them and she was an amazing woman, amazing woman, and uhm, bringing peace between the different Zulu kings and so on and uhm, she just died in a car accident in a very bad road.

DAISY: Shoe….

OLIVIER: But she, yeah, wanted me many, many, times to go and teach clowning to the kids and so on. So, I hope I …

DAISY: Maybe Olivier, we'll stay in touch I think, hey. [laughs] But uhm, thank you. Thank you so much for uhm, this interview and for this time and I hope if you're willing, well I can just stay in touch maybe if there is just the odd question uhm…

OLIVIER: Of course, of course, please don't hesitate.

DAISY: Thank you, thank you, thank you so much! [laughs] Thank you very much and yeah, thank you again for this interview and I'll definitely stay in touch with you. Merci beaucoup.

OLIVIER: No, pleasure.

DAISY: Merci beaucoup. [language 1:00:17]

OLIVIER: [language 1:00:26]

APPENDIX C

CERTIFICATE OF VERACITY

We, hereby certify that in as far as it is audible the aforegoing is a true and correct transcript of the recording provided by you in the matter:

(NAME OF AUDIO: EMILIE OWEN INTERVIEW WITH THE GENERAL MANAGER OF THE OLD AGE HOME)

DATE COMPLETED : 24/06/2019

NUMBER OF PAGES : 21

EMILIE: So Bernie, thank you for agreeing to do this interview with me. Um, so, yes. I'm gonna just take it a bit general and um we'll see where it takes us but perhaps a good way to start is um just taking it back to the clown and just going – what is your first impression or response of the clown or a clown? What, what, what do you experience the first time you hear that or the first time that I've at least presented this to you?

GENERAL MANAGER: Let me just tell you that in my own personal capacity, okay, I've never gone to circuses and magic shows and things like that because I, I believe it's trickery.

EMILIE: [Laughs].

GENERAL MANAGER: So but that said, children are thrilled with clowns. Old people are thrilled with clowns. It's just that gap between that some people say oh, no. you know.

EMILIE: What is it that makes you nervous about it?

GENERAL MANAGER: No, no I'm not nervous about it. I'm not nervous about it.

EMILIE: No?

GENERAL MANAGER: No it's just, I have this ethos that people must always be who they are with you.

EMILIE: Yeah.

GENERAL MANAGER: And if you dress up in something else or you are somebody else, there could be an element of shock and surprise that could come out of it.

EMILIE: [Laughs?]. I love how you smiling while you saying that. Okay, good. Well hopefully this experience will offer something that ja, it's a different experience of the clown and something new. Um, so, what do, do you, I mean we've, we've spoken a little bit beforehand um about some of the things that the residents do. So what are the other forms of therapy or entertainment that you've had already in the home up until now?

GENERAL MANAGER: Not much. Soup.

EMILIE: Yes okay so soup hall.

GENERAL MANAGER: And then they have people coming to play bingo with them and they love that. So that's a little bit of a different experience and then people come and do a braai for them and that is like exceptional for them because it's not the standard food that they getting so that … Mother's day, Father's day – we just do different events. We did a Valentine's Day event this year.

EMILIE: Beautiful.

GENERAL MANAGER: We put up valentines, we bought um flags to hang across.

EMILIE: Yes I remember.

GENERAL MANAGER: And we put flowers and roses on, so that was one of the things.

EMILIE: Beautiful.

GENERAL MANAGER: And they love that. You know they love just being entertained.

EMILIE: Yeah. And the social worker? You said that they do some, sometimes like um

GENERAL MANAGER: Ja she does.

EMILIE: You told me something extraordinary which was athletics. Or athletics day.

GENERAL MANAGER: Yes. Ja, ja. The athletics day. They're actually planning for it now. So they starting to get ready for the choir so they going to be singing. And then they going to be doing … they do the athletics as well you know.

EMILIE: But very slow athletics.

GENERAL MANAGER: Ja. But they good hey. They good. Like they throw that ball and it actually gets to where it's supposed to be which is quite amazing.

EMILIE: Wow.

GENERAL MANAGER: Ja, it's quite awesome.

EMILIE: And is there a particular activity that you find that the residents appreciate the most or is it just…?

GENERAL MANAGER: Music.

EMILIE: Music.

GENERAL MANAGER: Music is, music always gets them. They, they just wanna get up, dance, do their thing and others just sit around watching and laughing and smiling which is amazing.

EMILIE: Wow. Okay, so music. Any particular type of music so like from their era?

GENERAL MANAGER: No probably that to their era which is like 40's, 50's.

EMILIE: Perfect. And um can you tell me a little bit about the home and why it was created?

GENERAL MANAGER: Okay, St. Vincent de Paul …

EMILIE: Ja.

GENERAL MANAGER: …It started with the nuns. There was a convent here. The main building was a convent.

EMILIE: Oh, this main one over here?

GENERAL MANAGER: Yes, the main one, it was a convent and it had a girls school. So a girl's school – the girls lived in the convent with the nuns and they taught them. And then the school went to St. Theresa's which was on the other side over there, and St. Theresa's became the school. But the convent, the nuns still stayed in that building. And then the building got too big for them, so they built this other building over here, moved into there and they donated the building to St. Vincent de Paul. So St. Vincent – you need to do some research around St. Vincent de Paul because it's a global organisation. They feed the hungry and the poor and they take care of people – and quite a, quite a huge …

EMILIE: Organisation.

GENERAL MANAGER: … Organisation that does this stuff. So St. Vincent de Paul had this building and they didn't know what they were going to do with it. So they looked at it and they said look, it's run down, it's not in great shape and what have you but let's do an old age home for people in the community. The aged in the community. And it just started filling up.

EMILIE: Wow!

GENERAL MANAGER: And now we don't just do the community, we do the whole of Gauteng. So people from all different areas in Gauteng come apply and come to us.

EMILIE: Ja, because I've noticed that you have quite an array of cultures, of races …

GENERAL MANAGER: Ja, multi-denominational, multi-racial, no segregation.

EMILIE: Wow. And um, age wise as well – you've, you've got quite a range. Last time it was [60].

GENERAL MANAGER: Ah, shame my 107 died.

EMILIE: When?

GENERAL MANAGER: Ah, it's such a sad story. So he went to hospital. He wasn't – he was battling to breathe so we sent him to hospital. They kept him in hospital for about 4 days and then he passed away.

EMILIE: Okay, so this was fairly recent though.

GENERAL MANAGER: Ja. So …

EMILIE: But up until this point you had from 60 …

GENERAL MANAGER: To 107. Now we've got 60 to 93, 94.

EMILIE: That's still…

GENERAL MANAGER: Still quite old ja. So he went to hospital and then the church that brought him here was supposed to bury him.

EMILIE: Okay.

GENERAL MANAGER: Now the church is saying they can't bury him, blah, blah, blah. His body's still laying at Helen Joseph, this is three weeks ago. And now they approached the government to give him a funeral. Now, a paupers funeral and I don't want to exaggerate but if you go and look at paupers funerals, that government mortuary takes these bodies and puts them all on top of each other in a corner somewhere and when they've got enough bodies, they go and dig one big trench and they put all these coffins in that big trench. So that's like a mass burial. And I'm so distraught that they actually doing this with this man.

EMILIE: Wow!

GENERAL MANAGER: Because they never took or made an effort to find his family. Eventually when he had passed they found his family. They were his step children but they were still his children.

EMILIE: So tell me a little bit – so the people that you have at the home currently, how many are there? How many residents?

GENERAL MANAGER: At the moment we've got 81.

EMILIE: Eighty one residents. So the majority of the people here, are they, are they in difficult scenarios? Do they see family a lot? Are some of them abandoned?

GENERAL MANAGER: No, no, nothing like that but some are. abandoned.

EMILIE: What is the …?

GENERAL MANAGER: About 30, 35 of them are about destitute, totally destitute; no family. They came, brought them here, visited once or twice, gave wrong phone numbers, wrong addresses. We can't get hold of them.

EMILIE: Wow!

GENERAL MANAGER: That's it.

EMILIE: So this is – the home is a non-profit?

GENERAL MANAGER: It's a non-profit.

EMILIE: It's a non-profit organisation and so you …

GENERAL MANAGER: And it's an NGO.

EMILIE: And it's an NGO.

GENERAL MANAGER: So it's a non-government as well.

EMILIE: And so you offer residency as well as frail care?

GENERAL MANAGER: Ja.

EMILIE: for, for the community.

GENERAL MANAGER: Well mostly our mid-care and then as time goes on they move to frail care because …

EMILIE: Okay, okay. But you offer both? And what are – I mean I'm hearing about one person but what are some of the challenges that um, I suppose some of the elderly face as well as what some of the home faces?

GENERAL MANAGER: So dementia, Alzheimer's – that's the top of the list. Stroke victims which always need help. They need more help than mid-care that can walk around. So – and diabetics that have had amputations and those kind of things. So it's like a broad spectrum of forgetting, remembering, forgetting, forgetting, forgetting, remembering and when they do remember they forget that they were already, that, that was already sorted out so it's like a circle for them.

EMILIE: Ja. And are you saying even, even the residents that I suppose are, are quite able and that are … that that's already trickling through the, the dementias?

GENERAL MANAGER: Yes, ja, ja. Most of them. Most of them.

EMILIE: Alright. And um, the elderly every day, I mean, if you could just try and give me a bit of an idea of how, how the day goes. Is it quite rhythmical? So they up in the morning, breakfast…

GENERAL MANAGER: Well, when the bell goes they will just start mobilising towards the … [laughs]. And before breakfast they have a cup of tea or coffee and then they start getting ready to come down to breakfast. But it's dependent on how many care workers we've got to bath them, get them ready, bed bath them or wash them, help them get dressed and get them downstairs. So it's quite a busy time in the morning. And then of course once they finished eating they'll go and find their little seat where they go either to watch TV or to go outside to the smokers' balcony or to go to their rooms again and just relax again. So ja, they, they actually just free to do as they please.

EMILIE: Beautiful. Do you find that um there's a good rapport between the elderly …

GENERAL MANAGER: No, no. They always fighting.

EMILIE: Always fighting. [Laughs]. Between each other as residents?

GENERAL MANAGER: Ja, ja.

EMILIE: Playfully or is it quite serious?

GENERAL MANAGER: No, no, no sometimes it gets quite serious but ja, it's – look it's part of, it's part of getting old, you know. So something small will just irritate somebody and there's a whole fight.

EMILIE: And what about the residents? What about the staff? What about you what …?

GENERAL MANAGER: Well so far 9 out of 10 times the staff have got dementia training, Alzheimer's training, so they know that if the person asks them the same question ten times they've got to just answer in a way that's not going to be aggo, aggressive.

EMILIE: Yeah, but I'm sure it can be quite exhausting and taxing as well.

GENERAL MANAGER: And for me it's quite exhausting [laughs?] because I find them coming to me and asking for the same thing over and over and over but you know, I've got that nature so …

EMILIE: Ja, ja you just ... Do you find that that can be quite tiring just in general, with the staff and with challenges? I know you've had quite a few financial challenges but now thanks to the grace we actually, ja, walking in here today celebrating some good funds.

GENERAL MANAGER: Yes, er, um, the staff have a roster which they actually get

10 days or 15 days between working and not working so yes, it is pressure, pressurised. They start at seven and they finish at six. It's an eleven hour day and that's picking people up, moving them, ...

EMILIE: Wow!

GENERAL MANAGER: Taking them, washing them, bathing them, making their beds. It's quite a...

EMILIE: It's busy.

GENERAL MANAGER: Busy job.

EMILIE: Ja, but um, I find that there's quite a good rapport between the staff here.

GENERAL MANAGER: Ja, ja.

EMILIE: Is that the case?

GENERAL MANAGER: Ja, ja. We have got – everyone's got their challenge you know.

EMILIE: Completely.

GENERAL MANAGER: And sometimes somebody has a problem at home and nobody knows about it and they come and they a bit grumpy and – but ja. We get on with the, the thing, the nature of the business.

EMILIE: And, so let me see, um I suppose … it's ja, you kind of explained kind of a … Is there just a daily kind of general mood in this space?

GENERAL MANAGER: No. I think it's different every day.

EMILIE: Every day.

GENERAL MANAGER: Just depends on also what the resident's mood is that day. You know what I mean?

EMILIE: [Laughs]. Okay, so that's interesting. So actually each day you never know what to expect. Sometimes up …

GENERAL MANAGER: Ja, you never know what to expect. That's right, you never know what to expect.

EMILIE: Um, is there – okay, I'd love to actually ask you about this. So there's I suppose you know, someone like myself goes oh wow, getting older. I haven't really considered it and sometimes I mean set me up until now the people I've spoken to, they can be quite a hesitation so there's like a general unease about reaching the period where one has to enter an old age home. Why do you think this is the case? Do you feel like that?

GENERAL MANAGER: Actually people, people resist going to old age homes. You know more their families bring them to old age homes and they say no, no, I don't belong here or I don't want – and some of them are actually afraid because they don't know what to expect and to anticipate and once they just meet a friend, start a peer group, it all starts settling down, you know.

EMILIE: Ja. Do you feel like the elderly are kind of scared at this stage or scared for like the end?

GENERAL MANAGER: No, I don't think so. I think that most of them or well some of them actually said no I wish I could just die tomorrow. And they have, you know. So, but they get to a point where, no I'm not going to breakfast. I'm done with this now. I don't need to do this anymore. And also, I mean like most of them worked all their lives and then to just be sitting and doing nothing, that must get to somebody. That must get to somebody. So I mean I know it would get to me because weekends I can't even sit still for ten minutes. I'm either cooking or cleaning or doing something you know, but I keep busy. And they, they probably come from the same thing. They've been busy all their lives looking after children, looking after grandchildren, doing washing, cleaning and now they do nothing, so it must be a huge adjustment to go from being an active person to that kind of thing.

EMILIE: And when did you start working here?

GENERAL MANAGER: I started here on the 01st of March last year,...

EMILIE: Okay.

GENERAL MANAGER: But I was on the board for five years before that.

EMILIE: Prior to that.

GENERAL MANAGER: Ja.

EMILIE: Okay, so you've actually had a long relationship with the home.

GENERAL MANAGER: Yes, long relationship with the home.

EMILIE: And why, why do you do this?

GENERAL MANAGER: I actually don't know because you know I was in corporate all my life. I've been in a management role in, in the corporate environment all my life and before I retired, I retired in 2016, I was in software sales and I had a client base of 98 customers and up until this day they still phone me and say are you sure you don't want to come back? Are you sure you don't want to come back?

EMILIE: What keeps you here?

GENERAL MANAGER: No, I don't know. I enjoy … mostly I enjoy it, you know what I mean. And I've enjoyed getting us down in the deficit you know, putting in proper systems and structures that we don't overspend, that we don't waste, that we um consolidate petr- driving trips so that we save petrol and that wasn't in place when I came here.

EMILIE: Ja.

GENERAL MANAGER: You know, everyone just did what they wanted to irrespective of whether it was allowed or not allowed and there was no – there were no rules. There were no rules and no order. There was no order. So it's all changed.

EMILIE: Ja, so you've, you've brought a lot of that.

GENERAL MANAGER: And a lot of staff don't like me because of it but ja, I'm not here to be your friend. I'm here to save the company so that other old people can still use this facility and it doesn't close down.

EMILIE: That's amazing. Um what do you think could benefit the home and the residents at this stage? Just, I mean obviously finances of course always...

GENERAL MANAGER: Ja.

EMILIE: But um …?

GENERAL MANAGER: Ja, I think they enjoy being - they enjoy being entertained and they enjoy having people come and talk to them that they don't know and you know, just having a conversation.

EMILIE: So social engagement.

GENERAL MANAGER: That's right. I want to actually get the schools here. I really want to get at least three schools here.

EMILIE: Beautiful. What, what is your imagination of the schools? Is that having kids actually come in and …

GENERAL MANAGER: Yes, and sitting with these people like their grandparent, you know. Come adopt a grandparent and come and sit and talk to the grandparent and let them tell you a story about their life, you know. And also encourage younger people to support the aged.

EMILIE: Yes.

GENERAL MANAGER: Because that doesn't happen.

EMILIE: You've got a school just over here.

GENERAL MANAGER: A pre-school.

EMILIE: Do you find that the sound of the pre-school has an effect …?

GENERAL MANAGER: They love it. They love it. The old folk love it.

EMILIE: Okay.

GENERAL MANAGER: I even love it. Because when I come in, in the morning and they crossing the path over there I get out of my car and I talk to them, oh good morning, good morning. Ah, good morning ma'am, good morning ma'am. And they dance around and some of them give me a hug and the other day one of them hugged me and said you smell so beautiful. You know, it's so great, ...

EMILIE: Something about that playfulness.

GENERAL MANAGER: So it just stimulates your day. You know, it just …

EMILIE: Beautiful. And um you've also got a – is it a small chapel?

GENERAL MANAGER: Ja, we've got a chapel here.

EMILIE: And you offer services?

GENERAL MANAGER: So it's mostly catholic.

EMILIE: Ja.

GENERAL MANAGER: But we also allow people to have their families' memorial services there.

EMILIE: Okay, great.

GENERAL MANAGER: So when somebody passes in the home and mortality is the nature of our business anyway. So the family will come, have a service and have the memorial service here and whoever can get to go to the funeral, we send a bus, but we only send one bus and we limit the amount of people that will go because we need to send care workers and all that with then it's quite a resource, intense thing.

EMILIE: Do, do some of the residents come to the funerals?

GENERAL MANAGER: Ja, ja. They all come. They are – they come to the funerals, ja.

EMILIE: And how do you think that – is it something that …?

GENERAL MANAGER: It's just like going to a funeral you know. And some of them don't want to go to funerals and some of them enjoy and love going to funerals and those that go out, they really enjoy it because now it's a treat for them.

EMILIE: It's going out.

GENERAL MANAGER: Ja, going out and it's cake and tea, you know,

EMILIE: And then do you offer like weekly services?

GENERAL MANAGER: Ja, there's a service every day.

EMILIE: Every day?

GENERAL MANAGER: Ja, except Saturdays and Sundays, there's a service every day.

EMILIE: In the morning, afternoon?

GENERAL MANAGER: In the morning.

EMILIE: Wow.

GENERAL MANAGER: Ja, in fact we had...

EMILIE: What time do have the services?

GENERAL MANAGER: Last week and Wednesday was Ash Wednesday...

EMILIE: Oh yes of course.

GENERAL MANAGER: And we had Ash Wednesday and the minister actually came – Father [Stonia?] came in and gave me ashes and ja – and he went to the frail and he did all the frail with ashes and …

EMILIE: Wow! What do you think that brings the home?

GENERAL MANAGER: I think it – blessings. And this morning Raymar Raymar Church came, she came and she was having a service upstairs. So all the congregations, all the different denominations come in at some point.

EMILIE: That's really supportive and, because the home is a – it's largely a religious home. Am I right?

GENERAL MANAGER: Well, it's all race groups; so there's two Muslims, there was a Chinese, there was a … so you know, it's across.

EMILIE: Okay, Ja. Completely. But I mean I suppose there, there is a faith, a faith base that's here that I supposed offers a certain support.

GENERAL MANAGER: It does. It does.

EMILIE: That's special.

GENERAL MANAGER: Ja.

EMILIE: Thank you. I think this was really, ja really good to hear and is there anything you feel that I should know, that you want me to know about.

GENERAL MANAGER: No, I think you've covered everything. Ja. And other things will be surprises as you go along. As you walk into it I'll tell you about lime green and....

EMILIE: Yes, yes really. Actually wait that's a fantastic question I'd actually like to insert. There are things that you've done in the home to help and support the elderly, so you've um – maybe you can tell me a little bit about them so even if it's the walls or what …

GENERAL MANAGER: Okay so we've painted, we put up curtains. We ur...

EMILIE: When you say you've painted, so can you tell me a bit about the …

GENERAL MANAGER: So we painted, well the painting, the painting is just an ongoing thing. It's an ongoing thing you know. As and when we get donations, we can paint. Or companies coming to say they can paint. So Seven Adventists has adopted us for a year and they have an ambassador programme which is the youth and the youth will come Sundays from time to time and do some maintenance work.

EMILIE: Perfect.

GENERAL MANAGER: So they gonna try and finish the ground floor for me.

EMILIE: Beautiful. And so you chose what colour?

GENERAL MANAGER: Lime green. Lime and lime and lime. Lots of lime.

EMILIE: Yes.

GENERAL MANAGER: So all the, all the variants of lime. So it goes from pale, bright to the bright lime and the colour job that the paint stalls give, those are all the colours that we going to mixing into that lime green project; along with stainless steel at the bottom of the doors because that was a donation but we need labour resources to put that up.

EMILIE: To be able to do that. But you chose lime green specifically because …

GENERAL MANAGER: It's uplifting for Alzheimer's and dementia and it gives them a positive outlook so they, they embrace the colour.

EMILIE: Ja. So you actually have done research behind all the changes that you've put into this place.

GENERAL MANAGER: Most of. Most of. Like I mean this I would have like to have had the bright green but when you go upstairs you will just see how beautiful it is. So another company, a group of bikers came and painted the whole first floor.

EMILIE: Wow.

GENERAL MANAGER: So that was based on a newspaper article that went out here.

EMILIE: Yes.

GENERAL MANAGER: A reporter came in here and she said can I write an article for you? So I said yes, you can write an article for me. And that was just when I started here. Okay, I've got it here somewhere. And after that people started coming to give us dried goods, started to give us …

EMILIE: Please can I get a copy of this?

GENERAL MANAGER: Sure.

EMILIE: Thank you.

GENERAL MANAGER: So, let me tell you the funny thing about this is my daughter lives in Hillcrest, my daughter and my grandchild.

EMILIE: Look, you've already got copies.

GENERAL MANAGER: Ja, lives in Hillcrest and my daughter phones me and she says, mom, you in the media. I said, what are you talking about? She says my friend in Namibia phoned me and said I just saw an article of your mom in the, on the internet. So …

EMILIE: Aah, beautiful.

GENERAL MANAGER: Ja, so that was the article.

EMILIE: Perfect. Perfect.

GENERAL MANAGER: So these, this group of bikers, they called *Vuil*, you know, vuil as in dirty in Afrikaans.

EMILIE: Oh yes. V-U-I-L.

GENERAL MANAGER: But it's voluntary upliftment improves lives. So they go around to homes in the area. They're a community based thing. They all work but they all contribute to a fund and then they go and find a house that the mother and father are living in there, the house is run down, it needs curtains, it needs a coat of paint, it needs a stove. They will upgrade that house.

EMILIE: So you have actually received a lot of support.

GENERAL MANAGER: Lots and lots.

EMILIE: From really different organisations.

GENERAL MANAGER: Ja, some organisations – another organisation is adopting us for a year. I can't give you the name but – two actually. So the one supplied us with the Photostat machine about a month ago and they going to supply all the supplies for it, all the toner, all that stuff and it's connected to their network. So they'll know exactly when we need toner and it will just arrive. We won't even have to phone them.

EMILIE: Yes, phenomenal. So I mean, I mean there's actually lots of change and bringing in....

GENERAL MANAGER: Another company came and repaired and replaced two baths that had big holes in and we couldn't use those baths. They replaced the baths. Another company came and built our refuse centre, so the refuse bins always stood behind the resident's building here. And because of the heat on there flies were an issue and from the railway we have a big challenge of rats. So, because of the attraction of the heat, and the food, and the smell, it was attracted so we would have a whole lot of rats there at the bins. So this company built the end over there, I'll show you and they put a shelter over it so the sun doesn't beat down on those drums, on those bins and no flies, no rats.

EMILIE: Wow. So actually you are constantly looking to better the home...

GENERAL MANAGER: Ja to improve the home.

EMILIE: And to improve the lives of the residents that are here.

GENERAL MANAGER: Of the residents. Most definitely.

EMILIE: Thank you Bernie.

GENERAL MANAGER: Ja.

[END OF AUDIO – 26:25]

APPENDIX D

CERTIFICATE OF VERACITY

We, hereby certify that in as far as it is audible the aforegoing is a true and correct transcript of the recording provided by you in the matter:

(NAME OF AUDIO: FOCUS GROUP 3 - 2ND RECORDING OF ELDERLY 09 04 19) EDITED

DATE COMPLETED	:	05/05/2019
NUMBER OF PAGES	:	8

DAISY: There we go…[testing the recording device]

DR. CAMERON HARRIS: Yeah, I can see that is running.

DAISY: And that is running…perfect. Okay, so you can just leave that. And then if you want and you feel that you are too far you can just move this [referring to the recording device] closer to you when you speak on the table, but otherwise it should be fine. I am going to switch off the television [Emilie as Daisy leaves room].

DR. CAMERON HARRIS: Ok so we can start. Perfect. So, thank you everybody. So, we will just talk in a conversation so when you guys have something to say please just chip in. Uhm, tell me first, what were your first impressions when Daisy first arrived. Was it something that was quite unfamiliar to you and uhm, kind of a surprise?

*HARRY: It was unfamiliar and a surprise yes…

DR. CAMERON HARRIS: Ok…

*HARRY: …but then I didn't take it too seriously… I just thought it was somebody who came to ah… just do uh… [pause to think]… uh… [short pause] uh… entertain the residents…

DR. CAMERON HARRIS: Ya… ya, so you could quite quickly see what sort her soft of intentions were, but it was not something you would have expected to happen?

*HARRY: Ya…

DR. CAMERON HARRIS: Have you had any other visitors like Daisy come in before?

*VIOLET: Yes…

*JANET: [quiet in the background on top of *VIOLET] …[inaudible] beautiful!

*CLAIRE: [Speaking slightly over *VIOLET] Not since I've been here…

DR. CAMERON HARRIS: Not since you've been here [responding to *CLAIRE]… but you [responding to *VIOLET] remember…

*VIOLET: No not like Daisy. Musical, we have…

DR. CAMERON HARRIS: Ok…

*VIOLET: and preachers, we have… [inaudible 00:21] come in… We've got different ones coming…

*HARRY: [Interrupting *VIOLET] She means like a group with a karaoke group, things like that.

DR. CAMERON HARRIS: Oh, I see…

*HARRY: Not like Daisy.

*VIOLET: Daisy's alone!

*HARRY: She's a solo act… and really like she's doing a fine job.

DR. CAMERON HARRIS: So she is a bit different because there is only one of her…

*HARRY: Ya!
*VIOLET: Yes!
DR. CAMERON HARRIS: …and also what she does is a bit different.
*JANET: [Cross talk] She's beautiful!
*VIOLET: Much different!
*JANET: I like her very much. I like her very… she is pretty and we ready to sing with her… Daisy, daisy…[laughing]
DR. CAMERON HARRIS: She is pretty?
*JANET: …and she's ready to make you laugh [inaudible from 00:01:51].
*HARRY: [Cross talk] She makes your forget your troubles.
DR. CAMERON HARRIS: She makes you forget your troubles?
*HARRY: Ya. Even your aches and pains…You know, you completely forget about them.
DR. CAMERON HARRIS: Well that's good, I mean that's… I know she will be very happy to hear that. And that is what you said about the entertainer, I suppose that is what a good entertainer does.
*JANET: I really like entertainment… really I like her very very much [inaudible 02:16]… I like her very much [inaudible 02:15:3] Some of the people, they enjoy when she starts dancing with them [laughing] and then all the people is dancing with her [laughing] [inaudible 02:39].
DR. CAMERON HARRIS: Really?
*JANET: Yes.
DR. CAMERON HARRIS: I was going to ask about that, what did she actually do with you guys because I know there was quite a bit of interactions. She does not just… [slight pause]…entertain separately she sort of gets you involved, is that right?
*HARRY: There's it!
*JANET: Ya! Ya!
*VIOLET: Yes!
GROUP VOICES: Yes [mumbles of general agreement].
*HARRY: Oh yes, she involves everyone.
DR. CAMERON HARRIS: Can you tell me a bit about that?
*VIOLET: She will…[Mumbling]… She will come and entertain you and ask you, and tell you no come and join me and then she starts dancing and playing her music and if you want to join, fine, if you don't want to in… join her, no problem… and then she carries on until she goes to the next one.

DR. CAMERON HARRIS: [Said at the same time with *VIOLET] the next one. So, you do not feel forced in anyway?

*VIOLET: No no no no!

*HARRY + GROUP: Not at all [cross talk of general no's 03:24]

DR. CAMERON HARRIS: Good.

*HARRY: She will even go out of her way… [Cross talk. Pause]…She even goes out of her way to get the records that you like…

DR. CAMERON HARRIS: Oh right?

GROUP VOICES: Ya! [General agreement].

*HARRY: I told her about the… the… [Pause. Thinking]… The Platters and I told her about the Golden Hits and really she went out of her way and she really got them…

*VIOLET: She got them!

DR. CAMERON HARRIS: Wow…

*VIOLET: Really… he told her about the Golden Hits…

*JIM: [Cross talk] Ya. Like um… If you're a Zulu. Then she'll play…put on Zulu music for the one guy…[*JANET laughing and agreeing in the background].

*JIM: He likes this type of music, then she'll play that type of music and so on…

*VIOLET: that type of music…

*JANET: Ya! Ya!

DR. CAMERON HARRIS: So she really tailors it?

*JANET: Yes [laughing]

*JIM: So what do you like? Do you enjoy Jazz? She'll play jazz… But what I was going to say that is that the difference between the Karaoke and… and… and… uhm… Emilie is that the Karaoke… [mumbling]… is approaching everyone and they doing a show for everybody. Whereas this is a one on one.

*VIOLET: Yes, she caters… she catered for each one. Right? Your music…

*JIM: [cross talk] You like this type of music… yes…

*VIOLET: If you like the olden days… The Evergreens…

*ANDY: [Arriving] Um… Daisy said I must come and sit here in the corner…

DR. CAMERON HARRIS: Yeah should I get a chair? [Chair sounds]. You alright? [Speaking to *ANDY]. That's good. So um… [Back to speaking to the group] So it wasn't like one performance for many, it was like an individual thing?

*VIOLET: Yes, she wanted… she pleased each and every one. Whatever nationality you are.

*JANET: [Cross over talk] Ya! Ya!

DR. CAMERON HARRIS: So she tailors it to you?

*HARRY: Ya…

*VIOLET: Tailors it and brings it to the book… yes…[Cross talk 04:50].

*JANET: Even with these people… even with these people… with the Alzheimer's…sometimes they walk [inaudible 00:04:53]…most of them are very lonely… [inaudible]… and I think she helps them, and they enjoy it so much…

DR. CAMERON HARRIS: So, the one to one kind of personal thing makes people feel less lonely?

*JANET: Yeah! Yeah!

DR. CAMERON HARRIS: Yeah, I can imagine that.

*JANET: Ya ya… she… and then there's one of them here… [mumbling; thinking]… Beverly? What is her name [group try help her find a name].

*HARRY: Louise?

GROUP VOICES: Which one?

*JANET: The one who was working with uh…. June!

*ANDY: What's happening here?

*JIM: [Side conversation with *ANDY] They are discussing and giving feedback on the lady who is an entertainer here.

*ANDY: Daisy?

*JIM: Yes. They just going around the table. Just to say what you thought about her.

*JILL: [Responding to *JANET] Oh, Sue? Her name is Sue… Sue something

*CLAIRE: Susana?

*JILL: Sue.

*CLAIRE: Sue.

*HARRY: Ya [inaudible 05:38]

DR. CAMERON HARRIS: Oh, Alright Sue Hall, is that another visitor who came in?

*HARRY: Ya ya. [inaudible 06:04:5]

*CLAIRE: But she was a bit different.

*JANET: What is her name?

*CLAIRE: Sue.

*HARRY: Ya ya. She also worked here… [inaudible/mumbing]…you know her? [laughing] [inaudible 06:00].

*HARRY: No Sue's a… a narrator [slightly muffled and unclear]…

DR. CAMERON HARRIS: Uhm, sorry she's a?

*HARRY: A storyteller.

DR. CAMERON HARRIS: A storyteller, right. And again, that would be more to everybody rather than individually?

*HARRY: Ya.

*HARRY: Yes… but they enjoyed her.

DR. CAMERON HARRIS: Hi so sorry, good to meet you, I am Cameron .

*ANDY: *Andy

DR. CAMERON HARRIS: So they are talking about Daisy and she has asked us just to collect some information and some feedback on her visits, on Daisy's visits.

*ANDY: Yes, Daisy.

DR. CAMERON HARRIS: Because she is doing some research and she wants to know what she can do that people like, what works well, and maybe what does not work quite so well. She just wants some opinions about her visits.

*JANET: Yeah.

*ANDY: You see, when I studied psychology for the little ones…

DR. CAMERON HARRIS: Oh yeah?

*ANDY: … they said the little ones have 'surplus energy'.

DR. CAMERON HARRIS: Yes?

*ANDY: Ya… [Laughing]… now, Daisy [Laughing]…

DR. CAMERON HARRIS: I have noticed that, she's got surplus energy.

*ANDY: Sho! [Laughing] She has got surplus energy, Daisy! [laughing]. You sit and watch her, [Laughing] you think, now when are you going to get tired? [Laughing].

*JIM: I think that's what actually catches her.f you're a person just standing there… I think you've hit the nail on the head there.

*ANDY: Ya!

*JIM: The energy!

*HARRY: She doesn't sit still [Laugh]. She's up and about.

*JIM: She even had the one guy just about… I think he's 80 or 90… how old is he? [Asking the others].

*HARRY: 90.

*JIM: Remember, she went to entertain him and then she came to you…

*HARRY: Ya

*JIM: And the guy was just about also… and he was laughing. [Cross over talk with some respondents]… and he's not exactly a guy that's outgoing and all that, but he was just carrying on with her as well…

DR. CAMERON HARRIS: So, she manages to pass that energy onto you? [Slight pause]. She's not forcing it on you?

*JIM: Correct! When you put it that way, I would say so ya. It's coming from the people. Like she's entertaining *VIOLET. Next thing *VIOLET will be getting that energy from her, from Daisy, whatever, ya!

DR. CAMERON HARRIS: So, see she is one of those kinds of people that can pass that on…yes.

*JIM: Pass that on… yes.

*VIOLET: She is a real entertainer. She… she entertains each and everyone according to who you are and what you like. And then she comes by, and she knows what to bring, what to play, and she plays it for you and… how much passion to be… for you to be interested in her music or in whatever she brought.

DR. CAMERON HARRIS: So, she has like a little recorder or player… what is it like, a CD player?

*VIOLET: That's right… like a radio.

*HARRY: No. It's uh… She's recorded in the…uh… on the phone.

DR. CAMERON HARRIS: Oh right, so she is playing it through her phone? Okay…

*HARRY: Ya! And then she does whatever she does… and then she gets those numbers. The records.

DR. CAMERON HARRIS: Oh I see. So she finds them on like the internet or find them… and plays them for you?

GROUP VOICES: Yes! [General agreement].

*JIM: She find them yes…

*VIOLET: She's cute! She's wonderful really for her age! [Inaudible 00:08:53].

DR. CAMERON HARRIS: And then, how does she match up to what you might, or what your perceptions of a clown might be?

*VIOLET: [Continuing as if she has not heard his question / having a separate conversation] No if she sees you sitting there.. you don't want to be involved. She will get you! She will! She gets each and every one of us.

*HARRY: She will catch your attention! Without coercion! Without coercion! Just by coming to you… you know? Like, she's not even flattering you… but man, you… [laughing].

*VIOLET: And he's on a wheelchair… Ay, she got him very nice [inaudible 00:09:26]. He's a praying man [inaudible 09:34] But… Daisy.

*JANET: [Cross talk] Daisy flower… [Inaudible 09:35] and then you get a balloon and then blow the balloon up [inaudible 09:37].

DR. CAMERON HARRIS: Oh wow, okay…so she does the balloon thing? [cross talk inaudible 09:39].

DR. CAMERON HARRIS: So, does she like tricks being played on her then if she is playing tricks on you guys? Does it goes two ways?

*ANDY: Yes!

GROUP VOICES: Yes! [General agreement].

*JANET: Yes, she likes to play tricks [inaudible 10:02].

*VIOLET: What did she play?

*JANET: [inaudible 10:03].

*JILL: [Speaking over *JANET. Cross talk] She has a wonderful sense of humour. She has a lovable… a lovable personality. I appreciate her very much. We appreciate her very much because she takes us down memory lane.

DR. CAMERON HARRIS: She takes you down memory lane? That is interesting. So, she helps you remember? But how does she do that? Is that through the music or?

*JILL: Yes [mumbling], and with music. With songs… Like Frank Sinatra songs. Frank Sinatra [laughing]…Dean Martin… Engelbert Humperdinck.

*HARRY: [Cross talk; Interrupting]. What amazes me most about her Cameron….

*VIOLET: Cameron…[Catching his attention].

*HARRY: What amazes me most about her is that she…[Slight pause]… she knows the 50's music.

*JILL: Ya!

*VIOLET: Ya. How does she know the 50's music? The Evergreens!

*JIM: That's right, ya!

*JANET: [Inaudible 10:59; Cross talk]… and the red nose. And she's beautiful!

DR. CAMERON HARRIS: And people like Frank Sinatra and those guys…

*JIM: It's applicable to the people here. Because these people don't know the … the…

DR. CAMERON HARRIS: the more recent…

*JIM: [Cutting] they know the 50's and the 60's, all these people here… That's what brings out a response from the people, because she's talking about Frank Sinatra.

DR. CAMERON HARRIS: In your day?

*JIM: In our day…

*VIOLET: She does it so well you would think that she was born in those days yes.

RESPONSENT (unclear who): Ya!

DR. CAMERON HARRIS: So, she does it so well as if she was young then? Okay…

*JIM: Yes.

*HARRY: She does the dancing so good; you would think she was born in those days.
*JIM: Yes!
*VIOLET: Ohhh Yes! [As if reminiscing].
*ANDY: Yes yes!
DR. CAMERON HARRIS: So, she has done her kind of… homework?
GROUP VOICES: [Laughter and general agreement].
*JIM: The dance would be applicable to the different kinds of music. If it's Jazz, it's this. If it's Zulu, it's that… You know what I'm saying? She would play that song and dance accordingly. And she's got energy. Geez [expression].
*JANET: [Cross talk] Yes like when she came in today, she was like 'oh my goodness, how are you?' [inaudible 11:57].
*ANDY: Her name suits her [laughing]. As fresh as a daisy!
*JANET: [Cross talk 12:06] everyone, everyone…
DR. CAMERON HARRIS: And was it this space she was using mainly or did she go out into different spaces?
*JANET: Yeah!
*VIOLET: Yes, but I saw her just now going out those doors, then then she comes in from there. I don't know if she goes to frail care, but frail care people don't talk… much. I mean they frail.
*JIM: She might have been on the veranda.
DR. CAMERON HARRIS: Yes, and did she go into the frail care at all?
*VIOLET: [Inaudible 12:36] I don't have knowledge about that.
*JANET: [Inaudible 12:36]. Yes, I take her there. I take her to them!
DR. CAMERON HARRIS: Oh really?
*JIM: Oh you talking about the frail.
*JANET: Yes, and they enjoyed her so much! [laughing]. One day, I take her there.
DR. CAMERON HARRIS: Okay, so she has been in there…
*JANET: [Cross talk] Ya, one day, I take her there.
DR. CAMERON HARRIS: …and in the dining room as well. And separate bedrooms as well?
*JIM: No not going into their bedrooms and that. They got a dining room for the frail people.
DR. CAMERON HARRIS: Oh ok, I see.
*JIM: Obviously not for the very frail that can't get up. But for those that can get up it's just around the corner. So she could go entertain there. But not to the frail as in to

their beds, no.

DR. CAMERON HARRIS: Oh, I see it makes sense. And so I do need to just ask is there anything that you did not like during the visits? I suppose there is two ways to ask this…Is there anything you did not like or anything you would like to change? Change or do more of even? What could she change?

*VIOLET: No! It was just fine with what she did for us! And really impressive and I love it, what she did for us.

*ANDY: Everything she did.

*JANET: Ya!

DR. CAMERON HARRIS: Ok so it's positive?

*VIOLET: The men, the old, the aged… oh, she was wonderful.

*CLAIRE: It changed all that. It makes such a difference! [Pause]. And she's got something for every age [muffled sound 13:57].

DR. CAMERON HARRIS: That's cool. Yes, it's interesting, I think she has literally got for all ages… I think she has done some visits to uhm, children as well. I think she has.

*CLAIRE: Really?

DR. CAMERON HARRIS: Which is interesting…

*VIOLET: Oooo [inaudible 12:07]…I think the children will love her very much. [inaudible 14:14]. We weren't so impressed until we found out, this person she is putting life into us and we feel happy and we dance with her.

*JANET: [Laughing]. Ya!

*VIOLET: Although we don't get up and jump around like her [laughter], we sitting on the chair and we moving like her or we eating while she is talking like we doing now. Yes. She was wonderful.

DR. CAMERON HARRIS: And so, would you say that you got more used to her during the visits…

*Violet: [Cross talk] Yes

DR. CAMERON HARRIS: …and therefore, the visits become more…what is the right word…uhm effective as she went on or would you say it was always the same?

*VIOLET: You will not believe me, I was longing her until when I saw her coming in now. I was so happy and I felt released.

DR. CAMERON HARRIS: Released?

*JANET: [Laughter] I also! Yeah!

DR. CAMERON HARRIS: That is an interesting way of putting it.

*VIOLET: I felt released.
*JIM: [Cross talk] I think the residents were, once when she came the first time, and a second time, they still had to get used to that she was coming on a Tuesday and a Friday. I mean, they were then looking forward to that. And as *VIOLET was saying, the moment she is arriving you can already see the residents were getting happy and that.
DR. CAMERON HARRIS: So, there is a certain anticipation [inaudible 15:31]…and a sort of cycle of things?
*VIOLET: That's right.
*JIM: [Cross talk] A cycle of things. Ya. It took a few weeks to get into that cycle but its good now.
*JANET: Everyone, everyone [Inaudible cross talk15:41]…
*VIOLET: She was wonderful!
DR. CAMERON HARRIS: And I mean it sounds like you all get a certain feeling of upliftment when she is …um… and how long does that last for? Would you say that the day that she is here it keeps you buoyant for at least a day?
*HARRY: [Cross talk]. Two or three days. Two or three days.
*DR. CAMERON HARRIS: Two or three days?
*JIM: Ya, it goes on for like two or three days ya.
DR. CAMERON HARRIS: Oh, so that is great.
*JIM: When she is finished after an hour, we have forgotten our troubles.. and we think about her the next day, and the next day until she's here again, and then it carries on.
DR. CAMERON HARRIS: So, the thought of her stays with you for quite a few days?
*JIM: Oh ya!
*JANET: I think she is a real real actress!
DR. CAMERON HARRIS: A real actress?
*JANET: Actor. Actress.
DR. CAMERON HARRIS: Ya, ya.
*JANET: [inaudible 16:20].
DR. CAMERON HARRIS: And would you say that the description of clown is suitable? I think you know she has got the red nose, and she is dressed up in a certain way…
*VIOLET: No, that did not disturb as at all. Her actions stole our hearts. [cross talk16:52].

DR. CAMERON HARRIS: Stole your… oh that's lovely.

*VIOLET: Her actions stole our hearts [*JANET laughing in the background].

*JANET: [Cross talk]. All our hearts! All our hearts!

*JIM: But *Violet, I think what he's asking is would you say that even if she wasn't dressed as a clown and she was just entertaining, is the clown got any effect on the thing or what?

*VIOLET: Nothing…

*JIM: Not really? But she just chose to do it that way…

*VIOLET: Ay! [Agreeing].

DR. CAMERON HARRIS: Right, so you feel it would work, it would still work without it OK?

*VIOLET: Yes, and the way she speaks to us. I'm watching her. I am sitting here, and I'll watch from her from there …until it's just us…yes…

*JIM: Oh yes, she puts in a lot of effort. She really loves the people and that. She's not just doing a job and gets it finished. She puts that effort in, you know, a 110% in all she does.

DR. CAMERON HARRIS: That's great. Just a couple of more questions before we stop because I need to chat to the staff as well before I go. Is there anything in particular that you would say stood out or anything that she did or any particular visit that is particularly memorable.

*CLAIRE: Yes, the dancing. I love her dancing which knows how to do!

*VIOLET: Dancing.

*HARRY: Yes…

*CLAIRE: She's fantastic!

DR. CAMERON HARRIS: I would have loved to have seen that. So, and is it quite varied dancing depending on what…

*HARRY: On what type of music she's playing.

*CLAIRE: Yes. And she is brilliant.

DR. CAMERON HARRIS: And so, you would all agree that the dancing is one of the things that stands out?

GROUP VOICES: [General agreement].

*JIM: Most probably, ya sure…

DR. CAMERON HARRIS: Is there anything else?

*JANET: I tell her I've got a big red [inaudible 00:18:26] cover over my bed … a cover over my bed with a Daisy… [inaudible18:36]…

DR. CAMERON HARRIS: She was so pleased with the daisies on your bed? *JANET: [laughing; inaudible]. And we started singing…

DR. CAMERON HARRIS: That is really pretty. Oh and she started singing about the…

*HARRY: [singing] Daisy, Daisy…[laughing]

*JILL: [inaudible 18:51; cross talking]. You know even the staff... even the staff. She has captured the hearts of the staff because this time of the day they tired. A young person gets tired too. They appreciate [inaudible 19:09]. They appreciate your visit here today. And ah… You see she brightens us up, she's got our wellbeing at heart because she tells me she remembers the song too and you can smile, no matter what pain you have, or what adversity…

*VIOLET: That's true!

*Jill: … you can smile, even if you can't say a word. I forgot who the singer was, but Daisy's got it. She knows all about those years, and those singers, and the words of the song mean so much to her. And then, religiously speaking, she always thanks her loving Creator, for giving her life and the ability to share her happiness in life with others.

DR. CAMERON HARRIS: That is a lovely way of putting it. That she has got something that she can share with you and help , you know, on days when you are not feeling quite right, she can bring you back up again. I mean she will be really pleased to hear that and everything you have said. It has been really useful. There is a lot in there that we have spoken about that she can pick up on and put together and kind of report back on how it has gone. To her supervisor as well.

*VIOLET: Yes!

DR. CAMERON HARRIS: Uhm, Great, so um, thank you all very much.

*VIOLET & *JILL: [Cross talk]. It's a pleasure.

DR. CAMERON HARRIS: It was really kind of you to take the time out to chat with me and uhm thank you.

*JIM: [Cross talk]. Pleasure, of course.

*JANET: I love her so much. I love her so much [Laughing].

*VIOLET: And you know what? Sorry not to jump into conclusion…

DR. CAMERON HARRIS: Please?

*VIOLET: She would come to me and she'll start whatever she is starting and I am in aches and pains but as soon as Daisy stands in front of me it is gone, and by the time she leaves, coming to *Mr Bow, and then they come back again [laughter from group], and then I have the aches and pains back again [laughter from group]

DR. CAMERON HARRIS: So, they come back relatively quickly?

*HARRY: Yes, as soon she moves away [laughing]. Yes.

DR. CAMERON HARRIS: So, we'll have to keep her here all the time? [playful; group laughing]

*VIOLET: Yes! Yes! [Laughing].

DR. CAMERON HARRIS: I will tell her that [laughing].

RESPONDENT 4: Yes, tell her that, hey? And she could not believe it when she asked how old am I and I told her I am 84. She said 'jooo'….she said I'm Daisy, and I said you are Daisy and I am *VIOLET:, we both got fl… fl… flower names, so you will also reach that age, do not worry [laughing].

DR. CAMERON HARRIS: We will be lucky if we reach that age. Yes

*JIM: I told her the other day, I said what she is doing, I said remember in the Readers Digest years ago there was a section called "Laughter is the Best Medicine". And that is true hey…

DR. CAMERON HARRIS: Laughter is the best medicine?

*JIM: …ya… because you forget your troubles. Look if you are tense and all that you are going to do damage to yourself

GROUP VOICES: [Cross talk of General Agreement].

*JIM: …and when you laugh and that you get rid of all that, and actually it's relaxing.

*ANDY: Yes, that is true.

*JANET: [Inaudible: 22:00].

DR. CAMERON HARRIS: [cross talk 22:07] laughter is the best medicine but she'll know about it because it is her thesis you know.

*VIOLET: And he is doing that to me, he'll just see me looking at him like that , coming, then he'll start marching and then I tell him, turn, right about turn, and then he turns, like a soldier, and he turns back. And then believe me in that split second it does that, I do not feel tense, I feel calm. But as soon as you sit back, and you start to eat you, ay, really you feel those pains are back again [laughter].

DR. CAMERON HARRIS: That's really interesting.

*VIOLET: I'm telling you the truth…

DR. CAMERON HARRIS: No, it makes a lot of sense. It's something I have really never thought of that before…If someone is relaxing you…

*JIM: [cuts in] because when she comes to you or you or you… they not gonna say 'oh' [a sound that mimics like when you are in pain], they not depressed. They actually happy. Just as Daisy approaches her, she is already. Before she starts playing…so she's

got the energy that rubs off.
*VIOLET: [Cross talk] Yes! Thank you *Jim!
*JIM: Look, not everyone can do this, I am certain not many people can do this type of thing I am sure…they see it is false.... She just does her thing and she is genuine you see. People can pick up on that. Anybody can just say I'll come and dance and stuff [inaudible 0:23:23:4].
*JANET: She's a real entertainer. For all these types of people. For all of us. For old people [inaudible 23:22].
*JIM: No she makes the people happy and that….
*JANET: I think so…
*JILL: [Cutting in] Excuse me, Are you 90 years old? Are you 90 years old?
*JANET: No, I am 88…[inaudible23:59]
DR. CAMERON HARRIS: ...that is close enough [laughing].
*CLAIRE: She's a wonderful lady for her age.
*JANET: but…[Inaudible 23: 54] But she takes me with my walker... [inaudible] 23:57].
DR. CAMERON HARRIS: Oh she was messing with your walking, with your walker.
*JANET: My walker, Yeah [laughing].
DR. CAMERON HARRIS: I heard that one of the staff were actually hiding her bag as well because she was playing tricks on them?
*JIM: Yes, this guy over here, I think it was last week before she came to you. Remember you he was sitting there. Forgive me I cannot remember his name [inaudible 0:24:15:8].
GROUP VOICES: *Stewart
*JIM: Ya, *Stewart, I mean he doesn't always laugh like that. He was killing himself over there…we are not talking about a person who is always laughing… Usually he is quiet and sitting. And she was busy with him there. He was down like this, I'm telling you.
*VIOLET: Yes!
*JIM: He was laughing. I couldn't believe it. He was a changed person. First time I've ever seen him like that.
*HARRY: [Laughing].
DR. CAMERON HARRIS: So, it did have a very good effect?
*JIM: Yes!
*VIOLET: Of Course!

*CLAIRE: Cameron, where is she going to be touring?

DR. CAMERON HARRIS: I actually don't know…we will have to check with her. I think it's within the country. It's within South Africa.

*CLAIRE: Wish her all the best.

DR. CAMERON HARRIS: Thank you I will pass that on.

*CLAIRE: …and I am sure she will make many more friends. And I hope that she makes a lot of money.

DR. CAMERON HARRIS: [Laughter] I'll pass that on… I am sure that she …well I don't know if that is her main priority but, I am sure…

*CLAIRE: [inaudible25:13].

DR. CAMERON HARRIS: Great, so thank you all very much and have a good rest of your afternoon.

*JIM: Thank you.

GROUP VOICES: Thank you.

DR. CAMERON HARRIS: Thank you very much for talking to me. It is really valuable for Daisy to have this feedback. I am just going to turn these off now.

APPENDIX E

CERTIFICATE OF VERACITY

We, hereby certify that in as far as it is audible the aforegoing is a true and correct transcript of the recording provided by you in the matter:

(NAME OF AUDIO: FOCUS GROUP 1 - 2ND RECORDING OF STAFF 09 04 19)

DATE COMPLETED	:	04/05/2019
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DR. CAMERON HARRIS: We are going to start now, as Emilie said, are you all alright to be recorded today in this chat?

RESPONDENTS: Yes…[General sounds of agreement from group].

RESPONDENT 1 (FAYE) No problem.

DR. CAMERON HARRIS: Thank you. Thanks. So, as I was saying, Emilie…I have worked with Emilie at the University and I have had some input onto her project and I am a lecturer at Wits. I am actually a music lecturer so I am directly involved in the kind of work, drama work, that Emilie does. But I am of the same school, we are all together in the Arts School, which is how I got to know Emilie, aka Daisy [laughter from group]. So I think I will just ask firstly. Is there anything in particular that stands out for you like any event or anything that happened during one of Daisy's visits that is particularly memorable for you that you can tell me about?

RESPONDENT 1 [FAYE]: Uhm…[laughing] okay, I was not really like going every day when she comes. Maybe she will come this week then if I will be busy with something, then my colleague, who is not here, will be there. So, what I have seen like is… like the residents they were…like she will get called here, from that corner, from that corner, "come dance with me!", "come do this with me!". So, what I can say is they were excited about it and it was that little something that they needed also to be cheerful, and… even the staff, this one particularly. They would start from here in the corner then you will see that ahh…Emilie is here. Otherwise I think ya….

RESPONDENT 2 [MARTHA]: Yes, but she was giving life to the greyness…You know she can come here and maybe we are busy and we are in some of a mood when she come here you can see here is life…everybody is alive. And then the residents they start laughing and we all start dancing. I leave my job and we go out and we dance. That was nice. That was really good for the home.

DR. CAMERON HARRIS: So, you do feel that she actually changed people's moods?

RESPENDENTS: Yes [General sounds of agreement].

RESPONDENT 2 [MARTHA]: Yes, yes, that was really good for us. Actually, most of the time she finds us working… you know to work with the people, the old people, is not a small thing, it's a big thing. Sometimes your mind is that side, it is this side…but when she comes here you will forget about everything and then we are one team. We are the family and then we start dancing and even the residents they start standing up. The ones normally you see that they are always sitting down. They enjoy standing up and start dancing and that was really…amazing…

DR. CAMERON HARRIS: Wow…cool.

RESPONDENT 1 [FAYE]: The other woman that was outstanding was one of the residents, she is using a walker, so she asked Emilie to sit on her walker and then she pushes her, so they were [inaudible 02:57] …[laughing].

DR. CAMERON HARRIS: [laughing] So they were doing some sort of walker dance?

RESPONDENT 1 [FAYE]: Yes…yes [laughing] so, with Emilie on the walker with her legs going up and down, so, she was enjoying it so much.

RESPONDENT 2 [MARTHA]: [Cross-talk] And to be honest I didn't know the name, I didn't know the name, I was thinking, is 'Tracy' the name? Until I read the form and I saw 'Emilie' on the form and I said, "now who is this one?" [laughing].

RESPONDENT 1 [FAYE]: Daisy!

RESPONDENT 2 [MARTHA]: I was saying 'Daisy', then I saw 'Emilie' and then I saw 'Daisy' and I said. "oh, the real name is Emilie" [laughing].

DR. CAMERON HARRIS: Yes, but we had to talk about that and whether I should call her 'Emilie' or not, or whether 'Daisy', because everyone knows her as 'Daisy' [laughing].

RESPONDENTS: Yes…[general agreement and laughter within the group]

DR. CAMERON HARRIS: And she is 'Daisy' for the...

RESPONDENTS: [Laughing].

REASPONDENT 1 [FAYE]: Yes, for the site…

DR. CAMERON HARRIS: Well yeah, she is…Uhm so that is great. And she was in the area when I was in there, the sort of common room. Is that where she did most of her work?

RESPONDENT 1 [FAYE]: Yes, in the dining room.

DR. CAMERON HARRIS: So, let us just get back to the mood thing. How long would you say that after she has been here, after her visit, would you say that the effect of the visit lasted long or for a short amount of time afterwards, quite short?

RESPONDENT 1 [FAYE]: Otherwise if you can get feedback from all of them they will say "ay it was short". They'll want her to come again.

RESPONDENT 2 [MARTHA]: That was short [inaudible 04:13].

RESPONDENT 1 [FAYE]: They were expecting her, more of her, so unfortunately…

RESPONDENT 2 [MARTHA]: [Cross-talk] Also if they could give her, maybe quite… not late in the rush hours like 15h00. 15h00 is the time we are preparing them. We must prepare them for supper and then they must go to sleep. At that time all of us are concentrating on, us like me, must concentrate on what they are going to use for the breakfast in the morning. Once I concentrate this side, the other side is gonna fall. So, if they can take maybe after lunch because their lunch is 12h30 until 13h00. If they can start from 13h30 that time, their tea time…

DR. CAMERON HARRIS: So preferably after lunch, before tea?

RESPONDENT 2 [MARTHA]: Yes, maybe until half past, until 14h30 to 15h00 then it is fine. Yes, 15:00 to finish.

EMILIE ENTERS WITH TWO ADDITIONAL RESPONDENTS

DR. CAMERON HARRIS: Hello.

EMILIE: Hello.

RESPONDENT 2 [MARTHA]: Yes, 15:00 to finish not to start

DR. CAMERON HARRIS: Right, because that just goes into all of the routine and all of the busy work for an early evening?

RESPONDENT 2 [MARTHA]: Yes.

DR. CAMERON HARRIS: Hi, good to meet you both. I am Cameron. We are recording here just so you know and I hope that is okay that we are recording our conversation in here. Just to sort of tie things up and get a sense, of your sense, of Daisy, also known as Emilie, uhm I am from the University and the same School of Arts that Emilie is working in at the moment. So, we were just talking about the uhm… the memorable things. Anything in particular that happened during the time that she was here yes. I have heard about the walker, the walker dance…[all laughing].

RESPONDENT 3: Ya! [laughing] She did all of those things…the dance… I can see she can entertain very well. She is a good entertainer. She is a good entertainer. I can say that. She did a lot of dancing, a lot of making them happy because I can see there is a woman that we have been watching in particular here and for that particular day, she came and was there, and this day she did not want to talk to anybody, but when immediately she came in and did what she did and put the music, memorise everything, or just dancing around the lady and she started laughing, I was just like 'ha! Come and see! She's now laughing, what's happening?' ….Ya, so she is very well entertaining. I must say, she is good. She's good. 100% she's good [group laughter].

DR. CAMERON HARRIS: Yeah…[laughing] uhm… I've got an issue now with having to look that way I have to kind of… [group laughter], but would you agree with that?

RESPONDENT 4: Yes, she is good, I can tell she is good. You know a lot of residents here some of them have got problems ne, they do not want to smile, laugh, you understand…so when they see such funny things, you understand…they laugh out their sorrows and all that ne, she is good. She's good .

[OTHER RESPONDENTS ENTER].

DR. CAMERON HARRIS: There's still some more people coming. Hi, good to meet you, thanks for coming. So just to recap we have been chatting about five minutes now and I am Cameron from Wits University. I work in the same school as Daisy, as Emilie and she just asked me if I could run this conversation because it is a bit easier than to have somebody else going rather than somebody known basically as a different person doing a particular thing. So, if we could just move on to say over the period of time, she was here which was about a month would you say that your feelings about the project or about her has changed at all? Is there anything you have noticed sort of develop or change over time?

RESPONDENT 4: I cannot say there is any changes to my side to the way I've been seeing her, she has been doing exactly what I read to her book, what she gave us her books, she was doing Masters in entertaining. She was doing exactly what corresponded to what she studied.

DR. CAMERON HARRIS: Right, so… It fits? and yet it was quite a specific thing but you do not think there was a change?

RESPONDENT 4: No. What will I say changed? I don't think… nothing changed ne?…She was just doing her entertaining work, I don't think anything changed, she was just focusing on her work and it was going smoothly throughout.

DR. CAMERON HARRIS: Now I know from the residents themselves you've had people visit in different capacities there is already. There is at least one other student who is been more of an arranger, so you are quite used to having people coming into this space but would you say over the month that uhm…you got more used to her being here or was it ever a challenge to have somebody working like that in your space that changed or was it something that came quite easily? Uhm that she fitted in quite easily?

RESPONDENT 5: I think it came quite easily and I think the change or impact it did make was that the residents were happy and they were entertained and so were we…it was good having them around because of her personality. She is a people's person or....

RESPONDENT 6: [Cross-talk] and it is very good having her around here[cross-talk 09:44].

RESPONDENT 4: Ya, really good having her around.

RESPONDENT 6: We have been here for a short period and like you said she has been here for like a month, and so have we, we have been here for like a month. But having her around here, around us was like, it was like a reviving of the spirit. The work that we do here becomes a lot sometimes and becomes draining, so having her around would like calm us down and it would be cheerful and that sort of thing. It creates a positive environment. So, it was good, it has been good. Always is.

RESPONDENT 4: Even having her around, you see, whenever she comes it will be as if we have known her for many years [Cross-talk; inaudible 0:10:23].

RESPONDENT 7: Ya exactly.

DR. CAMERON HARRIS: Oh right?

RESPONDENT 4: Sometimes it will be like we know this lady for [inaudible 10:30]....two week or three weeks, you just know her. [Cross-talk].

RESPONDENT 7: She has a welcoming face as well.

RESPONDENT 4: She is very accommodating.

RESPONDENT 7: She is easily approachable.

RESPONDENT 6: A jolly good fellow.

DR. CAMERON HARRIS: A jolly good?

RESPONDENT 6: A jolly good fellow.

DR. CAMERON HARRIS: A jolly good fellow.

RESPONDENT 6: Ya.

DR. CAMERON HARRIS: Well it is great to hear that it has worked in that way…I am just looking down the questions uhm…we have actually covered quite a few already…it is just in a different order from what we've listed them…So there is another interesting question here. Uhm, it sounds like you all agree that the visits overall are beneficial and beneficial both to the staff and the residents but if we were to use the word therapeutic as well would you say that they have a…that you noticed that they have a therapeutic aspect additional and if so, could you pin down what that might be. What different aspects?

RESPONDENT 8: Because most of the residents they just sit and watch TV but when she comes, they will stand up and dance with her. And through the movement, because, that encourages circulation of blood. And as time goes on they would feel better than when they're just seated.

DR. CAMERON HARRIS: You right, that makes sense.

RESPONDENT 8: So it has been good.

RESPONDENT 9: And it relaxes the mind as well because most of them are confused so, her coming here they would sort of…sort of…like get into like a certain space. Whenever she comes here with her red nose, I think their minds would quickly adapt like, "that there's that lady". Whenever she comes there are smiles. Their minds get relaxed and they are calm and then their… their… excitement like enlightens. So, it helps relaxing the mind as well, getting them into a good space. Ya.

DR. CAMERON HARRIS: So, you know, it gives them something to look forward to…

RESPONDENT 9: Exactly…

DR. CAMERON HARRIS: or to [inaudible 12:21] towards?

RESPONDENT 9: Exactly…

DR. CAMERON HARRIS: … and then when she is actually here the level of movement and use of their bodies actually uhm… helps them beneficially? Right. They mentioned that, the one's I was listening to a bit themselves, one of them, and the others agreed, that in fact they actually physically relax…

RESPONDENT 9: Exactly…

DR. CAMERON HARRIS: …you know their muscles relax which I though was fascinating. Uhm…and so did you feel in terms of the work, I mean you have given me some insights into the work that you do and the daily sort of routine of things and in fact it can be difficult, uhm one of the questions here refers to sort of the support to your work. Would you say that the kind of activity she was doing, the way she was working, could be thought of supportive to what you were doing? Do you think….it relates?

REAPONDENTS: [Sounds of general agreement].

RESPONDENT 4: It does… It does. Like sometimes, during ah, when she *was* entertaining, when she *is* entertaining them, it makes the residents…[inaudible 13:23]… it makes them maybe…maybe you have to make these people… [inaudible 13;27]… maybe you see them in general walking around, that they just gotta sit down and make sure he or she is really listening to whatever she was doing, even if it was music she was playing or dancing or acting…they are always playing around with her. It makes our work easier. Ya! It makes our work easier. Maybe you do not have to come and then start chasing one patient, one resident like 'come back here, come back here, come back here', but once they see her they will sit there and try get up with what she's doing or see what it's all about because its entertaining. They are focusing on everything she is saying so you will see them very calm, trying to listen, trying to grab everything, trying to maybe dance with her, sing with her…trying to laugh with her and it makes our work easier.

RESPONDENT 10: Even the type of music that she was using because she would use this old African music [laughter from group] so it reminds them of the old days [laughing]. [Cross-talk; inaudible 14:31]. It was helping them. The residents say she is very energetic, she is always smiling so…ya….

DR. CAMERON HARRIS: So, what it did is helpful?

RESPONDENT 10: Yes.

DR. CAMERON HARRIS: And the way she has moved around in your space she has never gotten in your way?

RESPONDENTS: [General sense of agreement disagreement].

RESPONDENT 4: No, not at all…

RESPONDENT 10: …but apart from the residents only, I think even with the workers, because sometimes you find that the resident they are just taking to another mood but when they hear the music or when she's dancing you take your concentration on what she is doing and off you let go of whatever bad thing …So it has been helping basically who has been around her.

DR. CAMERON HARRIS: Right, right, that makes a lot of sense. Uhm… Now we have been talking and I do not want to repeat the same sort of questions. The one good question here is just one which we touched on a little bit…But, would you like to see this as a more long-term project and in terms of the pacing of the week what you see…she is coming twice a week was I?

RESPONDENT 4: Yes. Tuesday and Friday.

DR. CAMERON HARRIS: On a Tuesday and a Friday. Did that seem to be a sort of good interval or do you think there should be more or less.

RESPONDENT 6: I think that spacing was good…

RESPONDENT 10:… because the residents are getting used to her and every time, she enters they will be smiling and they are ready to dance and everything so if they do not see her, [cross-talk] they are going to ask what happened to the red nose girl [laughing].

RESPONDENT 4: Why are we not dance a lot.

DR. CAMERON HARRIS: So, you think twice a week was a good amount?

RESPONDENT 6: Yes.

RESPONDENT: Yes it's nice, ya.

DR. CAMERON HARRIS: And in terms of it being more long term would you like to see it as a project carry on?

RESPONDENTS: [Sounds of general agreement].

RESPONDENT 7: Yes she should, she should.

RESPONDENT 6: Yes…I think it is a good project that if it takes a longer period, I think the benefits will be more than what we are seeing now in a shorter period.

DR. CAMERON HARRIS: For basically, a month?

RESPONDENT 6: Yes…

DR. CAMERON HARRIS: Great, and have any of you done anything else like these structured questions that I needed to ask you and in terms of this sort of sense of fun, I mean there is one question here on whether it was fun, helpful or useful, I think we already answered that because it does change the mood and take you to different places.

RESPONDENTS: Yes [Utterances of general agreement].

DR. CAMERON HARRIS: But is there anything just from your comments that you would like to add or have an opportunity to let us know?

RESPONDENT 7: It is good having her around here [cross-talk] and we want her here even more. Like we have just mentioned she had a huge impact in a short space of time so it could be elongated, there is nothing wrong with that. It could add like some liveliness to the elders and to us as well. So, if you can add one more student as well it is fine. [Laughing] It's fine having them around. It's therapeutic in so many aspects. So ya…

DR. CAMERON HARRIS: Thank you.

RESPONDENT 10: Yes, I want to add she is a good person. She is fun to be around her and I wish her all the best. I think she should get further and fly as high as she can but as a person, she is a good person. Yes, and you must remember it is not just about dancing. A lot of people can do that.

DR. CAMERON HARRIS: Right, the skill of the dancing it is about…

RESPONDENT 10: Your energy, your emotions, what you put out there.

RESPONDENT 4: Attitude…

RESPONDENT 10: Your attitude, yes. You can give me the same job but I do not think I can do it the way she does it. [General sounds of agreement from group]. Just in general. So, in general she is a good person and I wish her all the best and that she can fly as high as she can.

RESPONDENT 7: And she came to the right place…

RESPONDENT 10: [Cross-talk] at the right time yes.

RESPONDENT 7: She always puts smiles on people's faces.

RESPONDENT 10: Ya!

RESPONDENT 7: And this is [inaudible 19:03].

RESPONDENT 10: Ya… you see…a lot of people do not realise the impact that she is making… until then, you like oh, really, I smiled when she was dancing. Even if I was caught up in my own world but when she came out, I was like 'oh'.

DR. CAMERON HARRIS: So it was only afterwards that you realised you were smiling?

RESPONDENT 10: Yes!

DR. CAMERON HARRIS: Right. So, in a way it was quite a subtle thing? You know when something is not quite in your face about it but the fact that she has been using humour and has been using… sort of… human things, you only realise afterwards?

RESPONDENT 4: She's good!

RESPONDENT 7: And she can be a good humanitarian this one…

RESPONDENT 4: She's good. She's good…even when she sees you, she'll be like ha!

RESPONDENT 7: [Cross-talk]…and she'll be smiling like she knows you [laughing]

RESPONDENT 4: [Cross-talk; inaudible 19:49]. [laughing] You'll be like wow! In a short space of time you'll be like ha! 'I like this lady'. I'll say to my friend, you see this lady, I like this lady. [Laughter from group]. I just like the way she smiles, the way she talks, the way she is doing a good thing, and that is the most paramount something. Whenever you in any way you are, you try to be accommodating, do you understand, this is very very important, you try to be accommodating. She will make people laugh, even when they talk to you or they want to talk to you, they will laugh. And she made those people dance! Even when I see her in her car, when she was driving in, I try wave 'Hi, how are you?', because of the way she is. Because of how sweet her heart is. Because of how accommodating she is. So, she's good. She's good.

DR. CAMERON HARRIS: It seems like a lot of you saw her personal side of things?

RESPONDENT 6: Yes…

DR. CAMERON HARRIS: The fact that she is working, although she is working with a lot of people, it is almost like one-to-one?

RESPONDENT 6: Yes!

RESPONDENT 4: Yes, everybody is happy…she's doing that!

RESPONDENT 3: She captures everyone's attention, ne.

RESPONDENT 6: Ya, even those who can't walk she goes to them…

RESPONDENT 7: Ya, she will go them.

RESPONDENT 4: She will go to the admin, go will to the residents, to the residents, and she will also come to us, as the students. She will also go to them. She will entertain everybody. You must be entertained once she enters.

RESPODNENT 6: [Cross-talk] She will go to the kitchen! She does that!

RESPONDENT 4: She entertained!

RESPODNENT 6: [Cross-talk] Everywhere!

RESPONDENT 4: Yesterday we danced… what is that 'Soucha dance' [audio unclear 21:20] with me…[laughing with the group]…she said [inaudible 21:22]. [Laughing].
REASPONDENT 7: It was nice having her here.
DR. CAMERON HARRIS: Thank you all very much for your time. I know you have an awful lot to do especially since writing that time, as you said, to get the dinners get everybody ready tomorrow…So I do value the time to chat and I think it is really helpful for Emilie to have this and to wrap things up so. So, thank you.
RESPONDENTS: Thank you. [General utterances of thank you].

APPENDIX F

CERTIFICATE OF VERACITY

We, hereby certify that in as far as it is audible the aforegoing is a true and correct transcript of the recording provided by you in the matter:

(NAME OF AUDIO: FOCUS GROUP 2 – INTERVIEW WITH THE SOCIAL WORKERS 09 04 19)

DATE COMPLETED	:	05/05/2019
NUMBER OF PAGES	:	7

INTERVIEWER: DR. CAMERON HARRIS

INTERVIEWEES: FAYE (SOCIAL WORKER) & VERONICA (AUXILARY SOCIAL WORKER)

DR. CAMERON HARRIS: So, as you know uhm, Daisy's project of about a month has come to a close now and she would very much value any input you can give about how you felt the project went and how it fits into the wider kind of workings and aims of the home here. Uhm, so I suppose a good way to start with this will be what were your sort of first impressions when Daisy came in on the scene and did this change at all over time during the month.

FAYE: Uhm…okay, when she came ne first, like we didn't know like practically how it would be done, like what kind of impact it would have on, and how it would be different from the activities that we are doing. So, as the sessions progressed, we saw that wow, lovely, it is something different. Absolutely, a different approach to…uhm… entertaining, if I may say so, and just to bring that change of mood to the residents. So, really, we saw that change, a big change as the residents were responding and engaging with her. They loved it. It was fun, and they appreciated it.

DR. CAMERON HARRIS: Great, and what nature would you say the change had made? What was different about them?

FAYE: Uhm…it was more like being fun, changing the mood into like being fun and entertaining uhm, it was just a difference approach like from what we are doing because like we do like sometimes exercises, theses boardgames and so it was totally like different and funny and entertaining way of approach, like the way she was handling the ladies.

VICTORIA: Yes, and adding on that again, bringing back the music for the older age, it brought the older persons back there, and they were so excited that a younger person can bring such a music to them and it was a lot of fun to them. They even stood up and danced. So seeing her dancing with them, it was something else.

DR. CAMERON HARRIS: Right, it really does seem that music is a key and that is how it has come across in all of the interviews so far. That there was a kind of memory kind of transporting you back and they responded incredibly well to the music. I think sometimes it is like a stereotype of younger people that they listen to the music from now and do not know anything else. So, it is a pleasant surprise when they find somebody who is willing to dig a bit deeper down. Uhm, so that is great. Uhm…the effect…It sounds like you are both agreeing there's overall positive effect whilst Daisy was here and it was essentially a general change of mood that was very much linked to music and how that cheers people up. How long would you say that lasted after Daisy went? Uhm, would you say things went back to sort of normal relatively quickly or would you say the next day there was still sort of a sense of that? Because she came twice a week, right?

FAYE: She came twice a week. Let me tell you that even she used to come on a Tuesday and a Friday but on Wednesdays and Thursdays all the people were looking forward to seeing her again to come and entertain them. So they thought that she could come more often, like for her to come and entertain them on a daily basis like it was…

DR. CAMERON HARRIS: They would be happy to have her here every day?

FAYE: Yes, so they always had an appetite that they can see her again, coming again and do some other stuff again so…

DR. CAMERON HARRIS: And I guess that was something in itself if they have something to look forward to. It gives them an extra sense of structure and also something to look forward to. I mean that is always a positive thing is it not?

FAYE: Yes.

VICTORIA: Yes, it is true.

DR. CAMERON HARRIS: Yes, that makes sense. Uhm, and in terms of the sense of the clown character obviously, I mean Daisy could have come in and done work here in a number of different ways and it could have been individual, but she does work as a clown. How did you find that? How did you find that fitted in and what were your reactions to that?

FAYE: [Laughing] Being a clown? I think uhm people also started like acting like that. So they also like joined in to be that clown that Daisy…in that mood that Daisy brought into the home. So, whenever she came in here you would hear that there is noise. Even starting from here, cause she will come from here starting from here in this block so you will hear noise when she comes in [laughing]. Like people are excited saying "yes, okay, she is here!". So, she will just have that change of mood in everything else. That seriousness, it will just fade away, like when she comes, then... Because I remember there was one resident that I witnessed uhm she asked Daisy to sit on her walker, then they were dancing like that and she was pushing her and Daisy was saying: "No! You won't be able to…". [Changing voice as if the elderly lady responding] "No, [inaudible]". So, then they were coming from another direction coming inside the dining hall, so it was lovely and exciting and she really enjoyed it, so I think that is kind of ah the mood that she brought to all of us.

DR. CAMERON HARRIS: That is great, that is interesting. One of the questions I got down here was is there anything in particular that stood out for you? Obviously now the walker that was one thing. Was there anything else that you remember in particular that she did…that was particularly memorable?

FAYE: Uhm…no just that she would just involve like everyone, including the staff members, dancing. I remember also one day I was joining and dancing with them and there was this one lady what is her name…uhm *MARY (pseudonym)…I do not know whether their identity now… because I have said the name…

DR. CAMERON HARRIS: Oh it will be redacted because we are going to transcribe this.

FAYE: Transcribe this (overlap; said at the same time as Dr. CAMERON HARRIS). Oh okay, so ya, that time she would just laugh like this while sitting down, so Daisy like changed it into an action of saying… she was doing the way like she was doing and reacting [laughing]… She was doing this and doing that. Then she was laughing out so loud, they laughed, then I saw that oh okay that is how she had a way of engaging.

DR. CAMERON HARRIS: Of bringing people out of themselves by using humour?

FAYE: Ya.

DR. CAMERON HARRIS: Which is another question that was given here…the actual question is what do you think of using humour in elderly homes, do you think it is beneficial uhm for the elderly and even staff? So, I mean you have mentioned the humour so then… and obviously with being a clown the humour would not be quite the same?

FAYE: Ya…that humour, like we were saying, it was entertaining. It was…it had a great impact on them like to change that mood. Maybe they will be thinking… because there are some periods where we do not have like anything that we are doing with them, maybe we will be here [referring to the office they are sitting in]. So, in that time she comes and she lifts up like their moods and it was of great impact.

VICTORIA: Yes, and we have different kinds of beneficiaries here so some they do not even want to talk, they do not want to do anything, but, when Daisy comes, we have seen them react, we have seen them laughing. Some we do not even know if they have teeth because they always quiet but since she came like she changed everything. Like even now it is not boring to go out there and say laugh because you have got somebody that is coming. [Phone ringing in background]. When they hear “Hello” they know there is somebody like Daisy who is coming and that little nose [laughing]. She even put it. Ya, that little… we like that nose so much so …[laughing]. For them to see the nose it was like “Wow! Look at that now!”. We have seen that in a TV. Some of them it is their first time to experience somebody like Daisy. So as some of them they even said they liked her shoes, we like those shoes because they are old stylish ones, so we like it.

DR. CAMERON HARRIS: So, it sounds like this character really does make it possible for Daisy to do what she does? Her clown character?

FAYE: Yes, they even identify with her with her shoes. They say oh, there is Daisy with the black and white shoes.

VICTORIA: Yes…[laughing] and the red nose.

DR. CAMERON HARRIS: That is really a good point because if she did not look so obviously different in a way then she would not be as memorable and obviously memories are a thing for older people?

FAYE: Yes.

VICTORIA: Yes…true.

DR. CAMERON HARRIS: Uhm, and I suppose humour is a difficult thing to judge it sounds like Daisy got the balance right between being able to bring people out of themselves with some mimicry and what have you, but did not push so far with it anybody that humour might have gone the wrong way and that they would have felt exposed by the humour.

FAYE: The other thing also what helped, is she would ask and say, 'is there anyone maybe with a particular behaviour', to say, 'if I do this, they will maybe react in a different way'. So that she also did, like consulting. It helped in a way.

DR. CAMERON HARRIS: So, she will do this ahead of time?

FAYE: Yes, so she would know yes, what to expect and what to do. So ya.

DR. CAMERON HARRIS: That makes sense. Uhm, so a couple of these questions are a touch on the difference between general benefit and therapy and therapeutic aspects… and she would be very interested, Daisy, to know how you felt about that. Clearly there is an overall sense of it being beneficial in some way. But how would you say that linked into what you do here? Would you say it is supportive of your general way that you do things? And would you say that not only does it have a general benefit, would you say it has a specific therapeutic angle to what she does?

FAYE: I think it does. The play therapy-like kind of environment that was created by what she was doing, it really played a big role… uhm…considering like the way the residents were responding, so to say if we could uhm…uphold that and keep it going now-and-then we will do that, and if she can maybe have someone who can continue coming, and that will be like it was really therapeutic to the residents.

DR. CAMERON HARRIS: Okay, and which…uhm…there is a question here in terms of a longer-term project. Would you like to have these clown-based interventions happen more often or more long term? And you sort of already answered that. Would you agree that it would be worthwhile if this had been a longer project?

VICTORIA: Yes, I'll agree on that. Because even now I am thinking that for her not to come anymore it will take them back again but for her to come again, it will make them happy.

DR. CAMERON HARRIS: Yes yes, I mean that is the issue with any project for any defined period of time when it comes to the end what happens and how do you leave basically? How do you leave the project? Uhm, because like you say there is such a structure strong sense of anticipation and they got used to sort of a timetable of it, the sequence of the two times a week and if that does not happen anymore, I can imagine that they would be disappointed. Well that is great. I mean we sort of wound our way through the ten questions that I have here on this sheet. But just before we close is there anything in a general way that you would like to add anything that I have not asked.

FAYE: Uhm. No, from my side like the general comment is that…like… we learnt something from her project. Like I think it's safe to say we will plan also, like from our programs and everything to say we try and introduce something like this… like what Daisy has introduced into our lives. So that it can be continuous. So that they will get something more fun and more engaging rather than just playing the cards, playing dominoes, playing this and that. Singing, so it's more like including everything but in one thing. So, we will try and develop something like that. We will just also ask her for some tips to say how can we do this Daisy? So we will just keep in touch to just say we would like to continue with this kind of activity you are doing, please just guide us here and there on how to do it.

DR. CAMERON HARRIS: That sounds great. I am sure she would be delighted to hear that and she would certainly want to keep in touch in that way. Perfect, well thank you both very much for your time. I know that you are hyper busy and I do not know if this is a better or worse time to come in than late afternoon because uhm…

FAYE: I think it is also fine.

DR. CAMERON HARRIS: That is good. So, thanks, let us just make sure this is safe I am often so scared that you know do all of this and it doesn't save properly so I have to press that… (END).

APPENDIX G

Preliminary Processing Journal – Emilie – Summary

The journal entries covered the observations and experiences I had in the elderly home with both the elderly and staff. I was quite observant and detailed. I recorded the progression of a session from my arrival at the home and prior session check-ins with the social workers on duty, through to the commencement, duration, and completion of the sessions. I also recorded the progressions over the series of sessions. My Journals included what happened and visual ques for both positive and/or negative experiences in response to the work. My journals included a record of perceived (visual) emotion, overtly expressed emotion, and a record of my own personal feelings; this was largely to allow myself to reflect on the emotional landscape, and to be more aware of possible transference and/or countertransference as the researcher-therapist engaging, or more specifically, the therapeutic clown engaging.

The journals are extensive; the data is rich. This summary has had to be selective in order to keep within the limitations of this study.

Overall, I had a very positive experience within the home. I felt welcomed and appreciated by both staff and elderly.

As the researcher-therapist, I presented and held two roles in particular in the home for the elderly: the drama therapist-researcher – Emilie - and the therapeutic clown - Miss Whoopsie Daisy, more often referred to simply as 'Daisy'; thus, roles in and out of clown character.

I arrived at the home as the therapist-researcher, availing time to first meet and check-in with the staff on duty, in particular the social workers, prior to sessions. The social workers oversaw the sessions in practice; making sure everything was okay. The check-in was used to allow the social workers to feedback, or ask any questions regarding the sessions, and, from my perspective, to find out or discuss any information that may support the therapeutic clown sessions. This could include relevant resident-based information such as the general, or particular, mood of the residents or a resident, or any out-of-the ordinary behaviour that I should be aware of, like someone angry etc. Also, if someone is new or if someone has passed on. Essentially, what to possibly consider or look-out for that may inform my approach as the clown in the space. The check-in's appeared to facilitate a professional, co-worker relationship and environment, thus fostering a sense of teamwork and increased trust between us. In and out of clown character/clown role, it seemed impactful to meet the staff with a level of kindness, respect and enthusiasm. It appeared to contribute to both professional and personal relationship development.

*"We discussed *Janet and I explained how we had developed a type of friendship – that my presence and visits may have held much meaning to her. The social workers listened and guided me by telling me just to let her know that I would be leaving soon, that sessions would be coming to an end. This was something I had planned on doing but in a way that was more creative than this – not simply just stating that I would not be coming back. This could also do more harm than good. My feeling was that something in the clowning or creative arts could offer a smoother ending. It felt reassuring speaking to the social workers like this. I also felt very supported and part*

of a team. This kind of support was something I really did not take for granted. It also affirmed how the staff were key in the inclusion of the experience, the play and the sharing of joy – first, for them to be familiar with what I did, and secondly, for them to feel comfortable enough to let me do the work, and thirdly, for them to also keep an eye out and support outside of sessions*".*

The role of 'Daisy'. I changed into 'Daisy' in the admin block bathroom; this meant literally changing into my clown costume, and, as the performer/therapeutic clown, warming up and preparing for the sessions. I became Daisy the moment I had my nose on. As Daisy, I would not engage with the residents or staff out-of-character. The therapeutic medium is the clown, and so breaking this can affect the potential effectiveness of the work. I used the costume, and in particular the red nose, to visually signify that I was a clown, and different from 'Emilie'. I became 'Miss. Whoopsie Daisy', and more commonly and affectionately referred to as 'Daisy' by residents and staff. The staff appeared to get used to the role-dynamic quite quickly. As a therapeutic clown, making the shift clear from 'Emilie' to 'Daisy', and sticking to character, were vital in being taken seriously and showing the staff in particular, when and how to engage with me. This would also prove necessary to allow the staff to equally have fun with Daisy; they quite quickly learnt who Daisy was, how she engaged, and thus how to find their own playful engagement with her, outside of their professional relationship with 'Emilie'. This was not to say that they did not obviously know 'Emilie' and 'Daisy' were essentially one, but they understood the different roles.

Overall there was a very positive response to Daisy. Both the staff and residents appeared open, playful, and even quite trusting towards Daisy. The connection between Daisy and the staff and residents was quite immediate; this appeared to be largely due to the artform - the idea of presenting yourself to be seen by others (by an audience). This combined with being high energy, fairly noisy and also looking like a clown; looking unusual. Most importantly, I was open to connection: I made myself available, I was vulnerable, I allowed opportunity for eye contact. The immediacy of connection can best be described in the case of Janet on the first day I started sessions:

"[...] an elderly woman sitting on the front couch caught my attention immediately as she appeared completely awe struck by my sudden appearance; her eyes were wide, she was looking directly at me, her posture was up, and she was smiling with the same open-mouthed 'wow' as I had entered with. She was sitting with her walker next to her. She was gentle looking, she appeared kind, with white hair, a soft wrinkled face, older looking than many of the elderly near her and quite small - short, slightly hunched over. I was completely taken by her reaction to me. We held eye-contact. As I breathed her in (as if amazed that I was meeting her) she appeared to mimic me – breathing in at the same time, still with a big smile. This action felt quite synchronised. It was quite funny how we held this sense of being in awe of each other. We seemed to be absorbing each other's excitement and energy, and it just kept growing till we both needed to release our breath, or it felt as if we'd pop. I felt quite touched by this sudden and immediate connection with her, and incredibly energised by it too".

The staff and residents energised me. Their sense of excitement and joy got me equally excited to engage.

As residents and staff became more familiar with Daisy, so their comfort, confidence, trust and willingness to play increased. Positive visual ques included smiling, laughing, excitement, curiosity, a sense of pleasant surprise, bright eyes, general interest, eye contact, touch, conversation, and as time went, held attention, increased eye-contact, increased physical touch, more willingness to approach and participate with Daisy, more willingness to dance and sing without worry or care, watching and following Daisy's movements throughout the space, waving and calling Daisy over, as well as being more vulnerable, open and trusting enough to tell Daisy personal stories and even their feelings towards her. Some of the residents expressed their love for Daisy, and how happy she made them. Overall, residents appeared to enjoy and appreciate Daisy's presence. Residents and staff both appeared to have fun during sessions. The sessions appeared to make the residents happy.

Daisy made some of the residents feel better. An interaction with Harry, one of the residents:

*"I noticed *Harry waving as if calling me over. As I made my way to him he exclaimed, 'Daisy!", with a big smile. He was sitting in his wheelchair in his usual spot with a magazine in the sun. I told him I was pleased to see him. I told him that he looked particularly good today! He said, "yes I feel better now that you are here". I told him I too felt better now".*

In the case of Harry, this 'feeling better' seemed to include a level of pain relief, or at least being able to get him to forget his pains. This seemed to happen largely because of the music. Music seemed to offer a sense of nostalgia and joy:

*"*Harry said he couldn't dance today – he held his lower back as if to suggest back pain. I told him that that was perfectly OK. Jo (the principle) was sitting right behind him. *Violet was to his right at her usual table. *Jo waved at me. I waved back. He said to me, "where's the jive?". I said I have some music, is he ready? He said, "yes of course"[...] I had put on All Shook Up. He started cheering. "Shake! Shake!", he would say while laughing. I was still standing/dancing very near to *Harry (he was behind me), when suddenly *Harry started singing. His mood was changing. He was brighter and more cheerful. I turned and I took his hand and started singing with him. From someone who was not feeling OK and refused to dance, he was now suddenly singing and "dancing" (and fully participating) – it was quite an immediate change of mood. I would say the music definitely affected his mood. We sang, and I danced with him in his wheelchair while our friend *Jo cheered on, tapping his legs. *Harry was smiling and laughing. *Veronica was near. "You make me feel young again", he said. I said to him "You are young", he laughed. We danced for the full duration of the song. I was reaching to stop the music from going to the next song, but the next song on the playlist, 'tutti frutty' began playing. *Harry said, "Oh I know this song!". I had stopped it, but *Harry seemed disappointed, so I continued. We sang and danced again. My playlist was largely filled with upbeat music of the era and this seemed to respond well with the elderly. As the song began to fade, *Harry held my hand near him. *Victoria and Violet were watching. He said, "shew... (pause) it brings back so many memories". He said again, "you make me feel young". I noticed his eyes welling up. He thanked me and said, "Look at my eyes, I have tears in my eyes. I am crying". He said this with a big smile. *Violet said, "ahh beautiful" from behind us. I wiped his tear. I said, "thank you for letting me dance with you". I said, "*Victoria, we have a good dancer here!". She replied, "I know" and smiled. I joked with *Harry that he's a charmer. He asked, "you think so?" "Yes", I said, and Violet*

*agreed nodding in the back. He laughed. *Jo was still watching. I asked *Jo if he loved dancing as I had noticed his legs tapping to the music. He said yes and told me how he used to tap on the stage with the hot lights. I told him I could definitely see the tap in his feet. He said he better not start, or he won't stop. I laughed and said don't tempt me. He laughed.*

Whilst some of the residents felt energized and touched. Daisy made others feel calm:

“I said, “what about a lullaby?” She said, “yes please”. I started singing ‘Tula Tula’. She started singing with me. She was looking into my eyes. There were parts that she would sing, and I would follow her. Especially through “Tul'umam 'uzobuya ekuseni”. She laughed when I got it wrong and enjoyed showing me how to sing it. We eventually just kept repeating “Tula Tu Tula baba Tula sana”. She smiled at me. She seemed calm and relaxed. I asked her if she was feeling a bit better. She said she was “feeling good””.

It felt like, for the most part, residents wanted to be seen, wanted their joys and troubles acknowledged and heard, like with Harry’s back, and even something as little as a mosquito bite:

“I then visited the woman who was a Jehovah’s witness (she always reminded of this). She had been bitten by mosquitoes and was intent on showing me. I told her that she was simply too sweet and that mozzies liked sweet people. She laughed”.

Towards the end, there was both happiness and sadness experienced, particularly on the last day of sessions. Daisy really meant something to the elderly:

“He [Harry] said, “you know, you make me happy. You make my heart happy”. I told him that he made me happy, and fit, because I always danced, and he was lucky in the wheelchair. He laughed. I told him that what we had was special, and that we would be connected no matter where we were. That this was very real, and fun, and glorious! He teared up. I told him not to cry, I wiped his tear. I told him that I was also sad to go, but that I had the best memories with him to carry with me. I told him to stop crying now and dance with me. He laughed. I played a platters song, and Tutti Fruiti which was more upbeat. We sang and danced”.

Janet too felt emotional over Daisy and the end of visits/sessions:

Janet had come back in to her couch, I went over to her to close with her too. As I came to her, she told the elderly lady that was new that I was her friend. After a moment, I told her that this was my last time visiting the home, as I had been cast in a traveling show and would be moving around the country. She told me that was very nice, and then said, “but you will come back?”. I told her that I would definitely try but that I wouldn’t be nearby as I would be travelling around South Africa. She would say things like ‘Ooo, how exciting!” and “wow”, and “you must take pictures” etc. but it was always followed by, “but you will come back hey?” or “you’ll visit soon”. I told her that I was very lucky to have made a friend like her. That she was very special, and I told her how lucky the home, and her friends were to have her. I told her how our memories were going to be the best part of my trip. She was slightly teary. I told her that I hoped she would keep the silliness going – she laughed and said with slightly closed eyes “yes, yes! Oh yes!”.

There was a lot of play, fun, and silliness, but the trick about therapeutic clowning is that there is no trick. The emotions are very real; what you feel and experience during a session is not fake, it’s not a show, and it’s not a joke. The use of a creative story ending, the traveling, really seemed to help – I had many well wishes instead of simply sadness.

Whilst most residents responded positively from the beginning, there were residents who took longer to trust Daisy. Trust is not always easily given to strangers, and for those who had possibly been left behind by their loved ones, this may have been harder. As Daisy, I did not force engagements, nor did I demand trust. I was, however, happy to (respectfully) work for their trust, even if there was the real possibility I would never been granted it. In the journals, it's clear that Daisy shifted and attuned to those she engaged with; doing what felt necessary in that moment. At the end of the day, the work needed to fit in accordance to what they, the residents and staff needed; not what I, as the researcher or clown, needed.

Three residents in particular seemed uncertain of Daisy. Even in these cases, the connection was still immediate, though distant. They were either physically distant, choosing to keep space between us, or emotionally distant, not wanting to fully engage.

On the first day, a gentleman seemed caught off guard by my presence. It felt like his reaction was largely in response to my appearance – visually seeing me:

"As I was about to make my way towards Janet, an elderly lady and gentleman were making their way towards the door, which I was clearly in front of. When the gentleman saw me, he stopped as if he were caught-off guard by my presence and/or appearance. His reaction was one of surprise and hesitancy. I picked up on what appeared to be slight uncertainty, nervousness, perhaps a lack of trust, concern or even slight fear of something clearly unfamiliar and unknown. He was, however, sheepishly smiling throughout this moment".

As with Janet, mirroring emotion or body language, seemed to encourage connection and, in this case, defuse tension:

"I remained quite still, returning a gentle smile and embodying an equal sense of shyness. Without thinking too much about it, my immediate reaction was to mimic/mirror a similar experience towards him – showing shyness, slight hesitancy, softening my facial expressions, bringing my shoulders in (as if shy), all while holding a sense of naivety and innocence. In this way, I hoped to appear more vulnerable and unaggressive. I wanted to convey that I meant no harm, and that I too was new and a bit unsure. It's in this similar experience that I hoped to connect further. When he looked into my eyes, I said "hello" quite shyly. I took a step into the room but he withdrew behind the elderly lady (I assume his friend). He appeared very curious and interested, peeking out from behind her while still maintaining a (nervous) smile. Whilst curious, he was not about to come out and shake my hand. He was tentative, and I respected that. As the clown, however, his retraction felt like an offer - a way to connect and (sensitively) play. He stepped forward a bit, perhaps still aiming to pass. This time, however, his move prompted me to retract; I jumped back. Suddenly, a big burst of laughter came from the elderly lady on the couch. I realised I had an audience, and she, and the staff sitting on chairs to the right of the room found this awkward engagement between myself and the gentleman rather amusing. The gentleman smiled and giggled a bit as they laughed. He looked at them, and me, and them again. He may have been using them as a kind of gauge to see how they felt about me. He moved forward again, though still behind his friend, as if using her as a bit of a shield. This time, the move forward prompted me to retract further, jumping onto the chair near me and crouching. This was both a reaction to his move, but it was also a strategy on my part to clear the doorway for him to pass. Again, laughter from the elderly lady and those in the lounge area. He giggled as I jumped, though still appeared nervous. As he came closer, I looked away as if pretending not to see him. He approached, then stopped, I looked at him, he smiled, and then he quickly slipped passed through the

doorway with a chuckle. The lady on the couch laughed, I leaned over and looked through the door and he turned back to look at me. I waved goodbye. He smiled, waved and then moved out of sight".

Other relationships that developed over time were Mary and Violet. Mary was often quite angry, confrontational with other residents, closed off (literally with folded arms) and withdrawn (alone). Through the use of silly dance moves, casual banter and play, Mary went from being emotionally distant, literally not even wanting to show me when she smiled, to being far more open, smiling and laughing. Marta mostly enjoyed watching me. In the end, Marta expressed her love for me. Something I took to heart. It felt like we had achieved a lot together in a short amount of time. She allowed herself to be vulnerable with me. I noticed her wall lower over the course of the sessions, and her apparent comfort and joy increased over our sessions. Her laughter often appeared to surprise the staff.

*"Hello, Mary, my friend". *Mary told me that I was very sweet. This felt like a genuine compliment and coming from *Mary it meant even more. *Mary had slowly over the sessions really softened with me. She did not appear as grumpy to me – and it was lovely to see her this way.*

Violet too was emotionally and physically distant. She often sat alone and far away; a table next to the dining room window. She appeared to isolate herself there. In the beginning, she did not want to do much together, though she was happy to pass a few words between us. As sessions progressed, Violet increasingly seemed to enjoy my presence. She appeared to enjoy watching me with others. Over time, she ensured I would come and see her by waving and calling for me. She too expressed her appreciation of me. Violet landed up speaking the most in the feedback.

*"*Violet called me. I came over and greeted her, "beautiful *Violet, are you well today?" – "Yes, thank you Daisy", she said smiling. [...] *Violet told me about her family and how they often expected a lot from her which is why it was better being in the home. She said whilst she may look younger than her age (mid-eighties) she couldn't do things easily anymore. She struggled being left with the grand kids. She said she had spent time doing her part and now she was the one that needed the help. I told her that it looked like she was well taken care of here – she agreed. I told her, "and there's dancing and crazies like me". She said, "even better". I laughed.*

The first three sessions, much like within drama therapy, were an assessment period used to both evaluate my surroundings, those within it, and, more specifically, to see how the elderly had brought with me. Residents and staff were, overall, very playful. Over the course of the sessions, different things resonated more or less on different days. Props wise, residents appeared to enjoy my feather dusters, blowing balloons, and bringing them flowers in the beginning. Residents generally seemed to like my jokes and silly banter. They liked to tell me stories. Equally, residents appeared to respond to physical touch and contact. They often held my arm, kissed my hand or cheek, and opened up for hugs. I returned their kisses (cheek or hand), hugs and physical touch. These felt appropriate and loving. This touch and affection appeared necessary and meaningful. Tender and affectionate touch may not have been a regular experience for them; contact could have been reduced to carers who helped wash and dress them. In this way, Daisy may have provided warmth and affection in this regard.

*"As I turned the corner to get to the common room (the dining and lounge area), I immediately came across *Janet who was sitting on her walker like a chair and appeared to be patiently waiting for the tuck shop. I was thrilled to bump into her, and she too appeared thrilled to see me as she completely lit up – her eyes gleamed, she took a deep breath in and smiled. "Daisy!", she gasped. "Hello, Janet!", I said back. "It's so lovely to see you again", I said. I approached her. She said to me, "it was my birthday yesterday! I thought you would be here". I told her how I wasn't at the home yesterday, but that I was here now, and I wished her a very big happy birthday. She thanked me. I asked her if I could give her a big birthday hug. She opened her arms, as I came in for the hug, she pursed her lips for a kiss. I pursed back. She kissed me on the cheek, and I kissed her on the cheek. Thank you I said. She said, "no no, thank you!". She had a very small voice, but she was very clear and quite expressive when she spoke – closing and opening her eyes as she explained things. The physical contact between us was growing – this time with kisses on the cheek. Touch seemed to be very appreciated, and not just with her. For *Janet, touch was always followed by a smile. Though her face seemed to show a slight sadness even though she was smiling. I sensed that these tender moments meant a lot to her".*

With this said, some of the elderly gentleman were quite flirtatious and charming with Daisy, again, these were not experienced in an inappropriate or negative way on my part. Their charms and affections felt quite innocent. It felt important to make room for this kind of expression; and the artform allows for it – As Daisy, we could be young lovers and dancers in the space. We could express love for each other in these sessions.

*"He [Andy] then said, "do you know that song 'Daisy Daisy, give me your answer do!'. I was not sure if he had heard me singing it with *Janet, or if it was just serendipitous that he asked for it but I was pleasantly surprised it had come up again. I said, "oh yes!" and I played it. He sang along a bit, moving his torso a bit to the music. He thanked me for the song. He said, "if I was younger I would be your boyfriend". I said, "how wonderful!". He laughed! I bid him farewell and told him he that he was "my boyfriend". He smiled and blushed"*

Residents responded particularly well to the inclusion of dance and music. I specifically resourced music that would have most likely been familiar to them. Residents appeared to enjoy singing and dancing. Music appeared to make them quite nostalgic. Residents often reminisced, telling me of younger times and specific moments in their youth. Music and dance felt particularly meaningful to Harry, a resident who was wheelchair bound. Not only was he nostalgic about the music, he recalled every single lyric of songs like 'Tutti Frutti' by Little Richard. The dance also took a unique form: I would hold his hand and do the dancing around him, pretending as if he was swinging and twisting and dipping me. In this way, my dance seemed to give him the experience of being more physically able. He did not have to feel shy about dancing in a wheelchair. He often said that I made him feel young again.

As example of music which appeared to be significant was with Janet. When I first met Janet, she started singing my name:

"[M]y name is Daisy. Miss. Whoopsie Daisy". She smiled wider, gave a bit of a

"ha!" sound, and immediately repeated "Daaisy" in an elongated, slightly sing-song manner. She repeated, "Daaaisy.... Daaaisy". I joined her: "Daaaisy... Daaaisy". We were looking at each other, eye-contact, quite close, singing a song we were clearly making-up on the spot. It was surprisingly quite intimate as we sang and held this eye-contact. It felt as

though she was immediately open to me, trusting, open to playing, and participating. Again, it was very synchronised. As I felt her trust, I slowly (allowing her to keep in synch with me) played with the length of the name,
and the melody of sorts (just shifting the notes, the rhythm, the volume). She followed. Whilst I was gently leading in the beginning, at one point I couldn't quite tell who was leading and following anymore. We got louder and more operatic. We held a final, rather loud, note together. We received applause from the staff and some of the elderly in the room".

Over the course of the first few sessions, Janet would always sing 'Daaaisy... Daaaisy'. I began to feel like Janet was trying to sing a particular song. One day at home, I was talking about this song she kept singing, and my partner immediately went, "Oh I know that song". I had discovered Janet's song. It felt wonderful, and I could not wait to share it with her.

"She [Janet] then started singing, "Daaisy! Daaisy!". I was excited at this point because this was my opportunity to see if the song I had found was correct. I had brought the song last session but she was not around and so this was my moment to reveal it. I told her to hold on a second, I told her that I had a song that I think she may recognise. She Ooo-ed. I Ooo-ed back. I said to consider this part of the birthday festivities. I set the song up on my phone (hidden in my bag) and pressed play. The song started playing, I lifted my bag with the speaker closer to her ear so she could clearly hear. The music intro at first didn't seem familiar, and then suddenly as the song started and I sang with it (I learnt the song), "Daisy! Daisy! Give me your answer do!". This was a moment to remember. Her yes completely lit up. It was as if I had shown a present to a child on Christmas day. It was as if she couldn't quite believe it was playing. She immediately started singing along even if she got some of the lyrics wrong. She sang loudly and passionately. She even mumbled loudly as if she knew them all. There were two parts of the song that she particularly sang on. These were "Daisy! Daisy! Give me your answer do! I'm half crazy all for the love of you..." and then the end, "Upon a seat, of a bicycle built for two". As we sang, I noticed her eyes beginning to well up, she seemed very moved and overwhelmed by this song. We sang right till the end of this song, just the two of us, in the middle of the hallway. When the song ended she said, "thank you". It was a heartfelt thank you and I recognised this. I thanked her and told her that I hoped it brought her as much joy as it did I. She said, "Oh yes... (pause) Oh yes!"".

This was a meaningful moment for Janet, as well as for me because it impacted us both emotionally. Her joy affected me. I felt joy for and with her. I realised how important music was, how important this was for her, and the effort and thoughtfulness needed over and above sessions in order to have these moments during sessions.

Whilst I had set ideas of what I, as Daisy, could do during sessions, these were merely a guide, and sessions could change accordingly. As Daisy, I shifted and attuned myself to residents and staff in the moment – whatever they needed Daisy to be or do, whatever felt right and necessary for that particular person or group in that time, at that moment.

Inclusivity came across strongly in the journals. Inclusivity from the perspective of including both staff and elderly. As well as all the residents in the common areas – of varying mental and physical capabilities.

The staff appeared to really enjoy themselves during sessions. From those in admin, to those cleaners and nurses in the common room, I felt quite overjoyed at the level of participation. They seemed very willing to play and sing and dance. This work clearly provided an opportunity for them to engage and in doing so, appeared to equally bring them joy (noted in their laughter, their smiles, their dancing). Sessions appeared to fulfil something they needed too. I assumed that working in an elderly care facility could be difficult and challenging at the best of times. Seeing them dance with the elderly and I felt very much like we were one. We were sharing the fun together. All were welcome.

I also appreciated how the elderly were happy to share Daisy with others. After my moment with Janet and her song, she said, "she said to me "you can go and visit all your friends" again". It was sweet how she felt like she needed to tell me this; as if giving me permission.

The role of 'friendship' comes across in the journals. Many of the staff and residents called me their 'friend'. Over the course of the sessions, it appeared that friendship may have been important; having someone to see and validate them; someone to have fun with; someone to speak to. As Daisy, I treated everyone I came in contact with as a friend, and, over the course of the sessions, the staff and elderly really felt like friends. I respected and cared for them. As much as I appeared to make them happy, they made me happy. I appreciated their openness, welcoming attitude, trust and willingness to play with me. It was an honour to be in the home and to connect with them.

Throughout the sessions, the simple act of kindness, appeared to go long way.

Considerations:

An important learning moment stood out in my journals. The case of Petunia and session timing. On the 5th of April, the residents and social workers were late to return to the home after an outing due to bad weather. Rather than cancel, I waited. I was already dressed and I knew the elderly were looking forward to my visit. This was also the second last session and so it felt important. When they finally arrived it was great to see everyone. Of course, timing was now off, and so my session ran into the beginning of their early dinner service. What I experienced was that dinner was a chaotic period. The staff had to manage the elderly who were tired. This experience highlighted the importance of keeping to session times. During dinner, I offered to help hand out avos, playing a bit of a silly waiter. Once done, I tried to make my way out but a staff member called me over, asking if I could play music for two residents. I was hesitant but obliged. Petunia, one of the residents, was someone who loved dancing with me. When I came to them, she pushed her plate aside and wanted to dance. Managing this moment was challenging. Petunia locked onto my arm, and at one point, wanted us to try and escape together. I realised her wanting to leave was actually quite serious - it was not just being playful. I made my way with her to the social workers, for them to support, but they weren't there. Luckily, a nurse was near and I called her over when Petunia wasn't looking. The nurse arrived and I introduced her to "my friend". The nurse, kindly, told Petunia to come with her. Petunia immediately shifted in this moment, it's as if she knew she was not able to go. Petunia thanked me and waved goodbye. We blew each other kisses. The next day, I had spoken with the social worker, but it's as if Petunia did not even remember. She danced with me again, hugged me, and wished me well. Whilst things were okay in the end, it highlighted the importance of sticking to set times, as well as why staff support is equally important to have. The residents are the number one priority, remaining calm in challenging situations is key. Resolve requires patience and, in some cases, staff support. Not breaking character in this case, felt important – removing the nose could have confused her further.

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Owen

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H17/09/26**
PROJECT TITLE	Clowing with death: An investigation into the clown as a drama therapeutic tool in South Africa
INVESTIGATOR(S)	Miss E Owen
SCHOOL/DEPARTMENT	Wits School of Arts/
DATE CONSIDERED	15 September 2017
DECISION OF THE COMMITTEE	Approved
EXPIRY DATE	07 November 2020

DATE 08 November 2017 **CHAIRPERSON** (Professor J Knight)

cc: Supervisor : Mr W Nebe

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

_______________ Signature

____/____/____ Date

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

APPENDIX I

University of the Witwatersrand
Faculty of Humanities

Participant Information Sheet

Research Title

Drama Therapy: The experience of clowning with an elderly group in South Africa

Principle Researcher Name
Emilie Owen

Department
Drama for Life

Degree
M.A. in Drama Therapy (Research Report)

Summary of Research

This Research aims to explore the possible effects of clowning (a playful and comedic style of performance) in an elderly residence in South Africa. These 'effects' include how a group, or individuals within a group, might respond to and engage with a clown character in the space, as well as how they personally reflect on the experience via interview/focus group discussion. It simultaneously aims to document the performer-researcher's subjective experience throughout – as they too participate, observe and experience.

Thus, this research aims to determine if and to what effect the clown could operate as a potential therapeutic tool in adjunct to and in support of existing elderly care, using a drama therapy theoretical foundation and framework to inform, contextualise and assess the work therapeutically.

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<u>APPENDIX I</u>
University of the Witwatersrand

<u>Participant Information Sheet</u>

Good day,

As you know, I have visited your home and engaged with you and the residents as my clown-character 'Miss Whoopsie Daisy', sometimes just referred to as Daisy, on Tuesday and Friday afternoons. These visits, for the past four weeks, have formed part of research pertaining to my Masters in Drama Therapy at the University of the Witwatersrand.

It is with pleasure that I hereby formally invite you to take part in this Focus Group which will reflect on these visits. A Focus Group is a deliberate gathering of a selected diverse group of people (representing a larger population) with the aim of obtaining feedback in connection to a specific product or performance/s.

The session will be guided by a facilitator, named Dr Cameron Harris, who is tasked to obtain feedback through key topics of discussion and questions.

<u>Research Aim</u>
My aim is to explore the role of the clown, as an archetypal figure and method of performance, and determine to what effect the clown, as a vehicle for humour, play, and transgression, could operate as a therapeutic tool for the elderly using a drama therapy theoretical framework within a South African context. This entails engaging with or witnessing/viewing short interactive performances in the form of largely improvised but considered and appropriate Clowning Skits. The clown will be used as tool to invite play, joy, laughter and social-interaction among residents and possible staff of an elderly home.

<u>Research Activity Outline</u>
The aim of the Focus Group is to obtain feedback through set questions and discussion about the clown-based performance interventions. Dr Cameron Harris, a WITS University Professor, will be facilitating the Focus Group. With permission, the session will be recorded with an **Audio Recording device** (**no filming)**. The Focus Group is expected to take between 45 to 60 minutes.

The Focus Group will involve a group discussion based on the visits/performances, particularly around the topics of: humour; clowning; play; and the personal experiences thereof. A copy of the proposed discussion questions is attached on the page titled "<u>Focus Group Topics (Basic Outline)</u>".

<u>N.B.: There are no apparent immediate risks associated with this research. However, should the research procedure awaken any feelings of concern and/or discomfort, you are welcome to contact the counsellor whose contact information can be found on the attached information sheet. The listed counsellor has been notified of this research and can assist you if required.</u>

Anonymity and confidentiality cannot be guaranteed due to the inherent nature of the focus group involving multiple participants, however, anonymity and confidentially (and a general respect for people's opinions/disclosure) is encouraged.

In terms of the written research report, any reference to yourself in the research will be made in the form of an alias. The assigning of aliases is at random. Details as to the availability of the research will be made available when details concerning publishing have been finalised.

Should you have any queries, questions, or comments concerning the research, please do not hesitate to contact me on the attached information form. I would like to thank you for taking the time to consider taking part in this research.

Kind Regards,
Emilie Owen

<u>APPENDIX I</u>
University of the Witwatersrand
Faculty of Humanities

<u>Consent Form</u>

Focus Group

<u>Research Title</u>

Drama Therapy: The experience of clowning with an elderly group in South Africa

<u>Principle Researcher Name:</u>

Emilie Owen

I ______________________________ agree to participate in this research project. The research has been explained to me and I understand what my participation will involve.

I agree that my participation will remain anonymous.	YES	NO	(please circle)
If agreed to the above, I agree to be assigned an alias in the research report.	YES	NO	
I agree that the researcher may use anonymous quotes in his research report.	YES	NO	
I agree that the focus group may be audio recorded for transcription purposes only.	YES	NO	
I agree that the identities, personal details, and opinions of other respondents that may arise out of the focus group, be kept confidential to the best of my abilities.	YES	NO	
I agree that the information I provide may be used anonymously by other researchers following this study.	YES	NO	
I agree that in the event of loss or damage to personal property, injury in any form, loss of income, theft, and/or illness, the University of the Witwatersrand and the researcher (Emilie Owen) along with associated parties, cannot be held liable in any form - financial or otherwise. I understand that I partake in this research at my own risk, and feel comfortable enough that the appropriate measures have been taken to ensure my safety and well-being.	YES	NO	

__________________________ (Signature)

__________________________ Name of Participant) __________________________ (Date)

APPENDIX I

University of the Witwatersrand
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Counselling

If at any time during the research, the interview/s or Focus Group session/s you require the services of a Counsellor, the following HPCSA registered Drama Therapist is on standby to assist you. They can be contacted at:

Contact Person:	Sian Palmer
Website:	www.sianplamer.co.za
Email:	palmer.sian@gmail.com
Contact:	0828549821

APPENDIX I

Emilie Owen
M.A. in Drama Therapy (Research Report) 2018

Student Number: 361361
Title: Drama Therapy: The experience of clowning with an elderly group in South Africa

Focus Group Topics (Basic Outline)

Introduction:
Hello, my name is ___________________________.

Thank you for taking time to participate in this focus group that will reflect on the clown-based interventions, which included visits from Emilie as her clown-character 'Miss Whoopsie Daisy' – sometimes just referred to as Daisy, that you may have witnessed or engaged in. This focus group is part of a larger research project in accessing the use of the clown in South Africa, more specifically in how it might be of benefit towards the elderly and/or staff within an elderly residence as an adjunct to existing care and support. This research is exploring the possible relationship between the clown and therapy/therapeutic benefits.

During this focus group, I will ask questions and facilitate a conversation about Daisy (the relationship of the clown/ the use of clowning) in relation to your personal experience and observations. Please keep in mind that there are no "right" or "wrong" answers to any of the questions I will ask. The purpose is to stimulate conversation and hear the opinions of everyone in the room. I hope you will be comfortable speaking honestly and sharing your feedback with us.

Questions to prompt discussion with a staff group:

1) Question 1: What was your experience of the Daisy visiting – what did you notice? How did you feel?
2) Question 2: Did your feelings change from the first visit to the last?
3) Question 3: Did you find it fun, helpful or useful having Daisy in the space? Why?
4) Question 4: Do you think Daisy had a positive or negative impact on you, as staff, or the residents?
5) Question 5: Can you provide any specific examples? For example, were there any noticeable differences in you, the staff or any of the elderly who participated?
6) Question 6: Would you consider visits from Daisy or these clown-based interventions, 'beneficial' in anyway? Why?
7) Question 7: Would you consider visits from Daisy or these clown-based interventions 'therapeutic'? Why?
8) Questions 8: What do you think of using humour in elderly homes? Do you think humour is beneficial or therapeutic for the elderly and even staff?
9) Question 9: As staff, did you feel visits from Daisy supported the work you are already doing?
10) Question 10: Would you like to have these clown-based interventions happen more often/long term? And why?

Please Note: Slightly different and/or additional questions may arise during Focus Group Session.