

LESSONS FROM THE RED NOSE:
WHAT NURSES CAN LEARN FROM THERAPEUTIC CLOWNS

by

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Abstract

In this qualitative study, seven participants from two volunteer therapeutic clown troupes were interviewed about their experiences in order to discover how clowns and clowning techniques can inform nursing practice, specifically in the art of relationship. Clowning emerged as a complex art, combining the visual elements of the costume, make-up and props with ubiquitous humour, laced with sensitivity and compassion. Participants described having a *vocation* for clowning, with intrinsic motivation and passion. They articulated how their clown costumes and personas provided *emotional shielding*, giving them protection from – while also allowing entrance into – emotionally difficult situations. They also used *judicious humour*, intuiting when, where and how best to use humour in myriad patient situations in a way that brought relief to patients and families. Insights from clowning can help nurses to expand their relational art: In patient settings, when used judiciously, there may be no place where humour is off limits.

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Dedication

To Molly and Keara, my beloved daughters,
who share my humour and with whom I have laughed often.
You both continue to inspire me as I learn more, laugh more and be more.
I hope you always nurture the “inner clown” inside you.

and

To Mom,
who always encouraged me to follow my dreams,
and showed me that determination coupled with faith can overcome almost anything.
You taught me well.

Chapter One – Introduction

Laughter and humour in medicine have existed throughout the ages. Humour's healing potential has been described as far back as the Old Testament: "A joyful heart is the health of the body, but a depressed spirit dries up the bones" (Proverbs 17:22 New American Bible). However, the "science of humour" and humour's positive impact on health have only started to be documented within the last 30 years (Gelkopf, 2011, p. 1). As a natural progression of the use of humour in medicine, there has been a proliferation in the use of clowns in health care settings (Barkmann, Siem, Wessolowski, & Schulte-Markwort, 2013; Koller & Gryski, 2008; Spitzer, 2006). Therapeutic clowns have the ability to establish relationships quickly with patients using humour and minimal verbal communication. They bring a sense of levity and calm to many situations involving pain, suffering and anxiety (Adams, 2002; Nuttman-Shwartz, Scheyer, & Tzioni, 2010; Vagnoli, Caprilli, Robiglio, & Messeri, 2005). Furthermore, clowns have the added benefit of increasing staff engagement, well-being and morale (Barkmann et al., 2013; Blain, Kingsnorth, Stephens, & McKeever, 2011; Linge, 2011). However, clowns are not omnipresent in healthcare settings; nurses, on the other hand, often are. The purpose of this study is to examine stories from therapeutic clowns, to discover how clowns and clowning techniques can inform nursing practice, specifically regarding the art of relationship.

Historical Background

Clowns have been entertaining people for millennia. Clown characters as court jesters or fools have been recorded as far back as the ancient Egyptian pharaohs (Gibson, 2004; Towson, 1976). The court jesters in the Middle Ages, wearing brightly coloured

costumes and floppy three-pointed cloth hats with bells, worked to balance the “humours”. Medieval medicine considered health to be largely governed by four humours: sanguine, melancholic, choleric and phlegmatic. Imbalance of these humours produced distinctive emotional states. The court jester, through music, acrobatics and poetry, would be summoned to lift the monarch out of an angry or melancholic mood (Spitzer, 2006).

The use of clowns for healing in native cultures is also well documented. The Iroquois False Face Society has used masks and clowns for hundreds of years to exorcise illness and evil during spring and fall festivals (Fleming, 2003; Gibson, 2004) and the Hopi, native American Indians, have many sacred clowns who play a role in many aspects of life, including healing (Glasper, Battrick, Prudhoe, & Weaver, 2007; Koller & Gyski, 2008).

The advent of the modern zany and silly clown is attributed to a clown who in the 1860s appeared in a circus in Germany with baggy clothes, large shoes and a big nose. Auguste is a German slang word meaning a stupid, bumbling fool and this is what the audience shouted out to him. This clown carried on in this tradition, working in tandem with a White-face Clown, considered the oldest and most classic clown type. Early in the 20th century, Albert Fratellini, one of three famous clowning brothers, developed the Auguste clown type and is credited with introducing the red nose, which is synonymous with most clowns today. The Ringling Brothers circus clown further honed the character of the Auguste clown and provided the foundation for the modern clown (“History of Clowning”, 2015)

Clowning in hospitals is also not a new concept. According to Spitzer (2006), the Whirling Dervishes in Turkey episodically visited hospitals and used performance skills as part of their care. Further, he goes on to say that the cover of *Le Petit Journal* in September 1908 had a drawing of two clowns working on a children's ward in London. As well, the notable Patch Adams, a young doctor in the 1970's, began clowning for patients in the United States (Spitzer, 2006). He is well known among health professionals as a strong advocate for humour in medicine.

The use of therapeutic clowns in hospitals is said to have begun in North America in 1986 by Michael Christenson, a co-founder of the New York based Big Apple Circus (Barkmann et al., 2013; Kingsnorth, Blain, & McKeever, 2011). The concept has spread rapidly and has now become a popular initiative in acute and rehabilitation hospitals worldwide.

Terminology

The rapid expansion of clowns in health care settings in the last couple of decades has resulted in varying levels of professionalism and accountability, as well as a multitude of terms used to describe the clowns and their work. A review of the literature finds a variety of terms used globally to describe the therapeutic work of these types of clowns. An attempt will be made to explicate some of the differences.

Medical clowns are trained professional performers, often with a background in theatre arts, clowning, mime, acting, magic or music. They undergo rigorous training consisting of aspects of medicine, nursing, psychology, communication and performance arts (Hart, 2012). They are considered to be the most professional of all clowns and are considered integral members of the healthcare team and respected complementary care

providers (Doutores Da Alegria, 2005; Koller & Gryski, 2008). Medical clowning is intense work and therefore is felt to be not sustainable on a full time basis (Spitzer, 2006).

A medical clown can also be known as a clown doctor. Clown doctor groups exist in Europe, Australia, North and South America, as well as Hong Kong and South Africa. Their clown characters evolve from the clown's natural relationship with authority figures; in the circus, this is the ringmaster but in the hospital, it is the doctor (Koller & Gryski, 2008). Clown doctors, with names such as Dr. Do Little and Dr. Achoo, don white lab coats along with red noses and colourful costumes. This helps to make the institutional garment, and the medical staff who wear it, appear friendlier (Koller & Gryski, 2008). Clown doctors always work in pairs to encourage creative performance and to offer professional and emotional support. It is often thought that a partner can facilitate when a clown scenario appears to be getting out of hand (Koller & Gryski, 2008). The Big Apple Circus, in New York City, is the most widely known of the clown programs promoting clown doctors and is the model that a significant number of clown doctor programs around the world are based on.

Clowns often work within Child Life programs in hospitals and indeed, are evident in programs across Canada from Halifax to Vancouver. These clowns tend to be categorized by the term therapeutic clown, as they do not necessarily take on a doctor persona; they may have other personas. The clown's role is to reduce the stress experienced by children and their families. Absurd clothing, red noses, and outrageous props are used but very little make-up is employed; traditional clown make-up can be scary for some children (Spitzer, 2006). Therapeutic clowns within these programs usually work alone. It is felt that this solitariness displays vulnerability and therefore

mirrors the bewilderment of the child in the health care environment; this enables a connection between the clown and the child to be made (Koller & Gryski, 2008).

Caring clowns are sometimes considered to be at the “other end of the spectrum” in terms of professionalism (Koller & Gryski, 2008, p. 17). Although they are still considered to be a type of therapeutic clown, they are most often volunteers with limited clown or fine arts training and less understanding of the role and potential of the therapeutic clown in health care. In some circles, they are considered more entertainers than members of the health care team. Like their counterparts, the medical clowns, they espouse the silly costume and props along with the ubiquitous red nose and minimal face make-up. They also tend to work in pairs, as opposed to solo clowning.

A recent addition to the terminology is elder-clown. These clowns work specifically with the elderly. Again, these may be professionals or volunteers, although professionally trained clowns may be more suited for the demands of working with dementia patients as they received specialized training (Kontos, Miller, Mitchell, & Stirling-Twist, 2015; Low et al., 2013)

Despite some of the distinctions noted above, there is still much ambiguity about the nomenclature of each of the clown groups, including what they represent, how they are trained and how they practice their craft. In many cases, the term “therapeutic clown” is used synonymously with “caring clown”, “clown doctor”, “medical clown” and “hospital clown”, not only in the literature, but also by organizations, clown units and indeed, by the clowns themselves (“History of Caring Clowning in Canada”, 2008). Sometimes, the distinction tends to be made by contrasting those that are professional therapeutic clowns, thereby paid, with those that are volunteers.

While clown doctors or hospital clowns are, by virtue of their name, seen only in hospitals, other forms of therapeutic clowns may clown in many other venues such as homes for the elderly, hospices, and prisons. More recently, therapeutic clowns have gone into areas of the globe where war and suffering are inherent, such as Iran and Afghanistan (Doutores Da Alegria, 2005). This group, Clowns Without Borders, works to reduce psychological stress in refugee camps.

For the purpose of this study, the term therapeutic clown will be used and when the term clown is mentioned, it is always in the context of a therapeutic clown.

Professional Clown Programs in Canada

Paid therapeutic clowns exist only at the largest hospitals in Canada. The Winnipeg Health Sciences Centre had the first therapeutic clown program, started in 1986 and this prototype soon launched a similar program at the Hospital for Sick Children (Sick Kids) in Toronto in 1993. In 1994, the British Columbia (BC) Children's Hospital commenced their therapeutic clown program and in 1999 therapeutic clowning was brought to pediatric facilities in Calgary, Ottawa and London. The Windsor Regional Hospital and its Fools for Health program began in 2001 and the Dr. Clown program started in Montreal in 2002. Any other clown units (or alleys, as they are known) in existence in Canada are volunteer run (Baxter, 2008; "History of Caring Clowning in Canada", 2008).

Rationale for This Study

While the research literature shows that the merits of clown programs and therapeutic clowns cannot be disputed, the competition for health care dollars also cannot be disputed. Paid therapeutic clown programs are seen as an extravagance and a luxury

that few hospitals can afford; clown programs are often one of the first programs to be cut in favour of more tangible things like equipment or health care workers (Duffin, 2009).

Volunteer clown programs, on the other hand, require extensive training, set-up and buy-in from hospital and facility administration, as well as willing volunteers to run the program. Reliance on donations to fund either paid or volunteer programs is often not feasible.

In addition, in technologically advanced healthcare with minimal staffing, nurses have become increasingly task oriented at the risk of patient relationships and communication (Duffin, 2009). Could nurses adapt aspects of therapeutic clowns, including their ability to use humour in connecting with patients? If so, it might be possible for nurses to not only do the work that is required of them, but to do it in a way that helps to keep levity at the forefront, forging a relationship with the patient through humour. Indeed, this may even aid the patient in their healing as humour has been shown to be a valuable form of complementary medicine. By interviewing volunteer therapeutic clowns and by hearing their stories regarding their craft, their clowning techniques, and their ability to connect with people, the hope is that transferable, simple and effective means will be found.

Purpose and Research Questions

The purpose of this study is to explore the stories of therapeutic clowns in order to discover how clowns and clowning techniques can inform nursing practice. The primary research questions are:

1. What do therapeutic clowns perceive as influences in their becoming a therapeutic clown?

2. What attributes do participants perceive as necessary to be a therapeutic clown?
3. How do the participants describe the skills and techniques that are required to be proficient in their work?
4. In what manner do the participants choose their costumes and props to reflect their clown character or persona and influence their clowning techniques?
5. What are the participants' perceptions of their purpose and their role in the health care system?

Study Method

A qualitative approach was deemed the most appropriate method to answer the research questions. The study sought to understand the phenomenon of therapeutic clowns and the rich data provided by this type of method works best. Specifically, interpretive description methodology was utilized because of its focus on nursing clinical practice. Seven volunteer therapeutic clowns from two cities took part in the study; all had similar clowning training. Interviews were conducted using a semi-structured approach and photographs were included as a collateral data source. A thematic analysis was completed on the data.

Outline of Paper

This thesis is presented in six chapters. In the first chapter, the study topic is introduced and the research question is provided. In addition, the historical background, a description of terminology and rationale for the study is presented, along with the specific research questions. Chapter Two outlines the literature review, including the search and retrieval strategies along with an overview of current literature. The gaps in existing knowledge are highlighted. The third chapter details the research design,

methodology and related procedures. It includes a description of the sampling, data collection and analysis process as well as scientific quality and ethical considerations. Chapter Four discusses the study findings by way of themes, while the fifth chapter provides a discussion of these findings within the scope of the current literature. The sixth and final chapter provides conclusions, limitations to the study, recommendations arising from the study including suggestions for future research. References and appendices conclude the thesis.

Chapter Two – Literature Review

A review of the literature was carried out to help inform and substantiate the need for the study. Perusing the literature and the “state of science” about a clinical problem allows one to confirm, or perhaps challenge, that a problem is worth studying and to determine who has already studied it, how they have done it, and what conclusions have been reached thus far (Thorne, 2008, p. 54). This chapter describes the literature review, including the search and retrieval strategies, along with the findings of the review.

Search and Retrieval Strategies

The literature review provided a current understanding of therapeutic clowns; a broad based focus was pursued in order to fully elucidate their work. This widened focus helped to gain a comprehensive understanding of the global movement of therapeutic clowning in addition to the research being undertaken worldwide. As the concept of medical clowns is relatively recent, there were no limitations set as to dates of the articles. It was interesting to note that several of the countries where therapeutic clowning seems to be well established, such as Israel for example, have generated a number of the scholarly articles. Some of these were available in English, but others were in their native languages and published in more regionalized journals. Regardless, their contribution to the scholarly discourse was noted. During the course of the study, literature searches were conducted periodically in order to obtain the most current literature.

A literature search was conducted using CINAHL, PubMed, Medline, PsychInfo, Web of Science, and Google Scholar databases. The keywords used were “clown”, “therapeutic clown”, “clown care”, “clown doctor” and “hospital clown”. These were

then linked to “therapeutic play”, “complementary care” and “nursing”. While most of the citations were found through databases, a number of other search strategies were employed. Reference and bibliographic lists kept by various therapeutic clown organizations were also consulted; it appears that there is global interest in the growing body of research knowledge. A search of other unpublished or “grey literature” was also conducted. Relevant dissertations and theses were found through a variety of means. Ancestry searches were found to be valuable as were conference proceedings; this type of searching provided useful sources not found in the databases such as service evaluation reports or unpublished reports.

Literature was found from the disciplines of nursing, medicine, psychology, anthropology and the creative arts. Many of the citations found were either anecdotal or informational in nature, however. While they were interesting to read, added to my body of knowledge surrounding therapeutic clowns in general and were instrumental in development of this study, they did not provide much scholarly background in which to situate this study. However, there were a few relevant studies found that are worthy of discussion. These will be discussed in further detail.

Literature Review

The discussion of the literature review will focus on what scholars have been studying in relation to therapeutic clowns, what methods they have employed in generating understanding and the findings they have developed. These scholarly articles are grouped together by similar inquiries.

Literature related to the pediatric population. Research on the topic of therapeutic clowns tends to focus heavily on their work with the pediatric population.

There have been a number of studies that look at the effect that clowns have on children pre-operatively (Fernandes & Arriaga, 2010; Golan, Tighe, Dobija, Perel, & Keiden, 2009; Messina et al., 2014; Porat, Lerman, & Kara, 2014; Vagnoli, Caprilli, & Messeri, 2010; Vagnoli et al., 2005). These studies are all suggestive that clown interventions show a reduction in anxiety and stress. An Italian study investigated the possible positive effects of the presence of a clown in children with respiratory pathologies and concluded that the presence of clowns had a possible health-enhancing effect (Bertini, Isola, Paolone, & Curcio, 2011). Tener, Lang-Franco, Ofir, and Lev-Wiesel (2012) investigated the use of therapeutic clowns during medical examination of children who had been sexually abused; they reported that children experienced less fear and lower pain levels. The study of the effect of therapeutic clowns on disabled children demonstrated a direct physiological impact as well as an overall positive effect on mood and well-being (Kingsnorth et al., 2011).

The use of clowns in distracting techniques for invasive procedures has been studied and found to be effective in reducing pain in children in two studies, one dealing with intravenous access in an emergency department and the other dealing with intra-articular corticosteroid injections (Uziel, Weintraub, Rabinowicz, Hanuka, Rothschild, & Kotzki, 2014; Wolyniez, Rimon, Scolnik, Gruber, Tavor, Haviv, & Glatstein, 2012). However, clown presence appeared to be of no significance in two pilot studies conducted by the same researchers (Gorfinkle, Slater, Bagiella, Tager, & Labinsky, 1998). Of interest, however, is that in one of the two pilot studies, doctors and nurses found procedures easier to perform in the presence of clowns; yet, in the other pilot study, doctors found the procedure more difficult to perform with the clowns present. The

effect of clowns was studied in the treatment of children with botulinum injections (Hansen, Kibaek, Martinussen, Kragh, & Hejl, 2011). The duration of the child's crying was used as an indicator of the effect of the clown's presence. There was found to be no effect on children being treated for the first time, but in subsequent treatments, there was a positive effect of the female clown in relation to girls and a negative effect on boys younger than 8 years of age. This is the only reviewed study that considers a gender perspective.

All the above-mentioned studies tend to be quantitative in nature focusing on the use of observational scales, self-reporting questionnaires or various other clinical assessment measurements. However, Linge (2012), in her research work in Sweden, used qualitative methods exclusively. Her aim was to achieve a theoretical understanding of the experience of children with a hospital clown. She suggested that clowns represent a "magical safe area" between fantasy and reality. In addition, a qualitative study, also from Sweden, interviewed children and documented observational studies in an effort to elucidate their perceptions of clowns (Mansson, Elfving, Petersson, Wahl, & Tunell, 2013). The children viewed the clowns' visits as fun and helped make them feel at home; they were able to focus on something other than their illness.

Literature related to the adult population. There are limited studies on the effects of clowns on adults. Nuttman-Shwartz et al. (2010) did a qualitative study to understand the essence of intervention by medical clowns among adults with chronic illnesses; the authors analyzed reports of medical clowns using content analysis. In addition, research from Israel in the area of fertility suggests that a woman's chances of getting pregnant after in vitro fertilization were increased when a clown was brought in to

help her relax after implantation (Friedler et al., 2011). In a psychological study from Switzerland, research was done to understand the emotional reaction of adults to hospital clowns (Auerbach, Hofmann, Platt, & Ruch, 2014). Videos of hospital clown interventions were observed and were compared with emotional experiences induced in observers watching videos of circus clowns and then nurses. Circus clowns and nurses were selected because their work overlaps with the work of a hospital clown; circus clowns share some skills and entertaining capacity while nurses share caring elements. A list of clown specific ratings, the 29 Clown Emotion List (CLEM-29) was developed. The research gives an overview of the complexity of emotional reactions induced by clowns, which the study's researchers feel, is underestimated in the existing research on hospital clown interventions and their effect on patients' well-being (Auerbach et al., 2014).

In a study from Finland, the experience of parents with children in clown care services was explored through phenomenology (Tan, Metsällä, & Hannula, 2014). It was found that clown care creates a positive emotional state, promotes interaction between parents and their children and fosters affirmative environmental conditions. Clown care can also be associated with some negative experiences and the authors recommend recognizing barriers such as severity of the medical condition or developmental level of the child in order to improve clown care services (Tan, Metsällä, & Hannula, 2014).

Literature related to the geriatric population. "Elder-clowns" and their interactions with hospitalized and residential geriatric populations is generating interest as the concept becomes more popular; it is in the early stages of academic inquiry. Low et al. (2013) studied the effects of elder-clowns on nursing home residents in Australia;

they demonstrated lowered anxiety and agitation levels following interactions with clowns. Elder-clowns are also the focus of a very recent study in Canada (Kontos et al., 2015). During a twelve-week program with long-term care residents, elder-clowns' practice and techniques were examined through qualitative interviews and ethnographic observations. Findings highlighted the reciprocal nature of clown-resident engagement, which was termed "relational presence" (Kontos et al., 2015, p. 7).

Literature related to healthcare staff. Linge (2011), once again in an attempt to fully explore a theoretical understanding of hospital clowns' work, interviewed healthcare staff about the clown's work with children (2011). Her qualitative study found the "staff emphasized a psychological quality of care alongside the physical quality of care" (p. 7) as well as "joy without demands" which had a lingering effect in the form of vitality (p. 8). Blain et al. (2011) also explored the effects of therapeutic clowning on healthcare staff by using a mixed methods approach on nurses, testing both physiological parameters and conducting interviews. This study found that participating nurses experienced physiological changes, as well as self-reported mood changes, on the days the clown visited. In addition, the clowns "had a relational effect, enhancing communication between team members, positively affecting nurse-patient relationships, and improving the overall mood and atmosphere of the unit" (p. 10).

Further research with healthcare staff has shown similar beneficial effects. Koller and Gryski (2008) studied the effects of therapeutic clowning as a form of complementary health care, reporting on a survey conducted with hospital staff and parents. Just under half of the respondents stated that they experienced the clowns as a

support for their own work and nearly all of them evaluated the clown program as beneficial.

Literature related to the clown's perspective. There is very little research solely related to the perspective of the clown. Glasper, Prudhoe, and Weaver (2007) interviewed clowns on what worked best or least during pediatric encounters. They found that the clown's primary mission was to be fully present to the sick child, while maintaining spontaneity during their interactions (p. 26). In addition, the results showed that clown doctors view their role very seriously and seem themselves as valued members of the healthcare team. Linge (2008), in her first of many qualitative studies on clowns, wished to elucidate what features and working methods existed with clowns. She showed that clowns working in pairs could create different opportunities than working solely. They could "develop a sequence together, and stimulate each other in various encounters with children and staff" (p. 31).

Traditional clown periodicals and newsletters often report from the clown's perspective; however, these seldom address scholarly literature on the effects of clowning (Snowberg, n.d).

There is little to no literature that focuses on the clown's costume. Most references to the costuming are brief descriptions or pictorial illustrations; scholarly research articles contain neither of these.

Literature related to multiple groups. Rather than focusing on a particular subject group or specific treatment, several researchers chose to focus on multiple groups during their study, which provides a greater overall understanding of the impact of therapeutic clowns in a setting. Barkmann et al. (2013) surveyed hospital clowns, staff

and parents in a hospital in Germany in a three-part study. Each part of the study was analyzed separately. Although the hospital clowns were not yet fully integrated into the hospital routines, it was felt that they would be perceived as effective intervention for alleviating suffering and pain. The most significant findings for the clowns related to wanting increased recognition for their work, interdisciplinary contact and financial support. Staff and parents responded positively to the effect of the clowns on their pediatric patients. Staff reported that they would like more clown visits on the wards as they “viewed the performances as an enrichment of the daily routine” (Barkmann et al., 2013, p. 7).

In another recent qualitative study, children and their families, staff and the clown doctors were part of focus groups, observation and semi-structured interviews (Ford, Courtney-Pratt, Tesch, & Johnson, 2014). There was agreement across the perspectives that the clowns had impact in the immediate encounter. However, an important finding in this study was that there was impact beyond the immediate interaction. Mementoes left behind by the clown doctors gave a basis for discussion amongst children, families and staff and enhanced relationships. The authors noted that sometimes the clown doctors were not aware of the impact they had beyond the moment of interaction. Nurses reported learning about interacting with children from the clown doctors and “inspired them to work in new ways” (Ford et al, 2014, p. 294). The clowns reported that the research process itself impacted their work, self-reflection and self-evaluation.

Linge (2013) did a meta-analysis of her three part qualitative work with clowns, staff and children. She describes her findings from all three groups as three aspects of quality of care: *a quality of care that transcends boundaries, a non-demanding quality of*

care, and a defusing quality of care. She reported positive effects on the healthcare team such as elevated mood, increased morale, satisfaction of staff and better collaboration.

Literature related to current research focus. The only literature and research directly related to this study is an article by Duffin (2009) and Leef and Hallas (2013). Duffin's discussion paper outlines the development of workshops where performers from the New York's Big Apple Circus (regarded as the founder of therapeutic clowning) help nurses develop a heightened sense of their surroundings and the people they encounter (Duffin, 2009). Big Apple Circus founder, Michael Christensen, states that there are "parallels between clowns and nurses in that both are groups of professionals who can improve their performance by understanding their client groups better" and "if nurses can sense patients' moods, they will have better ideas about how to help them and will not simply carry out their duties mechanically" (Duffin, 2009, pg. 22). While there is no evidence that the clown techniques work, Mr. Christensen did report that nurses responded well to the workshop and stated that 91% of nurses were given ideas that would be considered useful in their practice. Further, clown activities "put staff in a better frame of mind" (Duffin, 2009, p. 24).

Leef and Hallas (2013), in their work with pediatric nursing students, became fascinated with the clown therapy and the therapeutic communication and sensitivity clowns used while engaging with patients. They coordinated sensitivity training workshops for nursing students and engaged clowns from the Big Apple Circus to help educate the students in sensitivity training. It was felt that the clown's ability to make a connection with patients would be an asset to nurses, as a large component of nurses' work currently is technical, causing patient relationships to suffer (Leef & Hallas, 2013).

Their research evaluated the long-term effectiveness of the workshop using a Likert scale. The majority of students reported, “applying the principles of engagement to increase patient compliance” and “using [*sic*] principles to identify and process their own stress and emotions” (Leef & Hallas, 2013, p. 263).

Chapter Summary

This chapter reviewed the current literature on therapeutic clowns. Although there are a number of articles from a variety of disciplines on clowns, many of the articles are discussion pieces; relatively few research studies related to clowns exist. The available research tends to focus mainly on the effect of the clown on the pediatric population. In most of the literature reviewed, whether scholarly articles or not, the authors unanimously agreed that there is a paucity of research regarding therapeutic clowns. Even those hospitals that have clown therapy programs in place seem to have little evidence to underpin the efficacy of their intervention. As therapeutic clowning becomes more widespread in healthcare, research is needed to both validate and give credibility to this form of care and researchers are urged to direct their attentions to more extensive research on all aspects of clowning. Specifically, there is a distinct gap in the literature around the focus of this study – comparisons between therapeutic clowning and nursing. In addition, the lack of discussion about aspects of the clown costume, which seems as integral to the clown’s work as the magic, music or movements employed by the clown, has highlighted the necessity to explore this aspect further.

The next chapter will discuss the research method utilized for this study.

Chapter Three – Research Design, Methodology, and Procedures

The purpose of this study was to explore the stories of therapeutic clowns in an effort to discover how clowns and clowning techniques could inform nursing practice. This chapter provides a description of the research method used to generate the knowledge necessary to address the purpose and answer the research questions presented in the first chapter. The chapter begins with an overview of interpretive description which is the qualitative research method employed; this helps to not only situate the study but also provides a foundation for further discussion. Following this, a detailed description of the study method is outlined, including sampling, data collection and data analysis. The chapter concludes with an examination of the ethical considerations as well as a description of the scientific quality of the study.

Interpretive Description Research Methodology

The purpose of this study was to explore the phenomenon of interest – therapeutic clowns; therefore, a qualitative approach was used. Polit and Beck (2008) state that the goal of qualitative research is “developing a rich understanding of a phenomenon” (p. 220). In the past, much of the qualitative research examining health or health behaviours was conducted using the three dominant qualitative methodologies: grounded theory, ethnography and phenomenology. These were developed within the disciplines of sociology, anthropology and philosophy respectively. However, the unique demands of nursing science require an approach that differs from these more traditional qualitative methods of research. Interpretive description research methodology works well since it is a method more grounded in nursing epistemological foundations, adheres to the systematic reasoning of the nursing discipline and yields legitimate knowledge for

nursing practice (Thorne, 2008; Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). As this project seeks to not only explore the phenomenon of therapeutic clowns, but also to seek what lessons nurses could learn from them for use in clinical practice, it is well suited for an interpretive description approach.

Interpretive description is a methodology aligned with a constructivist and naturalistic orientation to inquiry. It acknowledges the constructed and contextual nature of human experience while concurrently allowing for shared realities (Thorne et al., 1997; Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004). The philosophical framework assumes that “absolute, wholly objective knowledge is unattainable through empirical analysis” (Hunt, 2009, p. 1285). As well, the researcher and those who are researched together create understandings. The “inquirer and the ‘object’ of that inquiry interact to influence one another” (Thorne, 2008, p. 74). Lastly, no *a priori* theory can account for the phenomenon under study. These represent the epistemological foundation of interpretive inquiry that Thorne (2008) acknowledges are informed by the naturalistic inquiry tradition of Lincoln and Guba (1985). This philosophical framework, as described, is congruent with the purpose and scope of this project; I worked alongside those being interviewed to create clinical insight sourced from subjective and experiential knowledge.

This methodology acknowledges that a researcher brings theoretical and practical knowledge to a project. A researcher’s prior knowledge of a phenomenon under study is “considered to be a platform on which to design the project, and helps to establish its anticipated boundaries” (Hunt, 2009, p. 1285). Clinical expertise is acknowledged and this “theoretical baggage” (Thorne, 2008, p. 54) plays a significant role in shaping the

study. This approach also helps to expose how assumptions and preconceptions influence the design and development of the research (Hunt, 2009). This acknowledgement of a researcher's role within the study works well with this project; I had some previous practical knowledge about therapeutic clowning through personal friendship with a therapeutic clown as well as her own attendance at a clown workshop. Indeed, I was influenced by this "theoretical baggage" when shaping the project (Thorne, 2008, p. 54).

This particular research topic has not been previously explored and therefore, the inductive analytic approach indicative of interpretive description will help to illuminate the characteristics, patterns and structure of this phenomena so that credible and legitimate nursing knowledge, the knowledge that is required for clinical practice, is generated (Thorne et al., 1997; Thorne et al., 2004). The research products should inform clinical practice, not by creating a new truth but a "tentative truth claim" (Thorne et al., 2004, p. 7) about what is common within a clinical phenomenon.

Interpretive description as a methodology was a good fit for the structure and aims of this project on many levels. Its methodological elements will be elaborated on in the following section.

Methodology Procedures

Sampling. Thorne et al. (1997) contends that "people who have lived with certain experiences are often the best source of expert knowledge about those experiences" (p. 174). The population of interest in this study was therapeutic clowns volunteering in a hospital environment within Canada, as it is their experiences the study sought to understand.

Purposive sampling was used for this study as it provides information-rich cases and selects participants based on their particular knowledge of a phenomenon (Speziale & Carpenter, 2007). I was aided in selecting this type of sampling by the ideas of Thorne (2008) who states that purposive sampling is a more representative sampling technique as “the settings and specific individuals within them are recruited by virtue of some angle of the experience that they might help us better understand” (p. 90). Indeed, in this study, I was interested in therapeutic clowns with minimal fine arts, drama and clowning training, as their experiences would be the best to extrapolate to nurses. Therapeutic clowns with extensive training and those who make a career out of clowning would be far too dissimilar in background and training to be able to make any comparisons or cogent claims for nursing.

The participants were recruited from two Canadian therapeutic clown troupes in two cities located within relatively close geographic proximity to each other. It was known in advance that both these clown troupes were volunteer-based with clown training consisting of a weekend workshop. The clowns volunteer at two different community hospitals as well as a variety of seniors’ facilities; this provided a much broader perspective on clowning. Clowns within these two groups are both male and female and both genders were sought for participation in order to possibly discern gendered perspectives.

A key informant for each clown troupe had already been established, one through my previous participation in a clown training workshop and the other through personal friendship. It was felt that this relationship may have expedited entrée into the groups and would be a factor in aiding recruitment. For example, the clown workshop

participation the previous year had introduced me to some of the clowns in one of the troupes and had provided an opportunity to give a very early overview of the intended study. In addition, the personal friendship with one of the clowns in the other clown troupe provided a possible entry into that group. When asking for the dissemination of the initial recruitment request, the personal relationship was noted and the interest in therapeutic clowns was attributed to her. Following Research Ethics Board (REB) approval, an e-mail letter outlining the project and requesting volunteer participation was sent to the president of each of the clown troupes (see Appendix A). They were asked to disseminate the e-mail to the clowns having membership within the troupe. The participants were asked to contact me either by e-mail or by phone if they wished to be a study participant.

Despite my perceived entrée into the clown troupes, and prior interest in the study expressed by some of the therapeutic clowns, initial recruitment was slow. As the introduction and invitation to the study was done by e-mail as a virtual, rather than face-to-face request, I felt a more personalized recruitment request would facilitate participation. Following discussion with the thesis supervisor and with a related review of the REB submission, I attended the monthly meeting of one of the two clown groups, where a presentation was done regarding the study and recruitment posters were distributed (see Appendix B). This personalized introduction to the study had the desired effect by generating interest within the one clown troupe and several clowns volunteered to participate not only that same evening, but also in the ensuing weeks. Volunteers were limited to these two clown troupes due primarily to time constraints but also due to the financial considerations of travel. I did not live close to the clown troupes and therefore

had to travel to conduct interviews. Extending beyond these two clown troupes to garner further participants was unnecessary as there were sufficient numbers of participants recruited between the two troupes. Inclusion criteria included those clowns identified as being a part of one of the two clown troupes, English speaking, and available for a face-to-face interview. Retired clowns were included in the inclusion criteria provided they had retired within the last two years. This distinction was made so that their recollections and memories of events would be maximized.

Interpretive description methodology uses relatively small samples. Thorne (2008) states there is no firm and fast rule regarding what constitutes the right sample size for an interpretive description study and it is up to the researcher to make a defensible claim about the proposed number of subjects (p. 96). Time and resources can “become a reasonable element in the decision to constrain sampling” (Thorne, 2008, p. 96) and indeed these were important considerations in this study. The one clown troupe has membership around eighteen to twenty-one members, but the other troupe has significantly reduced numbers due to advancing age and health reasons. Their membership is very small with numbers less than ten members. Considering all these factors, the study’s aim was to interview between six and ten therapeutic clowns to garner sufficient comparative data for analysis. Ultimately, seven participants agreed to participate in interviews. Several clowns indicated interest in participating in the research after sufficient numbers had been reached; unfortunately, in the interest of time, their participation was gratefully declined. However, their names were noted in the event that the available data was not sufficient and they would be required for further data collection. One clown, who did not wish to participate in a face-to-face interview citing a

concern about time, wrote a detailed e-mail outlining some of her thoughts on clowning. While this was not used in the data analysis in the same way as the interviews – nuances, speech inflections and the ability to expand on and clarify statements was lacking – it was found to substantiate much of what the other therapeutic clowns had said. I used it as a collateral data source akin to the fieldnotes.

The idea of theoretical sampling was one that I explored while engaging in initial data collection and analysis, especially knowing that several participants were as yet untapped sources of data. However, while the general principle of theoretical sampling is sound, that of “explicitly seeking maximal variation on relevant phenomena that seem central to the focus of the study” (Thorne, 2008, pg. 92), the idea of seeking out contrary cases in such a small study seemed daunting. Indeed, Thorne et al. (1997) provides a word of warning in saying “caution must be applied to the use of single representatives of a specific position in our attempts to achieve maximal variation on any theme. Because no research subject ever represents the essence of a single variable and none other, serious errors can be made if we misinterpret the contributions of individual participants.”(p. 173). Ultimately, I felt it would be enough to use the principle of theoretical sampling when discussing the limitations on interpreting the findings, an idea also endorsed by Thorne et al. (2007).

The concept of saturation is one that is not espoused by interpretive description proponents. The claim of saturation – that no new variations on the theory will emerge from additional data collection – is one that Thorne (2008) feels is problematic when trying to fully understand all that is potentially relevant about a phenomenon. Therefore, the sample limits as expressed above, are justified while acknowledging, “there would

always be more to study” (Thorne, 2008, p. 98). Indeed, I experienced this tension when declining further participants to the study, believing that perhaps the richest data was yet to be found in those participants, while trying to maintain the practical aspects of the study, specifically time constraints.

While entrée to the groups, by either involvement in the workshop or personal friendship, may have aided in recruitment, I also simultaneously acknowledge potential bias and undue influence that this may have produced. I was aware that certain participants might volunteer to participate based on a relationship stemming from the clown workshop – either fellow workshop attendees or workshop leaders. In actuality, all the participants were unknown to me, except for the personal friend. I attempted to use this participant as a last resort only, recognizing that the friendship would cause bias and might alter the course of the interview. Indeed, it was only after this particular participant had already been interviewed, that three other participants came forward to volunteer. As mentioned previously, in the interest of time, their participation was declined. The interview with the friend was conducted in the same manner as the other participants, but it is unknown whether the information provided would have differed if I had been unknown to the participant. Reflexive notes kept during the interviewing period, identified that perhaps I was a bit more reluctant to direct the interview as much as she might have done in the other interviews as the interview had a more conversational tone to it. However, in the use of this friend as participant, I was encouraged by the words of Morse (2003, as cited in Polit & Beck, 2008) who states that “biasphobia” can undermine good qualitative research and that the best case should be pursued, as opposed to the average. The choice in using this friend, a seasoned therapeutic clown who had

frequently taught the workshop, was underscored by Morse's advice to "start with excellent examples of the phenomenon being studied" before examining weaker instances (2003, as cited in Polit & Beck, 2008, p. 356).

I attempted to overcome other types of sampling bias by having participants from two different communities, gender representation, as well as having participants situated across the novice to expert clown continuum as discussed in the next section.

Description of sample. Demographic data was obtained from all participants in order to provide a description of the study sample characteristics. Polit and Beck (2008) state that "this information is critical in interpreting results and understanding the population to whom the findings can be generalized" (p. 376). The demographic collection tool used in this study is found in Appendix C. Seven participants consented to participate; four were from one clown troupe and three were from the other clown troupe. Six of the participants were female and one was male; all were Caucasian. They had all completed some form of post-secondary education by way of various certifications and courses. Two had partially completed university and one had a degree from a polytechnic institution. Their previous occupations were varied; only one participant had experience in healthcare, as a former care aide. The participants' ages ranged from 58 to 82 years, with the majority of members (four) being in their seventies. Their clowning experience ranged from two years to fifteen years, with five of the participants having between twelve and fifteen years of clowning experience. All the participants had done an initial weekend training workshop held either in the city where they resided or the neighboring city. The training provided in both cities was very similar in content and design; the original workshop held in the one city informed the workshop developed in the other city.

Two of the participants had done other workshops elsewhere as a form of continuing education and three of the participants had also taught the workshop on occasion. The participants reported clowning between one and five times a month with the majority clowning between two to three times per month. All participants were actively clowning with the exception of one participant who was retired from clowning. However, as per the inclusion criteria, they were included as retirement had been within the last two years.

Data collection. This section describes the data collection process of this study. Thorne (2008) observes that this terminology is a misnomer as one is not so much collecting data as much as “constructing an understanding of what constitutes data and how [one] articulates it as such” (p. 123). In this study, the data collection came from multiple data sources; various sources are used to provide triangulation and contribute to the trustworthiness of the findings that are generated. Alternative data sources are an additional point of view and do not require separate methodological arguments for analysis (Thorne, 2008). Interviews were the primary source of data for this study, but photographs were also used as an alternate angle of vision. In addition, the use of the “thoughtful clinician” (Thorne, 2008, p. 84) added another dimension to the data. Each of these will be discussed further.

Interviews with therapeutic clowns were conducted between March 2015 and May 2015. Six interviews with seven participants took place. Two of the interviews were conducted in meeting rooms in public libraries and four interviews were done in participants’ homes, according to participant preference. Both locations proved adequate for interviewing in terms of privacy and ensuring confidentiality. Interviews lasted approximately ninety minutes in length; the final thirty minutes or so was mainly viewing

and photographing costumes and props. While the interviews could have been conducted via online means, I felt it was important to conduct face-to-face interviews to observe body language and have eye contact in order to help interpret what was being said. In addition, I anticipated that some of the content of the interviews could be sensitive; this is easier to respond accordingly when one is present (Tod, 2006).

When using the public spaces, the participants brought a variety of their props and in once instance, the participant also brought their costume. In the other instance, a photograph of their costume was provided. One participant was actually interviewed while in costume as they had just returned home from a clowning experience. In three instances, I was given photographs as opposed to having the opportunity to photograph the actual costume; there was no difference in the data collected by this method. These photographs were copied and were returned to the participants by mail. Interviews lasted approximately ninety minutes in length; the last thirty minutes or so was mainly viewing and photographing costumes and props.

Two participants, who clown together as a pair, requested to be interviewed at the same time. Their rationale for this request was that they could add to the other's narrative by prompting each other's memory of events, adding context to the stories that might be lacking in detail if they were interviewed separately. This idea of co-interviewing as a means of generating enhanced and enriched data was one that I had not considered. This request was discussed with the thesis supervisor who confirmed that such co-interviewing was sometimes appropriate (S. Grypma, personal communication, March 6, 2015). Following an amendment to the consent form and related REB approval (see Ethical Considerations), they were interviewed together as requested. I commenced interviewing

the two participants directing a research question to one participant first, followed by the other participant. However, true to their original reason for co-interviewing, they did start to prompt each other, add to the other's stories, or sometime correct the narrative especially in the recounting of some of the more emotive content. It did not seem appropriate to change the interview style at that time. Their reciprocal answering is made apparent in Chapter Four when quotes are attributed to them jointly. The effect of the synergy experienced in this type of joint interview is discussed further under data analysis.

Before the interviews commenced, the consent form (see Appendix D) was reviewed, when necessary, and signed. Time was allowed for questions and the data-recording device was checked for viability. A brief overview of the study's rationale was given along with a general expression of gratitude for the participant's time. A semi-structured interview style was undertaken with predetermined topics and open-ended questions asked in a sequential manner (see Appendix E). As a way to open the interview, the participants were asked how they commenced clowning; more challenging and complex questions were added later. The flow and trajectory of the participant's conversation determined when some of the questions were used; participants were allowed to go on at length at times and questions were not always asked in a linear fashion. Prompts were used when necessary to get participants to reflect further on a theme, or to get back on track. If a particular question had not been addressed, it was raised at a convenient break in the conversation. This tendency to have less structure and more depth to the interview is one endorsed by Tod (2006) when exploring a phenomenon where little previous knowledge exists regarding the area of study. As this

was the case with this study, it was felt to have value, even though the interviews were longer than anticipated in both conducting and transcribing. Fieldnotes were written up directly following the interview.

I found that her interview style was somewhat conversational. This became apparent during transcription of the interviews. Ideally, interviewers are neutral agents through whom questions and answers are passed (Polit & Beck, 2008). There was opportunity to change this in subsequent interviews; however, I felt that this style of interviewing lent itself to the participants relating more personal stories, those with more emotive content. Indeed, even while conducting oneself as an interviewer, it was difficult for me not to react on a more personal level at times and this no doubt affected responses to some extent (Polit & Beck, 2008).

The use of photographs was built into the original research design; these were to be used as a source of data alongside the interviews in this study. Thorne et al. (1997) notes that for the purposes of interpretive description, “appropriate collateral data sources often are available for...researchers interested in expanding the scope of their inquiry” (p. 174). Interpretive description’s inductive analytic approach will generate common themes, no matter the data source, as long as the perspectives from each inform the other (Thorne, 2008).

When using multiple data collection strategies, the idea is to match what one is studying with the data sources most likely to produce meaningful results (Thorne, 2008). As the clown’s costume and use of props are such inherently integral pieces of the clown’s purpose and persona, the photographs added context to the oral data collection. In addition, the costume acted as a variant form of photo elicitation; this occurred both

with its visual presence during the interview in real-time or as the subject of a provided photograph. The participant, in describing the costume often expanded on ideas previously discussed or exhibited behaviours that were noted in fieldnotes. Pink (2007) suggests that “we should not treat the visual as an add-on, but as an integrated aspect of the experience of interviewing or interacting with informants” (p. 365).

In some cases, I was able to take the photographs of both costumes and props at the time of the interview and in several instances the participants provided me with photographs. The clowns were made aware that if the photographs were used in the thesis, any identifying features would be removed.

Of note, however, is that while the original research design considered the photographs as being included in the final thesis write-up, it became apparent during the study that this would not be possible. The clown costumes and props are so distinctive to the individual clowns that, despite any attempts at anonymizing the photographs, it would be impossible to do so and participants could be recognized solely on the basis of their costume. However, this did not prevent me from using the photographs as part of the data analysis and indeed, the pictures of the clown costumes and props proved to be a valuable additional data source. This is discussed further in the next chapter on the study findings.

While qualitative research characterizes the *researcher as instrument*, and the idea that the researcher affects what is studied is acknowledged (Speziale & Carpenter, 2007), interpretive description goes further with the notion of the “thoughtful clinician” (Thorne, 2008, p. 84). Thorne (2008) maintains that the thoughtful clinician can be viewed as a potentially valuable data source and asserts this is often neglected in qualitative health

research designs. Further, the point is made that triangulating what a thoughtful clinician has observed with what others have experienced can be quite powerful. In this study, I came with the aforementioned “theoretical baggage”. My participation in a clown training workshop the previous year allowed me to have somewhat of an *emic* view and a subjective experience of therapeutic clowning that provided insights not otherwise available. Furthermore, as a nurse with a modicum of experience in humour in healthcare, this thoughtful clinician viewpoint can be of value when triangulating what the participants have related about patients, nurses, humour and healthcare.

No matter the data source and how it is collected, be it interview, photographs or “thoughtful clinician”, all elements are necessary to “look broadly at the phenomenon, scanning a wide circle of possibly relevant information about it” (Thorne, 2008, p. 123). The data analysis – making sense of the data – is discussed next.

Data analysis. There is no “recipe” for data analysis in interpretive description and while this frees one up to be creative and for intuition to take over, there is some inherent anxiety in the lack of structure as well. Data analysis occurs concurrently with data collection and I found that in the collection of the data, in the mulling over of the interviews, in the transcription process, and even in the examination of the photographs, certain ideas surfaced, and then were dismissed, only to resurface again at some point in the analysis.

I transcribed the interviews. While time consuming, this exercise is valuable on so many levels. Thorne (2008) encourages neophyte researchers to engage in the transcription process and indeed, the ability to listen to the voices, to hear the pauses, the hesitations and the tremulous nuances provides a level of richness to the data which

would otherwise be missed. In addition, listening to the interviews over and over helps to solidify feelings evoked at the time of the interview.

The co-interview, mentioned previously, had its own set of considerations for analysis. When the participants responded independently within the interview, I considered the data to be from two sources and this was analyzed accordingly. When the participants contributed to the narrative together, I took this as one voice and one source. However, it should be noted that there was a palpable synergy created when the narratives were given in tandem and this synergy contributed to the analysis and eventual findings.

Data analysis was iterative thematic or conceptual analysis. After the interviews were transcribed, they were read through multiple times, both individually and sometimes as a collection of two or three. This iteration helped me to see emerging patterns between and amongst the data. Initial notes were made in the side margins through this process; these were often my emerging thoughts or initial coding. These initial codes were broad-based and quite generic; despite this, I felt that coding still felt rigid and encumbered. Coding was replaced by the use of marginal memos. As suggested by Thorne (2008), marginal memos, highlighted to represent thematic similarities, are generally “more consistent with the evolving analytic thought of interpretive description” (p. 147). Through iteration and reflection, similarities and differences emerged and eventually these data bits became thematically related. This process is reinforced by Speziale and Carpenter (2007), who suggest clustering these data bits or ideas into meaningful units, as well as Thorne (2008), who describes these steps in data analysis as moving from “pieces to patterns” (p. 142). Themes seemed to develop not only within categories but cut

across them as corroborated by Polit and Beck (2008). A set of analytic notes, with jottings, questions, and all manner of random thoughts served to keep all the key elements together and aided in the eventual analytic findings.

While, on the surface, this analytic process is succinctly outlined and appears straightforward, it does not fully express the complexity of the data analysis process. The hard work and significant time investment could make inexperienced researchers easily prone to several pitfalls (Thorne, 2008). I was very cognizant of this admonition and attempted to avoid premature closure, misinterpreting frequency and over-inscription of self; each of these can lead to misinterpretation of meaning and lead to discreditable findings (Thorne, 2008).

As a way to critique the analysis, I went back to the literature to see how certain researchers might view elements or to determine if they had similar insights. One particularly prolific qualitative expert's work was consulted (Linge, 2008, 2011, 2012) and helped me determine that the particular angle of vision used in this study was sound.

I followed up with one of the participants to get further clarification on a statement they had made. It was a meaningful statement and the clarification was necessary to explicate it fully in the findings; I did not want to misrepresent the participant. This was not a member check, which implies that findings are taken back to the participants for validation; indeed, no member checks were done in this study. Thorne (2008) discourages the use of member checks suggesting it can lead to false confidence or conversely, derail the researcher from good analytic interpretation. In this case, the participant was able to provide context to the statement, which was valuable when discussing the findings.

I briefly considered the use of qualitative research software for theme generation. However, it was dismissed as having any real value because it cannot conduct inductive analysis; its use is mainly for data management (Thorne, 2008). Thorne (2008) states that it “can be supportive of your analytic process, not a replacement for it” (p. 138). I followed Thorne’s (2008) directive that new researchers should consider possibilities within basic word-processing programs.

Lastly, the various thematic elements were worked into a logical and coherent organizational structure for discussion. While this also took time and effort, the result is an effective appreciation for the context of the phenomenon and a way to present the findings in a sensible and organized manner. Ultimately, it allows the reader to extend their understanding of the phenomenon – the purpose of interpretive description.

Ethical Considerations

Qualitative research is subject to the same general guidelines that apply to any research involving human subjects. Issues of consent, confidentiality and privacy, and relationships between researchers and participants need to be considered in the design, review and conduct of the research. Some issues may be identified during the design phase, and some may arise during the actual research itself (Canadian Institutes of Health Research, 2014). Both of these scenarios became evident in this study and will be discussed further.

Ethical approval for this study was obtained from the Trinity Western University (TWU) Research Ethics Board (REB) on February 12, 2015. In the ethics approval submission form, I disclosed that one of the potential participants was a family friend. There was, however, no power relationship in place. One of the board members noted

that while the ethics approval submission form stated that a reflexive journal would be kept, they were unsure how this would work to address bias. However, they went on to say that it was a research design issue only, with no ethical ramifications (TWU REB Chair, personal communication, February 12, 2015). This particular point was duly noted at the time and was considered during sampling. It was discussed when reviewing sampling decisions.

The initial recruitment request was disseminated through a central contact person within each clown troupe; participants were asked to contact me directly to indicate interest in the study in order to preserve confidentiality. However, in two instances I was not contacted directly by the participants but rather heard through two different third party sources that the aforementioned participants were interested in participating. A significant length of time passed while waiting for the participants to contact me. When no contact was made and it was made clear that the participants were waiting for me to contact them, contact information was obtained and I contacted the participants. The thesis supervisor was consulted and provided feedback on any potential ethical ramifications of this slight change in recruitment procedure.

Following initial recruitment efforts, it became apparent that an amendment to the original consent form was needed. Speziale and Carpenter (2007) state that in qualitative research “the ethical aspects of the research process will always require ongoing critique and evaluation” (p. 59). This truism became apparent with the request from two of the participants to interview together. This was previously discussed under sampling. The original consent did not cover confidentiality when interviewing more than one person at a time and therefore the consent was revised to include this provision; the REB was

provided with the rationale when a request for an amended ethics approval was sought. The amended approval was received on March 16, 2015. One interview was completed using the original consent and subsequent interviews were all done using the revised consent regardless of whether there was one interviewee or two.

An informed consent was obtained from each participant prior to the data collection. This was sent by e-mail to each participant prior to the interview in order that they could preview it in advance and prepare any questions. At the time of the interview, each participant stated that they had indeed reviewed it and had no further questions; therefore, the consent was not reviewed again in the interest of time. A hard copy of the consent was signed and each participant was given a copy. The consent was detailed in that it contained the purpose of the study, the study procedures, confidentiality, risks and benefits of participation, ethics and researcher contact information. The participants were reminded that their participation was voluntary and they could withdraw from the study at any time.

Each participant was assigned an identification (ID) number; the identification number was used for the interview transcript of the study results. Additionally, photographs of the clown's costume were identified with the same ID number. Initially, I felt that the clown's photograph could be anonymized and incorporated into the study through the removal of the face from the photograph; ethics approval was received on this basis. As mentioned previously, however, it became apparent that the distinctiveness of the clown's costume would identify them regardless of any attempts at anonymizing. In order to preserve the confidential nature of the study, the costumes have been described with broad descriptors only and no photographs have been incorporated into

the written findings. In addition, the communities the participants live in, the facilities where they clown, their clown names and any other identifiable information were excluded when writing the findings.

Demographic data, signed consents, interview recordings, transcribed data and photographs were and will continue to be used and managed as outlined in the consent; this will achieve maximal confidentiality and anonymity.

No funding was obtained for this study.

Scientific Quality

In a qualitative research study such as this, issues of rigor and credibility are important considerations as it demonstrates that it is “a respectable approach to science” (Speziale & Carpenter, 2007, p. 48). In addition, it helps to accurately represent participants’ experiences. Credibility has been embedded throughout this study in a variety of ways. I made considerable effort to align the study with the principles of interpretive description methodology and to create an audit trail that documents decisions, and critical self-reflections. This enhances the trustworthiness and reproducibility of the study.

Rigor of this study was supported by the reflexive notes used to record thought processes, decisions and activities throughout the research process. As a neophyte researcher, there was value in recording the decision making process around all aspects of the study. Reflexivity situates one within the research process and helps to analyze what is influencing the researcher’s responses and how the researcher’s beliefs, values, experiences and interests may influence collected data. Jootun, McGhee, and Marland (2009) state that reflexivity is an “invaluable tool to promote understanding of the

phenomenon under study and the researcher's role" (p. 42) and as such, is an important auxiliary data collection method.

Fieldnotes were a part of the reflexive notes; they were written following each interview. These fieldnotes included personal reflections on the interview, key ideas that arose and detailed a broad, analytical perspective of the interview.

During data analysis, detailed notes on the analytic process were kept. These notes help trace the development of abstractions, the analytic reasoning process and assist with judging the extent to which the analysis is based within the data. They helped to "retrace the development of abstractions and ... ensure that the analytic directions are defensible (Thorne et al., 1997, p. 175). In addition, the thesis supervisor reviewed the findings and added insight to the analytic process.

Triangulation further contributed to the rigor of the study. Method triangulation through the use of multiple methods of data collection (analysis of costume and props photographs triangulated with oral interviews) helped to develop a "consistent and coherent picture of the phenomenon" (Polit & Beck, 2008, p. 543). In addition, by collecting data from participants in two different locations, the study was able to incorporate space triangulation and differentiate between characteristics specific to certain sites (Speziale & Carpenter, 2007). The use of thoughtful clinician, as discussed previously, provides additional trustworthiness to the study.

Limitations of the study will be addressed in Chapter Six.

Chapter Summary

This chapter provides a detailed description of the interpretive description research method and its suitability as a qualitative methodology for this study. Sampling

decisions were discussed. Ultimately, data was collected from seven participants through face-to-face interviews and photographs; data was subsequently transcribed and analyzed through an iterative process. Ethics approval for this study was obtained from the Research Ethics Board of Trinity Western University. Finally, a discussion of the scientific quality of the study was provided. The study findings are presented in the next chapter.

Chapter Four – Study Findings

This study set out to explore what lessons, if any, therapeutic clowns can teach nurses, specifically in the art of relationship. This chapter presents the results of the analysis of the study participants' rich data as obtained from interviews and photographs. Participants were guided in their stories by answering a series of interview questions designed to provide maximal insight into therapeutic clowns and their work. Five themes were identified from the data: *the clown within*; *the wholistic clown*; *the "magical" clown*; *the transcendent clown*; and an overarching theme, *the clown's role in healthcare*. Each theme consists of various subthemes; all serve to provide context and substantiate the main theme.

The themes move in a natural progression from a focus on the individual clown in the first and second theme, to the clown in a relational dynamic with others in Theme Three and Theme Four. The final theme is an overarching theme that outlines the role of the therapeutic clown in healthcare. As a note of consideration, however, that while the themes move in a linear fashion, they do not all seemingly carry the same degree of significance, quality or emotive content. However, as in the famous quote by Aristotle, "The whole is greater than the sum of its parts" (Aristotle, n.d.), the constituent parts are all necessary to adequately represent the gestalt of the therapeutic clown. Moreover, I have taken some liberties during analysis specifically by teasing out varied aspects of a single concept, thereby sometimes using one example to illustrate more than one construct. The clown's costume is one such example of this; its meaning is multilayered and is therefore used to illustrate several different subthemes.

Theme One: The Clown Within

This theme developed initially from the first question posed in the interview. That question, which queried the reasons why the participant first chose to undertake clown training, was easily answered by all the participants and highlighted certain characteristics that all participants possessed. However, as is the case with qualitative research, this theme was underscored throughout the interviews in far more subtle ways giving rise to various subthemes. Each subtheme, as described below, gives the participants' perspective of the "inner clown" in each of them.

Self-identification. The participants were drawn to clowning for various reasons, but they all suggested that even prior to the training, they had some innate clown characteristics, identifying qualities such as humour or quirkiness. The following excerpt illustrates this point:

I also used to work at one of the seniors care home here in town. That's where I learned about the caring clowns. Because [clown name] and [clown name] would come down and visit the clients. And when they came in there, I thought, I could easily be one of these. I decided, I approached them and said, "You know, I can do this!" When I told my family, I was going to do a clown course and become a clown, my family said, "What do you mean *become* [with emphasis]?"

Another participant stated:

It was better than I thought. I've always thought of myself as having a sense of humour and whether I do or not is open to interpretation but I like word play, spontaneity, the sort of slapstick approach. I've done a lot of skits here and in the army, and stuff. So I sort of fell into it, I think quite naturally.

Yet another participant liked the idea of clowning because it was different:

You were giving to people, helping them at a stressful time in their life. Both she and I were looking for something that was a little different, that was giving to people. She has been a volunteer for years. I've never volunteered in the hospital. Ever. So this was brand new to me. I didn't know the rules and regulations but she did. I think the idea; I really like things that are different.

All the participants sought out the clown training on their own initiative with the exception of one participant; she stated that she had been steered towards clowning by another therapeutic clown. This excerpt explains why:

There was a girl, who came from Calgary who was a clown, therapeutic. She approached me. She said, "I think you should become a clown." And I said, "Really?" And I said, "Oh, I don't think so." She said "Yeah!" And I said, "What makes you say that?" She said, "Well, I've watched you and I really like your eyes and I like your demeanour."

With these words, the friend intimated that the participant would make a good clown and encouraged her to do the clown-training workshop. In addition, the friend gave her a money back guarantee - if the participant did not like it, the friend would pay for the workshop. As it turned out, this guarantee did not have to be exercised; the participant described awakening through the night following the first evening of training, with clear insight to the "clown inside her." She describes it in this excerpt:

I woke up at a quarter to three in the morning, got up and filled out the whole ten pages [thoughts about a clown character] in about twenty minutes. And once I got through the whole three days and whatever, I realized, because they kept saying

that everybody has something inside of them that is dying to just get out and multiply and whatever. And I thought well, for heaven's sake! Because I didn't think that I was an outgoing person at all. I was quite happy, I love to paint and do needlework. You know, quite happy with myself. You know, I can stay right inside myself quite nicely. I was really amazed!

A persona and name as a natural fit. The clown character that is adopted by clowns is known as a persona; it is a reflection of an aspect of one's self and sometimes their physical attributes. Often, the clown's name works in tandem with the clown's persona as a descriptor or enhancement of the character. The participants related how determining a clown persona and name was relatively easy for them; most often they had one main persona and name with which they felt particularly comfortable. The persona or name seemed to reflect bits of themselves, somewhat of an "alter ego" in some cases, but for some participants it was more of an extrapolation of themselves. In a couple of instances, their clown name was a new take on their already existing name as illustrated in this participant's explanation of the name and character adopted:

Yes, the workshop invited you to invent or come up with a persona. My surname is [name] and at school I was called [clown name]. And it seemed a natural name for a clown. And I wanted to be a tramp, sort of a classical down and out tramp. You know, like Charlie Chaplin, who was a hero of mine.

An especially poignant story related how the participant used the name her toddler grandson had once called her as her clown name. She had looked after the toddler's sibling from his birth until his death from a terminal condition. When the sibling died, the toddler inexplicably stopped calling his grandmother by that name:

[Clown name] was a name that my grandson called me. From the time he could talk, he called me [clown name]. We don't know why. It has such great meaning to me. He called me [clown name] from the day he could speak until his brother died. When his brother died, he quit calling me [clown name]. He started calling me Grandma. When I asked him why, he said, “[Brother’s name] is gone and [clown name] is gone. Now you're Grandma.” He was two! Yeah. So when I took the course, and needed a name, I thought, there isn't a better name.

She summed it up by saying, “It was a meaning of love to me. It was a name of love.”

Another participant described her inner clown as being a remnant from childhood and even obtained a prop to help illustrate the name:

[Clown name] just came to me. I wanted to name a dog, if I ever got a dog, I was going to name him “Banjo”. It’s catchy. But then, I used to play drums when I was really young. Terrible at it! So I thought, what about [clown name]? It has a kinda neat ring to it.

Generous by nature. The commitment to be a clown is not one to be taken lightly. It requires an extensive time commitment that requires one to go with the ebb and flow of the patients’ needs, as opposed to a predetermined amount of time. Several of the clowns mentioned that they were not bound by time and if they sensed that a patient required more time, they would provide it. The following excerpts illustrate just this point:

Well, we would have been there until six o'clock that night if that's what they wanted. That's what you do. We know that when we go to these places. If that's what you need to do, that's part of the commitment. Because whatever else you

have planned, in my mind, unless it's extraordinary, that's more important. That's what we're there for, I believe.

This participant reiterated this idea when stating, "You read where the patient is and you respond. Whether it's a few minutes or it's twenty-seven minutes".

Further on the point of time commitment, several of the participants mentioned that it was not unusual to clown for extended periods of time, sometimes up to six or more hours at a time. They preferred to clown for longer because of the time it took to dress, apply their make-up, and adapt their clown persona; the time involved in preparatory work was offset by the length of the clowning. However, the clowns also mentioned the mental exhaustion that followed any clowning experiences and that longer periods of clowning also worked best in order to reduce the occurrence of this. This knowledge of expected fatigue seems to show a subtle generosity of spirit as the participants mentioned having to plan their life around this, demonstrating that clowning and those benefitting from it would always come first with these participants. The following participant summed it up:

When I first went to class, they said, don't plan anything else. Don't be thinking you'll go home, go out for dinner and be the life of the party. Once you go home, nothing will happen until you get into the shower and get out of your costume and start to unpeel, and then you might have to have a nap. And boy, oh boy, you sure can [have a nap].

Furthermore, the participants were altruistic in many other capacities other than clowning; each participant mentioned volunteering time and talents to myriad groups and causes. This information was presented more as offhand comments in relation to

something else as opposed to the participants attempting to highlight this fact or promote themselves in any way.

Of a fiscal nature, is the generosity shown by the participants when it comes to the resources required for clowning. Each clown purchases their own costume or sometimes many costumes, props, stickers, and give-away items. In some cases, this can be quite a substantial outlay. The costume and props are discussed further in this paper in the second theme, but suffice it to say at this point that the financial cost associated with clowning can be quite high. The participants, however, unanimously shrugged this off with one participant nonchalantly stating, “it is just the cost of doing business”. It appears that the participants view the clowning accoutrements as essential.

Clowning is integral. The participants, without exception, talked of their love for clowning and how they will clown until they cannot do it any more for either physical or mental health reasons. Indeed, as mentioned previously, the only participant that is no longer actively clowning has had to retire due to ongoing physical health challenges affecting stamina, not because of loss of interest in clowning. When asked if they would continue to clown indefinitely, the following participant illustrated their passion when saying, “Yes, as long as I am able. I couldn't see not doing it.” Another participant echoed this sentiment with “Probably. Some days I think, I can't do this anymore, but I think, no, I can't give it up!” This appears to demonstrate the participants’ devotion to clowning and how being a clown is a requisite part of their lives.

The various subthemes described above and the excerpts that illustrate them seem to acknowledge that those that are initially drawn to therapeutic clowning and stay with clowning have intrinsic clown characteristics. Some clown characteristics are more

obvious than others, but all are present in some form or another. Some of these characteristics may even have persisted from childhood, as demonstrated by the clown who had always seen Charlie Chaplin as a “hero”. These qualities are far more than just being a class clown, or having the ability to tell a good joke; none of the participants ever described their inner clown as being akin to this. While they describe humour as a quality, it is more as a way to bring levity to people, or to simply extract a smile. Indeed the inner clown that most of them alluded to seemed almost intangible, a certain something that people saw in them, or a desire to give back in a rather unique way.

It is important to note here that not all people that do the clown workshop stay with clowning. Participants related that while training weekends might host up to ten or more interested clowning enthusiasts, often there were only a couple (or even less) that remained clowning. They were not able to articulate the exact reason for this, but surmised that perhaps these initiates either lacked the necessary time to get involved in clowning or discovered that therapeutic clowning was not what they had envisioned. As there is a lot of time and money spent on organizing and conducting these training workshops, one participant expressed that, “we might need to do a better job of screening attendees [for the clown workshop]”.

The participants self-identified something within them that created the desire to clown, they found personas and names that were meaningful, they will clown as long as conceivably possible because they can’t imagine doing otherwise, and they all exemplify a generous and giving nature. The participants have revealed a passion for what they do, often stating “I love it!” when describing their work as a therapeutic clown. Passion derives from excitement, a curiosity, or a drive; it is a strong internal emotion. The

participants in this study appear to have commenced their clowning with some internal spark of passion, perhaps not even realizing its initial existence. The spark inside them seems to have been flamed by the clown training, fueled by their clowning experiences and maintained by their love of clowning. According to the participants, their inner clown, or the clown within, was necessary to commence their therapeutic clown work and is still necessary to sustain it.

Theme Two – The Wholistic Clown

The second theme moves from the more abstract concept of intrinsic factors detailed in Theme One to something more concrete. The data analysis provided much insight into the therapeutic clown as a wholistic entity; each component makes important contributions to the overall concept of a therapeutic clown. A couple of the subthemes are more visually oriented, such as the costume and the props, while the remaining subtheme is more action oriented, such as the quips and icebreakers used to establish relationships with patients. The attributes of the clown, as a subtheme, are included within Theme Two. They are features that participants indicated could be learned, adapted, expanded and taken on, much like the costume and props. This is in contrast to the intrinsic factors mentioned in the first theme. Those seemed to pre-exist in the clowns and were not things that ostensibly could be learned; they were already established. Like the costume and the props, the attributes contribute to the wholistic clown. All the parts are interconnected; one without the other fails to fully capture the quintessential therapeutic clown.

Costume. Ask anyone, from the very young to the very old, to describe a clown and they will undoubtedly articulate something involving a wig, a painted face,

outlandish clothes and more. The participants tend to follow these same parameters in the construction of their costumes. The costumes are personalized to the clown's persona and can easily identify the clown regardless of whether the clown's face is showing or not. This was noted previously in the third chapter when discussing data collection; it is hard to anonymize the costume to make it more generic. Pictures or individual descriptors are not included here for this reason. However, broad-based generalizations along with insights about the participants' costumes have been mentioned.

The participants seem to use the costume as a way to express creativity. Many of the clowns have created their own costumes by sewing them and in this way are able to impart a bit of themselves into it; they choose fabric and designs that appeal to them and add components that are reflective of their individual tastes. The costumes are generally very bold visually, with vivid patterns and bright colours designed to catch one's attention. This participant reinforced this when saying, "...I like bright and I figure a clown should be in your face, in a nice way!" The costumes are also conversation starters - another form of ice breaker with people - as demonstrated with overly large shoes, tiny hats, multi-coloured stockings or any other feature designed to elicit comments from those that interact with them. This participant summed it up succinctly by stating, "My costume makes people talk to me as well!" The costumes are practical in many ways with numerous large pockets for carrying things and are loose and comfortable for extended wear. They are easy to launder which helps to fulfill an important infection control aspect.

When describing their costumes, either the real garment or in a photograph, the participants showed much enthusiasm and great interest, expressing that their costumes

are “fun”. The participants appear to have great attachment to their costumes and are enthusiastic about how it helps them portray their persona, how it serves them in their clowning and even what it personally means to them. One participant described one of her costume layers as “my maternity dress from when I was expecting my last son and it is forty-five years old” and adding emphatically, “it still works!” She layers a colourful apron and frills over top of it. Further, this same participant wears a wig that her sister gave her following chemotherapy treatment for cancer. Her sister eventually succumbed to cancer but had asked that the participant wear her wig as part of her clown outfit. She continues to do so and when relating the story of her costume pieces, she seems to indicate that this is far more than just repurposing articles. She takes pleasure in these aspects of her costume as being meaningful and significant for her:

She [sister] is a part of me. And she was in remission when she asked me. And she had seen me wearing it and she was perfectly happy with all of it. She is with me always. My whole costume has a story.

A few of the participants had more than one costume. When asked how they decided which one to wear on any particular day, the following excerpt helps to explain it:

It’s what perks me up when I go down there, or the weather. It’s just like getting dressed in the morning. How did you decide what to wear there? It’s just a whim, basically. I have more dilemmas figuring out what shoes to wear.

Sometimes I’ll mix them up and have a green and a pink one.

It appears that clowns, in choosing a costume for weather, also have to choose practicality over pleasure sometimes.

While other aspects of the clown costume vary amongst the participants, the one constant is the red nose. The costume description provided by each participant included a glimpse at the ubiquitous red nose, described by one participant as “the world’s smallest mask”, a quote attributed to a famous clown apparently. Another participant, when relating a situation in which she did not have time to get her full costume on, felt that if she had “just [grabbed] a red nose” it would have sufficed as a costume. With the exception of one participant who eschewed the applied red nose because she found it hard to breathe and opted for a painted on one instead, all the participants wore professional glue-on noses.

The make-up used by the clowns is also an essential part of the costume. Participants describe the make-up as being something that “evolves over time to what feels comfortable”. One participant described how their make-up changed from their initial clowning experiences to their current regime. The participant stated, “To me, it [the original made up face] was too much. It wasn't me.” indicating that the make-up needs to be reflective of the person wearing it. Another participant reinforced the minimal approach to make-up used by most therapeutic clowns when saying, “A lot of make-up has left the clowns, that go into the hospital. They've reduced a lot of make-up.”

It is worth mentioning here that while this subtheme deals with the visual nature of the costume, a more philosophical view of the costume will be discussed in the next themes.

Props. “Prop” is the more commonly used terminology for the more formal “property”; this is a term used widely in performance arts. A prop is any object used

intentionally by the clowns as part of their clowning. It is distinct from the costume but has a number of different uses. It may have practical purposes such as the “drums” made by one participant to hold her jokes and other clowning paraphernalia:

For the longest time, I had two coffee cans [for drums]. I had decorated them up. I covered them with MacTac. And then put clown faces and all stuff on it. And then in the inside, I carried most of that stuff. So I don't need a bag.

Most of the time, however, the props are used as icebreakers with patients as a way to initiate conversation, immediately make a connection, or provide a means of garnering a laugh. For example, participants related how a puppet may be used as a way to initiate conversation, a visual magic trick might be used to engage a patient, or an imaginary dog with only the leash visible can be employed to get a wry smile from even the most short tempered, sleep deprived, and ill patients. The participants displayed a number of props and disclosed how these have been lovingly gathered over the years to form a wide-ranging collection. The props range from more expensive talking puppets to things they have created (such as a “holey” Bible which is a large book with holes created in it) to dollar store finds. They can be outrageous (a picture of a cat which is a “Cat scan”) to utilitarian, like the aforementioned magic trick. The following excerpt show how the props are used:

I have one of these [magic] change purses, do you know them? And if appropriate, I have the relative do that. It might be their dad or whatever, it doesn't matter. I'll ask them, "Do you want to do some magic?" And twenty-nine out of thirty say yes and you do this thing. Again, it's ice breaking, it's a laugh

and they are forgetting about hospitals, operations and all that stuff. It's not world shattering but you do what you can.

Stickers are a type of prop and participants use them constantly for patients and visitors. Most of the time they have a smiley face or some phrase on them. The clowns will use them to initiate conversation as illustrated in the following excerpt:

I give out stickers because I can stick them on their water bottle or on their coffee cup. And my joke always is, "I'd love to put the sticker on you, but it means I would have to stay and do all the laundry!" and that is perfect [to start conversation].

One participant related how stickers are used with the staff as a way to maintain a relationship with them:

We give out a lot of stickers, I find them very useful. But I give out about a fifth of my stickers to the staff. Because they're human beings, they are part of the system, you don't walk past them like they are not there. I often stop and might say, "You're improperly dressed!" and get my stickers out and give them one and they love that. I think it's important to make relationships with staff. You mightn't see the same one again [but] that's not the point.

As related by the participants, the props are a necessity for a therapeutic clown as an aid in gaining entrée to a patient's space and establishing a connection.

Personal attributes. As a part of the wholistic clown and as important as the costume and props already discussed, the participants relate that the personal attributes, or characteristics, of a therapeutic clown also contribute to their effectiveness. The participants were thoughtful when discussing attributes; it was one of the research

questions posed as a way to find out what constitutes a therapeutic clown, beyond the visual aspects. The attributes discussed by the participants are qualities that they often had to learn, initially in training, or sometimes on the job. Sometimes participants felt the attributes were qualities that might have previously existed but then had to be fostered by watching others.

Humour was discussed in the first theme as an intrinsic factor described in a broad context. However, when several of the participants described humour as a clown attribute, they narrowed it down to the need for self-deprecating humour as opposed to an all-inclusive humour. This participant expressed this idea by saying, “I put myself down, often. I think that's a valid humour. Not the other person, [but] me. I put myself down and it gets results.” This participant, echoing the same sentiment, said, “You have to be able to laugh at yourself. I'm not out there to laugh at anybody else.”

Humour in the form of “word play” as one participant named it, is effective for therapeutic clowns. Word play is a form of wit in which the words that are used become the main subject, primarily for effect or amusement (“Word Play”, 2015). Examples of this can be puns, double entendres, or phonetic mix-ups. One participant, pronouncing themselves as an avid proponent of this type of humour, regaled me with this witty word play: “Unfortunately, today in the English Channel, a ship carrying red paint collided with a ship carrying blue paint. The crew is understood to be *marooned* [emphasis added].”

Sometimes participants do not recognize humour in what they have said and yet, “somebody finds [a statement] hilarious and you’re just thinking, hmm [wondering what

was funny]? But for the moment...it just kind of works out that way, that...whatever you said was funny.”

The participants mentioned the ability to think quickly on their feet as being another essential attribute. As they enter and exit a patient’s space promptly and need to establish a connection quickly, they expressed the need to have an icebreaker, a quip or some comment as being integral. This did not come easy to some participants but again was established as a learned behaviour. One of the participants mentioned learning a valuable lesson right at the beginning of her clowning experience:

What you don't say is, “Hi, how are you today?” That's the biggest oops going, because if they were fine, they wouldn't be here. You say, “Hi, how did you get a room like this? Can you give me a recommendation as to how I can check in when you check out?” You've got to make it funny.

The participants highlighted the need to be able to find something in the room or something involving their props or on their costume that they could open up with immediately as an icebreaker. This participant will joke, “Holy mackerel, how many girlfriends can a guy have!” when there are a number of female family members around a bed.

However, the attribute discussed most often and one that appeared to have the most significance to the participants as it surfaced repeatedly in variant ways was sensitivity. Participants couched this in numerous ways – empathy, compassion, warmth, patience, humility, and being non-judgmental – but what they all seemed to be articulating was sensitivity toward the patient. Participants were asked what attributes are essential for therapeutic clowns; this participant felt it was important to “be open, to be

sensitive, [and] you have to be sensitive to other people's feelings. [You need to be] a good listener, and just love people. I think that's the biggest thing.” Another participant expressed this thought:

I'm very big, for want of a better word, on sensitivity and I think, that's one of the essentials. Empathy and a sensitivity. Somebody once said, good manners isn't really what fork that you use. It's a sensitiveness towards the other person. So I try to keep my antenna out all the time.

This same participant also said that one must be “sensitive to their [patient's] feelings” and further elaborated by saying, “You can always say [you should be] ‘politically correct’ or something. You don't want to overstep the boundaries about what they want to discuss or feel or anything like that. [You need] to know how to react with them.”

Sensitivity was also articulated as the ability to “read” people, discerning from a patient's body language and facial expressions whether the clown would be welcome, how long the clown should stay and how the interaction should evolve:

Judging people, I think I read somewhere once, rightly or wrongly, you judge people within half a second or so and I think that's very important going into a hospital. Facial expressions, body language, the way people talk. You've got to judge them right away and I think adapt your response to them. The first thing we do is ask at the nurses' station, “Can we come in and perform and what rooms can we not go in?” And having got that, you then go to any room that you can, you knock on the door and say, “Would you like a visit?” Their body language tells you, sometimes they shake their head and say no and you say, “Okay, we'll see you next time.” But I try to read people instantly and go from there.

Yet another participant articulated skills needed for “reading people, being able to adjust to where they are and listening rather than talking.”

In the following excerpt, the participant speaks of humility, honesty and mindfulness. As previously mentioned, these attributes all speak to a sensitivity shown to the patient through various avenues. Knowing that it is the clown that a patient would want to interact with, not the person inside the costume, the participant articulates the sensitivity involved in putting one’s self aside in order to let the clown persona shine through:

It almost sounds arrogant to say it, but I think there has to be a lot of humility. Even though you are doing all of this, it's still me out of the way and it's [the clown] and the other person. The person that has to be the perfectionist or whatever, she is back there somewhere and you have to make sure she stays back there so that [clown name] can come out and connect with the other person. I find that, that was one of the difficult things I had to do for a while. But I think you are absolutely correct, [another attribute is] honesty, in emotion, in word and deed. And [being] very mindful. Of what you say, how you say it and when you say it.

In summary, while components of the clown – the costume, the props, the personal attributes – can all exist independently of one another, it seems that they are most significant when they contribute together to produce the wholistic clown.

Theme Three – The “Magical” Clown

The third theme moves from the more individualistic properties of the therapeutic clown, as discussed in the first and second themes, to a discussion of the relational

aspects of the clown. It is the theme that seems to really express the rather mystical aspects of therapeutic clowns and their effect on the people they interact with. The participants related this theme in many ways throughout their stories but the descriptor that seems best in summing it up is “magical”. According to the online Oxford dictionary, “magical” denotes something “beautiful or delightful in a way that seems removed from everyday life” (“Magical”, 2015). Indeed, the participants related that therapeutic clowns do marvelous things from dissolving discontent to creating space and opportunity for people to express their vulnerabilities. Their perception is that their encounters are not commonplace, but rather unique and alluring.

Dissolving discontent. The participants related that the therapeutic clown seems to have the ability to “magically” dissolve discontent via the lighthearted way they relate to people or by virtue of their appearance. Whatever the reason, peoples’ temperaments appear to change quickly and rather wondrously, according to the participants; few people seem to be immune to the clown’s charms. This participant related how this diffusion worked on one particularly ill-tempered elderly man:

I have also had a nurse tell me, “Under no condition go into room so and so because that guy is so cranky!” And you go past the door and he is yelling for you to come in. And I'll say, “Oh, just a minute, I have to go get permission” and I'll go back to the main station and I will say “He's asking for me, should I just talk to him from the door?” And they will say, “Oh for gosh sake's, go on in and see him.” And honestly, you go on in and get him going. Well, one day this nurse said to me, “This man hasn't done anything for us for 10 days. Why don't

you just stay here until he's better and goes home?" Because he changed completely!

Another participant remarked about the change in demeanour in this excerpt:

I remember, she just opened the door a crack and she sort of peeked through and said, "What do you want?" "Well, [person's name] told us we had to come see you." But at first she said she didn't want us to come in, and so we said, "Fine, maybe we can come back at some other time." Then she changed her mind and said, "Oh, come in." And before we knew it, we had her whole family history. It was amazing.

Not only does the therapeutic clown have the ability to soften the disposition of patients, but the participants also described the therapeutic clown as being just as remarkable when it came to changing their own moods. Many of them describe how they sometimes lack the motivation to go clowning. As described previously, it can be exhausting work and they don't always have the impetus to go. In addition, sometimes they are not physically feeling well. However, once the clown costume is donned and their persona is adopted, their mood changes:

You might have had a row with your wife, you might have had bad news about your investment but you put the face on and that's all forgotten. If I'm not feeling well, it doesn't matter what the problem is, that's pushed to the background, almost magically. Let's say somehow you've got a stone in your shoe, which ordinarily would upset you and you'd have to stop and get it. That fades into the background I find, when I'm clowning. It's only when I come out, that it hurts. For me, it's almost magical. It's like placebos and things.

This participant remarked on her physical limitations and how that is overcome:

Oh, lots of times [not wanting to clown]. Do I really feel like going out? My ankles are swollen up like a balloon, when my hips were really bad. But you know, you've made a commitment. But still, once you've got that costume on and you get out there, everything else is forgotten and I'm back where I belong.

When describing the effect of the therapeutic clown on malcontents, either patients or themselves, the participants claim that being a therapeutic clown works to eradicate ill humour with the potential to create new possibility for relationship. This participant summed it up well, feeling that “for the most part, clowns have a good reputation for making moods lighter, for just making a better space.”

Magic shield. One of the very interesting phenomena discovered within the participants' stories was their belief in the ability of the clown persona and costume, indeed the very essence of the clown itself, to create a somewhat “magical shield” or barrier. The participants felt this worked as a protective element for the real person inside the clown costume. In a touching story, a participant recalled how a young man who was dying asked for the clown to come to his bedside to be with him. They had previously formed a relationship but it took the participant by surprise when the nurses called her to come back when death was imminent. She described how, rather flustered, she did not take the time to put her costume or face on – she went as “herself”. After the young man died, she found the processing of this event to be very difficult because she felt that she had not been protected from the emotive content of that experience. She recounted her story:

I was called back to a place one night to where a young boy was dying [tearing up]. And I didn't have time to dress. I had been in earlier to see him in my clown outfit. And he asked for me. So I went back and he passed away while I was there. I said I would never do that again. I would always grab something of my face and get myself back into where I am.

When asked if the death would have been easier to cope with as a therapeutic clown, because of its possible protective elements, she replied emphatically, “Absolutely! Absolutely! And I've gone and seen a lot of stuff since, and I would never do it without my outfit!” The participant stated that she had been present with both her mother and her sister when they had died; she had been “fine through that”. However, this situation was different – the young man had asked for the clown and she had not had the time to don her costume or make-up. She stated that even if she had thought to apply only the red nose, it would have helped her. It appears that the consternation over the lack of costume is due to her belief that it would have provided protective elements, with an opportunity to “be completely at ease with all around me”. She stated, “I don't think I would have changed anything if I had been ‘in face’ but I do know that all tears would have stayed in check.”

Paradoxically, the participants describe the concept of a shield also seeming to work somewhat in reverse; instead of providing protection for the clown, their perception is that it also safeguards a vulnerable patient. It is as if the anonymity of the clown allows the person freedom to share thoughts, feelings and emotions, indeed their most intimate selves, which they might never have shared with anyone else. The clown seems to provide protection to the vulnerable patient, which, in the participant's view, allows

the patient's unfettered emotions to emerge without fear of embarrassment, criticism, judgement or reproach. The participants expressed this repeatedly when telling how patients related to and with them:

[She] brought out her photo albums. It was a very dysfunctional family; there was some real sadness in the family. And she would just share. And it seemed like she needed to share and hadn't been able to for a very long time.

This participant also illustrated this element of not being real:

Sometimes you'll go up to someone and say, "How are you doing today?" They'll say "Bad day". We'll sit and chat sometimes. Sometimes all they need is someone to talk to, whether it's a clown or not. Sometimes, they'll talk to us before they'll talk to somebody else because we're not real. You put on a smile and you've got a costume on. They don't really know who you are, so it's easier to talk to someone like that than it is to someone they have to meet face to face.

One participant feels that people are willing to share things "because of the face, because of the costume...because it's not quite a human being." The participant believes that it is this non-human element that shields the patient.

The participants accepted this responsibility, that of accepting all manner of information and shared secrets, without question or criticism and seemed to acknowledge that it was just part of the clown's uniqueness. Another stated it was akin to talking to a dog; you can tell a dog anything, or in this case a clown, and the affection returned remains unconditional. The participants interpret this as being because clowns respond with touch and smiles rather than judgement and disappear almost as quickly as they come, often never to be seen again.

Transports one momentarily. The participants mentioned another seemingly “magical” element to the clown, the aspect of allowing a patient to be transported momentarily. Without leaving and without aid of medication or treatments of any kind, the participants feel that a patient can be taken away from their diagnosis, situation or pain and in this space can be free of burden and worry. Indeed, it is exactly this premise that makes up part of the mission statement of one of the clown troupes: “*We try to help them forget momentarily, the unpleasant things in their lives.*” One of the participants showed this dictum to me; she carries it with her as a constant reminder of her purpose. She stated that “for a little while, you can see when they are laughing and have a smile on their face, they are not in pain.”

Other participants reiterated this valuable purpose in allowing someone to forget:

I'll ask them, "Do you want to do some magic?" And twenty-nine out of thirty say yes and you do this thing. Again, it's ice breaking, it's a laugh and they are forgetting about hospitals, operations and all that stuff. It's not world shattering but you do what you can.

Another participant expresses her joy in “seeing everybody's face light up and being able to put a smile on their face and maybe let them forget about something for a little while.”

The study participants are cognizant of the effects of laughter on patients; they learn about this in their initial training and this is reinforced in frequent “laughter seminars”, as they are called. One participant quoted the work of Norman Cousins, a well-known laughter advocate, in raising her awareness of laughter's healing potential:

“Yes, it's a known fact, two minutes of a good belly laugh gives you what, three hours of uninterrupted sleep? That's from, oh, what's that guy's name? He had a

form of arthritis and was on heavy medications. He asked himself to be discharged from hospital, booked himself into a motel, asked a nurse to go get him all the funny movies she could find. Norman Cousins! The man not only didn't die, he was given six months or something but twenty years later, he was still going. He got himself off all medications. He believes it was the laughter.

The participants all embrace what they believe to be laughter's ability to transport one momentarily and use this technique at the start of their monthly clown troupe meetings; a minute or two of laughter yoga precedes each meeting.

Momentary encounter, lasting impressions. The last subtheme of the magical clown is the mystical quality of the transitory clown relationship that, the participants believe, may have a lasting impact on the patients. Although most often the participants have no knowledge of whether their encounter has a lasting effect on a person, in some cases they hear back later – sometimes years later – just how significant the encounter was.

The following story is particularly moving and is most significant when highlighting the fact that the clown's encounter with people need only be fleeting to be of lasting significance. Indeed, in this case, the clown made only the slightest connection with the patient, yet it appears to have had monumental importance. The participant describes it:

I was asked a few years ago, well, [clown name] was invited to the 100th birthday of the hospital volunteers.... One of the ladies said to me, "I need to talk to you." ... So, I finished with everyone else and came back to her and said, "Okay, you wanted to talk to me?" And she said, "Oh, not here." I thought I had said

something to offend her. I had used my holey bible [prop]. I thought maybe I had offended her so I was a bit nervous as we headed off into the corner. I'm going to start to cry again [voice catches and participant tears up]. She said, "Thank you for saving my life!" I said, "I beg your pardon?" "I need to thank you for saving my life." I said, "How did I do that?" She said, "Two years ago, you came into the hospital. I was recovering from my third suicide attempt in two years. I saw you come in the door and I went like that [put her hands up indicating stop]. I remember clearly doing [hands up indicating stop]. You just looked at me and smiled and gave me a little wave and quietly went to the other three [people] in the room, then left." She said, "In that length of time, I could see the difference in their attitudes and the atmosphere in the room. For the first time, I felt maybe there was hope for me. And now, two years later, I have not attempted suicide again and I'm a volunteer at the hospital." She said, "That's because of you." I said, "Are you sure it was me?" She said, "I *know* [with emphasis] it was you." And I said, "Can I have a hug?" Usually, I'm asking them if they want one! We just stood there and cried!

The participant related the profound impact this story had on them and their thankfulness for the opportunity to hear it.

Another participant stated that one must never become complacent about the effect that therapeutic clowns, or indeed people in general, may have on others; one, momentary contact may become an important influence. While relating this observation to be true of all people, the participant noted its significance when clowning:

Oh, absolutely [clowns having lasting impact]. And that's one reason I do it. You don't know, you never know really when somebody might come [back to you with feedback]. You do it and hope that you influence somebody. I believe that everyone you meet becomes an influence on you to one degree or another.

The impact of the clowns seems also to be useful in recruitment. This was previously mentioned in this study by one of the participants, who stated that seeing clowns in their workplace prompted them to pursue clowning for themselves. The same scenario was repeated by this participant when she related that “a lady came up to me and says, ‘I remember you. You came to see me in the hospital. Now I want to be a clown!’” The participants all seem to feel that their momentary connections should not be minimized; that the impact on patients may be far greater than they can discern.

The participants perceive that the therapeutic clown has the ability to dissolve ill humour, to shield both patients and themselves, to transport someone momentarily and to leave a lasting impact. These skills feel “magical” and “amazing” according to the participants. They do not perceive them to be everyday occurrences available to just anyone. The participants related that this seems to be from not only the costume, but also the make-up, the smile, and the ability to make instant connections. The humble clown, in the participants’ view, asks for nothing in return but a smile or a wave. This third theme has focused on some of the relational aspects of the therapeutic clown but the fourth theme will expand on this even further.

Theme Four – The Transcendent Clown

The fourth theme – the transcendent clown – also deals with relationship aspects of the therapeutic clown, not unlike Theme Three. It was the most difficult theme to pull

from the data and required much reflection. Initially, some of the participants' ideas seemed to be in alignment with those housed under the third theme – the “magical” clown. However, inexplicable tension existed; the ideas did not seem congruent. The participants' narratives were reviewed again. Many participants related stories, concepts and feelings that were not perceived as “magical” as much as extraordinary or beyond the limits of ordinary experience. “Magical” seems to imply something wondrous that is distanced from everyday life whereas transcendent implies that that it still occurs in everyday life, it is just better or greater than what is usual. The ideas forming the framework of this theme fall in a different plane from those articulated in the previous theme. Many of the participants related stories where they claimed to push boundaries and transcend limits.

A phenomenon that I found most telling was observed when the participants recounted their stories. Without exception, each participant was moved to tears when recounting some of their most profound experiences with patients. This display of intense emotion is so antithetical to what one usually associates with a clown – a lighthearted silliness with no depth or substance. Upon reflection, it seems to corroborate the transcendent properties that were seen emerging from the participants' stories; transcending the boundaries of what a clown is imagined to be and moving into a realm of emotion not thought to be likely from a clown. There are several subthemes that detail this transcendent nature of the clown.

The clown has liberties. The participants related how a therapeutic clown has the liberty to do things and to act in ways that others cannot. They claimed that clowns defy social convention by virtue of their costume and persona; the very essence of the

clown seems to transcend boundaries and societal norms. One participant, in a particularly eloquent way, described it as a “license to act soft”. What the participant meant by this phrase is that the costume gives a person permission to act silly or foolish; being a clown is justification enough. The participants related how they can do so much more as a clown than they could ever do as themselves. They described how the true nature of the clown seems to allow limits to be pushed and boundaries to be somewhat amorphous, saying, “The costume gives you liberties that you could never have and never use [as yourself]. And so the dichotomy between the one and the other is amazing.” Another participant feels that “the persona of the clown gives you permission, indirectly, to reach out in a different attitude and it’s fun.” This participant echoed the idea of fun:

Yes, it [the costume] works for me too, because I can be a bit more outrageous by putting the costume on because you don't really know me. I could be your next-door neighbour. Well, mine all know me now [laughs]! You have that anonymity. Yes, it gives you permission to be more fun sometimes.

The participants related that they feel that being a clown gives them leeway to be silly and effervescent but that it is sometimes difficult to “control yourself” when they are not in costume. Over time, the participants perceive that clown qualities transcend the costume and infiltrate the person inside. This scenario describes this:

One of the most interesting ways is walking down a hospital corridor. If I'm walking down now like I am now, well, let's put it the other way first, if I'm walking down as [clown name] and I see a nurse or volunteer coming along and they've got a bunch of flowers, I say, "Ohhh, you shouldn't have bothered!" and I go to take them as if they're for me or if I see a nurse with a cup of coffee, "Is that

a rum and coke?". I relate, but of course, I work dressed as I am now [street clothes]. And you've got to control yourself because you don't want to say to somebody, "Oh are those for me?" because, of course, it doesn't work [if you are not dressed as a clown].

This participant also related a similar difficulty when their costume came off:

When you have a red nose on, a funny costume and a different face, you can get away with a lot more than you can as a human being. And you know the place I find the most difficult now when I go in as Jane Doe [myself]? Elevators. People walk into an elevator and just stand there, straight face and don't talk. And we [the clowns] always had tickets, "Do you have your ticket to ride this?" "No?" "Well, here's your ticket" and the ticket was funny and stuff like that. So when I go on an elevator now, and we all say the same thing, all of us, you don't say boo [talk to people]. Well, I still talk in an elevator. "Hey, isn't this a lovely day", or lousy day or whatever!

Another participant describes how she sometimes has to quell her exuberant waving:

When you are walking down the street [as a clown], you are waving at people and they are honking or waving back. Then you go home and take your costume off and you're walking down the street and you figure you should still be waving! Oops! I don't have my costume on!

The participants all related these stories with mirth that seems to indicate that they perceive the "license to act soft" and the ability to transcend societal norms as a clown somewhat uninhibiting and invigorating.

The clown's audience is limitless. The study participants' narratives seem to highlight the limitless number of people that they feel can possibly benefit from their therapeutic work. Notwithstanding the small group of people that have a real identifiable fear of clowns known as coulrophobia, the participants claim that a clown's therapeutic effects transcend populations, ages, gender, ethnicity and more.

The clowns have limited contact with children in the hospital as most children are sent to the tertiary hospital covering the area. However, they see children regularly at community events such as parades and walk-a-thons. This participant described her sheer delight when interacting with children:

[I love] the smiles. All you have to do is look at somebody. When you are dressed as a clown, they are either going to run in fear or they are going to love you. When we left the park this morning, there was a grandmother and her granddaughter, about three, walking out to their car. She must have said "goodbye clowns" at least a dozen times from the time we walked from the park to the cars. You know the waving, the smiles, the pictures. We had to take pictures. How could you not want anything like that?

All the participants clown in seniors' facilities as well as the hospital and their stories of meaningful interactions abound. As the residents remain static, for the most part, the clowns are able to establish a relationship that sometimes continues for years. One of the participants described it like "going through a novel", whereas clowning at the hospital was "like a snapshot" because it is somebody different every time one goes in and "you have two to three minutes with each person and you are on your way".

Two of the participants related how they had developed a long-term relationship with a senior woman who was a resident in a care home; they were involved in her life in ways they never anticipated. They took her to medical appointments when it coincided with their regular clown visits, put up her Christmas tree and even helped her to move. They described how their relationship with her became very meaningful to them in other ways – this will be addressed later in this theme.

This participant related how their clowning impacted a non-verbal senior, demonstrating that delivering a humorous quip or even dialogue seemed to be unnecessary. They felt that the clown's presence and therapeutic touch seemed to be sufficient:

There's one lady. All she says is "better, better". How are you today? "Better, better". Then one time I says, "[Clown name], I think she needs a hug." So [clown name] gave her a hug and it was all of a sudden, "better, better, better, better, better, better!" Just that hug, "better, better, better". Oh, she was so happy!

It is not just the opposing ends of the population that are responsive to clowns. There were equally as many accounts of stories relating to young adults or middle aged people. This participant described responses she receives when driving dressed as a clown:

Do you know what? When you drive down the road even [you get responses]. I love pulling up next to somebody. You know, how everybody glances. You'll get the glance, then the double take. And in most cases, then you'll get the smile. A lot of them are the younger people. You know, the young guys, between the ages

of twenty and thirty. They'll look and it's a big smile and a wave. They get a big chuckle out of it. And that's so nice.

In the following touching story, one participant described how their clowning efforts at a cancer centre seemed to have had a great effect on a solitary young man going through an anxiety inducing chemotherapy experience. The excerpt, while lengthy, describes the man's plight and how the clown's work with him seemed to transcend a normal volunteer's interest and abilities. The participant perceived her efforts as being of great value to him at a time when he needed it:

One day I went in and there were about five people sitting in a row there, three of them in their ICU's [hospital gowns], their companions with them. "On my goodness, hasn't the bus come by yet?" "Oh, yeah, it is late". Anything to break the ice. Eventually, those five pushed on, but I'm very conscious that down there there's a guy sitting there. I would say he was in his late twenties, early thirties. He's sitting there like this [shows hands wringing and head hanging down]. He had a whole mess of papers in his hand, holding them all scrunched up. Just like this [shows hands wringing]. Well, that tells you big time. So I went over to him. "Are you new around here? Are you waiting for a clown bus to come along?" "No". Okay, I'm not getting very far with this guy. "Are you from here or are you from there?" "I'm from there". Okay, this isn't home. "Got any buddies around here". "No". I don't know. I'm starting to flounder, my mind is going, what else can I [do to] get some information out of him. "Do you have a pet or anything that you brought along with you from wherever home is?" "No, I had to have him put down last week". Oh, man. Yes, that's when you think, "Help!"

You are thinking, what else can I do? Then you start using the props. You're not supposed to touch them, but I think, to heck with it and I start massaging his shoulder, rubbing it. Then I see the papers loosening up and the hands relaxing. Then the radiologist gave me the eye and [gestures five minutes with her hand] and then that five minutes was up and she could see I was making progress with him. So she's saying [gestures five minutes again] and takes the next patient that came along. I was with him about fifteen minutes or so, so when he finally did go in for his first treatment, he was finally relaxed.

During her fifteen minutes with him, she describes what she did:

I was trying anything to get him to relax. I was rubbing. I couldn't sit down; there wasn't a chair right beside him. I had to stand up the whole time. I was just massaging that shoulder the whole time I was talking to him. I was trying to find out about his life. I was trying to use humour in a professional way, type of thing. Whatever I said to him along the way, or maybe it was just being there that was caring, because the guy was literally there, all alone, and he'd lost his best buddy, his dog. So he had so much going against him. Next week, the gal in radiology, she and I shared. "I could see you were really working for him". But it worked.

While this narrative displays the time and efforts that the clown took with this patient to eventually relax him, the clown's influence was made apparent the following week:

So the next week when I went in, I thought if that was his first treatment, he's got seven weeks of them, so he's got to be here. But there was no sign of him, so I started down the hall. There he was, down the hall. And he saw me. And as I got closer to him, his arms just came out and he enveloped me. He put his arms all

around me and said, "Ah, [clown name] thank God you were here last week. I would never have got through it without you." Agh...I was ready to cry."

These stories, while varying greatly in their content, serve to illustrate this subtheme for this exact reason – the people the clown interacts with also vary greatly. The participants relate that the therapeutic clown seems to move beyond jokes, to apply their qualities and skills to a rather limitless audience.

The clown as spiritual. As the fourth theme - the idea of transcendence - emerged and was ruminated on during analysis, the participant's perception of the clown as a spiritual being concurrently emerged as a subtheme. To me, the clown as a spiritual entity is likely the most thought provoking and somewhat disconcerting idea explored during analysis. Disconcerting, because this notion might be viewed as incongruent, even sacrilegious. That is, the idea of a clown, whimsical and silly, being thought of as spiritual may be antithetical to what one might expect. However, this concept of spirituality is one that participants seem to feel truly defines the transcendent nature of therapeutic clowns.

According to Johnstone (2012), spirituality is an emotional connection that individuals experience with whatever they consider sacred or divine. Using this definition, what the participants describe has a spiritual dimension.

The participants related how frequently they, as clowns, seemed to be in the right place at the right time, assisting people when they perceive it was needed it most. For example, two of the participants claimed to have had a meaningful long-term relationship with a senior; this was mentioned previously. They described being with her when she received a call that her sister had died. These participants went on to describe the

experience of being present with her through a series of sad events. They described their coincidental presence as being something “beyond us”, framing it with their spiritual connotation:

The first day we got there, some friend [’s]...daughter had died. The first three times we went there, we got there on days where something very sad had happened to her. We got to thinking, there's a reason. We are here, today, for this reason. ‘Cause none of it was planned. [Paused] I think we were there for a reason and I think it was something beyond us. Something higher.

These participants, who admitted to having spiritual beliefs of their own, offered to pray with her. According to the two participants, this woman had a faith as exhibited by a hymnbook, an ever-present Bible and “a number of other things, we knew right away”. On a day that seemed particularly difficult for this woman, the participants related that they asked if she wished them to pray with her, not knowing how she would respond:

She said she would like that. So, that's what we would do, always at the end of our visit, we would hold hands and have a prayer. But you know, with clowns, politics and religion are not supposed to be a part of us, so that's not something we talk about very often.

Another story involved the very precise timing that seemed to allow a pair of clowns to assist a family in grief. The participants felt that their presence somewhat helped this family process the death and created a lasting memory for them. The two clowns related this story together, each taking a turn to add to the other’s narrative and to fill in the gaps to complete the story:

CLOWN A: We went clowning at the hospital and you always go to the nurses' station to find out if there are any rooms that you can't go into. So they told us about this room....So we were going down the hall and there were these ladies standing out in the hall, in front of the room that we weren't supposed to go into. And we went like this [hand gesture], letting them know that we weren't going to go in. And they came up to us and started talking to us. There were two of them first. We were talking to them and they said, "Oh, wait" and were going to go back in.

CLOWN B: And what they said was, "We need a hug". So we each did that and then they started to cry.

CLOWN A: They told us their father had just died.

CLOWN B: They were coming out of their room to get a nurse to tell them. They were just coming out of the room as we were walking and we were saying, no [we won't go into the room].

CLOWN A: And then they went in and got another sister.

CLOWN B: One of them said, "Don't go!"

CLOWN A: "I want to go in and get my mother", and so they brought their mother out and we all stood there in a big bear hug. They told us afterwards that was the first time their mother had cried.

CLOWN B: Since their dad was diagnosed with cancer.

CLOWN A: With cancer. And um, they also told us their Dad would have loved us.

CLOWN B: They said, “This is so perfect. Dad would have loved this. This is perfect timing, this is just what we need.” They kept saying those kinds of things. And you know, the nurses had said to stay away.

CLOWN A: They kept saying, “Dad would have loved this! If only he knew.” And I said I think he does!

In this example, as the participants went back and forth with their recollections, they related that the synchronicity of being right outside this family’s door at one of the most vulnerable times in life was not lost on them. Indeed, they perceived it was not lost on the family either; in the man’s obituary, the clowns were mentioned. The one participant said, “We read in the paper, we were in the obituary. Thanking the clowns.” The other participant followed up with, “Thanks to doctor so and so [in the obituary] and all the nurses at the hospital and thanks to the clowns.”

Other participants mentioned being present at the time of a patient’s death too. As previously related, the young man dying of leukemia requested the clown to be his sole support as he transitioned from life to death. The reason for this is unknown, but the participant conjectures that “he wasn’t looking for levity. There must be something peaceful about a clown.” Also in the previously related story about the nursing home resident, the clowns who had a special bond with her were present at the time of her death. The participants, a clowning pair, knew it was near the end of her life and went to see her to say goodbye – they ended up staying. They relate the story in tandem once again:

CLOWN A: We knew it was down to the end and went to see her and just felt we needed to be there, so just stayed. We hadn't intended to. I mean, we intended to go see her knowing it was toward the end.

CLOWN B: All her family was mostly out of town, too, so she didn't have family close by at the time. So we stayed with her.

In summary for Theme Four, the study participants perceive the therapeutic clown as being able to extend boundaries by taking liberties, to clown to a limitless audience and to provide a somewhat spiritual presence when needed; they speculate how this seems to go beyond normal at times – a transcendence.

Theme Five – The Clown's Role in Healthcare.

This theme explores the role of the therapeutic clown in healthcare. This was one of the research questions posed to study participants. It was necessary to articulate, as the overall purpose of the study is to apply lessons from therapeutic clowns to nurses. If clowns are considered as entertainment only, as opposed to having a place in healthcare, then there would have been no need to instigate this study in the first instance.

The participants unanimously agreed that therapeutic clowns had an important role. They were also unanimous in stating that they were not integral but rather an adjunct therapy as demonstrated by this participant:

No, not essential. But you are part. You are a piece of the jigsaw for me. Life is a sort of a jigsaw and I'm one little part of the jigsaw as a clown. But I can drop the clown and be serious. You don't have to be a laughing clown all the time. You know, we are back to the ability to relate to the patient or the client at their level.

The participants previously all mentioned providing a momentary distraction from pain or diagnosis (as discussed in Theme Three) and it is in this context of healthcare that they mention this valuable role again and again:

Yes, I do [have a role]. This is a very serious place and if I can, for thirty seconds, get you to think about something else, other than your pain, or your predicament, or your diagnosis, or your whatever, then I have done my job as far as I'm concerned. That's my thing. I have made you think about something else for a few more seconds.

This participant stresses her thoughts:

Most definitely [have a role]. I think laughter is one of the best medicines you can get. It doesn't matter how bad you feel, if you see a clown walk into a room and that, it picks up your spirit.

Another participant discussed their belief in the value of smiles:

I think so [have a role]; otherwise, we wouldn't be doing it [clowning]. I think, most people are cheered up by a clown, if you're done up properly. Not the scary face. And it makes you smile. And a lot of people... think smiles are healthy for you.

Moreover, although the participants responded to the question about a healthcare role for therapeutic clowns, the more powerful response to this very question is embedded repeatedly in the themes, illustrations and excerpts already provided. None of the participants' excerpts, barring one or possibly two examples, provided insight into the role of the clown as pure entertainer, but all provided insight into and perceptions of the role of clown as caregiver on one level or another.

This theme corroborates the idea of therapeutic clowns having a role in healthcare, as articulated by the participants. From the clown's perspective, they appear to impact patients in varying stages of wellness and from all walks of life and see themselves as having a participatory role in healthcare.

Chapter Summary

As these resulting themes were teased from the data, and the participant's voices were heard through the transcription process and into the findings, the gestalt of the therapeutic clown emerged. Through their rich narrative, the participants related, and indeed exhibited through emotions, their perception of the therapeutic clown's impact. These perceptions and insights were translated into the various themes. The themes: the clown within me; the wholistic clown; the "magical" clown; the transcendent clown; and the clown's role in healthcare provide a portrait of therapeutic clowning. This portrait can be examined alongside that of nursing, allowing comparisons to be drawn and thus determining if therapeutic clowns can indeed inform nursing practice. The next chapter provides a discussion of the findings.

Chapter Five – Discussion

This chapter will examine and reflect on the study findings arising from the data analysis, as outlined in the previous chapter. The literature review, summarized in the second chapter, consists of mostly quantitative studies outlining generally positive responses to therapeutic clowns in all types of settings and all manner of interactions. However, providing insight into a clown's efficacy was not the purpose of this study; the purpose was to explore the stories of therapeutic clowns to discover how clowns and clowning techniques could inform nursing practice, specifically in the art of relationship. Five main themes were identified and discussed; these provide some insight into therapeutic clowning and give an exposé of a clown's relational practice as perceived by the participants in this study.

Initially, as outlined in Chapter One, I surmised that there would be techniques or “lessons” that might easily be transferable to nurses. Indeed, the title of this study, *Lessons from the Red Nose*, is suggestive that there would be an easily explicated “how to” guide for nurses to peruse and learn a few clowning tips which could be easily implemented in their hospital care routines. This does not appear to be the case. Through the exploration of therapeutic clowns' stories, the complexity of what they do and how they do it became manifest. Therapeutic clowning could be described as a “tapestry”, woven by threads depicting costume, persona, compassion, humour and so much more. This “tapestry” is not easily disseminated into individual threads, to be taken up for immediate use by someone else.

While no outright simple “lessons” have been gleaned from the five themes, several salient concepts have been extracted from them. These are worthy of further

discussion and comparison with current literature. This process of interpretation is integral to an interpretive description study as it helps one to view findings from alternate angles of vision (Thorne, 2008).

Three dimensions shed light on the therapeutic clown's relational dynamics. The concepts of *vocation*, *emotional shielding* and *judicious humour* emerged as thought provoking and compelling points intertwined throughout the themes. The first two concepts will be discussed, their impact on relationships will be highlighted and linkages will be made to nursing. Again, while clarifying that these are not "lessons" per se, within these two concepts exist parallels between therapeutic clowning and nursing which are deserving of further scrutiny. Finally, the concept of judicious humour will be discussed as it represents the essence of the study and comes closest to what I would consider a "lesson". Thorne (2008) describes this notion of summing up a study with a single idea or sentence as a "soundbite"; judicious humour is the "soundbite" of this study (p. 195).

Vocation

None of the therapeutic clowns in this study used the word "vocation" in describing their work. Additionally, it is rarely mentioned in the clowning literature. Despite this, however, within the themes, within the descriptions of the clowns' work and within the literature, there have been many associated connections, such as references to "a calling", to a passion and fulfillment in the clown's work and to the deep meaning associated with it. This speaks to the nature of a therapeutic clown's work as a vocation.

To fully elucidate this concept, some understanding of vocation is necessary. Vocation comes from the Latin word "vocare" meaning "to call" (McKay & McKay,

2010; Prater & McEwen, 2006). Indeed, the word “vocation” is often used synonymously with “calling”. Those in a vocation feel that their work has impact beyond themselves and has an effect on the greater good. They believe that their work utilizes their unique gifts and talents and is what they are meant to do. This is corroborated by Parker J. Palmer, author and educator, who writes about vocation stating, “The deepest vocational question is not ‘What ought I to do with my life?’ It is the more elemental and demanding ‘Who am I? What is my nature?’ ” (Palmer, 2000, p.15). It is felt that vocation or calling taps into one’s life purpose, using birthright gifts and when it is recognized and acted upon, one’s life is joyful, full of satisfaction and fulfillment (Cardador & Caza, 2012; Dik & Duffy, 2009; Domene, 2012; McKay & McKay, 2010; Palmer, 2000). There has been an influx of scholarly interest in the notion of calling over the last decade and in the limited but expanding body of literature, contemporary definitions of calling, similar to what has been described here, have been conceptualized (Domene, 2012; Duffy & Dik, 2012).

The therapeutic clowns interviewed in this study described intrinsic factors that motivated them initially to become a clown and the ongoing passion that they have for their work. They discussed how clowning seemed to be second nature to them and how, in putting on their costume and assuming their personas, they became invigorated, to the point of forgetting their own problems. Several participants described how they could not imagine their life without clowning and that it was integral to who they were; they were sustained in their work by the impact it had on others and the enjoyment it seemed to provide. As the clowns in this study were all volunteers, it gives further credence to the idea of clowning as a vocation, since vocation is work one does regardless of whether

there is payment; there is satisfaction in getting to fulfill one's passion and therefore wages and rewards are peripheral (McKay & McKay, 2010). The depiction of clowning that the participants gave and the depth of their feelings around it seems to illustrate therapeutic clowning as a vocation for most of them.

As mentioned, there is very little in the research literature about clowning as a vocation or calling. It appears that the "how and why" of a person becoming a therapeutic clown is viewed as less important than the clown's role and impact, especially in health related research. However, the notion of therapeutic clowning as a vocation is mentioned or alluded to in the general literature on therapeutic clowning (Achcar, 2011; Dana-Picard, 2015). In their seminal guide to hospital clowning, Wooten and Schwebke (2000) suggest that, like any other art form, clowning is a form of "calling", requiring talent, skill, and passion (p. 40). In interviewing potential candidates for the Theodora Clown Doctors in Italy, participants are asked to elaborate at length about themselves with the quintessential question being "Who are you?" (Poulie, 2014). This questioning highlights the unique gifts of the individual, their underlying motivation for pursuing clowning and their propensity for it.

If vocation is indeed using the unique gifts and talents that one possesses and that express one's true nature, then looking at how one develops and hones one's personal clown character is a logical next step. Bruce Johnson, an author and noted clowning instructor, refers to the intrinsic nature of clowning when he states, "there seems to be an instinctive element to clowning that cannot be taught. Some people show flair for clowning and are good clowns right from the start, while others never make good clowns no matter how long and hard they try. Every clown can learn to be a better clown, but not

everybody can learn to be a clown” (DATE, as cited in Henderson & Rosario, 2008). It is felt that the qualities of the clown are actually expressions of the real self; everyone has a unique clown character within them centered on the clown’s inner personality, consisting of deep-seated feelings and characteristics (Carp, 1998; Wooten & Schwebke, 2000). There is “no groping around to find or develop or invent [a character]” (Wooten & Schwebke, 2000, p. 15).

The concept of vocation or calling can also be applied to the nursing profession. Historically, it was Florence Nightingale who perceived nursing as a calling from God, with caring being at the core of the work (Mooney, Glacken, & O’Brien, 2008; Prater & McEwen, 2006). This spiritual or religious notion of vocation or calling is consistent with the traditional foundations of the construct (Duffy, Foley, Raque-Bodgan, Reid-Marks, Dik, Castano & Adams, 2012). It is this spiritual connotation that those in nursing circles seem to focus on when there is discourse on vocation, although there are many that would like to eschew this idea. The thought that the vocational inference interferes with the professionalism of nursing has resulted in a shift in thinking with a rejection of the spiritual associations of a calling in the way that Florence Nightingale perceived it (Carter, 2014; Prater & McEwen, 2006). Nursing scholars have reemphasized that the essence of nursing involves caring for others (Prater & McEwen, 2006). Indeed, several studies have focused on the intrinsic motivators for people to choose nursing; the need to be a useful, caring and nurturing caregiver are described as major motivating factors, while steering clear of any concept of vocation or calling (Brendtro, 1991; Carter, 2014; Kersten, Bakewell, & Meyer, 1991; Mooney et al., 2008). While the notion of being “called” by God to nursing is discussed in the study by Prater

and McEwen (2006), it is important to note that the participants were all enrolled in nursing at a private, faith-based university. However, the majority still described themselves as wanting to be nurses because they were caring, compassionate and empathetic (Prater & McEwan, 2006). As vocational psychologists delve into research about calling using the contemporary nomenclature, it would seem prudent that nurse scholars revisit this more updated version of the concept themselves for “the fact remains that the motives of nurses matter to individual patients and to society” (Carter, 2014, p. 697).

How does vocation affect relationships? A relational perspective is relevant in a discussion of calling given that it is theorized that such an orientation shapes how one thinks about and behaves towards others at work (Cardador & Caza, 2012). It is felt that when one gets joy and fulfillment from work, and one’s work is considered a calling, this positively impacts the relationships one has with people (Cardador & Caza, 2012; Duffy et al., 2012). Perhaps this explains the ease of connection with people and the impactful relationships that the participants in this study voiced. If therapeutic clowns are motivated in their work by feelings of vocation and calling, the relationships and connections they have with people may be positively affected. Accordingly, the same could be extrapolated for nurses; those nurses who feel that they are called to the profession may have stronger relationships with patients. Further research on vocation and its implications on relational practice would be needed for both clowns and nurses before claims with any credence could be specifically made for these occupational groups. Despite this however, the literature seems to support the general assumption that

those who feel called to their work, or who feel that they have a vocation, have enhanced relationships with people.

Emotional Shielding

The second concept for discussion is that of emotional shielding. In the chapter outlining the themes, the participants related how donning their costume and persona seemed to provide them with a type of barrier, safeguarding them from the emotional content of their work. Participants described how emotional shielding was necessary for them to be able to fulfill their clowning work without succumbing to the emotional aspects inherent in their work. One participant recounted how difficult it was to deal with her feelings surrounding a young man's death when she was not wearing her costume; this was discussed at length in Chapter Four. As she was present at his bedside solely in her role as a clown, it seemed that her ability to deal with the emotions surrounding his death was impaired by the lack of a costume. As clowns perceive it, their character appears to provide protection and shielding from direct emotional assault (Gervais, Warren & Twohig, 2006; Simonds & Warren, 2004; Wooten & Schwebke, 2000).

Concurrently, the costume and persona could also be viewed as shielding the person from the social constructs and mores that dictate what one should and should not do. Without the red nose, make-up or costume, one seems bound by societal norms and decorum. Participants in this study related how their costume and persona gave them permission to move beyond social boundaries without feeling exposed and awkward; such feelings lead to embarrassment and shame. These emotions are known collectively as the self-conscious emotions (Lewis, 2011). This "license to act soft", as explicated by one participant, is liberation from societal structures and expectations. With the persona

in place, clowns are shielded from the aforementioned self-conscious emotions (Henderson & Rosario, 2008; Wooten & Schwebke, 2000). The clown is “unable to understand the world in general and therefore operates under idiosyncratic ideas” (Carp, 1998, p. 246). It is these liberties, and the emotional shielding that comes with it, that are integral to a clown and are what provides the delight, especially to children (Dionigi, Ruch & Platt, 2013; Ford, Tesch, & Carter, 2011; McMahon, 2008; Nuttman-Shwartz et al., 2010; Oppenheim, Simonds, & Hartmann, 1997). Clowns are inherently risk takers and push boundaries where others could not (Ford et al., 2014; Gelkopf, 2011).

The idea of the red nose as having both a protective element as well as a liberating one, is supported by Carp (1998) when discussing her clown therapy. She suggests that the mask (red nose) creates a distinction between the clown and the person behind the mask, providing a protective element. Her suggestion of liberation, however, resonates differently than what is suggested here. That is, she posits that with the face “covered”, the body is free to more clearly express emotion (Carp, 1998, p. 254). Koller and Gryski (2008) allude to the ability of the mask or persona to liberate. They also take a slightly different approach by saying that the donning of a mask actually requires one to *unmask* [emphasis added], that is to drop all the other “masks” we may wear (p. 20). In essence, they are suggesting a liberation of the person from any expectations, be they societal or personal.

There is little to no research on the notion of emotional shielding for therapeutic clowns; however, the literature, as described previously, corroborates the idea that the clown’s persona and costume appears to shield the person inside from the emotive content of the clown’s work. What the limited literature also shows is that therapeutic

clowns are not wholly immune from the emotional aspects of their job. Indeed, the literature seems to suggest that the person inside the costume deals with a lot of emotional content that needs deconstruction after the clowning event has occurred. If this is not attended to, emotional burnout is a risk (Gervais et al., 2006; Goldberg & Nupp, 2009; Simonds & Warren, 2004; Wooten & Schwebke, 2000). This is part of the rationale for clowning in pairs; events can be reviewed at the end of the day with someone who has also experienced the same emotions (Simonds & Warren, 2004; Wooten & Shwebke, 2000). In addition, other suggestions for mitigating the effects of burnout include debriefing sessions, having a counselor or chaplain available for clowns to speak with, keeping a journal, and self-care, including physical activity (Gervais et al., 2006; Goldberg & Nupp, 2009, Poulie, 2014).

When participants in this study were questioned about the need for debriefing, or how they dealt with emotional content after clowning had finished, they either indicated that they never felt there was a need or that they just discussed it with their clowning partners if they had one. This is likely more of a characteristic of this particular sample group, which may not be representative of the larger therapeutic clown population. Certainly, the literature seems to suggest the very real danger of burnout.

Emotional shielding is a salient construct for nurses as well. Nurses often deal with emotionally difficult situations and especially if they work in units such as palliative care or oncology; they must step back from the emotive content of their jobs in order to carry out their duties effectively (Sandgren, Thulesius, Fridland, & Petersson, 2006; Thulesius, Håkansson, & Petersson, 2003). A grounded theory study of palliative nurses explicated this very well (Sandgren et al., 2006). The authors elucidated a theory

“Striving for Emotional Survival”, which consisted of “Emotional Shielding”; this was described as being able to protect the individual from emotional overload while caring for palliative patients and was made up of protective attitudes toward emotionally difficult situations (p. 84). “Emotional Shielding” was broken down into “Professional Shielding” and “Cold Shielding”. “Professional Shielding” was described as being a “protective attitude toward emotionally difficult events used to protect against getting too emotionally involved with patients and relatives” (p. 85). It was considered a more sound or healthy way to shield, involving the shifting between personal and professional life, balancing of intimacy, and showing empathy but not sympathy. This is contrasted with “Cold Shielding” which the authors describe as “hiding behind the profession, which is used as an emotional shield” (p. 85). This causes a cold distance between nurses and patients as nurses mentally distance themselves from emotional threats; this in turn leads to reduced quality of care. Nurses must learn to strike a balance somewhere on a continuum between full engagement to detachment in order to protect themselves emotionally; sensitivity to a patient’s needs and wishes are important, but keeping a professional distance is equally so (Sandgren et al., 2006; Thulesius et al., 2003). In addition, organizations should encourage self-care, prioritize the time to talk, and offer counseling to nursing staff with emotionally difficult working conditions (Sandgren et al., 2006). This parallels the suggestions for therapeutic clowns that were discussed previously.

From a relational perspective, according to Wooten & Schwebke (2000) the therapeutic clown must remain shielded from emotional content to maintain the character and integrity of the clown. This, in turn, preserves the “magic” of the connection

between clown and audience; clowns must remain in role at all times (Dionigi et al., 2013; Simonds & Warren, 2004). Dionigi et al. (2013) introduces the concept of *clown shift* in his study which is defined as “the cognitive change that occurs when a person leaves the habitual state of mind to enter the clown’s state of mind and vice versa” (p. 59). Clown shift allows one to remain attentive and focused (Dionigi et al., 2013). Attention is crucial as clowns move among patients’ rooms and use inductive and deductive cognitive skills to detect patients’ needs. This is the same for nurses (Simmons, 2010). Clowns need to have their full attention on their artistry or their patient interactions will suffer (Gervais et al., 2006). Of particular interest is a finding from Gervais et al. (2006) that found that those who had a clear demarcation between their own personality and their clown character were not only better protected from stress, but also better performers, putting their patients first (p. 80). Debriefing following clowning helps to illuminate both the positive aspects and shortcomings in the relational domain; this will help to improve subsequent therapeutic interactions and relationships (Dionigi et al., 2013; Goldberg & Nupp, 2009).

While the merits of emotional shielding for nurses and the resulting implications for relationship have already been explored and parallels with clowns highlighted, nurses do not have the same amorphous boundaries with societal norms that clowns do. Nurses are not seen as risk takers as clowns are (Ford et al., 2014; Old, 2012). While nurses have liberties with patients or clients due to the nature of their work (such as asking sensitive questions), nurses must always practice within the professional boundaries set by regulatory bodies and professional associations. These professional standards and

accountabilities do not provide them with the same leeway as clowns to be silly and carefree.

As a final point in the discussion on emotional shielding, the familiar poem, “The Clown”, by English poet Phoebe Hesketh is presented (Hesketh, n.d.). It highlights both the protective element of the clown costume as well as the need for attending to the clown’s emotional overload, illustrating that the clown’s paradoxical elements are understood well beyond academic circles. It is both poignant and thoughtful.

She was safe
Behind the whitened face
and red nose of the trade,
vocation more than certain
than a doctor's or priest's
to cheer and heal.
Hidden away from herself
she could always make us laugh
turning troubles like jackets
inside out, wearing
our rents and patches.
Tripping up in trousers too long
she made us all feel tall;
and when we watched her
cutting herself down,
missing the ball,

we knew we could cope.

What we never knew
was the tightrope she walked
when the laughter had died.

Nowhere to hide in the empty night,
no one to catch her fall.

Judicious Humour

The last concept to be considered is judicious humour. This represents perhaps the most important element of this study as it describes the most compelling “lesson” arising from the study and one that can be passed on, taught, and reinforced to nurses. Through the stories of therapeutic clowns, the use of judicious humour in healthcare, that is humour that is used prudently and with good judgement, was highlighted. This appears to help clowns with their relationships as they easily establish connections with people. The therapeutic clowns in the study were asked about their role in healthcare; this was more of an attempt to explore the use of humour as it was to explore the need to advocate for more therapeutic clowns in the healthcare system. The participants unanimously agreed that their work is invaluable and that humour has a place in health care.

Judicious humour describes humour used in a sensitive and caring manner, in situations and environments that are appropriate. Therapeutic clowns are skilled in judicious humour. They are trained to be sensitive and know when it is appropriate to use props or jokes, or when it is merely sufficient to be present (Dionigi, Flangini, & Gremigni, 2012; Glasper et al., 2007; Henderson & Rosario, 2008; Linge, 2008; Simonds

& Warren, 2004; Wooten & Schwebke, 2000). Clowns are used in a variety of situations where sensitivity is of vital importance: they assist children undergoing anogenital exams following sexual abuse, they are present in palliative care units, emergency departments, mental health departments and more (Henderson & Rosario, 2008; Marcon, 2005; Tener et al., 2012). In each of these contexts, the therapeutic clown adapts the interactions with sensitivity both to the patient and to the environment. The efficacy of clown therapy humour in some of these sensitive situations has been identified in the literature review and alluded to in the earlier part of this chapter.

Interestingly, the most notable advocate for clowning in hospitals, Patch Adams, does not actually wholly endorse clowning as a therapy (Adams, 2002). He feels that relegating the role of humour to specialist clowns, while healthcare staff is ignoring it, misses the point. He asserts that if laughter and humour are not infused into daily care, therapeutic clowns become just another specialty, like occupational therapists, or nutritionists, or social workers (Adams, 2002; Knowles, 2012). This is the case in Israel, where medical clowns work as integral parts of medical teams and medical clowning is recognized as an academic discipline with a formal academic program offered at the University of Haifa in Israel (Hart, 2012). Israel is the only country in the world to have an undergraduate program in medical clowning (Hart, 2012).

Following the premise of Patch Adams, and taking a cue from the participants in this study, nurses can and should incorporate humour into their nursing care. An in depth look at the benefits of laughter and humour goes well beyond the confines of this discussion, but as humour in nursing becomes more widely studied, salient points can be gleaned from that focused literature. Humour can be used as a defense mechanism,

especially for men; it can be used to conceal their feelings and gives them the time needed to prepare for a difficult situation (Åstedt-Kurki, Isola, Tammentie, & Kervinen, 2001; Oliffe, Ogrodniczuk, Bottorff, Hislop, & Halpin, 2009). Humour appears to have lasting effects, well beyond the immediate moments (Beck, 1997; Ford et al., 2014; Linge, 2011). Patients associate humour with trust and when a trusting relationship is established, it is much easier to assess a patient and discuss sensitive topics (Tanay, Wiseman, Roberts, & Ream, 2014). Humour facilitates a positive nurse-client relationship fostering feelings of togetherness and cohesion (Åstedt-Kurki et al., 2001; Beck, 1997).

Therapeutic nurse-client relationships are the cornerstone of relational practice (Doane & Varcoe, 2007). In the course of this study, relational practice has been mentioned in the context of both therapeutic clowns and nurses; however, from my stance as a nurse, that is the lens through which relational practice is viewed. Relational practice has been receiving growing attention in latter years (Stansfield & Browne, 2012). Relational practice extends far beyond interpersonal communication skills taking multiple contexts and relationships into account (Doane & Varcoe, 2007,2015). It is defined as “an inquiry that is guided by conscious participation with clients using a number of relational skills including listening, questioning, empathy, mutuality, reciprocity, self-observation, reflection, and a sensitivity to emotional contexts” (College of Registered Nurses of British Columbia, 2015, p. 21). While this definition does not explicitly reference humour as one of the relational skills, Doane and Varcoe (2015) explicate skillful relational practice as including nurses’ way of being with and relating to patients, colleagues and the context in which this is occurring (p. 304). Humour, as one small

relational variation, can dramatically change the outcome of a situation, analogous to the butterfly effect (eventually causing a tornado) in complexity theory (Doane & Varcoe, 2015).

Humour can be used in a variety of care environments, including palliative care, intensive care, and oncology units (Dean & Gregory, 2005; Dean & Major, 2008; Tanay et al., 2014). Caregivers in Dean and Major's (2008) study indicated that they had an instinctive awareness of when to use humour. This sensitivity, also described by the authors as embodied knowledge, suggests that nurses can trust their instincts to know when humour is appropriate by watching for certain cues (Dean & Major, 2008). Perhaps this is more indicative of experienced nurses who may tend to practice in the areas that were studied by Dean and Major (2008). Humour can be harmful if it is used inappropriately and nurses need to exercise some degree of awareness of developmental, individual and cultural differences to ensure humour does not become negative (Beck, 1997; Puder, 1998); negative humour can damage a relationship (Åstedt-Kurki et al., 2001). These admonitions infer that this goes beyond an instinctive awareness as suggested by Dean and Major (2008).

Humour is a skill and as such, can be fostered through practice. Through observation and experience, humour can be cultivated through such examples as surrounding oneself with optimistic people, and thinking about ways of accessing humour in one's life (Greenberg, 2003). This is encouragement for those nurses who may claim to not have a sense of humour. Humour is seen as a skill that may actually delineate nursing expertise (Dean & Major, 2008; Greenberg, 2003). As such, it is worth striving for, much like nurses strive for other skill sets on their journey along the novice to expert

pathway (Benner, 1982). Humour can be incorporated through any number of avenues (Old, 2012; Puder, 1998); as such, practical advice is given in a recently published handbook on incorporating clown-play into healthcare practice (Warren & Spitzer, 2014). Even if nurses do not have an innate sense of humour, and furthermore, do not wish to invest energy into cultivating one, there is one elementary principle nurses can adopt to improve relationships with patients. When the clowns in this study were asked what one thing they could impart to nurses, the unanimous response was “to smile”. The clowns believe in the power of a smile as a way to instantly lighten moods, cultivate good will and help to make the patient and the nurse happier. This is backed up by research (Bergman & Connaughton, 2013; Lau, 1982). Smiling is extremely simple, cost-free and requires very little effort.

Nurses occasionally resist incorporating humour into their practice, expressing that that they do not see it as their role, that a nurse’s focus is on the physical needs of the patient rather than the psychological and that they are overworked (Marcon, 2005; McCracken, 2015). In addition, humour and professionalism are sometimes seen to be mutually exclusive (Marcon, 2005; McCreddie & Wiggins, 2007; Tanay et al., 2014). One author theorizes that the history of professional socialization in medicine may be at fault, as “the focus on emotional distancing, conformity and hierarchy does not encourage the risk-taking involved in humorous encounters with patients” (Old, 2012, p. 18). This assumption is refuted by Dean and Major (2008), who suggest that “combined with scientific skill and compassion, humour offers a humanising dimension too valuable to be overlooked” (p. 1095).

Despite protestations that may occur, educators and hospitals are starting to recognize the value of humour and its effect on relationships. Humour workshops and lectures on clowning have been introduced in hospitals, schools of nursing and medicine (Duffin, 2009; Gibson, 2004; Leef & Hallas, 2013; Old, 2012). In clown workshops, nurses can be taught clowning techniques that provide positive effects and can learn to interpret when humour may be inappropriate, using sensitivity and compassion (Leef & Hallas, 2013; Puder, 1998). Response to such workshops has been generally positive with respondents reporting that the learned techniques are useful in practice but more so, assist in providing nursing care with an “open heart and open mind” (Duffin, 2009; Leef & Hallas, 2013, p. 263). Humour also helps practitioners cope with difficult situations and provides cohesiveness amongst staff members (Beck, 1997; Blain et al., 2011; Linge, 2011; Old, 2012).

In the discussion of judicious humour, and while promoting humour in nursing and other professions, it would be unwise to negate the role that therapeutic clowns do have. Their work encompasses many things that other professionals do not do; clowns have the time to laugh, play and engage with patients (Warren & Spitzer, 2014; Wooten and Schwebke, 2000). Therapeutic clowns have a place in healthcare. This is corroborated by almost all the literature procured for this study, notably the research studies delineating clowns’ efficacy with children and the elderly. Their important role is the impetus behind the drive to formalize training programs, create standards and accountability and engage in credible research. Advocacy and education about therapeutic clown programs would help to establish more such programs. This seems especially warranted when considering the surge in the elderly population (Low et al.,

2013). Until such programs are in existence, however, the simplest solution remains incorporating judicious humour into nurse-patient interactions.

Chapter Summary

This chapter provided discussion around three aspects of therapeutic clowns that also has applications for nurses. The concepts of vocation, emotional shielding and judicious humour were made apparent through the data analysis in the last chapter and were felt to be salient points. These key points were situated within the current literature and comparisons were made with nursing in regards to the discussion around vocation and emotional shielding; similarities between therapeutic clowns and nurses became apparent. Against the backdrop of these concepts, relational perspectives were highlighted to gain a sense of the art of relationship for both clowns and nurses.

Lastly, the concept of judicious humour was presented as a potential “lesson” that could be imparted from clowns to nurses. This study showed that the clowns’ use of judicious humour seemed to foster instant connections through the use of humour. The literature was consulted to see what is already known and a case was made for nurses to recognize that humour has value in their patient relationships and that incorporating humour as a skill set provides them with a modicum of nursing expertise. The next and final chapter will provide conclusions, limitations of the study and recommendations for practice and future research.

Chapter Six – Conclusions and Recommendations

If by chance some day you're not feeling well and you should remember some silly thing I've said or done and it brings back a smile to your face or a chuckle to your heart, then my purpose as your clown has been fulfilled.

– Red Skelton

In this qualitative study, seven participants from two volunteer therapeutic clown troupes were interviewed about their experiences in order to discover how clowns and clowning techniques can inform nursing practice, specifically in the art of relationship. Clowning emerged as a complex art, combining the visual elements of the costume, make-up and props with ubiquitous humour, laced with sensitivity and compassion. Participants described having a vocation for clowning, with intrinsic motivation and passion. They articulated how their clown costumes and personas provided emotional shielding, giving them protection from – while also allowing entrance into – emotionally difficult situations. They also used judicious humour, intuiting when, where and how best to use humour in myriad patient situations in a way that brought relief to patients and families. Insights from clowning can help nurses to expand their relational art: In patient settings, when used judiciously, there may be no place where humour is off limits.

Conclusions

The clowns in this study provided stories rich with descriptions of clowning and relationships forged through humour, sensitivity and therapeutic clowning skills.

Therapeutic clowning is a complex art form. Clowning is far more than being a quick hand at magic tricks or telling jokes. Clowning requires a passion and motivation

suggestive of a vocation and encompasses sensitivity, spontaneity, strong listening skills, and the discipline to stay in character.

Therapeutic clowns have a unique role as part of a healthcare team. Their ability to take time to play and to be fully present with a patient through the use of humour provides a psychosocial need not necessarily provided by healthcare professionals (Dionigi et al., 2012). According to the participants in this study, clowns have the ability to push boundaries and defy the social conventions that may characterize trained healthcare professionals, particularly the convention of emotional seriousness or even somberness. In a hospital context, where patients often feel they have little control over their environment, interactions with clowns can give a modicum of control back to the patient. For example, unlike with healthcare professionals, patients may choose whether they wish to engage with the clowns or not. The clown takes cues from the patient as to whether or not to be in relationship that day.

According to the participants, nursing could learn from clowns by being more attentive to the importance of smiling – not just as a friendly demeanor, but as a signal to patients that they carry a lightness that might counter the emotional heaviness that accompanies suffering. The clowns articulate that smiling is above all else in their interactions and that it has applicability in all situations. Smiling with sensitivity denotes compassion; smiling with humour denotes fun. The participants use smiley stickers and “smile checks” on patients. A patient’s refusal to interact with a clown is met with a smile and a goodbye wave. Clowns emphasize that a smiling countenance is the one thing that they would advise for nurses. They suggest that smiling intentionally may not

only change a patient's outlook but also the nurse's. Their summary of a lesson for nurses is to "just smile".

Relational interactions can be fleeting but still meaningful. The clowns recounted how even when their time with patients was sometimes brief—involving only a short exchange—they sometimes received feedback that the patient's interaction with the clown made a memorable impact, and had lasting effects. Ford et al. (2014) describes this effect as "impact beyond the encounter" (p. 293). This is valuable for nurses to reflect upon as time constraints are common in nursing: even brief encounters may be meaningful. Being fully present in the moment is of key importance here.

Humour has a potential place in every patient setting. Clowns in this study described how they used judicious humour in palliative care, cancer wards, nursing homes, medical wards and more. Their clowning techniques varied depending on the environment and situation. Jokes and schticks were sometimes replaced with sensitivity, a quiet presence and hugs. The most impactful stories that the clowns related in this study were those that told of how clowning seemed to ease the transition from life to death or how frightening cancer treatments seemed better tolerated because of a clown's presence. Humour seemed to assist many patients by giving them the ability to deal with life's vicissitudes. Indeed, it may be the juxtaposition of humour onto otherwise sombre and emotionally laden situations that gives it its particularly poignant impact.

Limitations

In chapter three, anticipated limitations were discussed. Here, the limitations of the study as completed are reflected upon. The sample size is the most obvious limitation, as a sample group of only seven participants cannot be considered to be

indicative of the therapeutic clowning community at large. It was, and is not, the intention of this study to generalize the findings. Rather, the findings are reflective of this particular group only, with their distinct qualities. The therapeutic clowns in this study were all retirees and clowning as volunteers, not professionals. Training consisted of a weekend workshop and “on the job” training; I found no research literature using a sample with similar characteristics. Additionally, only one male participated in the study. Inclusion of more males may have generated some interesting gendered perspectives on clowning relationships. For example, the male participant was the only clown in the study who preferred to clown solo. Whether this was indicative of his gender or just a personal preference is unknown but enhancing the variability of the study in this way would have allowed certain contextual meanings to be applied to the findings.

The compressed interview schedule required for this study was not optimal. Ideally, there would have been time between interviews to not only transcribe the interviews, but to also do an initial analysis of them prior to commencing the next interview. Thorne (2008) states that “concurrent data collection and analysis” should be strategically employed in interpretive description” (p. 99). However, due to travel and time constraints, this was not feasible; sometimes interviews were conducted back to back, although arranged in blocks of time. Travel time did allow for periods of reflection following the interviews and I felt that this helped to consolidate the nuances of the interviews and provided a preliminary start to the data analysis.

Recommendations

This study has led to a number of recommendations that can be delineated into recommendations for nursing practice, nursing education, and future research.

Recommendations for nursing practice. Current nursing practice is dominated by technology and an outcome orientation. This is being countered by resurgence in interest in exploring aspects of the therapeutic relationship (Jonsdottir, Litchfield, & Pharris, 2004). The clowns in this study demonstrated that humour has a definite, apparently positive impact on relationships, especially when used judiciously. As such, nurses should be encouraged to explore humour as one of the means of enhancing their own relationships with patients. While not suggesting that nurses take up clowning or provide comic routines in tandem with their nursing work, they can be encouraged to share humour with patients in simple, yet significant ways.

If using humour in therapeutic relationships is a new concept for nurses, resources should be sought that demonstrate not only the value of humour in relationships but also some simple techniques for implementing “clown-play” into nursing practice. This is the premise behind a recent book by Warren and Spitzer (2014), which works to bring theory into practice in easily integrated play activities. Nurse educators should be encouraged to present humour seminars outlining humour’s therapeutic benefits. As nurses become familiar with humour and the subtle ways it can be incorporated into therapeutic relationships to good effect, they may be more likely to start to use it.

One of the most significant ways to improve a relationship is to simply smile, according to the clowns. Smiling faces adorn the stickers that clowns freely pass out and a smile is *de rigueur* for the clown’s face. It infuses everything they do. Smiling was the

one piece of advice that all study participants had for nurses. Even nurses who do not feel they have a sense of humour can easily smile at patients; it is cost-free and takes very little practice. While encouraging nurses to smile more when nurses are feeling overworked and understaffed might seem unusual, workplaces may identify a “humour champion” who could use the concept of gamification, for example, where activities are made more enjoyable by applying principles of game design. This and other ideas could encourage more smiling in the midst of a busy workday.

Nurses should be introduced to the role of therapeutic clowns through presentations and nursing literature such as professional association journals. In places where therapeutic clown troupes do not exist, education such as this might prove to be the impetus needed to spark interest in either taking up clowning themselves or working for advocacy and implementation, similar to the groups that have driven and continue to drive the implementation of midwifery services in Ontario (Association of Ontario Midwives, n.d.). All that is needed to start is someone’s desire to effect change and a willingness to take on the cause; a grassroots movement is often the most effective, as it gathers together those with a common passion. In this sense, therapeutic clowns may be an untapped resource for nurses.

Recommendations for nursing education. As the nurse-patient relationship is first experienced and explored as a nursing student, it seems prudent that judicious humour, as a component of therapeutic relationships, would be introduced during nursing education. Nursing students should be taught that judicious humour has a place in all patient settings, enhancing not only the patient’s experiences but their own as well. While not every student will have a well-honed sense of humour, aspects of therapeutic

clowning, such as the sensitivity ingrained in a clown's work can be incorporated into a training program as suggested by Leef and Hallas (2013). They introduced a clowning workshop with nursing students, which proved to be very successful in emphasizing sensitivity as well as levity. Such training could easily be incorporated into the curriculum when discussing therapeutic communication. Medical schools are also recognizing the value in introducing humour concepts into their medical training (Gibson, 2004).

Recommendations for future research. A recommendation for future research, which would expand on the findings of this study and add further insight into the relational aspects of the clown-patient dynamic with its applicability to nursing, would be an ethnographical study of therapeutic clowning. An ethnographic approach would provide an element missing in this study – the opportunity to become immersed in the participants' clowning life, to observe their clowning interactions with patients and to make interpretations based on observation. Along with interviews from clowns, patients and even nursing staff, participant observation would help to provide context to the situations and environments in which the clowns work (Mulhall, 2003).

In the review of the clowning literature, especially the anecdotal literature, it became apparent that a number of former nurses have become therapeutic clowns (Cull, 2008; McCracken, 2015; Thies, Piatt, & Miller, 2003; Wooten & Schwebke, 2000). There is no research on the motivational factors that compel a nurse to take up clowning and a phenomenological study of clowns who were formerly nurses could possibly provide some valuable information. For example, how does a nursing background inform their clowning or conversely, how does clowning inform their nursing? Is there some

personal therapeutic benefit for nurses derived from clowning? From the perspective of those who straddle both the world of nursing and the world of clowning, some interesting insights may be gleaned.

Also recommended are further comparison studies between therapeutic clowns and nurses to examine some of the themes and constructs highlighted in this study, such as vocation and emotional shielding. In this study, these constructs were discussed and parallels made between the two professions. However, further research is warranted to provide a more fulsome look at the implications vocation and emotional shielding may have on both professions, especially in the art of relationship between nurses and patients – and potentially between members of the health care team. In addition, further comparison studies should move beyond volunteer clown groups to incorporate professional clowns with more extensive clown training. This would explore whether theatrical skills, advanced clown training, or those who clown as a career, would provide different findings.

The most surprising finding was that judicious humour may have a place in all patient settings. Accordingly, further research on humour in nurse-patient relationships would add to the discourse, especially in those areas where humour is traditionally not considered appropriate, such as areas where there is end-of-life care. The research literature on humour, explored earlier in this study, generally concludes that nurses should incorporate humour into their nursing practice. This generalization does little to address those nurses who believe themselves to lack inherent humour. If humour is seen as such a valuable component of the nurse-patient relationship, research should focus on how to foster humour in all nurses; to draw out the levity that might assist nurses in their

practice and their emotional response to the burden of care. The impact of a smile on therapeutic relationships, as previously discussed, would be a logical starting point, as this can apply to all nurses, not just those who have a well-developed sense of humour.

Chapter Summary

This chapter sums up an interpretive description study on therapeutic clowns. Conclusions from the study were presented, followed by study limitations. Recommendations for nursing practice, nursing education and future research were delineated. This study makes a unique contribution to nursing knowledge through its focus on therapeutic clowns with the intended purpose to learn what lessons can be extrapolated to nursing practice or, in other words, the body of nursing knowledge. While the focus was on relational perspectives, the study also provided insight into therapeutic clowning as well as humour.

The study's purpose was to generate meaningful knowledge that nurses can use in clinical practice. It is my hope that the study's findings, or "lessons from the red nose" will be of value to nurses as they continue to improve their clinical practice and therapeutic relationships.

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Appendix A

E-mail Recruitment Request

Hello,

My name is Sandra Graham. I am a registered nurse and a student in the Master of Science in Nursing program at Trinity Western University in Langley, B.C. As part of my course work, I am doing a research project on therapeutic clowns. Specifically, I am interested in learning how clowns relate to patients so that nurses may take some of these lessons and bring a therapeutic clown's compassion and playfulness into their work at the bedside.

I want to hear about how you relate to patients – the things that work and the things that don't. I am interested in how you prepare, how you relate to patients, how you dress to reflect your clown persona, what props you use and more. I will be asking you to share some of your clowning stories and reflections on what it is like to be a therapeutic clown. I would like to audio record these stories, as well as take photographs of your costume(s) and props.

If you wish to participate, I would arrange to meet with you for approximately one hour. At that same time, I would also like to take some photographs of your clown costume and any props you may use; therefore, some time may be required prior to our interview for you to assemble your costume. I will not be taking photographs of you wearing the costume due to privacy and confidentiality concerns. Later, I may contact you again for some clarification on some of the things you have talked about to make sure that I understand your point of view correctly. During the research period, you may ask me any questions. In addition, you may withdraw from the study at any time, with no consequences. Confidentiality is paramount. Your participation and anything you say in the interview, along with the photographs of your costume, will remain confidential. I will not be sharing any of your identifying information with anyone.

If you have concerns regarding the study that I am unable to address, you are encouraged to contact my thesis supervisor, Dr. Sonya Grypma at (604) 513-2121, Ext. 3283 or by e-mail at: Sonya.Grypma@twu.ca.

I hope to share the findings of my thesis with nurses. I would like to improve the relationships nurses have with their patients by giving them some knowledge of clowning skills with the hopes of bringing some of the many clowning qualities into their work.

Your participation in this project would be greatly appreciated. You may contact me by e-mailing or calling me at the contact information listed below. In addition, the contact information is available in a recruitment brochure that will be available at one of your monthly clown troupe meetings.

Thank you in advance for considering my request.

Sincerely,

Sandra Graham, BSN, RN.

Home: [removed]

Cell: [removed]

Sandra.graham@mytwu.ca

Appendix B

Recruitment Poster

**Calling all caring clowns!**

If you are a caring clown with a year or more of experience, I would love to hear from you about your experiences. I am conducting thesis research on caring clowns and you have valuable information to share! Please consider being a participant.

For more information, please contact Sandra Graham:

E-mail: Sandra.graham@mytwu.ca

Phone: [removed]

Thesis supervisor: Dr. Sonya Grypma, School of Nursing, Trinity Western University, Langley, BC. E-mail: Sonya.Grypma@twu.ca or Phone: 604-888-7511, ext 3283.

If you have concerns about your treatment or rights as a research participant, please contact Ms. Sue Funk at the Research Office, Trinity Western University.

E-mail: Sue.Funk@twu.ca or Phone: 604-513-2142

Appendix C

Demographic Collection Tool

Name:

E-mail

Address: _____

Phone:

Code:

Date of Interview:

1. Gender (circle): Male Female

2. Age: _____

3. Occupation/Previous Occupation:

4. Education:

5. Length of time clowning:

6. What type of clown training have you had?

7. How many times per month (on average) do you clown?

Appendix D

Copy of Consent – Approval Date March 16, 2015

(Original Provided on Trinity Western University School of Nursing Letterhead)

Project Title: Lessons From the Red Nose:

What Nurses Can Learn From Caring Clowns

Principal Investigator: Sandra Graham, Master of Science in Nursing Student
Trinity Western University, Langley, BC.
Sandra.graham@mytwu.ca / [removed]

Thesis Supervisor: Dr. Sonya Grypma, School of Nursing,
Trinity Western University
Sonya.Grypma@twu.ca / (604) 888-7511, ext 3283.

What is the purpose of the project?

This thesis project is being undertaken in partial completion for a Master of Science in Nursing degree in the School of Nursing at Trinity Western University (TWU). I am interested in exploring the stories of therapeutic clowns to discover what nurses can learn from therapeutic clowns and what aspects of therapeutic clowning can be transferred to bedside nurses. This knowledge will potentially allow the many positive aspects of therapeutic clowns to be utilized within any facility, not just those where therapeutic clowns are currently present. It is hoped that the study findings will be shared with the greater nursing community at large through publication in scholarly journals or through presentations and conferences.

I anticipate completing this project by September 2015. I have received no funding for this project. The Trinity Western University School of Nursing, as well as the TWU Ethics Review Board has approved this project and its procedures.

What is the procedure?

Your participation in this study is completely voluntary and in no way is an expectation of either your therapeutic clown group or your clown peers. The decision to participate is yours alone. It is important for you to understand what this research involves. This consent form will tell you more about the study, why the research is being done and what it will mean to you as a potential participant. As well, it will describe any possible risks or benefits to you should you decide to participate.

If you chose to participate in the study, you will:

- a) Send me an e-mail indicating your interest. I will e-mail you the consent form to review.

- b) Arrange a mutually agreeable time and place to meet. This may be your home but may also be another location such as a library meeting room or other easily accessible location.
- c) Review the consent form with me, the researcher, and sign it as agreement to participate.
- d) Participate in the interview lasting approximately one hour.
- e) Arrange your clown costume so that it is suitable for photographing. In addition, any props used in clowning will be photographed. To ensure anonymity, no faces will be photographed. Photographing the costume and props may take up to ½ hour. As an alternative, you may provide me with a photograph of your costume but it must not have your face or other identifying features in it.
- f) Potentially participate in a second interview, or be contacted by e-mail, to clarify my understanding of your descriptions and stories.

Who can participate?

You are invited to participate in this study if you are a member of either Kalamalka Caring Clowns in Vernon or Caring Clowns of Central Okanagan in Kelowna. You must be either a current clown or have been retired from clowning for less than two years. This is to ensure that you have a good recall of experiences, feelings and emotions associated with your clowning career. You must be interested in sharing your stories of clowning. It is best if you can think of memorable experiences so that you can provide vivid detailed descriptions of your clowning experiences. I am looking to interview at least 6 -10 clowns in order to have adequate data and stories to work with.

What are the potential risks and benefits of participation?

Participation in this study will require 1-2 hours of your time. This will be for the initial interview and possibly a second interview to clarify some of the themes that have emerged from the research. In addition, as your costume and props will be photographed, you will be required to gather your costume pieces and props and lay them out so they may be photographed.

There is a possible risk of psychological discomfort as you relate clown experiences that may be particularly emotional or disturbing to you. Should this occur, you will be provided with a list of counseling services in your area or be encouraged to debrief with members of your clown troupe.

Benefits of participation include the sharing of knowledge with the health care community and specifically, the nursing community. Nurses will benefit from insights you may provide on clowns' relationships with patients, the use of humour and clowning therapy. Potential benefits may result from your own personal reflection on your clowning experiences, resulting in a deeper understanding of your purpose and role as well as intrinsic satisfaction in helping the nursing community understand your work.

Will my participation be kept confidential?

Your confidentiality will be respected at all times. Information that directly discloses your identity will only remain with me, as the researcher, and will be disclosed only with your permission or as required by law. In the event that you prefer to be interviewed with another participant present, you will both agree to keep the others' identity confidential. The thesis supervisory committee will not have access to the identifying information. When the project is being reviewed and presented on completion, your identity will remain confidential.

Your interview transcripts, as well as your photographs, will be assigned an identification number and pseudonym and will be referred to throughout the study by that ID number only. The transcripts will be stored on both a password-protected computer and password-protected memory stick and only accessed by the researcher. The demographic data that you provide will be kept in a securely locked cabinet along with any paper copies of transcripts that might be used. Participation in the research will be kept confidential from your clown peers. We will meet either in your home or in a mutually convenient public place so that no one will know you are participating in the study.

After the project is completed, any documents will be securely stored for five years and then destroyed. Any further use of your interview data will require review and permission from an ethical review committee.

Withdrawal from the project

At any time during the study, you have the right to withdraw from participating or to withdraw any data related to yourself without consequence. No reasons are needed for your decision. You may withdraw by simply sending an e-mail to me or my thesis supervisor indicating your desire to withdraw and which part of the stories you shared with me may, or may not, be used for the research. At your instruction, the audio or digital files will be destroyed and any hard copies of data will be shredded.

If you have any questions or desire further information with respect to this study, you may contact me, Sandra Graham, at [removed] or Sandra.Graham@mytwu.ca. Alternatively, you may contact my thesis supervisor, Dr. Sonya Grypma, at Sonya.Grypma@twu.ca.

If you have any concerns about your treatment or rights as a research participant, you may contact Ms. Sue Funk at the Trinity Western University Office of Research at 604-513-2142 or sue.funk@twu.ca.

Your signature below indicates that you consent to participate in this study. You will receive a copy of the signed consent form. Your signature also indicates that you have had your questions about the study and your participation in it, answered to your satisfaction. Finally, your signature indicates that your responses may be

put in anonymous form and be kept for further use after the completion of this study.

Participant's Signature

Date

Print Name

I have explained the research project to the above subject and have answered his/her questions. I believe that he/she has full understanding of the information and the procedure described in this consent form and freely consents to participate.

Researcher's Signature

Date

Appendix E

Interview Guide

Initial opening: I am interested in hearing about your clown experiences to see if there is something that nurses could learn from therapeutic clowns.

1. Can you tell me a story from your clowning experiences that had a profound impact on you or really stood out for you in some way?
2. Can you tell me about what influenced you to become a therapeutic clown and what attributes you feel are necessary to be a therapeutic clown?
3. What skills or techniques do you need to have to be proficient in your work?
4. Can you describe what your perception is of your purpose and role in the health care system and specifically in the care of patients?
5. Drawing on your clowning experience, is there anything that might be applicable to how nurses relate to their patients?
6. Tell me about how you chose your clown costume. How does this reflect your character or persona? Tell me about some of your props and how you use them in clowning.
7. Is there anything else you would like to tell me about being a therapeutic clown?

Script for Debriefing

Thank you so much for your valuable participation in my project.

Reflecting on our time together, is there anything you would like to tell me about what it was like for you to participate in this project?

What did you gain from the experience?

Were there any negative aspects to your participation? If so, could you elaborate on them?

Your participation was integral to the project and it will benefit nurses by promoting clowning techniques to enhance their relationships with patients.