Medical Clowning and Psychosis: A Case Report and Theoretical Review

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ABSTRACT
The medical clown has become an accepted therapeutic figure in non-psychiatric hospital departments in recent years. However, the potential role of the clown in psychiatry, especially for the treatment of psychosis, has not been investigated. We report here on the functioning of a medical clown in an inpatient psychiatric department. A program using psychodramatic group therapy techniques with the clown serving as moderator was developed. We describe the case of one individual diagnosed with schizophrenia who in the course of four and a half months of group therapy led by the medical clown was able to adopt a succession of surprising roles. This process may have contributed to the patient’s remission. We discuss the special capacity of medical clowns to encourage communication and indulge in fantasy while returning to consensual reality. We suggest that this may have particular relevance in work with psychotic individuals.

INTRODUCTION
As disaffection has grown in recent years with the biomedical model of severe psychiatric illness and the limits of pharmacological interventions, new directions have been sought in research and treatment. Common to many of these efforts is encountering the sufferer as a person whose distress has meaning which may be grasped and form the basis of therapy.

A novel approach not yet evaluated in the treatment of psychosis is medical clowning. In general hospitals, medical clowns’ purpose is to minimize stress for patients and their families during hospitalization and treatment (1). Several randomized controlled trials (RCTs) indicate that the presence of a medical clown reduces anxiety in the presurgical period among hospitalized children (2-5) and their parents (6, 7). Medical clowns can alleviate the negative effects of hospitalization in children and enhance the well-being of hospitalized children, their parents and staff members (8). Humor therapy RCT by “elder clowns” in nursing houses did not reduce depression but significantly reduced agitation (9).

Medical clowns provide far more than a good laugh. They can play the role of a lowly fool; by comparison, the hospitalized psychotic patient may feel empowered. The clown can, as in psychodrama, show the patient how to maintain a distance from the role he is playing. For the patient, this distance can provide a perspective from which to rethink his sick role as a powerless patient. Finally, the clown invites the participant to adopt the role not only of family members and significant others (as is generally the case in psychodrama), but of any imagined fantastical figure he desires. In this manner, and by virtue of the makeup on his face and the red bulb on his nose, the clown allows the patient to stretch the boundaries of reality without fear of losing connection with it. This consideration in particular makes medical clowning an intervention worth evaluating in the treatment of psychotic patients.

In this brief case report we describe a group therapy intervention by a medical clown (AG) working in an inpatient psychiatric department. We focus on the therapeutic process of a specific patient with schizophrenia...
THE THERAPEUTIC CLOWNING PROCEDURE
AG, a medical clown who uses the professional name Professor Chimichurri, has developed the therapeutic program in which the treatment we report took place. This program included one hour a week of group therapy with AG costumed as a clown. Each therapeutic session involved a psychodramatic therapeutic paradigm with three stages: introduction and warming up, role playing, and de-roling. In the first stage AG asks each participant his name and how he feels today, and then explains the session’s procedure to the participants. Afterwards, AG plays some recorded music and each group member makes a movement which the rest of the group repeats. At the second stage, the role playing stage, AG ask each person in the group to choose a costume (hat or accessory) and to imagine himself as a fictional or real character whom they would like to meet (e.g., relatives, people they haven’t met for a long time, people whom they would like to meet either because they miss them or on account of unfinished business, etc.). The participant talks and behaves as the character and AG asks him why the character has appeared and encourages him to communicate with the group. Sometimes AG asks the individual to act again as himself in order to highlight the gap between their own vs. their character’s points of view. At the third stage, the de-roling and session summary, AG asks the group member to shed the character and to resume being himself. Afterwards, AG concludes the meeting while ascertaining that no one is confused. The role of the group moderator in this therapy includes several components: maintaining a positive atmosphere conducive to the functioning of each individual in the group; facilitating patient participation in each phase of the therapy; clarifying what was taking place on the stage whenever necessary; and reflecting the emotional states of the participants. The moderator refrains from suggesting psychodynamic interpretations.

THE STORY OF B
B, a 28-year-old religiously observant single Jewish man with a DSM-IV diagnosis of schizophrenia, participated in the group therapy. B heard voices telling him that he was a pathetic, worthless individual. He was intermittently catatonically and always with blunted affect, limited speech, passiveness and low self-confidence. Pharmacotherapy included in the past a wide range of antipsychotic medication, but for the duration of the treatment described here remained unchanged with quetiapine 600 mg daily. He did not function in individual psychotherapy. Nevertheless, he agreed to participate in group therapy with a medical clown.

Early in the treatment B chose to be a policeman. He was rigid, with minimal body movements and virtually no speech. Two weeks later, B chose to be “David the builder.” He made some sharp movements with a hammer that he took from the available accessories and seemed pleased with the character that he chose. By the next session, B chose to be “Barbapapa the policeman,” a fictional persona. He was happy and had a childish smile during the meeting. His next choice was to play a first grade teacher. He roamed all over the room. The therapist had a sense that B was becoming more enthusiastic in the group and starting to grasp its potential.

Subsequently, B adopted the role of a pantomimist. It seemed as if his body was freed while his speech remained mute, catatonic. Two weeks later, though stressed by an imminent meeting with the medical staff, B chose to be an energetic chef who baked cakes. Two weeks after that, B was the fictional singer “Kemari,” famous for his soul songs. B sang a popular song, to the applause of the group.

The next session was particularly dramatic. B became Simba the lion king. He entertained the group with tales of life in the jungle and declared that his duty was to protect other animals, a role he carried out symbolically. He continued to expand his dramatic repertoire, and, at the next session, played a stand-up comedian who successfully aroused laughter among fellow patients, his audience. (We stress that outside the group he exhibited no signs of mania.)

At the following meeting, B’s choice of roles took a turn for the amusingly bizarre. He became an astronaut visiting aliens. AG asked B about life in outer space, and suggested that B teach the group the famous alien dance. B surprised everybody by performing modern ballet movements, moving his hands and the rest of the body, while emitting eerie noises.

In the final meeting, B became Spiderman. He walked around the room by “launching” his cobweb with precise movements. He told the group about his relationship with Superman, whom he considered a dull figure. As Spiderman, he allowed himself to laugh at Superman, and demonstrated a cultivated sense of humor.

In the course of the meetings, over a span of four and a half months, B made great progress, as reflected...
in his greater social interactions and general functioning. Outside of the group as well, in outpatient follow up, B appeared more confident, and was able to join a sheltered workshop. He said that the voices no longer troubled him, though he was unwilling to discuss the matter further, and while he agreed that he felt better and had enjoyed the group therapy, he was unable to attribute his improvement to anything specific.

**DISCUSSION**

We have presented here the group therapy of a patient diagnosed with schizophrenia who had serious impairment of functioning, suffered from hearing malicious voices, and exhibited significant negative symptoms. In the course of four and a half months of group therapy led by a medical clown, his well-being, subjectively reported and objectively assessed, improved significantly, and he became far less symptomatic. While psychopharmacology may have played a role, B seemed to have improved to an extent beyond what he had known for many years, during much of which he had been on medication. We therefore attribute much of the improvement to the therapeutic process. To understand how this might have happened, we will try to provide historical and conceptual background about clowning (see ref. 10, to which we are indebted).

In the course of our lives, we are called upon to play different roles within the social world. These roles are units of culture which provide a template by which a person interacts with others. People ordinarily comprise within themselves a dynamic variety of roles for different situations. A balance between these different roles is an important aspect of health (11, 12). Drama therapy is an attempt to broaden the variety of roles which a person can wield, and to help him cope as well with the roles of others.

The clown may perform a special function in this area. A clown is considered to “lack an understanding of or respect for social norms and decorum” (13, p. 246). Either from miscomprehension or – like a Shakespearian court jester - out of deeper awareness of the situation and the daring to parody it, he acts in unacceptable ways. The medical clown, while exploiting these functions, makes special use of empathy and compassion in his work.

Yet the clown is a different kind of social role. Rather than developing in response to social interactions, the clown in his role is true to his own logic and understanding. This is a trait which can provide him with special empathy for a psychotic person. Similarly, the clown’s ability to embrace contradiction, to be both lovable and ostracized, to be in constant motion while flouting any rules of logic, can make the psychotic person’s world more accessible (14).

Moreover, a person with psychosis sometimes appears to concretize his fantasies till they appear real to him, rather than the fruit of his imaginings. A clown, by the absurd role that he plays, is a sort of walking Winnicottian transitional space, presenting the possibility of embodying a role without being consumed by it. This too is a model with special significance for the treatment of psychosis (15).

Finally, a person who is in sufficient distress to be hospitalized may find himself stripped of personal identity, constrained to eat, sleep, and bathe with others, constricted to the role of a “mental patient,” and at the bottom of the social hierarchy. The clown’s intervention here can be twofold. First of all, as with psychodrama, the clown holds out the possibility of assuming roles of the person’s choosing beyond remaining solely a mental patient. Even more than in psychodrama, the possible roles one may choose with a clown are unlimited by reality testing. Secondly, the clown, playing a figure of derision, allows the patient to feel less inferior than he ordinarily would in dealings with the purportedly healthy, normative staff. This too differentiates psychiatric medical clowning from psychodrama.

We suggest that medical clowning with individuals suffering from psychosis may offer special advantages over other therapies, including psychodrama or drama therapy. In particular, the clown, as a bizarre figure who flouts the boundaries of consensual reality, may be privileged with unique access into the world of the psychotic. But this strength may also present a danger by providing an unintended legitimacy of a psychotic reality.

A recent hi-tech innovation in therapy with psychotic patients bears a resemblance to what we are trying to accomplish with medical clowning. Leff and colleagues (16) used a computer-generated avatar to treat medication-resistant auditory hallucinations. The therapist communicates with the patient via a computer screen exhibiting a face chosen by the patient as appropriate to how the latter imagines the source of the voice, in a voice similar to the perceived auditory hallucination. As with our psychiatric medical clowning, the patient can learn to relate differently to the personified source of his psychotic distress. A potential advantage of medical clowning is that unlike avatar therapy, it need not be limited to hallucinatory symptoms but can deal with
delusions as well. Further work will of course be necessary to show that this is so.

In the case of B, all of these components of therapeutic clowning came into play. B started therapy silent and passive. Even before hospitalization, the roles he adopted in his life were severely restricted, and became more so once admitted. He was deeply unsure of himself, acutely uncomfortable in dealing with staff, and unable or unwilling to participate in individual psychotherapy. He was particularly reticent with medical staff. Yet invited to join a therapy group by a man with stripes on his face, a round red nose, a garishly colored jacket, and shoes the size of his arms, B agreed.

In the course of therapy, he chose a succession of roles which would have been unavailable to him outside of the group. First he was a policeman, which might have been some sort of punitive introject, that allowed him to identify with the aggressor. Subsequently, his choice of figures became increasingly absurd, in a way that conventional psychodrama might not have allowed. As he discovered his voice, he went from a silent pantomimist to a singer and stand-up comedian. Empowered, he became the king of the jungle and a superhero. Though deroled at the end of each session, the benefits remained with him afterwards. He no longer conducted himself as some sort of lower caste figure in a psychiatric department hierarchy. He was more active and comfortable being “himself” with other people. He was able to enter a rehabilitation program. The voices appeared to continue, but caused less distress. He remained wary of medical personnel, further heightening the contrast in his comfortable connection with the medical clown.

Of course, this is only an anecdotal case report, with the attendant limitations. A case report is hardly enough to prove the value of a treatment modality. Selection bias is inherent to a case study: Of the various participants in the therapy, we chose to tell B’s story because he seemed to flourish in this modality of therapy. The story of the other patients would have been less dramatic. We also used no structured scale to quantify B’s progress. These shortcomings need to be overcome in subsequent studies.

One may claim that the progress in B’s condition derive from the elements of drama therapy in the group activity. Perhaps drama therapy would have been sufficient to produce the gains we saw. And medication may have affected symptomatology as well. Our impression remains that the surprising freedom exercised by B in the group, the joyful absurdity of his choices of roles that might have been inhibited by more conventional therapy, and the empowerment and self-confidence which seemed to be beyond the symptomatic improvement one might hope to achieve pharmacologically, all point to the crucial benefit of the red-nosed therapist.

Corroboration of the special benefits of clown therapy with psychotic patients and in psychiatric wards will require wider experience and additional reports. A controlled study might usefully employ standard drama therapy for comparison. We hope that this promising therapeutic modality, new to psychiatry, will be further exploited and researched.

References