

CRACKING UP

Mental Illness and Stand Up
Comedy: A Social
Representations Approach to
Anti-Stigma Resistance



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ABSTRACT

Large scale attempts have been made to challenge continuing stigma towards mental illness without widespread changes in public attitude. From a social representations perspective, this qualitative study examines the potential role for creative approaches facilitate resistance against the negative representations that marginalize people with mental illness. Fourteen interviews were conducted with individuals from Stand Up for Mental Health, a stand up comedy program for people with mental illness. A thematic analysis elicited four global themes: supportive environment, renegotiation of self image, re-evaluation of group membership and contesting meaning. Results show the ways that the Stand Up for Mental Health program positioned individuals for active resistance against the negative representations of mental illness. The findings support previous suggestions that a proactive approach to social representations may have benefits in participatory health projects. While Stand Up for Mental Health is not a traditional health program its structure lends it to the same discussion.

Keywords:

Mental illness, stigma, social representations, comedy, identity

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CHAPTER ONE

1.0 Introduction

As Mark Twain once said, “against the assault of laughter nothing can stand”. Freud (1928) viewed humor as one of the healthiest defense mechanisms. He believed that humor allowed individuals to maintain a detached perspective in adverse situations, thus avoiding the depression, anxiety, and anger that might arise while maintaining a realistic view of oneself and the world. A novel and exciting program in Canada is exploring whether the cliché “laughter is the best medicine holds” true for the challenges of mental illness as well.

Mental illness presents a dual challenge. On one hand, people with mental illness battle with symptoms and the side effects of treatment. On the other hand, they endure social challenges that result from the stereotypes and prejudice, fueled by ignorance and misconceptions about mental illness. Modern investigations of stigma began with Erving Goffman (1963) whose influential work *Stigma: Notes on the Management of Spoiled Identity* defined stigma as an “attribute that is deeply discrediting” and that reduces the bearer “from a whole and usual person to a tainted, discounted one” (p.3). While the field has evolved, stigma, beyond any limitation, conjures images of social judgement, intolerance and discrimination.

The pernicious impacts of mental health stigma attacks on two levels: the psychological disposition as well as the interpersonal processes between individuals and groups. Public stigma is the reaction of the general public to people with mental illness that emerge in interpersonal interactions as well as stereotyping and negative images of mental illness in the media. With an arsenal of accompanying repercussions, ranging from health insurance and housing issues, to unemployment and decreased life satisfaction (Link & Phelan, 2001), stigma can prevent patients from receiving the best treatment, or at times stigma prevents individuals from seeking any treatment at all (Holmes & River, 1998).

With stigmatization, there is also the possibility that an individual will internalize negative messages. Self-stigma manifests diverse responses. Coined as the “paradox of

self-stigma” (Corrigan & Watson, 2002) some typical responses include decreased confidence, loss of self esteem and withdrawal; whereas individuals at the opposite extreme become energized by prejudice and express justifiable anger, feelings which are then channeled into activities such as activism and empowerment.

While most anti-stigma campaigns are centered on mental health consumer movements, or “Mad Pride” campaigns, Stand Up for Mental Health provides a unique entry into mental health empowerment and advocacy. In this paper, I will explore the possible contribution of the arts in the creation of positive group identities that will help mobilize marginalized groups to engage in resistance against stigma, an exploration framed through the lens of social representations.

1.1 Stand Up for Mental Health Program

“Most people think you have to be nuts to do stand up comedy. We offer it as a form of therapy” - slogan for Stand Up for Mental Health

Stand Up For Mental Health (SMH) is a twelve month program that teaches stand up comedy to people with mental illness. This innovative program was created in 2004 by David Granirer, a counsellor and stand up comic who also has depression. The program’s mission is twofold: to empower participants and increase their confidence and to challenge public stigma towards mental illness.

Each potential student undergoes a screening interview to make sure he or she meets the criteria for participation in Stand Up For Mental Health. Participants must:

- Have a mental health illness or mental health issues
- Have stable housing
- A support system of both peers and professionals
- Be stable on any medication they are taking
- Have a reasonable command of written and spoken English
- Have the motivation and desire to create healthy change
- Have a desire to do stand up comedy

The program consists of three phases. Following a brief screening interview, selected participants take an initial three month course in which students learn how to write, perform, structure and edit a comedy act lasting between 3-6 minutes. After three months of weekly classes, the students do their first “warm up” shows in venues

selected because the audience is known to be supportive. After 2-3 warm up shows, the participants are featured at a debut performance gala at a local theatre.

In the second phase, which last six months, classes are reduced from weekly to biweekly. The class focus now becomes honing comedy skills, learning advanced writing techniques and interactive comedy skills, and developing a whole new set for their Graduation Showcase. During this period, students perform regularly averaging 20-30 in various venues ranging from conferences and forums, treatment centers, university and college campuses, and other public events.

Once students have finished their first year, they are invited to join the Alumni Program, the third phase. This group meets once every two weeks which allows students to continue writing and performing. Please take this opportunity to review Appendix I (the CD), which is a video compilation of a few performances designed to give a flavor of the program. This inspiring and creative program provided the impetus for the research presented in this dissertation, in attempt to tease apart the different elements and conceive a suitable theoretical explanation for the program's effects.

1.2 Personal Motivation and Research Questions

This research was borne out of my love of the arts, my appreciation of their role in well-being and finally my own experiences with stand up comedy. In 2006, I took a stand up comedy class, also taught by David Granirer, which is how I learnt about the SMH program. I was intrigued by how such an obscure activity such as stand up comedy could produce such radiating effects on confidence, self-esteem and self-efficacy. While not a traditional art form, stand up comedy is a unique performance skill. And unlike other artistic mediums such as dance, theatre or music, stand up comedy uses words, language and stories that are not only *written* but also *performed* by the same individual. Through my own experiences in stand up comedy, both as a comic and as an audience member of a SMH show, I became interested in studying the features of the program that enabled SMH to create empowering spaces as well as the program's concurrent effect on public stigma. This curiosity led to the formation of two research topics. Using knowledge of community psychology, I sought to assess how the stand up comedy format used in the program created opportunities to negotiate new positive and

empowering identities. Furthermore, I sought to explore how these newly created positive identities are complemented by dynamics of stand up comedy to fuel resistance against the negative social representations of mental illness.

CHAPTER TWO

2.1 Conceptual Framework

In the section that follows I will describe the status of mental health stigma related research. I will continue by discussing the theoretical framework that will contextualize the program specifics and underpin my research questions. In the final section of Chapter 2, I will attempt to capture some of the literature specifically related to Stand Up for Mental Health, namely social representations of mental illness, the role of humor and a snapshot of the arts' role in positive identity creation.

2.1.1 Mental Health Stigma Research

Mental health stigma has been researched from multiple vantage points. Wahl (1999) investigated mental health consumers experiences of stigma whereas others have probed into the role anticipation of perception of stigma (Angermeyer, Beck, Dietrich, & Holzinger, 2004). Research has also illustrated the importance of considering subjective understandings of stigmatized conditions and societal reactions in order to understand the relationship between stigma and self esteem (Camp, Finlay, & Lyons, 2002). Other studies have explored how social support modifies perceived stigmatization (Mueller, Nordt, Lauber, Rueesch, Meyer & Roessier, 2006), the structural levels of mental health stigma (Corrigan, Markowitz, & Watson, 2004) and the potentially dehumanizing relationship with mental health professionals (Schulze, 2007).

Building on various theoretical explanations of stigma, mental illness anti-stigma programs have attempted to reduce the impact on people's lives through coping techniques and public campaigns to reduce the continued acceptance of prejudice toward mental illness. Although mental health research has explored at great length the

impact of stigma, only recently has the research attempted to explore how best to confront stigma. Within this field, three approaches to confronting stigma have been developed (see Campbell & Deacon, 2007 for review).

The first approach emphasizes individualistic explanations for stigma. It draws primarily on social cognition approaches which examine psychological attributes of perpetrators and targets and the interaction between them. As an example of this approach to mental health stigma, Corrigan et al. (2001) proposed a trinity of education, contact and protest grounded in social attributional theory as the most effective way to challenge stigma.

The lack of widespread results arising from individual approaches has shifted the focus to macro-social inequalities. From this perspective, stigma is not an individual reaction but a social process linked to power, dominance and exclusion (Parker & Aggelton, 2003). Macro-social stigma interventions regarding mental health have included changes in legislation; however, despite these changes mental health stigma persists at an alarming rate.

Link and Phelan (2001) adopt an approach that defines stigma in the relationship of several interrelated components, bridging the polarity between individual and macro-social approaches. In their conception, stigma exists when elements of labeling, stereotyping, separating, status loss, and discrimination co-occur in a consenting power situation. Building on this, Joffe (1999) accentuated that in the construction of stigma, individual and society are inseparably connected: a conception suited to an approach guided by Social Representations Theory.

2.1.2 Social Representations Theory

The discipline of social psychology must embrace both the social and the psychological in its aim to study the relationships between the individual and society (Moscovici, 2000). To sufficiently understand mental health stigma, we need an approach that focuses on the dialogues between self and society, emphasizing the co-construction of reality. Hence the capacity of Social Representation Theory (SRT) to simultaneously conceptualize the power of society and the agency of individuals demonstrates its utility for stigma research (Howarth, 2006).

SRT describes how and what people think in their everyday experience and how a wider social reality influences these thoughts (Moscovici, 1984). Moscovici described social representations as the practical tools that people use to orient and guide themselves in the world, forming dynamic systems of knowledge that shape our system of communication, our understanding of reality. Social representations concern the contents of everyday thinking that give coherence to our beliefs and ideas. Social representations serve to “make something unfamiliar, or unfamiliarity itself, familiar” (Moscovici 2000, p.37), to give meaning to and make sense of objects, persons and events that we encounter and to establish shared classification system within a group.

SRT has been criticized for having an individualist focus where *internal mechanisms* are the mode of the transmission of representations (Howarth, 2004). However, Howarth argues that social representations should not be understood as *being transmitted*, but rather *negotiated* within the social sphere *between*, not *within* individuals. As a deduction, Arruda (2003) proposes that the combination of social representations with identity and community theories enables social psychology to leave the laboratory and enter the real world.

2.1.3 Social Identity Theory

Social representations provide a unique perspective to study of identity: explicitly incorporating social context as an integral element of identity construction. SRT strongly complements our understandings of identity because our representations and knowledge systems define how we make sense of reality and the everyday and how we understand ourselves and others (Jovchelovitch, 1996). After all, identity, the process of making sense of who we are, is fundamentally about our own “meaning.”

Tajfel (1981) conceived social identity as “that part of an individuals self-concept which derives from his knowledge of his membership of a social group together with the value and emotional significance attached to that membership” (p. 255). As Duveen (2001) explains, identities are not only elaborated internally but concurrently constructed externally, linked with symbolic understandings generated in a specific context:

recognition of an individual's position within a given social milieu partially determines an individuals' sense of who they are.

When envisioning the contextual elements of identity, it follows that the social realm constrains and restricts our identity formation. We are born into a world of existing representations and our embedded location in the social space constructs our social identity. Social representations provide this “scaffolding” for identity construction, endowing our social categories with meaning, content and value (Howarth, 2002). In this way, we internalize social representations which then permeate our self-understanding. From the perspective of social representations, social identity appears as a function of representations themselves (Duveen, 2001). “Identity... is not some thing, like a particular attitude or a belief... it is the force or power which attaches a person or a group to an attitude or a belief, in a word, to a representation” (Duveen, 2001, p. 268). The social identities that are projected onto us reflect others' expectations and representations of the groups of which we are members. Social Identity Theory (SIT) provides an important perspective when attempting to make sense of group behavior and identity in terms of labeling, and the boundaries of inclusion and exclusion, integral components in the discussion of marginalization.

2.1.4 Marginalization

Although common reality is driven through the collective negotiation of social representations, different social groups have differential access to the social dialogue that determines boundaries of legitimacy. Social representations create a robust system of categories that prescribe our reactions to and interpretations of objects, persons or events. This process of classification is not a neutral affair: we label using existing positive or negative categories which predetermines how we respond (Moscovici, 2000). The unequal voice of social groups allows dominant social groups to determine favorable protocols for categorization. Accordingly, the process of social comparison, based on these in/out group divisions, frequently relegates out-group members to subordinate status. As Tajfel & Turner (1979) explain, establishing a positive difference between in-group and out-group strengthens the self-esteem of the in-group members.

Therefore, based on these in-group/out-group distinctions, different groups experience varying levels of legitimacy, belonging and exclusion (Howarth, 2001).

This pattern of diminished validation holds especially true for mental illness. The historical context which originally defined the in/out boundaries between “healthy” and “mentally ill” has long past but their effects continue to permeate the social representations of mental illness, and fuel the stigmatization of mental illness. However, an unexpected corollary exists to complicate discussion of marginalization. In certain conditions, stigmatized people may contest the stigmatizing representations and practices endorsed by dominant groups (Howarth, 2006). People with mental illness do not blindly adopt the negative meanings of mental illness provided. Instead, they may use various strategies to construct positive identities and in doing so reshape knowledge about mental illness.

2.1.5 The Possibility of Resistance

While the pervasiveness of power affords the dominant group the ability to subjugate “inferior” social groups, Foucault (1980) also emphasized the unstable nature of power, which acquiesces possibilities for resistance and change. Because social representations are described as elements in perpetual flux, discourse and practices that maintain the dominant social representations must be constantly reproduced in order to achieve the appearance of permanence (Kesby, 2005). This continual reproduction creates the opportunity for transformation and resistance. Clearly, power and resistance are inextricably linked: “resistance involves power, it requires it, releases it and generates effects of power ... and it is only because there is power in resistance that we can be ... optimistic ... that resistance will happen” (Sharp, Routledge, Philo & Paddison, 2000, p.31).

Social representations always imply a process of identity formation where identities are internalized and which results in the emergence of social actors or agents (Duveen, 2001; Howarth, 2006). This approach positions the stigmatized as agents not passive objects, enabling communities to actively propose alternative representations, contributing their voice to the discussion (Howarth). Breakwell (2001) proposed several

key dimensions that help to conceptualize each unique relationship between individual and systems of representation: awareness, understanding, acceptance, assimilation into pre-existent system of representations and the salience of the representations.

Resistance is the point where a stigmatized group or individual refuses to accept the influence of the dominant group, denying the representations imposed on their identity.

Howarth (2001) reminds us that a community or individual cannot establish or develop an identity in isolation from external pressures. In this respect, resistance effort must engage the larger social environment. As Arendt (1958) has pointed out, different representations and identities are brought into dialogue in everyday arenas through speech and actions. Furthermore dialogue and discussion, resistance may be contained to immediate contexts in which they occur; or they may perpetuate a broader social movement, becoming a coordinated attempt to influence social norms to cause social change.

Generally, the agency approach to resistance presupposes that stigmatized individual's or group's experiences of themselves contrast with the negative representations and that the victims of stigma do not share demeaning representations. However, given the possibility of self-stigmatization, these assumptions are not always valid. In applying this approach to mental health practice, we must therefore also discuss the process by which stigmatized groups, who may have internalized external negative representations, can formulate new healthy, positive identities.

2.2 Literature Review

2.2.1 Current Social Representations of Mental Illness

It has been argued (Rose, 1998) that mental illness represents a failure of a social representation to familiarize: mental illness remains feared, and Morant (1998) proposed that mental illness has been familiarized as unfamiliar. Most social representation research on mental health has focused on describing the types of social representations held by various groups which are believed to create a strict hierarchy of knowledge (Howarth, Foster & Dorrer, 2004). The roots of stigmatizing representations of mental illness are removed from our immediate memory, however, they continue to permeate our modern conceptions of mental illness.

Jodelet (1991) found a distinct contradiction in her study on the representations of mental illness. The villagers in her study overtly denied that mental illness could be contagious, which is incompatible with practices in their daily lives that revolved around customs of separation. Angermeyer (1997) investigated the social representations of mental illness among the German public, exploring the knowledge and beliefs about the causes whereas Dixit (2005) looked at meanings and explanations in India. Remarkably, despite vastly different social contexts there was a large amount of overlap in the understanding of mental illness.

Foster (2001) explored the understandings the “mentally ill” held by the medical profession. The results suggest that representations of mental illness could be further differentiated into “higher level” types, such as schizophrenia, and “lower level” types such as anxiety and depression. Research also suggests some level of agreement across mental health professionals’ representations of individuals with mental illness (Morant, 1998; 2006). Common themes include: representations of mentally ill as different, suffering from impaired functioning, and general distress. Similar to lay representations of the mentally ill, the sense of difference or “otherness” was central to description of mental illness, separating these individuals from the general community (Foster, 2001).

In a later study, Foster (2003) evaluated the social representations of mental health problems held by mental health service users. Foster argued that in representational projects, mental health is described as a journey and thus within these projects representations can change and develop in response to clients actions and responses in different situations. The discussion of changing representations centered on the dimensions of controllability and location, which extend the notion of Otherness found in the public and among health professionals. This discussion presents a more complex representational structure which challenges the professional distinction between “psychosis as otherness, and neurosis as more the domain of the self” (Foster, 2003, p. 642).

Very few studies of social representations of health have been proactive rather than reactive (Howarth, Foster & Dorrer, 2004). Krause (2002, 2003) is an example of a proactive approach, attempting to show how social representations can operate as the

vectors of change. Krause examined changes in representations resulting from a self-help group that was structured around community development and empowerment. This study illustrates that social representations theory could play a more important role within participatory projects in community health. While SMH does not fall into the conventional lines of participatory health projects, its ability to generate reflection, participatory structure and transformative power lends it to the same discussion.

2.2.2 Positive Identities and the Arts

Considering the consequences associated with stigma, research has converged on the detrimental effects of marginalization, focusing on how subjugated individuals are devalued, exposed to prejudice, and negatively stereotyped. The resulting literature paints a grim picture, suggesting that targets of stigma are doomed to lives of rejection, despair, and failure. In the attempt to hypothesize effective strategies to thwart the negative consequences of stigma, investigators should also attend to the individuals who are successfully overcoming stigma, cataloging factors that allowed them to achieve this outcome (Shih, 2004).

In recent years the arts have become a method for delivering 'outcomes' such as greater social inclusion and improved self-esteem and well-being (Matarasso, 1997). Art has become innovative therapy accompanied a growing body of literature that documents the relationship between the arts and positive identity. In a study of cancer patients who participated in artistic activities, art-making permits the opportunity to retain familiar personal and social identities, and to resist being dominated by labels related to their illness (Reynolds & Prior, 2006). Furthermore, Reynolds (2003) found that meaningful artistic activity may provide a source of positive identity for people living with chronic illness, even when they have not engaged regularly in art in their earlier adult lives.

Washington & Moxley (2008) helped foster new identities for homeless women through production of art installations. The publicity of the art installations helped generate public discussion about homelessness. Their methodology also used narrative as a central feature in which participants which lead to cathartic breakthroughs for many of the women.

The arts can be useful in de-emphasizing stigmatizing characteristics, creating new group memberships and developing critical consciousness around the social structures that constrain as well as enable possibilities for identity. While stand up comedy has not yet been studied in the art therapy literature, this program comprises several shared dimensions with performing arts and narrative.

2.2.3 Humor

In contemporary Western culture, a sense of humor is widely viewed as highly desirable personality characteristic. Individuals with a greater sense of humor are thought to be better able to cope with stress, to get along well with others and to enjoy better mental and physical health (Lefcourt, 2001; Peterson & Seligman, 2004). Humor connotes the ability to poke fun at oneself and to take things less seriously, enabling a philosophical detachment in the ways one looks on life (Martin, 2003).

Over a decade ago, Martin, Kuiper, Olinger, & Dance (1993) investigated the relationship between humor, coping with stress, and positive emotion. Their findings indicate that higher levels of humor are associated with more positive and self-protective cognitive appraisals in the face of stress and greater positive affect in response to both positive and negative life events.

Psychology has always been one of the disciplines contributing most to the knowledge on humor. However, research in humor and laughter, like in other positive phenomena, has occupied the periphery of psychological research during the twentieth century. Furthermore, humor is a contextual experience, contingent on the social surroundings that provides the meaning. Meaning in turn rests on social representations, therefore it follows that social representations shape what we find funny.

Kuipers (2008) has suggested four main social functions of humor (p. 367):

- Meaning making
- Hierarchy Building
- Cohesion
- Tension Relief

Jeffers (2006) offers explanations of how stand up comedy constructs individual and group identities through processes such as calling attention to social norms. He

provides detailed descriptions of how comedians inform audiences of the social norms that govern interactions in daily life by explicitly violating these norms during their performances; and consequently they can reinforce or challenge pervasive stereotypes.

Stand up comedy is another semi-dialogical form of communication and therefore can be another medium through which social representations are negotiated. “Like conversation, stand up is a ‘collaborative production’...[and] is made possible by the active involvement of [the audience and the performer] that make up the interaction” (Rutter, 1997, p. 92).

CHAPTER THREE

3.0 Methodology

Qualitative research is particularly useful when studying the ‘life worlds’ of participants (Flick, 2002). Given the complex nature of stigma and identity, a qualitative approach is useful as it allows an in-depth exploration of social phenomenon, creating thick descriptions of individual experiences. Furthermore, the decision to use qualitative research for this study was driven by the lack of existing qualitative research investigating such a unique program. While accounting for existing theories, qualitative research give the researcher the ability to be flexible and permits the data and the field itself influences the interpretations (Bauer & Gaskell, 2000; Esterberg, 2002). Even though stigma is bound strongly to *social* constructions of mental illness, the nexus of resistance in the social representations theory hinges on agency. Thus, the sensitive nature of personal experiences and self-concept and their integral relationship to agency are best suited to individual interviews.

3.1 Sample

Esterberg (2000) advises researchers to select interviewees who can offer the most comprehensive insight on the subject of study. Thereby I felt that only SMH program participants can provide exhaustive insight about program experiences.

Because of the limited number of possible participants, convenience sampling was used to recruit participants. At the my request, the program director invited former members of SMH to volunteer for research interviews. Therefore, self-selection bias limits the generalizability of results. Once respondents indicated that they were willing to participate, a one-to-one interview was scheduled. Participant profiles can be found in Appendix II.

A single interview with SMH's founder and coordinator was conducted to detail his inspiration and rationale for the program, the program's mission and his perspective on empowerment and anti-stigma through the vehicle of stand up comedy. Although this interview was not included in the analysis, its commentary contributes to the discussion of future policy implications of this work and colors some of the comments made by participants.

3.2 Data Collection

Semi-structured interviews were used because of their ability to openly explore topics, with the aim of eliciting the experiences of the participants in their own words. The adaptability of semi-structured interviews enabled each interview to be customized to each research participant while the topic guide assured the desired issues were covered (Esterberg, 2002). However, in following the direction of the interview responses, some questions were omitted, while others were added depending on context. A full list of questions can be found in Appendix III.

Written consent was obtained from all participants in accordance with ethical approval given by the Institute of Social Psychology at the London School of Economics and Political Sciences. A copy of the consent form is attached in Appendix IV. All interviews were conducted by the researcher, exploring several overarching areas of interest as outlined in the topic guide. Because of the self-selected nature of the research participants, interviews explored their past experiences to provide personal context to each participant's experience in the program. This contextualization enabled more substantial conclusions to be extrapolated. In preparation for the interviews, I watched the available SMH performance videos posted on the program's website to gather an overall impression of the jokes produced. No formal analysis of these videos were

undertaken; however, the videos help formulate appropriate interview questions and informs the themes that arose.

Two pilot interviews were conducted using the initial topic guide, which was subsequently modified to improve the flow of the questions. In any case, the pilot interviews were also analyzed, disregarding their primary status, due to the constraints on available population. Fourteen interviews were collected in total, but one interview was discarded because poor recording quality made transcription inaccurate. Interviews lasted between 40 and 90 minutes and were digitally recorded and later transcribed and manually coded. A sample transcript is included as Appendix V. While many questions remain, the responses gathered in this exploratory study achieved saturation (Guest, Bunce & Johnson, 2006).

The apparent tension between the creativity of the qualitative research process and the rigidity of evaluation stresses the researcher's influence in shaping the interpretation of the findings. The researcher herself is a positioned subject, which stresses the importance of reflexivity in analysis (Mauthner & Doucet, 2003; Rosaldo, 1989). As a former student of a related stand up comedy program, I was positioned to ask questions based on my own experiences. Sharing aspects of my experiences facilitated a sense of equality which occluded the professional split between researcher and participant.

3.3 Analysis

Thematic network analysis was used to systematically uncover salient themes that arose from the interviews and to present a clear framework summarizing the interpretation of the relationships between themes. Following the approach advocated by Attride-Stirling (2001), themes were identified and developed by reading transcripts in a multi-stage process that involved reflexivity and repeatedly revisiting the transcripts in order to clarify concepts. This approach was particularly appropriate to this research topic because it acknowledges the "fluidity of themes and emphasizes the interconnectivity throughout the network" (Attride-Stirling, 2001, p. 389) which reflects the theoretical connections between representations, power and resistance, identity and agency.

A voice-centered relational method of data analysis was employed (Mauthner & Doucet, 2003) which revolves around multiple readings of the interview text. After a first reading to explore the overall plot, a second reading detailed the reader's response, and a final reading that emphasized the voice of the participant. This approach allows the researcher to examine how and where some of their own assumptions and views — personal, political and theoretical— might affect the interpretation of the participant's response. In addition, a voice-centered approach helps construct the life that participants live and the world that they inhabit, adding distance between their way of speaking and seeing and the researcher's own.

The corpus was analyzed using a stepwise procedure to develop a coding frame based on recurring issues in the text, which eventually led to categorical organization of codes. The coding framework included both repetitive themes that surfaced from the data, as well as some preconceived, theoretically oriented codes appropriate to the social psychology stigma and the individuality of the SMH program. During the initial phase of coding, the text was dissected into smaller sections to facilitate the identification of similarities, differences and contradictions within the data (Strauss & Corbin, 1990). The process was characterized by adding, integrating and deleting codes as general themes began to emerge. Basic themes were expanded into organizing themes, grouped according to their topic similarity (Attride-Stirling, 2001). Functionally, themes embodied areas of interest which connected the data to the research questions, organized as patterns across the data set (Braun & Clarke, 2006). The organizing themes were then arranged into global themes that represented the overarching significance of the data (Attride-Stirling, 2001). The coding framework appears in table format in Appendix VI and VII with textual examples offered for each code to promote transparency and clarity. See Appendix VIII for graphic representation of the thematic maps.

The biggest obstacle in the construction of the coding framework was choosing the global themes. For example, the supportive SMH environment catalyzes the changes described in the other themes. Furthermore, I realized quickly it would be difficult to separate different themes, due to their theoretical interdependency. For instance, group identity and positive self identity both strongly affected how meaning

was contested. In spite of this, I believe that each has enough sub-themes to warrant their own discussion, which will in turn capture the reciprocal relationship between themes. This dilemma reflects the deeply interrelated components in the creation, maintenance and transformation of social representations.

CHAPTER FOUR

4.0 Results and Findings

The main objectives of this dissertation were to identify the primary aspects of the stand up comedy format and program that created opportunities to negotiate positive identities, and through the participant's insight, investigate how the dynamics of stand up comedy may be used as a tool to fuel resistance against the negative social representations of mental illness. The results from this study are presented in four broad sections, each corresponding to a global theme.

4.1 Supportive Environment

Since the environment plays a critical role in facilitating the processes described in the subsequent themes, the first topic I will discuss is the supportive and empowering context created by the Stand Up for Mental Health program. As described in previous literature, the process of resistance will take place in community settings that are salient in the lives of marginalized or oppressed groups or individuals (Maton, 2008).

For the participants of SMH, the environment provided a meaningful opportunity for participation and learning and it effectively incorporated a range of individuals with varying backgrounds, interests and skills. Learning a new and exciting skill, such as stand up comedy, helped level the playing field as this was an unfamiliar experience for all participants. This equalizing was important given the diverse levels of functioning and helped participants focus on the common goal of their performances. Moreover, mastering a new skill reinforced participant's sense of self-efficacy and confidence in their abilities.



Many participants accentuated the advantages that SMH had over a support group. While both involve supportive group dynamics, a key difference was SMH promotes a jovial environment full of laughter making it a “fun place to go” (L12).

“In a support group you all listen in respectful silence, but having a room full of people laughing is a way more powerful affirmation ... that they also get you, that they understand too...plus it’s way more fun” (H08)

Closely associated, SMH is a participatory process, full of discussion and interaction, instead of solitary sharing. In individual therapy and support groups, the primary focus is at the level of the individual whereas SMH helped to orient the participants beyond of themselves. SMH’s orientation around the goal of performing, rather than over “dwelling

in our misery” (B02), helps unite participants by incorporating a shared vision and a larger purpose.

As mentioned previously, individuals who overcome adversity develop a sense of mastery and self-efficacy from their accomplishment (Corrigan et al., 2001). Most examples demonstrating this relationship focus on activities directly related to mental health, which further equates their identity with their mental health diagnosis. This project incorporates a more comprehensive definition of well-being, thus, in spite of the indirect links between stand up comedy and mental health, the sense of achievement has a ripple effect into other areas of participants’ lives. Furthermore, stand up comedy also has many transferable skills such as developing confidence in public speaking and learning to work as a team.

“Once you’ve done stand up comedy in front of three hundred people, you can do a job interview, you can do almost anything.” (C03)

Additionally, the structure of the SMH program facilitated “psychosocial rehab” which helps participants become more actively engaged in the outside world. Reintegration with community is incredibly important because people with mental illness often withdraw from their communities leading to social isolation. For example, the consistent schedule gave people reason to leave their house and something to look forward to each week. In addition, the rigorous performance schedule forced participants to travel into unfamiliar areas of the city.

“I haven’t traveled in this city like this... I have been a hermit. You know, some months I wouldn’t even open [the curtains]. Bad, very, very bad and twenty-four hours a day I just wanted to die. So with David now I’m going all over the city now taking my little truck” (F06)

“I’ve never really been good at much, but I did this...now I’m doing more things than I used to do...coming to Stand Up for Mental Health gives me a reason to get out of bed. I love having shows ‘cause it gives me something to look forward to.” (L12)

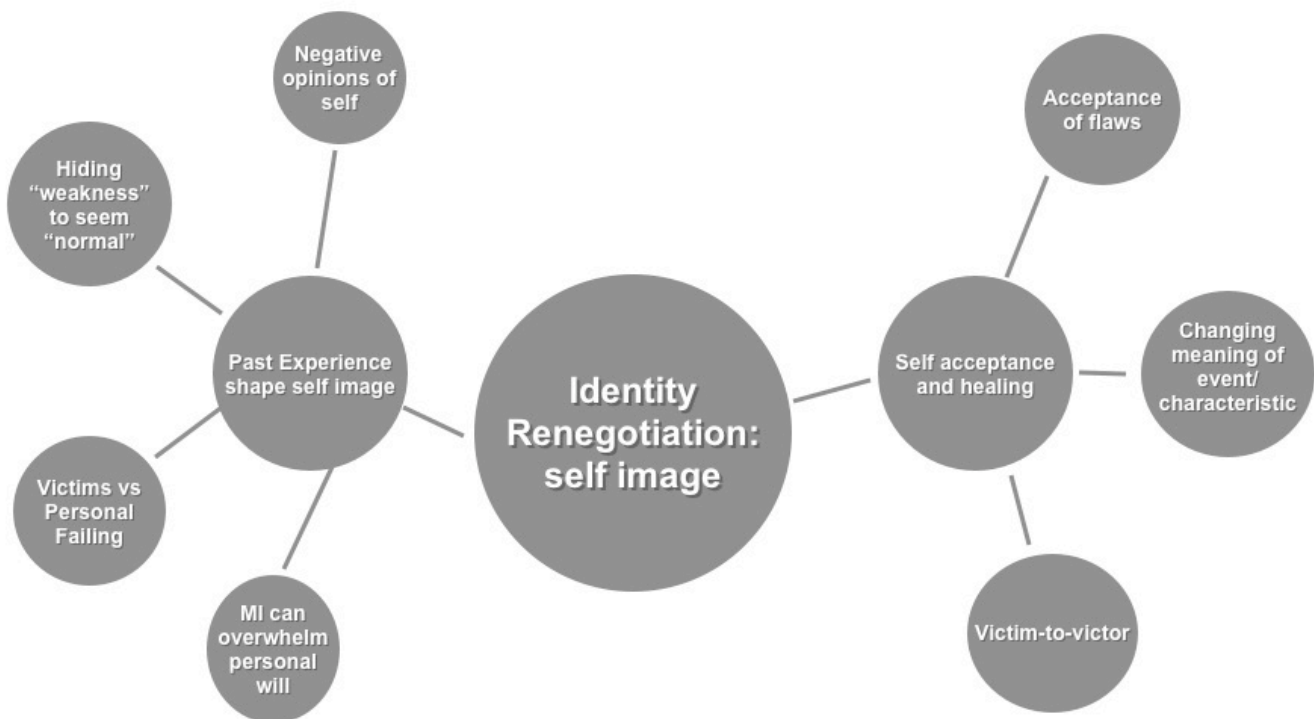
Finally, David’s impeccable leadership was a crucial element of the SMH environment. Participants described his capacity to motivate, his commitment and his ability to manage the group, skills which largely emerge from his experience as a counselor. Furthermore, his own mental illness made him both an expert from valued

social group (comedians) and concurrently, a member of the stigmatized group (“mentally ill”).

4.2 Identity Renegotiation: Self Image

Generating a more favorable identity took place in two main forms: changes in self image and re-evaluation of group memberships. While these topics have been separated for discussion in this paper, the pursuant processes are greatly interrelated.

All participants documented negative attitudes towards themselves to varying degrees, shaped through different life experiences and challenges often related to their mental health diagnosis. Among several participants, an emerging trend suggested that before SMH they felt pressure to “seem normal” and hid their weaknesses and personal



Global Theme 2: Renegotiation of self Image

struggles from the outside world. When individuals are coming to terms with their illness,

and sometimes even before a definitive diagnosis has been made, they try to make sense of their life, as Lucy (name changed for confidentiality) describes below:

"In so many ways I felt like I was an impostor, I felt like I was playing this role of somebody who was competent and that I had the whole world fooled. Just merrily going through my life naively thinking I have you all aced. It's almost as though I had taken on some dramatic role in some stage production and I was "Lucy." I was playing the "Lucy" role and doing the things that I was expected to do and I thought I was doing a pretty convincing part. Turns out, not quite so much" (D04)

The process of going public helped participant shed their masks, exposing all aspects of their lives. Although all participants had disclosed their status to some degree, they still felt like they were hiding aspects of their life because of their nonconformance with social norms, their fear of exposing weaknesses or the general sense that mental illness is not something that you talk about.

"I make this joke about putting my head in the oven, because I work at an appliance store, in my set. Everyone thinks I'm kidding...but I've actually thought about it. I have the keys and I could just turn it on. I keep that to myself cause how do you explain to people that you hate yourself that much, that on a daily basis you hate yourself that much" (F06)

Goffmann (1963) suggested that identity norms influence most of our interactions and individuals possess *impression management* strategies. However, in stand up comedy, comedians often engage in 'healthy' self-deprecation that revolves around their inability to meet these social standards (Jeffers, 2006). Therefore, the type of public openness created by SMH provided space where participants, under the preface of comedy, felt they could discuss these hidden facets of their lives that are inconsistent with social norms. In SMH this has two impacts: making fun of personal flaws signals to the audience that "hey! I'm aware of it and yes, I'm okay with it" (David); and second, the response of the audience, laughter and clapping, signifies that the audiences has received the information that a comic has shared. Their response may also symbolize the audiences ability to relate, expressing their sense of commonality. For the participants, this experience generates a sense of relief and affirmation.

"Laughter tells me whether I'm being received by society almost... 'cause when you hear laughter you're affirmed" (A01)

However, for a few participants, the risks of going public outweighed the benefits which led them to discontinue performing. Despite having disclosed to friends and

family, they perceived the level of public visibility as a threat, either to their professional careers or the personal relationships (namely dating). This indicates that even the most aware anti-stigma advocates are affected.

Another clear trend was the paradoxical experience of being treated as 'victims' of mental illness in contrast with the attribution of mental illness as a personal failing. Many participants shared anecdotes which expressed the public's understanding of mental illness as personal failure, which also implies that recovery depends on personal will and determination. This distortion in agency undermined the power and confidence that many participants desperately tried to cultivate. For example:

"I wanted the [medications] to work so bad...and then one after another, they didn't work and then I thought 'shit I can't even get this right. I can't even get well properly.'" (D04)

However, through SMH many participants experienced a cathartic healing process that helped them deal with their own self judgement. The process of writing jokes in SMH is based on sharing personal experiences and then turning them into something positive. Through this process, new meaning is attached to formally unpleasant situations when they become sources of laughter and affirmation.

Participant A01: Can I tell you a joke? It goes like this:

Setup: So I ran into some friends and these guys treat me like I was totally crazy, they wouldn't make eye contact or talk to me.

Punch line: Maybe they found the machete a little intimidating. [Joke continues] I feel bad for you I said because I have a mental illness and I might get better but you, you'll always be an asshole.

Researcher: What does that joke mean for you?

Participant A01: Well that was a really traumatic situation for me to see my high school friends and try to talk to them and have them be like "Woah this guy is weird" because I guess they heard that I have schizophrenia or something. So it's taking that stigma and turning it into something that you can laugh about.

Stand up comedy also provides participants an opportunity to tell *their* story, in *their* own way. The transition from victim to victor facilitated by SMH is a complex and powerful metamorphosis. One of the ways identity is established is through narrative, using stories about significant figures and events. Crossley (2000) suggests that creating and telling stories of one's life is a necessary part of developing and maintaining a coherent identity and sense of self because it is "through narrative [that] we define

who we are, who we were and where we may be in the future” (p. 67). Mental illness threatens identity and sense of self because an individual’s personal story is displaced by dominant illness narratives focussing on deficit and dysfunction (Carless & Douglas, 2008). The process used in SMH enables the retelling of participant’s narrative, allowing participants to “re-story” their lives in a more positive light, which promotes the reconstruction of a meaningful identity. In daily life, the stories we create are constrained by the conditions of possibility offered by a given context and the expectations of others, in essence a set of social representations. In the case of stand up comedy, individuals are freed from the limitations of reality in their creation of a comedic counter-narrative. In the comic reiteration of events, participants are encouraged to develop creative and surprising twists, which may refute the social norms and expectations that govern identity in the “real world”. The process promotes self-acceptance and healing provides participants a chance to envision more positive and constructive identities.

For many participants, this conversion from victim to victor commenced before SMH. SMH has a tradition of attracting applicants who are looking for a change: either in the approach to mental illness or in their personal feeling of empowerment and self confidence.

“I just wanted to be well, I just wanted to be happy. I wanted to be around people that weren’t viewing themselves as victims of their illness,” (D04)

“ I think that I just was really looking for, a place to get some power back... I wanted to get my confidence back. I wanted to quit hiding.” (G07)

Thus, the program cannot claim to be sole factor generating this transformation but rather has a supportive role in cultivating new positive identities. However, even when considering this caveat, it is crucial that the influence of SMH is not depreciated.

Many participants continued struggle with some degree of self-stigma but all were aware of their internalization of the negative representations of mental illness. Participants actively take steps in the effort to achieve a shift cognitive towards self-acceptance, both through SMH and other areas of their live. Research has presented empowerment and self-stigma as opposite poles on a continuum (Rappaport, 1987; Zimmerman & Rappaport, 1988). In spite of that, Corrigan & Watson (2002) describe “the paradox of self-stigma” as an either/or response between internalization and

righteous anger. However, I prefer to envision the responses to self-stigma as companion spectrum to the empowerment continuum. It is a *process* towards positive sense of self, and like the empowerment spectrum, individuals can be situated at various crossroads on this path, as was seen in this study. Furthermore, we must not overlook the interaction between self-stigma and external representations of group membership, an aspect which will be discussed in the subsequent section.

4.3 Identity Renegotiation: Re-evaluation of Group Membership

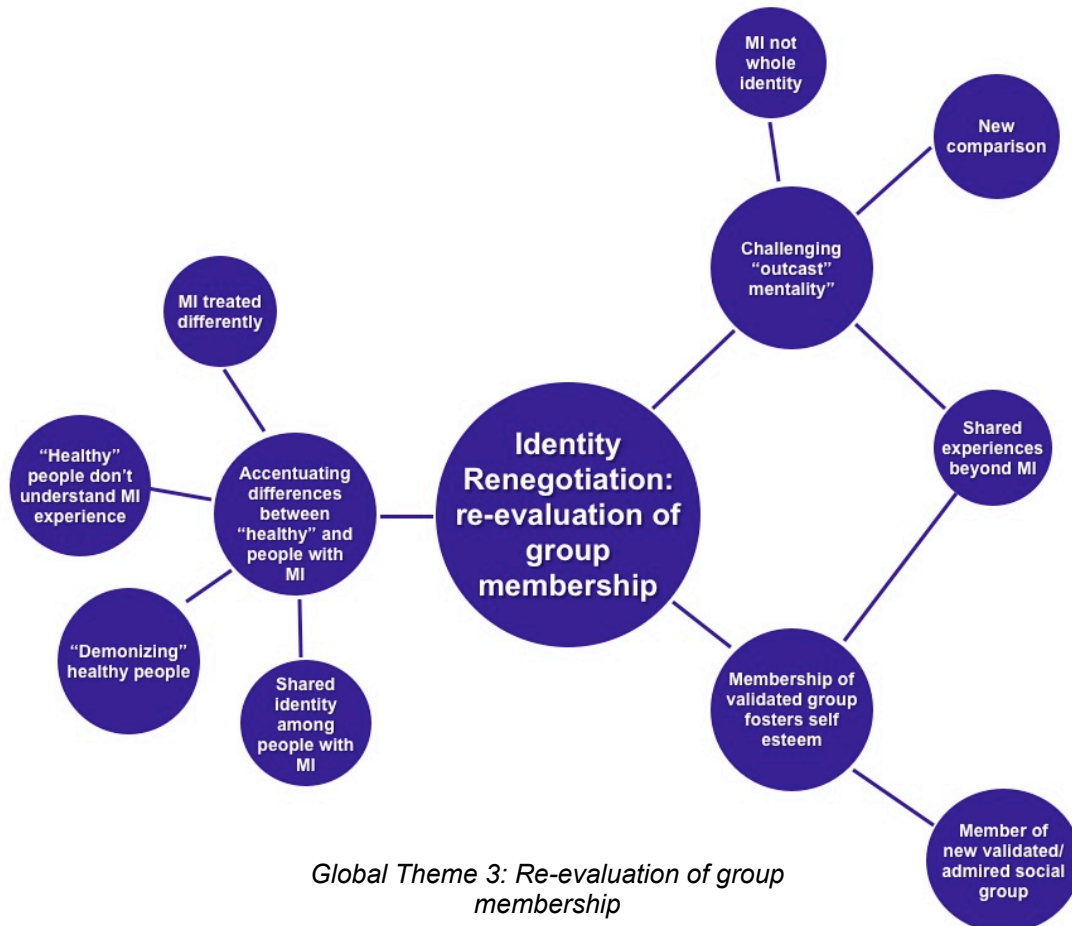
While the previous section focused primarily on individual level processes, the following discussion will be tailored to renegotiation of group membership. Antaki, Condor, & Levine (1996) contend that individuals attempt to do three things in social interaction: they invoke social identities, they negotiate the boundaries of these identities, and they provide evidence to document possession of those identities. No participant denounced their membership to mental health category, but rather employed two other prevailing processes in group re-negotiation. On one hand, participants normalized the mental health category through comparisons to other illnesses and de-emphasized the focus on “Otherness”; in addition, they highlighted their new membership as a “comedian.”

Consistent with previous findings, descriptions of mental health membership gravitated towards accounts which emphasized the ways in which participants felt distinct from and misunderstood by “healthy” people; differentiations imposed externally as well as manifested internally. While many participants stated that they felt more understood by people with mental illness, data also suggests that participants feel conflicted when their social identity is exclusively derived from this category.

“I don’t really interact with greater world in a sense... I believe in like having communities outside mental health in order to expand yourself and I’ve always done that through martial arts... I’ve always tried to create communities outside mental illness but...how do you answer, when somebody asks you what kind of a person are you? You can’t really say ‘I have mental illness,’ ‘I have schizophrenia,’ ‘I hear voices.’” (E05)

“Just because I’m bipolar, doesn’t mean that I get along with every George, Susan and Harry just because they’re bipolar.” (G07)

Many participants recognized that despite the pervasive influence of mental health in their life, they did not feel that it represents their whole identity.



"when they are throwing labels around, and the expectation is that your label defines who you are" (M13).

"I'm not my diabetes anymore that I am my heart condition or I am my OCD. That isn't the only thing that defines me." (N14)

This finding reflects how mental health membership overrides other group memberships, a pattern particularly prominent in mental illness more so than other "sick" groups. Drawing on comparisons with other illnesses, participants attempted to demonstrate the identity perversion that occurs with mental illnesses that doesn't occur with physical illnesses. In addition, participants illustrated ways that mental illness is treated distinct from other illnesses as well as its incongruence with "normal."

"Whenever you hear on the news about a person doing something, who happened to have mental illness, they always focus on the mental illness...[the media] would never say 'they committed a crime and they have diabetes'" (E05)

"it would be different if it was like 'oh, survivor of breast cancer' ...people then go 'oh, she's so strong' so it's different right?" (J10)

...it's like say if a guy comes into work, and he's like 'you know my diabetes is really acting up today or something like that so...why can't I walk in and say to my boss you know my voices are kind of high today?'" (L12)

A predominant feature of the stigma process occurs when social labels connote a separation of "us" from "them" (Link & Phelan, 2001). Participants made two attempts to change the boundaries of "us" and "them." Firstly, the participants mobilized comparisons that positioned mental illness membership in parallel with other "sick" groups. This demonstrates how stigmatized individuals can strategically manipulate their interpretations of their social environments to protect their sense of self-worth through selective comparisons (Shih, 2004). The most convincing analogies were drawn between diabetes and heart disease:

"And like I said, I take the meds, they're like insurance, but I don't feel the same way that I used to feel... It's kind of like if you have a heart attack victim and their arteries were all clogged they were told to eat healthier or else they'd have another [heart attack] and then a couple years later they had their cholesterol tested and it's fine. They just feel great and they've almost forgotten they had a heart attack. It's kind of like that. I do the things I need to do to stay healthy." (F07)

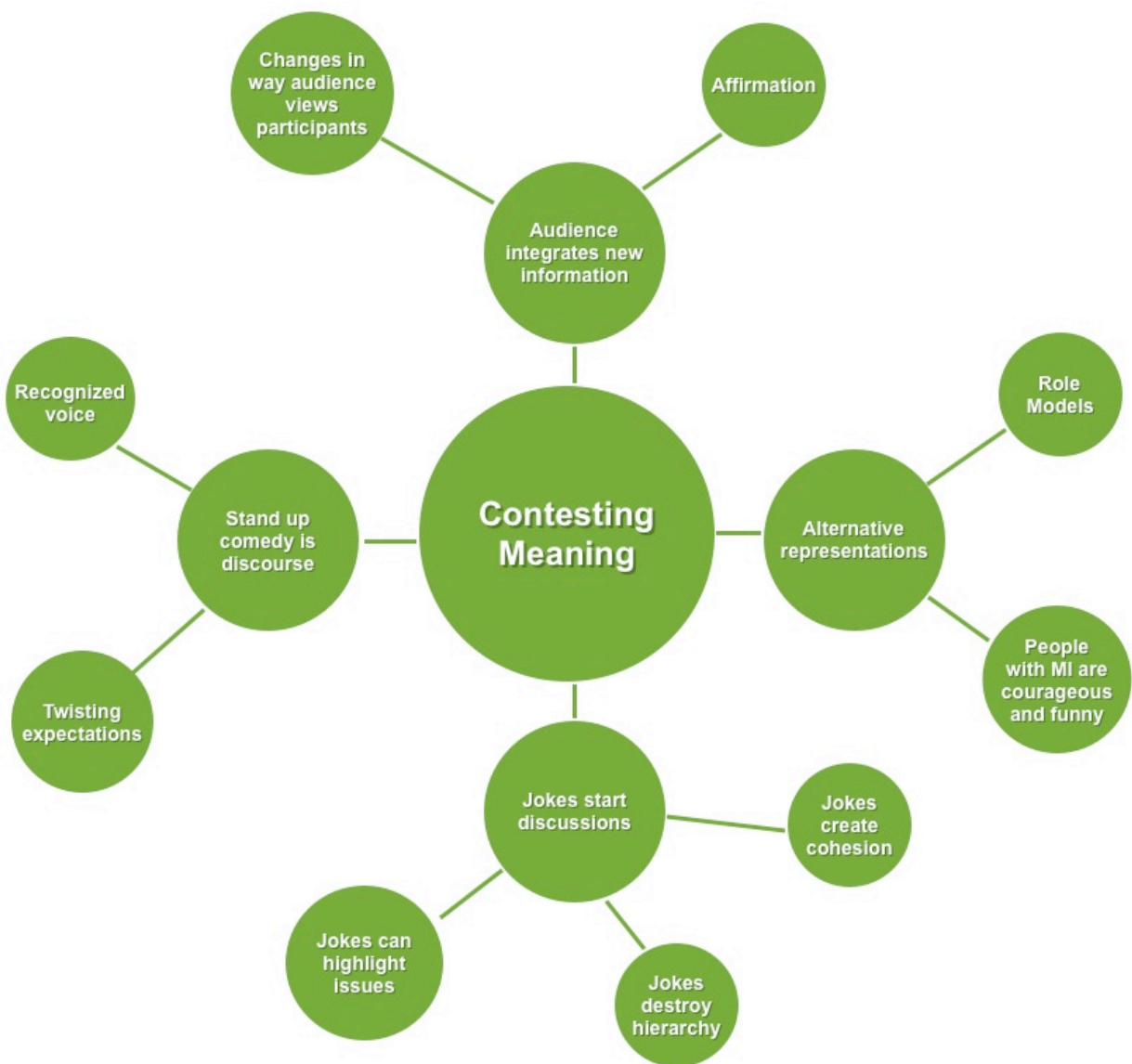
Secondly, many participants emphasized similarities that were shared across both "sick" and "healthy" groups. This tendency emerged from the language and descriptions in the interviews but was also predominantly featured in the performances and joke content. Redefinition of "us-them" divide was an effort to "normalize" mental illness membership and to fortify their claims to legitimacy. By endorsing characteristics that are typically associated with groups outside a specific category, in this case mental illness, participants attempt to interrupt the negative implications of their existing group membership. This strategy is important for changing external representations but also for its influence on personal understandings of their illness; helping further assist the victim-to-victor transition.

Another dominant contribution in the renegotiation of group membership is publicizing their concurrent association with the 'comedian' category. Most work on

social identity and stigma focuses on a single identity, usually the stigmatized identity. However, in reality individuals carry multiple identities and stigmatized individuals can also draw upon these alternatives in order to protect themselves from stigma. In this way, stigmatized individuals can strategically emphasize identities that are valued and de-emphasize identities that are not in any given social context (Hogg & Abrams, 1988). This is reflected in the structure of SMH. While in class with other individual with mental illness, the “mental illness” membership does not threaten their sense of self-esteem and confidence. However, in the real world, the prejudice and stigma directed towards mental illness devalues this membership. Considering this, many participants highlighted other meaningful aspects of their identity such as their employment or volunteer activities to deflect attention away from their mental health status. A few participants, namely individuals with continued involvement in SMH, exploited their involvement in comedy, since “comedian” category possesses a higher social value than “mentally ill.” Even participants who were no longer actively involved with SMH extracted a sense of pride and respect from their participation in the ‘comedian group.’ This finding demonstrates a lasting effect on participant’s social identity, enhanced through the development of collective self-esteem. Ultimately, changes toward a positive identity generate the possibility for participants to resist stigma in their daily life because participants can effectively distinguish between their own representations and the stigmatizing representations imposed on them.

4.4 Contesting Meaning

Three key dimensions of SMH facilitate the contestation of negative social representations of mental illness: voice, content and performance. Each of these areas involves an implicit discussion of power. Despite many of the benefits of SMH concentrating on the participants, the stand up comedy format creates possibilities for dialogue with the community at large. Engaging the community is essential because a community or individual cannot establish or alter a representation in isolation from external pressures (Howarth, 2001).



Global Theme 4: Contesting the meaning of mental illness

Three main voices exist in the mental illness dialogue: consumers, lay public and health professionals. With disappointment, I report that only the voices of the public and health professionals carry substantial weight. In many instances, the voices of mental illness consumers are silenced, perpetuated by the hierarchy of knowledge surrounding mental illness. Silencing becomes a vicious circle: stigmatization leads to lack of voice, while silence allows the stigma to gain more influence. As eloquently stated by one participant:

"the shame of mental illness has all it's power in the darkness" (J10)

In support groups and other forms of therapy, individuals often have a voice that is restricted to the immediate context, whereas SMH provides participants the opportunity voice their claims outside the group context as well. The performer-audience structure creates a space where a participant's voice is heard, recognized and validated. The space created by SMH affords mental health consumers a more prominent role in the process of delineating legitimacy. Furthermore, clapping and laughter affirms a collective understanding of the participant's shared experiences which reinforces to the participant that they are not alone.

"Humor is a great equalizer. Humor is what really forms community" (G07)

One possible limitation of the current program structure is that most audiences at SMH performance are "warm" i.e. familiar with the program or mental health more widely. On the contrary, performing to audiences already affiliated with mental health helps generate a broader and more inclusive mental health community, beyond just the mental health consumers. The discussions stemming from SMH performances help illuminate personal mental health experiences to family and friends, which is especially important in relationships where participants feel discussion about their experiences with mental illness are less acceptable. This eye-opening experience may potentially reduce some of the stigma that is generated in more intimate relationships. Furthermore, SMH performs to associations of mental health professionals which raises awareness about the medical profession's contributions to stigma.

"Clinicians see this broken, hurting side of their patients but when they come to our show, they see the same people on stage and they're funny and they go 'oh wow! This person has a lot more strength than I thought!'" (C03)

However, SMH also performs "gigs" that are open to the public whereby their message can be disseminated more widely. As with all of their performance, SMH present a contradictory representation of mental illness. These "patients" are on stage, publicly discussing their flaws and in the process exhibiting characteristics of strength and optimism to their audiences. The audience then integrates this new information into the existing social representation of mental illness which leads to important changes for

both the stigmatizer and the stigmatized. Individuals in the audience who also have mental illness integrate this positive portrayal of mental illness into their own self-concept. Unifying this conception with their previous self-image perpetuates the development of positive attributions of mental illness group membership beyond the SMH participants.

With equal emphasis, SMH also aims to change the perceptions of people who produce and maintain the negative social representations of mental illness. SMH hopes to challenge the image that people with mental illness are weak, violent failures; replacing it with the understanding that they are inspiring, successful people, who you would want as your friends, individuals deserving of a respected place in society. However, there is double-edged sword with performance as described below:

Participant B02: Well most people are pretty impressed with anyone who can get up there and perform, cause most people don't do it. So just getting up there and doing it.

Researcher: So it's not about what you say, it's about being on stage?

Participant B02: Well it helps when you're funny too, otherwise they might just feel bad for you and that would reinforce negative ideas that people with mental illness can't do things.

The proposition that performing was an integral aspect of the program arose in my discussion with the director, David Granirer. David described similar program he had piloted with recovering addicts where not all participants performed. He observed that the relapse rate was lower in the group of participants who had performed. This observation warrants future investigation where the support group dynamics are juxtaposed with the aspects of performing.

Participants believed that the messages and experiences they were sharing about mental illness were more effective than a lecture or seminar to raise awareness because its ability to link a person or face to the phenomenon.

"I don't think [anti-stigma policies] really influence the person's heart. They are more targeted and rational. When you hear it from real people it's humanizing, ground up is more humanizing way of educating people than policies I think..." (E05)

"Someone once told me after a show if they had an expert come in and tell them this stuff, they would have forgotten in two hours. She said that she will never forget what she saw us comics do. That was really cool." (K11)

Another decisive impact of performance is the content and function of performer's jokes. Although no formal analysis of joke content was undertaken, several ideas regarding transformation of power developed while watching the performance videos. Because these themes were mirrored in the interviews, I believe ideas merit discussion. Throughout my research it became clear that power is transfigured through the voice of the performer but also the structure and content of their jokes.

Firstly, the structure of stand up comedy is largely centered on expectation and misdirection. In the basic stand up structure, a "set up" is used to introduce a situation or context, with an accompanying expectation that emerges as a function of social norms. Subsequently, the comedian delivers a "punch line" that fails to meet these expectations. Furthermore, stand comedy relies heavily on exaggeration, a tool which serves to illuminate some of the fallacies of mental illness stereotypes by accentuating their absurdity.

The stand up comedy structure is very suitable for destructing the negative stereotypes associated with mental illness because of its ability to highlight social expectations and norms to the audience. Drawing attention to the implicit social structures through comedy, absurdity and exaggeration, SMH causes audience members to reflect on the origins and limitations of these norms. In essence, the program hopes in situations where the social norms serve to disempower and marginalize people with mental illness, the audience will recognize the alternatives; consequently creating spaces for new possibilities and the renegotiation of social representations that dictate the social norms in a given milieu.

A discussion of power would be incomplete without inquiry into joke content. In everyday situations, jokes can often be used to cut-down or undermine marginalized groups to maintain the superiority of the dominant group. When probed, participants stated it was different because they were subjects not objects of the jokes, which indicates a reversal relationship between jokes and power. Furthermore, in stand up comedy, there is an unspoken code dictating who each performer is entitled to make fun of, based on their own existing position in the socially constructed hierarchy. In this manner, jokes are a discursive tool used to deconstruct social system that promotes marginalization. However, jokes are not limited to the social critique of dominance. The

comic voice of the performer enables them to position themselves within groups, thereby using their jokes to create cohesion among others who share this group membership.

Through their performances, the SMH comics challenges the social preconceptions around "being mentally ill." However, many participants indicated the personal benefits were their primary reasons for involvement and many had not imagined the greater impact of the program apart from the explicit mission statement promoted by the program. The participants with more developed views about SMH role in challenging public stigma tended to be engaged in advocacy.

SMH prepares individuals to take stance in their daily lives but additionally, the performance is a public enactment of resistance. Despite the palatability of the humorous format, the message conveyed by SMH is not laughable. As Oring (2008) says "play is not the opposite seriousness," (p. 189) a statement aptly suited to the SMH program.

CHAPTER FIVE

5.0 Conclusion

Through this research, I have aimed to show the various routes through which social representations can begin to evolve in favor of more positive understandings of mental illness, for the individual and the community. The proactive approach to social representations as demonstrated by Krause (2002) indicates the potential for social representations to be integrated into participatory health programs. However, a main difference between this research and the study pursued by Krause, is that SMH attempts to change external representations as well as those of the program participants.

Many future studies are necessary to build on the results presented here. Due to the self-selective nature of participation in SMH, a control study should be undertaken where individuals are randomly assigned between different types of therapy. However, in my personal opinion this would undermine the benefits because I believe that the *desire* to be involved is a critical factor in the transformations that emerge. Of particular interest

would be study that follows the participants throughout the year long program to document the stages and any related changes in self conception. Few participants in this research were still actively involved so description are dominated by their recollection of the event. Furthermore, given the varying length of involvement with SMH, a longitudinal study would help determine is motives and goals changes throughout the program, specifically in the could from current SMH student to SMH alum. Another direction for future research must explore the impact on the audience members. This investigation would explore the reactions from a diverse cohort of audience members and evaluate SMH's effect on their attitudes towards mental illness.

Many participatory mental health programs revolve around consumer support groups and user-run services. Through the continued focus on mental health services, we continue to further reduce the identity of the “mentally ill” to their diagnoses. I am not suggesting that these wider structural changes are not important, but rather that positive identity is a multidimensional expression. I have attempted to show that positive identity is generated from many aspects of an individual's life. Participatory projects which emphasize the wellness and de-emphasize the illness identities of people with mental illness may be equally empowering. SMH shows one approach but the potential for other community centered programs is limitless. The continued success of SMH **must** occur in tandem with changes in the material and social context around mental health, driven by an evolution in our social representations of mental illness. However, removing prejudice and changing social attitudes takes time and participants must find a way to live productive lives within the current conditions. I believe that the precedent set by SMH participants demonstrates the multitude of ways that individuals can negotiate within the existing representations.

Resistance of negative social representations will shape the future direction of mental health policy and programming. SMH helps expand the public space where contradictory representations can come into dialogue. In this forum, the three voices of mental illness; lay public, health professional and mental health consumers, collide in a dynamic that is distinct from the “real” world. The “mentally ill” own the stage and comedy lends them a loudspeaker to make their voices heard. Revitalizing these marginalized voices will help tailor programs and policies to satisfy their needs.

Capitalizing on the positive potential, the resistance message promoted by Stand Up for Mental Health creates fun and laughter: a unique trait in mental health advocacy. With wisdom, Mark Twain once postulated that “the human race has only one really effective weapon and that is laughter.” After all, if we were to learn just one lesson from Stand Up for Mental Health, perhaps it would be that laughter is a sharp weapon and a potent medicine.

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APPENDICES

Appendix I: Stand Up for Mental Health Video

This video is a compilation created from the YouTube videos posted on www.standupformentalhealth.com. It is designed to help the reader understand the nature of the program and the content of the performances. The attached CD contains an .avi file that can be played on most the video software of most computers.

Appendix II: Participant Profile Table

Code	Age	Sex	High Level Education Completed	Employment Status	Occupation (if applicable)	Household income (per year)	Disability Collected (Y/N)	Marital Status	Children (Y/N)
A01	22	M	University	Student	N/A	10, 800	Y	Single	N
B02	51	M	Secondary School	Unable to work	Actor/Comedian	12, 000	Y	Single	N
C03	38	F	Secondary School	Part time	Janitor	20, 000		Single	N
D04	54	F	Secondary School	Part time	Advocacy and Mental Health Support	100, 000+	N	Married	Y
E05	25	M	University	Part time	Warehouse worker	less than 15, 000	Y	Single	N
F06	49	F	Secondary School	Full time	Administrative Assistant	28, 000	N	Single	N
G07	39	F	University	Full time	Coordinator of Employment Program	50, 000+	N	Divorced	Y
H08	46	M	University	Part time	Laborer	14, 000	Y	Single	N
J10	55	F	University	Unable to work	Registered Nurse	90, 000	N	Married	Y
K11	44	M	Secondary School	Student	Composer, Sound designer	40, 000	N	Cohabiting	N
L12	25	M	Secondary School	Unemployed	N/A	"Unknown"	Y	Single	N
M13	50	M	University	Part time	Peer Support Worker (Previously had been in army)	"Not Much"	Y	Single	N
N14	44	M	University	Part time	Adult Basic Education Teaching/Program Assistant	13, 000	N	Single	N

Code	Living Arrangement	Mental Health Diagnosis	Age at Official Diagnosis	Suggested Treatment	Medication (Y/N)	Medication Prescribed	Still Currently Involved?
A01	Independent	Schizoaffective Disorder	18	Medication, Counseling	Y	Lithium, Olanzapine	Y
B02	Independent	Depression/Paranoia	36 Depression, 44 Paranoia	Medication	Y	Seroquel, Risperdal	Y
C03	Independent	Depression/Anxiety	23	Medication, Counseling	Y	Seroquel, Trazodone, Moclobemide	N
D04	Independent	Depression/Anxiety (Recovered)	48	Medication, Cognitive Behavioural Therapy	N		N
E05	Independent	Schizophrenia	18	Medication	Y	Olanzapine	Y
F06	Independent	Bipolar, Anxiety Mood Disorder	19 Anxiety Disorder, 39 Bipolar	Medication, Cognitive Behavioural Therapy	Y	Lithium, Seroquel, Epival	Y
G07	Independent	Bipolar	28 Depression, 30 Bipolar	Medication, Counseling	Y	Lithium. Topamax, Seroquel	N
H08	Semi-independent	Schizophrenia		Medication, Counseling	Y	Trifluoperazine, Oxazepam	N
J10	Independent	Depression/Anxiety* (Recovered)	46	Medication	N*	*Was a misdiagnosis caused by thyroid problem. At time, medication was the suggested treatment but no longer necessary once thyroid condition was addressed	N
K11	Independent	Depression	No set age	Medication, Counseling	N		N
L12	Semi-Independent	Schizoaffective Disorder	18	Medication, Counseling	Y	Clozapine	Y
M13	Independent	Bipolar	32	Medication	Y	Lithium, Olanzapine, Metformin and Glyburide (for Diabetes)	N
N14	Independent	Bipolar Anxiety, Borderline Personality Disorder with Schizo-affective Paranoia	11 Depression, 43 Bipolar	Medication, Counseling, Diet change, Exercise, Vitamins	Y	B100s for stress relief, Metformin (for Diabetes), Zolof, Seroquel (for insomnia)	N

Appendix III: Interview Topic Guide

I Demographic details (collected from participant profile sheet)

II Will you tell me a little bit about yourself?

III Experiences with Mental Illness

Diagnosis Experience

- When were you diagnosed with [condition]? Can you tell me about that experience?
- How do you explain the causes of your mental illness?
- Had you been aware of mental health issues before through a friend/family member/coworker?
- How did you feel when you first received the diagnosis?
- Did it affect your self esteem?

Disclosure

- Who did you initially tell when you found out? Who knows now?
- Would you do it differently if you had the chance to do it again?
- How did your family respond? Friends?
- Have you ever avoided telling people about your mental health?

Everyday experience

- How does [condition] affect your everyday life?
- Do you have any side effects from treatment?
- Has it limited your life in any ways? Can you describe the ways you feel mental illness has limited your life? Is there anything missing from your life that you'd like to have?
- Explore: housing/job/dating/friends/family relationships
- Can you describe your experiences with mental health professionals?

Explore meaning of social support

- Who is part of your support system at the present time?
(Identify all people including family, friends, neighbors, health care professionals, clergy).
- How do these people support/help you?
- Are you a member of any other mental health support groups?
- How is your relationship with "healthy" people different from your relationship with other people with mental illness?

IV Understanding of Stigma

Understanding of mental illness and health

- What does the term 'illness' mean to you? How do you define it?
- When someone says, 'mental well-being' what do you think of?

Perceptions of mental illness

- What are some common perceptions of people with mental illness?
- Do you think these perceptions/stereotypes are true about you? Why not? How are you different?
- What do you want people to notice about you?

Stigma

- Can you describe a time when someone responded negatively to your mental illness?
- How did that make you feel? Did you do anything about it?
- Have you ever been the subject of a mental health joke told by someone else?
- How did that make you feel?

V Involvement in Stand Up for Mental Health

Stand up comedy and reasons to join

- How did you hear about the Stand Up for Mental Health program?
- Why did you want to join? What did you hope to gain in joining Stand Up for Mental Health?
- How did people respond when you told them that you were doing stand up comedy?
- Had you ever performed before?
- Why do you think most people are scared of doing stand up comedy?
- Did you feel scared when you started?
- What were your expectations? Did you have any goals.

Experiences in SUMH

- Can you describe the group environment at Stand Up for Mental Health?
- Did you have any first impressions of the other participants? (Once you got to know the, were your impressions correct?)
- How did it feel to talk openly about mental health in the group? What about disclosing to the general public?
- Were there any conflicts or tensions within the group?
- Where their any drawbacks of being so public?

Writing Jokes and Performing

- Can you tell me a bit about writing your jokes? What did you write about? Why?
- Where did your inspiration come from?
- Are many of your jokes mental health related? Why or why not?
- Do you have a favourite joke? Can you tell me about it?
- Have you performed your material?
- How many times? Can you tell me about that experience? (Changes from first performance to now?)
- Who have you invited to see your shows?
- Have you invited your health professionals/family/friends/employers?
- Employer and doctors responses?
- In your opinion, what do people think when they see you performing stand up comedy? What did your friends/family think?
- What is your favorite memory? Why?

VI Impact of SUMH on Life

- Have you noticed any changes in your life as a result of the SUMH program?
- Did you learn anything new about yourself in the process of SUMH?
- What have you taken away from the program?

VII Perceptions of Public Impact of SUMH

What is the biggest impact of the program?

If you were pitching SUMH to a friend, what aspects of the program would you highlight? (Strengths of the program)

Would you do anything differently if you were running the program? (Weaknesses and areas for improvement)

Do you think the Stand up for Mental Health program is effective at challenging stigma? Why or why not?

In your opinion, how does using humour/ comedy compare to education and advocacy programs in challenge challenging mental health stigma?

If there was one person you would want to see you perform who would it be? Why?

VIII Post-interview issues and notes

Evaluation of the interview, small-talk and off-the-record issues

Appendix IV: Research Consent Form

Nature of the research project

The aim of this project is to explore the experiences of Stand Up for Mental Health program participants as well as the program's contributions towards anti-stigma advocacy for mental health. This study is a requirement for the Masters Degree Program in Social Psychology at the London School of Economics under the supervision of Professor Ama de Graft-Aikens and Professor Caroline Howarth. This research project has been approved by school's ethics committee.

Procedures

The interview will be conducted in English and is expected to last approximately one hour. Participants will be asked a number of questions concerning their experiences with mental illness and their involvement in the Stand Up for Mental Health Program.

The interviews will be voice-recorded and transcribed to enable analysis of the collected data. The voice recordings will be heard by the researcher only, and all identifying information will be altered to maintain confidentiality. The recordings will be used solely for the project described above and erased upon completion in accordance with the ethical standards of confidentiality that govern psychologists.

Potential risks of this study

Potential risks of this study are slight and may include minor emotional disturbance resulting from discussions of personal experiences of mental health.

Confidentiality and anonymity

The information given by participants, which will be recorded, will be kept strictly confidential. All information will be identified by an identification code, not by the participant's name. Any form that requires the participants' name (e.g. this consent form) will be stored separately from other material. Names or other identifying information will never be associated with any research reports or publications that use the results of the interviews.

Right to withdraw

Participation in the study is entirely voluntary, and participants are free to refuse to take part or withdraw at any time. In addition, participants may refuse to answer any of the questions should they wish to do so. If you have any questions about this research project, please contact XXXX at XXXX (London, UK) or by email at xxxx@lse.ac.uk.



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Consent

In signing this document, I certify that I have read the information provided above and that I understand the nature and purpose of this study. I am aware of the potential benefits and risks associated with participation and that all questions I had about the research have been satisfactorily answered. I understand that my participation is voluntary and that I can omit any questions that I do not wish to answer. I understand that I am free to withdraw from the study at any time.

A copy of the informed consent will be given to you as well as a copy of the final report.

Participant Name (printed): _____

Participant Signature: _____

Date: _____

To be completed by investigator

Participant Code: _____

Signature of Investigator: _____



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Appendix V: Example Transcript

I: Interviewer

P: Research Participant (E05)

I: [Recording starts after giving a description of research project and researcher's own stand up comedy experience] So that's sort of how I'm here and, can you tell me little bit about yourself?

P: I grew up in Vancouver actually, I went to BCIT, I grew up in Richmond. I think had a pre-disposition to mental illness and I was a very introverted, shy I have always, I remember the earliest memories I have was being very, like whenever I'm around people, I'm very feeling physical sensations sort of and I never really knew what that was about. I thought I was, just, I thought it was just because I was odd. And I think I learned bad coping behaviors as a kid. And then I went to high school here and I think the bad coping behaviors and introversion, kind of led me to be awkward as a teenager and kind of isolated myself a bit. And triggered the pre-targeted predisposition to my illness became prevalent like it was triggered. So I was diagnosed when I was I think eighteen years old. So I've been in the mental health system for ten, fifteen years now.

I: What was it like being a teenager and receiving that diagnosis?

P: Well it was kind of good in a way that I finally had something like there was a label, I didn't have a label...

I: Label's usually mean negative.... [participant cuts off]

P: Yeah, but now I had a reason why I was like that, and why so at least I had a starting point. I've been in the mental health system for fifteen years. I think the major problem with mental illness is not necessarily the symptoms of mental illness, I think medication can lessen those but I think it's the social isolation that we go through... because for me being very self conscious; I think I'm awkward. I put labels my myself.

I: On yourself?

P: Yeah, I don't really interact with greater world in a sense. I have groups of friends that I'm myself with and like the social value role, I don't really interact with that. I believe in like having communities outside mental health in order to expand yourself and I've always done that through martial arts.

I: Okay, what type martial arts do you do?

P: Its mixed martial arts, Filipino, Indonesian, so mixed martial arts and I've always done that like I've always tried to create communities outside mental illness but I've, because of having... like how do you, when somebody asks you what kind of a person are you? You can't really say "I have mental illness," "I have schizophrenia," I hear voices because of this, I can't keep a job." Most jobs I have is have been warehouse work. And being self conscious I spend my time in the periphery within this communities, I don't really...

I: You don't want to be like the focal point?

P: Or even just sharing, right? Because you can't really share deep enough, you get into this mental illness and all of these things that... like being part mental health community... I don't

think other people can understand, so I kind of spent my time in the periphery. And I think I've done that for like fifteen years. Though I kind of create communities but when I do get there I don't open up entirely so I'm not really part of the group, right? And I think Stand up for Mental Health was good in a way because I was, separate, uh..... Like the greater community did not really know me or mental illness in general. It was a chance to maybe in a more formal setting kind of share more about yourself and situations. In a safe way, you know, share the things I don't normally.

I: Can you share a little bit about what sort of signs and symptoms you had when you were first diagnosed?

P: I heard voices. I was very paranoid, very self conscious, thinking about that ummm... like even laughter would trigger me. I would think it would be about me. I think it's called referential thinking. So I would hear dialogue and I would hear snippets of the dialogue and I would instantly think it's about me, it's like paranoia kind of a thing...

I: Do you mean if you heard people talking in a restaurant or something like that?

P: Yeah, I won't hear the whole dialogue but I'd hear snippets and then it would make my mind run and I would hear voices, usually berating me and talking bad about me, like I'm not a good person and all that stuff so...

I: Does mental illness run in your family, at all or...?

P: I don't know well, Philippines is not known for talking about it and like... mental illness is not well known in the Philippines. Back then when I was growing up there... I think when I was growing up I was more shy more in an introverted way than in a schizophrenic in a way.

I: So were you aware of mental health issues before you were diagnosed?

P: No. I wasn't until I sought out help, like I went to a psychologist. But yes since I knew there was something wrong with me. I sought out help and I knew I could probably get better.

I: How did you feel when you were first diagnosed?

P: Thankful for a reason since I didn't always know what I was doing but scared because I didn't really know much about mental health stuff.

I: Were your friends accepting since this a big change while you are in high school?

P: I never told them.

I: Okay. Why not?

P: I didn't really tell anyone at first.

I: Did you tell your family?

P: Yeah because I think I was having symptoms... visual symptoms. We lived in a house, a duplex right? We were living in the upper suite and somebody were living in the downstairs suite. And for longest of time, I thought a specific person downstairs was talking bad about me and I could hear her speak about me and voices and it got so bad that I would actually go down

there and talk to her like “why are you doing this to me?” And it became very noticeable type of symptoms of mental illness.

I: I see.

P: Yeah. My mom saw that, and when I went down to challenge that person, her [the woman downstairs] response.... I thought like ... I felt bad because she looked like she didn't know what I was talking about. So my mom saw me going downhill and so we went to mental health team.

I: What about your dad or any siblings?

P: I am an only child with my mom and dad but my dad has a daughter from another marriage

I: Okay. Did you share about your mental illness with them?

P: Not really, he's very traditional and I think my mom wasn't certain how he would respond.

I: Does he know now?

P: Yah but things are different now. I'm on meds and like doing stuff to stay healthy.

I: Do you feel differently about you diagnosis now than when you were first diagnosed?

P: I guess yah, I'm more comfortable with it I think. I actually find it like when I had to look for new houses or work something like that I have to get references and I've actually found that opening up about mental illness is ... more people are understanding about than I expected. Maybe things are changing.

I: Do you think your life is different because you have schizophrenia?

P: Yeah. Well, I think everyone has unique challenges that they face in life so I think that, as a person with mental illness, the worst thing I've done is that believing that I'm somewhat separate from the rest of the society. That they can't relate to me in any way. I think 100 % of the people have something they face, some issues... some unique challenges that they face so we aren't all that different but just some problems are more okay that other ones in our society so we talk about them more...

I: Can you describe any ways that you feel like schizophrenia has limited your life in any way?

P: Yeah, I think it has. I think it's just uhh, what do you call it... the label...

I: The stereotypes, the prejudice, that kind of idea?

P: No I think it's more of me like kind of outcast mentality. Limiting myself more than society does.

I: Can you tell me what ways you've limited yourself?

P: Like I've tried school but couldn't finish that really. I'm lucky 'cause I've had some jobs but some of my friends with mental illness haven't even really had that. I like to feel like I'm doing

stuff and taking care of myself but you know, sometimes I can't keep work so I go on disability. Most of the the friends I have... most of my friends are people with mental illness so... I'm not sure that is a limit because I like them and we get each others experiences which is really cool...

I: So you got quite a strong support network. How do they help support you?

P: Yeah, well it's more like we're making fun of each other's symptoms and you kind of have your own lingo, your own... you've created like your own inside world. You can be yourself with them.

I: What does social support mean in your life?

P: Well like I said, I think you need the mental health community support like a psychiatrist, a mental health worker. And probably friends within the mental health system but I think you also need to have some sort of diversity. Like if you that's your only group... you can't let mental illness define you as a person like you have to have other outlets...

I: That makes sense. What has been your experience with doctors and mental health care?

P: I'm lucky cause it's been quite a positive experience.

I: It's funny, everyone I have talked to has said the exact the same thing. Can you tell me about what made it a positive experience?

P: I think if you're just honest with your feelings and what's going on and you express it in a calm way. I don't like this tit for tat kind of a thing, it's not like that. It's sort of a mutual respect. We both know things about my illness.

I: So you've mentioned earlier that you didn't tell your friends, have you sort of changed who you've told over time as you became more comfortable with it?

P: Well my friends in high school... I don't have them anymore as friends. I wouldn't... we went our separate ways kind of thing.

I: I think that was quite common in high school. What about friends that you've made after then ... do you tell, do you share with other people now?

P: Not with my outside community so I kind of tend to separate them.

I: Why do you try and keep it separate? Who are you keeping it separate from

P: I guess it's that stigma in me about how people will respond to me expressing that [mental illness] whereas my friends and like, other people with mental illness, they know what I've been through and kind of share some same stuff and know that I'm not bad just because I have this diagnosis.

I: Can you tell me more about that? You're worried about other people responding by...

P: Like being scared of me, cause there are like, lots of bad stories about people with schizophrenia. Or like other mental illness they think it's our fault, like for me, I am very careful because I don't want "spin out" again so I take medication and do counselling.

I: Aside from Stand Up for Mental Health, are you involved in any other sort of support groups or advocacy groups for mental health consumers?

P: I belong to a consumer group, advocate group in Richmond, it's called RCFC... Richmond Consumer Family Council, something like that.

I: What sort of stuff do they do?

P: There is members from different parts of mental health community, like mental health organizations in the community and they meet once a month and they bring discussion topics that are being talked about in the....

I: Like psychiatrists, social workers like all of that kind of thing?

P: More like consumer groups. There is a member that is part of the Vancouver Mental Health Organization. And then the rest are like from the clubhouse for people with mental illness and different organizations and consumer groups.

I: So you're kind of like feeding back to your mental health system. Can you give me an example of a few of the issues you've discussed recently?

P: Like planning new programs and like giving input into what we need.

I: I see. I have a few conceptual questions now that are kind of tricky. What does the term illness mean to you?

P: Illness, [very very long pause] I don't really know.

I: That's okay. I have one more tricky one. So what does it mean when someone says mental well-being? What words or images.. what does it mean in your life?

P: Well for me, mental wellbeing is not necessarily getting rid of all the symptoms. Because I think if you go with the medication you're basically a zombie. I think it's as minimum of medication as possible and a lot of support and social supports, people you can bounce off your ideas on, your perceptions, because for me I want to Langara [local college] one time and I thought I was healthy enough thought I could do it on my own. And I found I was spiraling down and I didn't know it. I think mental illness just means that you have to be, you have to have support systems and like the medical system like the medication as well as social support that medication is to minimize your positive symptoms and social support is people that you can bounce off your and also like when you're out there, you think your perception is like hundred percent true. Like these people are talking about me, people don't like me and all that. But if you talk to someone about it and tell them about your perceptions, they might give you a different perspective on it and that might be enough for you to cope and maybe to even try to relate later on.

I: Do you feel like you have control over your health?

P: I think I'm learning that I have control over my health. I think in the past I thought you know this is it for me like I'm like.... But I'm changing that, working on recovering from that way

I: What does recovery symbolize to you?

P: I guess having the chance to just follow your passions... it doesn't necessarily mean symptoms go away, just means not interfering with your choices. It's mostly, you know, like a personal thing for me, I hold myself back.

I: So when you first received your diagnosis, you talked a little bit about the way you talked about yourself... How you felt. Can you describe that a little bit for me?

P: Like an outcast, somebody that, is not complete. Incapable of normal relationships, work normal work... Yeah, like normal things.

I: Have there been any changes in the way you feel about about yourself now?

P: I think most people with mental illness almost beat themselves more than society does I think. That's my own opinion. I'm am working on how I think of myself, I can recognize some good things and also notice some of the times that I am thinking things are, you know, a bit "in my head."

I: Do you have any experiences were someone has done something, said something that showed a negative view towards mental illness?

P: Yeah, I guess. Like when I'm off my medication because I try to go off sometimes because I feel so good sometimes that I think I could go off it and it's a totally different personality. I'm very argumentative and I tend to speak my mind and tend to scream. At home I would scream and all that stuff. I was in the hospital for four months about two years ago. The first time in like my fifteen years of I've had mental illness, that was the first time I've been in the hospital. I think when I'm like that, people notice that and that's when they become more judgmental.

I: In what ways do you see that they are being judgmental?

P: They just look at you funny and stuff. But like when I'm like that I can't work or anything anyways so it's less like... like it's not firing me or kicking me out but like smaller things like how they talk about you.

I: How do you think the media portrays mental illness? Can you give me some examples of stereotype associated with mental health?

P: Yeah, I don't think it's very good because it like whenever there is a like I've been told that only 5% of the crimes committed out there are committed by people with mental illness. This is one of David's jokes is that means like 95% of the people out there, crimes out there are committed by normal people then so but whenever you hear on the news about a person doing something that happened to have mental illness they always focus on the mental illness.. They don't focus on other factor... and in one of those things like if they're diabetic the headlines don't say "they committed a crime, they have diabetes"... It's kind of similar to like Muslims, like whenever they commit something it's a... it's a Muslim thing. Like you never hear when a catholic kills someone, it's never stated as a "Catholic person is killing. "it's a sort of the lens where do they put the focus.

I: Do you think there's, any positive stereotypes associated with mental illness? Hard to think of them.

P: I don't think so. No.

I: Do you know any mental illness jokes? Like I hear blonde jokes all the time, do you know any ones about mental illness?

P: A few. There's this one it goes.... Like it's a psychiatrist phone and the message says like "if you have OCD, press 1 repeatedly. If you have schizophrenia wait for a little voice to tell you what number to press." It goes on like that... "If you have multiple personalities, press 1,3,5"... you get it?

I: Yup. How does this joke make you feel?

P: Well, it's not good because it shows like only one side and like there is a lot more to mental illness than that but this is how like people see it.

I: Does it make you angry or upset or hurt your feelings?

P: Not really, cause it's partly true. But I can see the problem if this is what other people are taught about mental illness and think this is where the problem really is.. Being so closed minded.

I: Has anyone ever made a joke about your mental illness that you know of?

P: My friends but that's different, like we do it to each other and it's not like in a mean way.

I: Do you have any bad experiences?

P: I can't think of like a specific time but I'm sure it's happened. Like David says, like jokes can be a way to cut people down so maybe it has happened behind my back or something like that.

I: Now I'm going to ask you some questions more directly related to SUMH. How did you first hear about the Stand up for mental health program?

P: Friends of mine took it and they suggested I take it, but I tried to take it but I just never followed through and then, this 2008 is when I just followed through with it.

I: When did you first hear about it?

P: Maybe 2 years earlier? I can't really remember

I: Why you didn't follow through with it before?

P: I was just tentative. I was just kind of scared, I don't have any real reason... I wasn't sure whether I could do it, you know?

I: It's a huge commitment and it's a, I can understand the, took me, I remember the first day standing at in sort of the front of the microphone. hen, why did you eventually, what pushed you to through the last time?

P: I don't know, I just thought What the hell! Just go with it, see what happens

I: Go for it.

P: Yeah, yeah.

I: Had you seen one of the shows before you joined?

P: Not really. No.

I: What made you want to join?

P: It looked fun and something totally different from anything else I've ever done. Another way to talk about my experiences I guess but like I said, a safe way because there is some distance.

I: Have you ever performed before?

P: No, not ever, Would never have even thought about it.

I: How did people, like friends and family, react when you told them that you were going to be doing stand up?

P: I think most of them were surprised. It takes a lot of balls to get up on stage like that.. And try to be funny and not everyone can do that.

I: I know I was really scared when I first thought about doing stand up comedy. Why do you think most people are afraid to try it?

P: Well, like a lot of people don't like public speaking. And it's hard to be funny, you have to get it right otherwise you just blow and then people would boo and stuff. That would suck.

I: How would you describe the SUMH program?

P: Well I think it partially it is a support group, second it is uhh, I think it's just a way to voice your experiences with mental illness.

I: So how have you been involved for one year?

P: Yeah, yeah.

I: And do you still actively perform?

P: I haven't been. I would like to go back to the alumni group. I thought I'd focus on martial arts this year. Like I focused on stand up for mental health last year so I thought...[trails off]

I: So when you first started SUMH, did you have any goals?

P: Just to be able to stand up in front of the crowd without being afraid. Just to be funny. I spent quite a bit of... sort of energy on feeling self conscious, so that by standing there, that was kind of a like "Hey' I'm taking a stand against this!" I just wanted to get through it alive!

I: Haha.

P: Some people also like, really want to be comedians so that is cool too. Not me so much though

I: So what was your very first SUMH class like?

P: It was scary. I think, like five minutes into it, I just thought let whatever happens happen, if I screw up, well then I screw up and so I was yeah it was just like letting go of that, you spend the first few weeks before that show like just kind of scaring yourself. Like this is going to.. [gestures suggesting explosion] ... things are going to fall apart and all of that stuff. And then five minutes into it you say I'm too tired of thinking about that just let it go.

I: What was your opinion of the other participants when you walked in?

P: Yeah, like they were equals but we all have such different stories that maybe we could learn something new because I think they have observations that I would like to make as well, that like just never occurred to me... so it's kind of a like you share like similar experiences with mental health really, the stigma, the people you deal with. So and then you're focused only on one aspect of your life and you sometimes you miss out on other observations and they kind of fill that in.

I: Okay. Yeah everyone's got sort of a different view, different perspective.

P: Yeah.

I: Can you describe your relationship with David?

P: It is very good, he's a very positive. He lets you write your own jokes and then sometimes I like his idea that you don't have to be funny in order to make comedy-jokes. It's just that like your life experiences, like the observations that you make and then you go from there. So you take snippet of your life or what you think mental illness is and then you just build from there. He taught us that stand up is about expectations; the set has like a preset image that audience will automatically think of and then we go a whole other direction.. Like surprise! That is what makes things funny which is different from laughing with friends and stuff.

I: Were there any conflicts in the group?

P: I mean people have bad days and stuff and David is really good at dealing with that. It's a lot of unstable people to manage in one room and there is bound to be stuff going on for people. But David manages it really well and if you just want to vent during your time to share, you can. But David will stop you at some point to move onto the next person so that we can get stuff done.

I: How did it feel to talk openly about your mental health experiences?

P: It felt good actually. Like I said, I have this one life with my peers in the mental health system and then I'm kind of in the periphery in the other community. It was kind of a like a formal way of letting the other community know about what mental illness is.

I: Can you explain what you mean about letting the other community know about MI?

P: It's a part of my life that I keep restricted to groups that I know will understand and relate. SUMH is a way that we share that part of our lives with other groups.

I: I see. Can you tell me a little bit writing your jokes where you find inspiration from for you jokes? What sort of things you talk about in your act?

P: Mostly my friends, I have a best friend, we whenever we're together we just kind of make fun of each other, make fun of life. Kind of sarcastic like, it's like being racist to everyone. It's bad when you're racist to one, when you make fun of everyone it's somewhat okay. Mostly my friends, interacting with them.

I: So in your acts, do you talk a lot about mental health?

P: Yeah I think so. Most, some are the stereotypes of mental illness. Well for example like, being on welfare. When you're mentally ill, you're probably on welfare and the hoops you have to jump over and just to...

I: Just sort of a like poking fun at the system.

P: Yeah, and also poking fun of myself and, mental health community as well because we point fingers at the outside community for stigmatizing us. But we often stigmatize ourselves right but... I think partially it's because the community groups that... it's the language that is always, when you're dealing with the mental health system, is that the *others* are bad people. It's like you grow up with, when you're in the mental health system where it is other people stigmatize you, this is what they do. And then they don't really talk about you stigmatizing yourself, limiting yourself. And so easier to escape the outside stigma but you're always with yourself, right?

I: Yeah, I understand that. So much is made of the "us and them" divide but not sort of the "me and me" part of it. Do you have a favourite joke?

P: I have a few that I use a lot, they get the biggest laughs so I use them in every set pretty much.

I: Can you tell them to me?

P: I can't really remember them right now.. I don't want to get it wrong. Can we come back to that?

I: Sure. How many times have you performed?

P: Twenty times I think.

I: Wow, that's a lot... What different kinds of audiences have you performed for?

P: Well mostly people who are in the mental health system. Like either the staff members of the mental or the consumer groups themselves, so they can relate with that. I think the format for Stand up for Mental Health is very specific in its material they do. But I think the Granville Island shows [the Gala Showcases], I think a lot of *normal* people were there to so and I think we played for organizations other than mental health organizations like teachers and then [__Org Name] which is partially mental health but its...

I: Do you have any ideas on the potential of like the Stand up for Mental Health as an education program for "normal" people if it was taken in to audiences that maybe didn't know as much about mental illness... would it be helpful do you think to them?

P: Yeah I think so. In just in a sense that people with mental illness are not like the stereotypical like they're violent, they're crazy and all that stuff. When you go to a show you see a guy standing up there, he doesn't look like he has mental illness and when he is telling a joke,

it's not like..... I mean he's talking in a normal way, he's acting in a normal way. Yeah, I think just to break that stereotype of what mental person would look like or, sound like. You know to show that it could be like your friend, your coworker.... it could be anyone. But I think it couldn't do it on it's own that David would have to tell about why we were there otherwise maybe they would just think we were making fun of people with mental illness without knowing that we had a mental illness.

I: I see that is a good point. Can you describe what your first performance felt like?

P: It was scary.

I: What about once you finished, how did you feel?

P: Exhilarated. It was so good to get through it and people laughed.

I: How do you feel now that you had some more practice?

P: Yeah I think the last show was good. I was more, calm, the jokes were... you know you find your own way of telling your jokes, your own persona...

I: Yeah your comedic persona.

P: The first time it was I was rushing through it. Breathing heavily, you know trying not to breathe heavily, kind of stopping your breath because you can hear everything with a mike and I didn't want people to know how nervous I was. Now I'm more comfortable on stage since I know what to expect, well every audience laughs more at different stuff but I know more about what it will be like and I've got better skills and material in my sets... now I really like my jokes so I have a hard time choosing which ones to put in each show.

I: Do people ever come up to you after the shows? What's kind of feedback you get?

P: Yeah, some people go up to me and say "that's good for you," "those were funny jokes".... mostly positive... I think I've only had positive responses.

I: How do you feel when people laugh at your jokes?

P: It feels good it's kind of a high like you kind of you ...want to do it again. So... we had put all their garbage out on the table and people were just, "Hey that's cool." Like I said when you define yourself as a person with mental illness and it's usually some who is unemployed, someone who's maybe on welfare, somebody, an outcast and when you regurgitate all that stuff and you only hear a laughter instead of people judging you. It's a different feeling, you know...

I: Who do you invite to the shows for the general public like the Showcases or the Laughing Bean [coffee house where they do practice shows]?

P: Mostly family and friends.

I: Would you ever invite your doctor or maybe your employer?

P: Yah probably. I haven't yet- I never really thought to invite them cause they don't really know that I've done this program. And like most of the time we don't get to invite people because we're a comedy act that gets booked by people or conferences and stuff.

I: Yeah really cool. What do you think like what's in the audiences mind when they see you standing up on the stage?

P: Well I think like I said first of all its, that person doesn't look like he has mental illness. He looks like a normal person. Doesn't act like a person with mental illness, not the normal stereotype of a person with mental illness, so in that way, I think you've already won, you've already influenced them and then you get to share with them like your experiences with mental illness and its....usually when in other formats when you're its usually a very serious tone when you're trying to educate people about mental illness, it's like "don't stereotype them", "don't think of them in this way". It's almost negative like you know, and this is different. You're talking about the serious stuff right but it's in a good way and it's uh, and your educating but not in a very berating tone and negative ... humanizing the process.

I: What do you think your doctor or counsellor would say?

P: I think they'd think it's really cool. [Another participant] said that when her doctor came he was really impressed. You know, doctors and counsellors often only see the broken parts of us because we go to them when we need help. But this may show them another side of us.

I: So how important is humor in your experience daily life, more so that SUMH class or on stage, humor in just in your day to day life?

P: It's a big deal with me. Like I said when I'm outside society I'm usually very reserved, I don't, I try to control my emotions because it's like, if I don't I would be... uhh.. it would feel like it would destroy me. I don't when I'm with my friends its the number one coping mechanism we have is this humor.

I: How do you use humour as a coping mechanism?

P: I take things less seriously, look at it from a different perspective. I used to do this even before the course but when I was in the course I was always trying to make little moments or challenges into something funny.

I: Can you describe some of the impacts SUMH has had on your life?

P: I don't think I take things so seriously, like when I'm... like the big shows that we had, I don't think if I said a lot of that were normal people as well, so I'm kind of more comfortable in being out in public, it's not as scary. It's just I think more calmness I think, that's what it is.

I: What have you taken away from the program? [pauses but participant doesn't answer, therefore continues...] In terms of skills, little like bits of wisdom that you like integrated it into your life either from like David's lessons or from humor or from your peers?

P: I think the number one thing I get from that is that again with the stigma is that we stigmatize more of ourselves and others even if you just open up with some of them, most people won't react in a bad way, won't judge you like that kind of idea. That your some of your experiences are somehow separate than theirs, that they can't relate. I think that what I've got from that is especially like you asked me before did I get any responses from them, you know, I think they could actually relate to what I was saying- it's a spectrum and everyone is somewhere on that.

I: Were you aware of how much you self-stigmatized?

P: Not really. No... this program helped making you more aware of how I think about myself. I mean I've done counselling and that can be helpful in thinking about your life but it's so different taking that and performing it.. Once it's funny of course...

I: I see.. In your words, what do you think the aim of the Stand up for Mental Health Program is?

P: Well I think, first of all it's just the, it's a therapeutic thing. It's more for your, for you like a rather than an educational thing right. It's more to, help you and maybe, find that support system that you know like it's like a peer support, that's what they call it. Like helping each other and to finding out that you have similar experiences. Well yeah I think it's a, first of all it's a therapeutic and then maybe educational in terms that you're strengthening the idea that you're not alone that greater society doesn't mean that they can't relate to what you're going through.

I: What do you think the impact of the Stand up for Mental Health Program is on sort of on the wider public and community?

P: Well I saw in channel four, it's not a Stand up for mental health but its Comedy Courage. So it's being, the media is picking up on it. It's a good thing.

I: Is that program about mental health as well?

P: Yeah, I think it was actually David's student that did it. SUMH is creating buzz about mental health, especially because it's so unique that it gets lot of attention.

I: From my understanding, most participants joined for personal reasons. But have you after being involved, have you ever thought about the larger impact of the program?

P: Not too much, I mean I have but.. I thinks it's important to like to let others know about what mental experiences of a person with mental illness are... I think it's important to let other people know that you're, just by looking at you, by hearing you that you are not a freak right? You're just like anybody else.

I: What in your opinion is the best way to challenge mental health stigma?

P: I think it's... for me I think, the community itself should look at itself first. Like suppose how it...

I: You mean the mental health community?

P: Yeah. How it stigmatizes itself first. And yeah I think it should get a positive view of itself first before it can go outside.

I: How do you think the role of humor and comedy is different from holding a workshop or public lecture in educating?

P: Well ..a workshop has a more serious tone to it and its berating, usually a berating tone and I think this, it's more fun, it's in a more fun way like its educating in fun way.

I: Like when your kids everyone wants more when you're having good time.

P: Yeah, yeah.

I: Yeah that's really, really true. So not everyone thinks about the bigger picture but how does it feeling to be a part of a group that is changing the way mental health is viewed. If you think of it in the fact that fifteen years from now it will be a different thing for an eighteen year old who's being diagnosed. How does that make you feel as like your part of that?

P: Well I like the fact that it's ground up right rather than the...[struggles for the word]

I: Institution?

P: That yeah the institution or the policy makers doing the changing. I think you do a better job if it's the "common folk", like doing the changing rather than the policy makers trying to force people...

I: Do you think people are more receptive because it comes from the ground up?

P: I think so. Yeah.

I: Why do you think that is?

P: Well usually from policy makers, it's usually like policies they don't really ...I don't think they really influence the person's heart. They are more targeted and rational. When you hear it from real people it's humanizing, ground up is more humanizing way of educating people than policies I think...

I: What's your favorite memory from the program?

P: Getting a stand up ovation I think, getting clapping, sustained clapping for a minute. That was great.

I: Yeah, that's a pretty big achievement.

P: Yeah.

I: Do you think the program could be replicated without David?

P: Well I think eventually it has to because he's only one person, and I think he's got several classes throughout Canada and, I think he did something in America as well. I think it's important that it's more of a, franchises you know like, David is a great guy and he's very gung-ho, but he's got a family. I think for it to be a big thing it has to, you have to have other people. I think for it to sustain itself it has to be that way, because I don't think David could keep this up forever...

I: If you were telling it to someone who was maybe interested and you were going to give them three highlights, what would you say?

P: Well first of all it's not about being funny, it's about like coming from a real place. Like David says this, it's about a real emotional experience rather than....you just have to be aware of the emotional experiences you have and you build up from there, it's not about it's not just telling someone else's stuff.... there's structure to it to which is a good thing. And also like other people help you in making up jokes, helping setup a jokes and all that sort of stuff.

I: Its kind of a collaboration?

P: Yes, yeah. So you like come in with an idea like “okay I want to make this funny” and the everyone sort of sits and brainstorm

I: How does SUMH compare with any support groups you’ve been part of?

P: Well I think I’ve said in the website this is way better than any talk therapy that someone’s pushed on me. So it’s great, it’s different. Like from what I’ve seen they’ve always been like I sit, and I talk and this is what’s going on for me and the next person talks whereas I gather that this is much more interactive when you all your sort of work together.

I: Why is it so much better?

P: Well in a talk therapy system it’s usually you and a counselor and it feels like you’re, it’s a different thing, the dynamic is different. It feels like I’m subservient when I’m doing that and here its more, it’s just feels like your subservient and again the other talk therapy is very serious, very...

I: Have you done any group counseling?

P: Yeah, a vocational thing. That was good too, it was more informal but it has serious tone to it too.

I: If you were going to suggest areas for improvement for the program, what would they be?

P: For me I think, even though it’s a collaborative experience I think I wrote most of the jokes myself. Maybe get the comics to maybe write one or two jokes a week that by themselves and all that...

I: I know from my class we had to go home and write five jokes and bring them in and show them in the same sort of format?

P: No it was more experiences that you’ve had...like one thing I say is your experience with the, when your applying for welfare like experience with that, what happened, what did you feel, what did it feel like to you and then you, focus on that.

I: So you don’t necessarily have to show up with the jokes?

P: No.

I: Okay, that wasn’t as clear to me since it’s different from the Langara course. So what do you think your greatest challenges will be in going forward with this? In sort of in your involvement to taking it, either outside of Stand up for Mental Health or within that community?

P: I’m comfortable like doing this within the mental health community. I think I mean the like focus would be my experiences as a mental as a person with mental illness but I think it would be great if we did more shows that involve people other than that group. Creating awareness, you know, I think that would be a really great way for this to go.

I: Would you ever do an open mic night? Without the SUMH label?

P: Maybe one day I would, but I’m not sure. You’d know nothing about the audience, not even a little bit so that would make it really intimidating. Would I be performing with other SUMH people or all alone?

I: Either really.

P: Maybe with them I would because we'd be there together but I'm not sure how it would go over since there are so many mental health jokes. Because there is still stigma I'm not sure that a "normal" audience would like that... and David doesn't want us to fail so I'm not sure if it would be a good idea... unless you want to go into comedy and you'll have to get used to that more.. Like the hecklers and stuff.. That doesn't really happen at our shows.

I: If there was one person that you would want to see your comedy show, who would it be?

P: Probably my friends in high school, because I was kind of I don't think they really knew me that well....

I: How would that feel? How would that impact you?

P: They were my best friends, we were, we shared a lot but at the same time it was some of it I kept to myself, so I wasn't really, I'd like to just sort of be totally honest with them

I: What do you think their reaction would be if they saw you up on stage?

P: It would probably be in a positive way. Like look what I can do...

I: what do you think they would say to you after the show?

P: It probably would be a positive response. Like we didn't know you could do that, that's cool or something.

I: Well I think that's just about everything. Do you have any question you'd like to ask me or anything I haven't covered that you think is important?

P: No I really, I think this is a good thing you are doing here.

I: I'm very excited about it... I will send everyone a copy of the final report but that is ways off just yet! Thanks so much for taking time out of your day. If you have any questions you want to ask me later please don't hesitate.

Appendix VI: Codes and Textual Examples

Basic Theme	Code	Description of Code	Quote
Humor as a coping skill	Positive	Descriptions of ways to positively approach to mental health stigma	"I don't want everyone sitting around a circle sobbing and wailing about how horrible their lives are..." (B02)
	Humor	How humor is used in daily life	"It's always been a lot easier to laugh at the tragedies and make light of things" (B02) "Humour eases the burden, eases the pain" (N14)
	Laughter/Fun	Increased laughter and fun during and after the program	"In a support group you all listen in respectful silence, but having a room full of people laughing is a way more powerful affirmation ... that they also get you, that they understand too... plus it's way more fun" (H08) "For a few hours of week, I got to have fun and just be." (D04) "So just being able to be there, somewhere where I want to be. I don't want to wake up in the morning to go to a support group. I do want to wake up in the morning and go to class because it is better than a support group. It really is." (L12)
	Social skills	Developing new social skills	"so I'm kind of more comfortable in being out in public, it's not as scary. It's just I think more calmness I think, that's what it is. (E05)
The structure of SUMH has psychosocial benefits	Routine	Description in changes in schedule	".. Like I didn't go on a Saturday night for three years, for three years! David's classes started to push me out to have to do shows" (C03)
	Participation	Ways that program promotes active involvement	"We bring in set ups or stuff that is going on like our latest doctors appointments, or applying for disability, that sort of thing and if we don't have a punch line we work on it together, all adding bits to make it good." (N14)
	Leadership	Leadership's role in facilitating the SUMH group	"It was a definitely a support group in a way but at the same time it was kind of crazy because if you get so many people with issues in a room, there is bound to be somebody that is having a hard day. Yah so it's a little bit crazy in that manner- David trying to keep lids on everybody." (C03)
	Knowledge	Mental health consumer knowledge and experiences	"Doctors are different because they don't experience it... they just learn it from a book... I think they feel threatened by consumers getting involved in the field... well at least based on the experiences I've had" (M13)
Community engagement helps legitimate their place in society and their mental health knowledge			

Basic Theme	Code	Description of Code	Quote
SUMH encourages participants to look forward to future and beyond themselves	New Risks	Taking new risks as a result of the program, or after SUMH program	<i>I haven't traveled in this city like I have been a hermit. You know, some months I wouldn't even an open [the curtains]. Bad, very, very bad and twenty four hours a day I just wanted to die. So with David now I'm going all over the city now taking my little truck (F06)</i>
	Dimension	Adding new dimension in participants life	<i>"it's [SUMH] given more essence to my being" (A01)</i> <i>"I feel so bad most of the time and I have pockets now when I am with David's class... that I have a purpose that I didn't have prior to that" (F06)</i>
	Goal	Feeling a sense of purpose working toward the goal of performance	<i>"I like that it's not focussed around, you know, we are not sitting around talking about our mental illness and what are problems are. We are there to make comedy, we draw from these experiences but don't dwell in them" (B02)</i> <i>"There's an intimacy that's formed because you all have the same thing going on and people can't seem to help but talk about that because there's the common purpose of working towards the big show." (D04)</i>
Social cohesion built around positivity rather than commiseration about common insecurities	Solidarity	Participants feeling like they are in it together	<i>"It's nice just being around people who share your differences. You know, the human condition. You're part of the human condition. We now go on road trips and I feel so good around them... it's kind of like we are all soldiers and we're all fighting the same fight." (A01)</i>
	Friends	New friendships and sources of support	<i>"[SUMH] has become kind of like a family for me... I feel so good just being around them" (F06)</i> <i>"When we takes breaks in the class, everyone just hangs out and talks to each other. That is when I think we all become friends" (G07)</i>
	Mutual support	Encouragement and support from other participants	<i>"People in the group want to see you do well, so we all help each other write our jokes and make them good" (B02)</i>
Negative opinions of self	Failure	Descriptions of personal failures: actual or perceived	<i>"I wanted the [medications] to work so bad... and then one after another one, didn't work and then I thought 'shit I can't even get this right. I can't even get well properly.'" (F06)</i> <i>"My self esteem had already taken a big hit long before the diagnosis happened. I felt completely... I felt useless, on every level of my life." (D04)</i>
	Shame	Feelings of shame because of mental illness	<i>"It was very scary for the future because I had an episode of hypomania... I did some pretty goofy things." (G07)</i>
	Denial/Disbelief	Denial or disbelief upon diagnosis	<i>"My aunt and uncle have schizophrenia but I never thought it would happen to me" (A01)</i>
	Broken/Flawed/Incomplete	Feeling inferior to "healthy" people	<i>"They don't respect you or look up to you in the same way" (N14)</i>
			<i>"And you could see the weight come off this kid. It's like somebody had taken this big sign off, that she'd been carrying around like 'I'm Flawed.'" (D04)</i>

Basic Theme	Code	Description of Code	Quote
Because of the negative responses, participants tried to "seem normal," hiding their "weakness" from others	Pity	People mental illness are the subject of pity from "healthy" people and medical professionals	"You know, I think I'm very lucky. I think I do have my wits about me and I'm not at anyone's mercy... seeing a psychologist is never really been that helpful for me. I never, you know, it's like buying friendship in a way sometimes. They just kind of feel sorry for you." (K11)
	Capability	Family, friends, employers and health professionals treat persons with mental illness as less capable/competent	"Everybody talks about label right? I wasn't sure what the impact was going to be... And I wanted them to still view me as competent, that I could represent them [the company] and that I was not going to do something that was going to completely throw everything into a tis-wad because of the fact that I decided to have a moment of my own." (D04) "So [my sister] always very supportive but I'm always critical of my sister too but that's just me....like when she makes, you know a comment that "Oh, you can't serve me [the participant] wine," or something like that really annoys me. (K11)
Paradoxical experience of being treated as 'victims' of mental illness in contrast with mental illness being a personal failing	Condescension	Experiences of being treated inferior	"Doctors do that thing if you come with somebody [to your appointment], they talk to that person instead of talking to you..." (H08)
	Blame	Personal responsibility for having mental illness or the resulting behaviors	"I spoke not from the clinical side, the treatment I received and the meds that I was one, but I spoke about it from the experience of breaking down. Of pointing out that it wasn't necessarily just my fault. That this came to me as a gift that came with the brown eyes and brown hair, and everything else that came as a package... I wouldn't apologize for the fact that I'm only 5'4" when I'd rather be 5'10"" (D04)
	Uncertainty/Instability in Life	The unpredictable effects of mental illness and the consequences	"Does this mean that at any time in your life, your life could be going well and then all of a sudden for whatever reason your chemical go nuts and you could unravel" (G07)
Even with best intentions/ practices, mental illness can overwhelm personal will	Choice/Will/ Determination	Personal control over mental illness	"If we could control it we wouldn't be in there in the first place. We try to control and do whatever we can to keep functioning in society, to do our jobs or whatever..." (N14)
	Responsibility	Responsibility for maintaining health	"I take the meds, they're like insurance, but I don't feel the same way that I used to feel. My life is not, I don't have the kind of lifestyle that I used to have"
Compassion towards self and acceptance of flaws	Being 'real'	Not hiding flaws, being honest about all parts of personality	Researcher: What have you taken away from this program? L12: That I can do things, that I am capable. That I don't have to hide away. "the shame of mental illness has all it's power in the darkness" (J10)
	No Apologies	Not apologizing for flaws	"I don't have to be anyone other than who I really am. I used to spend an awful lot of energy.... being the person they expected me to be" (F06)

Basic Theme	Code	Description of Code	Quote
Changes meaning associated with an event or characteristic	Flaws	Flaws are good material for jokes	"All your weird quirks and flaws are actually your strengths in stand up comedy. Stand up helps us see those quirks as strengths." (K11) "I wish I was schizophrenic because I'd have more material to do then. They seem to have all the good stuff" (F06)
	New perspective	Reframing the way experiences are viewed	"it's kind of light, shining light on different aspects of your life" (A01) "[SUMH] allowed me to look at mental illness another way, at the funnier side of what I've gone through" (G07) "...showing how we took what is painful in our life and we made it into something so we can have a good time with it, made it into jokes." (L12)
	Narrative	Telling personal story	"He's making fun of things and he's telling his own story. He's actually telling the truth. So is that what it is... always speaking from my point of view, but lecture are someone else who maybe don't have the same story to tell." (E05)
	Re-telling	Adapting story in jokes	"What's unique in stand up comedy is that you get to tell your story, your way..." (J10)
	Own Stigma	Dealing with own stigma/ prejudices towards other people with mental illness	"[When I first started] I didn't know if my mental illness was serious enough that I should be here... It was really important for me to learn there is a spectrum of [mental illness] and there are some of us who suffer with it on a smaller scale and then there are people who are full blown, out there, all the labels and the weirdness... But it doesn't make the experience of mental illness any less real for each of us" (D04) "To be honest, I kind of felt like I didn't fit. I kind of felt like I was David's colleague and there were a couple of people that I thought were kind of interesting and there were a couple people that I thought were going to get on my nerves because they were really struggling." (G07)
People with mental illness feel that they are treated differently because of their diagnosis	Rejection	Fear of rejection	"I like to isolate and be alone as much as I can. Cause sometimes when you're in a bad mood or really depressed you might say something you don't really mean or something and people might think... they might not get you." (N14)
	Avoid/Withdraw	Avoiding "healthy" people because of fear	"I don't think other people can understand, so I kind of spent my time in the periphery." (E05)
	Social challenges	Indicators that social dimensions of life have been a challenge	"When I got better [on medications], I had nothing. I had lost all my social skills... I had lost my ability to relate to people" (A01)

Basic Theme	Code	Description of Code	Quote
“Healthy” people don’t understand mental health experience	Ignorance	People have faulty or incomplete understanding of mental illness	<p>“It’s got a bad history right, from the asylums and everything else... people just don’t know better.” (M13)</p> <p>“Fear causes stigma. Separation causes stigma. See, there’s that, it’s not an accident that there is stigma around them illness. Mental illness is awful. It’s scary, it’s disgusting. I wouldn’t want my daughter to have what I have. And so, looking at it from the outside like when people do stuff that’s not their normal character and you watch and... well what if she was air traffic controller or what if she was a doctor making choices for other people or what if you know, you don’t want that around. So then it’s only another step away from the legitimate fear to you know, the stigma zone, then you know, making stuff up about people and that kind of thing.” (G07)</p>
	Misconceptions	People don’t understand what it means to have a mental illness	<p>“I find it very hard to share what I’m feeling when it comes to mood and you know... And I’ve have a supportive of family but I feel that they don’t understand either.” (K11)</p> <p>“I’d like to be able to give people my experiences so it’s still so hard for me to tell someone what it’s like. You know like, Yes, I get overwhelmed, really quickly. I get it’s like a kaleidoscope when you see things you know, there is noise, there’s lights, there’s smells, there’s visual chaos, and I just and I can’t handle things sometime I have to just go away.” (F06)</p> <p>“They picture people out there on the streets, talking to themselves, and pushing shopping carts full of junk around, begging on street corners or sleeping in alleyways or whatever. All these misconceptions. Some of them are true for some people but not for everyone.” (B02)</p>
“Demonizing” healthy people	Expressing Experiences	Mental illness is not a topic for open discussion	“It’s just some problems are more okay that other ones in our society so we talk about them more...” (E05)
	Disclosure	Unsure consequence of telling people about mental health experiences	“It’s like stepping out onto the ice, you don’t know how thick it’s going to be and you hear a crackle and you think ‘let’s just hope it holds me’ and it’s a huge leap of faith in some cases” (D04)
	Invisible	Feeling as if unable to see person for mental illness	“It’s like, you either have to step out of the cloud [of stigma] and talk to somebody and have them see you or you have to give them like some kind of special glasses that they can see through you through it [the stigma of mental illness].” (G07)

Basic Theme	Code	Description of Code	Quote
Amongst people with mental illness there is a shared identity	Identity	Elements that influence their sense of identity	<p>"when they are throwing labels around, and the expectation is that your label defines who you are" (M13)</p> <p>"I'm not my diabetes anymore that I am my heart condition or I am my OCD. That isn't the only thing that defines me." (N14)</p> <p>" I don't do many mental health jokes myself....I have other things that I'm centering my act on... [things] that are more important to me, more influential in my life" (B02)</p>
	Belonging	Feeling a sense of belonging to mental illness group	"We all support each other, we've all had our own issues to deal with, coming from similar background helps us relate to each other" (C03)
	'It's not my whole life'	Assumptions that mental illness defines their lives and identity	<p>"Just because I'm bipolar, doesn't mean that I get along with every George, Susan and Harry just because they're bipolar." (G07)</p> <p>"it's almost like the cliché, well you are not a person with bipolar, you're not a person with schizophrenic. You're schizophrenic, and everything about you is that" (G07)</p>
Drawing new parallels between challenges faced by healthy people and other kinds of "sick" people	Own Challenges	Recognition that all people face unique challenges	<p>" I think 100 % of the people have something they face, some issues... some unique challenges that they face so we aren't all that different" (E05)</p> <p>"I think everyone has unique challenges that they face in life so I think that, as a person with mental illness, the worst thing I've done is that believing that I'm somewhat separate from the rest of the society... that they can't relate to me in any way." (E05)</p>
	Other illness	Comparisons of mental illness to other illnesses: Diabetes, Heart Disease, Cancer	<p>"it would be different if it was like 'oh, survivor of breast cancer' people then go 'oh, she's so strong' so it's different right?" (J10)</p> <p>"... it's like say if a guy comes into work, and he's like 'you know my diabetes is really acting up today or something like that so... why can't I walk in and say to my boss you know my voices are kind of high today?'" (L12)</p>
Emphasizing shared experiences with all groups, not just mental health groups	Sharing	Sharing stories and common experiences	And I think Stand up for Mental Health was good in a way because I was, separate, uh.... Like the greater community did not really know me or mental illness in general. It was a chance to maybe in a more formal setting kind of share more about yourself and situations. In a safe way, you know, share the things I don't normally. (E05)

Basic Theme	Code	Description of Code	Quote
Positive feelings emerge from being associated with an admired group such as comedians	Inspiration	Reasons for getting involved	<p>"I saw the SUMH documentary on TV and I was blown away. I cried the whole I'm like 'I can't believe these people are even talking like that, that's my language, right?' So I went to his website and his show was coming up so I dragged a girlfriend. You know what I cried the whole show? I was amazed that he was standing up there talking, about it, the way I like to talk about it because you know I identify and always have I've been called crazy, right" (F06)</p> <p>"I saw the show - David show. I saw this one guy, who's in my group now, sitting there and I was like at first, that person is really messed up. All of a sudden he gets on stage. And that was the reason that I joined because I was like 'whoa. This is so awesome.' That these people here, who I thought these people were like too screwed up to even say hello and all of a sudden they're telling jokes and I was like that's what I want to do. That was so awesome." (L12)</p>
	Hope	Positive thoughts for future	<p>"It's made me see things through different eyes. It made me see this part of my life that could turn into something that won't just leave me sitting around doing nothing all the time... I've actually thought of doing this as a career one day. So it's motivated me. Definitely motivated me it has given me something to do but in a more major way, like something to do. I never graduated high school. I wasn't good in high school this is fun it makes me believe that there is something out there for me... all my life I've been living a nightmare and now I'm trying to live my dream" (L12)</p> <p>"when people see the show, it makes them realize that mental illness is not a death sentence" (M13)</p>
	Funny	Characteristics of comics and funny people	<p>"I like it the best when people come up after shows and tell you that you did a really good job but sometimes if you do really fancy setting then they don't come up to you because you're just a performer" (B02)</p> <p>"Clinicians see this broken, hurting side of their patients but when they come to our show, they see the same people on stage and they're funny and they go 'oh wow! This person has a lot more strength than I thought!'" (C03)</p> <p>B02: Well most people are pretty impressed with anyone who can get up there and perform, cause most people don't do it. So just getting up there and doing it. Researcher: So it's not about what you say, it's about being on stage.</p> <p>B02: Well it helps when your funny too, otherwise they might just feel bad for you and that would reinforce negative ideas that people with mental illness can't do things.</p>

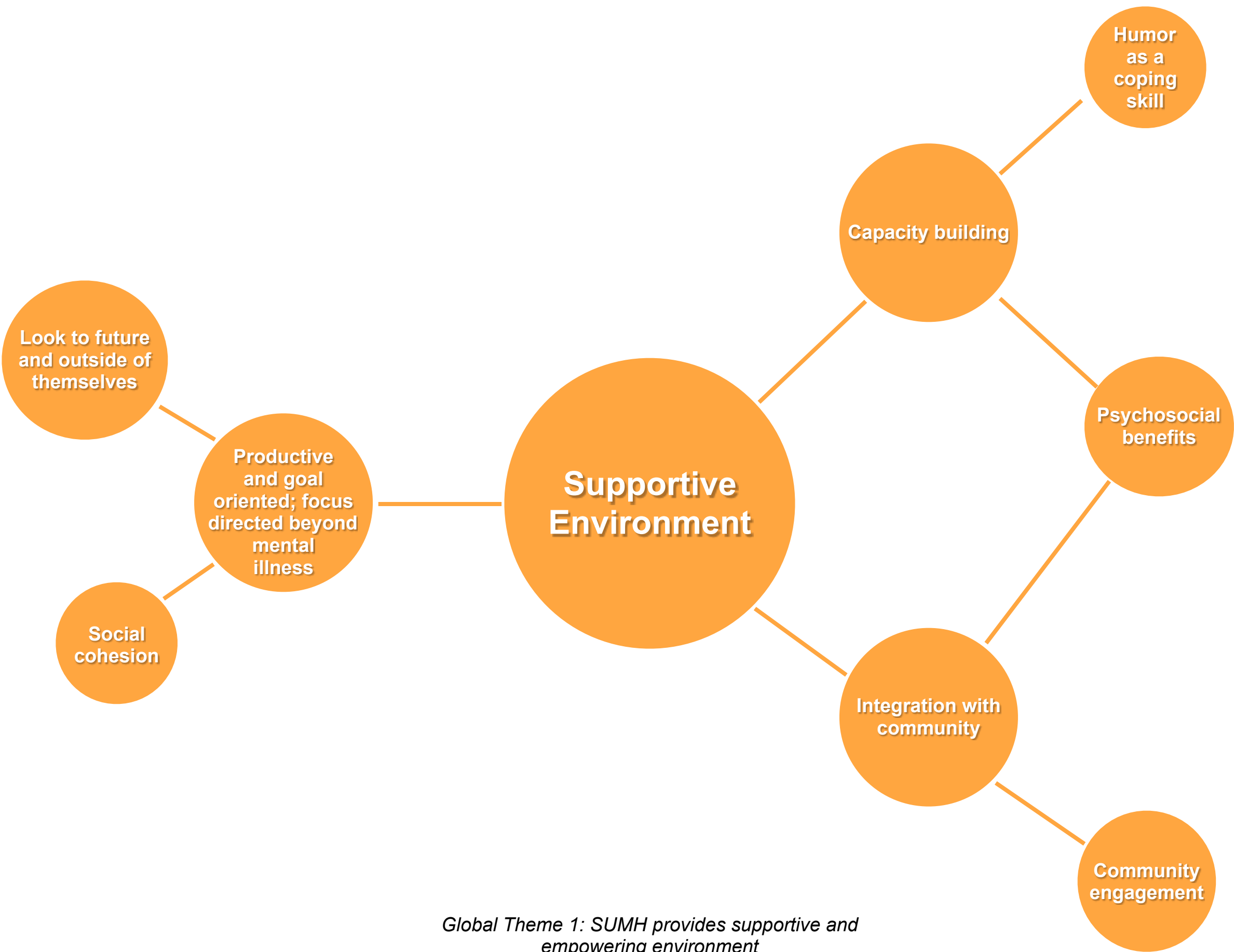
Basic Theme	Code	Description of Code	Quote
People with mental illness are courageous and funny	Confidence	Feelings of confidence during and after the SUMH program	<p>"[I've taken away] more confidence, from getting up on stage and performing 'cause once you can do that, you can do pretty much anything" (B02)</p> <p>"It was exhilarating, it was amazing. Especially in our opening debut at the Arts Club Theatre- I have trouble during the day most of the time but I literally felt good seven days after my performance, just because the laughter and everyone came up and said 'you're hilarious, you're hilarious.'" (A01)</p>
	Barriers	Factors that participants had to overcome in order to perform: fear, nerves	<p>"To be honest I didn't want to join. My family was like 'you should do that' and I was like 'hell no, I can't do that.' I didn't think that I was going to be able to. I didn't think that I could be funny. Before I got sick, I thought I was really funny, cracking jokes and stuff all the time, but afterward I was kind of serious and morose"(A01)</p> <p>"My family was so surprised. I'm not sure they thought I could do it" (C03)</p>
	Announcements	Responses when participants announced that they were doing stand up comedy	
Jokes can be used to create cohesion	Jokes about self	Making jokes about self	<p>"We are making jokes about our own mental illness... it makes it different" (B02)</p>
	Jokes about others	Making jokes about others	<p>Setup: So I ran into some friends and these guys treat me like I was totally crazy, they wouldn't make eye contact or talk to me.</p> <p>Punch line: Maybe they found the machete a little intimidating. [Joke continues] I feel bad for you I said because I have a mental illness and I might get better but you, you'll always be an asshole. (A01)</p>
	"Healthy revenge"	Stand up comedy as a healthy way to speak about injustices	<p>"I got to tell my story about all the things I went through with the medical system which is funny because I'm a nurse so I knew it from a whole other perspective before this. In SUMH, I got to get that little jab in." (J10)</p> <p>"comedy is a great way to get revenge, I don't mean that in an angry, bitter way, but a lot of people have had really bad experiences with psych wards, meds and mental health system and now we get to say all that stuff. It's really empowering to speak out about these experiences and abuses of power." (David)</p>
Topics/discussions can be highlighted through of jokes	Awareness	Participants feel like they are raising awareness about mental health experience through their jokes	<p>"We're trying to send out a message.. that here's hope for them, like there's a lot of people with mental illness that think that there's no hope for them..." (L12)</p>

Basic Theme	Code	Description of Code	Quote
Format of stand up comedy is about twisting expectations	Structure	Joke structure	<p>"David teaches us about set ups and punch lines first. It's about setting up an expectation... you know, like the audience will think one thing and then you go the other way" (M13)</p> <p>"We had, there were three kind of main formats. He has this, his kind of handbook and you kind of go through and he teaches his sort of formula for like no-fail kind of formats or which is kind of like the high school teachers version of the five paragraph essay." (H08)</p> <p>"David gives us some guidelines about who and what we can talk about because it's meant to be funny it's not meant to be hurtful." (C03)</p>
	Language	Reclaiming stigmatizing words	"You don't have to worry about someone else making a joke about 'those crazy people' because you've taken that back. It's gives people a way to take back words like 'crazy' or 'lunatic' because now they are our words and you can't use them." (David)
	Voice	Characteristics of their comic voice	"It's all real but I exaggerated to make a point, I make myself seem crazier than I really am." (F06)
Laughter and clapping affirms what the participant has shared	Pride	Being proud of their stand up comedy	"The messages are more powerful because we are telling our own stories... but it's not only that we are telling our stories, but we are doing it in a way that most 'normal' people wouldn't even attempt! I mean how many people can say they did stand up?" (A01)
	Recognition	Participants feel that both their stories are heard and recognized	"Someone once told me after a show if they had an expert come in and tell them this stuff, they would have forgotten in two hours. She said that she will never forget what she saw us comics do. That was really cool." (K11)
	Response	Description of audience response to jokes	<p>"[My favourite memory is] getting a stand up ovation I think, getting clapping, sustained clapping for a minute. That was great." (K12)</p> <p>"It feels good it's kind of a high like you kind of you ... want to do it again. So... we had put all their garbage out on the table and people were just, "Hey that's cool."" (E05)</p>
Changes in the way that close contacts view the participant: respect, admiration	Awe/Admiration/ Praise	Audience feedback after shows	"When people talk about their mental illness in such public way, and they get such a positive response back, instead of talking down to you or like when they watch you at work and all those negative things" (L12)
	Attitude	Attitudes towards people who would attempt stand up comedy	But for the first part, all that matters is that you got up on stage. That's all that matters. Especially because so many other people are afraid to do it [stand up comedy]. And people always say "oh how you that how do you get up on stage?" (M13)
	Seen in new way	Family/friends/others in audience see new side of participant	I know this from my family that they are just in awe, I'm known to be the shyest out of all of them, but seeing it they are like "Wow I can't believe she actually did that." (C03)

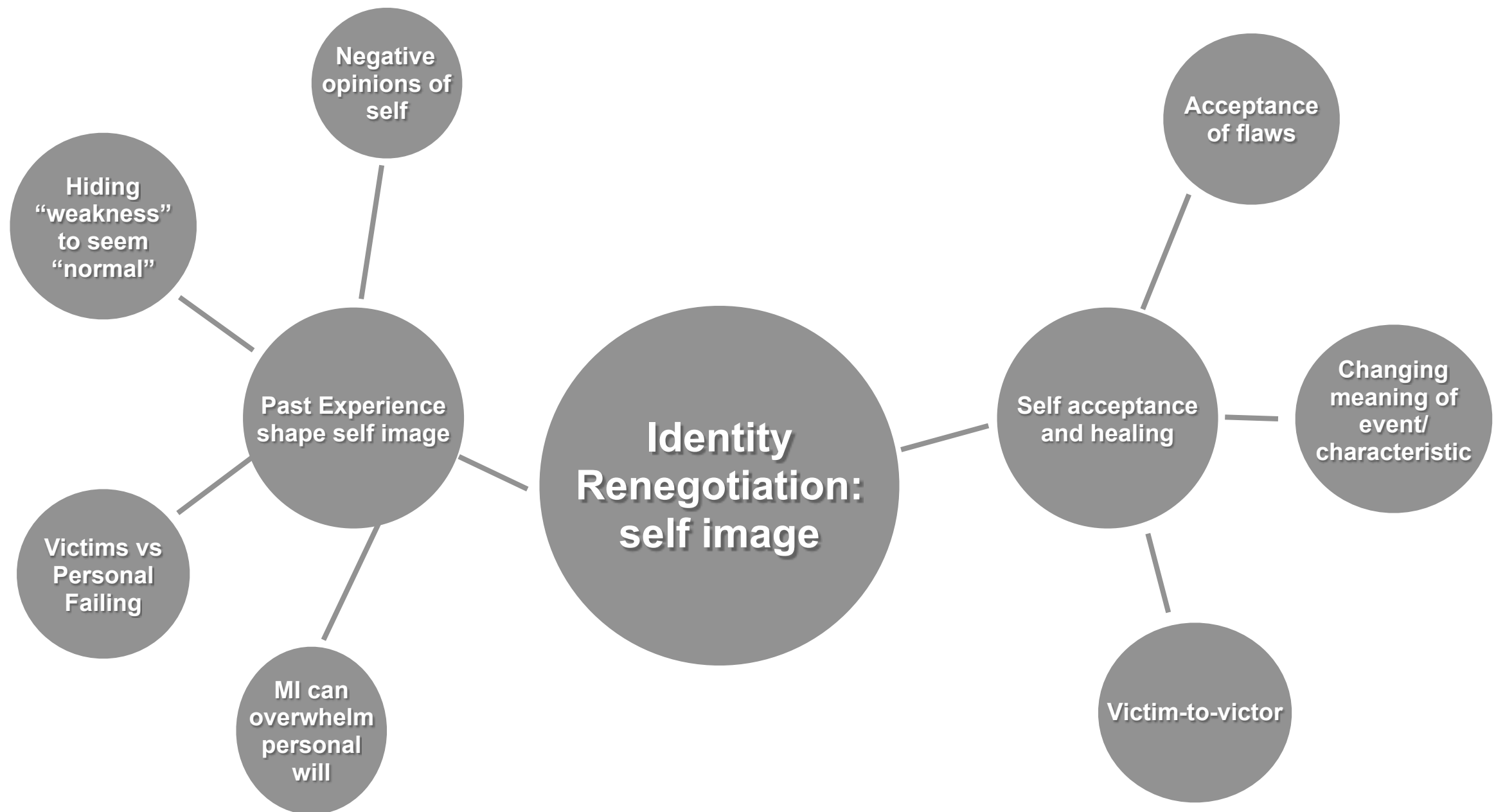
Appendix VII: Emerging Themes

Global Theme	Organizing Theme	Basic Theme
Structure of SUMH provides supportive and empowering environment	Capacity building	Humor as a coping skill
	Integration with community	The structure of SUMH has psychosocial benefits
		Community engagement helps legitimate their place in society and their mental health knowledge
	Productive and goal oriented; focus directed beyond mental illness	SUMH encourages participants to look forward to future and beyond themselves
Identity renegotiation: self image		Social cohesion built around positivity rather than commiseration about common insecurities
	Past experiences shape sense of self	Negative opinions of self
		Because of the negative responses, participants tried to “seem normal,” hiding their “weakness” from others
		Paradoxical experience of being treated as ‘victims’ of mental illness in contrast with mental illness being a personal failing
Identity renegotiation: re-evaluation of group membership		Even with best intentions/practices, mental illness can overwhelm personal will
	Self acceptance and healing helps generate positive self image	Compassion towards self and acceptance of flaws
		Changes meaning associated with an event or characteristic
	People tend to accentuate the difference between people with mental illness and “healthy” people	Victim-to-victor shift in self view, fostered through self-exploration
Challenging “outcast” mentality		People with mental illness feel that they are treated differently because of their diagnosis
		“Healthy” people don’t understand mental health experience
		“Demonizing” healthy people
		Amongst people with mental illness there is a shared identity
		People feel conflicted over the fact that they feel more connected with people with MI but don’t feel that MI represents their whole identity.
		Drawing new parallels between challenges faced by healthy people and other kinds of “sick” people
Being part of a validated group fosters self esteem		Emphasizing shared experiences with all groups, not just mental health groups
		Positive feelings emerge from being associated with an admired group such as comedians

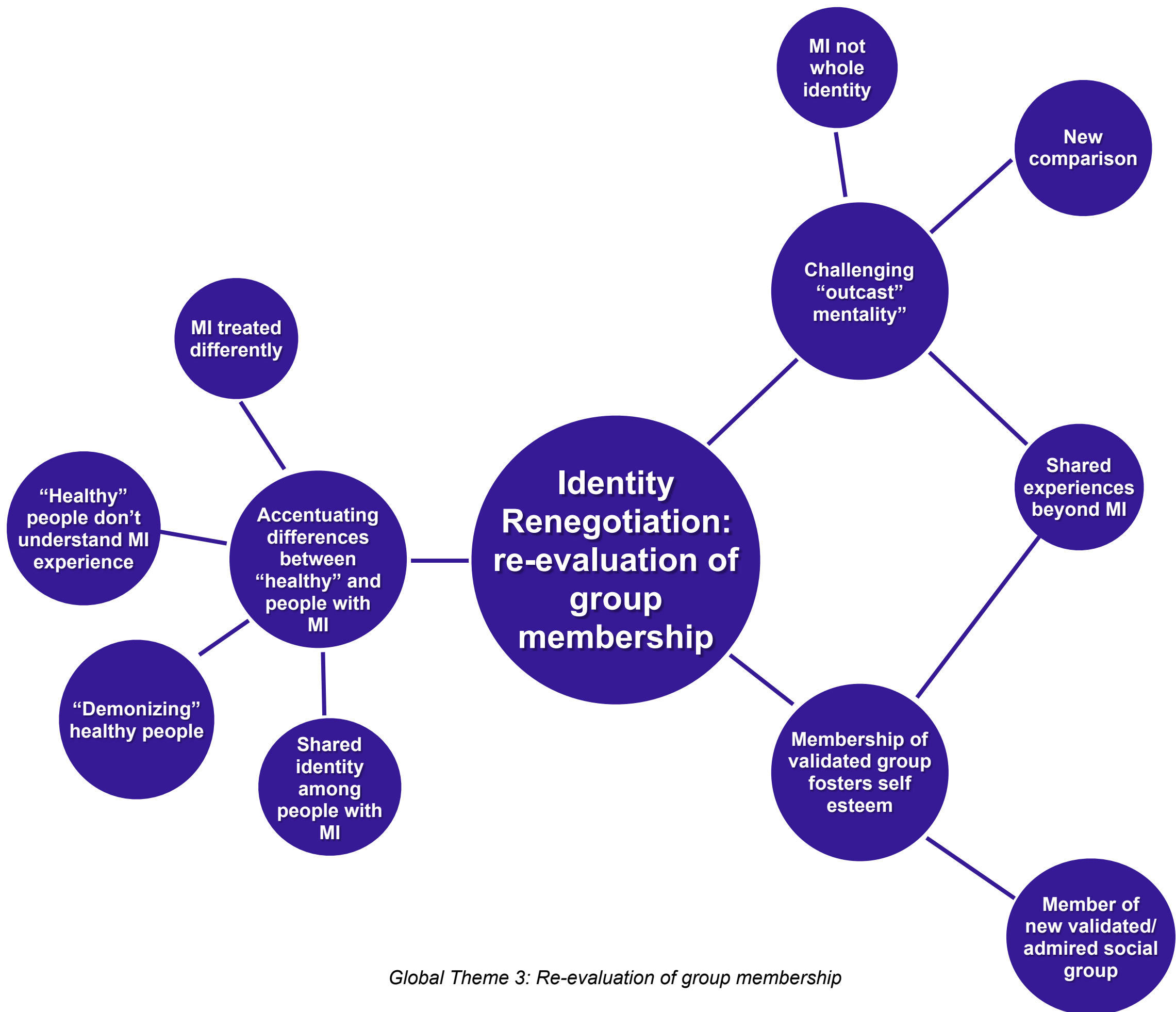
Global Theme	Organizing Theme	Basic Theme
Contesting meaning	Alternative “representations” of people with mental illness	People with mental illness are courageous and funny Exhibiting characteristics associated with overcoming the challenges of stand up comedy makes them role models (both to “healthy” people and others with mental illness)
	Jokes can be a way to stimulated new discussions about mental illness	Jokes can be used to create cohesion Jokes can deconstruct hierarchy through comparisons between different groups
	Like other forms of communication, stand up comedy is a type of discourse	Topics/discussions can be highlighted through of jokes
	Audience members integrate new information about people with mental illness such as strength, humour	Format of stand up comedy is about twisting expectations Structure of comedy gives the participant a recognized voice
		Laughter and clapping affirms what the participant has shared Changes in the way that close contacts view the participant: respect, admiration



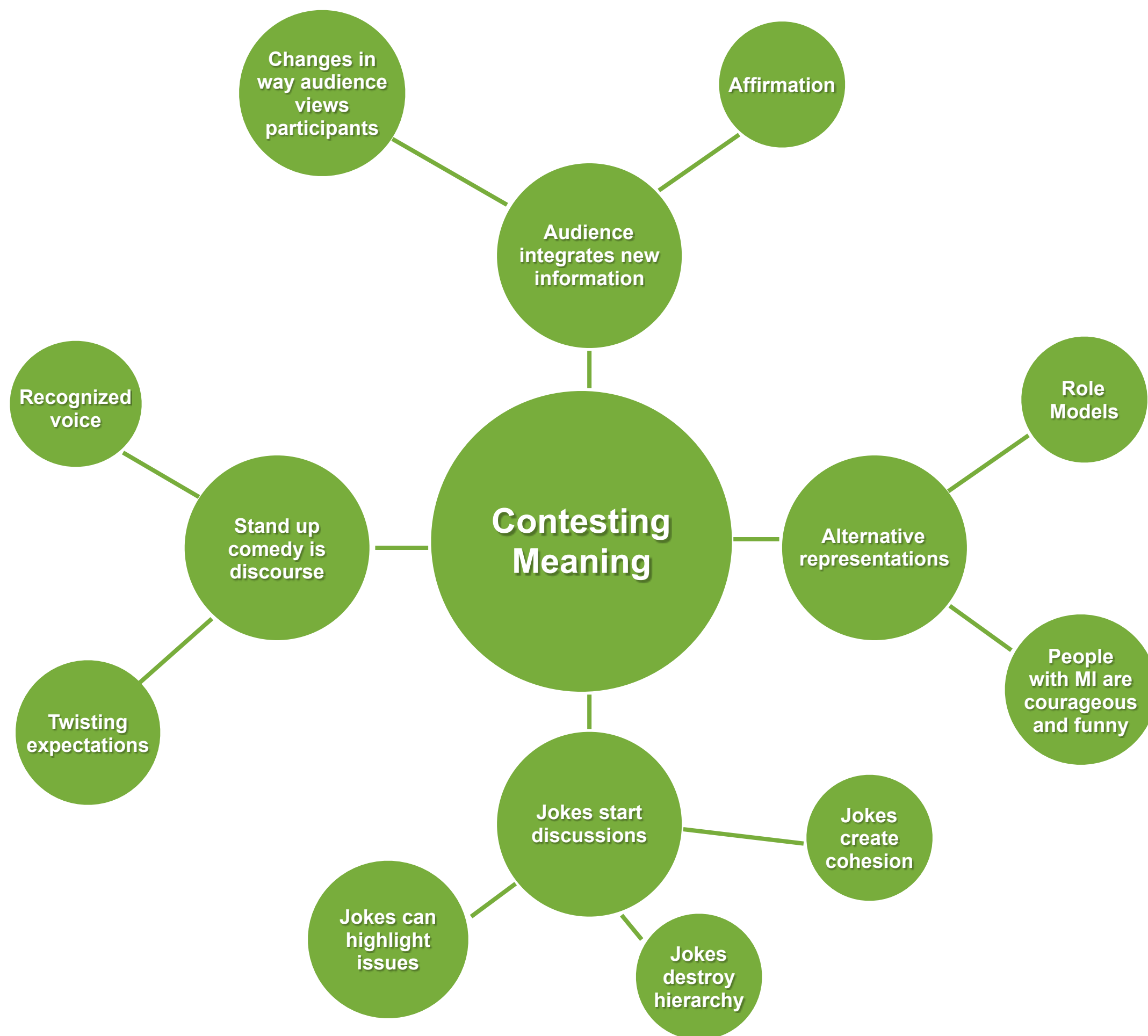
Global Theme 1: SUMH provides supportive and empowering environment



Global Theme 2: Renegotiation of self Image



Global Theme 3: Re-evaluation of group membership



Global Theme 4: Contesting the meaning of mental illness