« Integration of Anglo-American drama therapies in the French traditional psychoanalytic approach»

Sandrine Pitarque, september 2017, ECARTE conference

Historically psychoanalysts have been very present in French Universities and clinics. Which I think is very good! But French psychoanalysts are often… very French! They have developed a very rigorous thought concentrated on Freud-Lacan articulation, that sometimes may imply a difficulty to adjust their setting. Only a part of them have opened their work on other kinds of thinking, particularly in the fields of:

- Group analysis
- Psychoanalytic psychodrama (Foulkes, Bion…)
- Psychoanalysis for children (Winnicott, Klein…)
- Therapeutic mediations (Winnicott)

As psychoanalysis was so important in our country, many arts therapists have tried to base their research and their practice on that approach. They have developed their work on concepts such as:

- Didier Anzieu's 'psychic envelope' (that has strongly fed musicotherapy through the concept of sound envelope)
- Ophelia Avron's 'interlink rhythmic drive' and some key therapeutic positions that she took from Bion
- Therapeutic mediations have conceptualised
    - mediating object (Bernard Chouvier (Brun, Chouvier, and Roussillon 2013) following Guy Gimenez's 'relational object').
    - transference to the setting (Anne Brun (Brun, Chouvier, and Roussillon 2013)).
    - malleable medium (Marion Milner (1977) and René Roussillon (Brun, Chouvier, and Roussillon 2013))."

I strongly invite you, for more details on that question, to read the last issue of the British Association of Drama therapists journal in which Professor Anna Seymour has welcomed my first writing in English on that subject. Today I want to develop some of them in relation to my practice with teenagers in psychiatry. Trained as a drama therapist (at Descartes University) and as a psychoanalytic psychodramatist (at CEFFRAP) I have developed my work principally on those psychoanalytic concepts.

The setting

For teenagers in a psychiatric clinic, we created a setting particularly appropriate for this form of drama therapy. We find a good balance between providing both a caring practice, which should give a reassuring and stable framework, and an artistic practice that gives another dimension: playful, aesthetic, transgressive. The work stands outside the usual care path, and at the same time it is fully integrated into the thinking of the medical team. The presence of the psychologist, who comes specifically to our place just for a half-hour discussion among care providers, is an obvious sign of that.

The group begins with a 15-minutes open discussion. Then we propose one or two games to get the group together or to work on a precise objective (for example a technical work on emotions). After that, each young patient proposes a scene: he chooses the theme (if nothing comes, I propose one) and his partners. He has to choose at least one adult. They prepare the scenario for a few minutes and play it on stage. At the end of the scene they get applauded. We have a brief speech while the actors are seated on the stage edge, meaning still half on stage but already getting out of it. When all teenagers have played their scene we spend about 10 minutes around a table, writing or drawing on an individual book. The teenagers leave. The adults stay and the psychologist joins us for half an hour discussion.

In this work, I base my interventions on Winnicott's (1971) concept of illusion, along with Patricia Attigui's (theatre pioneer in the French Therapeutic Mediations) work (2012) as well as concepts coming from the therapeutic mediations. Here are some vignettes that I find very relevant to illustrate them.

The transference to the setting

Some psychoanalysts, adjusting their setting to children suffering from Pervasive Developmental Disorders, have conceptualised the transference to the setting (Anne Brun, 2013). The actions made by the children onto the room and the material are analysed by the clinician as an expression of the transference. Applied to drama therapy, I use this concept to 'listen to' all actions made by the teenagers as expressions of what they feel, what they are going through, here in the group or in their daily life. There are mostly unconscious expressions. We try to be sensitive to them and to think of what they may mean. As a drama therapist coming from the stage direction I have a particular sensitivity to the space: how it is occupied or let empty by actors, how it is invaded by bodies or by voices, how the separations (the stage – audience or the stage - backstage separations) are respected or not, etc.

Many examples of transference to the setting can be given in a group of teenagers. There is not one single signification for one attitude toward space and material, it depends on the relational background. Here are some possibilities of understanding some behaviours:

- At the beginning of the group, during the first two months, it takes time to trust each other. That can imply:

- late arrival and early leaving
- difficulty to go on stage, to be watched by other people
- playing from the back, staying in the back of the stage

- The arriving of a new participant may provoke anger and fear, as an invasion. That may materialize in:

- violence made to the equipment
- inability to stay seated or even to stay in the room,
- invasion of spaces we are not supposed to use : a closet, a lobby, even under the stage!

- Porous psychic limits can be identified when:

- a teenager can not help talking to the audience whereas he is acting on stage
- or talking to the characters whereas he is in the audience
- a teenager opens the stage curtain during the scene preparation (in our setting the actors prepare their scene on stage for a few minutes with the curtain closed ; they open the curtain when they are ready to play)

- Other noteworthy attitudes toward the space and the materials may be:

- To wrap oneself in the stage curtain (to hide oneself? To reassure oneself? To calm down?)
- To be seated in the audience with the feet on the stage (To be in and out?)
- To steal an object, even non valuable (to defy the rules? To take and keep something from the group?)

I'd like to develop an example even more specific to drama therapy : the case of a patient using the equipment to get his improvisations more meaningful. Tim[1] has participated to the group for one year and a half. He is a 14 year-old boy. He lives with his two parents, a brother and a sister. He acts very violently especially at school, not bearing any kind of authority and hardly bearing a group activity. His behaviour makes him being excluded from school, more and more often, longer and longer. An educational program sends him to our group. His first sessions of drama therapy are rather easy even if he arrives at the end of a scholar year in a constituted group. He rapidly agrees with the setting. He shows creativity, pleasure, ability to invent a scenario and play a character. At the first session after the summer break, he comes early and organises the space (the chairs and the tables that we place each week before the group). When we ask the teenagers what we are doing in this group, Tim is able to express that drama therapy helps him focusing on a precise objective, dealing with his anger and his violence and telling his problems. This appears to be a very good start to begin the year!

[1] All names have been changed

But his attitude in the group becomes difficult. He attacks the setting in many ways. During the speaking time at the beginning of the group he can't help wrapping himself in the stage curtain. In his improvisations Tim starts using as a scenery element one of the table we use at the end of the group. It is a very heavy item so you need to have a strong motivation to carry it up to the stage! Yet Tim will use this table all along the year in many different ways. At first the table is a simple seat.

> Tim is watching a horror movie with a friend. The murderer-clown in the film gets out of the screen and attacks the spectators. Tim's character and his friend reach to kill him and they use the table to lock the murderer's body up. Next week the table becomes a bed in a delivery room. A teenager (a boy) plays the woman in labour and another one plays the father holding "her" hand. A drama therapist trainee is the midwife. Tim gets out from under the table, where he was hidden under a large piece of fabric, as the baby appearing. Then he says: "14 years later". He asks his two partners, playing mother and father, to seat and he tells them that they are bad parents, that he hates them.

That's an improvisation that we consider to be the start point for Tim to work profoundly on himself. Later in the year the three boys of the group (there are also two girls) become more and more aggressive. We strengthen the setting with some new rules. For example: to help them being part of the start discussion we propose to use the stage curtain only during improvisations. At the same time we are all moved by the first Parisian important terrorist attack: Charlie Hebdo attack. It happened a Wednesday so we see the teenager the next morning. Everybody is in shock. We understand that the boys have watched some very violent videos before they were removed from the Internet. They ask us to play the attack. We accept.

> A drama therapist trainee and I are the journalists. Tim and another teenager play the terrorists. They begin the scene by closing the curtain and opening it. That is the first time we use this curtain as a theatre element. When opening it they say: Act I. Again that is the first time such a theatrical code is used in an improvisation. As if the unimaginable scene we are going to play needed an extra amount of distance that theatrical codes can give. The scene goes on as close as what the news told us about the real attack. The two terrorists kill the journalists invoking Allah. They close the curtain and open it again saying: Act II. We are now in the street just outside Charlie Hebdo. They kill a policeman (as the video showed it before being removed from the Internet). They steal a car and flee. They close the curtain and open it for the third time while saying: act III. From that moment, they have to invent because in the

> reality we don't know what will happen. (In fact the two terrorists will be killed outside Paris the day after). In our scene the two terrorists are arrested by the police. One of them reaches to escape. The other one, played by Tim, lets the policemen catch him and declares he has to pay for what they did, hoping his brother could escape.

After that session the boys play many improvisations with the death in the centre of the theme. Different images of the monster emerge from the scenarios: the monster inside us, the monster becoming reality, the living-dead… For Tim we feel that something is more personal. It seems to us that the improvisations where his personal story is part of the scenario are the ones where he uses the table as a scenery element. For example, one time

> he plays a father who is dying from a heart attack. The table has become a hospital bed. Another teenager and I play his children visiting him. At the beginning he sleeps. Then he wakes up and tells us there is no hope any more. And he dies. Next week Tim wants to play what happens next. So the table is now a grave! The children put a rose on their father and go to a café. There appears the father's ghost. He tells them: take care of each other and don't trust the others. Looks like a Shakespearian sentence!

With the team and the psychologist we associate after each session on what happened during the group, what we felt, what images came through each of us. Week after week this associative speaking makes us suspecting some deep secret inside Tim's family, a secret we suppose involving the father or a grandfather. The psychiatrist has that idea in mind when he sees the family. At one of these meetings, Tim's mother is alone with the psychiatrist. She reveals him that, some years ago, her father (Tim's grandfather) has sexually assaulted her daughter (Tim's sister). The grandfather has stayed in the family and he has always been very important to Tim. He just died some months ago and Tim was very sad of that. Tim is not aware of the abuse. But now the medical team knows.

In drama therapy Tim becomes very depressive. His improvisations are not meaningful and emotionally moving as they used to be. Tim plays a lifeless character or, on the contrary, a sportsman with no emotional involvement. Three sessions before summer break he announces he won't come back because he is leaving Paris for early holidays.

> During his last improvisation the table becomes a seat where he watches a movie, as it was the first time he put it on stage. Again a monster in a horror movie gets out of the screen. But that time the two teenagers are not afraid. They know it is not for real. They play the fear just to please the "monster" (embodied by the drama therapist trainee). The latter gets out of stage, desperate because he understands he didn't reach to fear them. This scene appears to be a very clever metaphor of what drama therapy process may bring. The monster is recognised as what it is: an image created by our fear. As soon as we are not afraid, it disappears.

Tim doesn't come back for the two last sessions. He is supposed to be part of the group the next year. But at the beginning of the summer, he has a meeting with the psychiatrist and his mother. Supported by the doctor, the mother reaches to reveal her secret to Tim. He is first very shocked to learn that his beloved grandfather was sort of a "monster". But knowing the truth and feeling the trust the mother gave him by revealing him the

secret, Tim begins to feel very confident. At the start of next year he announces us he is "cured". And actually he doesn't act violently any more. He can manage with authority and group obligations. He finds a place in a professional training programme, getting back to a socially valuable place.

Tim transference to the setting was very strong all along his participation to the drama therapy group. Not only in his way to disturb the group like when wrapping himself in the curtain during the discussion. But also in the way he used elements (the curtain, the table) as backups enabling him to enter in the fiction. I see that as if concrete objects helped him to dive in monstrous fictions while being sure to come back safely from that journey. The associativity of the team allowed us to listen to his transference building and help the unsaid to emerge.

Illusion and Hallucination: both forms of imaginary realities

The psychoanalytic form of drama therapy I conduct is also based on a particular conception of hallucination. Trained at the clinic of La Borde, directed for a long time by Jean Oury who died last year, I have been used to welcome delirium as an expression. Even if I don't understand this expression, it doesn't mean it has no sense. It only means I am not able to catch its sense. To my point of view this is a very important state of mind when working with delirious people. In drama therapy we can compare illusion and hallucination. They are both forms of imaginary realities but the latter is generally not valued. On the stage, fiction gives a framework in which the delirium can express itself without risk and can get value there.

Manon has been hospitalised at the age of 13 for kinaesthetic hallucinations: she feels insects in her belly. She reveals she has been abused by her step-father for some months. When learning that, her mother rejects her. That is the double traumatism (the traumatism itself and the consequences of its revelation) that Ferenczi (2004) explains so well in the lecture he gave in 1932 about the confusion between adults and children languages. At 14-year old Manon joins the drama therapy group. She first works on her emotions, as if learning again what they are, using the technical games we do before improvisations to re-discover joy, to manage her anger, etc. Then she creates a strong trusty relationship with the group through improvisations staging family situations she has never known (a grandmother who brings the girl to New York, a mother who organises a wonderful birthday party for her daughter…) In a third movement she plays metaphors of her abuse: a girl in the wood meets a wolf, he takes her, many times, she tries to escape, in vain, then the mother arrives and saves her daughter. We can notice that the first traumatism can be played but not yet the second one: in the scenes the mother helps her daughter, unlike the reality where the mother rejected her.

In a fourth step Manon plays many times a delirious character. Sometimes her acting is so true that we have a doubt whether she is acting or actually decompensating again. But no, she has only become a very good actress! Sometimes she transforms the delirium in a sort of shamanic trance. At the end of her participation to the group, her shaman doesn't need trance anymore. She uses art to do what has to be done.

> The scene takes place in Mali (the country of Manon's step-father: even if that man has raped her, he has also raised Manon as she has never known her biological father). Manon character's name is Shanna. Her partners are two girls: another teenager and a drama therapist trainee, playing two friends visiting the country. Shanna is their guide. After some visits, Shanna brings the tourists to a place where her family died. She prays and invites her partners to do so. Then Shanna sings. One of the tourists says that she has brought her cat. Shanna gets suddenly angry: the cat is a cursed animal in her country. She wants to eat it. The drama therapist trainee reaches to save the cat (to protect the other teenager of a symbolic violence as cats are very important to her!) Shanna accepts it. At the end of the improvisation she teaches a dance to the tourists, saying it is a particular dance, used in her country to welcome new arrivals.

In this scene, Manon uses esoteric as well as artistic actions to get in touch with her partners. We can also think that these actions help her to be connected to her past (the dead parents) and to her future (the dance for new arrivals). Acting her trauma, then acting her delirious period, she transformed them in an artistic way: formally (as she played better and better) and in the content (like in the last improvisation).

An 'illusion/counter-illusion' relationship

Some major progresses realized in the drama therapy group are made possible by what I call an 'illusion/counter-illusion' relationship (on the model of psychoanalytic transference/countertransference); my work with a supervisor allows me to bring out an image from the fabric of improvisations between a teenager and myself in order to make sense of what has occurred.

To speak again about Manon, but this time from my point of view, in my counter-transference or counter-illusion analysis, I can tell the relationship with this young girl has been part of my motherhood construction. When I met Manon, my little girl was 4-months. I was discovering happiness but also anxiety of being responsible of a so fragile living being. I was not sure at all to be able to be a mother. As I work with autistic children, when I looked at my daughter I often recognized the same behaviour. Which is natural as she was 4 months! But at that time I was not sure if she would grow up or stay at that state. I was not sure if I could be a mother that will accompany her in that development or if I will give her a psychotic orientation.

So I was in that kind of anxiety when I met Manon. She was suffering from being separated from her mother, who was still rejecting her. I appeared to be an adult that was able to protect her from the others (for example when she was verbally attacked by other teenagers in the group) but also from herself (for example when she entered the discussion circle with a knife taken in the kitchen). On stage I was an adult allowing her to express all the feelings and showing to her my own feelings. So she rapidly looked at me as a substitute mother, once a week. Her 'loving eyes' made me imagine I could be a mother, I could be a good-enough mother: as I played that kind of mother with Manon, I was indeed becoming a good-enough mother with my daughter.

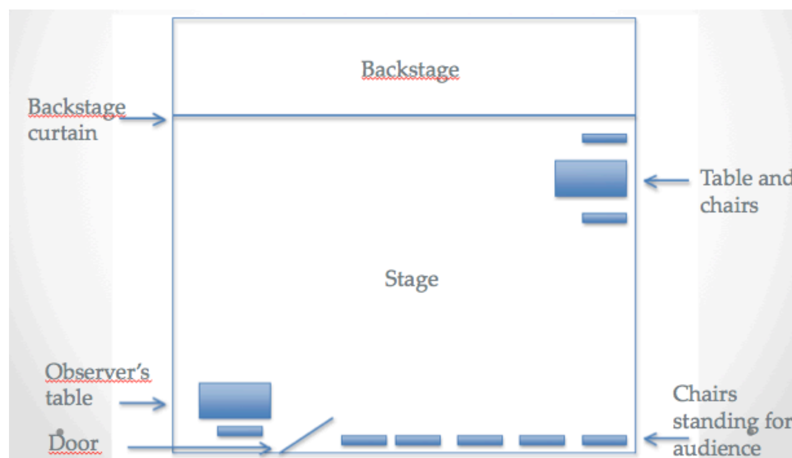
Of course that was the situation during the first months for Manon in drama therapy. Then her transference to me changed and she explored other kind of relations, including

aggressiveness towards me. For two years the evolution of Manon strongly benefit from our joint movement of self construction: me as a mother and a therapist, her as a teenager. Those constructions went through a round trip from illusion to reality, from stage to real life, for the both of us.

In that particular setting, the psychoanalytic approach in drama therapy is very efficient. By working with the teenagers as whole persons we help them to build themselves as a subject (I mean that word in the psychoanalytic sense of subject of his/her desire). It gives our frame a very rigorous dimension. Working with psychoanalytic concepts, we are strongly recognized by the medical team. Which in return supports the process by giving us time to think what is going on week after week.-But that very open approach may be more difficult in other frames. Here is now

A setting where the psychoanalytic approach is not enough

For children suffering from Pervasive Developmental Disorders, with little or no access to the verbal, I propose either individual therapy or a group of two. The session lasts about 45 minutes. Space is always organised in the same manner to provide consistency: the table and the observer's chair in a corner, a range of empty chairs along a wall, an empty space that is our playground, and a curtain to mark a backstage.



Different objects are placed in this space, as possible things for the child to work with: flexible seating, fabrics, music sticks, hand puppets, music set etc. Not all these elements are present together, they are brought over or removed from one session to another, depending on my feelings and those of the observer.

For several months, I do not know what we will play. We learn to know and to trust each other. This is often a difficult phase; the child may seek to 'destroy' the adult and/or the process. I then rely mainly on the concept of 'malleable medium' to commit myself physically and emotionally in the game, while 'surviving' – that is to say, continuing to play, to enjoy, to create.

But when basing my work only on psychoanalytic concepts, I go through three major difficulties :

- Indication: as I come only once a week, I don't know the children before they join the drama therapy group. It is then difficult to share with the medical team which child could be best indicated for my work.

- Evaluation: I may have trouble to evaluate the work on precise items. I am used to

work on an overall vision of the person and on the relation with the patient.

- Adaptability: this form of drama therapy is very expensive : one adult for one child. When the clinic asks me to work with a group of 3 children, it becomes very hard to adapt my method.

First movements towards integration

Recently, other models of drama therapy started to emerge in France, mostly coming from English and North American practices. They bring a more pragmatic approach and some very useful methods.

I began one year ago to use Sue Jenning's EPR as a tool for indication and for evaluation of my drama therapeutic work with children suffering from Pervasive Developmental Disorders. Psychiatric lists of symptoms as well as psychoanalytic terms were often irrelevant for me. None of them helped me creating a coherent group nor to easily adapt my propositions to all children.

One of the groups I worked with last year included 3 children. Lin is a 10 years old girl, very deficient. She only connects by hitting: people, walls, objects, etc. she hits everything. Abou is an 8 years old boy who doesn't look at us for some weeks. He screams a lot and seems only receptive when we offer him the possibility to produce music. Finally Nabil is a 9 years old boy that I know very well for having worked with him the previous year in another group. He is not autistic. He can speak even if he almost never does, he can understand a lot. He can play, I know it from previous year.

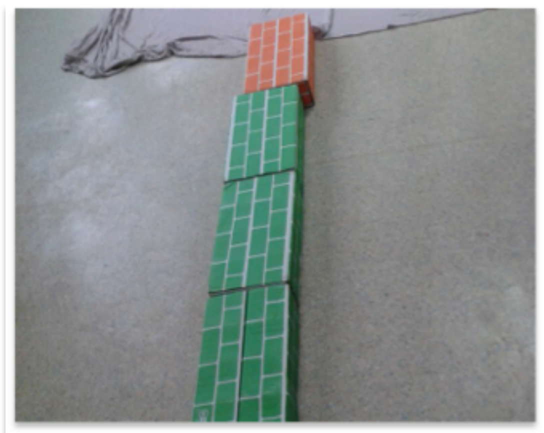
For some sessions we wonder what we are going to do with these 3 children, so different from each other in their way to connect with the world and with the people. EPR model helps us in many ways. Firstly we understand we have to play only on embody dimension with Lin. We propose her games using her favourite action: for example, discovering the space (walls, ground…) by hitting them. We progressively develop that action of hitting by giving it a form, for example the form of a high five that becomes our final ritual: we tell each other good bye by inventing a high five. Progressively Lin puts her repetitive behaviours aside and begins to smile to us. We keep on working on embodiment, adding a relational dimension, for example by playing the mirror with her. At the end of the year, she begins to accept to play with a piece of fabric between her and the adult. Even if it was only for a few seconds it seems she was entering the projection stage.

Abou enjoys the games of hitting we propose for Lin. He is very happy to play kind of percussions through these propositions. He then opens to the relationship with us and accepts other propositions, playing with an adult through the intermediary of an object. We propose him many games corresponding with EPR projection stage. The last two months we have some occasions to play role with him, especially the role of a mum comforting her crying baby. His screaming is finally making sense.

Nabil is less interested in the embodiment games even in their projection version. But, as we recognize his 'role' stage, we don't insist. We offer him a large space of acting that enables him to express many feelings he usually keeps for him: fear, aggressiveness, but also joy and pleasure. At the beginning of the year we play symbolic situations. One of these improvisations have been very moving for me.

> I am under a piece of fabric and he doesn't let me get out, whatever I may say or act. I progressively lose all my means as my words, my movements even my emotional expressions have no result. Whatever I do I remain stuck. I feel that I become empty, not having more any desire to speak or move or express my feelings. And this is how Nabil looks like every day: empty. So that is very moving for me that he makes me experience that state.

Later in the year we play many scenes based on the three little pigs, thus playing different roles: the mother who sends her sons away, the fearful pig, the brave pig, the wolf, and even new roles: a witch for example. The scenes are principally non verbal but the situations and the emotions are clearly identified.



This is how EPR model helped us to better work with this group of children, while keeping our internal psychoanalytic frame. This frame was not adapted to the work with three so different children and EPR model reinforced it. In the CEDRA[2] we created a metaphor for that issue: the goalkeeper. If your internal frame */ you as a goalkeeper* is adapted to the external frame / *the goal*, you can deal with all situations. But if the goal becomes taller (for example when I had to work with 3 very different children instead of one or two), then your internal frame is not enough any more. You exhaust yourself by trying to keep this too big goal. So you have to find a way to boost your goalkeeping with

[2] Cercle d'Etudes en DRAmathérapie, a group named we have built with four colleagues

new tools or to reduce the goal size. That is what we did when adding EPR model to our drama therapy frame and I think we did both: we boosted our internal frame by being more efficient in recognizing each child stage and then by offering them more adapted games. And we reduced the size of our goal by working on more precise elements, particularly with Lin and Abou.[3] Moreover, at the end of the year, it gave me the ability to give guidelines to the medical team to choose next year children. I explained them the kind of games corresponding to the 3 stages of EPR. And I asked them to constitute homogeneous groups according with these stages, that is according to what kind of games they observe the children naturally do. So I am sure that this year it will be even more easy and faster to work together in an appropriate manner.

As a conclusion

I keep on thinking that the psychoanalytic frame is a very important way of thinking. Its overall vision of the person, including history and environment prevents from some abuse of medical power. For example in France the rate of children taking medicine against what is called hyperactivity is about 2% versus 5 to 10% in the United States. Because we still try to see 'hyperactivity' as the expression of something the child can not tell or express more quietly, not only as a problem to solve.

But this conceptual frame, particularly when applied too strictly, prevents us from setting precise and early diagnosis for all non-environmental psychic disorders, particularly autism, dyspraxia and other cognitive impairments. Psychoanalytic approach also limits a quantitative and accurate assessment on precise items.

This is why I strongly believe that integrating drama therapy models coming from abroad will help French drama therapy to work better and address more issues. What I would like to do next is to try to build bridges between French psychoanalytic concepts that we use in drama therapy and English or American drama therapeutic concepts. So as to try to create some French drama therapeutic concepts. I hope those kind of bridges may feed all parts of the drama therapy world!

[3] With Nabil we remained on a psychotherapic general objective

Abstract

In France the historical dominance of psychoanalysis has brought an original way of thinking about the use of theatre and drama for therapeutic goals. Two important schools have developed in the 1970's and 1980's : the French psychoanalytic psychodrama, distinct from Moreno's, has brought many useful concepts particularly for group treatment ; and the 'therapeutic mediations' have constructed major theoretical and clinical thoughts. Recently, other models of dramatherapy started to emerge in France, mostly coming from English and North American practices. They bring a more pragmatic approach and some very useful methods. How can French traditional use of theater for therapeutic goals integrate those concepts? What does an integrative approach bring to the therapeutic process, both in terms of *savoir-faire* and *savoir-être*? How a traditional theoretical and clinical background, as is psychoanalysis in France, sometimes resistant to new approaches so as to keep a rigorous and solid frame, may also be nourished by some new methods.

Notes on contributor

Sandrine Pitarque is co-leader of the dramatherapy speciality of the Paris Sorbonne Cité Masters Programme. She also teaches theatre at the Paris Sorbonne Nouvelle University. She has created and leads many dramatherapy groups in psychiatry, for adults, teenagers and children. She supervises dramatherapists. She directs theatrical creations involving both professional artists and marginalised people. She is trained in psychoanalytic psychodrama and Gestalt practice.

References

Ancelin Schützenberger, A. 2008. Le psychodrame. Paris: Payot.

Anzieu, D. 1956. Le psychodrame analytique chez l'enfant et l'adolescent. Paris: PUF.

Anzieu, D. 1985. Le Moi-peau. Paris: Dunod.

Attigui, P. 2012. Jeu, transfert et psychose. De l'illusion théâtrale à l'espace thérapeutique. Paris: Dunod. First publication: 1993, Paris: Denoël.

Avron, O. 2012. La pensée scénique. Paris: érès. First publication: 1996.

Brun, A., B. Chouvier, and R. Roussillon. 2013. Manuel des médiations thérapeutiques. Paris: Dunod.

Ferenczi S. 2004. Confusion de langue entre les adultes et l'enfant. Paris: Payot.

Milner, M. 1977. Le rôle de l'illusion dans la formation du symbole, translated into French in Revue de Psychanalyse, 1979, 5–6.

Winnicott, D. W. 1969. De la pédiatrie à la psychanalyse. Paris: Payot.

Winnicott, D. W. 1971. Jeu et réalité. Paris: Gallimard.