Drama therapy role theory as a context for understanding medical clowning[1]

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Abstract

Most research in the field of medical clowning looks at humor as the main explanation for the beneficial impact that medical clowns have on hospitalized patients. The present paper attempts to challenge this idea by applying drama therapy role theory to the work of medical clowns. First, both 'clown' and 'patient' are defined and comprehended from a role perspective. Then, using primarily Landy's role method and ideas, the authors analyze clinical examples from the actual work of "Sancho" (a medical clown from the Dream Doctor's Project) by means of role theory. The paper illustrates that besides the typical clown tools and techniques, the medical clown uses role strategies as therapeutic interventions in the interaction with patients. Thus an innovative context for conceptualizing medical clowning is provided, which expands the scope of therapeutic clowning and the use of drama therapy role theory as well.

Keywords: Drama therapy; role theory; role; clown; hospitalization; medical clowning; therapeutic clowning.

In the last three decades, medical clowning was introduced into hospitals around the world as a tool that helps to "promote wellness and improve physical and mental health and quality of life of patients, their families and the healthcare staff who interacts with them" (Warren, 2002, p. 244). Medical clowns are seen touring the hospital's wards, bringing joy and humor to hospitalized people, and sometimes also escorting patients during frightening medical procedures. Consistent with the perception of the hospital as a place where pain and sadness are prevalent, the medical clown is often seen as the one in charge of introducing some laughter into an otherwise unhappy setting (Adams, 2002). On the one hand the clowns help the patients and their families to get distracted, even if only momentarily, from the unpleasant situation in which they find themselves (Koller & Gryski, 2008; Tener, Lev-Wiesel, Franco & Ofir, 2010); on the other, they try to improve the quality of life of the hospital and its staff through the introduction of humor and comic relief (Nuttman-Shwartz, Scheyer &Tzioni, 2010; Simonds, 2001).

Most studies on medical clowning focus on the positive effects that humor and laughter have been found to produce upon people. Quantitative research examined the clowns' contribution to the improvement of the patients' condition, connecting it with the presence of laughter, which causes the secretion of adrenaline and other substances that increase the blood flow and the level of endorphins in the brain, appease pains, decrease infections and accelerate the recovery processes (Glasner, Zaken, Biton, & Leibobitz, 2009; Golan, Rotton, 2004;Tighe, Dobija, Perel & Keidan, 2009; Miller Van Blerkom, 1995; Vagnolli, Caprilli, Robiglio & Messeri, 2005). Research suggests that humor and laughter help to alleviate stress and stress-related symptoms, foster the patient's general sense of wellbeing, and improve people's immune system (Bennett, Zeller, Rosenberg &

McCann, 2003). Moreover, psychological sources indicate that the use of humor brings about pleasure, forms a relaxed atmosphere, and enables the patient to cope with the fears and anxieties caused by hospitalization (Bernstein, 2003; Linge, 2008).

However, is the clown's beneficial influence on health only connected to humor and laughter? As medical (or therapeutic) clowning becomes further consolidated as a profession, some scholars have begun to argue that there might be other elements at play in the clown's contribution to health improvement. Recent studies also pointed to the use of imagination as a vital tool in the work of medical clowns (Elroy, 2006; Nutman-Schwartz, et al., 2010; Schayer, Nutman-Schwartz, & Zioni, 2008). Others have referred to the liminal status of the clown, who, through role-reversing and challenging the established hierarchies, may contribute to restore the patients' sense of control, and enable them to take a new perspective on reality (Citron, 2011; Doude van Troostwijk, 2006). Researchers have mentioned the clown's ability to generate empathy, express affects, and build a supportive relationship, as additional factors that may explain the clown's healing impact (Koller & Gryski, 2008).

The present paper contextualizes the work of the medical clown from a drama therapy theory. This line of thought has been recently pursued by the authors (Grinberg, 2009; Pendzik & Raviv, 2011), and has served to sharpen our understanding of the tools and processes that medical clowns implement in their work – other than the use of humor and laughter. As a related field, drama therapy (and the arts therapies in general) may provide a solid ground in which the new and expanding field of medical clowning may search for insights and tools of analysis. In this article, we will look in particular at the therapeutic aspects of medical clowning through the lens of the role theory articulated by

Robert Landy (1993, 1994, 1996, 1997, 2001, 2008, 2009; Landy & Butler, 2011). We will examine the concept of role, will look at the role of the 'clown' in its archetypal dimension, discuss the role of the 'patient,' and try to establish their connection with Landy's notions of role, counterrole, and guide. We will use clinical examples from the work of Sancho – a medical clown from the Dream Doctors' Project in Israel.

Landy's on roles: role theory and role method

Landy (1993) developed the role theory and the role method as a framework for drama therapy, following Moreno's (1987) view of the role as "the unit of culture" whose function is "to enter the unconscious from the social world and bring shape and order to it" (p. 63). Like Moreno, who claimed that individuals aspire to expand their repertoire of roles, Landy's perspective is based on the assumption that human beings naturally play a variety of roles in their daily life, and that through the interaction between these inner parts, and their contact with others from the social world, each individual comes to develop his or her own *role system*. The human personality is thus defined as a *construct* that is conceived as a dynamic system of roles, in which each single role represents one of its aspects (Landy, 2009; Landy & Butler, 2011). Although an absolute balance in the role system can never be fully achieved, Landy (2009) claims that the person's ability to experience and express more roles leads to a dynamic form of balance, which can be seen as a healthy management of the construct.

According to Landy (2008), life is essentially dramatic, and dramatic action is a central feature of human existence. Therefore engagement in dramatic play may enhance an individual's ability to support and maintain a healthy and flexible role system – the

kind which is required in order to cope with the complex and paradoxical nature of the human condition (1993, 2001, 2008, 2009, & 2011). In this model, a healthy person is someone who can accept contradictions to the point of "being effectively able to live a double life" (Landy 2001, p. 38). Dramatic play offers a platform to practice the tolerance needed in order to accept life's ambivalence, and the courage to see other aspects of ourselves. This is the core of the healing potential inherent in drama.

As the person matures, the layout of the role system becomes progressively intricate. Because roles are interconnected, any changes effected in a given role inevitably influence the rest of the system. Although individuals are usually motivated by a need to find balance, roles are not always harmonized. When roles reach a conflict peak, individuals may feel pressure – which could escalate to the point of being experienced as a profound sense of anxiety. In critical circumstances extreme roles may appear which were dormant and undiagnosed; by the same token, roles which are necessary for growth may become activated, either through life crises or therapeutic interventions (Landy, 1993).

The ability to expand our role repertoire is not simple, as each person learns a specific spectrum of roles within the interactions in which s/he grew up. However, Landy's model poses that no role exists in isolation from the others: The essential interconnectedness of roles implies that each role has complementary, contrasted, expanding or diminishing aspects. Moreno (1987) pointed out that just as every person "has at all times a set of friends and a set of enemies –[he] has a range of roles in which he sees himself and faces a set of counterroles in which he sees others around him" (p.63). Thus, like the antagonist in psychodrama, Landy's counterrole (CR) is the

opposite pole of the role. In Landy's (2008) view, roles adhere to their counterroles, thus creating dynamic dyads. Yet the counterrole

> "is not necessarily the opposition to the role as evil is to good, but rather other sides of the role that may be denied or avoided or ignored in the ongoing attempt to discover effective ways to play a single role. CR is not necessarily a dark or negative figure" (2009, p. 68).

In contrast to the role, which is perceived as an independent entity, the CR does not possess an autonomous existence, and is usually the depositary of those qualities that are banned by society, the family, etc. Once the CR is expressed, then other forbidden aspects generally come out into the open as well: feelings, thoughts, experiences, beliefs, and so on.

The third character in the triangle is the Guide (G), which acts as the bridge that connects between R and CR. Its main function is to integrate between the two by facilitating the client's finding his or her unique road. The guide is "a transitional figure that holds together the role and counterrole" (Landy 2008, p.106). It is the navigator that brings the person to the right track and helps him/her to overcome the obstacles that get in the way. In the initial stages, the drama therapist often undertakes the role of the G; in the course of therapeutic process, the client is helped to develop a strong and positive inner G. In this way, his/her repertoire of roles is also expanded.

The role of the Clown

A clown can be succinctly defined as a performer whose art is to amuse people. Although closely associated with the entertainer, the circus, and the street performer, the clown has a lot in common with *the fool*, as both of them "lack an understanding of or

respect for social norms and decorum“(Carp, 1998, p.246). In many languages, the word *clown* is synonymous to *fool* – and is also used in a pejorative sense to imply an outcast Indeed, when performing, the clown pretends to be a fool, and clearly, in many instances, their act borders with the unlawful or the immoral (Bouissac, 1990; Campbell, 1976).

The clown and the fool can be seen as complementary aspects of the same archetype (Nichols, 1980). “The fool is unaware of society, while the clown is unable to understand the world in general and therefore operates under idiosyncratic ideas” (Carp, 1998, p.246). In this capacity, the role of the clown is not limited to entertainment: In many cultures and civilizations the clown, court jester or fool also acted as a critic of the regime, a true social rebel who, in spite of his/her seeming stupidity (or precisely by virtue of it) was able to voice the truth sharply and cleverly (Green, 1997; Welsford, 1968). In Landy’s (1993) taxonomy of roles, the fool belongs to the *cognitive domain* and presents two *subtypes*: the trickster and the existential clown. These subtypes constitute some of the variations of the archetype – although not the only ones that exist:

> The function of the fool is to charm the master (and the audience) on the one hand, while offering up a critique of his foibles on the other. (…) There is a certain safety in his barbs and insights, in that he never has to be taken seriously because of his low social status. He establishes an empathetic bond with members of the audience, who, sharing in his privileged knowledge, desire to remain like him – superior in their own wisdom, though often at the expense of another (Landy, 1993, p. 183).

Handelman (1990) poses that rather than a normal role, the clown constitutes a *symbolic type* – a category that is distinguished from the *social role type*. While the latter is highly defined through interaction and context, symbolic types are self-referential: “consistently and wholly true to the logic of its own natural composition” (p.244) –

whatever that may be. In the case of fools, tricksters, and clowns, the role constitution is inherently inconsistent and paradoxical. Yet, they are perceived as independent figures, reified above context, and comprehended more as archetypes than as characters or personalities. Their power resides in their ability to "mold context to the logic of their own composition" (p.245). In other words, symbolic types are by definition the ones who play the tune wherever they go.

Handelman (1990) reminds us that the terms *clown* and *fool* are etymologically associated with the qualities of "power and regeneration" (p.247). According to him, the source of the English word *clown* may derive from the words 'clod,' 'clot,' and 'lump' (p,240) – terms that denote something cumbersome, dirty, or unfinished; and they are probably associated with the clown's lack of perfection and logic, and its overall irrational organization. The source may also be connected to the bodily characteristics of the early fool, who usually had a physical deformity – a dwarf, a person with distorted facial features, etc.

Clowns were mentioned in human history since 4500 B.C. In ancient Egypt they performed before Pharaoh. In China, clowns as entertainers were mentioned since 1880 B.C. In ancient Greece, they were added to comedies (Bala, 2010). Throughout medieval Europe and in the early Renaissance, clowns performed in the courts of kings and the nobility; but it was already possible to see clowns who performed independently on street shows. Carp (1998) points out that "the clown figure arose from the ashes of the court jester" (p. 246), evolving later into various categories of clowns: The clowns of the New Comedy (like the scheming one who blocks others), the Shakespearian jester, the Commedia dell'Arte type, the mime clown, the street clown and the puppet clown. Then

the circus clowns appeared: the white-faced clown and the red-faced clown: Hobo and August (Speaight, 1980). These two characters seem to embody thoroughly the essence of the clown. In Western culture, the white-faced clown is considered the classic clown and constitutes a personification of culture. While this clown is responsible and comical, its partner, the red-faced August (which means *fool* in German), draws its character from the fool, and thereby externalizes all the inverted traits, thus representing the denial of culture. Bouissac (1990) argues that, in fact, the white-faced clown expresses less about the culture than its fool partner, who, through his or her awkward behavior brings out into the open those aspects that the culture ignores or denies, and even manages to addresses social taboos that need to be noticed. The two characters usually appear as pairs, and it is possible to see in them the paradoxical essence of the clown – self-contradiction.

More than anything, the clown embodies paradox and symbolizes liminality (Citron, 2011; Miller Van Blekrom, 1995). Clowns are perceived on the one hand as amicable and funny children's heroes: "a benevolent figure, the true giver of joys and toys" (Bouissac, 1990, p.195); yet on the other, they are stigmatized and socially ostracized. Zuker (1967) points out that self- contradiction is the most significant trait of the clown: "Whatever predicate we use to describe him, the opposite can also be said, and with equal right" (p.307). In Handelman's (1990) view, this internal confrontation between contradictory aspects causes the clown to be in a state of perpetual movement between opposites, which makes its inner paradox become a form of logic: the logic of flexibility and incessant process. Because of its flexible, undefined nature, and its ability to be in perpetual movement – always fluid, always in a process –, the clown dismantles all absolutes, especially the rigid border. He claims that one of the intrinsic characteristic

of the clown is that it embodies the notion of *boundary*: a fluid in-between, the indefinite liminal, a sense of being out-of-place, the threshold that both separates and unites. From this inherent trait derive further perceptions of the clown as a shape-shifter, with elastic boundaries and an unusual point of view. Moreover, the clown's multi-faced, contrasting, essence grants it the ability to disintegrate realities, so that the function its function is not to break taboos, but to erase the borders between areas and to change the order of their relations. This keeps the clown in a perpetual *intermediate state*, which may explain its ability to quickly establish a *potential space* in the encounter with people.

From a drama therapy perspective, Handleman's (1990) ideas about the symbolic type imply that clowns carry through their actual presence a kind of *dramatic reality* that accompanies them like a surrounding aura. Thus, when medical clowns tour the wards of the hospital, they are taking *the intermediate zone* wherever they go, recreating it through their physical presence. They embody Winnicott's (2005) notion of the potential space by themselves, as if it was a garment or a piece of their costume. From this position, the clown's invitation to the patients to immerse, become engaged with, or participate in the world of *as if* is a swift and natural transition that prepares the ground for the expansion of roles and the development of emotional flexibility.

The hospitalization experience and the role of the patient

The general assumption about hospitalization held unanimously by patients, doctors, nurses, families, researchers, etc., is that it is a complex experience – if not a traumatic one: Hospitalization involves physical examinations (which at times may be painful or infringe on the person's privacy), elicits concern regarding the patient's

medical condition, produces feelings of apprehension about staying in a strange place (sometimes sharing the room with unfamiliar people), uneasiness about following a daily schedule that is dictated by medical procedures, or anxiety about being dependent on the medical staff and lacking control over one's life.

Applying Turner's (1982) notion of *liminality* in transition rituals Citron (2011) compares the experience of hospitalization with a rite of passage in indigenous societies. In his view, hospitalization usually involves a ritual transformation whereby the individual is transferred from the role of a *healthy human being* to the role of the *patient*, and subsequently reinstated as *healthy* or *recovered* upon discharge. He describes the process that individuals undergo from the moment they turn to the hospital until finally discharged, as one in which the patient is separated from the normal world by a series of rituals (filling forms, being interrogated, having checkups being performed on them). Gradually, the person takes on the role of *patient* adapting to the rules and regulations of the hospital. In this liminal stage, people are deprived of their, status, individual symbols and personal identity. In Citron's (2011) words:

> With his medical chart attached to a bed that is pushed by an orderly through corridors to elevators to additional corridors, the patient is being gradually separated from his daily routines and from the rest of society. By the time he is admitted to a ward, he will be stripped off his individual identity, status symbols and social affiliations. Although he does not lose his name entirely, he will be often referred to as the carrier of a certain disease, or as the preoperative patient, or as the patient by the door, the old one, the fat one, etc. His hospital gown is a uniform which marks his affiliation with other patients in a similar condition. They are his equals and peers now, even if in the world outside they have little in common. They are placed in the same space for the same reason. (…) Now they eat together (often the same food), sleep together (lights are turned off at a fixed time for everybody), see and hear each other in pain, use the same bathroom. Their personal space is limited to a bed, which defines their state of being, and to narrow strips on three sides of that bed, that may be used by the medical staff and by visitors. Their beds and night tables look identical. Their uniform routine

> differs significantly from the one they followed outside and resembles in many ways the ordeal of the initiates in traditional rites of passage. (…) Like the initiates in rites of passage, patients are expected to be obedient, to cooperate with the "medicine men" - the figures of authority who presumably know what's best for them. Finally, their admission and release from the ward is formally possible only with the signature of one of these specialists in a white coat. Once this signature is obtained, however, the patients are considered "transformed", or recovered (p.254).

Van Gennep (1977) states that rites of passage comprise three stages: 1) a separation, often involving a movement in space, 2) the liminal stage, which entails the erasing personal identity, and 3) a reincorporation phase, which habitually includes a ritual. Citron's (2011) description illustrates all three stages. Hospitalization is thus seen as a transition rite in which the individual is assigned the role of 'patient,' until officially de-roled (the reincorporation stage signaled by the signature of the release forms). This enforced 'casting' may have repercussions on the person's handling of their role system.

As the term's etymological roots imply (from Latin, *patientem,* "bearing or enduring without complaint"(http://dictionary.reference.com/browse/patient), the role of 'patient' is essentially a passive one. People tend to feel helpless as they become dependent on the medical staff, and experience a sense of uncertainty and lack of control as the various roles they take upon themselves in everyday life (social, professional, etc.) lose their meaning in the hospital. In terms of Landy's model, the fact that hospitalization tends to fix the person in the role of 'patient' may create an imbalance in the role system, whereby the flexibility of the individual to move from one role to another is diminished. Both the medical condition and hospitalization involve a reduction of the role system into a single, central role: the role of 'patient'. Casted in this role, the person's capacity for managing their role system is weakened.

The medical clown's role strategies as interventions

Medical clowns use various role strategies which, from the perspective of Landy's role theory, can be conceptualized as therapeutic interventions. By assuming certain attitudes about the 'patient' role, they prompt people to undertake additional roles, complementary roles, or discover counterroles. In some instances, the clown behaves in a way that appears to take no notice of the role of the 'patient' either by refusing to take its qualities and functions for granted, or by relating to other aspects of the person – beyond their role as 'patients'. Likewise, the clown's alleged 'ignorance' about medical conditions and their limitations allows them to offer a different version of reality – one that is ruled by curiosity, misunderstanding, and ridicule. In this way, they are able to engage those aspects of the person that are not contaminated by the fixed role of the 'patient' – and help to activate them. The clown's attitude produces a liberating impact because it frees the individual from the static posture of the 'patient' role.

Following are some descriptions of interactions in which the medical clown is seen as taking on a particular role in relation to patients. The examples illustrate the work of Sancho, a medical clown from the Dream Doctors' Project in Israel (http://www.dreamdoctors.org.il/eng/) working at the pediatric unit of Haemek Hospital for the last 9 years. Some of the fragments were taken from Sancho's diary; others are field notes from observations of his work.

The medical clown as the 'jealous one'

…I entered the therapy room where a boy was getting a blood transfusion. I acted as though I'm jealous: I picked a "butterfly" [sticker] and stuck it into my hand, as though I too was getting a blood transfusion! Then, pleased with myself, I showed off my blood

> *transfusion… I went out to the ward and placed a sticker on each child who was getting a transfusion, and to anyone who didn't, I sang "na, na, banana" [a children's tune that means "you don't have it and I do"], especially to doctors and nurses. It seemed as though the children without the transfusion were getting jealous, and those who were getting the transfusion came over to me to show me theirs. (…) I met a girl who was in one of the rooms, still without the blood transfusion, and after showing her off mine (I even asked her if she wants me to call the doctor for her so he could give her one too), I found to my "amazement" that she had a band around her arm, with her name written on it. I became "jealous" again and asked from one of the nurses to let me have one like that too; then I returned to the girl with the band on my hand* (Sancho, 2004).

In this *paradoxical intervention*, Sancho enlists the hospital's instruments and devices (infusion, strips, etc.) as theatrical paraphernalia in order to raise their status and turn them into 'treasured goods.' His innocence and the different angle from which he perceives situations enable him to do the illogical: 'act jealous' of the patients for having them. In the context of the hospital, these props signify the role of the 'patient' – which is clearly differentiated from its counterrole: the 'healthy ones.' The clown's acting jealous inverts their status by disconnecting the devices from the context of health and illness, denying the fact that the 'healthy one' is the valued role, and reframing access to the 'valuable goods' as a signifier of higher rank position. This manipulation of the situation becomes possible due to the clown's inherent ability (as a symbolic type) to shape or distort common social contexts (Handelman, 1990).

From the perspective of role theory, Sancho's attitude facilitates the examination and deepening of the 'patient' role – which is the child's major role at present. According to Landy (1993), roles are containers of thoughts and feelings. By acting jealous, the

clown reveals a hidden but weighty aspect of the role of 'patient:' the feeling of jealousy. Implicit in the role of 'patient' is the jealousy of the 'healthy ones,' who feel good and can get out of the hospital and return home without the doctor's authorization. By undertaking the feeling of jealousy so totally, the clown gives recognition to, and legitimizes, the existence of that feeling – as well as getting permission to express it. Furthermore, this role reversal enables the child to experience an aspect of the counterrole – the one who is the object of jealousy. In this way the clown expands the role of the 'patient,' which is otherwise very limited and passive.

Children adopt the qualities of the role that are transmitted to them by the environment; these include feelings of passivity, helplessness and misery, from which only the transition into the role of the 'healthy one' will rescue them. The clown's 'acting jealous' conveys a different message: He highlights a few of the positive sub-qualities that the role of 'patient' possesses: being *special*, being *treated*. In normal reality children would find such message hard to believe, and may even feel that they are being cheated. However, in the imaginary world that the clown embodies, a child can actually see these sub-qualities. Thus the medical clown acts as a *guide* that prompts the child to explore other aspects of the role, and eventually, to discover the counterrole – his or her healthy aspects, the parts that grant that child the capacity to cope.

The medical clown as the 'defeated one'

In the ward, Sancho encounters a child who cannot move his right side. The child sits on the bed, without energy, and his father sits next to him. Sancho introduces himself as Professor De la Spongga [floor washing] and asks what the problem is. He suggests exchanging the parts on the right side with new parts and holds a negotiation with

> *the father about spare parts, as car part dealers do. The boy claims that he cannot move his hand. Sancho ties a ribbon to his hand, starts moving it like a marionette, and holds a fight against the boy's hand while operating the hand with the tied ribbon. The hand hits him and pushes him out. Sancho is angry and challenges the boy to arm-wrestling and the boy responds to the challenge. Sancho fights him with all his might, but the boy wins and Sancho cries in despair. Then, when he wrestles against the father, Sancho wins and roars with joy. Sancho has beaten the father, the boy had beaten Sancho, and hence the boy is the strongest of all.*
> *Sancho takes out his guitar, places the boy's left hand on the strings, and shows him how to place his fingers on it while he sits close to him and sings, playing with his right hand. They play together in unison with perfect coordination. The boy asks his father to take a picture of them. As Sancho departs, he asks the boy to shake his hand, and he raises his paralyzed arm a little. Sancho turns this into a scene: "you fooled me; you said you cannot move it and here you did move it."*
> (Field notes from the observation of Sancho, 2009).

In their attempt to connect with the healthy part of the person, medical clowns may choose to overlook the limitations of the illness and focus instead on the functioning side of the patients. However, they can also use their inability to understand reality or their natural curiosity in order to inquire plainly and honestly about the illness (Grinberg, 2009). In this case, Sancho chose to focus on the limitation: He inquired about it, examined it, confronted it, played with it, challenged it, laughed about it, and was defeated by it. By focusing completely on the physical ailment, he managed to expand the possibilities of working with it, so as to enable the child to show vitality *through* the actual limitation. In so doing, the role of the 'patient' is both exposed and transformed.

Sancho played a variety of roles in the interaction: Professor De la Spongga, car part dealer, guitar player, etc. But one of the main roles he played was the 'defeated one.'

Given the fact that the role of the ‘patient’ can be experienced as utterly powerless (and sometimes the actual situation is so depressing), this is one of the most common clown strategies. Playing the ‘defeated one’ automatically places the patient in the counterrole position – as the ‘winner.’

> *In the room there was a girl with muscular degeneration. I could not estimate her age since her body was covered, and all she could move were her eyes and the tip of her tongue… I played music, cleaned, and did all kinds of clown's actions, and then I heard myself suggesting playing hide and seeking. I said, "I will count and you will hide". I counted to ten and came out cautiously to look for her in the room. I searched, and searched, and finally …I found her: She was hiding in her bed! "Now your turn!" I announced. I saw her tongue moving slowly, whispering the numbers in Arabic: "Wahad, tnein, talata, arbaa…." I hid really well, and when she finished I approached her very slowly and …at the very last minute she saw me. I tried time and again, but every time when I almost made it, she won* (Sancho, 2007).

As in the former case, Sancho chooses to play with the girl's inability to move. She is bedridden, and of course, she cannot hide or even pull the blanket over her head. But this ‘insignificant’ fact does not matter to the clown: He looks for her around the room and is surprised time and again that she is hiding in her bed. Sancho recruits the clown’s innocence and his inability to understand the situation in order to play with it. The absurdity of his conduct provides the aesthetic distance that the girl needs in order to collaborate with him. Winning over the clown offers a sense of empowerment to a bedridden child who may feel encouraged by the fact that s/he is the victor of something. In a final statement of his diary Sancho writes: *“I don’t mind losing like that, but it was not fair because she didn’t move at all and remained in the same place all the time…!”* This comment illustrates the unique point of view of the medical clown: As a clown, he

doesn't understand the limitations of the patient, and therefore, he honestly claims that it is “not fair” to loose; as a medical clown, he knows that being the winner works out for the patient, and thus, “he doesn’t mind loosing.”

The medical clown as the ‘courting lover’

Part of the depersonalization process connected to hospitalization is the fact that all familiar roles are taken away from patients – including their identity as vital sexual beings. The patient lies in bed, dressed in the hospital's pajamas, occasionally attached to devices, often ungroomed and unkempt. Different people touch their bodies for tests and treatments; the physical contact is functional, sometimes involving unpleasantness and pain, and they have no choice about who touches them. In fact, their body becomes accessible to any doctor or nurse. This situation may provoke anxiety, and/or create a sense of detachment between the person's psyche and their body. The anxiety may also intensify because of the connotations it evokes (as pornography has so often exploited the doctor/nurse situation, by turning the medical scene into a sexual one). As a counterpart to this, one of the strategies employed by medical clowns is playing ‘courting games’ – particularly with female patients (Grinberg, 2009). Here are two fragments from Sancho’s diary in which he plays the role of the ‘courting lover:’

> *I met the father of A. (an Arab girl that Mickey and I have been courting for a long time…). This time I got a hold of her father for a man to man talk. I explained him – in gibberish – that I want to marry A. He drew my attention to the fact that I did not have a ring… Maybe next time I shall bring her a huge ring and then we will see (I have among my accessories a huge ring the size of a big bracelet)* (Sancho, 2004).

> *…I am courting her desperately [an immobilized youngster] and she plays "hard to get". One day when I arrived, she was listening to music. I overcame my lack of confidence and asked her to dance, in a gentlemanly fashion. To my surprise, she did not respond to my charm and refused elegantly. All the presents, flowers and pots I dragged into her room did not make her change her mind. I am afraid she has someone else…* (Sancho, 2007).

These examples illustrate some of the features of the medical clown as a 'courting lover:' He sings serenades, brings flowers, proposes to her and so on, trying to win the woman's heart. In some cases, he makes gentle physical contact with her (holding her hand, dancing with her). Eventually he may involve other family members or medical staff in his courting attempts. By accepting to play with him, the patient gets into the complementary role of 'courted woman.' These courting games can be thought of as an antidote to the depersonalization involved in hospitalization: The clown's personification of the 'courting lover' facilitates the patient's perception of herself as a woman– both in a sexual and a vital sense – yet, in a non-threatening way. The clown plays with the cultural assumption that women draw their power from their feminine ability to make men fall in love with them. His endless devotion, his ability to allow himself to be controlled by her, and even the ridiculous way in which he conducts his courting, all contribute to the creation of aesthetic distance, and permit the actualization of a fantasy that decreases anxiety. He sees the woman in her – beyond the illness, the hospital's pajamas, and lack of makeup or hairstyle. His claim that "life is worthless without her" could be a valuable piece of wisdom for the patient to internalize. In fact, hospitalized women who agree to play a courting game with the medical clown may be drawing strength from their ability to refuse him (refusal being a luxury not to be taken for granted in a hospital). Thus, the

medical clown in the role as a ‘courting lover’ allows the patient to play additional roles (woman), and to regain some measure of control over her body, as well as confidence in her femininity.

As opposed to drama therapists, for whom playing the ‘courting lover’ with a patient may raise ethical or trasferential questions, the medical clown is protected by the role. Being a clown, he can play the role without eliciting a sense of danger in the patient, not only because his essence as a ‘fool’ provides him with an appropriated aesthetic distance, but also because the patient never see him as a person: *the clown is always in role*. It is part of the medical clown’s professional ethics not to get out of the role. The fact that the ‘clown’ role is extremely remote from ordinary reality also assists medical clowns in handling various ethical aspects of their practice. This 'role protection' creates a situation in which it is very unlikely for the patient to confuse the fictional world of the clown with reality. Nevertheless, as an essential part of medical clown's ethical codes, training programs always stress the importance of asking the patient's permission to get into an interaction, and to constantly make sure that this permission is still valid. This is seen as a vital part of respecting the patient's emotional and physical boundaries, as well as maintaining the line between the reality and play (Lindheim, 2005).

The medical clown as a ‘rebel’ or a ‘freedom fighter’

> *A few weeks ago I escorted a girl (I think she was 11) who arrived at the intensive care unit with diabetic imbalance…I knew she was coming [for treatment] and was truly expecting her… I met her at the art therapy room with another girl who has diabetes (10 years old). Both were happy to see me. I "chatted" with them in gibberish; then a 12-years old boy joined us…The three were recently diagnosed with diabetes and were just beginning to adjust to the huge change in their*

> *life. I took out my little guns and we dramatized an action movie for their therapist: I was a thief trying to steal money from the room; they were police officers arresting me; I pulled out the gun and they shot me... It was amusing, and their cooperation created a hot scene. Then they suggested going to the diabetes ward... We arrived at the clinic (on the other side of the hospital) sneaking in, according to the rules of combat in a built-up area. First, we entered the waiting hall, which was full of people; we blended with the crowd without eliciting suspicions, and then, following my signal, we drew out our guns and performed a cruel bank robbery. Encouraged by our success, we burst into the clinic. We moved from one room to another, attacking all the nurses roughly and viciously. Some we took hostage, and the others we simply killed. We explained that we are the "Ganga de la Sukrazita" [gang of the artificial sweetener], and we robbed all the sweeteners from the kitchen. From there we moved to the hospital's cafeteria, and since they refused to give us the money, we took their ketchup as loot."* (Sancho, 2004).

Hospitals are very rigid hierarchical structures, within which the patients rank among the lowest role status (Citron, 2011). The medical clown can challenge the structure through the creation of an imaginary world that inverts the hierarchies: The patient is given power and control, while doctors, nurses, and all those representing the elite – the remaining medical staff – are powerless and given over to the authority of the patient. Sancho's above description portrays an imaginary world like this: a gang of robbers, equipped with powerful weapons, guns, swords, and other accessories with which they 'take over' the hospital's staff. In spite of the seemingly violent narrative, through their incursion into this imaginary world, the children get in touch with two sources of power – expressing anger and being part of a group – both of which may be useful as vital coping strategies (Lahad, 2000).

The clown in this role serves as a guide that enables them to pursue the fantasy

within a controlled environment – through dramatic means and humor. The violence is not real: the guns are theatre accessories, the other weapons are medical devices that are 'transformed' by an act of dramatic imagination; the 'gang' robs ketchup and candies, or in the case of diabetic children, artificial sweeteners. It may be significant in this context that the children were all recently diagnosed with diabetes, and "were just beginning to adjust to the huge change in their life." Presumably, processing that change involves feelings frustration and anger for being forced to make such an adjustment in their life-style. According to Landy (1993) the rebel role (a subtype of the Affective Domain) provides audiences an opportunity to release their own anger (p.203). The *Ganga de la Sukrazita* can be a container for those feelings, while also providing a sense of control and a cathartic comic relief.

As pointed out earlier, hospitalization is often experienced by people as an unwanted imposition. One way in which it diminishes a person's sense of basic rights is related to the right to leave the hospital. With a child, the authority is transferred from the parents to the doctors. The mechanisms that are familiar to children in their relationship with their parents do not work here: all their pleas, explanations, crying, promises, and manipulations would not help. There are various ways in which the medical clown can help children to express their yearning to return home or their will to leave the hospital. Some of them are connected to their role as 'freedom fighters'. Following Grinberg (2009), we will review three main strategies employed by Sancho.

i. The escape

ii. The demand to be liberated by force

iii. The 'benevolent' doctor

The escape

> *It is true that I plan escapes. Once I had prepared a long rope made of sheets and even took food for the journey; but when we were ready for the brave escape, the window did not open (which of course I knew from the start, as the windows at the hospital might only be partially opened). This was a total flop for me, and it forced us to try to sneak into the elevators… I had coordinated with one of the nurses that she should 'catch' us at the very last moment; and then of course, I put all the blame on the miserable child…* (Interview with Sancho, 2009).

Many times Sancho attempts to persuade hospitalized children to run away from the hospital. He often takes a most active role in this: he is the one who presents the idea to them and actually urges them to escape. Sometimes the child cooperates, but most children won't (which probably reflects their understanding of the difference between dramatic reality and the real world.) However, the clown's proposal is significant not because of its feasibility, but because it voices a suppressed aspect of the children's hospitalization: their yearning to go home. In this way, the clown takes a similar role to the psychodramatic 'double' – the one who portrays "the protagonist's psychological experience to its fullest range" (Blatner, 1996, p. 28).

The demand to be liberated by force

> *At the end of the room, there was M., a girl of 16. On her head were her sunglasses. I picked them up, tried them on…they fit me exactly…! I seemed very tough…I drew out guns and dramatized scenes from "Pulp Fiction," "The good, the bad and the ugly," and "The terminator." Suddenly the doctors came in for their visit. Instinctively, I closed the screen. I gave M. a gun and we silently waited for them to complete their examination of another girl in the room. When they came near, I opened the screen by surprise! I demanded they raise*

> *their arms and made them stand in a line by the wall. Under gun threats, while M. is backing me up, I stole the stethoscope from one of them, took their files, and the pens from Dr. H (who is the chief doctor of the ward), and gave all that "loot" to M. Then, loud and clear, I stated our demand: "Home!!!!" I pointed at the file "write, Home". Dr. K did not lose his senses and he started negotiating with me. He said they could not write a thing because I have the file. I realized there is logic in his words, and reluctantly, gave them the file back saying: "Now write home". Dr. K. insinuated there is still a problem, as we were also holding the pens… He thought he is tough, this K… I had no choice but to give the pen back too. "And how can we examine her without our stethoscopes?" I returned those too. "And now," I ordered, "release them home…!" and I left the room as a winner! Of course these girls were not released, but something of the fantasy of "being home already" was there indeed (Sancho, 2004*)

In the structure of the hospital, the doctor is the one possessing knowledge, authority, and control, whereas the patient is without power. As in the case described earlier, Sancho managed to alter the power relationship between the patient and the doctors by granting her power in the imaginary realm. The clown functioned as guide: First, he introduced images from action movies, thus warming up the patient to the imagery he is about to use; then he led her towards a dramatic *as if* situation in which they both collaborated to 'set her free'. Through the clown's intervention as 'a freedom fighter', the patient was able to temporarily leave her role as 'patient,' and explore alternative options. This was possible both because of the total devotion of the clown to the role and the helpful collaboration of the doctors. Through their involvement in dramatic reality, the medical staff showed a more vulnerable part of themselves, which helped to reduce the power imbalance between the role of the 'patient' and the role of the 'doctor:' The fact that both doctors and patients played together in the imaginary realm

contributed to create an intermediate space in which all of them were given an opportunity to expand their repertoire of roles and gain some emotional flexibility.

The "benevolent" doctor

…The doctor was conducting a visit behind the screen. [Sancho] joined in, greeted the doctor, and introduced himself to the patient (a girl) and her mother as Professor Sancho. He examined the medical files and concluded: "O.K.: Go home". He instructed the doctor to discharge her, and handed the patient the sheets for her signature. The girl said that she cannot sign and Sancho ascribed that to the reason she was hospitalized… Trying to convince her that she should sign, he went out to the corridor and very loudly…explained to the doctor that since the patient had signed, it means that everything is all right now and that she may be discharged. The doctor cooperated and signed. Sancho returned to the patient and…ordered: "Home!!!" (…) He dictated his instructions to the doctor: "home, ice cream three times a day, pizza and hamburger three times a day, four hours of television a day, and release from school for a few months." While he was doing this, he consulted with the patient about other things she would like to get.
"Now you are getting out through the window" he said authoritatively trying to open the window (which opens only partially); he passed a hospital blanket through it saying "you can slide on the blanket; someone is waiting for you down there." The girl said "I cannot go through the window". Sancho suggested mockingly "would you like us to bring you a fire-fighters carrier with a high ladder?" The girl:"I cannot through the window; perhaps through the door". Sancho blessed her for her excellent idea and told the doctor to discharge her immediately through the door. He asked the doctor if he had more questions. The doctor said that perhaps she should get an EEG test. Sancho got alarmed and told the patient: "Oh no, this is bad; do not go there;" but then calmed her down… He gave the doctor a series of instructions about falsified tests that the patient should undergo and… left. (Observation of Sancho, 2009).

Sancho expresses the wish of the patient to be discharged and grants it

legitimization, even if in reality it is not possible to fulfill it. While it is clear that the clown is not really a Doctor (let alone a Professor), the patient can enjoy the scene without confusing it with reality. It is interesting to note that in the account of the three cases of liberation (discharge) described above, the clown 'slides' out of the scene at the end, leaving the authority in the hands of the medical staff. Thus, even in these imaginary situations the clown does not break the authority of the staff; he just bends the boundaries a little by legitimizing the patient's wish, collaborating with her, placing her in a position of power, and making the medical staff their accomplice in the imaginary realm. On another level, the clown's resort to fighting and rebellion has a further function: that of raising the patient's inner strength, his or her fighting tools, and survival mechanisms, as these qualities really need to be awakened and put into action by the patient, in order to fight the condition.

The medical clown as antagonist

One way of supporting patients is to stand empathically by their side, provide room for the expression of feelings, or encourage their empowerment by challenging the hospital's hierarchy. However, if a patient is in such a passive state that s/he cannot even recruit the inner strength required to get into dramatic reality, the medical clown has two choices: S/he can go along with this mood by creating a pleasant atmosphere, using soothing tools (soap bubbles, balloons, etc.) in an attempt to comfort the patient; or s/he can choose to make an intervention that challenges patients, prompting them to move into other (more functional) roles. In line with the need of eliciting the patient's survival tools, medical clowns may position themselves as antagonists to the patient, and from this

angle, challenge him or her to confront them. This is precisely what Sancho did with Skinny Johnny:

Skinny Johnny - The way of the warrior

> *Skinny Johnny was lying in his cart, helpless and uncommunicative. He is at the end of the road and everybody knows it. Any attempt to reach him ends up in weeping, which immediately makes his exhausted parents leap towards him. His father explains to him automatically that "the clown is only trying to play with you"…Pffff… as though he does not know…!*
> *I decided to act! First, I threw his mother out of the room. Skinny Johnny tried to protest but I ordered her to go and fix herself a cup of coffee. Dr. Herzel (the ward's chief doctor) kept his father busy and took him for a talk "to explain the situation"….So there were just the two of us: me versus Skinny Johnny.*
> *I started teasing him (Johnny had few candies in his hand, which he wanted just for himself and I tried to take them away from him). Johnny started to cry but there was no one to help him. He kept crying but I did not give in, I did not feel sorry for him….until he had no choice: He had to defend himself and started to hit me. Herzel and Avital [two medical clowns] came into the room and they took the role of 'the good clowns,' which enabled me to get deeper into the role of the 'bad clown'- And I was mean…!!!! A war developed in which he was urged by Avital and Herzel to beat me. Gradually, the skinny and apathetic Johnny turned into a fearless warrior. When his mother returned from her coffee break she saw Skinny Johnny dragging me around tied to a rope, begging for my life, while he had the look of the satisfied, smiling hero. The war ended with the distribution of candies to all the participants. He gave a candy to each one and left one, just one, for himself.* (Sancho, 2006).

Sancho's choice here was to create a fight by purposefully developing a situation in which Johnny would have to cope alone. Detached from his shielding parents, Sancho forced him to find his ‘inner warrior.’ He achieved this by undertaking the role of the

‘antagonist:’ He did not allow Skinny Johnny to remain in the role of the ‘defenseless and passive one,’ eliciting compassion and depending on external forces to save him. In order to *invoke* the role of the ‘warrior’, Sancho had to challenge Johnny, avoid surrendering to his automatic crying response, and hold on to the belief that somewhere inside Skinny Johnny, there is a dormant warrior that needs to be awakened. Johnny’s realization that his ‘passive-dependent’ role is useless in this situation, and that there was no one else to rescue him but himself, activated his ‘warrior’. The roles of the overprotective parents were substituted in dramatic reality by the two medical clowns who joined the scene, encouraging him to be active. Having recruited his inner power, Johnny was strengthened by external support as well.

As mentioned before, the clown’s dichotomy (August and Hobo) is part of the cultural legacy, a fact that allowed Sancho to fully play the ‘bad clown.’ In order to develop the situation dramatically, Sancho had to take the role to an extreme – for only a merciless opponent would defy the overwhelming supremacy of the ‘passive one.’ A strong antagonist was required to awaken Skinny Jonny’s counterrole, and the antagonist in this case, was also the guide. The more Johnny assumed the warrior's role, the more Sancho could enhance the struggle, which ended with the irrefutable victory of Skinny Johnny: A beaten Sancho was humiliated in front of Johnny's mother. The fact that a ‘real fight,’ with no compromises, took place between the two was of great importance, for it is questionable whether Skinny Johnny would have awakened the warrior role without it. As Sancho wrote in his diary: “Metaphorically, I felt very strongly that I was acting out his illness in front of him, and that he must fight it” (Sancho, 2006).

The fact that Johnny's mother witnessed him as a ‘fighting hero’ was also very

meaningful, as it provided additional recognition to the role – the imaginary realm thus gaining a place in the real world as well. The awakening of the warrior's role in Skinny Johnny was epitomized by the symbolic act of sharing the candies for which he was fighting. As a warrior, he could allow himself to be generous.

The medical clown's from role theory perspective

Throughout his writings, Landy speaks about conceptualizing the patient as the hero in a drama (1993, 2008, 2009, Landy & Butler, 2011, among others). Following Campbell's (2008) notions, Landy identifies two recurring features of the hero's journey: the will to cope with the unknown and the wish to go out on a spiritual quest. For the patient (surely, for a child) it may be hard to regard illness and hospitalization as a journey. Usually s/he would be concerned with the wish to be healthy and the will to return to normal life as soon as possible. However, one of the Landy's premises on psychological health is that it entails being "able to transform experiences into stories" (2008, p.110.) Just like drama therapists, medical clowns are also capable of turning the experience of hospitalization into a story by holding the metaphor of the journey for the hero/patient – a journey that involves coping with new and frightening situations. In this sense, the medical clown can be conceptualized as a **'**guide' who escorts the hero/patient into the unknown world of hospitalization, trying to help him/her discover their own inner powers.

> One of the primary functions of the guide is integration. Another is to help clients find their own way. As such, the guide is a helmsman, pilot and pathfinder, a helper who leads individuals along the path they need to follow. In its most basic form, the guide is the therapist. One comes to therapy because there is no effective guide figure available in one's social or intrapsychic world (Landy, 2009, p.68).

Indeed, not many guides of this sort are available in hospitals, where the staff is mostly focused on trying to heal the physical aspects of the condition. Nevertheless, being a liminal creature par excellence, the medical clown is able of integrating and holding together the physical and the emotional planes, the pain and the humor, the medical staff and the patients, and therefore of becoming a 'guide figure' in the landscape of the hospital and in the patient's world.

Pendzik (2008 & 2011) distinguishes between *role* and *character*. In her view, role refers to the archetypal level, whereas character defines the more human plane of a role. As mentioned earlier, in its archetypal strata the clown is a *symbolic type* that has the capacity to move above context and therefore, to disintegrate the framework of the hospital, keep its boundaries flexible and fluid, and establish its own prerogatives as a way of life. In this capacity, the medical clown is a 'wandering *potential space*' and people's relationship to him/her may be understood in terms of Winnicott's (2005) notion of the transitional object – albeit, an animated one. Furthermore, when the fix and passive role of the 'patient' meets the archetypal Clown, the encounter between them may produce a momentous impact: First, because the context that the clown imposes upon reality involves the freedom of liminality, the boundlessness of imagination, the containment of the potential space, and the flexibility of paradox. Secondly, because in terms of the patient's process, the encounter takes place in the *liminal stage* of a transition ritual (where the personal identity has been symbolically erased), thus the patient may be more open than in normal circumstances to be introduced to, and experiment with, previously untried roles. In this way, and through the art of its role, the

medical clown is able to make therapeutic interventions that help to restore the balance of the patient's role system or assist him/her to reconnect with coping mechanisms which have not been used or have been forgotten (Pendzik & Raviv, 2011).

As Grinberg (2009) has pointed out, keeping an eye on the dramatic structure of the situation, the clown can roughly assess a hero who is passively stuck in a plot, and recruit the theatrical roles of 'playwright,' 'director, and 'performer,' in order to look for the most effective way of advancing it. For this purpose, not only the clown and the patient are likely to get involved: Anyone around (family members, medical staff, other patients in the room, etc.) might be casted by the clown into complementary, supportive, or antagonistic roles, in an attempt to move on the plot or urge the hero into action (as Sancho did with Skinny Johnny or with the boy who couldn't move his right arm). In other instances, the clown uses a particular role in order to establish a unique and special relationship with a given patient (the 'courting lover'). On occasions, the clown takes a complementary or an adjacent role to the one into which s/he cast the patient ('courting lover- woman,' or 'same gang members'); in others cases, he helps the patient to expand and develop a role by deepening aspects of it that have not been explored (the 'jealous one' as an aspect of the role of the 'patient'); or takes the role of the antagonist, in order to help the patient to experience the counterrole (the 'defeated one' vs. the 'winner'; 'the warrior vs. the 'bad clown').

The flexibility of their own role system is probably another aspect that contributes to the impact that medical clowns have upon the role system of the patient. This doesn't mean that they lack depth: Clowns can go great lengths within a role; however, their fluidity as shape shifters makes them experts in quick role shifting pirouettes. As the

clinical examples illustrate, sometimes the clown's roles change several times in the course of a single intervention: Sancho may introduce himself as a 'doctor,' become a 'freedom fighter,' and end up as a 'consultant.' Moreover, the fact that each single role allows its conterrole to be open to public view does not diminish the role's depth. For instance, as many medical clowns who pick a name that includes the word Professor or Doctor, Sancho's professional name "Professor Sancho De la Spongga" contains at least two roles: on one hand, the professor; on the other, Spongga [floor washing in Hebrew slang]. The Spanish form "de la" gives the name yet a touch of Spanish nobility, while at the same time the name Sancho resonates with the renowned squire of Don Quijote de la Mancha – the clownish character eternalized by Cervantes. Sancho may introduce himself to the patient as the most senior doctor at the hospital, emphasizing that he is even more important than the hospital's general manager and showing the patients and their families the medical badge bearing his name. He conducts 'examinations' and pronounces his diagnoses and the required treatment to the medical staff. Yet, immediately following that, he may play the 'defeated one' and allow the patient to hit him and humiliate him. In this way the patient is introduced to the paradoxical nature of roles and the fluidity of the role system through role modeling and a live performance.

Whatever the 'adjunct role' the clown takes, it is clear that the *symbolic type* nature of the clown supersedes any other role. Thus, every role that the clown takes on is inevitably filtered through the prism of the archetypal clown: Whether playing a doctor, a car dealer, a courting lover, or a freedom fighter, all the characters are colored by the clown's unique and paradoxical point of view – one that exposes the paradoxes of the roles played, by presenting them through ridicule and mockery. By the same token, the

clown is always ‘in role;’ and it is only through the role that s/he can achieve therapeutic influence (Grinberg, 2009).

The undisputable fact is that, although there is a lot of humor in the situations that the medical clown embodies, a vast majority of the interventions that Sancho performed entailed some form of application of roles: role casting, role taking, role playing, role modeling, and so on; furthermore, the interventions can be conceptualized through the premises of role theory in drama therapy. It is at this crossroad, where the medical clown takes theatrical decisions that also carry emotional implications, where the role is used as an means to enhance a person’s sense of well-being, that the drama meets the therapy and we come to realize the ‘family resemblance’ that exists between therapeutic clowning and drama therapy (Pendzik & Raviv, 2011).

Conclusion

The medical clown works in states of continuous stress in which interventions are needed that require not only regular clown's skills, intuition, and sensitivity, but also therapeutic vision. Their work is psychologically intricate and complex. As the profession of medical clowning develops, their duties also expand from those of a funny entertainer to an integral part of the paramedical team: They escorts the patients and their family through their stay at the hospital, in a process that may last weeks, months, or even years, and may involve repeated hospitalizations. They must quickly develop contact with them, as well as getting to know the needs of the patient and his/her coping capability. Thus, it becomes apparent that it is not enough for medical clowns to come in with the sole purpose of changing the atmosphere and entertaining. In some cases, the

relationship calls for a continuous process, in which the clown can act as the guide in the child's journey with the illness and hospitalization processes (Pendzik & Raviv, 2011). Besides all the usual clown's tools and techniques, many of the skills that medical clowns have been developing in the field involve the use of roles. It follows that drama therapy theories and concepts, and role theory in particular, can assist the medical clown conceptualize their work.

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