

# Therapeutic clowning and drama therapy:

## A family resemblance<sup>1</sup>

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### Abstract

This paper compares therapeutic clowning and drama therapy, starting with a brief survey of the development of medical clowning as a profession, a definition of the field, and a claim to its ancient link with drama therapy. It then proceeds to analyze four vignettes describing the work of a medical clown in a hospital, and examining them through the lens of drama therapy concepts and theory. The paper shows that the clown's working techniques can be conceptualized using drama therapeutic models and theory, and that using this approach as a method of analysis can serve to enhance the body of knowledge of the rapidly growing profession of therapeutic clowning.

### Keywords

Therapeutic clowning, medical clowning, drama therapy, applied theatre, social theatre.

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<sup>1</sup> NOTICE: this is the authors' version of a work that was published in *The Arts in Psychotherapy*, (2011), 38, 267-275. Changes resulting from the publishing process, such as peer review, editing, corrections, structural formatting, and other quality control mechanisms may not be reflected in this document.

*“I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.”*

*Hippocratic Oath*

## **The birth of a profession**

The birth of medical clowning as a profession is a recent occurrence. Although clowns have been involved in health care since ancient times (Campbell, 1976; Miller Van Blerkom, 1995; Warren, 2002), and presumably, have volunteered in hospitals as entertainers for a couple of centuries (Citron, 2011), the advent of the profession as it is currently known in modern health care settings goes back only a few decades ago. Prompted by the revolutionary work of Patch Adams in the 1970's, medical clowning gained public recognition, first, through the publication of Adams and Mylander's (1993) *Gesundheit!*; and later, thanks to the movie *Patch Adams* (1998) in which actor Robin Williams takes the role of the red-nosed, legendary doctor.

Koller and Gryski (2008) state that the field's professional development can be traced back to two main models that originated independently from each other in North America during the 1980's: One is the New York Clown Care Unit, which was initially established as a collaboration between Michael Christensen of the Big Apple Circus and the New York Babies and Children Hospital; the other is the Therapeutic Clown/Child Life model in Canada, where Karen Ridd was hired by the Children's Hospital of the Winnipeg Health Science Center in Manitoba, both as a clown and as a child life specialist. Inspired by these examples, analogous experiments began to spring simultaneously in other places. Nowadays, the profession is practiced in many hospitals – predominantly in pediatric units – as well as in other health care settings worldwide

(Koller & Gryski, 2008). The profession's rapid growth still continues, as research offers considerable evidence pointing to the effectiveness of therapeutic clowns in providing complementary aid, which may noticeably "enhance the efficacy of medical treatment" (Miller Van Blerkom, 1995, p.462).

Another line of thought links the spread of this profession to new cultural phenomena that took place in the performing arts in the last decades, particularly regarding the interaction between performers and audiences. Citron (2011) claims that the development of the Modern Circus in Europe – the 'single-ringed art circus' – infused the trade with a renewed professionalism, which created a new concept of the clown. Fox (1994) strengthens this view by including clowning as one of the current branches of non-scripted theatre, and stating that the emerging genre of the "new vaudeville facilitates a more intimate, human contact with the audience" (p.59). Ott (2007) places therapeutic clowning among other interactive clowning practices (such as clown ministry, clowning in education and in social activism), through which clowns have tried in recent years to extend their work beyond the traditional realms of the stage and the circus.

The variety of denominations, such as 'medical doctor,' 'therapeutic clown,' 'clown-doctor,' 'hospital clown,' 'clinic clown' (among others), denote differences in style, emphasis, place of work, or even place of training. For instance, one tradition states that clown doctors should always work in pairs, claiming that this allows them to support each other (both in terms of the performance and otherwise), as well as freeing the patient from the pressure to participate (Linge, 2008; Simonds & Warren 2004; Warren, 2002). In contrast, another approach poses that the single clown may promote intimacy and a sense of collaboration with the environment, and that the single clown's vulnerability may act as a mirror to the patient's feeling of being *out of place*. Based on this discrepancy in practice, Koller and Gryski (2008) distinguish between 'clown

doctors' and 'therapeutic clowns,' by maintaining that the latter often work alone. Grinberg (2009) claims that it is more common for medical clowns in Europe to work in pairs, while Citron (2011) points out that, in Israel, the issue of working alone or in pairs has split the medical clown's community in two. Borenstein (2008) and Grinberg (2009) agree that the denomination 'clown doctor' is more typical of the U.S., whereas in most other countries they are called 'medical clowns.' Borenstein (2008) also affirms that the name 'clown therapist' expresses a wider scope, presenting therefore a more accurate representation of the profession.

To a certain extent, these differences reflect some of the underlying conflicts inherent in the profession, as well as the stage of development at which it finds itself. Such conflicts are also noticeable in the recent attempted definitions of the field. According to Gervais, Warren, and Twohig (2006), a clown-doctor (CLDr)

...is a specially trained professional artist who works in a therapeutic program within a health care setting. Unlike clowns who make occasional visits to hospital bedsides to "entertain," professional CLDr's are skilled and valued members of a clinical team and are therefore an integral component of the treatment process in the settings in which they practice (p.77).

This definition highlights the clown's artistic excellence and professional training, thus marking the difference between an occasional entertainer and the *qualified caregiver* – the specialized paramedic who is an integral part of the team of the health care setting. On a similar note, Koller and Gryski (2008) call for a definition of medical clowning that takes into consideration issues of professionalism and accountability, in light of the proliferation of the field:

At their most professional, therapeutic clowns are respected complementary care providers who are able to articulate their role in the care of the patients as integral members of the health care team. At the other end of the spectrum, volunteer clowns, though well-intentioned, may be simply dressed-up people

with little training and less understanding of the role and potential of the therapeutic clown (p.17).

A working definition proposed for this article is that therapeutic or medical clowns (also called clown doctors), are clown therapists who work in hospitals and other health care settings. The goal of the medical clown is to provide support for the sick and their families, promote their recovery process, and minimize stress in every possible way – including in the health care setting itself. The medical clown achieves these goals through the use of clown's skills, and by sensitively interacting with patients, families, and staff by means of humor and laughter, fantasy and empathy.

### **Drama therapy and therapeutic clowning**

*“Where is my fool? Ho, I think the world’s asleep, how now? Where’s that mongrel?”*

*King Lear, I: 4*

The development of medical clowning as a profession followed a completely independent path from that of drama therapy. Although clowning is undoubtedly a theatrical means, and its therapeutic implementation in health care is akin in many ways to the concepts articulated by Jennings (1974) in her seminal work, *Remedial drama*, therapeutic clowning and drama therapy became established as separate professions, growing up like two family members being raised in different countries.

This fact is reflected in the professional literature that has been generated in both fields. A wealth of literature has appeared on medical clowning, particularly in the last two decades. Although in their pioneering book, Adams & Mylander (1993) refer to art as primary care, speak about theatre as a healing resource, and provide links with

the American National Coalition of Arts Therapy Associations (NCATA), references to drama therapy are missing from the book. The same can be said about most literature on therapeutic clowning: Many articles discuss the curative potential of humor and laughter, presenting it as the main theoretical foundation of the field (Adams, 2002; Golan, et al., 2009; Glazner, et al., 2009; Koller & Gryski, 2008; Miller Van Blerkom, 1995). Research coming from the medical sciences and psychology focuses primarily on the impact of medical clowns on patients, their effect on preoperative anxiety, on the forensic examination of children, etc. (Cantó et al., 2008; Golan et al., 2009; Fernandes & Arriaga, 2010; Tener et al., 2010; Vagnoli et al., 2005, 2010). Other studies look at the influence of medical clowns with adults, in rehabilitation (Warren, 2002), fertility treatments (Friedler et al., 2011), or with the aged (Spitzer, 2006). A few others focus on the interaction between clowns, patients, families, and staff (Linge, 2008; Nuttman-Shwartz, et al., 2010; Schayer, et al., 2008). The transformative and healing powers attributed to clowns have also been examined from anthropological (Bouissac, 1990; Miller Van Blerkom, 1995) as well as from performance theory perspectives (Citron, 2011).

From their side, drama therapists have not ventured or even looked into the drama therapy structures at play in therapeutic clowning. To illustrate this point, there is no mention of medical clowning in the last edition of *Current approaches in drama therapy* (Johnson & Emunah, 2009) – a comprehensive collection essays of the main drama therapy methods and techniques being used and taught in the U.S. and Canada. References to therapeutic clowning are also absent from recent British compilations on drama therapy practice (Jennings, 2009; Jones, 2010).

One exception to this rule is the work of Zohar Grinberg (2009). In her unpublished M.A. thesis, Grinberg questions and challenges the prevalent view by which it is mainly the clown's use of humor, his or her ability to "put a smile on the patient's

face” and to create a light and amusing atmosphere, that are accountable for the success of the profession. According to her, research in medical clowning focuses primarily on the link between laughter and well being:

Most of the organizations dealing with medical clowning declare that their goal is to put a smile on the sick child's face, and rely on the researchers to find the connection between laughter and the improvement in the patient's mental and physical state... (p. 42).

In her opinion, the therapeutic aspects of clowning are not exclusively associated with humor and joy; they are also related to the dramatic tools (or more specifically, *drama therapy* tools) utilized by clowns. These include the facilitation of an encounter with the patient in the realm of imagination, and the variety of roles that the clown plays. In a genuine attempt to develop this view, she analyses medical clowning practices using drama therapy theories and concepts (among others, Landy's role-system model and Jennings' EPR paradigm.)

It is rather odd that drama therapy and medical clowning would not be more closely related as professions, since both are equally concerned with the therapeutic aspects of performance. In fact, profound historical and structural parallels suggest a family-tree connection between these fields: Clowns have been considered as healers in both ancient and contemporary cultures (Campbell, 1976; Charles, 1945; Clews Parsons & Beals, 1934; Highwater, 1981; Miller Van Blerkom, 1995). Moreover, according to Kirby (1976), clowning derives from the same archetypal source from which many dramatic forms spring, namely, shamanic ritual. Sketchily defined as “the practice of trance for the purpose of curing the sick” (Kirby 1976, p.140), shamanism is considered an ancestor to both drama therapy (Pendzik, 1988; Snow, 2009) and therapeutic clowning (Koller & Gryski, 2008). In Kirby's (1976) words:

...the performing arts that develop from shamanist trance may be characterized as the manifestation of, or conjuring, of an immediately present reality of a different order, kind, or quality, from that of reality itself. Shamanistic illusionism... seeks to break the surface of reality, as it were, to cause the appearance of a super-reality that is “more real,” than the ordinary (p.148).

As parallel descendants of shamanism, drama therapy and therapeutic clowning also coincide in the purpose for which this *other reality* is invoked or called for, namely, healing, alleviating, and promoting well being. And the main mechanism employed in order make this reality manifest is *dramatic imagination*.

Drama therapy thrives on imagination. In fact, a central therapeutic tool in drama therapy is the capacity to ‘download’ the world of imagination in the here and now in such a way that it is experienced as *almost real*. Through the use of dramatic reality, drama therapists add a complementary dimension to everyday reality – one which concretizes the subjective realm of imagination in the physical space, allowing it to be legitimized, explored, mastered, and transformed (Pendzik, 2006). As current research demonstrates, imagination is a powerful tool that can support both physical and emotional improvement, as well as promote therapeutic change (Karpelowsky & Edwards, 2005; Kaplansky, 2009; Lahad et al., 2010; Sabatinelli et al., 2006; Sheikh & Allman, 2003). According to Lahad (1992, 2000), imagination is one of the primary coping means that people possess in order to confront stressful situations or, in general, to meet the world. Drama therapy uses human imagination as a healthy psychological strength. It works by helping people put their imagination into action in ways that activate positive attitudes and outcomes.

Medical clowning is equally based on imagination. When a person is in a state of shock, pain, or distress, the normal access to this helpful psychological resource gets blocked. People are either too immersed in their feelings, or on the contrary, too

stressed, too much 'outside of themselves', to be able to use their imagination as a coping mechanism. The clown is a symbol of the world of imagination, a distinctive representative of this realm. Therefore, when a clown appears they instantly become the bridge that links us to the world of imagination: They have the immediate effect of reminding us to use a tool that we naturally possess. Just by being there, the clown guides us into the imaginary realm, thus helping us to activate the innate resource of imagination, in a way that even when the clown has gone, the resource would still be working (Pendzik, in Dream Doctors Project, 2010). As Simonds (2001) puts it:

We need to remind people that they are human beings and to show children that they can go on being children despite the nasty detail that they have cancer. We stay in their realm of fantasy; we try to transport them to another world and give them tools for the hospital voyage (p.8).

An additional quality shared by medical clowns and drama therapists is the ability to make therapeutic interventions from within dramatic reality. Unlike verbal psychotherapists (or even psychodramatists) who remain at all times in the roles of listeners, witnesses, or directors of their client's scenes, drama therapists can choose to be performers and make interventions from within dramatic reality (Pendzik, 2008). In some working modes (for instance, in Johnson's developmental transformations), drama therapists spend most of the session within the *playspace*, from which they offer the client "empathic feedback in embodied, imaginal form" (2009, p.96).

Medical clowns are always 'in role:' they do not leave it for a moment; and in fact, neither do patients. As Citron (2011) brilliantly explains, the hospitalization process is reminiscent in many ways of the liminal position which characterizes most rites of passage, as articulated by Van Gennep (1977) and Turner (1982). Separated from everyday life reality by the hospital's rules and regulations, stripped of their status and personal symbols, (for example, by homogeneously wearing the hospital's gown), patients are bound to stay in the role of 'patient', almost devoid of individual identity, for

as long they are hospitalized. Yet within this fixed role, a sense of flexibility may emerge as the clown approaches, as he or she represents someone who defies the role's very structure, plays with it, and expands its variations, shifting from one aspect to another, introducing paradox, and moving within the role with the freedom that only the Fool and the Trickster archetypes can offer. In this sense, like the drama therapist, the clown uses the role on-stage in order to make interventions from within dramatic reality.

### **Professor Doctor through the drama therapy looking glass**

*"Clowns vivify the widest possible vision of reality by showing us human nature in all of its manifestations."*

Jamake Highwater

In an attempt to bring together these two fields, we will analyze four vignettes described by medical clown Amnon Raviv from the Dream Doctors Project, from a drama therapy perspective. The Dream Doctors Project is a unique program that was founded in Israel in 2002 with the purpose of integrating therapeutic clowns into hospitals and other health-care institutions, particularly in the service of children. The main goals of the project are to support the rehabilitation of patients, to transform their experience of hospitalization (as well as those of their families) into a less traumatic one, to be a bridge between the different cultures, ethnicities, and religious groups that conform the population of Israel, and to integrate the Dream Doctors as creative arts therapists and paraprofessional care-givers into multidisciplinary medical teams. The program also seeks to establish medical clowning as an officially recognized paramedical profession, thus, promoting research and academic training in the field. The project is currently established in 18 medical settings throughout the country, with

about 70 medical clowns active in various pediatric wards and clinics. In addition, Dream Doctors have participated in special projects as part of international delegations sent to disaster zones, such as the earthquake in Haiti and the Tsunami in South Asia a few years ago (See: Dream Doctors Project, 2010, *In the trauma zone*).

Amnon Raviv has worked as a clown therapist for over seven years at Barzilai Medical Centre in the city of Ashkelon, on the northern region of the Negev and southern coastal plain. In recent years, following the violent escalation of the conflict in Gaza, and the rocket attacks on the western Negev settlements, Barzilai has been receiving many wounded victims of the conflict, becoming a frontline hospital for the region. Over the years, Amnon has worked with a wide variety of people, ranging from injured and acute stress victims from both sides of the conflict, to children undergoing weekly medical treatments, or one-time event surgical procedures. His clown therapist name is “Professor Doctor, Head of the Department.”

Case one: “There will be no pain”

*Omer was a nine years old girl when Professor Doctor first met her. She suffered from severe arthritis, and started to come to the hospital for treatment on a regular basis, once a week for over 3 years. The treatment involved a long and complicated procedure: First, she had to go through blood-pressure tests, and then, get a very painful injection in her thigh. The procedure involved waiting for a long time, and it brought up a lot of uncertainty: If the blood pressure was too high, she couldn't get the injection. Omer came mostly accompanied by her mother, and sometimes by her grandmother.*

*Professor Doctor used three styles in the interaction with her:*

- a) *In the waiting time, while Omer's blood tests were being made, he used the classical clown approach: Gigs, jokes, absurdity, magic tricks. They also talked and laughed about the things that Omer had experienced during the week – of course, looking at them from the point of view of the clown. This was amusing for Omer: Laughing enabled her to get the blood tests done while diminishing her anxiety.*

b) *In the second part of the procedure, she had to go to the treatment room in order to get the injection. Usually, at this point her anxiety went up again, and Professor Doctor discovered that she was so frightened and disturbed, that she couldn't listen to him anymore: He had to find a different way to reach her. So over the years, they developed together a ritual which they performed before getting into the treatment room. It consisted of dancing funny steps to a funny song which they both sang. The song was about how brave and beautiful Omer was, and included details about all the other characters involved: the mother, the nurse, and of course, Professor-Doctor – Head of the Department. Another core motif of the song was a recurring phrase repeated by Omer and the clown stating that "there will be no pain". In the treatment room Omer allowed only the presence of Professor Doctor.*

*She didn't want even her mother to be there, and the clown kept singing and trying to make her laugh – or at least, to draw her attention away from the treatment.*

*At the end of the treatment, Professor Doctor usually took Omer on his "spaceship" (a decorated wheelchair), and they travelled through the planets (the hospital), meeting with UFO's and aliens. Thus the last phase of their interaction involved a journey through an imaginary world of their own creation, until they said good bye to each other at the doorstep, on the way out.*

*For three years, Omer agreed to go through this medical procedure only if the clown was there. In fact, the treatments were scheduled keeping in mind the days in which Professor Doctor was available.*

In this description we can see clearly that therapeutic clowning involves much more than traditional clown techniques, such as jokes or magic tricks. As Professor Doctor maintains, these were only applicable at certain moments of the interaction, whereas at others, they were not useful at all. The clown's switch in the approach employed may be considered in light of Jennings' (1990) notion of *ritual and risk*. According to her, "every drama therapy session has a component of *ritual and risk*, and the balance of these two elements varies with the particular client group and may vary

over time as people change and develop” (p.61). The ritual factor is the familiar or structured aspect of dramatic reality: the structure of a game, its rules, theatrical conventions, a known musical pattern, or a song’s recurring refrain. The ritual acts as a container: it protects. Its predictability makes the person feel in a recognizable, safe space. The risk, by contrast, relates to the unforeseen part of dramatic reality: the unexpected twist of a game, the outburst of improvisation: it implies a creative step into the unknown. In Chesner’s (1994) view, drama therapists need to be aware of the balance between ritual and risk “at each phase of the session, and their task is to find appropriate structures to provide tolerable challenges” to their clients (p.125).

In the case of Omer, although the first stage of the medical procedure was anxiety provoking (because of the uncertainty it brought up), it wasn’t physically painful, and the level of *risk* she could tolerate was quite high: She was able to get warmed up with jokes, gigs, and magic tricks – all of which required from her to allow herself to be surprised and open to the unexpected. Chatting and laughing about the events of the week (from the perspective of Professor Doctor) also had a cathartic effect: Here, the ‘ritual’ elements were the known and familiar events, whereas the ‘risk’ was the clown’s point of view. She provided the contents; Professor Doctor shaped them into extraordinary occurrences by looking at them from his astonishing angle. Yet, as she moved into the second part of the procedure, this level of *risk* was no longer helpful for her. The *ritual* aspect needed to increase.

Coincidentally, the second approach used by Professor Doctor is properly speaking a *ritual* – albeit a creative one which evolved out of their interaction over the years. A quick look at the four parts that composed it reveals that it could be metaphorically regarded as a ‘preparation for battle’ ritual:

- a) dancing and singing patterns (warming up physically and psychologically, releasing fear through movement and song)

- b) naming the characters involved (invoking the protectors or helpers)
- c) words of encouragement and eulogy for the heroine (stirring up courage)
- d) a repetitive mantra: “there will be no pain” (inspiring fearlessness)

The third part of the interaction involves turning the hospital into an *as if* reality – and not just any *as if*, but an extraterrestrial space. Every aspect of the hospital’s daily landscape is transformed via dramatic imagination into an alien place. According to Duggan and Grainger (1997):

The use of here and now physical action and awareness are ... of inestimable importance therapeutically. Individuals who are suffering may become so sunk in their own distress that they develop a kind of numbness to other experiences. To re-enable them to be aware of what is going on within and around them in terms of actual physical sensation is in itself healing. If they are then lifted out of themselves and onto the plane of dramatic reality, they may thereby be sufficiently distanced from their pains to be able to open themselves to other feelings and experiences (p.126).

It is noteworthy that the hospital’s definition as ‘alien territory’– a distanced place that is very far away from ‘home’ – takes place only towards the end of the treatment, on the way home. Defining the painful procedure as a journey to outer space probably helped Omer to de-role from ‘patient’ role, to separate this experience from the normal flow of life and put it in a different context. A way of saying: “Life goes on, home is elsewhere; this was just one of these crazy journeys to outer space.”

Case two: “This is not the right time”

*“A merry heart doeth good like a medicine, but a broken spirit drieth the bones”*

Book of Proverbs, verse 17:22:

*On Monday, 3\9\2007, at 7:38 am, a qassam rocket fell very close to a school bus that was full of children on their way to school in the city of Sderot. The kids were brought to Barzilai hospital in a state of shock. They were gathered in the dining room with the staff: psychologists, psychiatrists, social workers, doctors, and nurses. The medical clown was not included among them.*

*Professor Doctor heard about the incident by chance, from a comment made by someone walking down the corridor. He hurried up to the dining-room, but as he was about to enter, one of the psychologists signaled him with his hand, in a gesture that could only be interpreted as "don't disturb us; this is not the right time for clowns." However, a clown is naturally a rebel, and is not bound to do what he is told. As he believed that this was precisely the right time, he therefore entered the room in utter disobedience.*

*The children were sitting in a circle, withdrawn and pale, quietly listening to the words of the psychologist. Professor Doctor sat among them, dropping the weird contents of his bag – obviously, "not on purpose". He then apologized while making funny faces, and collected the contents of the bag again. By then the children began to laugh, and in a few moments, the heavy atmosphere that surrounded them was softened: they looked less pale, and it seemed as if they could free themselves a little from the tension.*

*Afterwards, Professor Doctor accompanied the children through the different stations in the hospital where they had to undergo medical examinations and checkups. They played with him, moving from one place to another, holding hands with him, and turning the whole process into an adventure in which both the clown and the kids travelled through a different reality: The medical examination became a journey into the jungle, where the 'natives' they met (hospital staff), were so enchanted and fascinated with the visitors, that they kept asking lots of questions and examining them all the time.*

*At lunchtime, the meal became a potato chips-battle triggered by the clown, (much to the dissatisfaction of the dining-room manager.) The children were laughing really hard, and it seemed as if they had come back to themselves again. All the children were discharged that day.*

As in the previous case, the imaginary realm serves to contextualize the experience of suddenly finding oneself in a foreign territory: Dramatic reality offers the possibility of translating a difficult situation into an encapsulated version of it, which helps to contain and process it (Pendzik 2006). It also provides a measure of aesthetic distance through which the contents can be approached with a sense of safety and control (Landy, 1996 & 2001). Professor Doctor's choice of the 'jungle' metaphor allowed the children to define the situation in a way that they feel more control over it (they control dramatic reality). As opposed to the de-rolling function of the 'journey to outer space' of the previous example (which was made on the way out of the hospital), here the journey into the jungle had the purpose of facilitating their stay at the hospital by identifying the medical examinations with a pleasant metaphor: almost a vacation. Moreover, redefining the events in terms of a fictional genre the children are familiar with also helped them to make sense of it by providing the means for them to *story* their experience. As White and Epston (1990) claim, people are able to give meaning to their experiences by plotting them into stories; experiences which stay *unstoried*, are never told or properly expressed, remain as amorphous and meaningless contents of the psyche.

An important point to consider in this vignette is the psychologist's initial refusal to allow the clown to come in. This kind of dismissal brings to mind similar instances encountered by drama therapists (particularly at the onset of the profession), in which psychologists or other staff members minimized the potential of drama therapy as an intervention tool, or render it as inadequate in order to deal with a 'serious' situation. Jennings (1987) referred to this issue as a fear of the Dionysian aspects of the field – a fear that can be certainly extended to therapeutic clowning. At first sight, it seems that the situation is 'too serious for a clown'. Yet, as it occurs in many extreme situations where people are in a state of shock, rather than being counterproductive, the presence of the clown is perceived as something so completely out of the ordinary and illogical

that it expresses the absurdity of the circumstances and legitimizes the feeling that 'something is really out of order here' (Penzik in Dream Doctors, 2010). Furthermore, as Citron (2011) asserts, in the hierarchical context of a hospital the clown's vulnerability empowers patients, who may feel comforted by the fact that there's someone more vulnerable than them. The entrance of Professor Doctor to the dining-room gave the children not just an opportunity to laugh, but also to feel that someone is more 'untogether' than they are or that he can voice that part of them on their behalf. As Linge (2008) states, medical clowns may position themselves as the 'bearers' of a child's affects, which enables children to see themselves from the outside. This mirroring device in which a therapist portrays the vulnerability or fears of a client from within dramatic reality is known to drama therapists. It may be compared to what playback theatre performers' do when taking aspects of the teller upon themselves; or parallel some of Johnson's (1982) interventions in the *playspace*, such as *pre-emptying*, in which the therapist appropriates the difficult attributes of a client's role in order to induce the client to play a complementary one.

Moreover, according to Raviv (2011) the medical clown is a revolutionary figure that challenges, shakes, and even changes conventions at the hospital site, because it "brings a carnival spirit into this world, turning the hospital's rigid social structure on its head..." (p.4). This attribute of the role provides an advantageous starting point for the clowns, enabling them to make the imaginary world manifest right away. From the staff's point of view, given the situation, the clown was viewed as a potentially disturbing factor that could upset the order, and it seemed a logical choice not to allow him to come in. Yet the fact that he was signaled to stay out only made a stronger impact on the kids, who perceived him as a liminal figure, coming from 'another place.' The clown's defiance and disobedience of the rules made it clear to them that he does not belong to the staff, which immediately opened them up to collaborate with him. At some point, without the clown noticing it, the deputies of the hospital's director had entered

the room and witnessed the interaction between the kids and the Professor Doctor. Realizing the immense help that a clown therapist can offer to the medical staff, they decided to incorporate the clowns more closely in the work of the hospital team in mass crises interventions.

### Case three: A whole world of their own

*“To you, I am just a fox like a hundred thousand other foxes. But if you tame me, we shall need one another. To me, you will be unique. And I shall be unique to you.”*

Antoine de Saint-Exupéri

*J. was a seven years old Palestinian child from Gaza, who was hospitalized in the orthopedic ward of the hospital, with both legs amputated. He was lying in an Israeli hospital for several months, without his family, without knowing the language, and removed from his surroundings. He was alone most of the time.*

*When Professor Doctor came to his room for the first time J. was amazed and enchanted. They communicated through body language, gibberish, fantasy, magic tricks, music, and puppets. Together they created a whole world of their own. J. liked the magic tricks very much – especially the one of the handkerchief that disappeared in the air. Time and again he requested to watch the wonder, always trying to figure out how could this happen, and hoping that this time it will be revealed to him. Another trick that he liked was the magic book. This book was empty most of the time, but only when J. touched it with his finger (only him and no one else) the magic book became filled with pictures.*

*The clown became his friend: he waited for him impatiently and was sad when he had to leave. Only once during his hospitalization it could be arranged for his*

*mother and twin sister to come to visit him. On this occasion, J. was proud to introduce his new friend to them.*

*One of J.'s favorite acts was the play of the bubbles, in which the clown created an underwater world full of strange creatures swimming and gazing with funny faces at him. J.'s role in the act was to make the bubbles fly.*

*Professor Doctor often included members of the medical staff while playing with J. There were also other kids who stayed for a while in the same room, and took part in the interaction and the playing scene. They tried to help J. to find the missing handkerchief, or participated in the bubbles play. In the play, they became partners. Though they couldn't talk in the same language, they could communicate well enough to collaborate and to have fun together.*

Nonverbal communication is at the core of drama therapy. As Doktter (1998) states, role-play, voice work, myth, story-telling, and other forms regularly employed by drama therapists can be used non-verbally – just as in the other arts therapies. The visual aspect of drama is emphasized whenever language barriers are present. It is here that we realize that, although drama utilizes words, dramatic communication is not a purely verbal approach, but an embodied use of language. Theatrical language is visual, and clowns are definitely masters of body speech. In fact, a particular method of medical clowning, called the nonverbal or limited-verbal approach, defines “the essence of Therapeutic Clowning as a nonverbal Question-and-Answer Dance that proceeds at the pace set by the patient” (Thompson, 1998, p.1).

In J.'s case, language was only one kind of barrier in a long series of barriers. Professor Doctor's use of nonverbal communication in an attempt to find a common language between them was perhaps one of the ingredients for the success of the

relationship. A journey into dramatic reality is always an intimate one, requiring and building intimacy at the same time. Playing, creating fantastic worlds, journeying together to dramatic reality, were an international language that helped the clown to reach J., and to establish a metaphorical 'bubble of sanity' inside an otherwise untenable situation. As Lahad claims (in *Dream Doctors*, 2010), medical clowns working in disaster zones can manage to create around them an 'island of resilience.' Indeed, this was also generated through the clown's efforts to integrate other hospital staff and children in their games, thus expanding the island of dramatic reality to include other members of the hospital's community.

As Seymour (1998/1999) maintains, drama therapists should be aware of the political dimensions of their work, and in this context, it is clear that the attribute of marginality gave Professor Doctor an advantage in establishing a bond with J. As the quintessential representative of the limen, the clown is always an outsider, acting from the border, blurring hierarchies and challenging authority. This ability to operate from the margins allows them to help where others fail. Perhaps a well-intentioned staff member may not have reached as far or as fast as the clown. Their liminality allows clowns to move across boundaries of class, ethnic, political, or religious sides in a conflict, transcending borders and nationalities: they don't belong anywhere. J. may not have responded to Amnon Raviv with the same openness as he did to his clown character, even if Amnon would have been as friendly and funny as Professor Doctor was: It is primarily the role that facilitated the contact.

Citron (2011) asserts that clown doctors are in a paradoxical position: On the one hand, they are part of the hospital's system (they are authorized to enter into restricted areas, staff members may collaborate with them, etc.); on the other, they conspire against the system, exposing its flaws, revealing its power structure. Like the traditional court jester, medical clowns are all-licensed critics, allowed to tell the truth

(Welsford, 1968). In this regard, it is meaningful to point out that one of the dramatic worlds that J. and Professor Doctor constructed together (which J. enjoyed very much) was the underwater world, “full of strange creatures, gazing with funny faces at him.” This metaphoric image of reality which mirrors, encapsulates, and conveys the difficult aspects of the situation in playful, yet accurate ways, can only be put forth successfully by someone who is also an outsider – the recipient of strange gazes from funny faces as well. J.’s participation in the scene as the keeper of the quality of dramatic reality (making the bubbles fly) shows that the image somehow worked for him. On the other hand, it was the clown who connected him with the surroundings, by inventing games in which other kids and staff were also involved. The clown then functioned both as mirror and as bridge, as interpreter and as a guide between worlds.

The magic book and the disappearing handkerchief were also important symbols in this relationship – not only because of the sense of uniqueness (only J.’s finger filled the empty book) or the bond that they helped to create between the child and the clown. Professor Doctor was aware that J.’s requests to repeat over and over again these games, and his curiosity to understand how it happened, were somehow emotionally charged: Emptiness and fullness, just like appearance and vanishing, bring to mind an attempt to make sense of inexplicable loss. Perhaps by repeatedly dealing with them in dramatic reality, J. was trying to understand something of his own loss?

Case four: The adventures of Miss Esther (from Professor Doctor’s diary)

*“Stories are medicine”*

Clarissa Pinkola Estés

*It was a Monday morning and the pediatric ward was full. I entered room number three and I saw four little kids lying on their beds with forlorn faces. Their parents were sitting next to them. One mother was so tired that she hardly opened her eyes.*

*"Listen," I said quietly and in a mysterious voice. "Did you happen to see Miss Esther, by any chance?" The kids looked at each other, and then again at me, and said nothing. "Listen," I insisted, "I know she must be here, somewhere in the room..."*

*One of the mothers said that they didn't see anyone entering the room. "Well," I said, "it's hard to see her because she is so small..."*

*Now the kids became very attentive.*

*"Listen," I said for the third time, "I need someone with magic powers to look for Miss Esther."*

*I took out my magic book from my bag and checked everyone in the room, to see if he or she had the magic power. Pictures appeared on the empty pages when the kids touched the book. Their parents, though, didn't have the magic powers: The pages remained blank at their touch. It was of course an amazing coincidence that all of the kids had the magic powers; but there was not enough time to comment on it, because by then, the kids were out of their beds, all looking for Miss Esther.*

*Miss Esther (a finger puppet) was found through a joint effort. As soon as she was revived on my fingers, she began narrating, mostly through my lips, her unbelievable story: She told of her adventures in strange lands, where she had to stand on her nose, walk with her hands, put her legs on her head, and perform all sorts of bodily tasks in order to overcome dangers of all kinds: She had to swim in stormy waters, walk in the depth of the forest, and fly up to the sky, so as to rise above insurmountable perils and obstacles. Eventually, she switched to someone else's fingers (the kids' and parents'), continuing her account through their lips.*

*At some point Miss Esther had to fly away (out of the room, to the ward's corridor), and all four kids followed her, flying along with her, side by side. We all flew over the world for some time, and then headed back home again (to the room).*

Stories and storytelling are regularly used as intervention in drama therapy for a variety of reasons. First of all, they provide consistent structures that allow us to integrate parts of our lives that we do not know how to make sense of or explain to ourselves. Stories embrace our experiences by offering a framework of belonging – particularly for the most inexpressible and inconceivable ones –, so that we are not ‘left alone’ with them. Moreover, as Gersie and King (1990) assert, storytelling is always a shared experience that creates an immediate sense of bonding between people. Regardless of whether a person likes a story or not, listening to stories together has the general effect of connecting individuals by virtue of inviting them to share a journey into the world of imagination. According to Gersie (1997):

Since time immemorial, storytellers have familiarized adults and children with vivid story images which are pertinent to the listener’s character and to their specific situation...Through the careful creation of a believable illusion, tellers weave an associative thread between the listener’s world and the story of characters adventures. The story’s apparently incidental relevance enables the teller to elicit and to sustain the listener’s agreement to attend to the tale (p.8).

Furthermore, stories provide a safe aesthetic distance from which we can gather the courage we need in order to confront even the most painful aspects of life. Through aesthetic means (such as form, conciseness, structure, loveliness, humor, etc.), stories manage to tackle charged issues in oblique or indirect ways, thus bypassing psychological resistances. Finally, stories are helpful therapeutic tools because they offer perspective and guidance without being invasive.

The known world is the starting point, the connection with a reality which we can identify and recognize. In the process of its unfolding, the tale develops a story which contains and explores the unknown. A story is a guide because it takes us from resting place to adventure, through misfortune to culmination and the end. (...) When the journey is completed, we the listeners, emerge revitalized. The imagination has nourished and inspired our motivation which in turn contributes to realization and solution. We gain strength by identification with a

story character who initially had the will to persist and who found the courage and strength to prevail (Gersie & King, 1990, p. 35).

In the example from the clown's diary presented above, Professor Doctor finds a way to 'revive' and generate a playful bond between the disconnected individuals in room three (both children and parents), who were too exhausted, distressed, or sad, to use their healthy coping mechanism of imagination by themselves. The storytelling structure he used is brilliantly simple – especially as a means to engage little kids: The word 'listen' is pronounced in a mysterious tone three (magic) times – each one supplying a more intriguing piece of information:

- "Listen, have you seen Miss Esther?"
- "Listen... It's hard to see her because she's so small..."
- "Listen...I need someone with magic powers to look for Miss Esther."

The plot evolves according to Joseph Campbell's (1972) description of the Hero's Quest: In order to become eligible 'seekers,' most universal stories and myths would include at this point a 'test' that all potential candidates need to pass. In this case, they need to prove they possess 'magic powers' by touching a magic prop (the book). The fact that only the kids passed the test facilitates their quick constitution into a working team: They now belong together as a group; they not only have in common their role as patients, the random sharing of the same room at the hospital; they are also connected through some magical bond: Their joint efforts make it possible to create an island of imagination, to establish a *good enough dramatic reality* in which therapeutic interventions can be made (Pendzik, 2006).

Their success in finding missing Miss Esther is readily rewarded by her willingness to share of her story. Incidentally, some imperceptible parallels can be traced between the children's presumed experience of medical procedures at the hospital and Miss Esther 'unbelievable' account, which included having to perform all kinds of awkward physical extravaganzas and tasks – such as 'walking on her nose' – in order to escape from something more dangerous (which isn't even mentioned in the story). The heroine goes through water, earth and air – coinciding with the shamanic cosmic regions: lower, middle, and upper worlds (Eliade, 1972); and is subsequently passed onto the hands of other tellers – the children – in an attempt to enable other their experiences to be integrated in her account. Finally, she takes everyone on a trip flying over the world, and returns them home safely. It seems that not only Miss Esther, but almost everyone in room three have been 'revived' by Professor Doctor.

### **Conclusion: The difference that emphasizes resemblance**

Recently the authors presented separate papers at an *International Conference on Richard Schechner and Performance Studies* at the University of Haifa: Amnon Raviv on medical clowning; Susana Pendzik on drama therapy. We were pleasantly surprised that we were both assigned to the same panel: Therapy and performance.

Given the strong performative aspects it involves, it may seem appropriate at first glance to locate therapeutic clowning within the specific rubric of drama therapy called *therapeutic theatre*. However, a deeper look into it reveals that actually it does not qualify as such – particularly if we subscribe to the definition of this precise area of drama therapy that is proposed by Snow et al. (2003). According to it, therapeutic theatre entails the development of a play with therapeutic intentions, in a process that is

facilitated by a drama therapist (or a therapist with theatre skills), which is “brought to culmination in a performance for a community beyond the social sphere of the therapeutic group itself”(p.75). In our view, it is more accurate to consider therapeutic clowning within the wider spectrum of applied or social theatre – a branch of theatre that is concerned with its application in social contexts, which differentiates itself from the purely aesthetic experience, or as Thompson & Schechner (2004) claim “where aesthetics is not the ruling objective” of the performance (p.12). Even within this framework, and as Seymour (2009) points out concerning other applied theatre forms, it is necessary to define its connection with drama therapy, also in terms of its differences in order to have a productive dialogue between these fields.

The family resemblance between drama therapists and medical clowns is great. However, one of the main aspects in which these two siblings differ is the way in which they perceive and are perceived by the people whom they try to help – whether audience or clients. In this semantic distinction there is already a world of difference: Drama therapists would only occasionally perform *for* their clients or consider them as *audience* (Pendzik, 2008); and they would be generally be perceived by their clients as someone who belongs to ordinary reality, who may lead them or join them in a round trip into an imaginary world, but whose starting point is everyday reality. Medical clowns, by contrast, are more likely to conceive the people they work with as *audience*, and are generally perceived by their audience as belonging to the imaginary world. Throughout their interaction, the clown is seen, not as a therapist, but as a character from the imaginary realm (a fact that also creates some confusion among many medical clowns as to whether to see themselves as therapists or as ‘just clowns’).

This paper attempts to bring medical clowning and drama therapy together by applying drama therapy concepts and theory as a method to analyze medical clowning practices. It shows that the clown’s methods can be conceptualized using drama

therapeutic models and theory. As stated above, even if very successful and growing, medical clowning is a relatively new profession, and in that sense, it lacks the body of knowledge, and the theoretical foundations which the field of drama therapy has built in the past three or four decades. Most of the work of medical clowns is intuitive; the field still lacks its own theoretical models of assessment and intervention, as well as independent means for evaluating the clowns' work. On the other hand, there is a solid and fast growing mass of research pointing at the effectiveness of therapeutic clowns – precisely the kind of data which in drama therapy is hard to generate, possibly, among other reasons, because the processes are longer, less observable on an immediate basis, and the follow up is more difficult.

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