

Medical Clowning: An Embodiment of Transgressive Play

Matthew Allen Wilson

Matthew Allen Wilson is a candidate for the Masters of Arts degree in performance studies at New York University. His research interests include biopolitical performance; sideshow, medicine, technology, and the body; abjection, collective joy, and the politics of play; and architectures of participation. A graduate of Vassar College, Matthew became a clown doctor with the Big Apple Circus Clown Care Program, the first professional hospital clown program of its kind in the United States. He won an Emmy award for his contribution to the PBS Kids family favourite math mystery television series *Cyberchase*. Email: maw728@nyu.edu

“Medical clowns” are part of a growing field conducting play encounters in hospitals throughout the global community. One intention for a medical clown encounter with a pediatric patient is empowerment, or restoration of agency. This paper explores these encounters through the lens of performance studies, play theory, and the author’s personal praxis as a medical clown to investigate the impact on the multiple audiences involved in a hospital encounter: patient, family, and staff. Medical clown encounters evoke Bernie De Koven’s notions of a “well-played game” and “play community,” and warrant further research to ascertain the impact beyond the initial encounter.

Key words: *medical clown; well-played game; play community*

Author Note

This paper draws from the author’s artistic praxis as a medical clown, and begins with a quote to frame this investigation taken from an autobiographical live performance called CLOWN BAGGAGE, first presented at the Magnet Theater, and Ars Nova in NYC in 2010/2011. Support for CLOWN BAGGAGE was provided by Ars Nova, the New York State Council on the Arts, the New York Foundation for the Arts, the Bindlestiff Family Cirkus, and the Magnet Theater.

Acknowledgements

Special thanks to Dr. John Travis Gossey, Glen “Dr. Bovine” Heroy, Prof. Amr Kamal, Prof. Jessica A. Krug, Prof. Erin B. Mee, Prof. Amnon Raviv, Jarden Stern, and Prof. Wendy A. Suzuki.

My Clown Baggage

What did you want to be when you grew up? I vacillated among several occupations, but two vocations always prevailed: I wanted to be a doctor ... but I also always wanted to be a clown. I was pre-med at Vassar College, and I started a juggling group. I was a licensed New York State emergency medical technician, and I would

respond to campus emergencies on my unicycle (and I always arrived faster than the ambulance). I applied to med school, I applied to clown college, and in 2004 I joined the Big Apple Circus Clown Care Unit and became a clown doctor. I use medical clowning to investigate the playful mechanisms underlying human connection, disruption, and collective joy.

In this article, I shed light on the potential of medical clowns as embodied players trained to initiate play encounters in hospitals with the objective of empowering the patient. The presence of the medical clown, in concurrence with treatment in real time, acknowledges the duality of the child-patient’s realities: the desire for play and companionship amidst their very real and quite regular suffering. The impact of these encounters may extend beyond the patient to other participants, and maybe even beyond the encounter itself. This occurs through interactions with three intersecting circles of audience: clown with patient, clown with family, and clown with staff. I propose that participant empowerment and the rediscovery of agency is an effect of medical clowning that happens through play with each audience, and requires more investigation.

Why distinguish these three audiences? Each audience has very different stakes invested in a hospitalization,

which influence their agency within the hospital. The patient is the one hospitalized. Family members are present and impacted by the hospitalization. The staff facilitates the hospitalization. The medical clown has access to, and is an interlocutor between, all three, which presents a unique position for the medical clown. The philosophy of empowerment is based on the understanding that patients have limited agency while undergoing medical treatment (Haque & Waytz, 2012), so clown doctors present an opportunity for patients to exercise some form of control over their experience. In this context, medical clowns attune to and engage the three audiences—patients, family, and staff—in play encounters, evoking Bernie De Koven’s “well-played game.” These encounters have the potential to affect relationships and power dynamics for all stakeholders in the medical care system through the building of play communities (De Koven, 2013).

My Introduction to Medical Clowning

What is a clown doctor, or medical clown? It sounds like a potentially terrible idea. A lot of people are afraid of clowns. Of course, a lot of people are afraid of doctors. As much as I was always intrigued by clowns, and even wanted to be one, I didn’t always enjoy my encounters with them. My earliest recollection occurred in preschool when a clown bounded into our Halloween party, jingling, smiling, and unwittingly scaring all the children. I hid behind the teacher’s aide. Clutching her Levi-clad thighs, I peered around her from my place of imagined safety. I was dressed up like Dracula, and I was scared. A monster had appeared, way more physically imposing than my mini-vampire. The party swiftly soured until the clown spoke: “It’s okay! It’s just me! Ms. Amy!”

My preschool teacher was totally unrecognizable in her patchwork motley of colour, with her face caked in greasepaint. Her sweet, honeyed voice expressed confusion and concern. I liked my preschool teacher. I felt safe with her. But not today. My initial shock was replaced with shame and embarrassment. I was DRACULA. And Dracula was not supposed to be afraid of clowns.

That incident may have launched a life-long investigation into how to reconcile my fear of clowns with my fear of doctors, because once I got to college, I discovered this article in *The Washington Post*:

When a young patient recently needed a nasogastric tube—a plastic device that is threaded up the nose, down the throat and into the stomach to provide food—doctors, nurses and the child’s parents coaxed, pleaded, and finally threatened the child to get his help in having it inserted. They were at the point of forcibly holding him down, when one of the nurses recruited the help of [medical] clown Todd Robbins.

The child was crying, but Robbins engaged him by asking where the tube had to go. “Does it have to go in your eye?” Robbins asked and the boy shook his head no. “Does it have to go in your ear?” The child again said no, and pointed to Robbins’ nose.

Robbins, who happened to be a former sword swallower, then took the tube, put it up his own nose and threaded it down his throat to his stomach.

“Like that?” he asked.

The child nodded yes, and then to everyone’s surprise, reached for another nasogastric tube and inserted it himself. (Squires, 1996)

THIS!!! THIS made sense to me. Something about the playful encounter between this skilled clown, the staff,

and the patient transformed the circumstances. The play of the medical clown provided an alternative course of action for the staff, replacing forceful compliance with patient empowerment and agency. I was profoundly moved by this story, and spent hours in my bathroom with a copy of *Gray's Anatomy*, teaching myself the ancient sideshow art of the Human Blockhead (or how to stick objects in my nose), because one day, I might find myself in similar circumstances, and I wanted to be prepared. This became my vision for hospital clowning: legitimate circus and theatre skills, coupled with high emotional intelligence and improvisation, all in the guise of an eccentric, European-style clown persona working with patients, families, and medical staff.

The Play of the Medical Clown

The field of contemporary hospital clowning, or medical clowning, got its “official” start through the Big Apple Circus Clown Care Unit in 1986 (Citron, Aronson-Lehavi, & Zerbib, 2014). What does a Big Apple Circus clown doctor encounter look like? Typically, teams of two performing artists are assigned per shift at a participating hospital. They conduct “clown rounds,” designed to parody and mimic the ritualistic doctor rounds most patients encounter in a hospital. My work included clown rounds at New York-Presbyterian Morgan-Stanley Children's Hospital, Harlem Hospital Center, Yale-New Haven Hospital, Mt. Sinai Hospital, and ultimately as the supervising clown doctor at Memorial Sloan Kettering Cancer Center. The clown doctors dress in the tradition of a European circus or theatre clown, emphasizing eccentricity of dress, with minimal make-up, a red nose, and a white-doctor's coat. This guise immediately distinguishes a clown doctor from the rest of the hospital staff, in the same manner as the dress of a clown in the circus transgresses societal conventions with the intention of conveying a sense of “otherness” (Bouissac, 2015, pp. 22, 30; Raviv, 2014, p. 4). They have medical identification credentials granting them access throughout the hospital. Wherever a pediatric patient may be found, the clown doctors may go. Although perceived as “entertainment,” the main emphasis of the work is empowerment of the patient. Once permission is granted, the artists share the space with the patient (and family members and staff members) and an improvisational encounter unfolds. There is usually an attempt to create a beginning, middle, and an end before the clown doctors move on to their next visit. Multiple overlapping, intersecting, and interacting audiences experience each performance in this hospital setting. This includes the medical clown team and three levels of audience: the patient, the family, and the medical staff (Linge, 2013; Raviv, 2012).

Play in the Hospital

There is risk playing in a hospital. Schechner (1988) defines dark play as play where some of the players don't know they are playing. It subverts order, dissolves frames, and breaks its own rules (Harding & Rosenthal, 2011; Schechner, 1988, 2013). Life or death stakes might be involved. This affects how each audience engages with the medical clown and how the work of the medical clown is perceived. A hospital is a space where people come for treatment, seeking healing. People undergo painful and invasive procedures, and they emerge changed. People are born in a hospital. People die in a hospital. A hospital is a singular space where birth, death, and a myriad of life transitions occur every day. As Raviv (2014) states, the hospital is a site where life meets death. How incredible, and unique! This is the space in which a medical clown is searching for Bernie De Koven's (2013) well-played game, creating play communities that range from two members (the clown and her partner), to three members (clown, partner, and patient), to five (clown, partner, patient, parent, and staff member) or more in any number of combinations.

Stenros (2015) extends the notion of dark play to transgressive play. In a medical clown encounter, the clown requires permission from the patient, but at any moment, a staff member might enter the space and not know

play is occurring, another example of the overlap between the three audiences. This is a risky proposition in a hospital environment where medical assistance is often requested with a sense of urgency. When Amnon Raviv, a performance studies scholar and a medical clown with the Dream Doctors program in Tel Aviv, shouted for a nurse to “Come over quickly!” she rushed in. At first, she was alarmed, but “relaxed when [Raviv] told her [he] was in love with her” as he incorporated her into the encounter (Raviv, 2012).

Play is often idealized as a positive experience, though it encompasses both “good” and “bad” play (Stenros, 2015). Play is ambiguous (Sutton-Smith, 2009). Play requires permission, is pleasurable or enjoyable, and is purposeless (Brown, 2009). Absence of play, or play deprivation, particularly in children, has a negative impact on health and health outcomes (Gray, 2011; LaFreniere, 2011; Pellis, Pellis, & Bell, 2010). Research conducted in the first half of the 20th century recognized the impact of sensory and play deprivation during extended hospitalization, and led to the creation of Child Life programs and the beginning of what Pruitt (2016) describes as “the medicalization of play.” Medicalization refers to a process of transferring play from recreational pursuits guided by volunteers into play activities designated as therapy or therapeutic by professionals. The Association of Child Life Professionals (2017), a nonprofit professional organization for child life specialists, formed in 1982 as the Child Life Council. Four years later, the Big Apple Circus started the Clown Care Unit, introducing teams of specially trained performers to parody doctors and conduct “clown rounds.” These clown rounds, or “encounters,” start by asking permission of the patient: “Can I come in?” This question is an invitation to play, and play can only begin if implicit or explicit permission is obtained. Thus the medical clown encounter is a play encounter, though not necessarily a medicalized play encounter. Ideally, there is a beginning, middle, and an end. This play encounter has a narrative, linking it to Winnicott’s (1992) notion of “total happenings” and the field of narrative medicine (Charon, 2006). Total happenings help babies (or older pediatric patients experiencing psychological regression due to anxiety or fear of death during a hospitalization) master time. Masetti (2012) surmises that introducing total happenings into the hospital experience can help a patient developmentally, particularly with the idea that this hospitalization will eventually end.

It Starts With Eye Contact

What’s the least effort required for a moment of human connection while passing in the hallway of a hospital? I mention hallway because that is a common space in a hospital shared by each circle of audience. What’s usually the first level of interaction as two people pass in a hallway of a cancer centre? It starts with eye contact. Eye contact is asking permission to engage. If there is no eye contact, there is a decreased likelihood of interaction. Sometimes, even if there is eye contact, there is no interaction. There must be a breath, a moment of recognition, a physical call-and-response: “Hello. I see you. Do you see me? Aha! You see me, and I see you. We are now sharing this moment.” And then it is gone.

I’m looking for moments. Eye contact. Permission to engage. Recognition and disruption. When I say disruption, I’m referring to the moment that occurs after eye contact: recognition that the person is now in the present moment with you. Their current thought is now “you,” just as your current thought is “them.” Now “us.” There is not necessarily a joke, gag, or laughter just yet. It’s too early, and entirely unpredictable, and not necessarily up to you. The moments that compose an encounter are cocreated with *complicité*, or agreement, between medical clowns and audience.

Back to the hallway. What makes me different from anyone else they might pass in the hall? It starts with what I wear, and what’s on my face. I do not look like someone you would normally find in a hospital (unless you’re in a facility that supports medical clowning). I wear a doctor’s lab coat, because people with doctor coats are associated

with a hospital environment. Underneath the coat: red plaid pants, a red long-sleeve oxford, and a clip-on straight black tie. Nothing too outlandish. The pants are “loud,” but the outfit is tied together through a coordinated colour scheme and a typical conservative professional code of attire: tie, shirt, pants with a doctor’s coat.

On my face, I use base and powder to form an even foundation for my blush and eyebrows. I use a black grease pencil to stylize my eyebrows. Light powder blush for my cheeks and chin, with a small red clown nose and a moustache made from a twisted black pipe cleaner, topped with a red flat cap, turned backwards. The goal with the makeup is to highlight expressive features and heighten my appearance, without creating an alienating effect. The pipe cleaner moustache is clearly fake. I also carry extra pipe cleaners in my pocket. If someone admires my moustache, I offer to make them one. When they wear it, we take pictures, as if we’re long-lost family members.

I’m in the hallway, with a partner. Partners are important, because one person who “others” themselves through dress or gestures sends a different message than two people who choose to other themselves. There is more intention in two. That is why design is important. You have to imbue a sense of safety and trust to play in a hospital. You’re inviting strangers to accept a certain amount of social risk. By engaging with strangers in a hospital, you invite them to question their identity and place within that institution. You’re inviting them to step out of social roles and identities. Where does this begin? In the hallway. How? With eye contact.

When I walk down the halls of a hospital as a medical clown with my clown partner, we have chosen to distinguish ourselves with a set of characteristics that indicate “I am here to play.” It’s an interesting hybrid of fact and fiction. There’s a sense of eccentricity, absurdity in the dress and use of makeup, clown nose, and pipe cleaner moustache. This is all the fiction. The factual is my official medical ID. This grants me access throughout the entire medical facility. The picture and name on the ID is Dr. Berpundfahrt. Fact and fiction collide in this official identification document, which grants me agency and permission to search the hospital to initiate a well-played game.

My initial approach towards pursuing play in a hospital is to identify the smallest gesture I can enter with that might evoke a response, the tiniest invitation. An invitation can be a physical gesture, like nodding the head in acknowledgement or greeting. It can be clothing: The choices of colours and styles worn on the body evoke inquiry and delight, like an embodied playground of fashion. It is in makeup: the red nose, the bold eyebrows. And you constantly ask yourself, “What gestures can I employ to initiate interaction, where the receiver of the gesture can accept or decline?” The act of declining an offer can also be empowering.

Why these design choices with my apparel and my makeup? My eyebrows and moustache are part of a playful persona called Manolo, who was inspired by my first teacher of clown. I enjoy playing Manolo, and I can usually count on it evoking a positive response. It helps me create an invitation for engagement, and it helps hold attention.

So, Dr. Manolo Berpundfahrt is walking down the halls of a hospital. First, establish eye contact. If there is recognition, then maybe a “hello” or similar greeting is offered. If the “hello” is acknowledged and returned, you have permission for another interaction. Every piece of my wardrobe, my makeup, my props—each item is essential for communicating and instigating play with anyone at any time anywhere. My obligation is to assess opportunities for playful encounters with any individual in the hospital environment.

Rule number one when engaging with the patient is “the patient is in charge.” You ask permission of the patient before you enter the room: “Can we come in?” In that moment, the patient can initiate or terminate the encounter. Sometimes the patient might say yes, but the parent might say no or exhibit some form of resistance, which could be due to any number of factors: protecting their child, exhaustion, stress, apathy, distraction. So now the

medical clown team is balancing the needs of the patient with the needs of the second level of audience: the parent. Typically, if the child's needs are being met, the parent will often recognize that, and engage with the performance. If the staff enters the scene (which could happen at anytime), now there is potential for new tension. Do they have a task that must get accomplished? Do they need to chat privately with the parent? Do they need to examine the patient? This presents the third audience the medical clown team is engaging with. Sometimes all three audiences can be interwoven, forging a momentary play community composed of clowns, patient, family, and staff. Sometimes the parent and the staff step back, and the play remains between the medical clowns and the patient. Sometimes the patient engages with the staff and observes while the medical clowns continue playing with the family. The encounter is fluid, and finite.

In Practice

I remember an encounter that truly clarified my role as a clown doctor. I, Dr. Berpundfahrt, and my associate Dr. Bovine were invited to accompany a young patient to have his port cleaned. The team requests permission from the pediatric patient before they enter a patient's space. This space could be a clinic, an exam room, a private patient room, the intensive care unit, the emergency room, and so on. Permission to enter a space could also be equated with the permission required to begin a play encounter (Brown, 2009; Huizinga, 1949; Sutton-Smith, 2009). The young boy, around 6 years old, sat on his mom's lap while the nurse prepped his skin where a needle would be inserted to flush the subdermal device that had been implanted near his collarbone to provide easy access for chemotherapy and other intravenous treatments. Flushing the port was not the most comfortable procedure, and merely one of many painful interventions that a pediatric cancer patient experiences over their lengthy hospitalization. We began our interaction with amiable greetings and dialogue. The details are fuzzy, but I'm sure it involved introductions (Bovine knew the boy, I was meeting him for the first time) and a display of our medical IDs, which were attached to our white coats with retractable cords. These ID cords were one of several simple tools, possessed by almost every staff member in the hospital, that we could access to create moments of physical comedy, or *lazzi*, by getting tangled in them, displaying them repeatedly to everyone who passed us to confirm our official status as medical professionals, or getting slapped by their unruly pull. Clown doctors have a myriad of backgrounds that draw significantly from corporeal theatre (mime, dance, improvisation) and variety entertainment (magic, object manipulation, juggling, music). Using these skills, they craft an encounter attuned to the patient's developmental needs and physical condition. In this encounter, the mood was light as the nurse approached the boy with a needle. That's when he let out a tirade of obscenities:

"F@#k you you b@#ch I hate you get away from me!"

It was clear he was afraid and preparing for pain, and that maybe we should leave. I asked, "Do you want us to go?" His demeanour immediately shifted. In his soft, southern drawl, he said quite plainly, "Oh no, you're fine, I want you here." So Dr. Bovine and I pulled out some playing cards to attempt a magic trick, staying out of the way of the procedure, but still within eye-line of the boy, all of us in relatively close quarters with a curtain drawn around us: the boy, his mom, the nurse, Dr. Bovine and me (three levels of audience invested in one encounter). The nurse slid closer on her wheeled stool, and the boy erupted:

"I hate you g@d@#nit I hate you you ugly b@#ch!"

It wasn't the words that startled me. It was a combination of their vehemence and the abruptness with which our patient could shift, from focusing on us as a 6-year-old chatting with his clown doctor friends, to the blood-curdling, terrified ululations of a child under assault. We checked in again: "We can go, if you'd prefer us to come

back later at a better time...” As clown doctors, you’re constantly balancing the agenda of the child (which is paramount) with the needs of the medical staff and improvising accordingly to create some sense of completeness in the encounter. And sometimes the best thing you can do is abandon the game, or the bit, and revisit later to complete the visit. “No, stay, it’s okay. I want you here,” he assured us. And that’s critical: We take our cues from the patient. You honour the parents and the staff, but ultimately the focus is on empowering the patient and restoring agency. Recognizing patient agency during hospitalizations has been linked to improved well-being and desirable long-term health outcomes (Haque & Waytz, 2012). Dr. Bovine pulls out his recorder, and I retrieve a whoopee cushion. We begin a musical interlude, which our friend appears to enjoy, until the nurse makes contact and once again:

“I hate you I hate you get the f@#k away from me!”

Reflecting on that interaction, I truly learned that a clown doctor or medical clown is not there to distract, or to make anything better, or to decrease anxiety or lighten the mood. The presence of the medical clown acknowledges the duality of the child-patient’s concurrent realities: the desire for play and companionship amidst their very real and quite regular suffering.

Well Played

Play is considered “ambiguous” (Sutton-Smith, 2009). This brute, biological state that appears to cross species, gender, race, ethnicity, and socioeconomic status is ambiguous (Brown, 2009; Panksepp & Biven, 2012; Sutton-Smith, 2009). Yet through training and integration into an institution, the medical clown embodies this ambiguous state and makes it concrete. The trained medical clown, indoctrinated in physical theatre, *le jeu*, and improvisation, embodies transgressive play. The encounters transform relationships through the building of play communities, as defined by Bernie De Koven. De Koven (2013) emphasizes the play community over the play itself when he says:

The nature of a play community is such that it embraces the players more than it directs us toward any particular game. Thus, it matters less to us what game we are playing, and more to us that we are willing to play together. (p. 12)

Trained medical clowns have the tools to catalyze play communities and construct “the well-played game” (De Koven, 2013). So what is a well-played game? “Well” implies some sense of positive health and well-being. “Played” is the act of playing. “Game” is the container for play. A well-played game is a game we (the players) agree that we can all play together. The pursuit of a well-played game creates a play community.

Elevator Music

So how does medical clowning impact the relationship with the staff audience? Medical clowning appears to reside at an intersection of play, narrative medicine, and arts programming, all occurring within the hospital space. One of my favourite games to play is called “Elevator Music.” The elevator is a major point of intersection in a hospital (as it is in most buildings). People come together for a shared aim: transit through the facility. When the doors close, “The Girl from Ipanema” on Hammond organ starts playing (on my personal electronic music device, hidden in my pants), and the elevator starts to move. This occurs in an elevator that is typically silent, where there is never elevator music. So for anyone used to using the elevator, it’s a moment of surprise, disruption. Folks have permission to acknowledge (or not) this disruption. And the game grows with every stop. Because when the elevator stops, the music stops. When new passengers get on, the current passengers are now witnesses to the

surprise of the new passengers when they hear the elevator music. It's simple, wonderful, and full of potential for collective joy. The audience for this interaction is often hospital employees, particularly in the staff elevators, but can include patients and family members. It's interesting to witness the shift, from "silent strangers in an elevator," to "adults attempting to suppress their mirth," to "is this a party or an elevator?" filled with full-out laughter.

Arts programs in clinical environments have proven beneficial to patient outcomes and staff experiences (Sonke et al., 2015). An interesting correlation elucidated by Sonke and colleagues indicated that the presence of an arts program affected the nursing unit culture, which affected the nursing practice, which affected the quality of care. This interrelatedness parallels the impact the medical clown performance has on each circle of audience within the hospital space (Linge, 2013; Raviv, 2012, 2014).

Conclusion

Medical clowns are playful disruptors, deploying rehumanizing strategies and practices within an institution. Trained clowns maintain a critical, interdisciplinary, multimodal artistic practice whose success hinges on design, function, and experience (Bouissac, 2015, pp. 63–65, 105). They train to deploy communication through a myriad of channels: dress, makeup, gags, gimmicks, props, language, physical vocabulary, and corporal expressiveness (Hendriks, 2012). Medical clowns are expressive and attuned to the sensitive body, communicating across divides and through frames (Hendriks, 2012). The centre, the touchstone of this communication is play. Medical clown encounters take place within the frame of the hospital, where permission is requested to engage with three audiences: the patient, the family, and the staff. The initiation of a medical clown encounter shares characteristics of Bernie De Koven's well-played game, the pursuit of which is almost more important than the game itself. The play communities that form as a result of a medical clown encounter have the potential to impact patient agency and audience relationships beyond the actual encounter, and this warrants further investigation.

References

- Association of Child Life Professionals. (2017). History of ACLP. Retrieved from: <http://www.childlife.org/about-aclp/history-of-aclp>
- Bouissac, P. (2015). *The semiotics of clowns and clowning: Bloomsbury advances in semiotics rituals of transgression and the theory of laughter*. New York, NY: Bloomsbury.
- Brown, S. L. (2009). *Play: How it shapes the brain, opens the imagination, and invigorates the soul*. New York, NY: Penguin.
- Charon, R. (2006). *Narrative medicine: Honoring the stories of illness*. New York, NY: Oxford University Press.
- Citron, A., Aronson-Lehavi, S., & Zerbib, D. (2014). *Performance studies in motion: International perspectives and practices in the twenty-first century*. New York, NY: Bloomsbury.
- De Koven, B. (2013). *The well-played game: A player's philosophy*. Cambridge, MA: The MIT Press.
- Gray, P. (2011). The decline of play and the rise of psychopathology in children and adolescents. *American Journal of Play*, 3(4), 443–463.
- Haque, O. S., & Waytz, A. (2012). Dehumanization in medicine. *Perspectives on Psychological Science*, 7(2), 176–186. doi: 10.1177/1745691611429706
- Harding, J., & Rosenthal, C. (2011). *The rise of performance studies: Rethinking Richard Schechner's broad spectrum*. New York, NY: Palgrave Macmillan.

- Hendriks, R. (2012). Tackling indifference: Clowning, dementia, and the articulation of a sensitive body. *Medical Anthropology*, 31(6), 459–476. doi: 10.1080/01459740.2012.674991
- Huizinga, J. (1949). *Homo ludens: A study of the play-element in culture*. London, England: Routledge.
- LaFreniere, P. (2011). Evolutionary functions of social play: Life histories, sex differences, and emotion regulation. *American Journal of Play*, 3(4), 464–488.
- Linge, L. (2013). Joyful and serious intentions in the work of hospital clowns: A meta-analysis based on a 7-year research project conducted in three parts. *International Journal of Qualitative Studies in Health and Well-being*, 8. doi: 10.3402/qhw.v8i0.18907
- Masetti, M. (2012). *Clown's solutions*. Pressbooks: Simple Book Production. Retrieved from: <https://clownssolutions.pressbooks.com/>
- Panksepp, J., & Biven, L. (2012). *The archaeology of the mind: Neuroevolutionary origins of human emotions*. New York, NY: W. W. Norton.
- Pellis, S. M., Pellis, V. C., & Bell, H. C. (2010). The function of play in the development of the social brain. *American Journal of Play*, 2(3), 278–296.
- Pruitt, L. (2016). The medicalization of children's play in American hospitals in the nineteenth and twentieth centuries. *International Journal of Play*, 5(3), 262–276. doi: 10.1080/21594937.2016.1231882
- Raviv, A. (2012). Still the best medicine, even in a war zone: My work as a medical clown. *TDR: The Drama Review*, 56(2), 169–177.
- Raviv, A. (2014). The clown's carnival in the hospital: A semiotic analysis of the medical clown's performance. *Social Semiotics*, 24(5), 599–607. doi: 10.1080/10350330.2014.943460
- Schechner, R. (1988). Playing. *Play & Culture*, 1(1), 3–19.
- Schechner, R. (2013). *Performance studies: An introduction*. New York, NY: Routledge.
- Sonke, J., Pesata, V., Arce, L., Carytsas, F. P., Zemina, K., & Jokisch, C. (2015). The effects of arts-in-medicine programming on the medical-surgical work environment. *Arts & Health*, 7(1), 27–41. doi: 10.1080/17533015.2014.966313
- Squires, S. (1996, April 23). A funny kind of doctor. *The Washington Post*. Retrieved from: <https://www.washingtonpost.com/archive/lifestyle/wellness/1996/04/23/a-funny-kind-of-doctor/25412f43-f5f4-44a7-bb9a-3fd7c0e268b5/>
- Stenos, J. (2015). *Playfulness, play, and games: A constructionist ludology approach* (Doctoral dissertation). Retrieved from: <http://tampub.uta.fi/handle/10024/96986>
- Sutton-Smith, B. (2009). *The ambiguity of play*. Cambridge, MA: Harvard University Press.
- Winnicott, D. W. (1992). *The child, the family, and the outside world*. New York, NY: Perseus.