Journal of Medical Humanities
https://doi.org/10.1007/s10912-019-09570-0

Seriously Foolish and Foolishly Serious: The Art and Practice of Clowning in Children's Rehabilitation

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Published online: 23 July 2019

Abstract
This paper interrogates and reclaims clown practices in children's rehabilitation as 'foolish.' Attempts to legitimize and 'take seriously' clown practices in the health sciences frame the work of clowns as secondary to the 'real' work of medical professionals and diminish the ways clowns support emotional vulnerability and bravery with a willingness to fail and be ridiculous as fundamental to their work. Narrow conceptualizations of clown practices in hospitals as only happy and funny overlook the ways clowns also routinely engage with sadness, despair, discomfort and many other ways of being and doing. Our exploration of clown practices as foolish exposes the ways children's rehabilitation upholds particular neoliberal models of success and invites a re-centring of rehabilitation and health care research and practice towards relationship building, supporting meaningful projects and a continued nurturing of aesthetic and pleasurable ways of being-in-the-world in the present moment as valuable unto themselves.

Keywords Therapeutic clowns · Children's rehabilitation · Childhood disability · Applied performance · Failure

Introduction

Through this paper we aim to take seriously the work of clowns in children's rehabilitation. As such, we forefront the fundamental ways clown practitioners engage in a foolish, ridiculous artistic practice without resorting to taking the practice *seriously*, as code for "correctness," or "confirming what is already known" and accepted as traditionally valid and legitimate (Halberstam 2011, 6). We are a cross-disciplinary Canadian writing team, including a performance studies and health humanities practitioner and scholar (J.G.), a clown practitioner and teacher (H.D.), and a critical disability and rehabilitation studies scholar and clinician (B.G.).

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We argue that considering clown practices as foolish, that is as a brave and vulnerable emotional engagement with others with a willingness to fail, pushes beyond more dominant understandings of clowns as engaging only with humour, laughter, or happiness which might be construed with an oppressive, forced, false sense of joy, or "the tyranny of cheerfulness" (King 2010). The narrow conceptualization of clown practices as happy and funny overlooks the ways clowns also routinely engage with sadness, despair, discomfort and a host of other ways of being and doing that are also fundamental to the art of clowning and being human. Within health care, the foolish practices of clowns expose the ways that "seriousness" has come to be understood as the significant mode of learning and successful being-in-the-world.

Our conceptualizations of foolishness draw significantly on cultural and queer theorist Jack Halberstam's discussions of failure, creativity and re-thinking seriousness (2011). As such we propose that through the foolish engagement of their artistic practice, clowns in children's rehabilitation hospitals engage in a relational and aesthetic participatory practice with young people as well as others including families and staff. Our focus on foolish engagement pushes well beyond existing attempts to legitimize clown practices as "serious," including those attempts to demonstrate how humour and funniness might assist with "curing" or "fixing" sick or disabled children.[1] In what follows, we interrogate practices of clowning in children's hospitals to consider 1) how foolishness is fundamental to clown's artistic practices that focus on being physically, emotionally and sensorily in relationship with other people in time and space (rather than oriented to fixed, static therapeutic goals) and 2) how these practices upend what is traditionally valued as 'serious' in the health sciences.

In order to re-claim the work of clown practitioners in hospitals as foolish, our paper unfolds as such. First, we discuss the notion of foolishness as a brave willingness to step forward with uncertainty despite potential failure and as fundamental to clown practices. Next, we frame the health sciences and children's rehabilitation as "serious business," articulating the ways the field values certain ways of being and doing over others and what that means for the ways "therapeutic" care is traditionally understood and practiced. We then provide an overview of clown practices in hospitals, including a brief contextual history of this emerging field and an overview of scholarly literature. To put our discussions in context, we draw on two examples to highlight the fundamental foolish ways clowns place aesthetic, pleasurable and relational ways of being in the world at the forefront of their practices and how this runs counter to much of what is traditionally valued in healthcare and children's rehabilitation. We conclude by positing the ways that clown practitioners provide a kind of *aesthetic approach to care* and propose these principles might be considered important for all hospital practices.

Foolishness

The theoretical notion of foolishness finds its roots in two traditions: 1) applied theatre and performance studies, and 2) clown practice and pedagogy. In both of these traditions, foolishness can be understood as engaging with other people bravely and vulnerably with the willingness to fail and be ridiculous (Salverson 2006, 2008; Gray 2019; Gray and Kontos 2018). Responding to scholarship and practical theatre work at the intersection of trauma, social change and performance, applied theatre scholar Julie Salverson offers the "foolish witness" as one who enters an encounter with another person with the attitude of a clown: stepping forward with uncertainty and with the brave acceptance of likely failure (2008, 246).

Foolishness, as coined by Salverson, emerges from clowning's long performance history across cultures. Critical theatre historians have suggested that through The Fool in Shakespeare's dramas as a "popular" servant character (as opposed to a noble person) using bodily, physical humour and inattentiveness to structures of verse, Elizabethan thought and social organization around gentility could be disrupted and critiqued. In English historical contexts, it was in part through The Fool that debates about power could take place (Wiles 2005 [1987], 174). As another example, in many Indigenous cultures on Turtle Island (also known as North America), the figure of the trickster can be aligned with European approaches to clowning. While many Indigenous scholars recognize that this term, trickster, was constructed by nineteenth century European anthropologists (Reder 2010), many contemporary Indigenous storytellers draw on historical traditions from many nations and their own imaginations to talk, write and perform about a provocative figure who invites chaos, upends order and challenges the status quo (Reder and Morra 2010; Claxton 2008).

Drawing from these roots, contemporary clowns can be understood as functioning to make people laugh by embracing failure, weakness and the ridiculous (LeCoq 2001, 143-144). In this way, clowns might make us laugh, but this happens because of the ways they perform with weakness and fragility, failure and ridiculousness, rather than with a quick wit or intellect. Through clown training, theatre artists aim to be less defensive, exposing naïveté and fragility. Foolishness can thus be understood as the opposite of "being clever" as a "high" or intellectual sophistication.

Failure, as fundamental to both foolishness and performance-making, provides space to rethink what gets valued as successful, productive and/or positive (Bailes 2011; Stanley 2013; Tannahill 2015); indeed it was renowned Irish playwright Samuel Beckett who famously invited humanity to "fail better" (1983). For cultural and queer theorist Jack Halberstam, failure is often equated with "losing, forgetting, unmaking, undoing, unbecoming [and] not knowing" (2011, 2) and holds the potential to "offer more creative, more cooperative, more surprising ways of being in the world" (2-3). Failure, as disrupting normative societal standards, can open up critiques of neoliberal assumptions of success such as the accumulation of wealth by those who do not absorb social resources (Kafer 2013). Without diminishing a range of associated negative and difficult emotions, such as "disappointment, disillusionment, and despair," failure can also draw on these feelings to provoke and challenge the ways overly positive assumptions about contemporary life might be potentially destructive (Halberstam 2011, 3).

The clown's foolish willingness to try and to step forward despite likely failure should not be confused with the potential toxicity of positive thinking or the imposition of cheerfulness. Recent critiques have highlighted the problems presented by an overabundance of positivity rhetoric in North America. They suggest that "positive thinking" is offered as a way to move past structural mediators of health and wealth such as gender, race and class, to place the responsibility for success squarely on an individual's efforts and attitudes (Halberstam 2011, citing Ehrenreich, 2009). With positive thinking, and the dogged determination to keep trying, health and wealth supposedly emerge from character, determination and endeavor rather than being shaped by surrounding environmental and social structures. King (2010) discusses "the tyranny of cheerfulness" related to the pink ribbon campaign associated with women's breast cancer, where happiness and individual striving in the face of disease is lauded as a "successful" life affirming experience. Without diminishing the importance of genuine joy as well as reflecting and engaging positively for individuals, positive thinking downloads the responsibility of neoliberal success onto the individual and human struggling becomes bleached-out in

the rays of cheerfulness's supposed glory. With the oppressiveness of imposed cheerfulness, death, suffering, pain and anguish are erased from experiences of illness and disease in the wake of positive spins to promote normative "successes" such as raising funds.

Foolishness subverts the tyranny of cheerfulness and positive thinking by embracing failure and the sincere willingness to step forward with genuine uncertainty. It holds the potential to lose one's way, opening up unexpected directions. Foolishness privileges the nonsensible and non-sensical (and even the naïve, ignorant and stupid), centring these as different ways of being in and understanding the world. What might be traditionally dismissed by "the serious" (as academic research, bioscience and health care) as redundant or irrelevant is precisely what clowns embrace. Halberstam terms this embrace of the unplanned, unexpected and the surprising as "knowledge from below" or "low theory" (11). As a mode of accessibility, low theory "flies below the radar" and "detaches itself from prescriptive methods, fixed logics and epistemes" (16-17). Foolishness then can help to re-think "the project of learning and thinking altogether" (7), thereby also re-thinking notions of success and what it means to be "productive."

In the remainder of the paper, we invite a re-thinking of the ways "seriousness" has come to be understood as the only legitimate way of learning and being in the world (Halberstam 2011). Halberstam argues that "the desire to be taken seriously" is so strong that it is what "compels people to follow the tried and true paths of knowledge production… confirm[ing] what we already know" (6). Being serious, and being taken seriously, can be hindering in that it "means missing out on the chance to be frivolous, promiscuous, and irrelevant… and restricts visionary insights or flights of fancy" (6). In what follows, we articulate the ways the health and rehabilitation sciences construct notions of seriousness by investing in particular kinds of successes.

Health and rehabilitation sciences as serious business

Rehabilitation establishes itself as a serious enterprise through its longstanding alignment with biomedicine and its embrace of the scientific method to establish what counts as legitimate knowledge. These commitments mediate what is or is not understood as successful rehabilitation outcomes and the "evidence-based" interventions used to achieve them (Holmes et al. 2006; Kersten et al. 2010). "Serious" and aligned terms like "legitimate" tend to be code for disciplinary correctness as well as certain forms of training and learning that conform to what is approved and accepted. Outcomes-oriented health care is driven by faith in the scientific method to produce "objective knowledge" that can be efficiently applied across bodies with similar presentations and diagnoses (Holmes et al. 2006; Goldenberg 2016). Rehabilitation research is traditionally "tethered to conventional knowledge production and its well-travelled byways" (Halberstam 2011, 6). Wandering off into uncharted territory is frowned upon in favour of producing particular valued outputs, such as research funds and peer-reviewed publications, as well as upholding particular methodological approaches that value particular forms of knowledge production over others. Additionally as part of care, practitioners are trained to be scientific, objective, and confident in their advice. The moral imperative of health care is one of providing expert and scientifically sound assessment, treatment and "patient education," leaving any admission of doubt understood as a failure to provide adequate professional care (Gibson 2018).

Biomedicine's focus on curing disease is reconstituted in rehabilitation toward eliminating or addressing functional deficiencies and impairments. While ostensibly rehabilitation deviates

from medicine in its focus on enhancing quality of life and enabling social participation, the logics underpinning practice retain a commitment to normalization of the body and its functions which are extended to the promotion of normal social roles and the neoliberal goals of productive citizenship (Gibson 2016; Fadyl, McPherson, and Nicholls 2015). When aligned with biomedicine, rehabilitation practices are tailored to uphold specific forms of "normal" and success including "reproductive maturity [as hetronormative adults] combined with wealth accumulation" (Halberstam 2011, 2; see also Kafer 2013), understood to be socially valuable ways of being productive. These normative assumptions additionally infiltrate rehabilitation research design, anticipated research outcomes and the research-practice nexus. There is little room in the serious scientific aspirations of contemporary rehabilitation practice and research for risking failure through creative experimentation, promoting pleasure, supporting alternative ways of being and doing, particularizing care, and/or thinking about people differently.

In children's rehabilitation practice, where one might expect to see at least a greater tolerance for, if not an embrace of, foolishness, play and creativity, seriousness manifests in particular ways. Play is an integral part of therapeutic interventions to address impairments, and children are encouraged to play at home and through recreational pursuits. Play and pleasure are often used by clinicians as devices, tools, and tricks to secure the compliance of children towards realizing more "serious" therapy goals or as forms of assessment. For example, disabled children may be encouraged to pursue particular recreation activities by well-meaning professionals (and parents) with a notion of addressing goals of attaining bodily symmetry, reducing muscle tone, improving joint range of movement, achieving independent walking, modifying anti-social behaviours, or enhancing fitness (Gibson and Teachman 2012). Games and rewards are also employed in treatment sessions to make therapy fun and secure children's cooperation (Howcroft et al. 2012). Children may additionally be assessed on the ways they play, coded as "normal" or "abnormal"; play, then, is a means to codify, monitor and manage children's bodies (Goodley and Runswick-Cole 2010). The uptake of play for instrumental purposes in rehabilitation may be well intentioned but ultimately signals how play and pleasure are seldom pursued or valued as ends in themselves.

In the rehabilitation context, play and pleasure are not usually or only about creativity, spontaneous fun and being-in-the-world but rather as the means towards realizing the serious goals of achieving or approximating "developmental milestones" within the broader mandate of children's rehabilitation as science (Gibson, Teachman, and Hamdani 2015). As part of rehabilitation, play is co-opted by serious adults who determine and judge the quality of play and the ways it should be valued for learning and development. The bodies of disabled children continue to be controlled by well-meaning adults who own, understand and apply play in particular ways (Goodley and Runswick-Cole 2010). Foolishness, as an emotional vulnerability with a willingness to be ridiculous and fail and as fundamental to creative, spontaneous, fun playing, is largely overlooked in these contexts.

Within neoliberal societies, the work of children is to become productive, independent adults; adults, in turn, aim to support this work towards future productivity. As part of rehabilitation and developmentalism, children, including disabled children, are understood to be "less serious" or unformed in relation to adults, constructed as adults-in-the-making relevant only to their future potential (Burman 2008; Walkerdine 1993; Gibson, Teachman, and Hamdani 2015). Rehabilitation functions in tandem with efforts at home, school, and community to secure children's futures as productive, contributing, autonomous, and "normal" adults. A healthy dose of skepticism about what is valued as "normal," "good outcomes" and/or "best practices," including the precarious of static notions of "success," seems warranted, given how they translate into practices controlled and valued by adults.

As an alternative to constructing children in terms of future oriented aims, one of us (B.G.) has elsewhere suggested the importance of "living well in the present" (Gibson, Zitzelsberger, and McKeever 2009; Davies 1997). Such an approach encourages a re-focus on practices that build relationships and support personally meaningful projects for *children as children* rather than future adults. Here we extend this work to include engaging in practices and research that support aesthetic attention including focusing on sensory engagement, emotional awareness, and creative and imaginative possibilities for the child as person in the here and now. These considerations include the pleasures of attending to the ways young people might reach and move into the world with others through sight, touch, smell, taste, feelings/emotions and their imaginations. These goals move beyond traditional rehabilitation normative life trajectories and normalization goals to include the ways children come to sense their own bodies in the present moment in space and with other people.

Understanding the ways that the health and rehabilitation sciences are serious business helps provide an important foundation for the ways that "foolish" clown practitioners expose this seriousness as precarious. In what follows, we provide an overview of how clowns came to work in hospital settings and the philosophical underpinnings of their applied practices as rooted in performance histories and techniques.

Clown practitioners: an overview

A range of terms have been identified for clowns working in hospitals including Therapeutic Clowns, Clown Doctors, Health Care Clowns, Hospital Clowns, Elder Clowns, Medical Clowns, Clown Therapy (Carp 1998; Citron 2011; Kontos et al. 2016; Ford et al. 2013; Finlay, Baverstock, and Lenton 2014; Goldberg et al. 2014; Gervais, Warren, and Twohig 2007; Grinberg, Pendzik, and Kowalsky 2012; Kingsnorth, Blain, and McKeever 2011; Linge 2008, 2013, 2012, 2011; Sridharan and Sivaramakrishnan 2016). For the purposes of this paper, and understanding that these modifiers are conceptually loaded, we use the term "clown practitioner" to recognize the clown artist and the applied nature of the artistic practice in the hospital setting.[2] Clowning is a relatively new practice in hospital settings with very early practices having been documented in 1908 in England (Spitzer 2007; Citron 2011). In 1986, two significant events occurred that opened up the idea of clowns moving away from their purposes of entertainment (such as in circuses or theatre) towards supporting people as part of significant life transitions, including recovering from an illness or living with newly acquired physical differences (Citron 2011). First, child life specialist Karen Ridd started working as a solo clown practitioner in Winnipeg Children's Hospital in Canada (Warren 2004). Second, The Big Apple Circus opened its Clown Care Unit in New York City under the direction of the circus's co-founder Michael Christensen. With additional training in hospital procedures and policies, members of the Unit engaged as professional clowns to work within children's hospitals as "clown doctors" (Warren 2004; Citron 2011; Kontos et al. 2016).

The trend of engaging performance practices within applied performance spaces (not traditional/artistic performance spaces such as a theatre) paralleled trends in the performing arts over the same period and up to the present. Specifically in the 1970s and beyond, many artists began experimenting to engage audience members in more interactive ways, often blurring formal lines between performer and audience. Examples include the rise of site-specific performances and Augusto Boal's socially-based Forum Theatre (Bishop 2012; Citron 2011; Jackson 2011; Babbage 2004; Boal 1979). With the example of Forum Theatre,

audience members, whom Boal called "spectactors," are physically drawn into the action on stage, and the line between audience and performance is muddied. An audience member "assumes the protagonist role [by stepping into the drama], changes the dramatic action, discusses plans for change" (Boal 1979, 122). Aligned with these community or socially-oriented practices, clown programs have since opened up in hospitals globally, including Brazil, Argentina, Ecuador (and other countries in South America), Australia, Ethiopia, South Africa, Japan, Taiwan, Singapore, Lebanon, India, Tanzania, Malaysia, France, Switzerland, Italy, Netherlands, Portugal, and other European countries (Citron 2011; Warren 2004; Pendzik and Raviv 2011; Yingfeng 2018; European Federation of Healthcare Clown Organizations 2018). In 2005, Holland Bloorview Kids Rehabilitation Hospital in Toronto, Canada opened its clown program; author Helen Donnelly joined shortly thereafter.

When working in health care settings, clown practitioners engage in a performative art form. This means they use their bodies, including gestures, movements and voices, which are central to their artistic practices and the ways they engage with children, staff and families. They draw on a range of performance techniques, such as singing and instrumental music, mime (use of the performer's body for analysis and representation of physical objects), physical comedy (such as slapstick), imaginative play, improvisation, and dance, among others. They usually wear costumes that readily identify them as a specific clown persona, including donning a red clown nose. The red nose, as a "magical object," can invite playful encounters and signals to "non-clowns" that engagement outside of social and cultural codes is permitted (Butler 2012, 67).

At Holland Bloorview, clown practitioners work in a duo within the hospital and at the beginning of their shift, will gather information about children currently residing in the hospital through medical charts and through other staff members; this information informs their priority list of children to see on that particular day. With this information, they then move throughout the hospital in clown persona and engage in planned visits based on the priority list as well as unplanned encounters in hallways, patient rooms, outpatient areas and common areas such as the cafeteria and lobby. Planned or unplanned, they spontaneously seek out opportunities to engage with other people in clown encounters, or "plays," through their artistic practices (Warren and Spitzer 2011, 563). Fundamental to clown practices is the ability to respond to ideas, emotions, gestures and movements of those they encounter whether through "empty pocket clowning" in that they will use found objects within a client's room (Warren 2011, 184) or using "clown kits" to support playing including items such as scarves, mirrors, or small instruments like a ukulele or harmonica (Hendriks 2012, 463). Upon completion of their playful interactions on the unit, Holland Bloorview clown practitioners engage in a reflection of their practice with each other, including an artistic debrief (reflecting on the ways they drew on artistic techniques to engage with clients) as well as emotional reflection (expressing how particular "plays" made them feel and/or an interpretation of how other people engaged with them), including possible alternative strategies for engaging differently in the future. Clown practitioners document encounters in clients' charts to be shared with other clinicians (for more information, please see Donnelly and Vanden Kroonenberg 2018).

Regardless of the specific techniques of singing, dancing, imaginative improvisation, and slap stick (among others), clowns subjugate themselves to those they engage with by attending to the emotions, movements, ideas and physical presence of other people. Through "plays," clowns first must seek "silence" because, as physical theatre practitioner and teacher Jacques LeCoq discusses, "the spoken word often forgets the roots from which it grew" (2001, 29). Here the notion of play is embodied, active, improvisational, experimental, multi-faceted and

relational between people, things and within space and time (see for example LeCoq 2001; Thrift 2007). Through the "silence" of plays, the aim is to discover "moments when words do not yet exist" as a way to "better understand what *lies beneath* language" which might be construed as obscuring relations between people, things and places (LeCoq 2001, 29-30, emphasis in original). It is from this silence of play that either speech or action (as movement, song, slapstick, among others) emerges and allows for actions *with* another person; LeCoq asserts that "true play can only be founded on one's reaction to another" (30). But when words do become part of plays, they are rooted in feelings and embodied actions and "approached through verbs" (49) rather than being about a more intellectual "telling," "educating," or "dispelling knowledge" as might be more common uses of language with other health care providers. Words, or language that emerges in (a) play, are about what is being done or what happens between people as an extension of dynamic, embodied actions. This attentiveness to silence and actions between people, or "play[ing] *with*" (52, emphasis in original), is a kind of subjugation to another, allowing that other person to inform your own actions and playing. Given the potential for spontaneity and surprise, play and foolishness can also often be fun! In this way, clown practices can be described as embodied, spatial, aesthetic (emotional and sensory), experimental and responsive, in addition to foolish.

In the scholarly literature, the work and purpose of clown practitioners in hospitals has been overwhelmingly described in terms of supporting medical goals. Commonly clowns are discussed as engaging the "curative potential of humour" (Pendzik and Raviv 2011; see also Grinberg, Pendzik and Kowalsky 2012; Koller and Gryski 2008; Golan, Tighe et al. 2009), challenging established hierarchies (Grinberg, Pendzik, and Kowalsky 2012), as a source of empowerment (Koller and Gryski 2008), supporting 'problems' in an enjoyable manner or through 'distractions' (Duffin 2009) with the ability to generate empathy and support emotional expressions (Koller and Gryski 2008). Pendzik and Raviv (2011) discuss the ways that clowns are integrated into hospitals as para-professional caregivers in multi-disciplinary medical teams in order to "to transform their [client] experience of hospitalization (as well as those of their families) into a less traumatic one" (269). By situating clown practices as a "paramedical profession" (269), Pendzik and Raviv indicate that clown practitioners supplement and support *medical* work and outcomes that are normally the purview of other professionals. While it could be argued multi-disciplinary medical teams are constructed in order that members might collaborate to best meet client needs, health care team members tend to be rooted in the same medical traditions and approaches to care. By incorporating clowns into these teams, the risk is diluting or losing clown practices' important value and purpose beyond traditional biomedical goals.

There is emerging theoretical work that counters the narrow conceptualization of clown practitioners in terms of supporting medical goals and considers the imaginative, aesthetic and relational aspects of their work. For example, psychologist Lotta Linge (2011) moves beyond understanding clown practitioners as being only the bringers of happiness and humour to children and youth in hospital settings. Linge discusses the ways clowns "read" or attend to children's embodied and emotional responses through the clowns' playful, responsive actions and also promote surprise and excitement in children in hospitals, including what she terms a "joy without demands." This joy without demands is built through what Linge describes as verbal and non-verbal communication including movement and engaging the senses. This provides a kind of "reverse relation" where children are permitted to be a foundation or beginning point for clown encounters or plays without having to "perform" anything other than being themselves.

Other theoretical work has examined the emotional and relational aspects of clown practices. In Elder Clowning, as an arts-based approach in dementia care, sociologist Pia Kontos and colleagues discuss "relational presence" as a responsive and reciprocal "happening" between clowns and residents with dementia in long term care homes (2017, 52). They suggest that, as part of relational presence, clowns attend with an "affective relationality" to the emotions of another person (including joy and sadness), engage in a "reciprocal play[fullness]" where space is created for residents to offer their own moments to clown plays, and embrace a "co-constructed imagination" inviting and moving with residents' potentially nonsensical speech or imaginings (Kontos et al. 2017, 52-58). These emerging conceptualizations of clowns' practices in hospitals and other health care environments allude to the ways they are open, vulnerable, and fun. Aligning with LeCoq's approach to clown practices described above, they also provide spaces for clients to engage as active agents in playing. Our interest is to build on this important theoretical foundation to more clearly identify clown practices as foundationally *foolish*, which is ultimately overlooked in research about clown practices in children's rehabilitation and other health care environments.

Despite this important early theoretical work, much scholarly literature attempts to put clowning in a serious medical frame. For example, using language such as *curative* alongside *humour* suggests that humour and the ability to laugh might "fix" an (important) problem as a therapeutic intervention towards securing a child's "normative" future. Additionally, without diminishing the important emotional and embodied aspects of a sincere belly-laugh, it is important to question whether all laughter is good, who is doing the laughing or instigating the humour, and if there is an inherent "goodness" in humour (Billig 2005). Moreover empathy, as the ability to relate to or recognize a thing or person, is framed as a static goal to be attained, rather than a fluid human action as part of being physically and emotionally in relationship with other people and as something to continually be nurtured (Foster 2010). Each "outcome" such as humour, empathy, and playing as a distraction from the "real" work of medical professionals is framed in an attempt to take clowns seriously within the very serious business of health care. This is not to say clown practitioners do not or should not support joy and funniness, provide space to relate to others or to express emotions, and disrupt traditional hierarchical power structures in adult/practitioner–child/client relationships; however, we argue these are not fixed goals to be attained in the future trajectory towards "normal" adulthood but rather ways of *living well in the present as children*.

Ultimately, what is predominantly overlooked in this literature is the ways the foolish engagement of clown practitioners contributes to ways of living well in the present and in the world in new ways, including building aesthetic relationships with other people, things, and space/place through emotions, sense and imagination. The purpose, we argue, is not for clown practitioners to "fix" children through their plays but to engage in the art of clown as ongoing, fluid ways of being playful, imaginative, sensory, emotional, vulnerable, and in-relation. As a parallel example, as part of attempts to justify the relevance of the arts more broadly, it is often cited that artistic and performance work has "positive impacts" (i.e. financial gains) on local economies such art galleries, theatre, dance, and live-music acts, etc. (see for example Governenment of Canada 2018). However, we suggest that this argument misses the point. One does not attend a play in a theatre because ushers and other theatre personnel will be employed or because it helps the local bar when you have a drink afterwards with your mates; we suggest this is a welcome accompaniment. One goes to the theatre for a host of aesthetic and non-economic reasons including to experience a story, to be provoked, to experience ideas and feelings as part of a community, and/or to be moved in the moment of the performance.

Exemplars

In what follows we provide two examples to explore these ideas further. The first example, coming from author Donnelly's clown practice, provides a window into the ways aesthetic and relational engagement occurs between clown and disabled child through the art of clown and the practice of foolishness. The second example builds from informal comments made by research colleagues; this example interrogates cautiousness around clowns' foolishness within rehabilitation research and clinical practice, exposing what is predominantly valued as serious in the health sciences.

Example one: foolishness in practice

As our first example, we draw on an experience from author Donnelly's clown practice (also known as Dr. Flap[3]) at Holland Bloorview Kids Rehabilitation Hospital. The details have been modified to ensure anonymity of the child in the story. This example involves 'Daniel' who has congenital myopathy and was nine years old at the time of this story.

Daniel is a wheelchair user who breathes via a ventilator and tracheostomy tube. He has lived at Holland Bloorview since the age of two on the Complex Continuing Care unit. Daniel regularly plays with clowns and was very attached to Holland Bloorview's original clown, Jamie Burnett, who died in 2011; Burnett's clown persona was Ricky. Clown practitioners at the hospital, including Donnelly, were not initially permitted to disclose Burnett/Ricky's[4] death to Daniel due to his family's preferences; however, after several months, the clown practitioners were able to disclose news of his death.

The story described below took place approximately one year after Ricky's death when Dr. Flap was working with fellow clown Nurse Polo who was new to the hospital. At this particular moment, Dr. Flap finds herself without Nurse Polo and she enters Daniel's room. Upon her entering, Daniel demands: "Where IS HE [Nurse Polo]?" glaring at Dr. Flap, who becomes flustered, fabricating a slew of possible reasons for Nurse Polo's absence. Daniel responds with: "Before you come up with a lie, just forget I asked!"

Dr. Flap, feigning shock, insists "But I NEVER, EVER lie!" But Daniel reveals that she has lied – about Ricky. "Remember Ricky?" Daniel prods. "Well, he's DEAD. And you told me he was lost in the forest."

Dr. Flap is amazed and asks for proof of her lies. Immediately Daniel mimes a tape-recorder and plays at "rewinding" the recorder to the place and time when the discussion took place about Ricky. Dr. Flap follows Daniel's lead and enacts the "rewinding" sounds of this imagined tape-recorder with Daniel and physically moves backwards to indicate the backward movement of time. Together Daniel and Dr. Flap re-enact the moment where Dr. Flap tells of Ricky lost in the forest. There is the proof in the re-enactment - Dr. Flap *had* lied!

Dr. Flap then volunteers, "But later I *did* tell the truth; did you record that?" Daniel pauses to think and agrees that, yes, this moment of truth-telling was also recorded. Again, the pair "rewind" the tape together and re-enact the moment where Dr. Flap tells the truth about Ricky. Inside this play, Daniel asks Dr. Flap "Ricky's dead, isn't he?" Dr. Flap responds with "Yes, he is." The imagined "tape-recorder" is switched off. Daniel and Dr. Flap lock eyes, take a breath together and move on to play another game.

As is observed with this story and the ways Daniel and Dr. Flap play together, Dr. Flap/Donnelly as the health care practitioner does not hold privileged knowledge as she expertly determines the clinical course of action with the expectation that child-client Daniel will

comply. Rather, Daniel is an active agent bringing ideas and actions to their playing. He charges Dr. Flap/Donnelly with lying; he instigates the rewinding of the imagined tape-recorder. Daniel's words (for example "you told me he was lost in the forest!") are part of his accusatory actions rooted in feelings towards Dr. Flap/Donnelly, not as a way of relaying information or securing cooperation; Daniel's words are an extension of his actions of accusation and fuel what happens between them.

Dr. Flap/Donnelly attends to the silence of the play, as what *is not* said and what *is* said, and she embraces the ridiculousness of what Daniel extends. She does not stop or resist Daniel's enactment of an imagined tape recorder, for example, nor does she come out of character to have a "serious" discussion about Daniel's feelings and his friend's death. Instead, she follows his imaginative and emotionally-rooted actions and contributes to his playing by making rewinding sounds and physically moving backwards. She additionally does not turn away from his sorrow or sadness and impose a cheerfulness; rather she opens herself to his gestures of sadness for his lost friend by following his play. The ways she plays with Daniel and the foolish relationship she has built with him through the art of clowning opens up possibilities of engaging aesthetically, as sensorily and emotionally, as well as relationally, understood as responsive and reciprocal.

As an adult, Dr. Flap/Donnelly subjugates herself to Daniel through her ridiculous, vulnerable, and brave playing. It is Daniel who leads the improvisation about the moment where Dr. Flap/Donnelly lied about Ricky's death, exposing her "wrongness" as an adult and the failure and vulnerability of the lie. Dr. Flap/Donnelly doesn't cover up the vulnerability of the lie or attempt to move away from her own "wrongness"; rather she exposes herself and her practice to the possibility of becoming "undone" through the play. Daniel's actions as a child challenging an adult through this play must be appreciated. Daniel steps forward with bravery and uncertainty by accusing the vulnerable Dr. Flap/Donnelly, which make bare her ridiculousness in the lie. Through the exposure and exploration of the lie through *embodied and imaginative playing* (not *talking* for more cerebral purposes), Daniel and Dr. Flap/Donnelly together, bravely, come to a new understanding of Ricky's death and their friendship in the present moment. They are not relying *only* on words, talking or "cleverness" to explore; rather they foolishly engage their bodies, gestures, movements, and imaginations. Words here are an extension of their embodied and emotionally-rooted actions, which have emerged out of the silence of their playing as "what *lies beneath* language" (LeCoq 2001, 30). By paying attention to this low-lying action as "beneath" language, we can see the "utility of getting lost" as a "journey through the unplanned, the unexpected, the improvised, and the surprising" (Halberstam 2011, 16). In this way, Daniel is able to live well in the present moment with Dr. Flap/Donnelly as unplanned, unexpected and improvised. Dr. Flap/Donnelly, through her foolishness, is able to support Daniel's being-in-the-world as he imaginatively instigates the play, aesthetically building new relationships with people around him within the hospital space.

Example two: foolishness in research

As our second example, we focus on the ways research colleagues at several Toronto-based academic institutions including scientists, research associates and research students responded when we shared our interest in researching clown practices. When we discussed our research interest in clowns, most people immediately responded with warm smiles at the thought of them (we spoke with eight people). However along with these smiles, we repeatedly heard comments about how the clowns made them nervous. This was expressed in different ways

such as "clowns scare me," or "they make me feel uncomfortable"; however one colleague put it most succinctly by commenting that she was concerned the clown practitioners when encountered in the hospital "would make a fool of her." When pressed further – and asked if was there ever a moment when the clowns *actually* made a fool of her – she responded that no, such an occurrence never actually happened. But she acknowledged it was the feeling of potentially being ridiculed that put her on edge.

This particular example exposes what likely underpins the ways these adults, as (serious) scientists, approach their work and understand what is valued in health care and research. These colleagues are very productive, "successful" adults within children's rehabilitation and disability research. Their comments reveal how "seriousness" is legitimated and rewarded in this field and "the desire to be taken seriously" by colleagues is understood as paramount to success (Halberstam 2011, 6). The health sciences have their own power hierarchies between and amongst professional groups as well as emerging versus senior scholars. Researchers work within these hierarches to establish and improve their standing in the field and in the eyes of their peers. They are rewarded for producing particular kinds of seriousness understood as scientific evidence and associated peer-reviewed publications as "the tried and true paths of knowledge production" (4). The ongoing valorization of certain stable and deeply-rooted routines, conventions and traditions upholds particular disciplines and practices as rigorous and excellent, establishing certain ways of seeing and being in the world as "normal or natural, as obvious and necessary" (9). So invested in this seriousness, this normality and obviousness, even the *thought* of clowns practicing in the hospital led these colleagues to share with us the ways the clowns made them feel uncomfortable, scared them, and left them concerned they would be made to look foolish in front of peers and family. With the revealing of foolishness, there holds the potential to throw doubt on well fought for positions as experts.

The foolishness of clown practitioners, indicated by our colleagues as something to be avoided, upends and exposes the frailty of the models of success valued in the health sciences. The brave willingness to step forward with uncertainty, as "not clever" and as embracing potentially irrelevant and ridiculous "knowledge from below" (Halberstam 2011, 11), is approached as untrustworthy. The foolishness of clown practitioners reveals the ridiculousness of the commitment to "the hierarchies of knowing that maintain the *high*" in particular traditions and practices as limiting (16, emphasis in original). With the overvaluing of being serious and being taken seriously means there is a likely possibility of "missing out on the chance to be frivolous… and irrelevant" and perhaps more importantly "restricts visionary insights or flights of fancy" (6). By placing great worthiness on the "serious" and particular notions of success and productivity, these colleagues, and by extension the health sciences more broadly, become caught up in being "correct" and not risking the potential fruitfulness of wandering in the wrong direction.

With the permeation of seriousness into rehabilitation research and the emphasis of following "the tried and true paths of knowledge production" as having *high* value (Halberstam 2011, 4), it is important to consider what might be missed by getting lost within the *low*. By only focusing on the success of particular forms of knowledge production and scientific validation, rehabilitation emphasizes certain ways of being and doing in the world as more valuable than others. Drawing on different approaches to research beyond the tried-and-true opens up options to explore aesthetic, imaginative ways of being in the world for disabled young people as relevant to them in the present including relationship building and meaningful projects. Driven by curiosity, creativity and uncertainty, we invite fellow scientists to adopt aspects of The Fool within their work, including the willingness to be vulnerable, brave, wrong

and even ridiculous. Without being willing to be exposed as possibly redundant or irrelevant and recognizing the importance of being lost, becoming undone and not knowing, we question whether there is truly the potential to engage in work that is "more creative, more cooperative, more surprising" (3) and making meaningful differences in the lives of disabled young people.

Conclusion

Taking foolishness of clown practitioners seriously in children's rehabilitation invites a reimagining of practices and research. Our interrogation of foolishness and the work of clown practitioners in children's rehabilitation exposes the frailty of particular neoliberal models of success and recognizes "knowledge from below" as a relevant part of "re-think[ing] the project of learning and thinking altogether" and what it means to be productive (Halberstam 2011). The recognition of this accessible mode of low-ness opens up what might be possible for rehabilitation and health care research and practice including the support of relationship building and meaningful projects, as well as a continued nurturing of aesthetic and pleasurable being-in-the-world in the present moment as valuable unto itself.

Our two examples, of the foolish practices of Dr. Flap and what foolishness exposes about rehabilitation research, provide windows into the limits of rehabilitation's emphasis on seriousness. In both examples, the foolish practices of clowns uncover the ways hierarchies (for example between children - as lower forms of adults-in-training - and adults - as higher-level "experts"; among professional groups; between junior and senior scholars) are traditionally manifested and enacted in rehabilitation and health care more broadly; how certain *high* forms of knowledge are traditionally valued over *lower* embodied, imaginative and active knowledge forms; as well as how certain kinds of neoliberal productivity and "success" are valued over other ways of being in the world. The exposure of these things provides the opportunity to re-imagine rehabilitation practice and research that focus on supporting children's different ways of being and doing.

We propose that foolishness, as embodied and practiced by clowns in the hospital, is an important principle for all hospital practices. Clowns are not the handmaidens to other more "serious" medical and rehabilitation goals; rather we suggest they provide a kind of *aesthetic approach to care,* as responsively and reciprocally providing playful, imaginative ways for young people to sense their own bodies in the present moment, in space and with other people. Here we join scholarly conversations across disciplines to consider the interrelationship among aesthetics, relationality and care (see for example Thompson 2015; Gray 2019; Kontos and Grigorovich 2018; Dupuis et al. 2016; Parsons et al. 2017). Fundamental to this aesthetic approach to care is the willingness to be foolish, to draw on one's embodiment and engage vulnerably and reciprocally with another person with the willingness to fail and be ridiculous. This interrogation and re-claiming of clown practices as foolish offers an opportunity to other health practitioners and researchers to imagine how they might include different ways of approaching their work.

Without suggesting health practitioners and researchers lose sight of the important work of managing disease and symptoms, we invite colleagues to embrace different approaches to providing care and conducting research for *children as children in the here and now*. In clinical practice, more traditional medical, functional and developmental goals can be considered alongside a child's aesthetic and relational wellbeing, including joy, sadness, anger, pleasure, as well as being in the present moment in the hospital setting with other people. As part of this, clinical *relationships* between practitioner and child can be a central focus of rehabilitation

practice as much as clinical *outcomes*. Clinicians might put aside assessment checklists or outcome measures from time to time to focus with young people on relational and/or self-expression, mutual and creative exploration or just being together. Similarly in research, risking stepping forward with uncertainty with the brave acceptance of potential failure or of being exposed as a fool might be welcomed in the quest to creatively think about and engage with disabled young people differently. We encourage researchers to consider different approaches to research that are more comfortable with ambiguity, doubt, mutual exploration of ideas and co-production of knowledge, and where outcomes are not measured or known in advance (such as arts-based, or post-qualitative approaches). Openness to these alternative or "risky" forms of research, either in one's own research or in acceptance of others' work, has the potential to expand knowledge horizons and re-imagine researcher-participant hierarchies and relationships. Future challenges, then, are to seek out these foolish opportunities across practice and research and further consider the relevance of aesthetic approaches as fundamental to more humanistic hospital practices.

Acknowledgements Julia Gray is supported by a Social Science and Humanities Research Council of Canada Postdoctoral Fellowship; Matching funds are from The Kimel Family Opportunities Fund through the Holland Bloorview Kids Rehabilitation Hospital Foundation.

Barbara Gibson holds the Bloorview Kids Foundation Chair in Childhood Disability Studies.

We would also like to recognize friend and colleague Jamie Burnett, who was Holland Bloorview's first therapeutic clown practitioner, was author Helen Donnelly's clown partner for three years, and who died in 2011 at age 33. Jamie practiced as a truly foolish clown: his work inspired his colleagues and stretched the field of therapeutic clowning. We are forever in awe of his commitment and passion.

Endnotes

[1] We use the term 'disabled children' rather than 'children with disabilities' in keeping with current usage in critical disability scholarship. Disability is not considered a condition of individuals as is implied by the phrase 'with disabilities' but rather something experienced as a result of prejudice, discrimination and social exclusion.
[2] Throughout this paper, we will refer to both 'clown practitioner' and 'clown persona.' As a general note, a 'clown practitioner' refers to the practitioner/performer who embodies the clown persona as the character on the unit; the clown practitioner takes on a 'character/clown' name and persona.
[3] Donnelly's clown persona is named Dr. Flap.
[4] As part of this example, we will use the clown persona name (e.g. Ricky or Dr. Flap), when referring to the clown character in the story, and we will use both clown persona name and practitioner last name when referring to the clown practitioner as health care practitioner (e.g. Ricky/Burnett or Dr. Flap/Donnelly).

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