

Applied theatre in hospitals

I position my TCH bedside methodology broadly under applied theatre. Applied theatre is an inclusive term used to host a variety of powerful, community-based participatory processes and educational practices. Historically, applied theatre practices include Theatre-in-Education (TiE), Theatre-in-Health Education (THE), Theatre for Development (TfD), prison theatre, community theatre, theatre for conflict resolution/reconciliation, reminiscence theatre with elderly people, theatre in museums, galleries and heritage centres, theatre at historic sites, and more recently, theatre in hospitals (Nicholson 2014).

‘Applied’ refers to an act that takes theatre practices out of the obscure black boxes and brings them back to the ‘open air’ [...] [It] should be understood as a contemporary theatre practice that has many different histories and varied rationales depending on where it is happening.

(Thompson 2012: xix)

Thompson concentrates on the evolving process of applying theatre to community audiences and invests in learning about being human, being a citizen and being empowered to think and act in the particular moment and context within which theatre takes place. He also argues that the ‘act of applying [theatre] is an unfinished process that encounters situations that are themselves evolving and not fixed examples of social practice’ (Thompson 2012: xxi). But aren’t all arts an unfinished process? Arts change over the years because humans change and environments change. Different styles of theatre and forms of theatrical applications outside traditional venues have been discovered, without which we would still be making theatre for middle-class audiences who can afford to attend.

From my research of applied theatre interventions in healthcare, I believe that theatre in hospitals *is* an unfinished process for many reasons. First, it encounters examples of an artistic practice that is continually evolving within the development of the arts in healthcare settings. This is the growth of the arts and health field that I discussed in the introduction. Second, TCH is the product of an unceasing experimentation with the art form in clinical contexts and environments, an artistic need to move on to new discoveries of the way theatre works in the community, investigating the needs of communities. As with all experimental practices, it desires answers. Questions created by the needs of hospitalized children, the specific demands of clinical space and time, the physical and emotional condition of the

audience, the opportunities for making a difference in children's lives, and the occasional disappointment of having opportunities denied, are central to the experimentation with applied performance in hospitals. Third, TCH is an unfinished process of articulating the experience of hospital performance in words that make sense to those who have been involved in the experience, both the artist and the audience. The artist often struggles to find meaning in illness and pain: whether that is in direct relationship with family members or in professional relationship with audiences. Holding onto the principle, 'theatre for all, the sick, the poor and the sufferers', is a strong starting point, a creative motive, an enthusiastic beginning towards understanding theatre and communities in contexts of illness. Finally, TCH is an ongoing cultural process with potential to develop further from its strong interaction with children in hospital and the surrounding setting. The setting is an important aspect of TCH work but not more important than performance itself. Theatre that is 'applied' to community settings does not lack in aesthetic integrity (Brodzinski 2010). It is only fair to say that TCH, as all applied theatre practices, is rooted in the role of the space, the story, the characterization and the audience-artist relationship. At the same time, hospital performance develops in a continuing dialogue with the setting and the clinical context. TCH is always in transition and thus, perfectly positioned in applied theatre's unfinished businesses.

TCH is an interdisciplinary process. The act of applying theatre in relation to illness, like other research in this field, takes the artist into related disciplines including health and medical humanities, child wellbeing, the philosophy of illness and psychology. Primarily, the artist serves the arts and although they familiarize themselves with other disciplines, and learn from them and through them, they exercise learning from the perspective of the art form. The TCH artist uses knowledge from other disciplines to inform practice in hospital and create portable, child-centred, entertaining and relaxing performances that are offered to sick children while undertaking treatment. The objective of TCH is to harness theatre as an art form to improve child wellbeing in hospital while contributing to the wellbeing of those who care for them, such as their parent/carers and by extension, the wider family. The artist becomes a 'guest' in the house of illness but never stays too long. They enter the world of sickness for a while, bringing to the lives of children an air of normality that is associated with life outside the hospital, and they exit quietly – no applause and no 'bravos'. Working on the margins of the healthcare system is not necessarily a bad thing. 'One of applied theatre's strengths is in its status as the outsider, the visitor and the guest' (Thompson 2012: xx).

This viewpoint encourages me to say that the outsider artist works in collaboration with healthcare but does not serve it nor interrogate it, which reminds me of the role of the TiE practitioner who works in but does not serve the educational system. The artist's job in hospital is to reconnect the arts with wellbeing, which suggests a holistic approach to illness and healing that is rooted in ancient civilizations and systems of treatment and cure. For example, Hippocratic medicine treated the patient as a 'whole' (body, mind and spirit) and not just the symptoms of the disease. Hippocrates 'prescribed' massage, herbal diet,

hydrotherapy, sea bathing (Osborn 2015) and theatre performances in the open-air Theatre of Cos Island in Greece to treat the body, the mind and the spirit. These experiences were enriched by worshipping and participation in religious ceremonies, and offered the patient a rounded caring experience and improved wellbeing. Although no claim can be made that my TCH practice draws on Hippocratic values exclusively, one sees a connection between believing in alternative supportive treatments and offering theatre as an alternative method of supporting patients. The TCH artist enters healthcare with the belief that theatre works as a complementary 'prescription' to medication and clinical remedies. Whereas many people in western societies speak with confidence about traditional medicine and how it works for the patients, TCH makes a holistic proposition.

Research evidence strengthens this view. Kostenius and Öhring (2009) and Aldiss, Horstman, O'Leary, Richardson and Gibson (2008) argue that theatrical interventions can reduce child pre- and post-operative clinical stress and enhance their wellbeing. The TCH artist can use these findings to inform their practice. This perspective insists that there is no professional from within the healthcare system, no doctor, nurse or therapist, who can claim holistic practice because their practice is constructed around traditional medicine. Even if they do support holistic thinking, they are usually limited by medical regulations not to apply it to their patients. The visitor-artist faces no such limitations. The artist brings into healthcare a non-medical approach to illness and a system of values that is new to the clinical context. Those values – aesthetic, social, cultural, and ethical – may be incomplete and even irrelevant to the hospital context but they may generate an integration of artistic and clinical values (I oppose the imposition of artist values upon the clinical and vice versa) with aesthetic fulfilment. A commitment to these values explains why being a guest in healthcare is a good thing. TCH seeks to benefit children's wellbeing in ways that the healthcare system cannot achieve alone.

Those artists who engage in TCH, as many applied theatre practitioners do, are often motivated by the desire to make a difference to the lives of children through theatre. In that case, they may be elevated by idealism and altruism, courage and compassion. They come from outside the healthcare system to help and support children, give them normality and hope, bring a smile to their faces and change the ways they experience illness during their hospital life. This is the 'guest in applied theatre' position that I discussed earlier. What can be wrong with that? Nicholson (2005) suggests that working in a context (clinical) that is not theirs may create an 'uneven balance of power' between altruist (the applied practitioner) and recipient (the audience) and she argues that

Because practitioners often work in contexts in which they are outsiders, for all kinds of reasons their good intentions about 'helping' others in 'need' may be construed as patronising or authoritarian, contributing to keeping 'others' on the margins rather than taking centre stage.

(Nicholson 2005: 30)

From this standpoint, Nicholson (2005) discusses the reciprocal relationship between altruism and self-interest, between the artist and the community in applied theatre practice, and the effect of this relationship on the development of social citizenship. In its best collective form, applied theatre is offered to the community as a gift. It is, nevertheless, not always obvious why and how people need help and thus, what is intended to be beneficial for the audience often turns out to be more beneficial for the giver, the applied theatre artist. This is because the diagnosis of the 'needs' of others may fall into personal interpretation. The artist, for example, assumes that a child in hospital needs a performance for a reason. The artist might assume that one child needs the performance more than another does; a child with critical illness needs it more than a child who is in hospital for a short stay, but again this is only an assumption. In fact, the artist does not know which child needs the performance and therefore they rely on the children themselves to decide if they want the entertainment or not. The artist does not know what it is exactly that the child needs. Therefore, they cannot make any accurate predictions about the ways in which the performance will support each child. Altruism sometimes acts as a blind person who cannot see with their objective senses but can only perceive things with their minds. Moreover, because the blind man has a desire to see, his perception of what might be there can almost feel real. The altruistic artist can sometimes perceive the needs of the audience from such a personal and subjective perspective as if they were blind. They are passionately motivated to benefit children in hospital but can only perceive and interpret things through filters of personal understanding. However, altruist's authority to make interpretations of the child's needs and decisions about the work needs attention. In my experience, the artist occasionally perceives their role as rescuers who enter hospitals to show their ability to love and perform for those who are in need. However, the performance is clearly not a heroic act, and certainly should not appeal to the artist as a victory in the battle with the child's illness. Applied theatre practice is a process that may require bravery, care and compassion, especially in communities that have experienced suffering and trauma, but it should not be seen as a relationship between artists who act as heroes and audiences who are victims waiting to be saved.

Calvert (2015) summarizes deep-seated concerns about heroism in applied theatre work as these have been developed from provocations presented at the Theatre and Performance Research Association (TAPRA) Tenth Anniversary Annual Conference, 3–5 September 2014. Calvert discusses shared anxieties amongst TAPRA applied and social theatre working groups about 'the relationship between heroism [...] and the inflections of risk, bravery, care and compassion that identify the hero, and the tensions between individual and collective empowerment' (Calvert 2015: 175).

In addressing these concerns, applied theatre becomes an exercise in resolving the tensions of power and control between the practitioner and the audience, the individual and the community, the artist who is representing others and the others who are dependent on them as the representors of their own stories and rituals. Applied theatre practitioners should be aware of the idea of giving and what this 'giving' can teach them about the act of applying theatre to communities. We should be wary of egoism. Theatre should be a gift that the artist

gives to themselves, a special feeling of completion and happiness, but it is also a gift to the audience. There should be no expectations of return or ownership. What a dishonest and dangerous image of the community artist that would be! Thus, the emphasis on altruism and heroism in a TCH context should be countered with an alternative view that rejects egoism and self-centred attitudes towards acting for children who are sick, and holds that the value of the work lies in encouraging the children to work together with the artist to make performance happen in the moment. This type of encouragement is complex, but suggests a shift in the power that a child experiences when they are ill, as the artwork is created and offered to the children with scope for activating them, engaging and involving them in it, at various levels. The notion of 'empowerment' in applied theatre and what it means in relation to hospital audiences is a good starting point for the discussion of the fictional as a deviation from painful realities. But first-place is given to the definition of hospital audiences.

TCH audiences consist of children of all health conditions during their stay in hospital and children of all age groups till early adolescence, from babies (months old to toddlers), and early years up to 12. TCH audiences usually lie in their beds but if their condition permits it, they may also move to the hospital's play centre, education centre and school or physiotherapy room, if this is the only other suitable space for TCH to happen. Very few hospitals have their own theatre and even then, some children are unable to leave their beds to visit another room where a theatre performance is taking place. So, often the artist resolves, with the support of the nurses and play specialists, to overcome this difficulty by performing bedside or in other hospital rooms convenient to the child. TCH's chosen audiences are considered by society as 'patients' but TCH 'disturbs' the norm and treats them as audiences. The artist invites them to collaborate and participate in a performance that is distinctive for its intimacy, sensitivity, generosity and respect for the person, the individual – not the child labelled as 'patient'. Every performance in hospital is different. Every artist takes a different ownership of the theatrical event in the space where it takes place. Every child embraces the opportunity to participate in the performance in different ways. In this way, the artist and the child get involved in different aspects of the play, taking away different benefits from it. This personal experience of TCH makes every performance unique, unpredictable and unrepeatable. It makes every child in hospital special, every participant exceptional.

Returning to the idea that TCH is a process of 'empowerment' in performance, I need to clarify that for ease of expression I use the term 'empowerment' throughout the book, but the meaning I give to the word is specifically related to the child's personal awareness that they have the power to participate in the performance. The artist by no means gives power to the child to play, but rather creates the dramatic conditions and playful atmosphere to encourage the child to use their own power and ability to play. In the absence of an English word, at least to my knowledge, that defines the power of being aware of having it, I cautiously use 'empowerment'. I spent a lot of time working on the concepts of applied theatre practice and empowerment in my doctorate thesis (Sexton 2004), from which I borrow some ideas for this book. Empowerment (in translation) has been used as a term for democratic audience treatment by Augusto Boal to describe his ideas about awakening

critical consciousness. Boal is known for encouraging spectators to participate actively in performance and become actors (thus, the audience became spect-actors). He writes in his first and most influential book, *Theatre of the Oppressed*, that

the liberated spectator (the one who discusses plans for change, makes decisions, tries out solutions and trains himself for action), as a whole person, launches into action. No matter that the action is fictional; what matters is that it is action!

(Boal 1979: 122)

For applied theatre practitioners, it has not been difficult to use Boal's notion that audiences need to be engaged in action, because applied theatre is about taking action in education and in society. Boal's techniques came to offer the applied theatre practitioner a kind of reassurance that they can make effective theatre that can change passive spectators into active participants an effective theatrical phenomenon. Empowerment develops by addressing communities' specific social problems, in order to be truly and deeply engaged with the performance and participate actively towards a solution of the problems presented. Boal's techniques are widely used in order to 'problematize specific issues', and help audiences relate the problem to their own lives, positions, values and attitudes in the same or similar situations by asking, 'what would or should I do if I were in the shoes of this character?'

Boal's theatrical practice revolves around social transformation and revolutionary theatre. He is, metaphorically speaking, a practitioner who asks his audiences to fall into overflowing rivers (social problems in particular contexts) and for his actors to assist in rescuing the audience. This makes his theatre extremely 'dangerous' and exciting for both actors and audiences because it makes those involved both interested in action and responsible for their own actions, which again is a political position with clear educational intentions. The unique value of Boal's interactive theatre has always relied on the fact that communities as spectators were educated through theatre by being required to rehearse their own lives during the performance and by putting themselves in specific dramatized situations through forms of participatory theatre. Boal (1979: 142) said, 'instead of taking something away from the spectator, evoke in him a desire to practice in reality the act he has rehearsed in the theatre'. That idea enabled practitioners such as TiE actor/teachers to act in the praxis of drama and communicate ideas and notions in groupwork (Jackson 1993: 28). The impact of Boal's work is evident in TiE programmes, and other forms of applied and social theatre that offer learning opportunities for the audience to experience situations of 'real life' in a dramatic context, and a way of living and exploring complicated and sensitive issues. Applied theatre is a process that takes theatre into new, broad, not didactic, forms of learning about a person's role in community life by raising their awareness of what they can achieve.

According to this perspective, therefore, the hospital performance provides a framework within which the artist encourages the child to participate in the fiction, investing in a positive change of moods and behaviours that may happen during and after the performance.

Helping the child to become less bored and more active while being ill is significant. TCH proceeds with realistic aims that can be achieved, and does not claim transformation of communities as applied theatre practitioners traditionally aim to do. Applied theatre work has been recognized for its ambition to 'learn from each other in the service of community', a collectivism that allows each member of the community to have a say, and question social reality in order to create local culture and identity in sociopolitical theatre programmes. I am fascinated by the mission of applied theatre practice to improve societies, but the trick is to be aware of the limitations of this method when defining TCH practice. Transformation is a big claim, and often it is also an unrealistic promise. This is because applied theatre practice is open to the unpredictable, the unexpected, and sometimes, the unmeasured. My intention is not to criticize the intentionality of applied practice. Rather, it is to orientate TCH within its range as accurately as possible and avoid laying claims for social change and major changes in children's lives where these do not exist.

Unlike other applied theatre forms, such as Theatre for Development and Theatre-in-Education, which use theatre towards social and political transformation, TCH uses theatre as a process of wellbeing. The expression 'political' here demands an explanation because it affects the analysis of TCH practice. Applied and social theatre 'borrow' from the climate of the 1960s – the 'political' difference and the 'alternative' culture – the notion of making theatre in different, liberal, radical, creative, unconventional and spontaneous ways. TiE's 'politics', for example, are concerned with systems of government; the process by which these systems might change; the active engagement of pupils (audience participation) in the practical processes of changing society; the relationship between the systems of government and the pupils' own ideas, which may oppose and develop or defend and sustain the sets of values and ideologies that already exist in societies. Therefore, to identify applied theatre as 'political' means that it is as political as any type of theatre can be. Graham Holderness (1992) notes:

Theatre may be 'political' without becoming 'political theatre', in the sense that a play may represent political matters or address political issues, in exactly the same way as a play can represent love, or old age, or poverty, or madness; if, that is, the play performs that representation of politics in an objective way, without taking sides.

(Holderness 1992: 2)

Within this context of 'political', applied theatre is political because it always deals with social values and specific dilemmas that, ideally, affect people's social ethos and attitude. Even when not dealing directly with 'hot' social issues, applied theatre practice embodies transformation and social change in the ways that it helps audiences become capable of researching, questioning, investigating and daring to oppose what they have been used to believing or doing. Above all, it is political, one way or another, either by reinforcing the pre-existed values and ideologies, or by questioning them for change. So, art and politics are inseparable. But are all applied theatre productions alternative? The question is whether all

practitioners are treating audiences as active participants who are allowed to make judgements; are taking a brave step in dealing with controversial issues by, ideally, trying to be objective; are being sociopolitically conscious and aiming to encourage their audiences to analyse society; are raising a thematic range of socially sensitive issues to question preconceptions in society; are developing outreach to audiences from various social classes (including the working-class audiences 'neglected' by conventional theatre); are developing an artistic and aesthetic freedom while negotiating these issues with audiences in creative ways; are focusing on locality and acknowledging the importance of making theatre in the service of community; are choosing to perform outside theatre venues; are choosing to challenge boundaries and perform to prisoners, the disabled, refugees, the poor and the elderly – those forgotten by the governments; are intervening in social environments and making theatre with people who would not normally make theatre; and are believing in the human and social possibility for change.

Here, a 'yes' to the multi-scaled question above would be naive and unrealistic. We need to consider that applied theatre can still be creative in 'seeing freshly with new eyes and new understanding' with permission to 'look again, to reconsider, to find new connections between the actual and the possible, the given and the imagined, the personal and the social and to investigate alternative pictures of the world' (Jackson, A. 2007: 146). Indeed, applied theatre can still be effective without making big claims of radical, unconventional ways of working with communities. Applied theatre works on the margins of social, educational, cultural, and justice and healthcare systems, and, at its best, encourages community engagement; raises social and personal awareness; reconnects communities after traumatic incidents of crisis; comforts and improves a sense of belonging to a group of people with similar interests, passions, experiences and needs; reflects on the needs of communities and individuals; and initiates debates about the improvement of our societies. Applied theatre is, therefore, not a transformation, nor political change, nor social reformation, but something greater. It is a process in progress that involves our active participation in making, remaking, constructing, deconstructing, analysing, reviewing, questioning our practice, challenging our ideologies, and criticizing and recreating our lives whether we agree or disagree with change, whether we aim for change or not, whether we think ourselves capable of bringing change to ourselves, others and the world or not. It is a practice in exploration, investigation, imagining and hoping for a better world. Thus, not all applied theatre practitioners apply forms of theatre that strictly aim at political and social transformation.

This is to be welcomed and coincides with Michael Balfour's (2009) view that applied theatre practice is 'a theatre of little changes', a playful practice between the artist and the audience, a theatre with focus on aesthetics and a theatre that moves away from an emphasis on the need for sociopolitical change. Balfour argues that where aesthetics are central, the little changes emerge from the quality of the process that participants go through in making theatre, the quality of the open relationships that are established during the process, and the quality of the work that is created. Although there is no specific definition provided of these little changes,

it seems to me that this term implies progress in experiencing theatre, community life and personal relationships with others in creative, inspired and safe ways within the dramatic.

TCH is also theatre of 'little changes'. It creates possibilities for the child to explore the aesthetic dimension of theatre in hospital settings through creativity, imagination and active participation. It makes no big claims for the personal and social growth of the child, but it does provide space that allows them to inter-play, interact and communicate with the actor. The child and the artist ideally meet together in the story and establish a relationship as an audience-actor in the fictional. The quality of the relationship and the process of engaging in the story are defined by respect and recognition of the child as important to the performance. When this happens in hospitals, it demonstrates a change in the routines and habits of hospital life. The child is not an inactive patient in bed anymore. Rather, the child becomes an active participant in a creative event located in a hospital. The child does not depend on actors to make decisions for them about the story. Rather, the actor invites the child to share ownership with them. This is an area that will come into the discussion of my practice again and again in the next chapter. The TCH artist is present *with* the child in drama, and both the artist and the child are part of the artistic process. That is what I call the quality of the process. Thus, the analysis of the artistic process matters to TCH because it helps us understand the effects of the aesthetic on children with illness.

To the eyes of the artist who lacks acquaintance with TCH, these effects may not seem to be changes at all. The inexperienced lack skills to *see* the quality in process. Besides, these changes can only be judged accurately within the process and the particular context in which the theatrical experience takes place (Prendergast and Saxton 2013). What is 'little' in one context may be a great achievement in a different context. A smile, a laughter, a song, a spontaneous gesture and an improvised word are not little things when they come from a child who is experiencing pain and stress. These are not indicators of little changes. In fact, these can be changes that make a great difference to the ways children deal with the ordeal they face during their stay in hospitals. This understanding broadens applied practice's prospects and potential. It expands its purpose and gives different meaning to change. A positive change in the mood and behaviour of a child in hospital may look less glorious and triumphant in the eyes of the activist-artist but it is magnificent, genuine and valuable in the eyes of the child.

Over the years of researching the impact of bedside theatre on children, I have come to realize some important components of this positive change: an acceptance of hospital theatre performance as a flexible medium that is not preoccupied by determined outcomes; an awareness of the child's illness as an aspect of life; an adoption of a more empathetic approach to hospital performance by the artist; and an awareness of the quality of the collaboration between the artist and the child and the ethics that are attached to it. For example, the artist recognizes that while the audience is in need of support and entertainment to improve their wellbeing, the children have the right to participate or not to participate in the theatrical experience. TCH is about respecting the child's unique situation and clinical condition.

This is particularly difficult as talking about illness and working with individuals who suffer from it is often a 'taboo' topic. People do not know what to think of illness, what to feel and what to say but this needs to be overcome. TCH is a form of applied theatre that facilitates rich opportunities for maintaining optimism and self-confidence through creative participation in theatre. This is what I call the effects of 'empowerment' within TCH.

Hospital performance with children is an organic process in which the artist integrates the child's responses and uses them for the growth of performance. Far from performing to the child, the TCH artist is responding to the child's availability: what the child wants, what the child can do and what the child does in the moment. As they walk into the hospital room, the artist uses their perception to notice any specific tired, fatigued or lethargic moods in the child. Facial expressions, gestures and verbal communication offer the artist some indication of how the child is and how he or she is responding to the conditions in the room. These indications will guide the artist in facilitating the performance as a living and evolving experience with the child. The child becomes central to the synthesis of the actor-audience relationship and part of the making of theatre in hospital. This process has a certain degree of organic plasticity, a kind of elasticity based on improvisation involved in it. This means that although there is a script, the structure and pace of the TCH performance can be altered: making it shorter or longer than initially rehearsed, cutting or adding lines to the script, including or not including singing, using or not using puppets and props, and so on. The 'stretching' of structure and pace aims to create a flexible performance that is sensitive to the needs of the child. This 'stretching' requests the artist to be attentive and responsive to the child's ability and mood when they meet. Because TCH operates in agreement with the child that they will make the performance their own together, they are free to speak or not to speak during performance. They are free to act or not to act, to ask questions or to fall asleep, to bring their soft toys in, to interact and enjoy the performance too, or to stop the performance at any point and rest. Therefore, the TCH artist needs to be confident to invite the child to share control of the performance.

This is not unusual in applied theatre practice. TiE, for example, recognizes audiences as valuable participants in the evolution of the performance. I have been involved in TiE programmes all my life in the United Kingdom and abroad and from my observations of audience participation in hospitals I have come to realize that audience participation is challenged in hospital settings. Theatre-in-Education (TiE) empowers children to become active and critical learners through theatre in educational settings (Jackson and Vine 2013). TiE audience participation is used to help children to learn in alternative ways within an *aesthetic framework*, as Jackson (2007: 152) explains in his book, *Theatre, Education and the Making of Meanings*, one that 'allows actors and audience to meet on metaphorical ground'. He argues that it can be created anywhere in and outside a conventional theatre venue. If the conditions are right, if the focus and the purpose of the event are clear, if the artistic conventions of space and time are agreed, and if the physical space is appropriately configured, then the audience will be in a position to be open to the theatrical experience and gain pleasure, awareness and insight into the meaning of life.

I would add to this argument that if an aesthetic framework is effective, it creates opportunities for the audience to express their ideas and emotions in the fictional with safety. In TiE programmes, for instance, the art form provides audiences with the conditions to examine the implications of the issues they explore in drama enabling them to explore different perspectives of contemporary themes within the security of the art form (Readman 1993). Security is associated with the notion of how a theatre participant acts in protected and unthreatened fictional situations. Readman's position compels the artist to ask whether applied theatre is a practice that forces the audience to forget about their real lives and pretend that what they experience on metaphorical ground is true (when they know that it is not) and behave as if their real life of encountering difficulties and pain is not true (when they know that it is). Should the fictional be seen as a safety net protecting audiences from reality? Applied theatre should aim to offer opportunities for involvement in the fiction, which may enable the audience to transport to another location at another time and experience a story that may relate to their true lives. However, does it aim to erase or challenge reality? Can emotions become diverted? Can trauma in communities, the emotional pain of refugees, the nostos of immigrants, the anxiety of prisoners, and the fear of death in cases of children facing critical illness be forgotten? Should theatre aim to help the audience divert from reality for as long as the performance lasts or ignore reality? Are we comfortable with this role of applied theatre? These questions reflect some of my concerns about the meaning of theatre in hospital, the experience of illness, and the stress that is often attached to it; concerns that are commented on throughout this book.

My view is that TCH is a reciprocal experience of theatre *through* illness and the experience of illness *through* theatre. What I mean by this is that theatrical experience is used to help children experience their illness differently and not to ignore it. This is achieved by encouraging children to do things that they are not expected to do as patients (play, laugh, sing and even dance), and collaboratively enjoy theatre as a lived experience. All this liberates them from passivity and boredom. It is a moment-by-moment experience where one gesture, one line and one song, is leading to another. When this kind of empowerment is achieved in TCH performances, it enables the children to experience new ways of staying in hospital, something they did not know how to do before the performance, something that no healthcare system, doctor or nurse could teach them. Successful aesthetics can lead the people involved towards paths of theatrical experience and new types of learning.

One of the most significant things about this new insight into the world of ill children through theatre is the child's agreement to become involved in the artistic practice. When participation is achieved, the child is recognized for their ability to be creative, to respond verbally and physically. Each child brings something into performance that could become essential to the experience of theatre. All responses, all moods and all behaviours are valuable because they have something to contribute to a composition of new theatrical experiences, and by extension, to new experiences in the child's life. TCH places the child in the centre of the performance in dialogue with the artists, offering them confidence and self-respect. As the TiE practitioner acknowledges the child as a learner-participant capable