

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

**ProQuest Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600**

UMI[®]

The Role of Playful Humor in Art Therapy

Elizabeth A. Adams

A Research Paper

in

The Department

of

Art Education and the Creative Arts Therapies

**Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
Concordia University
Montréal, Québec, Canada**

September 2002

© Elizabeth Adams, 2002



**National Library
of Canada**

**Acquisitions and
Bibliographic Services**

**395 Wellington Street
Ottawa ON K1A 0N4
Canada**

**Bibliothèque nationale
du Canada**

**Acquisitions et
services bibliographiques**

**395, rue Wellington
Ottawa ON K1A 0N4
Canada**

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-74861-8

Canada

Abstract

The Role of Playful Humor in Art Therapy

Elizabeth A. Adams

A pilot study was conducted to explore the role of playful humor as an adjunct to art therapy with children from families with dysfunctional relationships in crisis. The combination of play and art therapy is recognized as effective with children; however, the role of humor in this setting has not been reported. Six children (3 male, 3 female) from ages 9-15 years were studied for a 3 to 7 month period. Each child engaged in non-directive art therapy with humor introduced in the form of jokes and playful interchange throughout the therapy. Detailed records were kept of the humorous interplay including reflexive notations by the therapist/investigator. It was observed that humor facilitated a rapid formation of a therapeutic alliance, establishment of the play space and creation of a playful atmosphere. This playful atmosphere facilitated the expression of feelings and advanced the working through of problems. As therapy progressed, the children developed a greater receptiveness to humor, as they expressed their feelings and tackled their problems through playful art expressions. This enabled them to gain a degree of mastery over their problems. The therapy contributed to the children's development of a healthy humorous outlook toward the self and to life in general. While a larger sample population needs to be studied, this pilot study demonstrated a beneficial role for humor in conjunction with art therapy and play with children in family crisis.

Acknowledgements

I am grateful to George who could always make me laugh, to Irene Gericke who reminded me to laugh through the grim bits of the research process, to Elizabeth Anthony who gracefully read and edited my writing and diplomatically helped me to focus on one funny situation at a time and especially to Septimus Rumsey who was my most beloved clown and mentor who modeled a way of seeing human beings as precious and life as an adventure.

This work is dedicated to Jennifer and Nathan and to all the children who have shared their playful humor with me.

Table of Contents

| | |
|--|-----|
| Table of Figures | vii |
| List of Tables | vii |
| Chapter 1: Introduction..... | 1 |
| Chapter 2: Literature Review | 5 |
| Nature of Humor | 5 |
| Humor In Children..... | 12 |
| Nature of Play | 17 |
| Connections Between Humor and Play | 21 |
| Humor in Classical Psychotherapy | 22 |
| Humor in Creative Arts Therapies..... | 26 |
| Children with Mood and Behaviour Disorders | 29 |
| Chapter 3: Introduction and Methodology..... | 39 |
| Introduction to the Research Study | 39 |
| Methodology | 40 |
| Session 1: Establishing The Playful Framework..... | 40 |
| Ongoing Therapy | 42 |
| Data Collection | 47 |
| Termination..... | 49 |
| Chapter 4: Observations | 51 |
| Session 1: Establishing The Playful Framework..... | 51 |
| Sessions 2-6: Strengthening the Playful Framework..... | 61 |
| Middle Therapy: Exploring the Playful Framework | 69 |
| Termination | 91 |
| Chapter 5: Discussion and Theoretical Viewpoints..... | 99 |

| | |
|---|------------|
| Chapter 6: Conclusions | 112 |
| Recommendations for Future Research | 114 |
| References..... | 118 |
| Appendix A: Art Therapists Survey..... | 129 |
| Results | 129 |
| Added comments | 130 |
| Discussion..... | 131 |
| Conclusions | 131 |
| Questionnaire..... | 132 |
| Appendix B: Consent Form | 133 |
| Appendix C: Observations and HOHO Charts..... | 134 |
| Appendix D: Case Histories..... | 137 |
| Case 1: Cheryl | 137 |
| Case 2: Daniel | 138 |
| Case 3: Amy | 139 |
| Case 4: Jason..... | 140 |
| Case 5: Arthur..... | 142 |
| Case 6: Tanya | 143 |
| Appendix E: Partial Transcript: Session 3, Jason | 146 |
| Appendix F: Termination Letter, Daniel | 153 |
| Appendix G: Diploma for Imaginative Thinking | 154 |

Table of Figures

| | | |
|------------|---|----|
| Figure 1: | Amy: Bad dog drawing | 65 |
| Figure 2: | Amy: Her family | 65 |
| Figure 3: | Jason: Dino-dragon, carrot, pencil and dragon | 66 |
| Figure 4: | Amy: I love mice | 66 |
| Figure 5: | Amy: Cat with food | 75 |
| Figure 6: | Amy: Cats in Hawaii | 75 |
| Figure 7: | Amy: Mr. Meanie painting..... | 76 |
| Figure 8: | Amy: Mr. Meanie sculpture..... | 76 |
| Figure 9: | Amy: Ms. Cheerful..... | 82 |
| Figure 10: | Jason: Bad dream, chained | 82 |
| Figure 11: | Jason: Monster jail with sign | 83 |
| Figure 12: | Jason: Bad dreams | 83 |
| Figure 13: | Jason: Cafeteria | 85 |
| Figure 14: | Arthur: Fire hydrant – coin bank..... | 85 |
| Figure 15: | Jason: Roasting marshmallows apparatus..... | 86 |
| Figure 16: | Amy: Polar bear | 86 |
| Figure 17: | Tanya: Cartoon number 1 | 96 |
| Figure 18: | Tanya: Cartoon number 2 | 96 |

List of Tables

| | | |
|----------|---|----|
| Table 1: | Summary of Assessment Data..... | 52 |
| Table 2: | Humorous Occurrences for First Six Sessions for Each Client | 58 |
| Table 3: | Time Variability of the Therapy Experience..... | 69 |
| Table 4: | Humourous Occurrences: Cheryl | 71 |
| Table 5: | Humourous Occurrences: Daniel | 74 |
| Table 6: | Humourous Occurrences: Amy | 77 |
| Table 7: | Humourous Occurrences: Jason..... | 81 |
| Table 8: | Humourous Occurrences: Arthur | 87 |
| Table 9: | Humourous Occurrences: Tanya | 90 |

Chapter 1: Introduction

To everything there is a season, and a time to every purpose under heaven; a time to weep, a time to laugh; a time to mourn, and a time to dance. Ecclesiastes 3: 4

Humor is not a form of escaping reality; it is a playful way of perceiving and evaluating reality. (Yorukoglu 1993 p. 58)

This pilot study addresses the question: How do children with behaviour and mood disorders from families with dysfunctional relationships respond to playful humor in an art therapy setting? The focus of the study is on individual therapy with latency-age¹ children from families in emotional chaos. These children have various disorders originating from the emotional disorganization of the family -- disorders such as anxiety and depression, impulsivity as an impulse dyscontrol disorder, school phobia, oppositionality and mother-child problems. The subject areas then include: humor, play, art therapy and children in challenging family environments.

This report contains a literature review, a report on the pilot study with reflexive notes, and a discussion of the research results. My definition of playful humor is based on my synthesis of the current literature and my experience of its emergence in the therapeutic setting. As I refer to it in this study, playful humor

¹ Although Tanya is 15 years old, long past the latency age, I found that because of her 6-year separation from her mother, in many ways she was at an earlier developmental stage than her chronological age. For example, her appreciation of humor suggests that she was still in latency. For this reason she is included in the study.

refers to an open atmosphere of acceptance and tolerance for ambiguity and incongruity as expressed in interactive sharing of jokes, cartoons and spontaneous kindly banter.

The literature review begins with an exploration of the definition of humor as multi-various and elusive to precise definition. A review of the origins of humor concludes that humor originates in the early mother-child relationship, where the child begins to develop a sense of amusement about the human condition. An appreciation for humor continues to develop through childhood as outlined in the section on Humor of Children. A brief review of play reveals that the origins of play and humor are closely connected, and as some would say, different aspects of creativity (Roeckelein, 2002).

With this understanding of play and humor, a review of the history of humor in psychotherapy is sketched, describing the misinterpretation of Freud's theories of humor and wit that led to a taboo against the use of humor in psychotherapy until recently (Bergmann, 1999). This led to the reluctance of earlier researchers and clinicians to take humor seriously. It is pointed out that some contemporary psychologists now recognize the beneficial and detrimental dimensions of humor. In the past 10 years they have begun to apply systematic inquiry to the study of humor (Roeckelein, 2002). This has led to unification of the theories of humor and a new framework to view the humor construct within psychotherapy. This framework suggests that humor is important where incongruities exist. Only a few investigations have been reported on the use of humor with the creative arts therapies and these have been focused exclusively

on adults. Virtually nothing has been written about the use of humor in the creative arts therapies with children.

Of particular interest are children in challenging family circumstances facing ambiguities such as children with behavior and mood disorders in families with dysfunctional relationships². Accordingly this was the patient group selected for the research study. The study is presented through the methods, observations, discussion and conclusions format. The methods section describes the exact approach and means of data collection employed. The observations section describes examples of the humorous interplay between client and therapist. The discussion presents the relationships between the observations and the existing knowledge base. Finally, some suggests for future research are offered.

Throughout, the study is written from a reflexive stance featuring reflexive commentaries, including the therapist/researcher's self-questioning of interventions, choices, effectiveness of the research itself and a critique of the piloting work. This reflexive stance acknowledges the researcher's role in the research process. The first person 'I' is used to present the data from multiple standpoints and question the researcher's presuppositions and values. The reflexive inquiry is employed in this pilot study to promote a dynamic, creative and flexible process that can lead to the recording of research dilemmas, predispositions of the researcher and developing theories (Kleinsasser, 2000). As with all qualitative research this pilot study does not claim to be objective

² *In disorganized families parents often behave in disorganized way. children may see such behavior as unloving and contrary to the child's need for a loving caregiver. This is an incongruity that may cause significant distress in the child.*

(Banister, Burman, Parker, Taylor, & Tindall, 1994) but it does offer a different way to look at the phenomena of objectivity and subjectivity. By taking a reflexive stance the researcher's subjective viewpoint, biases, and motivations are delineated and acknowledged. Reflexivity then provides a means of objectifying the subjectivity of the study and its findings.

Chapter 2: Literature Review

Humor is a genuine mystery...In any of its basic applications, there is at present only one way to define the term "humor" adequately, so as truly to convey its meaning, and that is to define it ostensively: here is an example, here is another quite different example, and there is another - that is what "humor" means. (Latta, 1998 cited in Roeckelein, 2002, p. 1)

Nature of Humor

Humor comes from the Latin word meaning moisture. In ancient times it was believed that there were four essential fluids in the body called the four humors. When kept in balance one was said to be in a good humor. "It could seem that our topic [humor] is fluidity in contrast to rigidity and stasis" (Sanville, 1999, p. 32). William Fry coined the word "homeodynamics" (Fry & Salameh, 1993, p. xvi) to describe the complex, flowing, ever changing and dynamic nature of humor. Modern psychologists variously define humor as: "an action or statement that is comical or amusing; as whatever the individual thinks is funny; and as that which produces laughter" (Dean, 1997); "an amused attitude toward the human condition" (Schimel, 1992, p. 109); and "a vehicle for giving expression to some of our innermost wishes or fears so that we may begin to take the necessary action that may foster change" (Lemma, 2000, p. 174). Allport (as cited in Kuhlman, 1984, p. 28) observed that insight and humor both indicated "the capacity for self objectification, the ability to construe oneself as both subject and object". In his study he found insight and humor to have a correlation of +0.88. "There is still disagreement amongst theorists as to whether verbal play and

humor are distinct, or whether play is a particular type of humor” (Lemma, 2000, p. 62). Weisfeld (1993) draws a distinction between the characteristic expressions of humor -- laughter or smiling, the cognitive processes of humor or “what makes something funny” (p. 142) and the pleasurable affect of humor. It is his opinion that defining humor by its affect is consistent with the classification of other emotions by emotion theorists. All these definitions are probably partially right as they describe a highly complex physiological and psychological human response. Like the proverbial elephant, humor appears to have many parts and currently defies concise definition.

Although no psychological rules of humor have as yet been established there are many theories of humor. In general the various views of humor are mostly compatible and overlap in their meanings. In the most recent survey on humor, *The Psychology of Humor*, Roecklein (2002) simplified the list down to three general areas: “play/spontaneity, release/relief, and incongruity/unexpected relationships”(p.238). Play and incongruity are the two aspects of these categories that most closely apply to this study.

Bariaud (1989) writes that although there are a number of other theories of humor, many researchers support the notion that humor is related to incongruity (e.g. Berger, 1987; Hayworth, 1928; Nilsen, Donelson, Nilsen & Donelson, 1987; Keith-Spiegel, 1972 as cited by Weisfeld, 1993). Incongruity implies the pairing of two things that are usually not combined in the presented way. Such a combination produces surprise in the observer or listener. According to the incongruity theory the central element of humor is incongruity,

either the perception or the expression of humor. However, without the “playful framework” (p.18) the same incongruity might result in a reaction of fear or incomprehension rather than in mirth or a humorous response. Rothbart (1977) includes the distorted facial expressions and peek-a-boo as examples of incongruity appreciated by infants.

Bariaud (1989) further suggests that there is a distinctive quality that differentiates humor from unintentionally funny or comic events. For humor to be present there ought to be a form of mutual give and take, an offering of an incongruous combination of words or images and the recognition of the humorous intent of the humorist. Thus humor has a social, inclusive quality.

Bariaud (1989) asserts that humor is both a cognitive and affective process. For this reason he says that the recipient will appreciate the humor if the recipient is in synchronicity with the humorist. That is, there is a mutual desire to enter into the playful attitude and to consider the meaning of the incongruity. Therefore the joke or humorous gesture must be understood and also accepted as a humorous offering before it can be found funny. This element is particularly interesting as it applies to children in therapy as it implies that a child must be able to enter the playfulness of the therapist in order to show an appreciation of the gesture and that the therapist must likewise enter the playfulness of the child to show an appreciation of his/her humorous expression.

Another theory that has long been associated with humor is the superiority theory (McGhee & Chapman, 1980; Franzini, 2001; Weisfeld, 1993). In this form of humor there is a type of one-upmanship involving ridicule, derision and

competitive banter. Usually three participants are required for this type of humor: the humorist, the butt of the joke and the audience or observer. This type of humor is more common among adolescents (McGhee & Chapman, 1980) but McGhee (1989) observed that children would target adults as the butt of their laughter. This sort of hurtful and exclusive humor may be the source of much concern regarding the risks of the use of humor in therapy. However, this form of humor was not employed in this study.

Weisfeld (1993) explored the evolutionary basis and function of humor. His research includes evidence of “cross-species prevalence, early (presocialization) onset, specific neurophysiological mediation, presence in related species, and stereotypy” (p.143) to show that humor was selected for specifically in evolution and therefore has a function in human behavior. Although the details are well beyond the scope of this study, it is particularly interesting to note from an art therapy perspective that the expression of humor is mediated through the hypothalamus and the limbic system of the mid-brain (Black, 1982). Chapman's (2001) recent work links effective art therapy intervention with children in crisis to the ability of art activities to stimulate the emotion centers of the brain. She has demonstrated that art making, for example drawing or painting, calms the trauma-induced survival responses in the reptilian brain and reengages the limbic and prefrontal brain, thus allowing the children to access his/her higher cortical functions, and coping strategies, begin to express themselves through artwork, and also to use the previously shut down verbal function, The expression of humor through laughter originates in the emotion

center or limbic system (Black, 1982) and the appreciation of humor is controlled by the right frontal lobe of the cerebral cortex (Brownwell & Gardner, 1988 as cited in Weisfeld). It would be interesting to explore the neurological basis, if any, for how art therapy and humor could be combined to promote healing since they appear to activate some of the same processing systems in the brain.

The function of humor as expressed by Weisfeld is particularly germane to this pilot study. Weisfeld observed that humor is an extremely social activity that offers benefit to both the initiator and the recipient of the humor. The recipient receives the humorous product of emotional pleasure through laughter or positive facial expression, and turns his or her attention to the initiator as a sign of appreciation. The initiator values this attention and the connection to the recipient. Thus, Weisfeld observes humor is a form of reciprocation with mutual benefit for both the giver and receiver of humor. For example, "the exchange of a joke is a form of reciprocal altruism" (p.147). He thus tentatively proposes that the functional purpose of humor as it evolved in humans is "to induce the subject to seek out informative social stimulation and to reward others for providing such stimulation" (p. 162). We begin to seek out and participate in this social reciprocation of humor at a very early age. Children begin to laugh at approximately four months. These humorous interactions Weisfeld argues promote human growth and development.

Like Weisfeld (1993), Bariaud (1989) suggests that the humor framework establishes a social interaction between the producer and the appreciator of the humor in which the appreciator feels in tune with the producer. A bond of

inclusion is formed through the humorous exchange. Bariaud goes on to explain that the creator of the humor initiates the framework to prepare both parties for the humorous exchange. This is usually done with cues that can be as subtle as a facial expression or as explicit as a question like, "Would you like to hear a joke?" Children more than adults require clear cues to help them prepare for the humorous exchange.

Contemporary investigators have overcome the earlier reluctance to study humor and have begun to explore humor empirically. Consequently there is a growing body of knowledge on humor. Many have developed definitions and assessment tools within which many inconsistencies and discrepancies exist. To date, Roeckelein (2002) points out that there are no so-called laws of humor. However, rigorous exploration is underway to find a theoretical conceptualization of humor. To this end, in *The Anatomy of Humor*, Haig (1988) divided the over one hundred theories of humor into five categories: "incongruity, changes in affect or tension, superiority, social communication including control and modulation, and psychoanalytic approaches" (p.9). Murdock and Ganim (1993 as cited in Roeckelein, 2002) describe humor as a multifaceted aspect of creativity. In the study they distilled 13 definitions of humor and 11 theories of humor. Among the many definitions they found a considerable diversity of content, but within the 11 major theories, they observed commonalities and consolidated the concepts and theoretical frameworks into three basic categories: "play/spontaneity, incongruity/unexpected relationships and release/relief" (Roeckelein, 2002, p.238). Murdock and Gamin `suggest that

these three categories could serve as the bases for future research to better understand humor as a construct.

Some current understandings of humor are rooted in classical theories of psychology. As Barron (1999) notes: "in referring to humor Freud frequently emphasized its transformative and transcendent qualities" (p.1). Humor brings unconscious material into conscious awareness and thereby juxtaposes previously uncombined and apparently incongruous notions (Giovacchini, 1999; Lemma, 2000; Yorukuglu, 1993). The reconciliation of incongruities is central to Jung's description of the transcendent function, often reached through active imagination (Jung, 1997). Grotstein (1999) has also come to appreciate the Jungian archetype of the trickster and its role in humor. He wrote, "In respect to the study of the phenomenon of humor, the impact of my formulation is that the unconscious has been insufficiently appreciated as being a clever jokester and sophisticated humorist" (1999, p. 77). Humor then could be viewed as a therapeutic tool as it connects directly to the unconscious and allows for healing under the guardianship of the superego. As Freud (1908) also suggested humor allows suppressed unconscious content to emerge by passing the superego.

This theoretical framework has engendered more formal research into the role of humor in personal interchange (reviewed in Roeckelein, 2002). Of particular interest, "Martin and Lefcourt (1983) researched the effects of humor on the relations between negative life events and current levels of mood disturbance (e.g. depression, anger, fatigue)" (Lemma, 2000, p. 98). They found that subjects with a good sense of humor suffered as much stress as did those

who did not use humor, but the humorists were better able to cope with it better. Newman (as cited in Lemma, 2000) used Martin and Lefcourt's humor scales to investigate whether people could be taught to manage stress. The experiments indicated, "reframing events humorously is adaptive" (p. 98). In 1987, Porterfield tried to replicate the work of Martin and Lefcourt but found something different – in his study the sense of humor mitigated depression rather than helping participants deal with stress. Lefcourt (2001) presents many examples of research supporting the notion that humor is an "emotion-focused coping strategy" (p.113) and that humor has been found to be a moderator of stressful experiences. Masten (1986) conducted a study with children using cartoons, IQ scores, and peer and teacher ratings that found humor to be a consistent predictor of social competence. These recent studies support the relief and release theories that suggest humor serves as an energy releaser. Freud also believed that negative emotions were released through laughter (Ruxton, 1988). Consistent with these theories the recent research seems to show that humor has beneficial effects on mood disturbances and can be seen as a sign of resilience in the face of stressful social situations.

Humor In Children

It is thought that humor originates in the primary relationship between the mother and child (Bollas, 1995; Lemma, 2000). Smiling and laughter shared and mirrored between them establishes a basis for a humorous attitude acquired by the child as he or she develops. Lemma writes: "Under normal circumstances, the mother communicates the advantages of independence to the baby primarily

by making learning fun, through play and humor, and so facilitates the baby's freedom to become a person in his own right" (2000, p. 50). She further suggests that the mutual interaction of parents and infants in games, such as peek-a-boo, helps to establish a rhythm of communication for the infant and affords the earliest experiences of humor in the form of amusement and pleasure. Humor is then experienced as a mutual phenomenon that helps to regulate the affective responses of the baby. Moreover, humor provides a means of integrating the disappointments of failure with pleasurable experiences. Here the mother helps the child develop a sense of "amusement about his own predicament and so also about the human condition" (Lemma, p. 52). Humor then can be said to serve as a source for the regulation of affect, the integration of conflicting feelings and an amused or somewhat distanced perspective on life in general. As the baby's greatest source of stimulation Bolland (1995) suggests that the mother may well represent the child's first encounter with the "clown". He writes: "A mother who is amused by baby and who can get baby to laugh at himself before he consciously knows what the joke is all about helps to develop a sense of amusement in the human predicament well before the self comprehends his condition" (p. 241). It has also been observed that the peek-a-boo interaction between baby and mother qualifies as a game-drama rehearsed by the players with clear rules to follow (Schimmel, 1992). The infant learns the rules to this game very early. Schimmel explains that these early mother-child laughter games promote two types of learning for the fortunate children. They learn a sense of expectation and an awareness that what they do influences

another's behaviour. Thus the humorous interaction is like a mutually beneficial reciprocal dance that stimulates and teaches social interaction as it promotes the attunement of the child with the mother.

Although the nature of adult humor has been studied with increasing vigor over the past twenty years (Bergmann, 1999), the developmental phases of humor in children has had more limited attention. A few researchers, most notably McGhee (1979, 1989), have pioneered and consolidated research on the development of humor in children: both the humor they produce and the humor they appreciate. As the child develops cognitively, socially and emotionally, his or her humor also develops in its nature and complexity. Bariaud (1989) outlines the two most supported theoretical perspectives: i) one view sees humor development in children as primarily cognitive (McGhee, 1979, 1989; McGhee & Chapman, 1980) and therefore useful for learning; ii) the second suggests that humor is an emotional process and beneficial for coping with stressful situations (Bariaud, 1989; Lefcourt & Martin, 1986; Wolfenstein, 1954).

McGhee (1979) suggests that as children develop intellectually so does their capacity to create and/or appreciate humor. He observed that children progress through stages or phases of humor in a predictable sequence but at varying rates.

There is some controversy about the child's earliest perceptions and initiations of humor and exactly what characterizes humor at this initial stage. McGhee sees humor linked with incongruity, the juxtaposition of two apparently unrelated elements. Humor then is related to production or comprehension of an

incongruity. In contrast with Bolland (1995) and Lemma (2000)³, McGhee's first stage of humor development starts at around 18 –24 months with the emergence of make-believe play. At this point the child engages with incongruities in pretend play activity, replacing one object for another – a stick could be a pretend fishing pole, for example. As language skills improve, the child makes use of incongruous labels, and actions. Humor evolves into manipulation and play with words and labeling. It has been observed (Bariaud, 1989) that children's abilities to play with incongruous combinations of words and/or actions can be enhanced by parental encouragement and that this activity engenders creativity and humor. Stage three starts at around age three with the emergence of conceptual thought (Piaget, 1962). At this point, children begin to understand things as concepts with multiple qualities. They begin to play with incongruities related to the appearance of things. Between three and six children can make up and recognize stories of incongruous categories. Yorukuglu (1993) observed that children of this age have a keen appreciation for comic events and behaviours. They are amused by many things around them. They also like nonsense words and rhymed sequences. This is the stage when children show the greatest capacity to create their own humor, even if others don't find it funny. At roughly age seven children begin to understand concrete operations thinking (Piaget, 1962) and are ready to enter stage four in the development of humor. The children begin to comprehend that two things can exist at the same time; the principles of the conservation of mass, volume and energy are acquired. Between 7 –11 years of age children are often very realistic in their thinking and

³ Bolland (1995) and Lemma (2000) think humor appreciation begins earlier.

therefore some incongruities would be seen as unacceptable or not real. This is the stage of the great popularity of the canned joke and the riddle. A joke like, "what weighs more, a pound of feathers or a pound of lead?" would be very amusing at this stage. Between 9 and 11 some understanding of the allusions behind the incongruities are perceived.

In general McGhee (1980) suggests that children find jokes or humorous stories particularly funny when they are just at the edge of their developmental level: they can get the point but it is not too easy. Thus appreciation of a joke is said to be maximal when it is neither too easy nor too hard. Often a joke about something that the child has just learned to accomplish is found to be very funny. This is called the "cognitive congruency principle" (Haig, 1988, p.67) and supports Weisfeld's (1993) view of the function of humor to induce an individual to seek out informative social stimulation, affirmation and validation. In adolescence the child is acquiring abstract thought and increasingly more complex and multileveled humor can be conceived. Adolescents often use humor to express social derision. They also enjoy distortions of reality. Not much has been published on the development of humor in adolescents to date.

Beyond McGhee's stages there are a number of significant factors that influence the development of appreciation and expression of humor in children. Very early, children learn that adults vary in their appreciation and tolerance of humor (Bariaud, 1989). Bariaud suggests that children initially learn that they are being funny based on the responses of the adults with whom they interact and that humorous production or creation requires a "playful framework' (p.18).

Bariaud's playful framework is akin to Winnicott's transitional space where a trusting environment is created and the client is liberated to explore alternatives.

Nature of Play

The origins of play and humor are closely connected. Play resembles humor in its ontogeny (Weisfeld, 1992). Humor and play begin to develop at a similar time in early childhood and emerge in a parallel fashion. For example, McGhee (1979) points out that the peek-a-boo game that appeals to infants in the first year and evokes the laughter response may correspond with the development of object constancy. McCune (1993) explains how the very young child (18-24 mos.) gradually develops the capacity to focus attention through perceptual and representational activities that she characterizes as play. She states that the child develops a conscious awareness of the self and other through the mechanism of representation and perceptual play. The child starts to acquire knowledge of the world through sensory-motor activities. By the age of one the child begins to develop representational play that involves pretending. In this type of play the child is able to hold the idea of an object or a person in his/her mind even though it is not present. Representational consciousness is always accomplished with a partner (usually the primary care giver). Through representational play such as the peek-a-boo game or other hide and find type games, the child develops increasing skill and control over the two modes of thinking. The child gradually experiences the self as separate from mother and objects. Thus at this early stage play is instrumental in cognitive development and establishing consciousness of the self and other.

This separation awareness is key to Winnicott's concept of the transitional space. In this way the child begins to differentiate the outer and inner worlds. The psyche establishes ego boundaries as it distinguishes me from not-me, as Winnicott (1971) states. However, if the play space between the mother and child is not safe enough and the child does not receive enough positive reinforcement for that newly actualizing self, then the child's sense of self and other is poorly developed and separation from the mother is incomplete.

Earlier theorists tended to concentrate on one aspect of play. Freud and other psychoanalysts have focused on the emotional purpose of play as a source of pleasure and a relief from internal pressures. Freud connected play, pleasure and creativity. The child at play could create any scenario or reenact scenes in his imaginary world changing the outcome or stopping the play at will. Freud saw the "repetition phenomenon" (Coppolillo, 1991, p.805) working in children's play. The child would repeat a circumstance from his life until he or she was able to assimilate the emotional material in the event. The reenactment of scenes in the child's life would help in their resolution.

Piaget (1962) classified play into three formats: sensory motor play, symbolic play and games with rules. Sensory motor play is the earliest developmental stage of play attained by the child between birth and two years of age. The child acquires a skill and then repeats it just for the pleasure of it. Symbolic play is practiced between two and six years. At this stage play is full of make believe; any ordinary objects will be used to represent something else in play. A banana might be used for a telephone, for example. Children normally

reach the rules-based game playing stage by 6 years of age. All these formats of play can be seen in art making. Experimentation with media could be seen as sensory motor play. Art itself is a symbolic language and group art activities may involve some game-type activities. Piaget saw play as an important means of cognitive growth in children. It becomes the vehicle for learning and advancement from one developmental level to the next. Piaget as an educator was not conducting psychotherapy but nevertheless he viewed play as having a central role in the child's cognitive progress toward maturity.

Liebmann (1986) asserts play cannot really be defined by one or two activities. She points out that the "same activity may be playful and none playful" (1986, p.13). This "playfulness" quality is more like an attitude than an activity and can be applied to many different circumstances. A non-literal quality, enjoyment and a sense of freedom are usually involved.

Liebmann suggests a list of characteristics of play:

1. play is gratifying and pleasing,
2. play is without objectives or added agendas,
3. play is off the cuff and freely chosen by the player(s),
4. play is proactive,
5. "play is related to what is not play" (p. 13)

It is significant that Liebmann includes the fifth characteristic. Here she is referring directly to the possibility of reenactment of real life problems in make-believe or symbolic ways through play. The distancing of the problem from the child through play, humor, or art making allows the child to consider difficult

issues with less fear. In this way the child can practice within the safe make-believe world of play established by the mother or the therapist.

In contrast, Arieti (1976) writes of children's play that it "implies a special attitude to life, one that promotes an evasion of reality" (1976, p.127). He goes on from this rather ambiguous statement to add that the elements of make-believe and creativity are hallmarks of play. This idea links with Freud's (1908) impression that the opposite of play is not seriousness but reality. Play has the ability to make reality palatable. It appears that the child embraces play as an integral aspect of his or her reality whereas the Euro American adult play is often employed as a diversion from reality as well as a rejuvenating resource.

Recent research in attempting to define and measure children's play has observed that play can more readily be quantified by observation of the characteristics of the playful child rather than the play activities (Barnett, 1990). Unlike earlier measurements of play, "the Playfulness Instrument" (p. 321) is both reliable and valid. The test measures "a child's predisposition to approach his or her environment in a playful way" (1990, p.333). The playfulness instrument identifies five components of playfulness: cognitive spontaneity, social spontaneity, physical spontaneity, manifest joy and sense of humor. These qualities were first identified by Lieberman (1965, 1966). They bear some resemblance to the traits Rubin, Fein & Vandenberg (1983) chose to characterize play: 1. play is regulated and chosen by the player (the child). The current interests and concerns of the child are the subject of play; 2. play occurs in the realm of make-believe; 3. play is not controlled or limited by powers external to

the child; 4. play engages the child in active participation. This transcendent, transformative quality of playful fantasy combined with humor was employed with the children in this study.

Connections Between Humor and Play

“Play is associated with humor, humor always has a playful quality”

(Giovacchini, 1999, p. 91)

Taking Freud's original formulation further, Winnicott recognized the importance of love, work and play (Lemma, 2000). “For Winnicott, it is play that is universal” (p. 41). Play, like humor, emerges in early childhood, originating, as Winnicott described it, within “the potential space” (1971, p. 41) between the mother and child. Through playful and humorous interactions with the mother, the baby develops a sense of amusement. Just as with humor, described earlier, play facilitates the emotional and cognitive processes that allow for adaptation to the external world. “A mastery through play motive underlies all humor – for children” (Kuhlman, 1984, p. 15). Winnicott goes further to say, “playing facilitates growth and therefore health” (1971, p. 41). This is echoed by Carp who wrote, “Play, spontaneity, lightheartedness, humor and creativity are primary ingredients in the healing process” (1998, p. 248). Sanville (1999) also described humor and play as inextricably linked agents of change and health. She offers anecdotal examples of the therapeutic use of humor with children and adolescents. Some child therapists who employ play also write stories about humorous incidents with their clients (Beren, 1992; Levinson, 1984; Novick, 1983). Weisfeld (1993) also describes playfulness and curiosity as a strong

correlates of humor. Humor and play then, while different, come from the same familiar roots. Lemma (2000) points to recent research that has found play to have an evolutionary function just as humor does (Weisfeld, 1993). Both humor and play can be said to provide “a bridge from unconscious fantasy to reality” (Lemma, 2000, p.64; Yorukoglu, 1993).

Humor in Classical Psychotherapy

Humor was first integrated into the psychoanalytic theory, in 1905, when Freud wrote, “Jokes and the Relation to the Unconscious” (as cited in Bergmann, 1999). In this volume, he set down his belief that humorous material in jokes was able to bypass the censor of the unconscious and allow otherwise repressed material to enter the conscious realm. The pleasurable effects of jokes were expressions of unconscious wishes, a release of suppressed material. The joke, as Freud defined it, was told at someone else's expense and for the pleasure of the teller. Jokes were therefore either hostile or aggressive or else obscene or exposing (Grotstein, 1999).

Distinct from jokes and the comic, humor was the topic of Freud's second book (1927). Unlike the joke, humor, he said, was told at one's own expense. Humor, he asserted, was on a higher plane than jokes. Humor was liberating (Bill, 1938); it had an air of rebelliousness and grandeur in opposition to the complexities of the external world. Humor was a benign expression of the super-ego acting as a comforting mother to the ego. Humor, therefore, allowed the person some insulation against the vicissitudes of everyday concerns and predicaments. Humor then was a means of assuaging suffering or discomfort.

“Humor, on the other hand, is seen as a defense against the disagreeable: thus the energy that would otherwise produce pain, in humor results in pleasure” (Grotstein, 1999, p. 71).

Freud (1927) wrote that only some people could appreciate the humorous attitude and that some had no sense of humor at all. He also mentioned that humor is close to the reactionary processes and to regression. He described humor as both transcending reality and distorting it. Freud did not write about how humor could be utilized in psychotherapy, although he is reported to have used it in his own therapeutic work. He is also said to have criticized his writings on humor and he did not go back to the topic nor refer to it again in subsequent writing. As Grotstein noted: “seriousness, sobriety, abstention, and neutrality have long been considered to be the sine qua non of analytic demeanor” (Grotstein, 1999, p. 78). Grotstein further stated that this ambivalence and lack of application of humor in the practice of psychoanalysis persisted and was matched by a longstanding taboo against the use of humor in the behavioral sciences.

After Freud’s seminal works and until 1969, the only papers published on humor cautioned against using it in psychotherapy. Ernst Kris (1938) described humor as a defense mechanism and thus a source of resistance in therapy. Edith Jacobson (1946) wrote that humor was about the ego’s ability to detach itself from a threatening circumstance. Wolfenstein (1951) wrote that children were not able to appreciate double meanings in jokes. Lowenstein (1958) was still very hesitant about humor. He expressed that jokes could be used with

particular individuals at appropriate moments using the psychoanalytic technique, but that some patients could not sustain a joke in therapy and that the joke could easily be misinterpreted as seductive or offensive. Thus, he discouraged the use of humor in therapy. Kubie (1971) warned against the risks of using humor in therapy for similar reasons. It is Grostein's (1999) opinion that the advent of ego psychology from classical psychoanalysis eclipsed and de-emphasized Freud's perspective on humor and the unconscious. With the focus on ego function, the id, or the unconscious, the value of humor was temporarily overlooked.

Bergmann (1999) noted that the theoretical perspective on humor and its use in therapy only began to change with Rose (1969), but the concepts were slow to be adopted. Rose was probably the first to apply humor to psychotherapy. He found humor could be both beneficial as it is aligned with the observing superego or a deterrent as it can represent resistance. Nevertheless, humor was not adopted into the mainstream. Kuhlman (1984) relates his opinion that the fervent followers of the young science of psychology in attempting to validate their work as serious science rejected the whole concept of humor as anathema to the field. Kuhlman goes on to report that in the more recent past psychology has begun to expect its practitioners to be more flexible, creative, spontaneous and empathic, qualities that can be associated with humor. It is therefore apparent that over the years, the texts on psychotherapy give differing views on the merits of humor.

More recently, humor has begun to be studied as a useful tool in therapy (Barron, 1999; Fry & Salemah, 1993; Lemma, 2000). Roustang (1987) reported

using humor as a beneficial part of therapy. Friedman (1994) expressed his perspective on humor as he wrote: "People reveal their unconscious both by what they find funny and the jokes they tell" (p. 49). Poland (1994, 1996) has written extensively on the use of humor in therapy. He suggested that the ability to employ humor is a sign of self-acceptance when one is able to laugh gently at one's self. He also observed that some persons are not able to express humor for no known reason and some are prevented by the development of depression or neurosis. He wrote that "mature humor is a reflection of analytic work successfully done" (Poland, 1996, p.181). Thus, it would appear that the taboo on the use of humor in therapy is dissipating.

Current psychological literature expresses an attitude of acceptance of the benefits of humor in therapy (Prerost, 1994) and this has led to a re-evaluation of Freud's articles on humor and its relationship to play (Bergmann, 1999). Sanville (1999) summarizes Freud's view of humor. She writes "that humor originates in the play of children and that the role of the other and of the social surround are factors in the unfolding of the playful mode" (p. 39). For example, Bader (1994) considers it important to reflect pleasure back to the patient who may not have had such feelings mirrored to him as a child. Bergmann suggests that humor is exerting an increasingly important role in psychoanalysis as it already does in our everyday lives. He therefore commends the work of Freud on jokes and humor as models for present day psychoanalysis.

Humor in Creative Arts Therapies

The use of humor in creative arts therapies has been limited. One article that features humor with the creative arts therapies in a unique and prominent way is Carp's "Clown Therapy" (1998). She bases her therapy on the psychotherapeutic value of the clown character, or what Jung would refer to as the trickster archetype. Participants are assisted to gradually come to embody the clown by drawing the trickster archetype out of their inner selves. By this means, Carp believes that the healing power of the clown is enacted, thus promoting individuation through the conscious integration of the heretofore-unconscious archetype of the trickster. Like humor the clown is a "connection between conscious and unconscious, the known and unknown within" (p. 248). Carp relates the thoughts of Ulanov and Ulanov (1987) who warn of the client's use of the clown role as a defense that allows a person to avoid true feelings and problems. Here is the old argument against humor made by psychoanalysis and now realized to be a justified warning but not a dictum against humor. She suggests that the trickster "brings the power of the universal into everyday experience through individual synchronistic occurrence and creative imagination" (p. 248) acting as a sacred guide for the soul. This role is similar to the idea that humor can be an occasion for the transcendent function to manifest through the mechanism of Jung's active imagination. Her view is that the therapist works as a witness and guide through the psychotherapeutic process, through active empathy. As I interpret this process, the function of the clown in clown therapy

is very similar to the function of humor in other psychotherapies and application of humor to art therapy has merit.

Other practitioners within creative art therapies have also initiated the use of humor. Gladding (1998) writes briefly about play and visual art under the title "Play and Humor in Counseling with Other Creative Arts". He cites a number of examples of counselors who used comic strips. The clients searched for comic strips that depict their situation, filled in the balloons of already drawn strips or drew their own cartoons to promote change and understanding. In this manner, the adult clients conceptualized their problems in a humorous manner.

Despite the resurgence of interest in the role of humor in psychotherapy and drama therapy, it would appear the primary authors in art therapy have little to say about the use of humor. Malchiodi (1998) in her recent text on art therapy with children emphasizes the therapist's purpose of enabling art making, listening, being present, facilitating verbal communication with the child, employing props and toys for this purpose and reflecting feelings back to the child. While she mentions being "curious and inquisitive" (p. 63), reparation and recovery does not manifestly include humor. In *Art Therapy Practice*, Harriet Wadeson (2000) explores innovative art therapy approaches with many populations. She describes creativity as the core of art therapy practice and points out the great diversity that exists in the field. With many practical examples she draws the big picture of art therapy but no direct reference to humor is made. In her earlier book (1989) humor is mentioned as a possible option for therapy but no explanation or clinical examples are given. Judith Rubin

(1999) in her recent introduction to art therapy suggests that art therapists “need to examine new and potentially helpful adjuncts” (p. 229) to art therapy. She adds that art therapists are, by nature, less doctrinaire and rigid in their approach to therapy than verbal therapists but she makes no direct reference to humor. Riley (1997) in her recent book on art therapy with adolescents, points to the brief therapeutic work of Selekman (1993). His approach, she suggests is that “playful interpretations, humor, and spontaneity are all essential to the therapeutic process” (Riley, 1997, p.248). So far, it appears that few contemporary experts have (Appendix A: Art Therapists Survey) reported the supplementation of art therapy with humor.

In a search of the literature, only two articles by Mango and Richman (1990; Mango-Hurman, & Richman, 1994) that combine art therapy and humor were located. They reported in 1990 on working in short-term treatment with eight severely disturbed adult psychiatric in-patients, who were asked to make a drawing of a funny incident that happened to them. They hypothesized that the joke teller would reveal his/her emotional state and present concerns through his or her jokes or cartoons. They focused on these humorous art images/cartoons and assessed 106 drawings. They found the exercise built therapeutic rapport, brought the problems out and allowed the participants to share very difficult material that could not be shared in other settings. The clients reportedly experienced mutual understanding and empathy within the group, and with the therapists' assistance. They saw art therapy as contributing to solving their problems. Further research into the use of humor and art therapy was

recommended. As a follow-up to this work, Mango-Hurman and Richman (1994) again employed art therapy and humor in their research. Groups of African-American and Hispanic adult patients, at the discharge phase in their hospitalization, were asked to depict funny incidents that had occurred to themselves or to others. The groups met once a week for up to six months. They observed that the combination of humor and graphic art, as two means of self-expression, allowed the patients "to feel free to bring up ethnic material, which otherwise might remain unexpressed" (p. 215). However, they could not differentiate or distinguish between the relative impact of art or humor. Again they found that humor helped to build rapport and a feeling of universality as similarities between the group members were brought up in the drawings. Especially interesting to this group was that unresolved issues of identity were brought to the surface through the humorous drawings. Possibly due to the difficulty in isolating the influence of humor or play or art activities in a therapeutic setting, little has been written about the use of humor in art therapy.

Children with Mood and Behaviour Disorders

From its early beginnings, art therapy has been found most effective in the treatment of children experiencing emotional and behavioral deficits⁴ (Anderson, 1992). Children with emotional and behavioral disturbances, expressed as disturbed or withdrawn behavior, often have difficulty expressing their concerns verbally, and therefore can benefit significantly from the safe expressive mode of art therapy (Case & Dalley, 1992; Linesch, 1993)). All the children included in

⁴ See Appendix D for a review of the mood and behaviour disorders relevant to the client population studied.

this study have one or more of these diagnoses. Margaret Naumburg (1987) and Edith Kramer (1971), for example, with completely different approaches but both pioneers in art therapy and psychoanalytically trained, worked successfully with children with behaviour problems and emotional disturbances. Kramer (1971) describes many examples of aggressive children being successfully treated with art therapy. She highlights the attitude of “ambivalence” (p. 193) in these violent and aggressive kids, who show both anger and admiration towards their aggressors, often family members. She gives examples where “art therapy played a decisive role in the substantial reduction of aggression and in enduring positive changes in the child's personality” (p. 207-218). Lowenfeld, coming from an art education background and employing a developmental approach also used art therapy effectively with children suffering from different physical and emotional disorders (Anderson, 1992). In this “ambiguous space” is a place where humor and art therapy may function synergistically.

Family therapy theorists see the child suffering from behaviour and mood disorders as symptomatic of family dysfunction (Minuchin, 1974, 1981). Dysfunction in a family stems from the family's inability to problem solve. The disorganized family is stuck, unable to find new ways of getting around a difficulty. Such families share a number of common characteristics: an inability to express the full range of emotions, an inability to conceive of alternate ways of considering an issue, an inability to own personal mistakes and an “intolerance for ambivalence about themselves” (Keith, Connell & Connell, 2001). Most often in these cases a child in a severely disorganized family will be the external signal

of the internal upset. "When a child is brought into therapy by his family, he has already been diagnosed by the school, his pediatrician, the court, the police or his peers"(Minuchin, 1981, p. 455). As family therapists have observed, the child acts as the "identified patient" (Goldenberg & Goldenberg, 1990, p. 11), "the family member who is expressing, in the most visible way, a problem affecting the entire system" (Minuchin, 1974, p. 129). All but one of the children in this study were assessed as the identified patient in her or his family.

The child may express the family problems in various ways, but of principal concern here are behaviour and mood disorders, which may include depression, suicidal ideation, school phobia, anxiety, aggressivity, and oppositionality. Depressive symptoms in boys and girls differ: girls typically display " body image distortion...loss of appetite...[and] lack of satisfaction" (Wilson, Nathan, O'Leary & Clark, 1996, p. 480) whereas boys often show " irritability...social withdrawal...and drop in school performance" (p. 480). Depression in children is most often associated with a disturbance in the family interactions and increased criticism of the child in the home (1996). It has been found that children with depression are more likely to have a depressed parent.

Suicidal ideation may evolve out of depression. Psychological therapies are recommended. Pharmacological treatments have not been as effective in children as they have been with adults.

Anxiety Disorders include: Panic Disorder, Agoraphobia, Specific Phobias, General Anxiety Disorder, Overanxious Disorder [childhood version of generalized anxiety disorder], Social Phobias, Post-Traumatic Stress Disorder

and Obsessive-Compulsive Disorder. Wilson, Nathan, O'Leary and Clark (1996) define anxiety as "a fragmented cognitive affective process in which the individual has a sense of unpredictability or uncontrollability over potentially negative or harmful life events" (p. 135).

School phobia falls under the general heading of childhood anxiety disorders. It is characterized as "a child's specific reluctance or refusal to go to school due to fear of separating from parents" (Anderson, 1992, p. 471). This is a subclass of separation anxiety disorder, an excessive concern about the possibility of separation from the family or parent. Another form of anxiety disorders is overanxious disorder or extreme worry about future events. One child in this study expressed symptoms of overanxious disorder accompanied with sleep disturbance and nightmares. His family was in a state of extreme stress over his progressive hearing loss as well as other disturbances in family relationships.

Although the diagnostic symptoms of anxiety and depression have been treated as separate diagnostic classes in official nosologies such as DSM IV (Mineka, Watson, & Clark, 1998), research findings reveal a 50% overlap between depressive and anxiety disorders (Wilson, Nathan, O'Leary & Clark, 1996). Clark and Beck (1989) report on a cognitive model that shows anxiety and depression to be associated with maladaptive cognitive processes. Although they reported their research to be inconclusive at the time, they did associate negative thinking and distorted cognitive processes with both disorders. They also observed that the cognitive processes of both anxiety and depression were

alike, in that prior to the expression of either disorder, individuals are predisposed to heightened responsiveness to negative environmental stresses. Cognitive content was found to be distinctive for patients with anxiety or depressive disorders; individuals with depression focus on thoughts of loss and failure while the those with anxiety anticipate harm and danger (Watson & Kendall, 1989). Smith and Allred (1989) found that negative life events increase anxiety and depression. Their results were unclear as to whether events involving loss or failure lead to depression or if threat or danger lead to anxiety. Similarly, Nezu and D'Zurilla (1989) postulated that the interaction between stressful events and problem-solving responses predict the affective outcome. That is "variables within the transactional/problem -- solving model" combine to result in the expression of depression and anxiety (p.310).

The presence of social support from close friends and or family and group membership helps to buffer against the effects of either disorder. Marital problems tend to augment the effects of either disorder (Wilson, Nathan, O'Leary & Clark, 1996). Marital disruption, divorce or the chronic spousal discord of parents has played a role in the lives of each of the children in this study.

Bowlby's attachment-object loss theory may partly explain this sequential relationship and the close affinity of anxiety and depression (Mineka et al, 1998). In many cases uncontrollable aversive events refer to disordered attachments that are significant factors in both anxiety and depression. The sequential relationship between anxiety and depression reflects the childhood response to separation or loss: initial alarm followed by despondency. As anxiety occurs in

response to the threat of a loss or the initiation of a loss, when the loss is somehow averted or assuaged then the despondency, or in this case depression, may not occur. All but one of the children in this study lived their early lives in households disrupted and disorganized by alcoholic, depressed and/ or violent parents.

Aggressivity and acting out, taken to an extreme, fall under the DSM category of oppositional defiant disorder (ODD). ODD is characterized by negative and defiant behaviour, including anger, temper tantrums, swearing and rebellious responses to adult authority (Wilson et al., 1996). Conduct disorder (CD) is an even more extreme example of acting out in which the child expresses aggressive behaviour in the home, at school and in the community. The rights of others are disregarded including animals and property.

Adjustment Disorder with Mixed Disturbance of Emotions and Conduct according to the DSM IV (1994) is usually acute, with clinically significant emotional and/or behavioral symptoms that develop in response to a psychosocial stressor. The level of response is typically considered to be in excess of what would be expected given the nature of the distress. Symptoms include disturbance in conduct with manifestations of emotional symptoms like anxiety or depression. There is often a marked impairment in social functioning associated with this disorder.

A resentful attitude, argumentativeness, belligerence, blaming of others, annoyance and anger have often been observed to begin in childhood and grow increasingly serious as the child enters adolescence (Wilson, Nathan, O'Leary &

Clark, 1996). This sort of behavior is expressed in a smaller percentage of girls than boys. Genetic, psychological and social factors have been found to offer some explanations for origins of this sort of oppositionality (Wilson, Nathan, O'Leary & Clark, 1996). However, both psychological and social factors may have been at play here. Extreme anger and aggression in children have been linked with learning, cognitive and family factors. Research has found that in some children watching aggression in real life leads them to act aggressively (Heath, Bresolin, & Rinaldi, 1989; Centerwall, 1992). Spousal discord has been found to be the strongest indicator of childhood aggressiveness (Amato & Keith, 1991). Crick & Dodge (1994) observed another factor that seems to be at play with aggressive children. They found that these children often misperceive the intentions of others as hostile. . Behavioral treatment and skills training as well as cognitive therapy have been practiced with the aggressive and acting out children. A more directive art therapy approach would be more suitable with this population.

In general findings indicate that inept disciplinary practices including severe physical punishment hitting, or beating and nagging combined with inadequate supervision or attention for children are the two significant contributors to childhood aggressive behavior. Children in lower socioeconomic classes have disproportionate rates of conduct problems and delinquent behavior (Lahey, Loeber, Hart, Frick, Applegate, Zhang, Green & Russo, 1995). Factors that seem to be impacting the children are the frequent sequelae of low incomes such as large family size, overcrowding and poor parental discipline, rather than

the economic status of the family per se. Finally, children of families headed by single mothers are also found to be negatively influenced by stress leading to antisocial behavior (Patterson, Reid, & Dishion, 1992).

Children who have been exposed to violence and chaos seem to show a number of traits, some of which can be observed in T. Moore et al (1990) say that children from such disturbed families often show poor self-esteem due to the disruption of mother-child interactions. These characteristics seem to apply directly to the children in this study who suffered both the disruption of marital accord and mom's absence. In *Breaking the Silence* Malchiodi (1997) writes about her work with children from violent homes. She suggests the importance of establishing rapport with the child, "the creation of trust and support" (p.96). Malchiodi mentions a number of strategies, many of which I employed with the children: 1. Give the child permission to be a child through art and play that encourage make-believe and experimentation. 2. Provide art making which symbolically provides a venue for the child to gain control of stresses. 3. Allow the artwork to be an externalization of feelings of anxiety and confusion fears and worries. She states, "assisting the child in personal expression, communication, and coping with and alleviating stress all contribute to heightening a positive sense of self" (p.94). Children from violent homes, for example, commonly express anger (Malchiodi, 1997). She suggests the use of clay with these children is particularly effective as feelings can be acted out with aggression and energy that is less possible with other media. Malchiodi says that many children from such disruptive homes have not developed an internal locus of control.

Several of the children played with clay or plasticine within the metaphor as a means of gaining a new sense of self and mastery over his or her world.

Ainsworth and Bowlby (as cited in Cassidy, 1995) confirm that the healthy development of a child is largely dependent on the sensitive care and attention of the primary caregiver. These were unfortunately lacking in some cases with the children in this study. For example, the mother of one child was struggling with a violent, alcoholic partner whom she ejected from the home while therapy was ongoing. In another case the mother likewise ejected her alcoholic partner during the time of therapy. This woman was often overwhelmed by her role as a single mom of five children with a very limited income. Improvements in a child's attachment can occur if the mother's circumstances and ability to nurture her change. In support of this challenging task another adult, like a therapist, who is nurturing, and consistent, can assist in the child's new perspective by establishing a strong bond with the child (1990). This was the approach I took with the children in this study. In chapters 5 and 6, case materials are used from child clients having these diagnoses. Case material on each child included in the study is presented in Appendix D.

There are many inherent ambiguities and incongruities in a disorganized family. Confused and disorganized family functioning is chiefly due to the family's level of "maturity, tolerance for ambiguity, the capacity of be amused by the self, the capacity to be playful and the capacity to self regulate" (Keith, Connell & Connell, 2001). The child is often trying to hide the shame of the family whether it is violence, addiction, mental illness or a myriad of possible root

causes. They are confused by the reality of their lives compared to the reality they imagine or they see in other families. As a result of these pressures a child in such a disorganized family may express symptoms of behavior and/or mood disorders. With this population of children it appears there is a place for humor, with its capacity for playfulness, new and amused perspectives on the self and others, and tolerance for the incongruous and ambivalent. Accordingly, a research pilot study was performed to address the role of playful humor in children with mood and behaviour problems from disorganized families.

Chapter 3: Introduction and Methodology

Introduction to the Research Study

Recent literature indicates that humor in psychotherapy is beneficial to the client, but it is virtually silent on its use with children in art therapy. Children from families in crisis exhibiting behaviour and mood problems live in ambiguity and predicament, where stress and mood changes are present. For this population, the family situation presents particularly difficult ambiguities and discontinuities around love and hate of parents and siblings. It is my supposition that humor could promote a comfort level with ambiguity, stimulate a more flexible perspective, and promote diverse possibilities for coping in such children. Playful humor combined with art therapy should offer a means of recognizing and accepting these discontinuities either directly or through metaphor, by learning to cope in more adaptive ways. This review points to the benefits of each form of therapy and highlights that such a combinatory approach has not been reported to date in this client group. Thus, this study will be unique and has the potential to begin to characterize the beneficial role of playful humor integrated with art

t

certain risks, to open up to self-discovery through interpersonal communication, and to gain a sense of being in control.

Methodology

Humor can be said to serve as a source for the regulation of affect, the integration of conflicting feelings and an amused or somewhat distanced perspective on life in general (Lemma, 2000). For the purposes of this pilot study, I strove to model this perspective of playful humor in the therapeutic space. My primary approach was non-directive art therapy presented in a playful framework with adjunctive humor and narrative therapy components.

Playful humor, as I conceived it and employed it in this study, involved the reciprocal dance of playful interaction and appreciation of humorous expressions between therapist and client. This interaction was initiated by the joke presentation from the therapist and in some cases interchange of jokes in the first session. This joke offering continued to be a feature of each session but gradually the spontaneous appreciation and production of humor within the sessions evolved to become a natural mode and aspect of the interactive process of play resulting in an atmosphere of playfulness.

The committee for research with human subjects for the hospital approved the study. An informed consent was obtained from the parents (see Appendix B).

Session 1: Establishing The Playful Framework

In the first session, following our introductions I gave a brief description of art therapy and assured the client of confidentiality. We toured the room and the materials. I began the process of introducing humour into therapy by asking the

client if she/he liked jokes or funny stories. After the answer, I asked, "What do you find funny at home?" "What do you laugh about with your family?" After the reply, I said, "I have a joke for you, would you like to hear it?" If the child said yes, I would tell a joke appropriate to the child's developmental stage⁵. Using the approach of Yorukoglu (1993) and Adams (1982), I asked if they knew a joke to tell me⁶. If they did have a joke, I listened, responded with enthusiasm, and then asked if I could write down the joke and keep it for my collection.

The remainder of the session included a semi-structured art activity designed to allow the client and myself to get acquainted. The child was offered a choice of media and told that art activity in this instance was seen as a means of self-expression or communication, not an art-making exercise. There would be no judgment or critique of the creations. When an opportunity afforded itself I would inject a playful, humorous perspective on the first session circumstances. I would wonder out loud, for example, if they might be thinking that I was a rather strange ancient-looking person to be working with them. I wondered too if they might be feeling a little nervous as I was. I would point out that I had brought my clown nose in case I got particularly nervous. I would go onto explain, "I sometimes feel calmer when I put it on." "Would you like to see it?" This dialogue altered for each child, depending on the child's age and special circumstances, but I tried to include some playful humorous interchange in the session.

⁵ Except for J who was effectively deaf and in this case I used visual humor

⁶ I was fascinated to read about Yorukoglu's use of the first joke with children. However, I was very skeptical about the diagnostic significance of this approach. Nevertheless I employed the request for a first joke in the pilot study as a primer and a way of initiating humor into the session.

Reflexive Note

This initial approach seemed to have a positive effect on the children. They cooperated freely and appeared to be at ease with the joke receiving and telling although they were rather surprised at first. The procedure was beneficial for me at the beginning of therapy as it put me at ease with the children and their obvious pleasure helped us both to relax and interact more easily. In one case, I was unwilling to initiate a joke in the first session, as the client was extremely oppositional. As a result I found myself questioning the value or benefit of the pilot study in general. I asked myself the question when is it inappropriate to engage in playful humor? On many occasions throughout the process I would have to stop and reexamine my motives and the premise of the project. I still believe my decision not to introduce humor in the first encounter with a very distraught client was the correct approach. I also had to completely change the art therapy during this session. So clearly, sensitivity to the circumstances is required.

With the majority of children the use of humor in the early sessions seemed to ease the child and therapist into the therapeutic relationship. It helped to establish rapport between us and stimulated a rapid initiation of the therapeutic alliance.

Ongoing Therapy

As the sessions progressed, I continued to offer a joke at the beginning of each session. I attempted to make the jokes fit the interests and developmental

stage of each child⁷. On a few occasions, I used cartoon images instead of jokes.

In addition to the joke interchange ritual, spontaneous expressions of humor initiated by myself and by the children occurred throughout the therapy. My own humorous responses included visual humor in the form of funny drawings or 3D objects that fit into the art therapy process, contextual humor that occurred in the course of our interactions, self-deprecating⁸ or self-directed humor - making fun of myself, and an appreciation of things the children said or did that I found amusing. This latter response as expressed in the form of laughter and sometimes then an explanation of what I found funny. The children themselves often interjected their own humorous material sometimes as verbal humor, usually contextual, as visual humor in the form of funny artwork creations or as a combination of both.

In all the sessions, I continued to play with the client in a collaborative manner with an open, curious and positive attitude. In response to the work of the children I sometimes produced humorous plasticine objects that integrated into the play. I also used non-verbal expressions to mirror the clients' feelings and to express an attitude of flexibility and toleration of ambiguity -- joy, anger, pleasure, sadness, or any feeling they expressed during the session were welcome.

⁷ As I progressed with this procedure I found searching for developmentally appropriate and inoffensive jokes to be increasingly challenging and time-consuming.

⁸ The term *self-deprecating humor* is, an example of funny, as opposed to hostile humor. Commonly it is used (Franzini, 2001) to describe humor that turns back on the humorist as, a clown who trips over his own feet and laughs about it. This could also be called "self-directed humor" (Lefcourt, 2001, p. 72). For the purposes of this paper and in the interests of clarity self-directed humor will be used throughout the paper.

I used an interactive approach drawn from the humanistic model (Axline, 1989; Rogers, 1961) to emphasize the use of "reflection of feeling, safety...warmth...[and] empathic understanding" (Rogers, 1961, p.167). My attitude and relational stance consisted of a combination of a narrative therapy and art therapy (Anderson and Goolishian, 1992; Riley, 1997). From the therapeutic position of "not knowing" (Anderson and Goolishian, 1992, p.36) I adopted a collaborative stance with the client. Externalization of the problem was used to separate the child from his or her problem. This approach involved collaboration with the child, a playful approach to discovery of his or her skills to solve the problem, externalization of the child's story or narrative thus separating the child from the problem and personification of the problem by literally naming it⁹. This externalization was achieved first through dialogue and then by means of art expressions. The next step after first finding and defining the "problem plot" was to begin to devise the alternative story "counterplot" (Freeman, Epston, & Lobovits, 1997, p.96).

The therapy provided opportunities for the clients to make decisions and solve problems with the materials in order to improve their decision-making and problem solving skills (Rubin, 1984). This therapy was designed to achieve mastery over the art materials and allow the clients to gain confidence in themselves and a sense of competence beyond the art room.

My approach to the creative process was to be open-ended about the activity, with an emphasis on process rather than product. I offered

⁹ For each client this approach was altered to suit the individual. Personification of the problem, for example, did not suit the oldest children.

encouragement to participants to go ahead and try to do whatever they wanted. For some of the children more containment and direction helped them to feel safe and contained so they could play; in this case spontaneous play would have been threatening. There were no consequences of failure and no hidden agendas. When the child reached out and pursued a challenging goal, I encouraged him or her. Often, they would turn to the task with great concentration and shut out the world and their problems. When the goal was achieved, they showed a great deal of pleasure in the accomplishment. This sort of experience helped to engender a sense of joy in mastery (Ruch, 1998) over the art materials and by extension, over their lives.

Sometimes when we played a game that the child had created, I would amplify the situation to make it more comic; for example, saying in a playful manner, "You're beating me, oh dear, now what am I to do?" This would encourage a playful atmosphere. Whenever something did not work out during the play, for example the legs of the dinosaur fell off, a humorous approach was applied to remedy the difficulty. The child was encouraged to deal with their problems within the playful framework, sometimes in metaphor and sometimes directly. Thus, they practiced coping with their problems, without being overwhelmed by them. Often this involved a "titration" process in which the child would be assisted to approach and then withdraw from the problem, gradually oscillating in and out as a means of working through the problem. This allowed the child to confront the externalized problem in a supportive environment with a lighter mood.

In some cases I had to regulate the amount of humorous play, so the child did not get out of control. I had to be especially careful with dramatic interactive play with puppets or stuffed animals so that the child might experience joy, but still remain in control and not become over stimulated and giddy.

Reflexive Note

Four of the six clients were outpatients and therefore dependent on their parents for transportation. At times this became a source of frustration for me, as they were not always reliable. After missed sessions we sometimes lost our momentum and the children sometimes expressed embarrassment at their absences. The joke ritual usually helped to break the spell.

One aspect of joke telling is the necessity for rehearsal. Sometimes my delivery and timing was less good and I think this reduced the impact for the client. More preparation would have improved this.

From the outset, working as a therapist-in-training as well as a novice researcher seemed to compromise the effectiveness of both tasks. As a therapist my goals of progress and positive change in the client required that I see the child with Freud's 'third eye' while expressing empathy and sensitivity. My role as a researcher required a greater distance and objective observations. Although the research was important, my priorities always lay with the child and the delivery of the art in therapy. Throughout the pilot research study I was constantly aware of my limitations in this regard.

My confidence and enthusiasm for the use of humor in art therapy wavered during middle therapy. Needless to say, much of the work involved

slogging along in pursuit of an unknown outcome, which would be determined by the nature of the therapeutic process and the emerging strengths of the children. As a novice therapist and researcher I began to lose my resolve. After observing positive responses from the children in the early stages, I found myself wondering what my goals were at this stage. I grew unsure about the purpose of the joke in therapy and I pondered the limitations of the use of the joke interaction. I found the more spontaneous humorous interactions and banter to be more meaningful for some of the children and myself. However, the children who needed more structure still appreciated the joke sequence but I didn't! I found myself trying to analyze the results before the study was over. I was beginning to take the whole thing too seriously and I had to remind myself to rely on my own sense of humor to deal with the ambiguity of my double role as therapist and researcher at this stage.

Data Collection

In the beginning, I made two sets of notes and took pictures of the artwork after each session. One set of notes was for the hospital records and included: a brief description of the client history, the observed behaviour, the therapist's perception of the observed behaviour, and a restatement of therapeutic goals. The second set of notes was for the research records and contained: detailed observations of the interactions between the therapist and the client, expressed emotions, a description of the art activities, a description of the art work, any humorous events, stated goals, progress towards the goals and my reflexive responses.

It was extremely challenging to articulate the nature of the humorous interactions with enough detail to characterize them in these general notes. I therefore developed an observational chart, modified from Rubin (1984), to record various observations about the session including use of humor and response to humor (see Appendix C). In addition to the observational chart, I started to audio tape the sessions. The taped records ameliorated the difficulty of my dual therapist/researcher role so that I could remain attentive to the client without feeling anxious that I might be missing something during sessions.

The observational chart was still insufficient to characterize the humorous interplay. It was not sufficiently detailed to capture the humorous occurrences and the other observations were not material to the study. As I observed the humorous exchanges more closely, I began to distinguish the significant component parts and characteristic qualities of the humorous exchanges that needed to be recorded. I therefore revised the observational chart to focus exclusively on the humorous occurrences in each session (see Appendix C). This "humorous-occurrence, humorous-observation" chart (HOHO) recorded the content of the event, the initiator, the type of humor, delivery (auditory, visual, written), context, rationale/motivation, responses, and a reflexive comment by the therapist. The HOHO chart assured that I recorded all elements of each occurrence. The audiotapes allowed me to verify the details and fill in the gaps. I believe a major outcome from this pilot study was the development of this HOHO chart.

Termination

The procedure for each session did not change during termination except that we processed the emotions associated with this part of therapy. On the final day of therapy I again asked the questions that I had asked on the first day: I told them that I was going to ask them some questions that I had asked a while ago. "What do you find funny at home?" "What do you laugh about with your family?" I then added what do you find funny yourself?

Reflexive Note

At the time I felt that during the termination stage the joke sequence was merely serving as a diversion from the processing of emotions associated with ending and saying goodbye. By this time finding appropriate jokes was becoming increasingly challenging and I was frankly getting tired of it. As the therapeutic relationships were so secure, the interchange seemed to have lost most of its usefulness at this point. Nevertheless, the jokes and what seemed like my interminable quest for the perfect joke, did have an ameliorating affect on me, as the therapist, and I think may have provided a stabilizing quality to the last sessions for the children. My feelings of sadness about the endings, and my angst, as an inexperienced therapist, concerning my ability to help the children to have 'good' terminations, were partly offset by the humor material. They forced me to look at this difficult time with a joke in my pocket, so to speak.

In addition to the answers to the direct questions about the joke sequence and the children's attitudes to humor, I received spontaneous feedback, which suggested that for several children, the humorous atmosphere of the sessions

was a memorable and meaningful element of their therapy experience. Even Arthur who had maintained his cool exterior throughout the sessions admitted that I told good jokes and asked me where I had found them all.

Chapter 4: Observations

This study involved six children ranging in age from 9 to 15 years old with a number of behaviour and mood disorders (Table 1). The clients were referred to me through the emergency ward follow-up team. Supportive case materials are given in Appendix D. Pseudonyms have been given to the children to protect confidentiality.

Session 1: Establishing The Playful Framework

The First Joke

The questions “What do you find funny at home?” “What do you laugh about with your family?” revealed a limited experience of humor in the home. Humor did not appear to be a large part of their family life for any of the children. In response to the request for a joke from the child, three of the children thought of a joke to tell.

Cheryl (9) first mentioned that she and her family laughed at television shows. She then immediately related her joke: “What do you get if you cross a parrot and a pig?...A bird that hogs the conversation.” She delivered the joke with enthusiasm and confidence and this informed me that she was in the habit of telling jokes. She enjoyed having the power to tell the joke. When it was obvious I did not know the answer, she tried to give me a hint and she waited until I said I did not know the answer. The joke on the surface is a riddle with a play on words. However, Cheryl's joke revealed more than a child's riddle. Cheryl was referred to therapy as part of an overall family therapy strategy as her brother was acting out, oppositional, and violent at home. Her brother was

Table 1: Summary of Assessment Data

| Client | Age | Diagnosis | Reason for referral | Family context/dynamics | Therapeutic goals |
|--------|-----|---|--|---|--|
| Cheryl | 9 | Parentification | Violence in family | Alcoholism and violence/spousal and sibling conflicts. Brother with psychiatric problems is violent to Cheryl | To recapture missed opportunity to play and to work through violence issues and develop self confidence |
| Daniel | 10 | PTSD, impulse control | Sexually assaulted and violent behavior at home | Abandoned by drug-addicted mother, living with father, grandmother and brother. Volatile home environment. | To play to recapture missed nurturing from early stages of development - to build self-esteem, to gain mastery over emotions and impulses to reduce his anxieties |
| Amy | 11 | School Phobia and anxiety | School refusal | Amy's family has a long history of psychosocial difficulties and psychiatric problems. Her mother is a recovering alcoholic (for the past 4 years). | To build self-esteem, increased mastery over her daily life, a more flexible attitude to problem solving and an enhanced ability to make decisions and act independently and thus to conquer her anxieties |
| Jason | 11 | Overanxious disorder, sleep disturbance | Nightmares, anxiety at home, sleeplessness | Highly stressful family dynamic partly focused on client's deafness. | To gain mastery over his fears and allow him to express his feelings |
| Arthur | 12 | ADHD, mood and behavior disturbance | Violent behavior at home, running away, depression, suicidality | Alcoholic parents. Family discord | To build trust and support the expression and sublimation of emotions through art expression. To decrease anxiety and to gain a sense of mastery and control |
| Tanya | 15 | Adjustment disorder of behavior and mood, oppositionality | Running away, conflict with mother, suicidality, violence, oppositionality | Single mom and four siblings at home. Alcoholic step dad. Prolonged separation from family from age 5-11 yrs. | To build self esteem and gain mastery over her feelings and behaviors, to explore feelings surrounding past rejections and abuses and to make connections between past and current relationships |

completely overwhelming the family with his behaviour, much like the hybrid parrot-pig. Her joke expressed the core conflict with which Cheryl and the family were struggling.

Amy (11) reported that she and her family laughed at the antics of her pet cats. She told a joke of her own invention; she was the only one to do this. She began with a half apology. She said, "It's one that I made up myself, not one I read." I encouraged her and she went on. "With what sort of feet does a bear cross the street?...Bear feet." This joke revealed her well-developed imagination and her skill with words. The joke on the surface seems a benign play on words. However, during therapy Amy's issues contained a sense that she was out in the world "unprepared." She had school phobia and could not travel on the bus to school due to an overwhelming anxiety. She had very unclear boundaries with her mother and so she felt unprotected when she is away from her mother. Therefore, crossing the street or taking a chance, while in bare feet or unprepared, is a perfect metaphor for her vulnerability in the world. Again the first joke revealed the child's core conflict.

Arthur (12) said there was nothing particularly humorous at home and at first he could not think of a joke. He then explained that this was a joke his teacher had told but it was not very funny. He then related the following joke: "A drunk goes into a forest and finds a leprechaun. The leprechaun says, "I'll grant you two wishes if you let me go." The drunk agrees and asks for a beer that never runs dry. Instantly a stein of beer appears. The drunk says, "Great, give me another one." This joke seemed to be an adult joke, which did not appear to

have any relationship to Arthur's presenting issues: oppositional behaviour, ADHD symptoms and acting out at home. The joke is amusing as you first realize how silly the request was for a second bottomless stein and then it has a sour ending as you realize how pathetic the drunk was. I could not see any connection between Arthur and the joke at that time as there was no indication of alcoholism in the assessment report. I was puzzled by the joke. During the first 6 sessions, it was clear to me his behaviour was influenced greatly by his family life but it was unclear what was affecting him so deeply. It was revealed much later, in a second assessment interview, that both his parents were alcoholics. It is amazing to me that Arthur and his parents had successfully avoided divulging the "family secret" during the assessment and Arthur kept it secret for many sessions of therapy. Yet Arthur had communicated the problem to me in the unconscious material of the joke in our very first session.

All three children who volunteered a joke in the first session revealed something of their core conflict in the joke¹⁰. When I asked the children for permission to write down their jokes for my collection, they were generally impressed that they would have such a distinction. By this means they seemed to understand that they were contributing or helping me. Their contribution of the joke seemed to help establish a collaborative affiliation between us rather than the authority differential the therapist/client titles project. The collaborative stance is important, as the next step was to introduce play between us, to build the transitional space, and implement the playful framework. The humorous

¹⁰ This fascinating case example convinced me of the diagnostic value of jokes, and the unconscious material embedded therein (Yorukuglu, 1993).

element also seemed to help establish a playful attitude. It reduced the hierarchical structure by promoting a common level of play between us and facilitated the rapid establishment of the therapeutic relationship.

Among the three children who did not volunteer a joke in the first session humor played different roles. Daniel reported that everyone in his family, except his grandmother, laughed if someone spilled something, like when dad spilled the popcorn. During the first session, as I tried to open a new tube of gold glitter glue, the tube exploded all over me, and the table where Daniel was working. There was a moment's pause. I looked at Daniel with an expression of wide-eyed amazement on my face. Then I smiled and Daniel and I laughed together. This incident caused a lot of delight for Daniel. He was amazed that I could have made what he saw as such a big mistake, and not take it very seriously. The incident was like a comic version of his impulse dyscontrol eruptions at home when he would lose complete control of his emotions in a fit of uninhibited rage. In this case, the explosion, although rather startling and dramatic, did not cause anyone to show an inability to cope or cause angry reprisals. We cleaned the glue up and went on with other things. But the event was very significant for Daniel, who laughed heartily not so much at me as with me, as I responded with amazement at the sight and range of the mess I had created. He did tease me later in the session when I mentioned that he was rather good with his hands. He smiled and said, looking down at my gold sparkly hands, "You're pretty good with your hands too." He was referring to my expert handling of the glue tube as

well as my ability to draw. It now seems understandable that Daniel found the metaphoric event both funny and liberating¹¹.

Jason (11) was virtually deaf which added a barrier to communication, and a secondary challenge to the art therapy process. At first verbal communication was halting at best with Jason, so I relied primarily on visual communication. Basic therapeutic tasks like establishing a therapeutic alliance and promoting a sense of mastery and self-assurance were accomplished without the usual flow of conversation. Jason did not volunteer a joke because I did not ask him for one. I felt that this would be too complex an interchange for the first session. Jason's family was very stressed and as a consequence Jason had overanxious disorder, with extreme anxiety at home and sleep disturbance. He was quite nervous and withdrawn at the start of the first session. We began to establish a playful framework by creating a portfolio/envelope, which, while collaborative, was not particularly funny. He then made figures with the plasticine and I made a humorous figure in response to his sculptural creations. He was surprised and delighted by my creation; he got the idea we were there to play and relaxed somewhat. Finally, he asked, "How will you put them (his plasticine objects) in the envelope?" This struck me as very funny since we had struggled so hard to grasp the meaning of the word envelope and then to make the envelope with the understanding that his artwork would be stored there. This was an incongruity for Jason as it looked like we weren't going to be able to use it. We both agreed that this was rather odd and funny and then we put the things in a box for

¹¹ I wonder if McPhee's (1979) assertion that things closest to the top of one's mind when presented in a comical way extract the greatest humorous response was operating here with Daniel?

safekeeping. Without being asked Jason initiated a funny comment into the first session.

I didn't engage Tanya (15) in the joke telling sequence in the first session because of her extreme oppositionality, verbal aggressivity, her swearing, and subsequent disclosure of sexual abuses and suicidality, although I did inject a small spontaneous humorous comment that was accepted later during that session. As the session began Tanya was in extreme distress, angry and verbally aggressive and completely uncooperative. She had arrived with an escort from a lock-up unit in a provincial correctional center where she had been sent by court order and at her mother's request. A playful framework did not seem to be appropriate at this crisis moment.

It appears the children understood the interchange that signaled the entry into the humor framework. Bariaud (1989) emphasized that especially with children the "cues" that demonstrate to the client the initiation of a humorous framework be very clear. The process in the first session was explicit in this regard to guard against the child misunderstanding the humorous nature of the comments and having a negative or frightened response. The "I have a joke. Do you want to hear it?" at the beginning of each session signaled the beginning of the playful framework for the rest of our time together. This stance allowed for the spontaneous playful humor to arise within the session without being misinterpreted as criticism or giving rise to some other negative affect. In fact, this part of the session rapidly became a ritual.

Table 2: Humorous Occurrences for First Six Sessions for Each Client

| Client | Session #1 | Session #2 | Session #3 | Session #4 | Session #5 | Session #6 |
|--------|---|--|---|---|--|---|
| Amy | <p>Amy was tense unsure of what was going on. I asked her if she enjoyed jokes or funny stories and what she laughed about with her family at home. She answered yes she did like jokes and funny stories and that the family laughed at the antics of her two cats. I offered her a joke and she was able to tell one of her own invention. "With what sort of feet does a bear cross the street? Bear's feet."</p> <p>Cheryl was very outgoing and excited about art therapy on the first day. She was able to tell me a joke and she enjoyed the joke I told to her. She spoke about humor in her family. - Laughed at TV.</p> | <p>Amy offered another made-up joke. She also drew a cartoon about her dog putting painty paw-prints on the carpet. She tried on the clown nose and the feather boa today. A playful atmosphere was evident. I made a little dog figure to match her dog drawing, which she liked - I'm not sure she found it funny.</p> | <p>Smiled and laughed more easily. Regular joke exchange</p> | <p>Joke telling scenario has become part of the routine in each session. She expected it and responded with enthusiasm.</p> | <p>Drew comic rendition of cats in a family portrait picture Regular joke exchange</p> | <p>Regular joke exchange</p> |
| Cheryl | <p>Cheryl was very outgoing and excited about art therapy on the first day. She was able to tell me a joke and she enjoyed the joke I told to her. She spoke about humor in her family. - Laughed at TV.</p> | <p>Cheryl told me a pun - liked my joke, laughed. Tried on the clown nose and laughed at herself in the mirror. Said she wouldn't recognize me with the clown nose on. Said that some big boys at school and her older brother told bad and mean jokes.</p> | <p>Regular joke interchange. Tells of trying to play a joke on her mother that mom did not understand. Mom was just angry with her.</p> | <p>Regular joke interchange.</p> | <p>Regular joke interchange.</p> | <p>Brought in joke book, and laughed at her own drawing of a skunk running, this was my perspective as she thought she had drawn the silhouette of a car</p> <p>Arthur announces his wish to leave, terminate</p> |
| Arthur | <p>Arthur was rather sullen and cool on the first session. He said he liked funny stories and his gym teacher related jokes and told one that he said to him. He said there was nothing particularly humorous at home. "A drunk goes into a forest and finds a leprechaun the leprechaun says I'll grant you two wishes if you let me go. The drunk agrees and asks for a beer that never runs dry. Instantly a stein of beer appears. The drunk says, great give me another one"</p> | <p>Arthur was in a very bad mood this session. We worked through some physical interchanges that allowed him to relax some. When I finally told him a joke he was ready to laugh and enjoyed it (the restaurateur who asked for a clean glass). He also found the mythical creature I made out of clay amusing.</p> | <p>Reported the art therapist's jokes weren't so bad and laughed at one joke. Seemed mildly amused by my clay sculpting of figures while he worked in clay.</p> | <p>Microsoft joke: they had to change 'click any key' to click return key because people couldn't find the any key. Al knew this joke already Initiated the Bonzie Buddy voice: art therapist laughed. Made a self deprecating joke on himself about paint spilled on his pants and then described a funny story about having to run through the dog poo in the back yard</p> | <p>Regular exchange</p> | <p>Regular exchange</p> |

Table 2: Humorous Occurrences for First Six Sessions for Each Client (continued)

| Client | Session #1 | Session #2 | Session #3 | Session #4 | Session #5 | Session #6 |
|--------|---|---|---|--|--|--|
| Tanya | Tanya was extremely oppositional and verbally offensive during the first session. She was angry and scared. She disclosed an assault she had suffered recently and did some drawings to illustrate it. The therapist responded to a comment made by Tanya part way through the session that the figure didn't look like her by saying "well I don't think the ears look like your ears". This was intended to be a humorous remark and Tanya seemed to take it as such. | Played guessing game about what sport she was good at. I offered some funny, not likely options before I suggested closer choices. Tanya smiled at this. She asked for her candy that she had left behind the previous week. I gave it back and told her how hard it was for me stop myself from eating it. Later I asked her to be sure to take it this time because I was not sure I would restrain myself from eating it this week. She smiled at my playful joking. I also suggested that stores in her shoes might explain the 3 lbs that she said she had gained. She wasn't so sure. But realized that I didn't think she was fat. | Art therapist tells a joke and Tanya likes it and says she will tell it to one of the staff. Tanya showed joy in mastery of feelings drawings we did together, something like the squiggle game. | Enjoyed the joke received them as gifts and pays close attention to them. I drew a funny cartoon in a squiggle game and she laughed at this. There things are going on among very serious subject matter | Told a joke that she appeared to enjoy but she didn't really understand it as far as I could see. She still likes the exchange and the gift of the joke. | Art therapist tells basketball joke. Tanya laughs. She was also amused by the doodle drawings. |
| Daniel | Daniel was a little subdued on the first day in therapy but he relaxed very quickly. I asked if he liked funny stories or jokes and he replied yes. He said that at home they laughed at spilling accidents. The first one didn't work too well as he didn't really understand the way the joke asking and telling worked but the second one time he got it and laughed saying "that was a good one". ("Why do sharks only swim in salty water? Because pepper water makes them sneeze.") While he did not know a joke during the session, the glue tube exploded when I tried to open it. This incident caused a lot of delight for Daniel. He was amazed that I could have made what he saw as such a big mistake and not take it very seriously. | Offered Daniel a joke and he grinned in response. Playful humor was created through fish figures set on toothpicks. | Daniel laughed at funny drawings in squiggle game. Daniel asked the art therapist, "anything funny this week? Laughed at principal joke saying, "now that's funny". Although a bit unsure of the process Daniel gradually relaxed into the squiggle game. By the end he had begun to play and enjoy the therapist's funny drawings. | Regular joke exchange about daydreaming and the danger of being hit in the head by a soccer ball while playing soccer. Daniel admitted that this had happened twice already. He was able to make fun of his day dreaming with self-directed humor. | Regular joke exchange teasingly asked if he could come back tomorrow. | Regular joke exchange. Grinned and snorted at the joke. At the end of the session he noticed the mug labeled Kyle. He mimicked Kyle whose eyes seemed to be popping out of his head. I laughed and I asked how Daniel thought he looked like that and he said "too many cheese puffs could do that to you" - this was the first joke Daniel offered in the sessions. |

Table 2: Humorous Occurrences for First Six Sessions for Each Client (continued)

| | | | | | | |
|-----------------------|--|--|---|---|---|--|
| <p>Daniel (cont.)</p> | <p>It seemed to have served as a metaphor for his own explosive nature and in this case the explosion although rather startling and dramatic did not cause anyone to show an inability to cope or angry retaliation. We finally cleaned the glue up and went on with other things but the event was very significant for Daniel he laughed heartily and not so much at me as with me as I responded with amazement at the sight and range of the mess I had created.</p> | <p>In response to the dragon I had made Jason produced a plasticine carrot as a visual joke. We both laughed at it and appreciated the joke. J said that without wings the dragon looked more like a kangaroo - another visual joke. I made a baby dino-dragon as offspring of one of his creatures and one of mine. He grinned at this. He picked up the carrot saying that it was his lunch and pretended to eat it.</p> | <p>Makes a bishop chess piece with a long Pinocchio nose. Finds this funny. Made a chess clock and pretended to use it while playing rapidly with the chess pieces that we had made of plasticine. This was funny to Jason.</p> | <p>Jason suggests that I add warts and spikes to the nightmare to make him look even scarier but in the end he decided that he was a rather funny looking thing. When we talked about nightmares not being too smart Jason thought this was funny. Mention is made of a good level of trust developing between art therapist and Jason by session 4 - comfortable playing with some difficult issues.</p> | <p>Jason makes a plasticine ball and has the monsters kick it around like a soccer game. One scores a goal. He cheers and laughs with delight. Jason decides to feed the nightmares various things that we hated to eat. Jason had a lot of serious fun doing this. He gained a strong sense of mastery over the nightmares through this play. Jason said that he would like his nightmares to have a funny ending.</p> | <p>Jason uses his voice to simulate the growly voices of the monsters. He also makes and serves them 'ugly food that they don't like. He makes retching noises for the monsters. Pretends that the monsters are trying to ask for their food politely but they can hardly do it. He imitates this scenario. All these things are funny enactments.</p> |
| <p>Jason</p> | <p>As Jason is deaf I did not try to engage him with auditory jokes. Instead I used visual gestures to communicate humor to Jason. The first session Jason made chess pawn. In response I made a knight. He was very surprised by this. He smiled and showed delight in the gesture and found the response somewhat funny.</p> | <p>In response to the dragon I had made Jason produced a plasticine carrot as a visual joke. We both laughed at it and appreciated the joke. J said that without wings the dragon looked more like a kangaroo - another visual joke. I made a baby dino-dragon as offspring of one of his creatures and one of mine. He grinned at this. He picked up the carrot saying that it was his lunch and pretended to eat it.</p> | <p>Makes a bishop chess piece with a long Pinocchio nose. Finds this funny. Made a chess clock and pretended to use it while playing rapidly with the chess pieces that we had made of plasticine. This was funny to Jason.</p> | <p>Jason suggests that I add warts and spikes to the nightmare to make him look even scarier but in the end he decided that he was a rather funny looking thing. When we talked about nightmares not being too smart Jason thought this was funny. Mention is made of a good level of trust developing between art therapist and Jason by session 4 - comfortable playing with some difficult issues.</p> | <p>Jason makes a plasticine ball and has the monsters kick it around like a soccer game. One scores a goal. He cheers and laughs with delight. Jason decides to feed the nightmares various things that we hated to eat. Jason had a lot of serious fun doing this. He gained a strong sense of mastery over the nightmares through this play. Jason said that he would like his nightmares to have a funny ending.</p> | <p>Jason uses his voice to simulate the growly voices of the monsters. He also makes and serves them 'ugly food that they don't like. He makes retching noises for the monsters. Pretends that the monsters are trying to ask for their food politely but they can hardly do it. He imitates this scenario. All these things are funny enactments.</p> |

Each session I asked if I could tell a joke. I told the joke if the child agreed. This was one of the ritual play activities that we shared together. The purpose of this interchange was to introduce humor and to embody the back and forth of a humorous exchange or playfulness that mothers naturally employ to establish a bond with their baby (Bollas, 1995).

At the outset I was both curious about how each child would respond to the humor elements in the therapy and dedicated to establishing relationships that would promote progress and a way out of their difficulties. I was also very aware of the magnitude of this task and the seriousness of the conflicts that brought each child to treatment in the hospital. I was dubious about my ability to effectively help them with or without humor at this stage. However, as I met the children I had an inkling of their resiliency and it was to this resiliency that I addressed myself and introduced the humor.

Sessions 2-6: Strengthening the Playful Framework

While the first session with each child held uncertain expectations for both of us, during the next several sessions a playful and mutually supportive relationship began to form. This was a process in which trust developed and the therapeutic alliance was established. To establish an atmosphere of playful humor I employed intentional and spontaneous humor techniques that were of relevance to the client's own conflict situation or personal characteristics. For example, I continued the joke telling ritual at the beginning of each session and attempted to make the jokes fit the interests and developmental age of each child (McGhee & Chapman, 1980). I also interjected humorous observations, examples of illogical reasoning, exaggerations to the extreme, self-directed humor, an enjoyment of the client's humorous creations or other humorous situations to maintain a sense of playfulness and an atmosphere of security.

This attitude became a marker for our relationship and I believe greatly helped the children tackle their issues in the short time we had together.

The joke telling sequence soon became a ritualized pattern that provided a stabilizing element in the sessions. The children expected and responded to the jokes. Some received the joke as a gift. Positioning it at the beginning of each session helped to initiate an atmosphere of playfulness. The joke cued the children and brought them quickly into a mindset where they were reassured that this was a safe place to play and express their feelings through the creative process (Bariaud, 1989). It framed the session so that even if parts of the session were hard and serious, there remained an underlying sense that, like the play, we were doing this together.

Cheryl (9) brought a pun to the second session. She was pleased when I found it funny. However she questioned me when she mentioned how her brothers told mean and bad jokes. In Cheryl's life experience humor was derisive and hurtful. The joke space during the sessions was appreciated and enjoyed but it created a paradox for Cheryl, as jokes at home did not work. She reported trying to be playful with her mom but it backfired when her mom shouted at her. This was the beginning of a long exploration for Cheryl about how things can be good and bad at the same time. She often brought in a joke to the session.

In the early sessions Daniel (10) received the jokes with interest. The joke sequence served as a cue to start the sessions and his playfulness. He continued to tease me gently about the glue explosion, but in general, humor

provided lightness and shared laughter. Sometimes he found the jokes hilarious and other times merely amusing. Daniel had a great need for play due to a deprived early childhood. Although at home Daniel was out of control, oppositional, angry, full of fear and general anxiety, these feelings and concerns were channeled through the metaphor in the artwork, the primary therapeutic agent. There was a lot of playful contextual interaction around the artwork. After concentrating very hard on the creation of a toothpick house, for example, he sat back, sighed with great pleasure and grinned showing his joy in mastery of the materials.

Although Amy (11) was very timid at first, not speaking above a whisper, she both appreciated and initiated humor in the context of playful humor and art therapy. Her predominant mode was to employ humor in her art making (visual humor). She often illustrated an idea in comic-like form with funny elements and she would also add a humorous caption to these drawings. In the early sessions her pets were the focus of her funny imagery. Amy drew a cartoon-like picture in the second session, which depicted herself as 2-year old with a dog on a carpet covered in black paw prints. The caption read, "bad dog" (Figure 1).

This cartoon was revealing as the dog was the only faithful influence in Amy's early life, as her mother was an alcoholic and unreliable. So in fact the dog was not bad but her whole life was bad. The comic drawing revealed the unconscious material of the poignancy of her early life. In a later session, Amy drew her family and her two cats (Figure 2). Amy portrayed the cats in a comic manner within a scene where her mother is portrayed with arms too short to hold

her and her brother is shown as distant. The cat that likes to get out and prowl around peers out the window, and the other cat that sleeps a lot is barely visible in his basket. The cats reflect two, as yet unexplored, sides of Amy -- one side wanting to get out and the other needing to stay home. Her unconscious self-exploration was depicted in this comic style.

Although Jason (11) was a good lip reader, due to his deafness communication, humorous and otherwise, took place more in the visual realm and with notes on a pad. Instead of the joke interplay I presented visual humor in the form of plasticine figures created to relate to the creations Jason was making. Jason caught on quickly. In the second session he created a plasticine carrot to feed the dragon I was making. This sort of give and take of humorous objects became a hallmark of the sessions with Jason. He made a dinosaur and I made a "dino-dragon", which Jason found very funny (Figure 3). He was also amused with the dragon as he thought it looked more like a kangaroo. At the end of the session, he offered the carrot to me, which I interpreted as an attempt to acknowledge our growing relationship. It also reflected his family role of over-responsibility at home -- caring for the adults in his life. Jason had a tendency to be quite self-critical. Sometimes these expressions had a comic flavor. In an early session he made a very life-like replica of a pencil, complete with eraser and all. I responded with appreciation of this creation, which pleased him but he said, "It doesn't really work" and showed me how he could bend it in half. Then he smiled broadly.



Figure 1. Amy, bad dog (12" x 16")

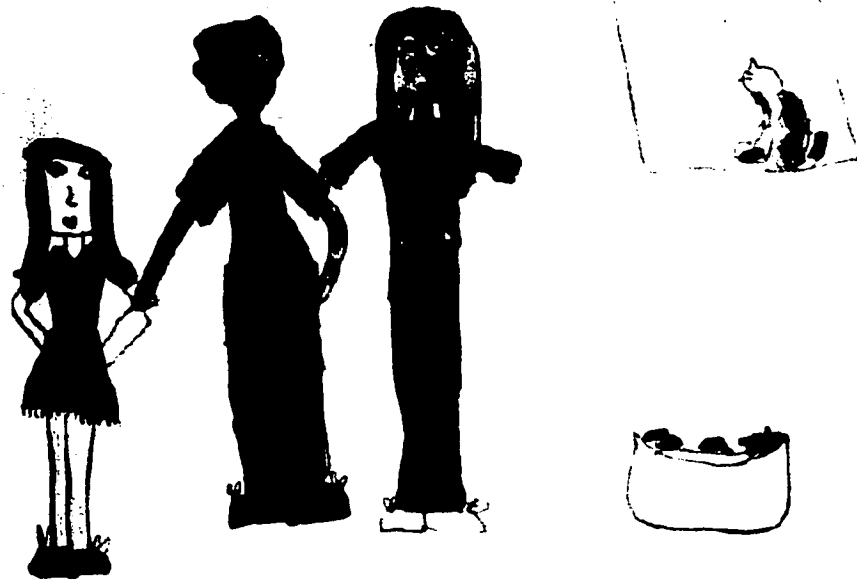


Figure 2. Amy, family portrait (12" x 16")

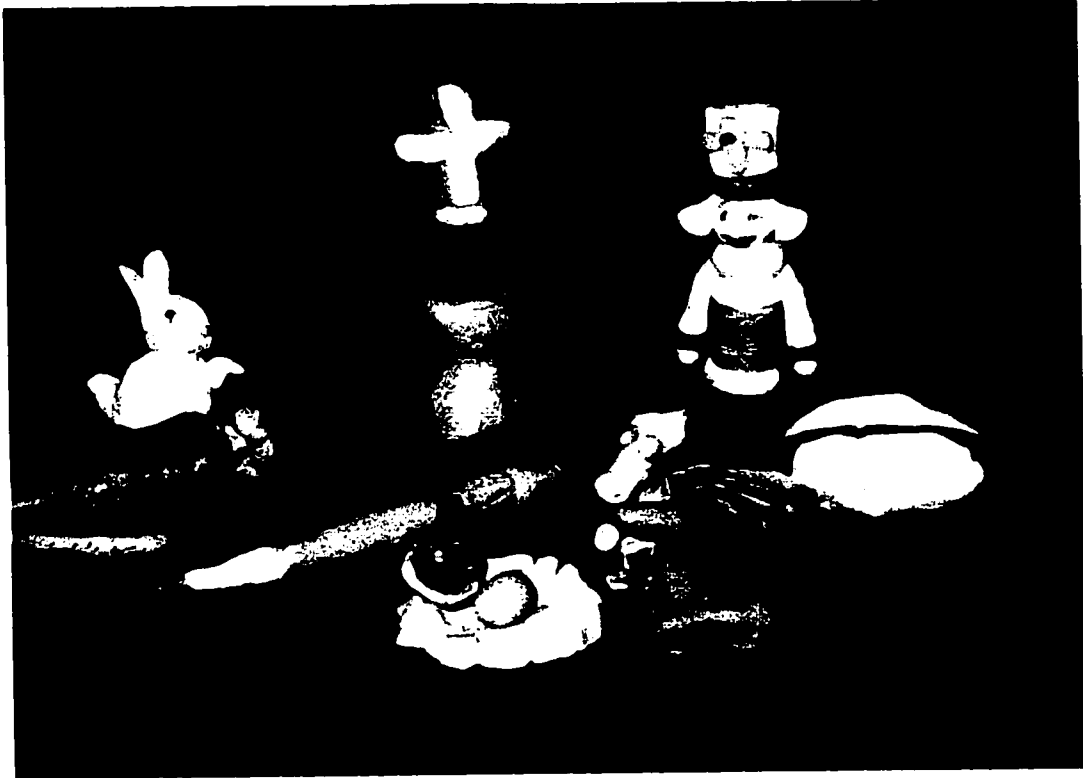


Figure 3. Jason, Dino-dragon, carrot, pencil and dragon (carrot 2.5" long)

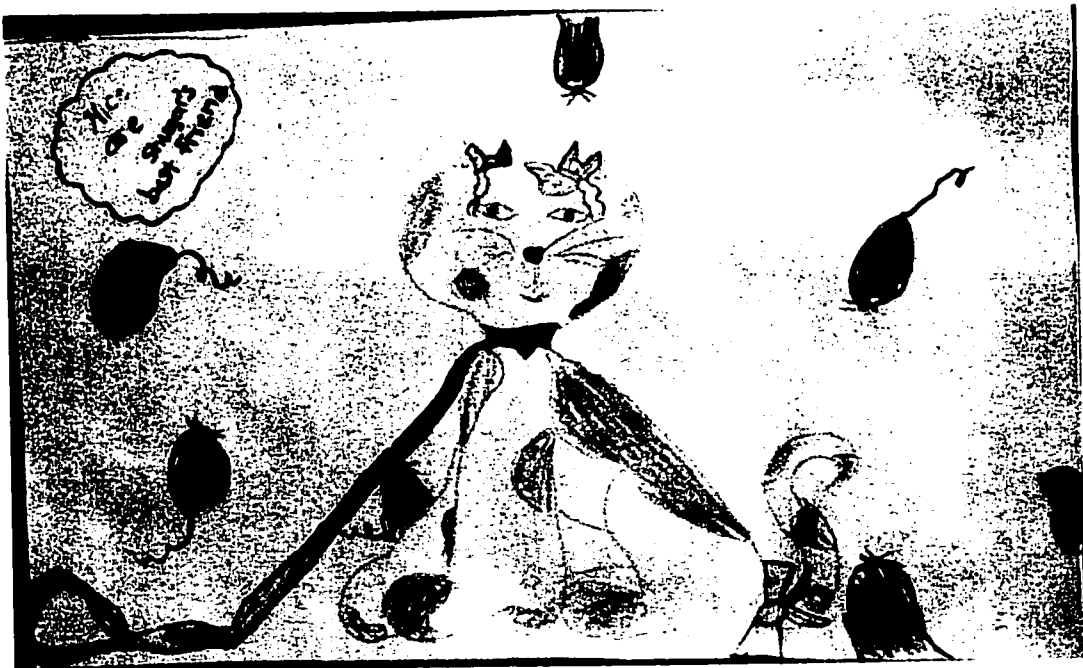


Figure 4. Amy, I love mice (18' x 24")

Arthur (12) being a preadolescent was “cool”. Although I tried to aim the jokes at this level he would give the impression of having heard the joke already or imply that it was a bit lame. I was always willing to admit and often did, that I needed a new source of joke material. This self-directed comment was more enjoyable than the joke sometimes. He was often loath to laugh at the jokes although sometimes he could not help himself. In general, beyond the joke interaction, the humor in the sessions was contextual. For example, while building a sculpture he had managed to drop the masking tape into the wastebasket, by mistake. With a sheepish grin he remarked, “I wish it was that easy on the court!” This self-directed humor was a first sign that Arthur was willing to show a little of his non-perfect side. In Arthur’s family alcoholism was a closely guarded secret so exposing anything was very difficult for Arthur. At one point when he had somehow managed to get glue on his forehead, I suggested that this would not be a good time to bang his head against the wall. He then went into a dramatization where he pretended that his head and then his hands were stuck to the wall. He pretended to be asked by another person, “Are you ok Arthur?” It was clear he was stuck to the wall but the fictitious person left saying, “Let me know when you get hungry.” We both laughed at the humorous enactment . This dramatization again reflects Arthur’s willingness to reveal his closely guarded imperfections and share himself with me. He was also able to look at the idea of expressing anger with physical aggression, part of his presenting problem, in a humorous manner. He was also beginning to see his behavior from a humorous perspective. Arthur had portrayed himself being

stuck with no one really noticing. This serious situation was processed the following week when Arthur was able to articulate his feelings of pain, anger and hopelessness living in an alcoholic household. The humorous enactment was revelatory of Arthur's family predicament. Furthermore, the humor provided a metaphor, which allowed Arthur to talk about his secret and recognize that someone was listening.

Tanya (15) enjoyed the jokes I told her and often asked me to repeat them so she could remember them to relate to others. She seemed to receive the jokes as gifts. However, although she always smiled or laughed at the jokes it was clear that she sometimes did not understand them. For example, when told a joke relating to her interest in basketball – Q: "Why was Cinderella such a bad basketball player? A: "She had a pumpkin for a coach" she did not know the word 'coach' as a wheeled vehicle. In this example, her deprived upbringing, and her limited language skills, prevented her from recognizing the word play. Although her intelligence seemed normal, her development appeared to be delayed, and her appreciation and understanding of jokes fit a much younger child. Nevertheless, like a child learning to speak, she valued the jokes and wanted to hear them each session. The artwork was the therapeutic modality and the humor was an enriching agent for Tanya.

During the fifth session Tanya was still struggling with feelings of anger and rejection by her family. As she worked in clay she complained that her pants were too tight – she needed new ones but her mother wasn't going to buy them. There was apparently no solution to this problem. I commiserated with her about

this issue and then I suggested that she probably wouldn't want her pants to be hanging loosely. She laughed. The image of her pants being so big that they wouldn't stay up had not occurred to her: the idea struck her as very funny. The humorous remark seemed to release her sense of hopelessness temporarily and Tanya was able to refocus her attention on her creative work.

In art therapy sessions two to six, humor seemed to promote a positive emotional experience shared between the child and the therapist. This in turn established a strong therapeutic alliance in which serious and amusing thoughts and feelings could be explored. Humor also began to promote the playful discovery, expression, or appreciation of the absurd and incongruous occurrences that happened in the course of therapy.

Middle Therapy: Exploring the Playful Framework

The number of sessions with each client and the overall length of therapy varied (Table 3). The children responded differently once the playful space and a trusting relationship were established.

Table 3: Time Variability of the Therapy Experience

| <i>Client</i> | <i>Age</i> | <i>Number of Sessions</i> | <i>Overall period (weeks)</i> |
|---------------|------------|---------------------------|-------------------------------|
| <i>Cheryl</i> | 9 | 17 | 27 |
| <i>Daniel</i> | 10 | 17 | 25 |
| <i>Amy</i> | 11 | 27 | 28 |
| <i>Jason</i> | 11 | 13 | 12 |
| <i>Arthur</i> | 12 | 15 | 27 |
| <i>Tanya</i> | 15 | 36 | 26 |

During the middle therapy sessions Cheryl (9) enjoyed the humor and jokes (Table 4) considering the latter a gift. She sometimes told me jokes, which was surprising as jokes in Cheryl's family were reportedly used to put people down and to shame them. Cheryl used the humor to relate to me. For example, she brought me a book of jokes. She sometimes asked for a joke, as she liked a well-structured session. She even offered to help me find a joke for the next session. She would sometimes tell me a joke she knew was rather gross just to see how I would respond to it. Would I accept it and her or would I reject both? Cheryl lives in a deprived environment and her mother is not reliable. In a session, involving dramatization, she enacted a scene where two bullies laugh derisively at their victims. Cheryl did not really understand humor as it was so distorted in her life. She liked that I liked jokes and so she enjoyed them. The art therapy had allowed her to deal with her violent family situation and her position of parent to her mother. For example, the play activity allowed her a respite from her daily life as the adult in the family. Instead of the arbitrary and unpredictable chaos of her life at home, she was enabled to plan and manage her play experience in the therapeutic setting. She was also able to express her feelings through the art in a safe place.

At one point, there was a disturbance in the therapeutic alliance between us. I had begun to tape record the sessions and although she agreed to allow it, her fear of the foreign machine caused her to withdraw and disengage from our playful interactions. She stopped talking and exchanging eye contact with me. My countertransference at first was to feel angry – likely her feelings towards me

Table 4: Humorous Occurrences: Cheryl¹²

| Observation Session | Middle | | | | | | | Termination | | | |
|---|--------|---|---|----|----|----|----|-------------|----|----|----|
| | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| Creates humor (verbal, written, visual) | ☺ | | ☺ | | | | | ☺ | | | |
| Makes up funny comments | | | | | | | ☺ | | | | |
| Uses humour to master difficult situations | | | | | | | | | | | |
| Enjoys the humour of others | ☺ | ☺ | ☺ | ☺ | ☺ | ☺ | ☺ | ☺ | | ☺ | ☺ |
| Laughs/smiles at others' jokes | ☺ | ☺ | ☺ | ☺ | ☺ | ☺ | ☺ | ☺ | | ☺ | ☺ |
| "Gets" most jokes | ☺ | ☺ | ☺ | ☺ | ☺ | ☺ | ☺ | ☺ | | ☺ | ☺ |
| Amused at own expense | | | | | | | | | | | |
| Laughs in the midst of adversity | | | | | | | | | | | |
| Enjoys incongruous objects, actions or events | | | | | | | | | | | |
| Expressed joy in mastery of play | | | | | | | | | | | |
| Performs incongruous actions/pretending/fantasy | | | | | | | | | | | |
| Tells a joke | ☺ | | ☺ | | | | | | | | ☺ |

¹² The data in this table came from the HOHO chart and is adapted from humor categories used by Ruch (1998).

for putting her in a potentially threatening position over which she had no control. This circumstance was very like her home environment in which violence and fear of reprisals without warning were all too familiar. At one point she turned her back to me and I switched the baby figure for a game-playing piece and placed the two other child figures in absurd locations in the dollhouse scene she was playing. When she turned back, she looked down at the figures, her eyes darting around the scene. Then she looked up at me and laughed heartily. This was the beginning of the re-attunement of the therapeutic alliance. Together we addressed her fears of the mysterious tape recorder and what it was really doing. In the following session Cheryl recorded many fairy stories into the machine. She enlisted my help to play different roles and then we listened to the stories played back on the tape. She was delighted with the results and often asked to replay part of a session. The 'dreaded' tape recorder finally became a symbol of her freedom to play and control experiences and a mechanism from which she derived pleasure in her own playful self-mastery.

Throughout therapy Daniel (10) enjoyed the humor and jokes (Table 5). In the middle sessions, Daniel kept a breathtaking pace, moving from one activity to another finishing, cleaning up and moving on as if he was trying to cram as much as possible into each session. This behavior also suggested a level of agitation similar in kind to the impulse dyscontrol he struggled with at home. As a means of calming Daniel, reducing the pace problem and giving Daniel some control over himself, I introduced him to Snuffles. Snuffles was a large stuffed bear that, I explained, was having trouble because he was jumpy

and agitated and the other bears in the room were finding this intolerable. (That is why we found Snuffles sitting face to the corner the first day we met him.) Together we tried to help Snuffles, to slow down. Daniel was very sympathetic and worked very hard to help him. He controlled the pace of his play with the plasticine and the bubbles so that Snuffles wouldn't get over excited. Snuffles took part in all the art therapy activities from then on. Daniel enjoyed entering into the fantasy and role-playing. The playful nature of the sessions gave Daniel some extra joy. I believe that the humor facilitated Daniel both to take control of his breathing and heart rate so he could stay calm, and to experience the joy of childhood. He genuinely laughed at Snuffles and suspended reality to enter into make-believe.

Amy (11) used humor throughout the therapy (Table 6) especially in her artwork. As therapy progressed Amy would begin a session in a rather anxious mode asking me for direction or ideas but as she began to engage in the art making process she would become absorbed, relax and play. Sometimes she would then add comic details that seemed to snowball as she went along. It appeared as though she became fully absorbed in the playful humor that freed her to be more and more creative with her funny images.

At times she was able to use humorous art expressions to work through deep feelings of loss. In the middle sessions Amy was informed that she would be unable to keep her beloved cats; they were going to be given away. She was devastated and during the session when she found out about this loss we

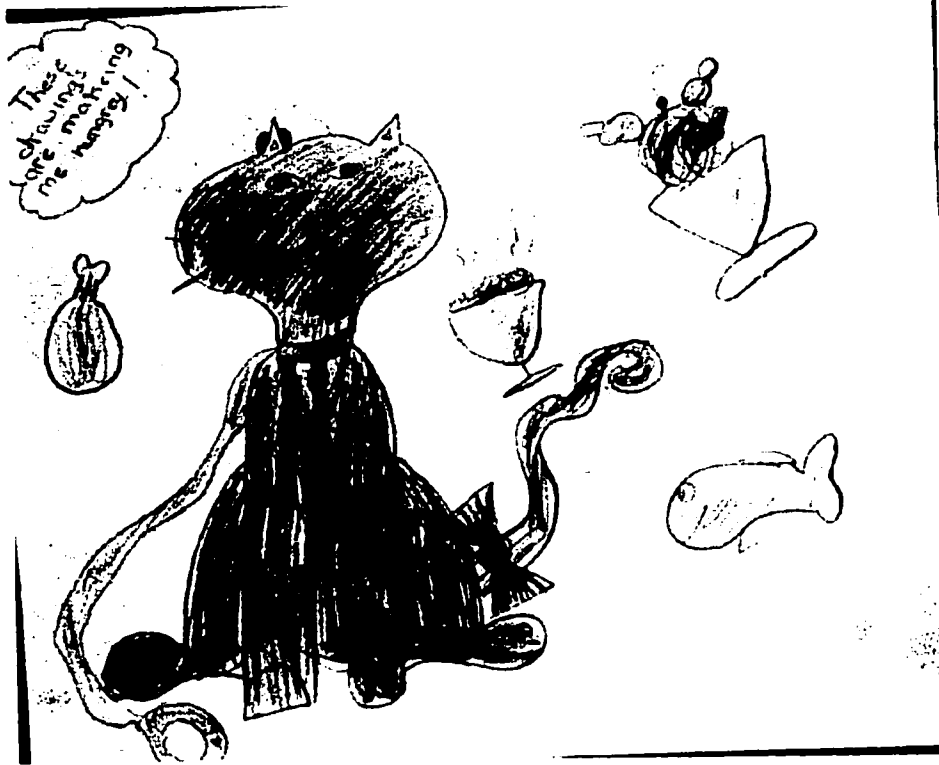


Figure 5. Amy, cat with food (18" x 20")

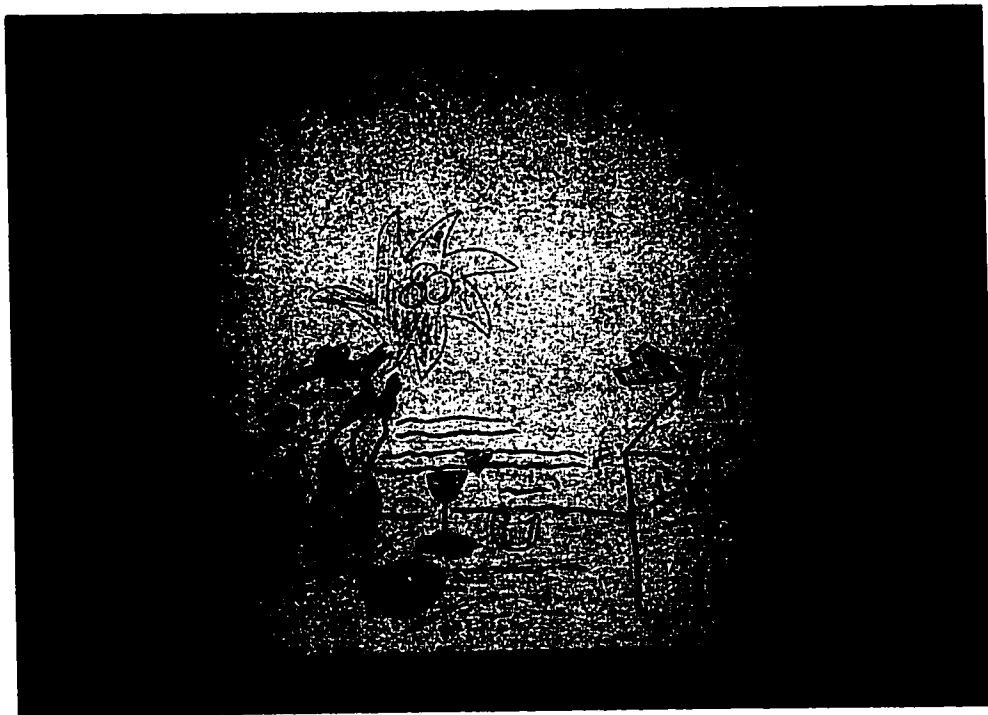


Figure 6. Amy, cats in Hawaii (18" x 24")

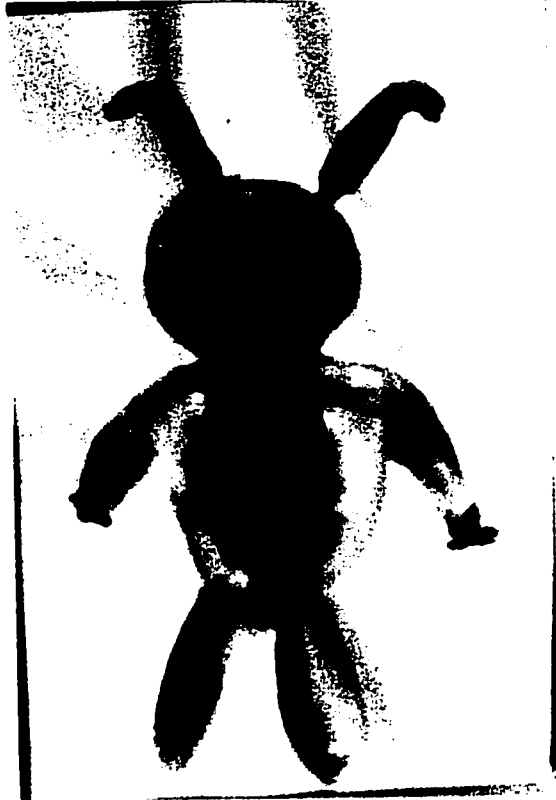


Figure 7. Amy, Mr. Meanie painting (18" x 24")



Figure 8. Amy: Mr. Meanie sculpture (4" tall)

discussed what she might do to deal with the feelings associated with this loss. She chose to draw special photo-like portraits of the cats with special bows and ribbons and extra fluffy tails. She confided in me as she went along that the cats didn't really look like this. She was making them look especially fancy. As the drawings progressed Amy became calmer and decided to add comic backdrops for the cats. One backdrop was decorated with mice and she wrote a caption, "Mice are my best friends" (Figure 4). On the other background she added pictures of all sorts of tempting foods because the other cat did nothing but sleep and eat (Figure 5). At completion Amy was feeling peaceful again and she was very pleased with her funny drawings.

On the second occasion Amy had just been informed that the cats were already gone and that she would not be seeing them in the future (at this time Amy was living on the psychiatric ward of the hospital). Again her mood was very depressed. She created a large postcard as if sent from the cats vacationing in Hawaii (Figure 6). The details on this image were again very funny as was the note that one cat wrote back to her. She wrote, "Dear Amy", "I'm sorry that Butch is not in the photo but he was busy at the buffet. "Love, Pumpkin". For a second time, it appeared that Amy employed humorous art making to make the best of a difficult life circumstance.

Amy also used humorous images to gain a sense of mastery and control. She almost always got the jokes and enjoyed them. Often Amy employed humor with her art making to express feelings or ideas related to her problems. Although Amy's creative behavior here could be interpreted as a means of

escaping the pain of grieving, through fantasy play, I feel that her playful humor in this case was a means of working through her grief. To begin with we talked very seriously about her loss, the notes she had written to herself in her diary and the deep sadness, loneliness and helplessness she felt at the arbitrary loss of her pets. She also made a very 'black' drawing about her bad feelings before she began the comic ones. As loss of her childhood, due to a painful divorce, her mother's alcoholism, and her brother's mental illness had not really been processed, grieving, by making a tangible sign of her devotion and love of the cats, was a symbolic expression of the many missed chances in her babyhood.

In another example Amy was able to employ humor as she worked through her core issues. In the early sessions Amy and I considered what was stopping her from going to school, getting out of the house, visiting her friends and generally having an active life. She decided to name this anxious, repressive character "Mr. Meanie". His first portrait was a painting of a watery black and red devil-like figure, 24 inches high (Figure 7). Many sessions later she decided to portray Mr. Meanie again. She told me how she had taken back much of her life, that Mr. Meanie wasn't very powerful or influential in her life any longer. The new Mr. Meanie was much less menacing. She sculpted him to look like a grumpy goblin (Figure 8) only 3-4 inches high. We joked about how he had shrunk and why he had such a scowl on his face. She pretended to speak to him about how he would now have to stay in the house and do nothing, the way he had treated her before. This was a very triumphant occasion. Amy felt great joy in mastery as she created this figure and his alter ego Ms. Cheerful, a sprightly

'cheerleader' (her word choice) with lots of energy and a life full of activity (Figure 9). It appeared as though Amy was able to use her imaginative playfulness, her artistic skills and her humor to work through and tackle her school phobia. Her ability to create the figures, make fun of Mr. Meanie, and laugh about the antics of the characters, through the metaphor suggests that she had gained a degree of mastery over her problem. The dynamic of externalization was a significant therapeutic factor here. Mr. Meanie, the "disabler" was personified, externalized and related to as an entity outside and beyond Amy. Mr. Meanie allowed Amy to gain perspective of her fears and phobias and thereby to take control over them.

Jason used humor throughout the therapy (Table 7). In the first few sessions Jason (11) and I discussed his fears and the way his sleep was disturbed by nightmares. Once the playful space had been established (session 2), we began to play with this serious problem (see Appendix E). I made a small plasticine creature that I introduced as a bad dream. Jason's initial response was, "OOO, Oh dear". As we began to play with the bad dream Jason chose to chain him up (Figure 10) and put him in a box. Later he made a special jail-like place with bars and a warning sign that read "Caution: Beware, Bad, Bad, Horrible Monsters inside" (Figure 11).

Jason asked me to modify the bad dreams to make them even scarier adding a tail and warts, but the modifications only made them more comical (Figure 12). Then he started to make things for the nightmares, such as very unappetizing things to eat; things like mushy peas, fish, etc. Jason began to speak on behalf of the monsters. They complained about the food being so bad.



Figure 9. Amy, Ms. Cheerful (4" tall)

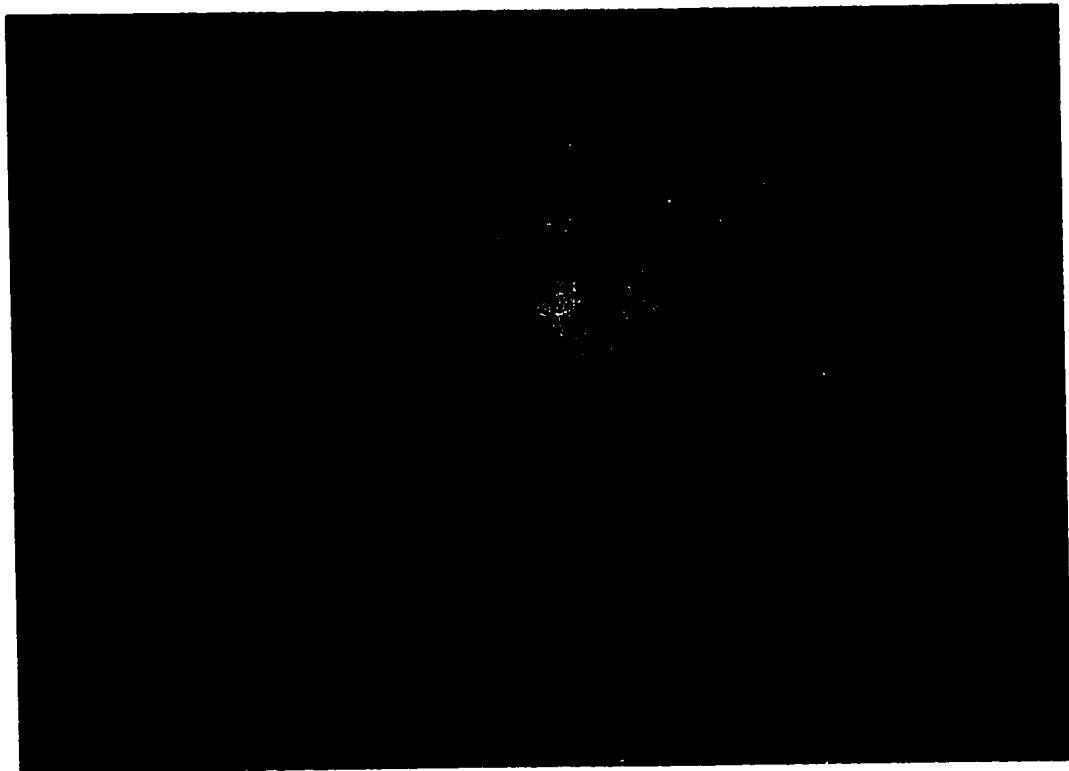


Figure 10. Jason, bad dream, chained (2" long)

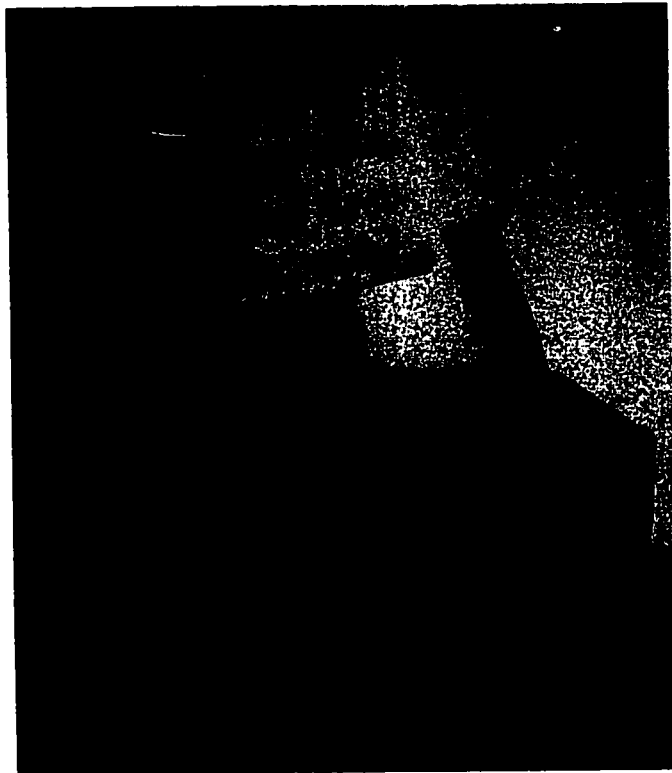


Figure 11. Jason, monster jail with sign (4" tall)

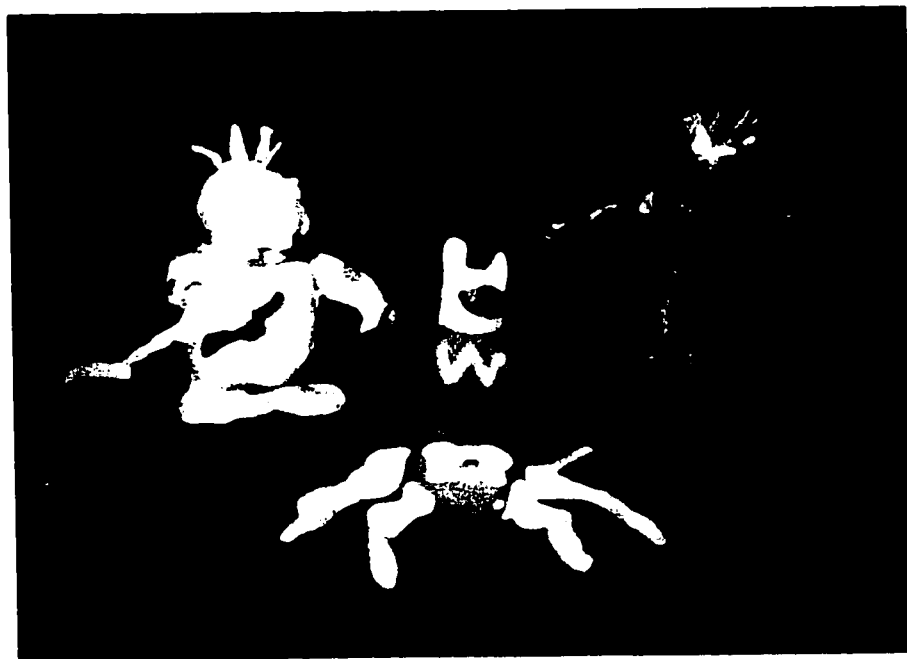


Figure 12. Jason, bad dreams (3" tall)

He also created a cafeteria with 'good' food and 'bad' food but the monsters did not have enough money to buy the good food and so they had to eat the bad food (Figure 13). Of course, Jason had enough money to buy the good food for himself and me. He next decided the monsters could have good food if they ask politely for it, but the monsters are not able to ask this way. It was just too hard for them. Eventually, he used the figures to dramatize comical scenarios and "played" with the bad dreams to make them do comical things. In one session, he made a new nightmare and then used all the nightmare creatures to play a soccer game. He spoke for one of the monsters in a monsterish voice, "Hurray, I scored!" The new nightmare won the game against the older more scary nightmares. Jason used play and humor to create a new version of his life, in which he had control of his nightmares. He could play and befriend them, and in this manner, he mastered some of his fears.

In a follow-up meeting Jason's parents corroborated that nightmares were no longer a problem for Jason, although there were still daytime monsters and stresses to conquer.

Throughout therapy Arthur (12) enjoyed the humor and jokes (Table 8). During the middle sessions Arthur used contextual and self-directed humor while engaged in art making. It was hard for Arthur to reveal or share very much about himself for fear of inadvertently revealing the family secret around alcoholism. External appearances were paramount and weakness or any foibles were not to be exposed or even admitted. These family rules and restrictions made it hard for Arthur to function in therapy. He felt he needed to control



Figure 13. Jason, cafeteria (10" x 12")



Figure 14. Arthur, fire hydrant – coin bank (16" tall)

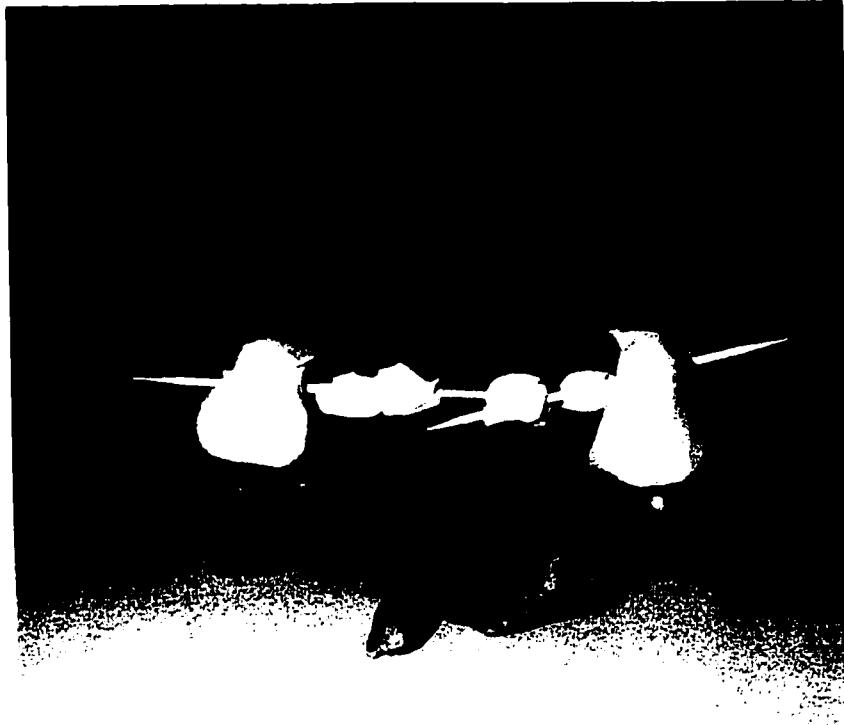


Figure 15. Jason, roasting marshmallows apparatus (3" tall)

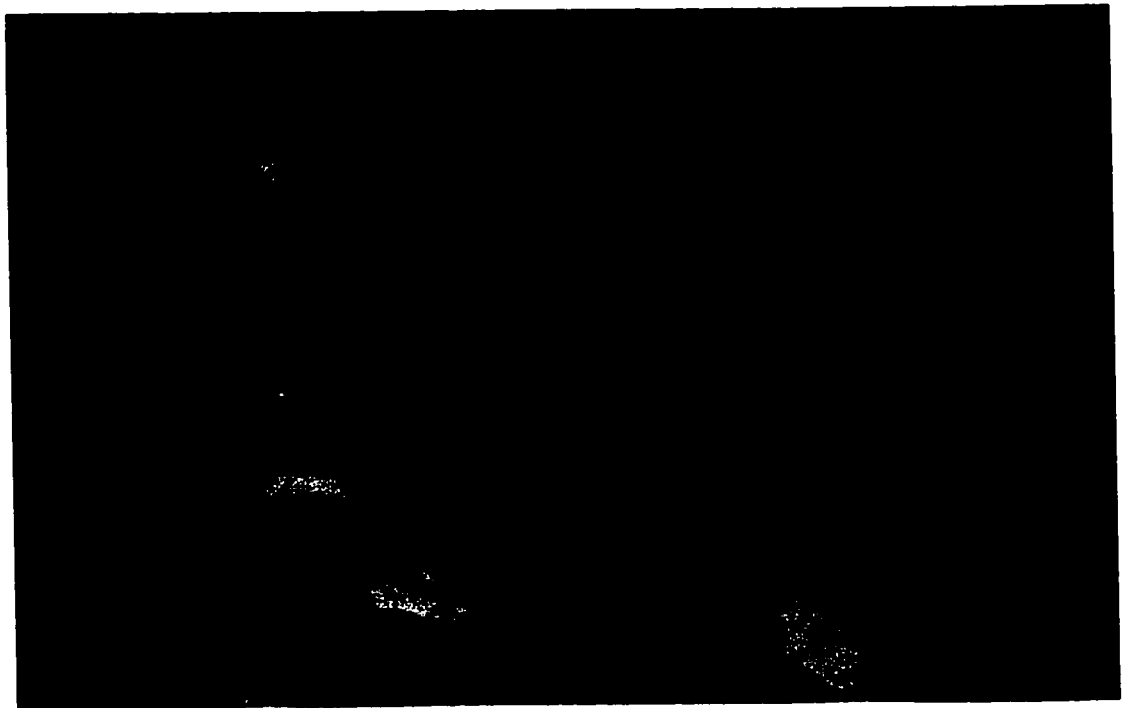


Figure 16. Amy, polar bear (5" tall)

himself in the outside world so the secret would not come out. However, by the middle of therapy the secret became known through a disclosure to my supervisor and myself by his mother in a family meeting. This turned out to be a great relief to Arthur. So he was able to express himself a little more within the art making and through humor. For a brief period, Arthur spoke earnestly about the grim reality of his alcohol-addicted parents and the implications for his life. Then he needed to return to a more symbolic form of communication with art making, play and humor. In one session, he drew a cartoon strip. In the strip, the hero is "Bald Boy" a character with no hair like Arthur. For a number of sessions, Arthur created a coin bank with great precision out of papier-mâché. When it was nearly finished I suggested to him that the bank looked a bit like a fire hydrant jauntily dancing on one foot (Figure 14). I explained that all the fire hydrants in a small town that I knew were painted to look like animals and other things. Al paused and said, "It would be funny, you know, seeing a dog peeing on a hydrant, a dog peeing on a dog. It would be like, "wait a minute ... is the fire hydrant peeing on the dog or the dog peeing on the fire hydrant?" Al laughed at this self-created joke. Another day he told about how it feels to come off his medication at the end of the day. He mimicked himself bugging his brother to go out to play ball. He made fun of himself acting like an annoying fly buzzing around his brother's head. The playful atmosphere allowed Arthur to reveal himself a little. The acknowledgement of his parents' disease gave him a chance to show himself to be a bit fallible and even a bit funny. He had stopped stealing things, making holes in his bedroom walls, threatening to run away from home

and hurt himself. It is unclear if the provision of a playful space was a significant contributor to Arthur's change. Adjusting his medication had a great effect in controlling his ADHD. I think the art therapy contributed to his sense that he is not alone in dealing with his family circumstances.

Throughout therapy Tanya (15) enjoyed the humor and the jokes (Table 9). She saw the jokes as gifts and since she is so needy she readily accepted everything she was offered. For example, in the early sessions she would use every bit of paint and paper provided. She needed a lot of nurturing. She didn't use humor in her artwork. She often picked someone, like her sister or a friend or her escort, to tell the joke to after the session. The humor was a relief from her habitual feelings of anger.

The jokes told her she was not a monster and she did not frighten me. It broke down the hierarchical structure of therapist /client and allowed Tanya to see herself in a more positive light, as a normal person, worthy to receive a joke. Throughout the sessions Tanya talked and sang to herself. I began to notice that she sang when she was painting, feeling relaxed and at peace. The lyrics to these snatches of song often related in some way to her current concerns or circumstances. Although they weren't funny they did suggest light-heartedness and the peaceful freedom one associates with children's play. Tanya also talked to herself. At first whenever she was not pleased with her art making, if she dropped paint on the floor or if something was not right, she spoke very harshly to herself. It was as if a very harsh superego was speaking or maybe she was speaking, in transference, the words she imagined I was thinking. When I asked

her about these outbursts she often seemed confused as if the comments were unconscious utterances. I always assured her that mistakes were part of the process and she was doing well. As the sessions progressed this critical voice altered into what I consider was the voice of her archetypal jester or trickster. Instead of saying things like " Ohhh! That was really stupid Tanya!" she would stop, look hard at the mistake or situation and then she might drop her head on her chest for an instant and laugh a little. Then she would say, "OK" and resume what she was doing. It appeared as though her perspective had changed from one of harsh criticism of herself to humble comic tolerance.

Reflective Note

The early middle therapy sessions were most confusing for me, the therapist/researcher, as the exact goal of therapy at this stage was unclear to me. The therapeutic alliances were strong and most of the extreme symptoms were ameliorated. So, "what now?" was my inner thought. Could the work be finished? As the therapy progressed I observed more subtle changes occurring in the children and expressed in their artwork. Humor interchanges, both the jokes and the spontaneous playful humor, became symbols of the collaborative energy we shared in the pursuit of healthier ways of thinking and being.

Termination

Surprisingly, the children used humour during termination, while I found it was more difficult to be humorous during this phase of the therapy. I had reached the point of emotional and physical exhaustion at the end of the term and the end of the program. I was sad about the terminations, and I focused on

trying to help the children deal with these difficult inorganic terminations that didn't seem to have any logical purpose or explanation. I was also dealing with multiple terminations of my own with the conclusion of the program and my departure from Montreal. For me, at that time, *nothing was funny*, an unusual circumstance in my life. I had to struggle to see the funny side of things, to stand back and use what Freud called the third eye. I began to understand the point of view that suggests humor could be seen as callous and insensitive on some occasions. However, I had to see the process through to its conclusion. It became clear that for some of the children humor had become an old familiar friend, welcome at the end and indeed used as a mediator for the stress of the goodbyes. In some ways, this time was like the first day of therapy in which I glimpsed the resilience of the children and it inspired me to begin. At the end the more evident resiliency of the children and their newly acquired ability to tolerate the incongruities of some things inspired me to see the humor even in these endings.

Daniel's (10) final session contained a significant humorous response (see page 105 of the discussion). Although Daniel was feeling uncharacteristically sad, as I was, during the final session because we were ending the therapy, he was able to tease me in a comic way and thus turn sad feelings into mirth and finally to redeem our last session into a meaningful goodbye. Humor during termination was infrequent and not a focus of our time together. The last termination session with Daniel reminded me of our first "explosive" session (see Table 2). In this session, Daniel played a joke on me while answering the

question, "What do you find funny at home with your family?" By saying "never" and baiting me, we were able to share spontaneous laughter again. This event was like a bookend to the funny experience we shared in the first session that was likewise a stressful moment. I thought this was a gift for me. I gave Daniel a goodbye letter at the end of the session (see Appendix F) acknowledging his skill and determination in tackling his problems. This letter included an example of the approach of playful humor, which coloured all the sessions.

As Jason's (11) therapy was more condensed over a much shorter period of time, termination seemed to have less of an impact. He was able to continue to play and create and appreciate humor up until the last day. The final days of termination were partially taken up with packing the figures into boxes to take home. In spite of this symbol of ending Jason continued to play, creating fantasy figures out of plasticine. He made humorous things like an elaborate mechanism for roasting marshmallows (Figure 15) for my aging dragon without teeth. The next day he suggested that the old dragon puppet should be hard of hearing. We shared a funny interchange with the dragon who just couldn't hear what Jason was saying. This was a comic interchange that was really a self-directed joke. On the final day the fantasy play verged more toward violent deaths and destruction rather than humor but we nevertheless laughed together when I mistook his pronunciation of *word* for *weird* and inadvertently made a very odd sounding sentence. This laughter helped to release the tension associated with our final day of therapy.

Amy (11) grew more quiet as therapy approached its ending but she would emerge to her more buoyant self would emerge at times and she continued to create artwork (Figure 16) up until the final day of termination. But the humorous things stopped three sessions before the end of therapy, although she showed joy in her mastery of the materials. We processed the feelings associated with termination; this was a valuable but not an amusing exercise. She answered the final questions: 1 What sorts of things do you laugh at when you are at home with your family? "TV". 2. What sorts of things do you find funny? "TV. sometimes I read, things people do or say at school, and no one really tells jokes". I shared with Amy my own feelings of sadness that we were ending and I shared my pleasure at her creative ability to tackle Mr. Meanie and gain control of her life again. I mentioned her skill with words and her great progress getting back to school, making and visiting her friends and working at her relationship with her mom. On the final day of therapy I presented Amy with a diploma to acknowledge her bravery in tackling her problems (see Appendix G).

Arthur (12) withdrew a little as termination drew closer. Although he continued to show appreciation for humorous comments and gestures he didn't create humor during this ending time. Interestingly when he came to answer the final questions on the last day there was a marked increase in the elaboration and detail offered in the answers to the termination questions compared to the first session answers:

1. What sorts of things do you laugh at when you are at home with your family?

"Brothers do funny things, or the dog's antics make us laugh. The dog is in charge of the house ... he gets to sit on the bed or the couch before Dad."

2. What sorts of things do you find funny?

"Comic strips. When I win at sports and beat someone out who is usually better than me. Depending on my mood, some times I think things are really funny, and sometimes I don't. Once in a while I can flip myself out of a bad mood by seeing the funny side. With my friends we sometimes make fun of each other like a bad haircut or an uncool jacket, for example. We call each other pet names, like I'm skin head or I use a funny voice or mimic the antics of a teacher".

Arthur's answers to the first set of questions in session one were:

1. "No".
2. "Not really".

Tanya (15) found nothing really funny on the final day but two days prior to termination she made drawings that were simple cartoons (Figures 17, 18). Both were heads with bubbles and both said, "What's up dude?" These drawings were a big departure from her usual non-representational paintings or clay images that had no humorous content at all. At the end she also made funny comments, again a significant departure for Tanya.

Summation

At the termination stage my priority was to help the children to experience the ending of therapy as a "good" goodbye, one with meaning, which would

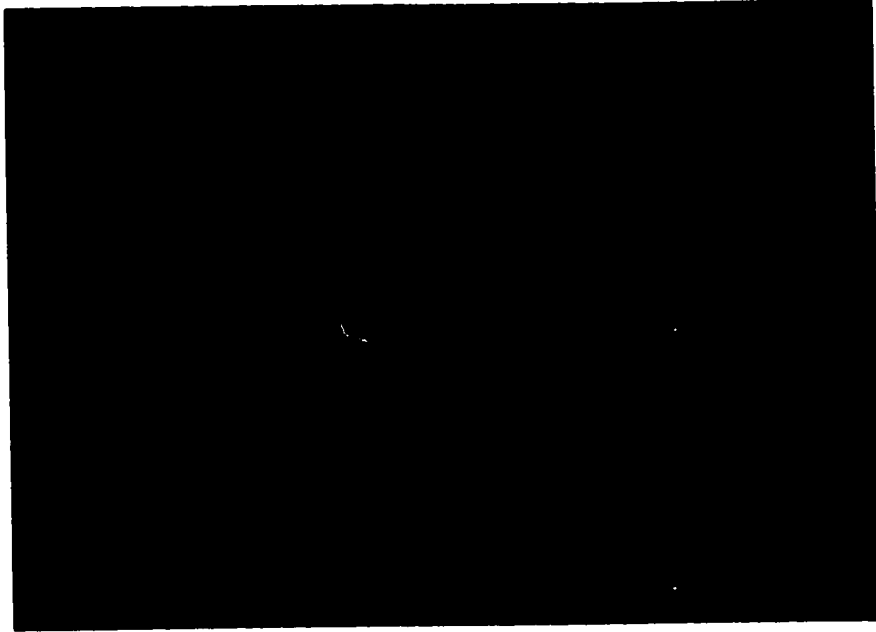


Figure 17. Tanya, cartoon number 1 (12" x 14")

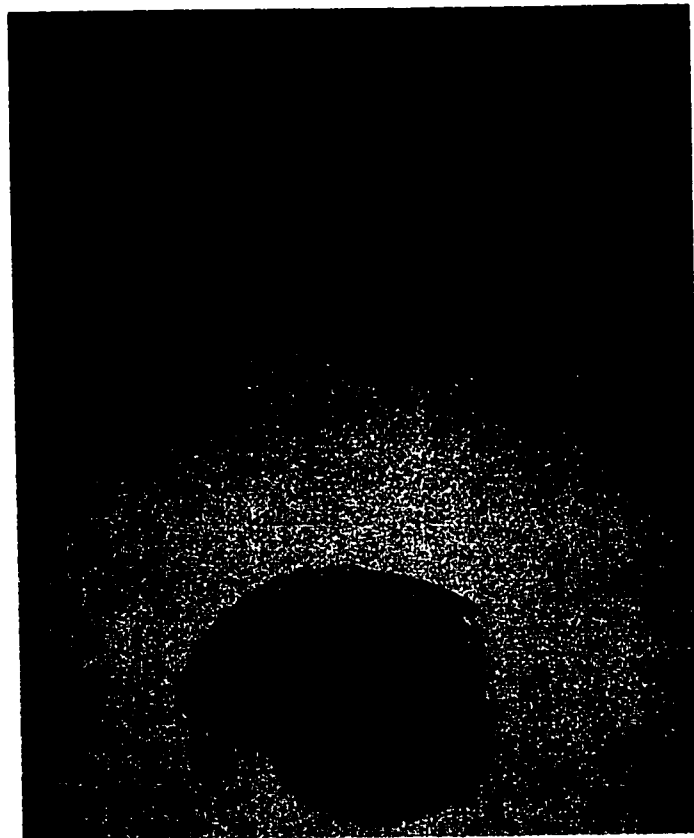


Figure 18. Tanya, cartoon number 2 (12" x 18")

remind them of their resiliency and intrinsic worth. We worked, therefore, on the exploration and expression of feelings associated with endings. As many of these children had experienced traumatic separations from their mothers or fathers these exercises brought forward powerful memories. However, throughout this time the children also continued to play and work within the metaphor and within this media various humorous incongruities arose that we shared and enjoyed together.

At this stage it was difficult for me to step back from the therapeutic relationships and consider if humor had played a significant role in the therapy. It wasn't until after the sessions were over that I recognized it. The playful humor instilled a level of enjoyment into the sessions, stimulated play and art making so that the children were better able to explore their issues either through the metaphor of play or directly through art making and begin to find creative solutions to their real problems. Furthermore, I think the humor exchanged between the children and myself -- the joke telling and the spontaneous humor interactions also served to give meaning and add "goodness" to their terminations. I think that the experience of appreciating humor and being appreciated as a humorist supplied the children with an introjected image of themselves as valued, worthy of respect and a source of joy to others even in difficult circumstances.

Reflexive Note

My own bias coming into this study was in favor of the use of humor. I have always been comfortable using humor in my relationships with peers and

elders and as a playful means of communication with children in different settings. Nevertheless, in spite of the growing interest in the use of humor in psychotherapy and the suggestion that it would be advantageous to provide formal humor training as an elective part of an academic curriculum (Franzini, 2001), I would not propose the use of humor in therapy as a universal approach. It appears to me now that a therapist would only want to approach the use of humor in therapy if he or she had a level of comfort with humor in human interactions.

During the therapy I had varying degrees of contact with the parents of the children. In some cases I saw the parents briefly, but not therapeutically, before and after each session. In some cases we had interim and follow-up meetings and in one case there was virtually no contact with the parent. I consider that, in most cases, including the parent(s) as part of the collaborative team, working towards the health of child and family would further facilitate systematic change.

Chapter 5: Discussion and Theoretical Viewpoints

“The capacity to be humorous and to enjoy humor reflects an ability to play with reality thereby creating a safe space within which possibilities can be entertained and rigidities of thought and feeling are relaxed. I shall call this safe space the humorous space.... Like play, the humorous space can allow for a new, creative, structuring of concerns and anxieties as it allows for a greater receptiveness to novelty by challenging rigidity in our emotional attitude” (Lemma, 2000, p.70-71).

This study looked at six children with behavioral or mood disorders from families with dysfunctional relationships. The children entered therapy with the therapist (a stranger) in a hospital environment following a family crisis that precipitated a trip to the emergency ward and an interview with a psychiatric team. On the first meeting humor, in five of six cases, appeared to assuage the child's first-session nervousness. Humor seemed to have the effect of allaying their understandable fears and uncertainties about entering into a therapeutic relationship (Hammer, 1990). This non-threatening humorous approach also appeared to ameliorate the perceived inequality of power/control between therapist and client. The humor seemed to help the child to see the therapist as “a friendly person who is on their side” (Yorukoglu, 1993, p. 80). Remarkably, in all three cases where the clients elected to tell a joke, the joke revealed their core conflict, just as Yorukoglu (1993) had reported, even when they were attempting to keep the ‘family secret’. Later in the course of therapy humorous expressions of individual children further revealed their core concerns or feelings. This result

is consistent with the theory that humor provides a bridge to the unconscious and conscious processes (Freud, 1927; Jung, 1997; Lemma, 2000; Yorukoglu, 1993).

It is known that art therapy enables the child to externalize feelings and issues in the form of artwork (Malchiodi, 1997, 1998; Rubin, 1984). Narrative therapy elicits the naming of the problem, (Freeman, Epston, & Lobovits, 1997) and a strengthening of the externalization and separation of the problem from the child. Play has long been used to allow children to freely explore their issues within the secure environment of the transitional space (Winnicott, 1971). To all these approaches – art making, narrative externalization and play - humor was added to create a playful framework. This combination of humor, art therapy, play and the narrative approach (HAPN) was found to quickly and effectively establish a therapeutic alliance.

The continued use of humor through humorous interchange and self-directed humor by the therapist helped to reinforce the playful framework. The attempt here was to recreate the original mother-child attunement, which for these children had been universally weak due to the existence of family problems during early childhood. By mimicking the early process of mirroring (Bollas, 1995), playful interchanges and a buoyant atmosphere, the children were able to begin to play freely and begin to strengthen their use of humor¹³. The three older children (Amy, 11; Arthur, 12; Tanya, 15) used this secure play space to directly engage their problems while the younger clients did it through metaphor. Universally, the children expressed an increased ability to use playfulness to

¹³ It was important for me to maintain the perspective that my goal was not to foster humor production, but through humor and art therapy to facilitate health.

cope with their issues. All effectively developed resilience to their problems and reformulated their issues with the HAPN therapeutic approach. More importantly, they acquired a sense of mastery and self-confidence, which will hopefully help them as they continue to live with their families with dysfunctional relationships. Due to the nature of this pilot study, it is impossible to report on the durability of the HAPN approach¹⁴. I suspect continued reinforcement, probably less frequently than weekly, will be required for these coping skills to be firmly rooted. All the humorous occurrences served to show the diversity in response and outcome from supplementing art therapy with humor. In some cases the humor was quickly integrated into the sessions or expressed in the artwork itself providing therapeutic insights. In other cases, it remained as a tool to enhance communication and to build trust but really was not instrumental in revealing and then tackling the difficult issues. In general, I think the jokes and playful approach greatly accelerated the strengthening of a trusting relationship between the client and myself. Where the client was receptive, and I think this may relate to the depth of the problem, the child was able to use the humor to look at his or her situation. The humor allowed the children some distance and objectivity, which would have come through traditional art therapy (Kramer, 1976) but I believe at a slower pace. The humor allowed me to engage the clients on their primary concerns in the first or second session. However, as shown with Tanya, humor was effective to help her tackle her problems even when humor could not be used in the first few sessions. It is difficult to extrapolate these limited

¹⁴ It cannot be determined which aspect of the HAPN approach had the most influence on the clients and hence the outcome.

experiences to generalities. Suffice it to say, I believe humor was helpful with most of these clients.

The researcher observed that sharing a joke builds camaraderie and a playful attitude, which allows some otherwise unspeakable issues to be introduced and new viewpoints to be shaped. This is consistent with Hammer (1990), who writes in *Reaching the Affect* about various styles of psychotherapy, including the playful style. For him the playful style embraces the use of humor in therapy, which he sees as essential to balance more somber therapeutic work. For example, "via humor, we can provide an atmosphere of play in which patients feel protected from their conflictual impulses and primitive affects" (p.109). Thus, playful humor can be seen to provide a safe place to consider and understand ones impulses and difficulties. He points out further that laughter has been found to increase respiratory activity, oxygen exchange and heart rate. Further, "when laughter subsides, the pulse rate drops below normal and skeletal muscles become deeply relaxed" (Henry & Moody, 1985, p.8). Hammer adds that laughter is found by medical studies to stimulate the production of catecholamines, the alertness hormones. Although inconclusive, this study suggests that humor, creativity, and insight may be closely linked. Hammer hypothesized that the employment of one of these functions could lead to the induction of the other two. In fact humor has been considered to be a facet of creativity by many researchers (Roeckelein, 2002). Hammer finally suggests that playfulness is central to humor. It " involves turning things over, turning them around, looking at them from new, unexpected angles" (p. 116). This approach

was indeed the method I tried to maintain in the sessions with the six children in this study. With playful humor we turned things around and upside down, looking at their lives, mostly through metaphor, from different and unexpected perspectives. My hope was that this playful humor could link with creative activity and insight to begin a different approach to life outside the therapeutic setting. The observations from this study support the conclusion that the children began to see their lives differently and show resilience in their daily lives. In some cases it was clear that the children were functioning better. For example, Jason had stopped having nightmares, Daniel and Amy had gone back to school and were adapting to their home environments and Tanya's comportment at the group home had changed from confrontational oppositionality and violence to cooperative enthusiasm for her schooling and friendships. However, given the short duration of the study and the inability to monitor the children following the termination of therapy sessions or interview their parents, it was not possible to determine persistence of the change of attitude in their daily life. Neither was it possible to determine to what extent the playful humor in therapy was the factor that caused these changes. Future studies should include such observations and controls.

Comparing the cognitive processing of phonological jokes (puns) and semantic jokes (word play) Goel and Dolan (2001) found in their study that the cognitive processing of jokes occurs in different and distinct regions of the brain and that affective appreciation of humor "involves access to a region of the brain that represents and controls reward-related behaviors" (p. 238). This seems to

reinforce the responses I observed in several of the children who seemed to receive the jokes as gifts or rewards.

On a number of occasions during therapy, I observed the children making use of humorous play during the therapy sessions to help assuage the negative impact of life's stressors (Lefcourt and Martin, 1986). Martin (2000) notes, "that there are several possible mechanisms by which humor may moderate stress" (Roeckelein, 2002, p.268). By way of qualification, Lefcourt and Martin (1986) added that "in order to moderate the effects of stress, the individual must ... produce humor, particularly in the stressful situation he or she encounters in daily life" (p. 62). In this pilot study three of the children made use of humor to reduce life stresses during therapy. For example, Amy made use of visual humor to help her come to terms with her profound sense of the loss of her beloved cats while she was living on the psychiatric ward of the hospital.

Another example of humor used as a mediator of life stress occurred on the final day of termination. Daniel, whose mother, a cocaine addict, left and rejected him at a very early age, had been struggling in previous sessions with the concept of termination and found it completely baffling and depressing. On the last day Daniel expressed despondency and bewilderment. I began by asking him the questions about humor that I had asked all the children on the first day of therapy – "What do you find funny at home?" "What do you laugh at with your family", and "What do you find funny?" Daniel was painting and not looking at me as I asked the questions. He was uncharacteristically low and was not offering his usual verbal banter. He seemed to be struggling with his deep

feelings of loss, disappointment and possibly anger. The few words he had spoken were unusually quiet and somber. To the first question he answered briefly that he and his family found movies, like *The Three Stooges* funny. To the second question Daniel replied, "Nothing really". I paused and then asked again. "Is that just for today or every day?" He answered without looking up, "Every day". There was a long silence while I considered this answer and tried to catch Daniel's eye to verify the remark. When he finally looked up he was grinning and we both broke down and laughed. The spell was broken. Daniel was still very aware of the termination and we shared an emotional goodbye at the end, but the stress of that moment of sadness was dissipated by Daniel's ability to see the funny side of life.

Both Amy and Jason, went through a similar process, first expressing their anxieties and then, over time, naming and externalizing the anxieties, gaining mastery over the anxieties through play, humor, and art making, and then discovering that these fears were not as scary as they thought. Rather, they were funny. Clay figures such as Mr. Meanie and the bad dream monsters embodied their problems and yet with their own skills the children turned them into comical figures that could be controlled and played with. Playfulness and humor were integral to the therapy with Amy and Jason. The humorous play worked especially well with the narrative therapy approach where externalized problems are named and given characters (Freeman, Epston, & Lobovits, 1997; Marnier, 2000).

Universally, the children expressed an increased ability to use playfulness to cope with their issues. The durability of this outcome was not determined and should be a topic of any future research. It would be important to establish if a short period of therapy would be sufficient to allow the children to maintain their playful attitude when they are reintroduced into their disorganized environments given their fundamental position of vulnerability as children. As the previous examples related, the transitional space can become transformational. Within the give and take of the mutual play space, the child has a potential to find health (Winnicott, 1971). At a certain point in therapy, once the child has deeply experienced the freedom of self-expression through play in a safe, nurturing environment, the child is able to internalize those positive experiences and establish affirmative introjects. Giovacchini (2001) calls the resulting capability "a nurturing matrix" (2001, p.9). Then the child is ready to separate and become autonomous and can play and live creatively without the catalyst of the therapeutic venue (Abram, 1996; Coppolillo, 1991). The therapist's empathy for the child substitutes for the mother's empathy for the baby and makes internalization possible and separation begins (Abram, 1996). "Winnicott posits the paradox that at the point of the infant separating from mother s/he is at the same time filling up the potential space through playing and cultural experience" (p.325). If the child can experience and internalize the feeling of being lovingly held in the transitional space, where spontaneous play is possible and where humor emerges, that internalized transitional space may make the difference. In this study such an environment was created for the children providing a

framework for humor, a safe enough place to look at their difficult circumstances from a different perspective, to see things differently and perhaps then to act differently and see themselves differently. Bader (1993) suggests that the therapist's use of humor in therapy can communicate to the client that he or she is enjoying his or her work and by extension the client may devise that the therapist takes joy in the client (child). In this study I think this phenomenon was a factor – my playful humorous attitude with the children established a sense of my joy in and enjoyment of them as in the early mother/child humor interchange discussed by Bollas (1995).

Giovacchini (1999) conceptualized the Winnicottian transitional space as a transitional stage during which the developing child, or the client in therapy, works toward achieving object relationships. The transitional stage in this sense is a liminal moment (Bariaud, 1989; Kuchner, 1991), literally a time when the person explores the qualities of the external world, and begins to internalize that external world at the same time as he/she explores the needs and impulses of the inner world of the self. "This is an in-between stage between the inside and outside and contains elements of both" (p.92). During this transformative stage the person comes to recognize a fundamental human incongruity, the irreconcilable ambiguous condition of being vulnerable and autonomous, dependent and self-sufficient simultaneously. Giovacchini suggests that as the child comes to realize his/her dependence and vulnerability he/she develops play and thus can tolerate the ambiguity. The fantasies created in play help to dispel fears of vulnerability and dependency and allow the idea of autonomy and self-

sufficiency to exist in make-believe. In the transitional stage the person travels back and forth between the outer and inner worlds. Giovacchini postulates that humor emerges from the playful space. Humor provides the perspective that, while the incongruity may be threatening, it is also amusing. Therefore, Giovacchini's work shows that humor erupts out of play within a secure transitional space that affords a momentary sense of mastery over one's sense of vulnerability. The intermingling of the inner and outer worldviews creates incongruities that give birth to humor. Children from families with dysfunctional relationships, like the ones in this study, often find the grim reality of the outer world overwhelming and toxic. They may be convinced of their vulnerability in an environment beyond their control, and their dependency on caregivers unable to support them or their feelings. It is my view that within this pilot study the children were enabled to enter the transitional or transformative space where they could, through play, reconsider their inner and outer worlds within a safe therapeutic environment. Humor was proffered as a catalyst, a means of playing peek-a-boo with the grim reality of their problems. By approaching and retreating from their problems they were gradually reconnecting with their sense of personal autonomy and self-sufficiency.

Recent research on the neurobiology of shame has revealed some significant information about humor (Kaufman, 1996; Nathanson, 1992).

Although it is beyond the scope of this inquiry, I think that the information adds a degree of significance to the role of humor as it was employed in the pilot study and suggests exciting possibilities for future therapeutic practice. "Shame is the

pain caused by damage to the self" (Nathanson, 1992, p.196). It occurs as an adaptive function that helps to regulate our experience, behavior and social relationships. When a child's enthusiastic joy is not reflected back by the caregiver, the parasympathetic system takes over and shuts down the positive feelings (Tangney & Dearing, 2002). The resultant affect is shame – a strong feeling of estrangement and alienation. "Whenever an individual's fundamental expectations...are suddenly exposed as wrong, shame is activated'" (Kaufman, 1996, p.61). Short term, this is normal and adaptive for human beings but if the effects of shame are prolonged or particularly intense, shame may become internalized and cause ruptures in relationships (Kaufman, 1996). Recurring shaming can create a "learned helplessness," the incapacity to imagine a different scene, a new future" (Kaufman, p.88). Clusters of symptoms, verbal and non-verbal behavior, feelings and thoughts are indicative of internalized shame: for example, a sense of exposure and isolation, powerlessness, vulnerability, avoidance of eye contact, sense of failure, withdrawal from others, not wanting to be seen by others as well as aggression and blaming others. Combinations of these symptoms were evident in all of the children in this study and such feelings and behaviors are common among children in families with disorganized relationships (Anderson, 1992; Hadley, 1993). Hadley (1993) found in her survey of adults from disorganized families, a significant association with internalized shame.

Mechanisms that have helped to dismantle internalized shame are similar to the playful humor approach employed in this pilot study: shift the emphasis

from the self to the behaviors or externalize the problem and enlist the client's skills to tackle it, develop a sense of compassion and understanding toward the self so that the client can practice self-forgiveness, and employ humor to help transform shame into humility. The idea is to help the client to recognize the imperfect world as normal, not shameful, so that he or she can laugh at his or her own mistakes, identify with the archetype of the fool or jokester and make a fool of herself or himself without fear. Finally, the process of moving from shame to humility transforms the client from one who cannot tolerate being seen to one who can re-experience joy and regain her or his own authority or mastery. Again, I make a connection to the peek-a-boo game here, where being seen and then not seen is the essence of the game. The jester or jokester archetype typically holds a mask over her face and peeks out at the audience in a flirtatious sort of way. This also reflects the peek-a-boo gesture that cements a relationship of pleasure and enjoyment, one in which both participants have a strong sense of self-worth. As I understand it, shame becomes a well-established neural pathway due to the repeated reinforcement of shaming experiences. It seems as though introducing a framework for humor, in which the child can begin to feel free to see and be seen in new and sometimes humorous ways, may start the establishment of new neural pathways for acceptance of and adaptation to our incongruous and ambiguous world.

The children in this pilot study showed many of the characteristics associated with shame, from withdrawal and anxiety to acting out or blaming. By means of playful humor in art therapy, in which a safe transitional space

recaptured intersubjectivity akin to the peek-a-boo game of the earliest mother-/child relationship, clients in this pilot study gradually grew to see the world as an imperfect but accepting place where they felt able to see and be seen. Within the framework of humor they were enabled to see themselves and their lives through the eyes of the jester who seeks to see the other and to be seen by the other in a form of "altruistic reciprocation" (Weisfeld, 1993). Through the visual modality of art therapy, the metaphorical world of play and the humorous view of the new perspective, the children may have acquired a new vision of the present and of life in the future. Through the use of narrative approach, the children and I were also able to explore a new version of their lives, an alternate story or "counter plot" (Freeman, Epston, & Lobovits, 1997) with different outcomes. The transformative qualities of creative art expression, humor, and play enabled sublimation and generally fostered a more resilient self.

Chapter 6: Conclusions

“A capacity for sympathetic laughter at oneself and one’s place in the world... With such humor there is an acceptance of oneself for what one is, an ease of being amused even if bemused” (Poland, 1996, p.174).

This pilot research is a preliminary effort to investigate the role of playful humor in art therapy with children with mood and behavior disturbances from families with dysfunctional relationships. Playful humor appeared to facilitate the rapid formation of the therapeutic alliance and establishment of a transitional play space within which the child felt safe to engage in art making. The investigator believes that the playful atmosphere, established through the use of humor, also facilitated the expression of feelings and advanced the working through of problems. As therapy progressed, the children were able to articulate their feelings and tackle their problems through creative art expressions and playful behaviours. The ritualized use of joke telling, initiated by the therapist, was one mechanism employed to help create an atmosphere of playful humor. Other more spontaneous humor events were interspersed as seemed appropriate in each session. It was also found that the therapist’s playful, humorous attitude produced a sense of the therapist’s enjoyment of the therapeutic experience and by association the therapist’s enjoyment of the child. As with the original clown /mother mentioned by Bollas (1995), the introduction of playful humor into the therapy produced a sort of peek-a-boo game atmosphere in which the child grew to believe that he or she was a source of joy to the therapist. This mechanism may have helped the child to feel worthy to be a bona fida player in the peek-a-boo game of life. Thus the introduction of playful humor offered the children the

pleasurable experience of a humorous atmosphere in the therapeutic setting. Over time the children showed a level of comfort with the incongruity of the humorous attitude to situations and they initiated their own spontaneous humor into the sessions. In some cases playful humor enabled the child, through the use of metaphor and/or art making, to have a more creative approach to mastering problems that arose in the therapy sessions, originating within his or her disorganized family life. In most cases the therapy contributed to the children's development of a healthy humorous outlook toward the self and to life in general. As these children's problems have their source within the family setting they cannot be solved for once and all. However, with their newly acquired playful appreciation of the absurdity or incongruity of life's situations they have acquired some resiliency to life within their families.

In the past twenty years, and most significantly in the past ten years, we are seeing increasing interest in interdisciplinary humor research. Essays and clinical anecdotes indicate many potential therapeutic benefits from applications of humor. However, most advocates of the use of humor in therapy have written from traditional psychodynamic perspectives (for example, Mosak, 1993; Fry & Salameh, 1993). This pilot research represents an initial exploration of the use of humor with children from an art therapy perspective. As mentioned earlier in the literature review, some art therapists (Riley, 1997; Wadeson, 1989) do mention the use of humor or the potential use of humor in art therapy with children or adolescents. However, there is apparently nothing written to describe the therapeutic use of humor with children in art therapy. As the questionnaire (see

Therapist's Questionnaire, Appendix A) suggests many professional art therapists working with children use humor therapeutically, but it hasn't been documented until now. Thus this study represents a first step toward the exploration of the therapeutic use of humor in the field of art therapy.

While a larger sample population needs to be studied, this qualitative pilot study demonstrated a beneficial role for humor in conjunction with art therapy and play with children. A more controlled study would be needed to provide proof of the effectiveness and value of humor. Many questions remain to be answered: is it possible to isolate the relative benefits attained by art therapy and humor together?

Recommendations for Future Research

I believe that I was able to establish a working therapeutic alliance with the clients in this study by the end of the first or second session. This seems very rapid, especially considering the extreme circumstances of a client like Tanya. From this pilot study the impact of various influences, including my personal approach, historical factors, family circumstances or the effects of other therapies cannot be distinguished from the use of humor during the art therapy. As an extension of this pilot study a topic for future study could address the hypothesis that humor accelerates (and strengthens?) the establishment of a strong therapeutic alliance with children.

To further investigate the current use of humor in art therapy by art therapists, a comprehensive questionnaire could be compiled to investigate the experience level and specific client population of the therapist/respondent, the

frequency and nature of humor used in art therapy, the value and function of humor in the art therapy sessions plus other pertinent details. The results of such a questionnaire would provide a heretofore-unpublished account of the degree and extent to which humor is employed in the field of art therapy in North America (see Therapist Questionnaire Appendix A).

Increasing the frequency of the use of cartoon images to augment the jokes would make the introduction of non-spontaneous humor at the beginning of a session more practicable. It would also be advantageous when dealing with children with hearing defects¹⁵. I feel that although there was a benefit in modeling the archetypal fool myself, I now believe that I was relying too much on my own initiative. I think giving the children an opportunity to practice and embody the 'fool' by bringing their own jokes or cartoons would have been very beneficial. In this way the children could bring in cartoons that they found funny. They could then tell the jokes and thus gain a sense of mastery by employing their own judgments about what is and isn't funny and gain confidence in their own unique sense of humor. The searching process would also take place beyond the therapy session and thus possibly become an adaptive habit. The use of cartoons would allow the investigator or therapist to see what the client found funny, and any themes or attitudes that might be apparent. This would be important, in particular, in multicultural work. Humor and the cultural contexts of therapist and client could form a rich source for further research, as would the examination of humor from a qualitative process perspective.

¹⁵ This might be a material change in the procedure and so would have to be studied to determine the impact on the outcomes.

It would be interesting to include interviews with clients regarding their reflexive responses to occurrences of humor in therapy at the beginning, midway and at termination. The first and last session would have been a good opportunity to administer a very brief humor test for humor appreciation and humor initiation. The coping Humor Scale and the Situational Humor Response Questionnaires (Lefcourt, 2001), for example, were designed for adults. However, an adapted oral test could be employed for future investigation with children.

Another possible focus for further research could be the preparation of a complete survey of measures for testing humor. Roেকেlein (2002) has just published a book containing references to all the known humor scales and measures. From this body of tests a careful analysis could be made to determine the tests that might apply to the art therapy process and to children. From this work a test might be adapted or several tests could be combined to specifically measure a client's abilities to express and appreciate humor and to see life experiences from a humorous point of view. Such a measure could then be applied as pre and post tests within a study and control group of clients during a standard course of art therapy, and one where humor is introduced. The results of such a test would support or challenge the findings from this pilot study. In a similar manner a differential analysis of different kinds of humor – self-directed, therapist initiated jokes or spontaneous and contextual humor, for example, and their roles in art therapy sessions could be coupled with correlations with age of client, stage of therapy and specific problems of the client.

On a biological level, further enquiry into the neurobiological function and effects of humor would help to suggest how the combination of art expression and humor in therapy might contribute to human health.

References

- Abram, J. (1996). *The language of Winnicott*. London: Jason Aronson.
- Adams, P. (1982). *A primer of child psychotherapy*. Boston: Little Brown & Co.
- Anderson, F. (1992). *Art for all the children* (2nd ed.). Springfield, Ill: Charles C Thomas.
- Anderson, H. & Goolishian, H. (1992). The client is the expert: a not-knowing approach to therapy. In S. McNamee, & K. J. Gergen (Eds.). *Therapy as social construction. Inquiries in social construction.* (pp. 25-39). Thousand Oaks, CA: Sage Publications, Inc.
- Arieti, S.(1976). *Creativity*. New York: Basic Books.
- Axline, V. (1989). *Play therapy*. New York: Churchill Livingstone.
- Bader, M. (1993). The analyst's use of humor. *Psychoanalysis Quarterly*, 62, 23-61.
- Bader, M. (1994). Using humor to resolve intellectual resistances. In H. Streaan (Ed.), *The use of humor in psychotherapy* (pp. 25-36). London: Jason Aronson Inc.
- Bariaud F. (1989). Age differences in children's humor. In P.E. McGhee (Ed.), *Humor and Children's Development: A guide to practical applications*. New York: Haworth Press.
- Barnett, L.A. (1990). Playfulness: Definition, design and measurement. *Play and Culture*, 3, 319-336.
- Barron, J.W. (ed.). (1999). *Humor and psyche*. Hillsdale, NJ: The Analytic Press.

- Beren, P. (1992). Narcissistic disorder in children. *The Psychoanalytic Study of the Child*, 47, 265-278.
- Berger, A.A. (1987). Humor: An introduction. *American Behavioral Scientist*.
Humor, the psyche, and society. 30, 6-15.
- Bergmann, M. (1999). The psychoanalysis of humor and humor in psychoanalysis. In J.W. Barron (Ed.), *Humor and psyche* (pp. 11-30). Hillsdale, NJ : The Analytic Press.
- Bill, A.A. (1938). *The basic writings of Sigmund Freud*. NY: Random House.
- Black, D. (1982). Pathological laughter: A review of the literature. *Journal of Nervous and Mental Disease*, 170, 67-71.
- Bollas, C. (1995). *Cracking up*. London: Routledge.
- Carp, C.E. (1998). Clown therapy: the creation of a clown character as a treatment intervention. *The Arts in Psychotherapy*, 25, 245-255.
- Case, C. & Dalley, T. (1992). *The handbook of art therapy*. NY: Routledge.
- Cassidy, J. (1995). Attachment and Generalized Anxiety Disorder. In D. Cicchetti & S.L. Toth (Eds.), *Rochester symposium on developmental psychopathology: Emotion, cognition and representation*, 6, (pp. 343-363). Rochester, NY: University of Rochester Press.
- Chapman, L. (2001). The effectiveness of art therapy interventions in reducing posttraumatic stress disorder (PTSD) symptoms in pediatric trauma patients. *Art Therapy*. 18, 100-104.

- Clark, D.A., Beck, A.T., (1989). Cognitive theory and therapy of anxiety and depression. In D. Watson & P.C. Kendall (Eds.), *Anxiety and depression* (pp. 379-411). San Diego: Academic Press.
- Coppolillo, H.P. (1991). The use of play in psychodynamic psychotherapy. In Melvin Lewis. *Child and Adolescent Psychiatry* (pp. 805-811). New York: Wilkins.
- Dean, R. (1997). Humor and laughter in palliative care. *Journal of Palliative Care* 13, 34-39.
- Franzini, L. (2001). Humor in therapy: The case of training therapists in its uses and risks. *The Journal of General Psychology* 128, 2, 170-193.
- Freeman, J., Epston, D., & Lobovits, D. (1997). *Playful approaches to serious problems*. New York: W.W. Norton.
- Friedman, R. (1994). Using humor to resolve intellectual resistances. In H. Strean (Ed.), *The use of humor in psychotherapy* (pp.47-50). London: Jason Aronson Inc.
- Freud, S. (1908). *Creative writers and daydreaming*. Standard Edition, Vol. 9. (pp.141-153). London: Hogarth. Press.
- Freud, S. (1927). *Humor*. Standard Edition, 21:159-166. London: Hogarth Press.
- Fry, W., & Salameh, W. (Eds.). (1993). *Advances in humor and psychotherapy*. Sarasota, FL: Profession Resource Press.
- Goel, V., & Dolan, R.J. (2001). The functional anatomy of humor: Segregating cognitive and affective components. *Nature Neuroscience*, 4, 237-238.

- Giovacchini, P.L. (2001). Dangerous transitions and the traumatized adolescent. *American Journal of Psychoanalysis, 61, 1, 7-33.*
- Giovacchini, P.L. (1999). Humor, the transitional space, and the therapeutic process. In J.W. Barron (Ed.), *Humor and psyche* (pp. 11-30). Hillsdale, NJ: The Analytic Press.
- Gladding, S. (1998). *Counseling as an art: The creative arts in counseling* (2nd ed.). Alexandria, VA: American Counseling Association.
- Goldenberg, I., & Goldenberg, H. (1990). *Family therapy* (3rd ed.). Pacific Grove, CA: Brooks/Cole Publishing.
- Grotstein, M.S. (1999). Humor and its relationship to the unconscious. In J.W. Barron (Ed.), *Humor and psyche* (pp. 69-88). Hillsdale, NJ: The Analytic Press.
- Hadley, J. (1993). Common aspects of object relations and self - representations in offspring from disparate dysfunctional families. *Journal of Counseling Psychology, 40, 1, 348-356.*
- Haig, R.A. (1988). *The anatomy of humor: Biopsychosocial and therapeutic perspectives*. Springfield, IL: Charles C. Thomas.
- Hammer, E. (1990). *Reaching the affect: Style in the psychodynamic therapies*. Northvale, NJ: Jason Aronson, Inc.
- Hayworth, D. (1928). The social origin of the function of laughter. *Psychosocial Review, 35, 367-384.*
- Henry, B., & Moody, L.E. (1985). Energize with laughter. *Nursing Success Today, 2(1), 5-8.*

- Jacobson, E. (1946). The child's laughter: Theoretical and clinical notes on the function of the comic. *Psychoanalytic Study of the Child*, 2, 39-60.
- Jung, C.G. (1997). *Jung on Active Imagination*. London: Routledge.
- Karen, R. (1990). Becoming attached. *The Atlantic Monthly*. volume and page numbers not available
- Kaufman, G. (1996). *The psychology of shame* (2nd ed.). New York: Springer.
- Keith, D.V. Connell, G.M. & Connell, L.C. (2001). *Defiance in the family: Finding hope in therapy*. Philadelphia, PA: Brunner-Routledge.
- Kramer, E., (1971). *Art as therapy with children*. NY: Schocken Books.
- Kris, E. (1938). Ego development and the comic. *International Journal of Psychoanalysis*, 19, 77-90.
- Kubie, L. (1971). The destructive potential of humor in psychotherapy. *American Journal of Psychiatry*, 127, 861-866.
- Kuchner, J. (1991, May). The humor of young children. Paper presented at the meeting of the National Association for the Education of Young Children, Unionville , NY.
- Kuhlman, T.L. (1984). *Humor and psychotherapy*. Homewood, IL: Dow Jones-Irwin.
- Lefcourt, H. (2001). *Humor: The psychology of living buoyantly*. New York: Kluwer Academic/Plenum Publishers
- Lefcourt, H., & Martin, R. (1986). *Humor and life stress*. New York: Springer-Verlag.

- Lemma, A. (2000). *Humor on the couch: Exploring humor in psychotherapy and everyday life*. London: Whurr.
- Levinson, L. (1984). Witches--Bad and good: Maternal psychopathology as a developmental interference. *The Psychoanalytic Study of the Child*, 39, 371-392. New Haven CT: Yale University Press.
- Lieberman, J.R. (1965). Playfulness and divergent thinking: An investigation of their relationship at the kindergarten level. *Journal of Genetic Psychology*, 107, 219-224.
- Lieberman, J.R. (1966). Playfulness: An attempt to conceptualize a quality of play and of the player. *Psychological Reports*, 19, 1978.
- Liebmann, M. (1986). *Art therapy for groups*. Cambridge, Massachusetts: Brookline Books.
- Lowenstein R. (1958). Remarks on some variations in psychoanalytic technique. *International Journal of Psychoanalysis*, 39, 202-210.
- Malchiodi, C. (1997). *Breaking the silence*, (2nd ed.). London: Brunner/Mazel.
- Malchiodi, C. (1998). *Understanding children's drawings*. London: Jessica Kingsley.
- Mango, C. & Richman, J. (1990). Humor and art therapy. *The American Journal of Art Therapy*, 28, 111-114.
- Mango-Hurman, C. & Richman, J. (1994). A note on ethnicity in humor and art therapy. *The American Journal of Art Therapy*, 11, 214-215.
- Marner, T. (2000). *Letters to children in family therapy*. London: Jessica Kingsley.

- Martin, R.A. & Lefcourt, H.M. (1983). Sense of humor as a moderator of the relation between stressors and moods. *Journal of Personality and Social Psychology*, 45 (4), 1313-1324.
- Martin, R.A. (2000) [to be completed next draft]
- Masten A.S. (1986) Humor and competence in school-aged children. *Child Development*. 57, 461-473.
- McCune, L. (1993). The development of play as the development of consciousness. In M.H. Bornstein & A.S. O'Reilly (Eds.), *The role of play in the development of thought* (pp. 67-79). San Francisco: Jossey Bass.
- McGhee, P.E. (1979). *Humor, its origin and development*. San Francisco: W. H. Freeman.
- McGhee, P.E. (1989). *Humor and children's development: a guide to practical applications*. New York: Haworth Press.
- McGhee, P.E. & Chapman, A.J. (1980). *Children's humour*. London: New York : J. Wiley.
- McGhee, P.E. & Goldstein, J.H. (1983). *Handbook of humor research*. New York: Springer-Verlag.
- Mineka, S., Watson, D., & Clark, L.A. (1998). Comorbidity of anxiety and unipolar mood disorder. *Annual Review of Psychology*, 49, 377-412.
- Minuchin, S. (1974). *Families and Family Therapy*. Cambridge, MA: Harvard University Press.
- Minuchin, S. (1981). Introduction to structural family therapy. In H. Green, & J.L. Framo (Eds.), *Family Therapy*. NY: International University Press.

- Moore, T., Pepler, D., Weinberg, B. Hammond, L. Waddell, J. & Weiser, L. (1990). Research on children from violent families. *Canada's Mental Health, 38*, 2-3.
- Mosak, H. (1993). An "Adlerian" approach to humor and psychotherapy. In W. Fry & W. Salameh (Eds.), *Advances in humor and psychotherapy*. (pp. 1-18). Sarasota, FL: Profession Resource Press.
- Nathanson, D. (1992). *Shame and pride: Affect, sex and the birth of the self*. New York: W.W. Norton.
- Naumburg, M. (1987). *Dynamically oriented art therapy*. Chicago, IL: Magnolia Street (reprinted from Naumburg, M. (1966). *Dynamically oriented art therapy*. NY: Grunge & Stratton).
- Nazi, SUM. & D'Zurilla, T.J. (1989). Social problem solving and negative affective conditions. In Watson, D. & Kendall, P.C. (Eds.), *Anxiety and depression* (pp.285-315). San Diego: Academic Press.
- Nilsen, A., Donelson, K., Nilsen, D. and Donelson, M. (1987). Humour for developing thinking skills. *Humour. 44*, 63-75.
- Novick, K. (1983). Modes of communication in the analysis of a latency girl. *The Psychoanalytic Study of the Child, 38*, 481-500. New Haven, CT: Yale University Press.
- O'Connor, E. & Braverman, L.M. (Ed). (1997). *Play therapy: Theory and practice*. New York: John Wiley and Sons.
- Piaget, J. (1962). *Play, dreams and imagination in childhood*. New York, NY: W.W. Norton.

- Poland, W.S. (1994). The gift of laughter: On the development of a sense of humor in clinical analysis. In H. Strean (Ed.), *The use of humor in psychotherapy* (pp.139-147). London: Jason Aronson.
- Poland, W.S. (1996). *Melting the darkness: The dyad and principles of clinical practice*. Northfield, NJ: Aronson.
- Porterfield, A. (1987). Does sense of humor moderate the impact of life stress on psychological and physical well-being? *Journal of Research in Personality*, 21, 306-317.
- Prerost, F. (1994). Humor as an intervention strategy. In H. Strean (Ed.), *The use of humor in psychotherapy* (pp.139-147). London: Jason Aronson.
- Riley, S. (1997). Social constructionism: The narrative approach and clinical art therapy. *Art Therapy Journal of the American Art Therapy Association*, 14 (4), 282-284.
- Roeckelein, J. (2002). *The psychology of humor*. London: Greenwood Press.
- Rogers, C.R. (1961). *On becoming a person*. Boston: Houghton Mifflin.
- Rose, G. (1969). 'King Lear' and the use of humor in treatment. *Journal of the American Psychoanalytic Association*. 17, 927-940.
- Rothbart, M. (1977). Laughter in young children. *Psychological Bulletin*, 80: 247-256.
- Roustang, F. (1987). How do you make a paranoiac laugh? *Modern Language Notes*, 102, 707-718.
- Rubin, J. (1984). *Child art therapy*, 2nd ed. New York: Van Nostrand Reinhold.
- Rubin, J. (1999). *Art therapy: An introduction*. London: Brunner/Mazel.

- Rubin, K.H., Fein, G.C., & Vandenberg, B. (1983). Play. In Paul H. Mussen (Ed.), *Handbook of child psychology: Socialization personality, and social development, IV* (4th ed.) (pp. 693-774). New York: Wiley.
- Ruch, W. (1998). *The sense of humor: explorations of a personality characteristic*. New York: Mouton de Gruyter.
- Ruxton, J. (1988). Humor intervention deserves our attention. *Holistic Nursing Practice*, 2 (2), 54-62.
- Sanville, J.B. (1999). Humor and play. In J.W. Barron (Ed), *Humor and psyche* (pp. 31-56). Hillsdale, N.J.: Analytic Press.
- Schimel, J. (1992). The role of humor as an integrating factor in adolescent development. *Adolescent Psychiatry*, 18, 118-126.
- Selekman, M.D. (1993). *Pathways to change: Brief therapy solutions with difficult adolescents*. New York: The Guilford Press.
- Smith, T.W. & Allred, K.D. (1989). Major life events in anxiety and depression. In Kendall, P.C. & Watson, D. (Eds.), (1989) *Anxiety and depression* (pp. 205-223). San Diego: Academic Press.
- Tangney, J.P. & Dearing, R.L. (2002). *Shame and guilt: Emotions and social behavior*. New York: Guilford Press.
- Ulanov, A. & Ulanov, B. (1987). *The witch and the clown: two archetypes of human sexuality*. Willamette, IL: Chiron.
- Wadeson, H., Durkin, J., Perach, D. (1989). *Advances in art therapy*. New York: J. Wiley & Sons.
- Wadeson, H. (2000). *Art therapy practice*. New York: John Wiley & Sons.

- Watson, D. & Kendall, P.C. (1989). Common differentiating features of anxiety and depression: Current findings and future directions. In P.C. Kendall & D. Watson, (Eds.), *Anxiety and depression* (pp.285-315). San Diego: Academic Press.
- Weisfeld, G. (1993). The adaptive value of humor and laughter. *Ethology and Sociobiology*, 14,141-169.
- Wilson, T.G, Nathan, P.E. O'Leary, K.D., & Clark, L.A. (1996). *Abnormal Psychology*. Boston: Allyn and Bacon.
- Winnicott, D.W. (1971). *Playing and reality*. London: Tavistock.
- Wolfenstein, M. (1951). A phase in the development of children's sense of humour. *Psychoanalytic Study of the Child*. 6, 336-350.
- Wolfenstein, M. (1954) *Children's Humor: a psychological analysis*. Bloomington, IN: Indiana University Press.
- Yorukoglu, A. (1993). Favourite jokes and their use in psychotherapy with children and parents. In W.F. Fry & W.A. Salmeh (Eds.), *Advances in humor and psychotherapy*. Sarasota, FL: Professional Resource Press.

Appendix A: Art Therapists Survey

To further investigate the current use of humor in art therapy by art therapists, a questionnaire was administered to a group of professional art therapists at an international annual conference of art therapists (November, 2001). The questionnaires were administered in an informal manner, usually in a classroom or crowded hallway, following a lecture or workshop session. The questionnaire was answered often prior to a conversation about the topic including anecdotes in relation to the person's clinical experiences using humor and art therapy.

The therapist questionnaire (see exact questionnaire at end of this Appendix) was intended to elicit and explore attitudes to the use of humor in art therapy. It was distributed to 33 individuals (32 female and 1 male) at an international professional meeting for art therapists (November, 2001).

Results

The questionnaires were distributed by hand. Almost all the people, 32 out of 33, answered the questionnaire. The individuals approached to answer the questionnaire, included leaders in the field of art therapy, including Harriet Wadeson, Shawn McNiff, Shirely Riley, and Cathy Malchiodi, Lani Gerity, presenters at the conference with years experience as therapists and a few (under 5) young therapists.

Responses of Therapists:

1. Do you employ humor in you art therapy practice?

Yes ... 30 ...

No ... 1 ...

2. If yes, how often is humor present in your therapeutic sessions?

Every session ...10... *“almost”, “when appropriate”*

Every so often ...9...

It appears once I have established rapport with the client
...8...*“depending on client it can be part of the rapport process”, “often”*

Other ... 0...

3. Do you think humor could be an adjunct to art therapy?

with children: 15, with adolescent:14, with children and adolescents:26, *“and adults”, “ yes, if appropriate”, “depends on the child”*

Added comments

Respondents (30%) wrote extemporaneous remarks on the questionnaires for clarification. Four of the ten made cautionary remarks about the possible negative impact of the use humor in therapy.

1. I also think it could be primary.

2. Humour is present orienting, grounding and can help diminish the perceived inequality of power/control between therapist and client, especially if you laugh at yourself. Care needs to be taken to be respectful of the client however.

3. We have a humor cart that we use with some patients in our hospital from pediatrics to adults (Expressive Arts Program).

4. May not see positive reaction yet I think they do enjoy it but just can't show it.

5. Depending on the client it can be part of the rapport process. It's all in the timing and where the client is.

6. Be careful when you define humor – it could mean sarcasm. (used humor every day)

7. Do have to be careful and take the lead of the client (used humor after rapport established)

8. Laugh with client, not at client. (used humor every so often)

9. I wish I knew more therapeutic jokes.

10. Yes, if appropriate, depends on child.

Discussion

96% of respondents indicated that they employed humor in their art therapy practice. Of these 33% used humor every session, 30% used humor every so often and 27% used it once rapport was established. One respondent indicated that she didn't employ humor but added that it appeared once rapport was established (client introduced humor?) and this respondent noted that she thought humor might be used as an adjunct for adolescents and children. These results support the hypothesis that the vast majority of experienced art therapists employ humor, as an adjunct to art therapy in a clinical setting with children .

Conclusions

The purpose of this questionnaire was to get a preliminary glimpse of the attitudes and observations of a heterogeneous group of art therapists regarding the use of humor in art therapy. It is acknowledged that this small sample is insufficient to draw conclusions from. However, further more comprehensive surveys would be of benefit to clarify this question. Any future surveys of this

sort would require more precise definition of terms (for example, "humor"), questions regarding the categories of clients and their problems and theoretical framework of the therapy. However, as a start it is encouraging to note that the use of humor therapy was acknowledged and expanded on by many well-qualified and experienced respondents.

Questionnaire

The objective of this questionnaire is to determine the prevalence of humor during art therapy with children.

Do you employ humor in your art therapy practice?

Yes ___ No ___

If yes, how often is humor present in your therapeutic sessions?

Every session ___ Every so often ___ It appears once I have established rapport with the client ___ Other ___

Do you think humor could be an adjunct to art therapy with children ___, adolescents ___ or children and adolescents _____?

Any comments or opinions expressed in answering this questionnaire will be anonymously attributed. This questionnaire is part of a master's research paper investigating the differing roles playful humor may serve in art therapy.

Elizabeth Adams is presently an art therapy intern and student at Concordia University, Montreal, Quebec in the Department of Creative Arts Therapies.

Appendix B: Consent Form

CONSENT FORM TO PARTICIPATE IN RESEARCH

This is to state that I agree to have my child, _____, participate in a program of research being conducted by Elizabeth Adams of the Department of Creative Arts Therapies of Concordia University.

A. PURPOSE

I have been informed that the art therapy session will be conducted to meet the therapeutic needs of my child, with particular research inquiry focusing on the differing roles playful humour serves in the course of the therapy.

B. PROCEDURES

The procedure will be for the art therapist to conduct regular art therapy sessions and introduce playful humour into the sessions where appropriate, in order to achieve therapeutic goals. This may take the form of playing games, sharing jokes or drawing humorous images. These sessions will be audio taped and perhaps photographs of any images or artwork, will be made. These tapes and images will remain confidential and if they are used in any public way such as a seminar or publication, they will be anonymously attributed. The records will be retained in the same manner all medical records are maintained at the Montreal Children's Hospital.

C. CONDITIONS OF PARTICIPATION

I understand I am free to withdraw my consent and discontinue my child's participation at any time without negative consequences. If at any time I feel it necessary to withdraw my child from this study I can contact Bonnie Harden, Montreal Children's Hospital, Psychiatry Unit, 2300 Tupper Street, Montreal, H3H 1P3, Tel: 514-934-4400 loc. 3352.

I understand my child's participation in this study is confidential.

I understand that the data from this study may be published without identifying my child. The research paper will be bound and a copy will be in the Concordia library.

I HAVE CAREFULLY STUDIED THE ABOVE AND UNDERSTAND THIS AGREEMENT. I FREELY CONSENT AND VOLUNTARILY AGREE TO HAVE MY CHILD PARTICIPATE IN THIS STUDY.

NAME (please print) _____

SIGNATURE _____

WITNESS SIGNATURE _____

DATE _____ / _____ /2002

Appendix C: Observations and HOHO Charts

| Observation Chart | |
|---|---------------------|
| Name: | Session No.: |
| Date: | |
| Verbalization | |
| Development or change apparent over time | |
| Response to Humour | |
| Use of Humour | |
| Observation Guide adapted from Rubin, J., (1984). Child Art Therapy, 2 nd Edition. New York: Van Nostrand Reinhold pp.278, 279 | |

| Observation Chart (continued) | |
|--------------------------------------|---------------------|
| Name: | Session No.: |
| Date: | |
| Approach to the material | |
| Tempo of work | |
| Degree of absorption | |
| Energy expended | |
| Manipulative action | |
| Attitude toward the material | |

| Humorous Occurrence – Humorous Observations Chart (HOHO) | | |
|---|----|----|
| Client | | |
| Session | | |
| Humorous Event | 1. | 2. |
| Initiator (C/T) | | |
| Type (Joke, contextual) | | |
| Delivery (Auditory, visual, written) | | |
| Context (What happen up to this point?) | | |
| Rationale Motivation (Speculation if client initiated or if you initiated it - why?) | | |
| Response (Laughter, smile, snort, smirk, ignored, another humorous event) | | |
| Reflection (My feelings, my insight into the event) | | |

Appendix D: Case Histories

Case 1: Cheryl

Identification of Client

Cheryl is a 9 year old white English-speaking female attending grade 3, living with her natural parents and siblings.

Reason for Referral

Cheryl was referred to art therapy by the ER follow-up team as part of a number of family therapy strategies to deal with a circumstance of extreme family crisis and strain. Cheryl was referred to assist her to deal with the effects of living in a violent home under extreme stress conditions.

Family History

Cheryl lives with her mother and father (step father to her older siblings) and her older brother, and her older sister. Cheryl's mother has a history of physical abuse in her family of origin. Cheryl's family has a history of psychiatric problems and impulse dyscontrol problems. Her parents have had a tumultuous relationship influenced by violence and alcoholism.

Clinical Diagnosis

Cheryl was found to be a bright and cheerful girl with self-esteem issues who has had significant adult-type responsibilities in the household including keeping track of her mother's timetable, watching out for her older brother and doing housekeeping tasks in a challenged, violent family environment.

Goals of Art Therapy

Art therapy goals for Cheryl include providing a safe, consistent and nurturing therapeutic space in which Cheryl can play – be a child and where she can experience a child-adult relationship free of violence and the influence of alcohol. Further goals include helping Cheryl to gain a sense of mastery and self-esteem through the creative process.

Case 2: Daniel

Identification of Client: Daniel is a ten-year-old boy, English-speaking, of average intelligence. He lives with his father, older brother and paternal grandmother.

Reason for Referral:

Daniel was referred to the ER follow-up team because of his inability to control his angry and destructive outbursts at home. His impulse dyscontrol is exacerbated by his brother's teasing and has become uncontrollable in the home. When he starts showing anger his behavior escalates out of control. Daniel is exhibiting similar disruptive behavior in the school yard where he is also being teased. Daniel was sexually assaulted about a year earlier, by a group of boys from school.

Family History

Daniel and his family have been deeply influenced by severe drug dependency and abandonment by Daniel's mother in his early life. The family is under stress due to time pressures of a one-parent family. Sibling pressures and ADHD are also stress factors in the home.

Clinical Diagnosis

Daniel has a history of parent-child and parent-parent relationship difficulties, a history of sexual assault with probable posttraumatic stress disorder as well as impulse dyscontrol problems at home.

Goals of Art Therapy

Goals for Daniel include establishing a strong therapeutic alliance to encourage play in the transitional space and to offer an opportunity to recapture some missed nurturing from early stages of development. Through art expression and play to build Daniel's self-esteem, help him to gain mastery over his emotions and reduce his anxieties.

Case 3: Amy

Identification of Client

Amy is an 11 year old, Caucasian, English-speaking, female. Amy shows excessive shyness, has limited friendships, and difficulty playing outside of the home. She also shows over-responsibility towards mother, not wanting to go out for fear that mother will be hurt.

Reason for Referral

She was admitted to the psychiatric ward of a large urban hospital because of anxiety related behaviors associated with school refusal. Amy stopped attending school due to depression, crying, shakiness and anxiety at school. According to the intake notes Amy does not express her feelings about circumstances in the family, like her mother's alcoholism or the separation of her

parents. At assessment, she was extremely anxious and shy, not speaking above a whisper.

Family History

Amy's family has a long history of psychosocial difficulties and psychiatric problems. There is depression, agoraphobia, social phobia, and alcoholism in the family history. Amy's mother and father have been divorced since Amy was three.

Clinical Diagnosis

Her primary problem was school phobia with mother-child relationship problems and separation individuation problems.

Goals of Art Therapy

The goal of the art therapy was to help Amy to develop a new perspective on her life at home and away from home and thus to confound the school refusal anxieties. In short, goals for Amy were to build self-esteem, increased mastery over her daily life, a more flexible attitude to problem solving and an enhanced ability to make decisions and act independently.

Case 4: Jason

Identification of Client

Jason is a very intelligent 11-year-old boy. Jason is the eldest of two boys from an intact family. Jason lost approximately 50% of his hearing due to an early illness. In recent months he lost an undetermined amount of auditory function from a viral infection. It is unclear if this recent loss will be permanent. In my experience he cannot hear my voice.

Reason for Referral

This child was referred to the ER follow-up team because of the escalation of phobic behaviour in the home, his reluctance to go to sleep at night for fear of frightening dreams and anxieties and worries related to the September 11th crisis and subsequent horrifying news reported in the paper. There is an extreme amount of anxiety in the home as both parents are extremely disturbed by Jason's increased hearing loss. A palpable level of tension exists between the parents.

Family History

Jason's father had been an extreme epileptic from his early teen years. His daily, unpredictable seizures were often extremely violent in nature, some of which may have been directed toward Jason's mother. Successful surgery did not end the emotional sequelae of the others concerning the violence of these events. The mom and boys appear to be close while the dad seems more remote. Jason's little brother is an ingenuous and winsome child, outgoing and playful, and has no hearing impairment.

Clinical Diagnosis

Jason has a history of overanxious disorder (childhood version of generalized anxiety disorder) accompanied by sleep disturbance with nightmares, and generalized anxieties in the home.

Goals of Art Therapy

- to establish a warm, containing relationship, a strong therapeutic alliance
- to establish a warm, containing relationship, a strong therapeutic alliance

- to assist Jason to gain mastery over his fears and allow him to express his feelings, his fears and anger.

Case 5: Arthur

Identification of Client

Arthur is a 12-year-old white, English-speaking male of above average intelligence living with his natural parents and attending high school.

Reason for Referral

Although Arthur has good friends and does reasonably well at school, he has difficulty at home and expresses anger dyscontrol and depression. Recently Arthur has barricaded himself in his bedroom, climbed out the window, damaged his room and threatened to kill himself. In the past he has threatened to hurt himself and had threatened his sibling with a knife. Recently valuables have been disappearing from the house and Arthur has been kicked out of class twice.

Family History

Arthur lives with his natural parents and his older brother who has not yet finished high school. Arthur and his brother are the progeny of his father's second family. At the time of referral no psychosocial abuses in either parent's family of origin were reported.¹⁶

Clinical Diagnosis

Daniel has a history of problems of impulsivity, probably due to the spectrum ADHD and /or impulsivity as an impulse dyscontrol disorder and

¹⁶ In the first termination follow-up meeting and subsequent assessment it was revealed that both parents have a long history of alcoholism and that ADHD symptoms have been passed down for several generations in the father's family.

probable associated oppositional defiant disorder with perhaps depression and anxiety.

Goals of Art Therapy

Initial art therapy goals for Arthur include providing a safe, consistent therapeutic space, building trust and supporting the expression and sublimation of emotions through art expression. Other goals include decreasing anxiety and helping Arthur to gain a sense of mastery and control through the creative process.

Case 6: Tanya

Identification of Client

Tanya is a 15-year-old black female, tall, handsome and muscular. She moved to Canada from Granada at the age of 11.

Reason for Referral

After assessment by the ER follow-up team Tanya was referred to art therapy. Prior to this she had been admitted to the Emergency Ward of a metropolitan hospital with suicidal ideation. This admission closely followed her admission to a restrictive group home by court order and at her mother's request. She was discharged concurrently with termination of therapy. She had run away from home. She had been very oppositional with her mom not following curfews and apparently staying out late with an older man. There were a number of altercations with the police. In the group home, she expressed suicidality, was extremely oppositional, verbally aggressive, and rude; she threatened to kill herself with a knife.

Family History

Tanya was born in the Caribbean. She didn't know her biological father, and her mom has had a number of partners over the years. All were somewhat abusive. At the age of five her mother and older sister moved to Canada to start a new life for the family leaving Tanya and her two older brothers, in separate homes. When Tanya was 11 she and her brothers came to Canada to reunite with the family. Until recently Tanya's stepfather, the father of her two half-brothers, had also been living in the home. Mom has recently returned to work. Mom is a caring parent but is often overwhelmed by the socioeconomic stresses and demands of single parenthood.

Clinical Diagnosis

Tanya has a history of adjustment disorder with predominant disturbance of behavior and mood, suspected conduct disorder traits with major mother-child, mother-mother relationship problems and probable significant oppositionality

Goals of Art Therapy

- to promote self-expression and sublimation of emotions through the art activities
- to foster self-esteem and mastery through the creative process and by means of the therapeutic relationship
- to help to define future goals and to set attainable short-term goals for herself in order to recognize successes – (this includes some planning for discharge from group home and preparation for life outside the institution)

- to explore feelings surrounding past rejections and abuses and to make connections between past and current relationships

Appendix E: Partial Transcript: Session 3, Jason

January 21, 2002

Therapist: Hi Jason (11), please come in.
(Pauses while he looks around)

What would you like to do today?

Jason: **Playdough**
(Long pause as he begins to build with plasticine)

Therapist: Did you get to play chess this week?

Jason: **The computer**

Therapist: Do you ever play with your dad on you mom?

Jason: **Oh, I play with my dad.**

Therapist: Is he a good player?

Jason: **Not really**

Therapist: mmm ... So he's not as good as you but he still likes to play though?

Jason: **He's stupid?**

Therapist: No. He's not a good as you are but he still likes to play?

Jason: **Oh. Well, not necessarily; he's always loosing.**

Therapist: That would be discouraging I guess
Goes on with plasticine building

Jason: **The bishop!**

Therapist: Oh, that's quite a bishop, wow; you know he looks quite a bit like Pinocchio

Jason: **Who?**

Therapist: He looks like Pinocchio

Jason: **Oh**

Therapist: With the long nose

Jason: **They're not really supposed to have faces**

Therapist: Really – they're not? Didn't the playing pieces start out as royal figures?

Jason: **There aren't very many of those.**

Therapist: Oh.

Long pause. What are you looking for? More gray?

Jason: **What is that?**

Therapist: It's a different looking bishop - I'll show you in a minute. Oops his cape came off. Just a minute
Shows the plasticine bishop to J

Jason: (smiles) **Oh that's nice.**
Pause while he makes something else

A chess clock! *Plays with the chess pieces he made this week and from the box of previous week's pieces. He pretends to be playing chess and using the timer. He moves the pieces quickly like a speeded up tape; then stops and grins. He plays with the bishops.*

Therapist: Those two bishops are strange looking together. Oh he lost his nose!
We do some repairs.
Are there two timers, one for each player?
Jason plays with the characters some more.

Jason: **There are no more chess pieces to make. We don't want to play chess really. We don't have to...**
We go back to building.

Therapist: Jason, your Mom says that you have very bad dreams sometimes. Is that still true?

Jason: **What?**

Therapist: You sometimes have very bad dreams – is that right?

Jason: **Yah**

Therapist: Do you remember what's in the dream that's scary?

Jason: **Oh, I don't remember.**

Therapist: You don't remember.

Jason: **Well not really. I can't think of it right now**

Therapist: You just wake up frightened.

Jason: **Yah**

Therapist: And then what happens?

Jason: **Well I want to go downstairs.**

Therapist: You wake up by yourself?

Jason: **What?**

Therapist: Do you sleep in your own room by yourself?

Jason: *almost under his breath like an aside* **Yah but Charley's no help anyway.**

Therapist: Laughs. Oh, how come?

Jason: **Well he's just little and he doesn't have bad dreams.**

Therapist: He doesn't have bad dreams.

Jason: **No.**

Therapist: So he doesn't understand that.

Jason: **No.**

Therapist: So then you go downstairs and talk to your mom and dad?

Jason: **Yah**

Therapist: Are you able to go back to sleep then or is it sort of scary?

Jason: **It goes away after a while.**

Jason and therapist go back to making things

The therapist presents a small-undifferentiated creature

Jason: He grins **An anteater!** (a happy exclamation about the therapist's creation) *(shows what he is making)*

Therapist: which way is it going?

Jason: **What**

Therapist: which way is it going?

Jason: **Oh** (smiles, a little laugh) **I don't know.**

Therapist: I can't tell which end is which

Jason: (smiles) **I can't either**

Therapist: OK

Pause then Jason shows his finished animal

Therapist: Oh ..he's very cute.

(Pause)

Is he an elephant or a woolly mammoth?

Jason: **What?**

The therapist writes the question on the pad beside her

Yah, he's an elephant.

Therapist: Oh.

Jason: **Grrr** *makes growly sounds with creatures playing together, moving pieces around as in a game.*

Therapist: Shall we make a game board?

Jason: **Oh, ok.**

Therapist: How do we do it?

Jason begins to draw the game board -very focused

Jason: **Do you have something smaller?**

Therapist: A pencil like thing?

Jason: **Yah** *the therapist goes to get pencils and markers.*
Jason writes in details – words on game board

That's if you roll something you have a choice.

Therapist: OKThere we go – *responding to the board's evolution* That's the "end" ok

Jason: **Do you want to make a tiger?**

Therapist: OK.....This is going to hard Jasonthis is going to be hard to survive.
This is going to be hard and scary

Jason: **Some of it, yah.**

Therapist: Jason, we have 5 more minutes ok? *Makes a gesture showing an open hand with five fingers.*

Jason: **Oh** *disappointed* I won't be able to finish this

Therapist: next week

Jason: *brightening* - **Oh, OK.**

Therapist: *Finishes another plasticine figure*

Jason: makes a funny face, half amused half worried **Who's he, an alien?**

Therapist: He's a bad dream.

Jason: **Oh dear.** *Surprised expression*

Therapist: He looks pretty bad don't you think?

Jason: **What are you going to do with him?**

Therapist: Oh I don't know, I thought maybe you could put him in the game but I'm not sure.

Jason: **Well...**

Therapist: *Tentatively* He could just watch I guess.

Jason: **Could I put him in a cage?**

Therapist: Sure – definitely!

Jason works on making the cage with little success, there isn't really enough time for it – there are only three rungs on the cage

Jason: **It's not secure.** *Jason crinkles up his face to show the failure.*

Therapist: *laughing* - I think you are right, there are a couple of bars too few.

Jason: **Huh?**

Therapist: *Slower and more pronounced.* I think you're right there are a couple of bars too few
He can sneak out.

Jason: **Grins Yah**

Therapist: You know what maybe we could put him in a box for now.

Jason: *with enthusiasm* - **We could chain him**

Therapist: That's true. *Therapist gets up to search for a box; meanwhile Jason is busy chaining the nightmare. Returning with the box.* Does he fit in here? Ho you've chained him. Good - good stuff.
Therapist places box on table, watching as Jason puts the bad dream in the box.
Ah you're going to put him in there.

Jason: *triumphantly* -**Aha**

Therapist: He deserves it. He's stuck now. Oh his head fell off.
We make repairs.
He's not feeling good.

Jason: **Hmmm**

Therapist: He's feeling sick

Jason: **Huh?**

Therapist: He's feeling very sick.

Jason: **He is?**

Therapist: mmhm I guess that's a good thing

Jason: **A good thing?**

Therapist: Yah

Jason: **I could make him some medicine.**

Therapist: OK, I'll find another box to put all these things in.

Jason: *Jason brings the medicine he has made for the bad dream. Oh, No. He pulls the medicine away and decides not to give it to the bad dream.*

Therapist: Just for a minute there I thought you were going to help him, but no.

Jason: smiles **No.**

Therapist: All right we'll put him away and make sure he doesn't get away

It's time to go now; I hope you have a good week J

Jason: **Yah**

Jason gets up to go and then goes back to the plasticine He hands the thing to the therapist

Therapist: What's this?

Jason: *crinkling up his nose* **Twenty-five cents.**

Therapist: Wow, thanks!

Jason: **Not very much.**

Therapist: I'll think about what to do with it.

Jason: **Oh**

Therapist: thank you.

Jason: **Bye Bye**

Therapist: **Bye Jason**

Appendix F: Termination Letter, Daniel

April 2, 2002

Dear Daniel,

The time for us to travel on in two different directions has arrived. It is sad to think that we will not be walking any farther together. But I will remember with great joy many adventures and explorations we have shared. Beginning with an explosion of golden glue and including so much creative building and play.

Snuffles is also sad today but he wanted to say thank you for helping him to control his jumpiness. Now he only feels jumpy when reeeealy scary things happen, like when a much larger bear moves into the art room. Then he does the breathing exercises that you taught him before he goes over to shake the bear's paw and introduce himself.

I am very proud of all that you have accomplished this year Daniel. You have proven yourself to have a thoughtful, caring, courageous, playful and loving spirit that can tackle and overcome very tough problems. Even though it's sad to have to say goodbye, I rejoice to have known you and to have traveled with you for this part of the journey.

Warm best wishes,

Elizabeth

Appendix G: Diploma for Imaginative Thinking***Diploma******In******Imaginative Thinking******Awarded to: Amy******March 27, 2002***

After many months of difficult work Amy has been successful in keeping Mr. Meanie out of her hair and away from her creative imagination. With wit, mischief and cunning and especially her inspired imagination Amy was able to bamboozle Mr. Meanie and banish him to his room where he is not allowed to do much of anything. This was not an easy victory. Amy was able to wrestle her life back from Mr. Meanie. She is now free to live her own life, make her own friends, her own decisions and her own mistakes. Congratulations!