Humour and the Therapeutic Alliance in Art Therapy with an Adolescent Population

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Abstract

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This research paper uses a historical-documentary research approach to link literature and theories to explore the undeveloped topic of humour and its effect on the therapeutic alliance in art therapy with an adolescent population. In order to do so, this paper will analyze existing literature and data from various fields of social sciences to examine the pros and cons of humour from a therapeutic perspective, and the impact of using humour with the adolescent client in therapy. The role of the therapeutic alliance and how it affects adolescents in therapy is explored. A brief overview of adolescent psychology and the role art therapy can play with adolescents is given. This paper will also explore how humour can be incorporated into art therapy practice, and give suggestions for possible interventions.

Keywords: humour, therapeutic alliance, adolescents, art therapy

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Introduction

"The human race has one really effective weapon-humour".

-Mark Twain

Adolescents are a population that I have great interest in working with, and I have enjoyed incorporating humour in my practice while working with youths as an art therapy intern. Humour has always been a big part of my life as far back as I can remember. I often used humour as a coping mechanism to deal with the difficulties I experienced growing up, especially in the very challenging years of my adolescence - or at least I assume I did - I've done my best to repress those horrifying years! I guarantee that if you went back to my high school and asked any of my teachers to describe me they would most likely refer to me as the class clown, or odd, and probably also bothersome, as I would often interrupt the teacher with a clever (or as they saw it, obnoxious) remark. Now that I think about it, maybe avoid going back to my high school... All this to say, my personal experience with humour has influenced my research and interest in the topic. It is my personal experience and belief that humour has incredible power, and has the ability to make the world a more tolerable and even enjoyable place, even at the worst of times.

Adolescents are a challenging population to work with in therapy, and so many are in need of help. Adolescence is a time of major physical and psychological changes as they navigate towards adulthood where adolescents are often faced with intense emotional states and social pressures (Case & Daley, 2014; Erikson, 1963). Mental illness affects many adolescents, with numbers only rising. According to the Canadian Mental Health Association (n.d.), 10-20% of Canadian youth suffer from mental illness, with a total of 3.2 million adolescents at risk of developing depression. With the second highest hospital care expenditure in Canada being mental disorders in adolescents and with the youth suicide rate in Canada being the third highest in the industrialized world, it is clear that adolescents are suffering and are not getting the help they need (Canadian Mental Health Association, n.d.). Adolescents in therapy have a high drop-out rate, or unsuccessful outcome in therapy (Kadzin, Siegel, & Bass, 1990). This could be related to the challenge of establishing a therapeutic alliance between the adolescent and therapist. The therapeutic alliance has been shown to be a primary factor in the successful outcome of therapy (Barber, Connolly, Crits-Christoph, Gladis & Siqueland, 2000; Horvath & Symonds, 1991; Kendall, 1991; Lambert & Barley, 2001; Mohl, Martinez, Ticknor, Huang, & Cordell, 1991; Plotnicov, 1990), and some believe it is more pivotal in adolescent therapy;

however, more challenging to establish with adolescents than with adults (Lambert & Barley, 2001; Shirk & Saiz, 1992).

Humour is shown to have many benefits on an individual's physiological and mental well-being (Berk, 1994; Elliot, 2013). Some research demonstrates that humour is essential in helping to establish the therapeutic alliance, as well as strengthening it (Bachelor, 1995; Beck, Friedlander & Escudero, 2006; Gelkopf, Sigal, & Kramer, 1994). Riley (1999) believes that humour, spontaneity and playful interpretation, are essential in art therapy with adolescents. That being said, little to no research has been done on the effects of humour on the therapeutic alliance, and none have been conducted using the population of adolescents, nor in the context of art therapy. When is humour healing and when is humour counter-therapeutic is a theme that will be followed throughout this paper.

While this paper focuses on an adolescent population, I have included research using other populations, as the information and existing studies available was limited for adolescents in the areas of the therapeutic alliance and humour.

Methodology

Statement of Purpose

The purpose of this paper is to explore *the use of humour in art therapy with adolescents and its effects on the therapeutic alliance.* I will investigate how humour has been and can be used in therapy, its effects on the therapeutic alliance, and the integration of humour in art therapy. The primary focus of this research is with an adolescent population. This research will use a historical-documentary theoretical methodology, which involves the collection of literature, which will then be then analyzed and summarized. This research will also include suggestions from the author on possible interventions using humour in art therapy with adolescents and areas for further study.

Theoretical Research

This paper will utilize a historical-documentary research methodology, which is part of qualitative research. In qualitative research, the focus is on the social meaning of different experiences through texts and words rather than numbers (Hesse-Biber & Leavy, 2010). Theoretical research integrates and critiques existing theories with the intention of generating new theory and knowledge (Junge & Linesch, 1993). In theoretical research, theory is the data and the methods are logical analysis, evaluation, and synthesis (Junge & Linesch, 1993).

The goal of historical-documentary research is "to produce systematic, reliable statements that either increase the available pool of knowledge about a given topic or bring existing knowledge into a more precise focus by means of new interpretive pattern" (Reitzel & Lindemann, 1982, p. 169). It includes critical analysis and synthesis of sources from various fields which allows for incorporation of an abundance of literature including experimental and non-experimental, as well as qualitative and quantitative studies in order to link theory, research and practice together and consists primarily of a literature review, criticism, and discussion (*Art therapy & drama therapy handbook: Policies and procedures for the art therapy & drama therapy options magisteriate in creative arts therapies,* Department of Creative Arts Therapies, 2015, p. 7).

There already exists an abundance of literature on the use of humour in therapy, however, little exists on the effects of humour with adolescents, even less on the effects of humour on the therapeutic alliance, and almost nothing has been written on the use of humour in art therapy. As "historical analysis is particularly useful in obtaining knowledge of unexamined areas and in re-examining questions for which answers are not defined as desired" (Marshall & Rossman, 2006, p. 119), this theoretical approach is most appropriate for this research.

Hart (1998) believes the important reasons for reviewing the existing literature are to identify relationships between ideas and practices, to discover important variables that are relevant, to gain a greater understanding of the structure of the subject, and to synthesize and gain a new perspective. This describes my motivation for choosing this methodology, as I intend to bridge ideas, and existing theories together in order to have a greater understanding of the role that humour plays in therapeutic practice. There has yet to be research that focuses on the effect of humour on the therapeutic alliance in art therapy with an adolescent population. Using historical-documentary research, I hope to synthesize the data found in the literature and establish links between theories to fill the gaps and discover new perspectives.

Ethical Considerations and Researcher Bias

Qualitative methods are characterized by subjective responses by the researcher (Deaver, 2002). As my responses will be subjective, a main ethical consideration with this type of research methodology is researcher bias. As I cannot eliminate my beliefs and viewpoints, I intend to be reflexive and transparent about my background, experiences, motivations, and beliefs throughout my research. I have personally experienced humour as something positive,

however as a novice art therapist entering into the workforce, I would like to learn as much about the uses of humour, and the possible negative affects it can have with clients in order to be an asset to my field and clients, and avoid doing any harm. As a white female coming from a Canadian cultural background, my experiences and beliefs about humour reflect this. While humour is a universal concept, there are cultural norms and variables such as content, timing, who is the audience or who is present during instances of humour, and appropriateness that may differ in other cultures (Adamle & Turkoski, 2006).

Other ethical considerations to be aware of are omitting negative information and only reporting positive findings, falsifying authorship, data, findings and conclusions (Creswell, 2012). I intend to review the possible negative sides of humour in therapeutic contexts as well as adhere to the ethical guidelines of the Canadian Art Therapy Association (CATA), which requires providing appropriate references to sources used. In order to do so I have followed the APA (6th ed.) guidelines of citation in order to fairly evaluate the data and give honest attribution to the sources I have used and to ideas which are not my own. To further enhance validity, I will use triangulation, which is the use of multiple sources, views, methods, and theories to help interpret findings (Creswell, 2012; Johnson, 1997).

Data Collection and Analysis

Randolph (2009) states that the goal of data collection is to gather a representative, semi-exhaustive, exhaustive, or pivotal set of relevant literature, and to accurately document how the data was collected. In this paper, I will be taking a representative sample of the existing literature. The type of data that will be collected for this research will be primarily from academic journals, online databases, and published books, using both quantitative and qualitative research findings as well as case reviews. Considering the scarceness of the literature and research done on the use of humour in art therapy, an integrative approach to allow for data collection in a broader search context will be done. This search will include other helping fields such as nursing, social work, different schools of psychology, psychiatry, occupational therapy, family therapy, leisure science, and child psychiatry. Tracy (2010) states that multiple types of data, methods of analysis, and researcher viewpoints allow for a richer understanding, a deeper scope, and different aspects of problems to be explored. I will also incorporate my viewpoint and my personal experience as an art therapy intern in order to be transparent and avoid researcher bias, as well as to help inform possible future interventions. Keywords used in order

to discover the data were; humour in therapy, humour and therapy, humour and art therapy, humour and adolescents, humour and the therapeutic alliance, the therapeutic alliance (working alliance, helping alliance, working relationship), the therapeutic alliance and adolescents, adolescent psychology, and adolescents and art therapy.

The steps that are typically taken with this type of research and which I will be following are as follows; establishing a research question, collecting the data, analyzing the data, synthesizing and summarizing the data, drawing conclusions from the data and adding suggestions for potential interventions and future research in relation to what the data has informed.

Organization

I have established three main categories by which to organize the data. These categories are: humour, the therapeutic alliance, and adolescents. The data has been organized thematically under these categories and subcategories have been created based on the themes that arose from the literature. Subcategories are: the benefits of humour, the effects of humour on depression and coping, humour in therapy, humour in art therapy, negative effects of humour in therapy, the importance of the therapeutic alliance in therapy, the effect of humour on the therapeutic alliance, art therapy with adolescents, the importance of the therapeutic alliance with adolescents, humour with adolescents, and the effect of humour on the therapeutic alliance with adolescents in art therapy. The data that has been included is based on its relevance to the topics. After the synthesis and analysis of the literature, I then proceed to the discussion and review the limitations of the research. Suggestions and recommendations for future research will be given based on the conclusions that were found. This research will help bring forth unexplored possibilities, which will help inform potential future research that can be done to advance the field of art therapy.

Questions

In this research paper, the major question being asked is: how can humour be used effectively to build a therapeutic alliance in art therapy with an adolescent client? I will be examining whether or not humour has a place in therapy, and its potential for using humour to help build a therapeutic alliance. Additionally, I will explore the importance of the therapeutic alliance with adolescents, and how the adolescent client can benefit from art therapy practice.

Operational Definitions

Humour. The Oxford Dictionary (2015) defines humour as "the quality of being amusing or comic, especially as expressed in literature or speech…The ability to express humour or amuse other people." The Merriam-Webster dictionary's (2015) definition of humour is "The mental faculty of discovering, expressing or appreciating the ludicrous or absurdly incongruous…Something that is or is designed to be comical or amusing."

Therapeutic humour. The Association for Applied and Therapeutic Humor (2000) states that "Therapeutic humor is any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life's situations. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual".

Art therapy. The Canadian Art Therapy Association (CATA, 2013) defines art therapy as combining "the creative process and psychotherapy, facilitating self-exploration and understanding. Using imagery, colour and shape as part of this creative therapeutic process, thoughts and feelings can be expressed that would otherwise be difficult to articulate" (What is art therapy, para. 1).

Adolescence. A broad definition provided by Merriam-Webster (2015) describes adolescence as "the period of life from puberty to maturity terminating legally at the age of majority". This stage of development will be further discussed in the literature review section of this paper.

Therapeutic Alliance. The therapeutic alliance, which is also referred to as the working alliance, helping alliance, working relationship, and therapeutic relationship, signifies the strength and quality of the shared relationship between therapist and client in therapy (Horvath, 2001). The alliance consists of a positive bond, including respect, confidence, acceptance, caring and mutual trust between client and therapist (Bordin, 1976; Horvath, 2001). The alliance also encompasses a sense of partnership, mutual collaboration and engagement, and shared commitment to the goals of therapy and the interventions used (Haweley & Garland, 2008; Horvath, 2001).

Literature Review

The following literature review will explore the benefits and importance of humour, the therapeutic alliance, and its relevance with adolescents in art therapy, as well as some of the challenges and negative aspects of using humour in therapy and its limitations.

Humour

"Humour is an antidote to all ills".

-Patch Adams

The etymology of the word humour comes from the Latin word meaning moisture (Ruch, 1998). It originates from the classic Greek theory of the four humours of bodily fluid, which were blood, phlegm, black bile and yellow bile, which were essential to the body (Ruch, 1998). These 'humours' were believed to influence psychic and physiological function, and when in balance it was said that that individual was in a good humour (Ruch, 1998). Humour made its first appearance in psychoanalytic theory by Freud in 1905 in his book *Jokes and the Relation to the Unconscious* (as cited in Bergmann, 1999). He saw humour as being one of the healthiest defense mechanisms (Freud, 1928; Freud, 1905/1960). Freud saw jokes or puns as distinct from humour, and that jokes were a means of expressing hostile, aggressive or sexual impulses, typically at someone else's expense (Freud, 1928; Freud, 1905/1960). He saw humour as being on a higher level than jokes, the difference being that humour is at one's own expense (Freud, 1928; Freud, 1905/1960). It is no shock that Freud believed humour to be expressions of the unconscious, and that humour has the ability to bypass the unconscious allowing repressed material to flow into consciousness (Freud, 1928; Freud, 1905/1960). A sense of humour can be defined as the ability to create, comprehend and appreciate humour (Freiheit, Overholser, & Lehnert, 1998), while humour coping is defined as the ability to use one's sense of humour to moderate the effects of stressful situations (Freiheit et al., 1998).

Benefits of humour.

"Humor can alter any situation and help us cope at the very instant we are laughing."

-Allen Klein

There have been numerous studies on the benefits of laughter and humour on physical and psychological well-being. Elliot (2013) believes that humour generally enhances an individual's well-being both biologically and socially. He explains that the brain's neural circuitry supports laughter and that humour has the potential to heal and motivate action (Elliot,

2013, p. 211). Furthermore, a study by Martin and Kuiper (1995) shows the positive effects of humour on emotional well-being. The authors found that daily laughter decreased daily stressors and negative emotions.

Dr. Hunter Doherty "Patch" Adams, a doctor known for his signature red clown nose, uses humour and clowning in his medical practice and founded the Gesundheit Institute (1971), a free hospital that integrates traditional and alternative medicine. Adams (1998) speaks to the healing qualities of humour in all aspects of life, and feels the benefits of humour on physical and mental health are infinite to both the client and the professional treating the client. He believes that humour is vital in healing all problems and that humour and love are equal partners for a healthy life (Adams, 1998).

Mannell and McMahon (1982) used mood measures and a humour diary with university students to test whether or not humour was related to their psychological well-being. They found that participants who reported more humorous incidents during the day exhibited an increase in positive emotions as well as a decrease in negative emotions, such as fatigue, hostility and anxiety.

Humour helps build social relationships and increases social bonding. Studies show that humour has aided interpersonal relationships (Garrick, 2006; Wanzer, Booth-Butterfield, & Booth-Butterfield, 1996). Wanzer et al., (1996) found that individuals with a high degree of humour had lower levels of loneliness, were more socially attractive to others and reported an increased sense of belonging than those with lower levels of humour.

Humour has also been found to have many physiological and neurological benefits. Laughter produces endorphins, which are the body's natural painkiller; this in turn relaxes and produces positive feelings in the body (Berk, 1994). Humour and laughter have been found to help in boosting the immune system, increase the body's ability to combat infection, restore homeostasis, massage vital organs, generate an increase in natural killer cells that fight cancer, increase energy and generally produce feelings of physical well-being (Fry & Salameh, 1987; Garrick, 2006).

The effects of humour on depression and coping.

"Comedy can be a cathartic way to deal with personal trauma".

-Robin Williams

Freud (1960), who was one of the first to examine the use of humour in psychoanalysis, observed humour to be a positive defense mechanism and useful strategy for coping. He also found humour to be beneficial in re-directing misguided hostile energies. McGhee (1979) believes that humour has the capability of lifting us out of depression. Humour has also been seen to be a moderator of stress in regards to depression (Nezu, Nezu, & Blissett, 1988).

Danzer, Dale and Klions (1990) conducted a study to test whether or not humour had the capacity to counteract depression. Their study consisted of inducing 38 university undergraduate women ranging from 18 to 24 years of age with depression. In order to induce depression, the participants were all shown slides developed by Velten (1968) that have proven to induce depression. The slides are shown in progression from less to more depressing content, and the participants are asked to read them, think about and feel them. After successfully inducing depression in all the participants, they were then assigned to one of three groups: the humour group, the nonhumour control group, and the waiting control group. Group one listened to a humorous tape, group two listened to a tape on geology and the third group sat in silence. They found that the group that received the humour treatment reverted back to what their baseline level of depression was before viewing the depressive slides, while the other two groups remained in a depressive state. They concluded, therefore, that humour was more effective in reversing the effects of induced depression. While this is telling of the benefits of humour on depression, some limitations of these results are that the depression was induced, and therefore its effects may differ in length and degree. The study also only used women and it is possible that men respond differently.

Crawford and Caltabiano (2011) believe that humour skills enhance an individual's ability to cope with adversity and increase emotional well-being. They hypothesized that using a humour skills program would increase the levels of positive affect, optimism, self efficacy and perceptions of control as well as display a decrease in levels of perceived stress, depression, negative affect, stress, and anxiety. They used an adapted version of McGee's (1999) Humour Skills Manual, which consists of an eight-week humour skills program. The participants were 55 volunteers from the community who were randomly assigned to one of three groups: a humour

skills group, a control group, and a social group. In comparing the humour skills group to the other two groups their hypothesis was supported. They found that the humour group showed notable increases in emotional well-being and decreases in negative symptoms.

Mannell and McMahon (1982) had similar findings in their study where they used mood measures and a humour diary with university students to test whether or not humour was related to their psychological well-being. They found that participants reporting more humorous incidents during the day exhibited an increase in positive emotions as well as a decrease in negative emotions, such as fatigue, hostility and anxiety. They also discovered that social interactions generated the largest amount of playful incidents of humour while mass media accounted for the lowest amount. Kuiper and Martin (1998) found that positive humour and increased laughter can serve as a coping strategy and can moderate the affective impact of stress and negative life events. In a study by Martin and Lefcourt (1983), it was discovered that being cognitively involved in humour while stressed reduced the effects of stress.

Garrick (2006) states that humour is common among workers who face death and traumatic material on a daily basis such as firefighters, police officers and paramedics. She explains that humour helps them cope and get through the day while doing their job and that it is a positive health skill. She gives examples of the use of humour by war veterans and survivors from concentration camps. There has been a lot of humour literature discovered in concentration camps; the prisoners attribute their use of humour and faith as key in their ability to survive (Garrick 2006).

Sliter, Kale and Yuan (2014) conducted a study on this subject, examining how exposure to traumatic stressors impacts firefighters and whether humour has the ability to shield the impact of these stressors. Their findings indicate that coping humour did in fact buffer the impact of traumatic stressors, helping to prevent burnout and post traumatic stress disorder (PTSD) among firefighters. As there are many individuals dealing with workplace stress and burnout, humour can be used as a positive coping strategy for individuals under stress, whether traumatic or general stress. Bonanno et al., (2002) also found that positive emotions and laughter help individuals to cope with trauma and loss by removing negative emotions.

Humour in therapy.

"In therapy, a humorous attitude is a form of mental play with a serious purpose".

Richman, 1996, p. 561

Therapeutic humour has been defined as:

> The conscious and purposeful use of humor by a professional health practitioner for the purpose of activating a positive therapeutic change in an individual's feelings, behaviors, thoughts, or even physiology. It is the purposeful intention of using humour for the client's benefit that distinguishes health practitioners (therapists) from those who are not health practitioners (Sulatnoff, 2013, p. 394).

Richman (1995) identified five principals of therapeutic humour. His first principal is that the client-therapist relationship must include the freedom to be humorous and rests upon the necessity of a positive client-counselor relationship (p. 272). The remaining four principals state that therapeutic humour is stress reducing, life affirming, is interactive, and increases cohesion (Richman, 1995).

Both Garrick (2006) and Gladding (1995) believe that humour is a powerful tool that has a natural place in therapeutic settings and is a resource that should be used. It has been observed that many clinicians include humour in their therapeutic practices (Salameh, 1983). For example, Prerost (1985) used humorous imagery for depression in psychotherapy and found it to have a positive impact.

Ellis (1977) finds that humour has the ability to shift negative and self-defeating thinking patterns and adopt attitudes of playfulness and optimism. Humour allows an individual to view the positive as well as the negative side of situations and permits them to accept ambivalence (Ziv, 1984). Therapists can model the use of humour with their clients, and can effectively teach the client self-nurturing skills and emotional management (Middleton, 2007).

Humour can help a client to feel safe to express difficult issues and emotions in a more unobtrusive and camouflaged way, and it also reduces the distance/power dynamics between client and therapist (Dewane, 1978). Humour and laughter relax the mind and reduce anxiety, while also reaching emotional content and bringing out feelings of hostility (Gelkopf, 2011). Humour can help to overcome resistance and be helpful when dealing with taboo subjects (Gladding, 1995). When they are brought out in therapy, these feelings can then be explored in the safety of the therapeutic setting.

Entering therapy can provoke anxiety in many clients, especially if they are new to therapy. Using humour in therapy can help to decrease this anxiety while also promoting insight (Schnarch, 1990). When the therapist uses humour with the client, it helps to normalize the

situation (Dewane, 1978). While the therapist may run the risk of seeming imperfect when bringing humour in the therapy session, this also gives the client permission to behave imperfectly. This in turn helps the client to see the therapist as being human (Dewane, 1978). Franzini (2001) believes that humour can be a gift to the client in therapy. He finds that not only does it help to establish rapport and reveal the client's irrational thinking, it also allows the therapist and client to share a positive emotional experience. This is often rare in the therapeutic context, and can therefore help demonstrate a positive outlook to the client, helping the client to have a realistic and manageable perspective thus leading them to see that their problems can become solvable (Corey, 1986). When speaking about his use of humour in therapy, Schnarch (1990) enjoys using over-dramatization of situations to help the client gain perspective. He explains that:

> Humour and the capacity to see the meaningfulness and folly of human existence, is a requisite capacity, and burnout antidote, for caring and involved therapists. Clinical insight and intuition let us see in people's lives, humour makes it gentler and kinder for everyone involved. (p. 86).

Schnarch (1990) maintains that just like with any other event during the course of therapy, it is appropriate for the therapist to consider the systemic and dynamic meaning of the clients' joke or humour, however this not does automatically mean interpretation. Richman (1996) cautions therapists about forcing humour with clients but adds that "humour when sensitively and properly applied enriches therapy, increases the mutual enjoyment of client and counselor, draws people together, and – I believe – even saves lives" (p. 1).

Humour in art therapy. While there is a paucity of literature and research on the use of humour in art therapy, Mango and Richman (1990) find humour to have a place in art therapy. They state that: "Art, psychotherapy, and humour possess one major feature in common - they can be expressions of the fluid, symbolic, and sometimes poetic primary process described by Freud (1960), rather than of the more discursive, prosaic, and formal secondary process" (p. 111).

Mango and Richman (1990), two authors, among the few, who have done studies on humour and art therapy, reported on visual and verbal expressions of humour in art therapy in their study using psychiatric in-patients where patients were encouraged to use humour in their expressions. Their sessions began with a warm-up period of joke telling, followed by a period

for drawing, where they were instructed to depict something funny that happened to them, and ended with a group discussion. The authors hypothesized that each drawing and joke was an expression of the creator's current struggles and emotional state, and metaphor for their needs. The authors found that humour brought the patient's problems to the foreground, and that it depicted the pain behind mental illness. It was also noted that topics that were shared during the art therapy sessions were often ones that were seen as shameful in other places and therefore kept hidden. They also found that the participants enjoyed the expressions and that the humorous drawing was a pleasant and effective way of establishing a therapeutic relationship.

Silver (2003) who created the Draw-A-Story Assessment and the Silver Drawing Test, assessed the way humour is expressed in drawings using 888 participants of varying age and gender. The participants chose two stimulus drawings from a selection of animals, people, places and things. They were then instructed to imagine something happening between the two and then to depict this in a drawing. Silver (2003) identified several types of humour: disparaging humour, lethal humour, ambiguous or ambivalent humour, playful humour and resilient humour. In her study, she found that 17% of the drawings expressed humorous material, and that males produced more of the humorous responses and that their responses were more negative humour than that of the females. Silver (2003) found that humour had the tendency to reflect the client's personal situation, as well as moods, fantasies, and attitudes towards others and the self.

Kopytin and Lebedev (2013) studied the effects of group art therapy with 112 war veterans being treated for stress-related disorder in a psychotherapy unit of a Russian hospital. They studied the use of humour by incorporating Silver's Draw-A-Story assessment and the Silver Drawing Test, testing the connection between humour and changes in cognitive skills, self-perception, personality function, and quality of life. The authors found significant increases in humorous responses from the art therapy group, and found higher rates of humorous material than Silver did. They found that creativity, emotional content, cognition, and self-image significantly increased for the art therapy group and did not for the control group, therefore confirming their hypothesis that humour serves as a therapeutic factor linking to creative and cognitive resources. Kopytin and Lebedev (2013) also found that art therapy enabled the veterans to more freely express humour, both visually and verbally.

Negative effects of humour in therapy. While many studies demonstrate the benefits and positive uses of humour in a therapeutic context, there exists some controversy and views

that the use of humour in therapy can produce negative effects. Humour and laughter can be tools that clients use to escape or cover up anxiety when facing difficult material. It is important that the therapist be able to distinguish between this type of humour, and recognize how it can detract from the situation, versus humour that enhances the situation (Corey 1986). Humour can also be exploited by the client as a way to avoid difficult topics, and can be a way to test if the therapist can be distracted away from the issues at hand (Schnarch, 1990).

While humour can be a positive and important tool in coping, it is important for the therapist to recognize if humour is the sole coping strategy the client uses, as it could mean that the client has not developed other methods of coping (Moran & Hughs, 2006).

If a client is using inappropriate humour, this may be indicative that he is trying to hide his true feelings (Marcus, 1990). The overuse or inappropriate use of humour can mean that the individuals are distancing themselves from emotional pain. Since distancing and denial can obstruct the therapeutic process, it is imperative that it be dealt with (Garrick, 2006). Another thing to keep in mind while using humour in the therapy process is that nervous laughter can be an indication of low self-esteem (Garrick, 2006). That being said, the therapist can also observe the client's use of humour and can address the issues of self-esteem and denial head on, which can end up being productive.

Kubie (1971) expressed strong concerns about the use of humour in therapy, especially for the inexperienced therapist. He feels that humour may be used as an escape or defense when the novice therapist is faced with new or challenging situations. It is important that the intent of using humour with a client in therapy be for the benefit of the client and not of the therapist, as it could give the client the impression that the therapist is not taking the client's issues seriously (Sultanoff, 2013). Gladding (1995) states that humour is inappropriate in therapy when it is experienced as a put down, is badly timed, or if the therapist is using it to avoid dealing with the client's anxieties. In general, the therapist should not use inappropriate or demeaning humour with clients but use humour positively, in a way that enhances the therapy experience. However, humour may be used and perceived differently in different contexts and cultures. What content is appropriate and with whom it is appropriate to use it with may differ in various cultures (Adamle & Turkoski, 2006). Schnarch (1990) cautions that humour may not be beneficial with all populations, and that individuals with cognitive or hearing deficits may miss part of the joke and feel diminished as a result. Prerost (1984) adds that for an adolescent client there is risk in

them feeling that the therapist is belittling them, and the therapist should be careful to use humour that is appropriate for the age of their client.

Prerost (1984) warns that if adequate care is not taken, a humorous remark could negatively affect the therapeutic alliance. Therefore, Saper (1987) believes it is important to know your client thoroughly before bringing humour into the therapeutic setting, as there may be a lack of agreement about what is considered humorous. Sultanoff (2013) states that when a therapist uses humour with intention, and the client understands it, then humour has the potential for being therapeutic.

Schnarch (1990) believes that the clinical use of humour is a learned therapeutic skill, and that like all other therapy techniques, it is often abused. Before a therapist brings humour into the therapeutic setting, they must be open to humour and recognize its importance in their own lives (Garrick, 2006). More importantly, the therapist needs to discover what humour means to each individual client (Adams, 1998).

The Therapeutic Alliance

The concept of the therapeutic alliance has its origins in psychodynamic theory (Horvath & Luborsky, 1993; Horvath, 2001). It can be traced to Freud's early work on the connection between therapist and client and the dynamic of transference (Freud, 1913; Horvath, 2001). Freud originally believed that the therapeutic alliance was a form of positive transference, and that the positive relationship between therapist and client was a result of the client identifying the therapist with a positive and caring person from his or her past (Horvath & Luborsky, 1993; Horvath, 2001). Freud believed that this positive transference gave the client belief and trust in his or her therapist (Freud, 1913). Freud later reformed his view on the therapeutic alliance to allow the possibility of a valuable therapist-client relationship grounded in reality, as positive transference signifies a distortion of the real relationship (Horvath & Luborsky, 1993). It was seen that the client's ability for his or her reality-based self to develop a relationship with the therapist created the possibility for healing to occur (Horvath & Luborsky, 1993).

Later, Greenson (1965) coined the term *working alliance* and established a positive alliance between therapist and client to be fundamental to successful therapy (Horvath & Luborsky, 1993; Horvath, 2001). Object relationists believed that, as part of the therapy, the client develops the ability to form a positive and rewarding relationship with their therapist that is different from their relationships based in childhood (Horvath & Luborsky, 1993). Bordin

(1975) developed a pan-theoretical concept of the alliance, completely departing from the psychodynamic viewpoint with an emphasis on collaboration and consensus between client and therapist (Horvath, Del Re, Flückiger, & Symonds, 2011). Bordin (1979) describes the therapeutic alliance as a collective bond between client and therapist and believes that building a bond, agreeing on goals and establishing tasks are the qualities of the therapeutic alliance.

Theorists argue about whether or not positive transference and the therapeutic alliance are different constructs or whether all aspects of the relationship are expressions of transference (Horvath & Luborsky, 1993). Hatcher (1990) states that every relationship is affected by our previous interpersonal experiences. However, the question that is still being debated is the degree to which the past relationships of the client influence the alliance (Horvath & Luborsky, 1993). That being said, most have come to the conclusion that the definition of the therapeutic alliance must take into account the influence of past experiences on the client while at the same time outline the alliance as a distinct facet of the current relationship (Gaston, 1990).

A strong alliance is seen to make positive contributions in cognitive, behavioural, gestalt, and psychodynamic therapies (Horvath & Symonds, 1991). Horvath (2001) found that the alliance was theorized to be an important component in all helping relationships and modalities, and is not exclusive to psychodynamic therapy.

The importance of the therapeutic alliance in therapy. According to the literature, the therapeutic alliance is vital to the successful treatment of individuals. The strength of the therapeutic alliance has been seen to be the primary factor for client's improvement and is regarded as an essential tool in therapy (Lambert & Barley, 2001). The following section will give examples of its importance and effects in therapy.

Horvath and Luborsky (1993) state that the existence of a strong alliance makes it easier for the client to tolerate the discomforts related to uncovering painful issues in therapy. They add that this allows for the possibility of postponing immediate gratification in therapy by using the cognitive endorsements of therapeutic tasks and affective components of the therapeutic relationship (p. 564). Reandeau and Wampold (1991) examined whether the clients' involvement in therapy is greater in high alliance or low alliance relationships. They studied verbal transactions with low and high alliance dyads as well as using the *working alliance inventory* (WAI). They found that high alliance clients tended to respond to their therapists challenges by involvement while low alliance clients were avoidant. Researchers have found

that higher involvement and trust in therapy results in greater outcome of therapy (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Moras & Strupp, 1982), therefore, having a high therapeutic alliance would result in higher client involvement, which would subsequently result in a greater positive outcome and success in therapy.

It is often stated that the strength of the therapeutic alliance is predictive of the outcome of therapy, and that clients with a poor therapeutic alliance are more likely to drop out of therapy early (Mohl et al., 1991; Plotnicov, 1990). In their meta-analysis using the results of 24 studies relating the quality of the therapeutic alliance to the outcome of therapy, Horvath and Symonds (1991) found a positive association between good therapeutic alliance and outcome of therapy. In a study by Barber et al., (2000), this is explored. They state that the therapeutic alliance is a substantial predictor of outcome in many different therapies. Using a sample size of 86 outpatients diagnosed with chronic depression, generalized anxiety disorder or avoidant or obsessive-compulsive personality disorder, they used measures that tested the alliance. They found that therapeutic alliance predicted successful change in symptoms and that participants who reported a higher alliance improved more, thus demonstrating the importance of the therapeutic alliance.

The effect of humour on the therapeutic alliance.

"Humor is a rubber sword – it allows you to make a point without drawing blood".

-Mary Hirsch, *Humourist*

In a study by Gelkopf, Sigal and Kramer (1994), we can see how humour can be helpful in strengthening the therapeutic alliance. Using participants from a schizophrenic inpatient community, they found that humour created a positive atmosphere. They also found that with the experimental group who used humour, there existed a positive and strengthening effect on the therapeutic alliance between patients and staff, versus the control group. Thus, they concluded that humour is beneficial to the development of a positive therapeutic alliance.

Megdell (1984) conducted a study to test the effect of counselor-initiated humour on the relationship between client and counselor. He hypothesized that there would be increases in client's attraction ratings towards their counselor during moments of shared humour, rather than during instances on non-shared humour and nonhumour. Using 30 clients and 10 counselors from two alcoholism-counseling agencies, he conducted one initial counseling session for each client. The clients and counselors were paired in same-sex dyads, and had no previous

therapeutic contact with each other. The counselors were instructed to initiate spontaneous humour and not comedy routines or practical jokes during their counseling sessions, and to employ humour related to the process and content of the counseling session. Following the counseling sessions, the clients viewed the videotaped session twice and the counselors viewed it once. While reviewing it, the counselors used a 10-point stop-chart recorder. They turned the dial when they perceived themselves to be initiating humour. During the first viewing of the videotaped session, the clients used the 10-point stop-chart recorder, and turned the dial to two when they perceived the counselor to have initiated humour and they found it humorous, and turned it to one when they perceived the counselor to have initiated humour, but they did not find it humorous. On the second viewing of the tape, clients used the 10-point recorder to demonstrate how positive their feelings were towards the counselor at each moment. They discovered that their hypothesis was correct, that client's attraction ratings significantly increased in magnitude and frequency with counselor-initiated shared humour, and that this had a significant positive impact on the counselor-client relationship.

Research on the therapeutic alliance by Beck, Friedlander, and Escudero (2006) report that the therapist's warmth, optimism, rapport, commitment and humour are fundamental aspects of successful treatment. Bachelor (1995) used a phenomenological methodology in her qualitative study to explore the client's perspective of the therapeutic alliance. She found that the majority of clients preferred a nurturing-type alliance to insight-oriented or collaborative alliances. The nurturing-type alliance is characterized by trust, friendliness, being non-judgmental, empathic understanding, and facilitative attitudes such as de-dramatizing the therapy situation through the use of humour. They found that friendliness, trust and facilitative attitudes fostered the client's self-expression and disclosure.

Sultanoff (2013) believes that just as empathy expresses a level of understanding and caring to the client that aids in the building of an alliance, the use of humour can increase the bond between client and therapist (p. 393). He discusses a case where he began seeing a client who had had three different therapists over the past year, each with whom she had terminated therapy after the second session. Sultanoff (2013) explored her reasons for early termination by incorporating the use of humour, helping the client to feel at ease and better understand her reasons for abandoning therapy. The client remained in therapy with Sultanoff for a year. He

believes the initial use of humour helped him to connect with the client, establishing a therapeutic alliance, which therefore led her to remain in therapy (Sulatnoff, 2013).

Adolescents

"Adolescence is like having only enough light to see the step directly in front of you".

-Sarah Addison Allen

Erikson (1963) describes adolescence from a developmental perspective, as discovering one's way towards adulthood by means of exploring moral and social encounters. He states that when this is navigated successfully, it will lead to ego integration (Erikson, 1963). The adolescent's view is typically a narcissistic one, which Riley (1999) explains, is "necessary at this developmental stage to move into a more secure level of maturation" (p. 139). Peer relationships become progressively more important for the adolescent. As they search for individuation and distance from family, the adolescent will turn to peers for guidance and support (Erikson 1963; Riley, 1999).

The phase of adolescence appears for most to be the most trying of phases, littered with constant challenges and crises. During this phase of development, the adolescent is struggling to deal with more changes and transitions than in any other phase including physical, emotional, cognitive and social changes (Miller, 2012). Case and Daley (2014) state that this phase is "characterized by emotional confusion, unhappiness, vulnerability and distress in the search for individuation and separation" (p.10). In dealing with these intense feelings, it is not uncommon for the adolescent to act out and turn to maladaptive behaviours such as violent mood swings, exploration of sexuality, substance abuse, self-harm, and eating disorders (Case & Daley, 2014; Levens, 1995; Milia, 2000; Shalmon, 2005).

In discussing adolescent development, Riley (1999), makes an important point that the adolescent does not always mature physically and psychologically at the same time, and she places emphasis on how complicated a time this is. She advises to be aware of gender and cultural differences in adolescence, and notes that other cultures may perceive adolescence very differently. Riley (1999) states that it is hopeless for the therapist to attempt to approach the adolescent clients with psychological techniques created for adults, and that the therapist must be interested in their opinions and open to their worldviews. She recommends looking at each client as coming from an unfamiliar culture, as each client is unique and has his or her own experiences and belief system. Riley takes the point of view that the client acts as the expert,

who then informs the therapist. She focuses on the youth's personal narrative to give her information such as their social, economic, and family influences, and notes that it is important to look to the clients external life and understand how they see themselves and their world.

Riley (1999) finds that when working with adolescents, it is common for therapists to experience a great deal of counter-transference and unresolved issues of their own adolescence. This can often lead therapists to avoid this population, and she firmly believes that in order to work with such a challenging demographic as adolescents, you not only need to have a sense of humour, you also need to thoroughly enjoy working with them (Riley, 1999).

Art therapy with adolescents. Entering a new therapy environment can feel very threatening for anyone, especially the adolescent. Providing art materials to the adolescent client may ease any pressure they may be feeling (Riley, 1999). As we have seen in the literature, many adolescents turn to maladaptive coping strategies when feeling overwhelmed with the multitude of challenges they face at this stage of life (Case & Daley, 2014; Levons, 1995; Milia, 2000; Shalmon, 2005). Art therapy can function as an alternative coping strategy, can help with self-soothing, and allows the client to sublimate negative affect and aggression into the image (Shalmon, 2005).

Riley (1999) believes that art therapy is incredibly effective with adolescents, as they are in an exceptionally creative period of their lives and have developed the ability to think abstractly. It is common for adolescents to have preconceived negative ideas of verbal therapy from how it is depicted in movies and television shows, and they do not have such preconceptions of art therapy (Riley, 2001). Because art therapy is non-verbal, and playful in nature, it is appealing to the adolescent client, and they are often drawn to art therapy over verbal therapy (Riley, 1999; Shalmon, 2005). Art therapy allows for non-threatening expression of inner feelings, where the adolescent can express and control exposure and communication of personal issues through metaphor and through the art allowing for a sense of safety, which is important for the adolescent in therapy (Riley 1999; Riley, 2001). Riley (1999) adds that "art used in therapy can meet the adolescent's need for control, narcissistic expression, creativity, exaggerated logic, and experimentation directed towards appropriate individuation" (p. 65).

The use of images in art therapy decreases defenses, which typically slows down traditional verbal therapy, adding to its therapeutic quality (Wadeson, 1980). Art making in therapy adds depth to verbal therapy and has the power to uncover traumatic memories that may

be resistant to verbalization (Case & Daley, 2006; Milia, 2000; Riley, 2003). The image allows the adolescent to distance themselves from their problem, externalizing it (Riley, 2001). Adolescents are more attracted to using art as a language than to verbal questioning, as making graphic designs and symbols is already appealing to them, and something they frequently engage in (Riley, 2001). They often do not have the words to express their deep feelings, once they are able to depict them in an image, they are able to verbalize and come to an understanding of them (Riley, 2001). Riley (1999) finds that adolescents often drop any hostility when they are given art media and allowed to visually express themselves. She adds that the image also has the ability to bypass defensive language so often used by adolescents.

The importance of the therapeutic alliance with adolescents.

"There is nothing like a gleam of humor to reassure you that a fellow human being is ticking inside a strange face."

- Eva Hoffman

Shirk and Saiz (1992) believe the therapeutic alliance to be more pivotal in child and adolescent therapy than with adults. The therapeutic alliance has been considered a critical instrument in positive change in child therapy and has been seen in psychodynamic, experiential, behavioural and cognitive behavioural therapies (Axline, 1947; Kendall, 1991).

It can be exceptionally challenging to create a therapeutic alliance with adolescents as they are frequently in therapy involuntarily, they do not recognize the presence of problems, and are at a stage where they are striving for independence and feel the need to differentiate themselves from figures of authority (Eltz, Shirk, & Sarlin, 1995; DiGiuseppe, Linscott & Jilton, 1996; Shirk & Russell, 1998). Adolescents often have difficulty in completing successful therapy. An estimated 50-75% of youth referred to treatment terminate before treatment is completed (Kadzin, Siegel, & Bass, 1990). Therefore, it is important to note that the therapeutic alliance plays a significant role in attrition and early drop out prevention in child and adolescent therapy (Shirk, 2001; Shirk & Karver, 2003). Kazdin, Holland and Crowley (1997) found that a poor therapeutic alliance acted as a barrier to participation and influenced the drop out rate in their study on child and family outpatient therapy.

As Hawley and Garland (2008) state, there is little research on the importance of the therapeutic alliance with adolescents. Thus far, the research has focused mainly on adults. This

is why for their study they used 78 adolescents from the age of 11 to 18 entering into a community-based psychotherapy program, the parents of the adolescents, and 38 therapists.

Their findings show that a stronger adolescent alliance is significantly associated with decreased symptoms, improved family relations, higher levels of perceived social rapport, satisfaction with therapy, and general increased self-esteem (Hawley & Garland, 2008). They also found parent rapport with the therapist to be positively associated with therapy outcomes, and that the alliance was relatively stable from one to six months into treatment. However, the therapist's perception of the alliance was not found to have a significant impact. Their study demonstrated how important the working alliance between adolescent and therapist is, especially from the perception of the youth and parent, and how a strong alliance can decrease negative symptoms and increase positive outcomes of therapy.

In their meta-analysis of the therapeutic alliance in child and adolescent therapy, Shirk and Karver (2003) found that the therapeutic alliance was modestly connected with positive outcome in therapy with children and adolescents. They also found that the association between alliance and outcome with children and adolescents was the same as with adults. They confirm, however, that there is a paucity of research on the subject of the therapeutic alliance in relation to child and adolescent therapy, and therefore many of the studies that they used contained a range of relationship processes and were not all directly related to the therapeutic alliance *per se*. This demonstrates that more research on this area with this population of adolescents is needed.

Humour with adolescents in therapy.

> If the therapist has not retained a sense of humour, is not comfortable with sexual issues presented crudely, and has lost touch with the confusion and pain of their own adolescence, s/he would be well advised to choose another client population. (Riley, 1999, p. 79)

It is seen in studies with adolescents that poor coping is associated with depressive symptoms (Dumont & Provost, 1999; Herman-Stabl, Stemmler, & Peterson, 1995; Robinson, Garber, & Hilsman, 1995). As has been reviewed, humour is reported to lower levels of depression (Danzer, Dale, & Klions, 1990; McGhee, 1979) and be a positive coping skill (Crawford & Caltabiano, 2011; Kuiper & Martin, 1998), therefore, bringing humour into therapy may model the use of humour for coping, and having more positive coping strategies can lower the depressive symptoms in adolescents.

Prerost (1981) created the Humorous Imagery Situation Technique (HIST), which utilizes directed daydreams, a technique of guided imagery, as a foundation for the use of humour. Prerost (1985) states that this method is useful with children and adolescents, especially those who are resistant to therapy. He adds that the HIST is non-threatening in nature, but rather expressive, which adds to its benefits with adolescents in therapy, who are often resistant (Prerost, 1985). Hamar (1967) and Schoettle (1980) also found that guided imagery was successful in treating children and adolescents. Prerost (1985) believes that when humour is directed at the imagery level, positive effects are seen in daily functioning. He states that the HIST gives an outlet for impulse expression by directing the impulses into humorous discharge resulting in a reduced need for defenses in the adolescent.

Prerost (1985) assessed the effectiveness of the HIST in a study with a 16 year-old female client. The client suffered from feelings of depression and loneliness. The client received three assessment sessions in order to develop client-specific imagery needed for the HIST which are taken from real-life experiences that are stressful and often avoided by the adolescent. She then received 19 sessions for the HIST treatment. The HIST procedure begins with the therapist guiding the client into a state of relaxation. The therapist then guides the client through a series of client-specific imagery scenes. The client is asked to describe their experience and interact with the characters, situations, and events in the fantasy. Humour is then introduced in two methods, the first by focusing the client's attention on the possible humorous responses of other characters in the fantasy, and the second by interjecting elements, which create a humorous scene such as incongruity. For example, the client's cold and non-nurturing father was kissing and hugging everyone in the scene. It was found that this client was able to laugh at her own shortcomings, and her presenting problems significantly decreased, and she reported an enhanced enjoyment in peer and family interactions.

In their study, Freiheit, Overholser and Lehner (1998) wanted to assess the relationship between humour and depression in adolescent high school students and psychiatric inpatients. Using 140 adolescent inpatients diagnosed with depressive disorders and 85 adolescent high school students, they measured both groups for depressive symptoms. They used measures to test for humour appreciation, coping with humour and humour creativity. Participants created cartoon captions, which were then rated by 6 professional comedians. Their results indicated that using humour to cope with emotional stress and difficult situations was inversely related to

depression, and that using humour to cope is an important skill during adolescence. They also found that the two groups did not differ on the humour measures, in that both depressed and non-depressed adolescents were able to appreciate humour and use humour creatively at similar levels and that when both groups used humour to deal with stress, they experienced notably lower levels of depressive symptoms.

Erickson and Feldstein (2007) conducted a similar study using a non-clinical sample of adolescents with the hopes of discovering more about the relationship between humour and coping style, depressive symptoms, defense style and adjustment in this population, as most research on the topic has been done with adult participants. Their study revealed that humour is a beneficial coping mechanism for adolescents and showed a decrease in depressive symptoms and increase in positive adjustment.

Humour can allow individuals to gain control, whether perceived or real, by redefining the conditions as less threatening (Crawford & Caltabiano, 2011). McGhee (1999) states that even in more serious situations, humour provides individuals with a sense of empowerment and control over their environment, which is caused by a cognitive shift in perspective. Adolescents often feel threatened by the therapist, as they are resistant to authority and the adult world (Riley, 2001). The adolescent may not be in therapy out of choice, they may be brought for treatment by their parents or guardians and may not admit to having a problem or agree that they need help (Prerost, 1984). As a result, they may feel powerless, therefore, the use of humour in the therapy setting may help the adolescent to see the situation as less threatening and feel that they have more control, and can also be considered as part of the trust formation process (Crawford & Caltabiano, 2011).

The effect of humour on the therapeutic alliance with adolescents in art therapy.

"It's a positive thing to talk about terrible things and make people laugh about them".

-Louis CK

Thompson, Bender, Lantry, and Flynn (2007) conducted a qualitative study using interviews as their main source of data collection with 19 families with high-risk youth in a 12-week strength-based family therapy program. They found the building of the therapeutic alliance during the therapy process to be vital, and their findings support that a strong therapeutic relationship substantially predicts outcome, no matter the length or type of treatment.

Another notable finding in their study was that the adolescents highlighted their appreciation for the therapist's humour as a quality that aided in establishing a connection with the therapist. They found that humour increased their degree of connection and comfort. They also noted they found the therapists informality to be a positive factor, and that it broke barriers between them. Additionally, they also found that the bond with their therapist promoted a stronger bond with their family.

Malchiodi (1997) emphasizes that an alliance must be established quickly with the adolescent client, and advises using a nonthreatening approach, one that communicates concern and respect. Riley (1999) also believes that an alliance needs to be established early on in therapy, and that it is essential in adolescent treatment. She believes that imagery is the key to making early therapeutic alliances with adolescents. Riley (1999) finds that the art allows the adolescent to experience the comfort of distance as the therapist can explore a topic by relating it to the art rather than the client. By keeping his/her eyes on the artwork, the art therapist also has the option of avoiding direct eye contact with the client, which is often uncomfortable for the adolescent (Riley, 1999).

While to this date there exists no study that examines the effect of humour on the therapeutic alliance in art therapy with any population, in reviewing these studies we see how important the role of the therapeutic alliance is with adolescents, no matter the method of therapy, and how big of a part it can play in the continuation of therapy and successful outcome with adolescents. We can also see how challenging the therapeutic alliance can be, and how the difficulties in overcoming these challenges may be helped with humour and how incorporating art in therapy can enhance the therapeutic alliance.

Discussion

In reviewing the literature, we can see there are numerous studies and reports on the benefits of humour physiologically, neurologically and psychologically. It has been shown that humour acts as a positive coping mechanism (Crawford & Caltabiano, 2011; Kuiper & Martin, 1998) and can lower levels of depression in both adults and adolescents (Danzer, Dale, & Klions, 1990; McGhee, 1979). We can also see the positive effects of humour in coping with trauma and its use as a buffer against workplace stressors, burnout and PTSD (Garrick, 2006; Sliter, Kale, & Yuan, 2013). Freiheit, Overholser, and Lehner (1998) emphasize that using humour to cope is an important skill during adolescence. We can also observe the importance of the therapeutic

alliance and how it is a main factor in the outcome of therapy (Lambert & Barley, 2001). However, there are many contrasting views on when humour is best incorporated in therapy. Some believe that the therapeutic alliance should already be strongly established, while others feel that humour could be beneficial in therapy at any point in time (Thomson 1990).

Sultanoff (2013) believes that humorous interventions aid in building the therapeutic alliance, and therefore should be incorporated from the beginning of therapy. He states "therapists who are able to create humorous interventions from a genuinely warm and caring perspective can increase their connection with clients" (Sultanoff, 2013, p. 393). Richman (1996) states that humour can enrich therapy. He believes that humour increases enjoyment of therapy and brings the client and therapist together. Using humour in therapy can help the client to feel safe to express difficult content and allow them to speak about it in a more unobtrusive and camouflaged way (Dewane, 1978). This helps the client to overcome resistance and be more at ease in discussing taboo subjects (Gladding, 1995). Additionally, using humour in therapy helps to decrease anxiety as well as promoting insight (Schnarch, 1990). If the client does not already use humour as a form of coping, the therapist can model the use of humour and from there teach them emotional management and self-nurturing skills (Middleton, 2007). Similarly, art therapy allows for such indirect expression of difficult subjects, therefore adding humour into art therapy practice may add to the client's feelings of safety in expressing difficult emotions.

Humour has been shown to normalize the therapy situation, reduce the distance between client and therapist, and humanize the therapist in the eyes of the client (Dewane, 1978). Humour has the power to break the tension in the therapy setting, as well as bring in aspects of positivity (Franzini, 2001). Humour also allows individuals to feel in control of the situation by redefining it as less threatening (Crawford & Caltabiano, 2011). This is especially helpful with adolescents who see the therapist as a figure of authority. The prevalence of maladaptive behaviours and coping strategies at this stage of development (Case & Daley, 2014; Levens, 1995; Milia, 2000; Shalmon, 2005) could speak to the fact that adolescents are a population who are often in therapeutic settings and who struggle in therapy (Kadzin, Siegel, & Bass, 1990). It is more of a challenge to establish a therapeutic alliance with adolescents, and they have a much lower success rate in therapy as a result (Shirk & Russell, 1998). That being said, a stronger therapeutic alliance has been seen to significantly decrease negative symptoms and improve

social and family relations, self-esteem, as well as satisfaction in therapy (Hawley & Garland, 2008).

While there have been few studies done on the use of humour in art therapy, we can see from those that exist that humour has a place in art therapy. It was seen that art therapy allowed clients to more freely express humour, and that humour helped to therapeutically link creative and cognitive resources (Kopytin & Lebedev, 2013) while the use of humour in art had a tendency to reflect individuals feelings, thoughts, and attitudes (Silver, 2003). Humorous drawing was also seen as an effective and pleasurable way of establishing a therapeutic alliance (Mango & Richman, 1990). While no studies exist focusing on the use of humour in art therapy with adolescents, adolescents respond well to art therapy, as they often do not have the words to express their deep feelings; however, once they depict them in an image, they are able to verbalize them and have a better understanding of them (Riley, 1999; Riley, 2001). On top of that, art is a natural language for this population, and is a non-threatening approach to therapy, helping to decrease defenses (Riley, 1999; Wadeson, 1980). It was also found that using humorous guided imagery with adolescents gave them an outlet for impulse expression resulting in directing any impulses into humorous discharge, which resulted in a reduced need for defenses (Prerost, 1981). Riley (1999), in speaking about her experience working with adolescents in art therapy believes that humour, spontaneity and playful interpretation, are essential in art therapy.

Although several studies have noted that humour has been one of the factors that have played a role in the therapeutic alliance, none have focused directly on it. There is also a paucity of research exploring the therapeutic alliance with adolescents and no study that directly looks to answer the question of the effect of humour on the alliance with adolescents in art therapy. Based on all the positive aspects attributed to humour including the positive effects it can promote in both the body and the mind as well as on the extreme importance of the therapeutic alliance in itself and in effective treatment of adolescents, and taking into consideration the acknowledged positive impact of art therapy with adolescents, incorporating humour in art therapy for the treatment of adolescents is an intervention worth incorporating and exploring.

Limitations of This Study

In evaluating the literature, there appears to be a tendency in many studies to use small sample sizes (Hawley & Garland, 2008). Many studies had an uneven gender ratio in their participants, and some used only women (Danzer, Dale, & Klions, 1990). Freiheit, Overholser, and Lehnert (1998) noted that in their study, there were questions of validity in their self-report measures of humour; that it is possible that individuals feel that they are funnier than they are; and that a laboratory setting can be artificial, and may inhibit participants. There has also been some concern of experimenter bias, and a possibility that participants were simply matching the researchers' behaviour (Crawford & Caltabiano, 2011). Most of the studies utilized an adult population, and there is minimal research done with adolescents, especially in relation to the therapeutic alliance and to humour.

Most of the existing studies employ quantitative research methods, which are limited in their ability to get an in-depth perspective from participants. Using a qualitative study would enable the researcher to gain a deeper understanding of the subject from the perspective of both the client and the therapist. The different approach used in qualitative methods could be incredibly rich, and would make it possible to hear directly from adolescents, giving them a voice.

Suggestions/Future Research

The question of how to incorporate humour into therapeutic practice, and more specifically into art therapy practice, is a difficult question to answer, and in conducting my research, I have yet to find a clear solution to this. It seems likely that many therapists and helping professionals use humour with clients but do not document it, especially as it may arise spontaneously in their practice. That being said, Sultanoff (2013) states that " without conscious and purposeful creation, and some guidance as to what makes therapeutic humour therapeutic, the humour remains random, and the therapist has no basis from which to create a humorous therapeutic intervention" (p. 394). This leads me to share several thoughts on possible humorous interventions that could be utilized in art therapy practice.

One such intervention could be the creation of a meme. A meme is defined as "an image, video, piece of text, etc., typically humorous in nature, that is copied and spread rapidly by Internet users, often with slight variations" (Oxford Dictionary, 2016). Social media is an increasingly popular place to express oneself, especially for the adolescent. Memes have

become a popular form that many people have begun using to express how they are feeling in a humorous way on social media. The client in art therapy could create such a meme, either by drawing, or using other materials such as a computer program to express how they are feeling during therapy. I believe the use of memes in therapy can add to the diversity of tools that the clients use to express themselves to the therapist, and additionally can help the client see the humorous side of it, as memes often over-dramatize or demonstrate the incongruity of a situation.

Another possibility for an intervention would be to have the client create an image where they find something humorous in a difficult situation. This could also be done collaboratively with the therapist to help strengthen the therapeutic alliance. The client could create a humorous image of their "problem" as a monster or creature, or create a caricature of sorts of their "problem". This could help them see their "problem" as more manageable and less threatening.

More research would be needed to test the efficacy of these potential humorous art interventions, especially as there is little research on using humour in art therapy. Additionally, there has not been enough research done on the therapeutic alliance with adolescents, and the majority of the studies I found were using an adult population. Another area to consider for future research would be the differences between cultures and genders, as the majority of my sources come from western countries and each different culture experiences and appreciates humour and adolescence differently.

An additional important area for future research is on the effects of using humour on the helping professional. Some theorists have suggested that the use of humour is beneficial for the professional and that it helps prevent burnout (Adams, 1998; Schnarch, 1990). However, little has been explored from the perspective of the therapist or helping professional, and research has instead been focused on the clients' experience. I believe this would be an interesting avenue for future research in the area of humour in therapy.

It seems clear to me in considering all the many aspects of my research on humour in art therapy with adolescents that a pathway exists to build on this work and I aim to continue to explore and develop interventions using humour in art therapy.

"If it weren't for the brief respite we give the world with our foolishness, the world would see mass suicide in numbers that compare favorably with the death rate of lemmings".

-Groucho Marx

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