Humour in Art Therapy

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A Research Paper

In

The Department

Of

Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements

For the Degree of Master of Arts (Art Therapy)

Concordia University

Montreal, Quebec, Canada

August 2014

CONCORDIA UNIVERSITY

School of Graduate Studies

This is to certify that the research paper prepared

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Entitled: Humour in Art Therapy

and submitted in partial fulfilment of the requirements for the degree of

Master of Arts (Creative Arts Therapies; Art Therapy Option)

complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

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Abstract

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This qualitative research paper uses theoretical data in an attempt to understand the use of humour in art therapy primarily with an adult population suffering from a psychiatric disorder. The existing literature on the use of humour in the fields of psychotherapy, psychiatry, psychology, creative arts therapies, occupational therapy, and counseling informs this theoretical research. The focus of the research is currently underdeveloped, therefore, the objectives are to provide a synopsis of the variety of humour approaches that has been used in therapy and to highlight the opportunities and challenges of using humour in art therapy. This research paper includes an examination of representations of humour as well as therapeutic humour. Neurological responses to humour and humour development are explored. Finally, further thoughts on the reviewed literature as well as recommendations for future areas of research are offered.

Acknowledgements

Special gratitude and appreciation to Irene Gericke, my academic supervisor. I would also like to thank my family- my mom (editor and mentor) Diane, my dad, Rob and my sister Kim for their ongoing support and confidence in me. As well, I would like to thank my partner Miguel for his support, love, and for making me laugh. I would also like to thank my furry family; Jam, Pickle, Ewa, Hunter, Tasha, Rocco and Emma.

During these past two years in the CATS program I have met so many great people who were incredibly supportive. I would like to thank all of them, my professors and fellow classmates. A final thank you to all my friends, of whom I haven't seen much these past two years.

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Introduction

"Humour is a means of obtaining pleasure in spite of the distressing affects that interfere with it; it acts as a substitute for the generation of these affects, it puts itself in their place"

(Freud, 1905/1960, p. 293).

I believe humour is an important component in life. Most people of all ages and cultures can respond to humour. As an artist humour has been a central theme in most of my artworks. I use humour on a daily basis with friends and family, and I have incorporated humour into my therapeutic sessions with clients as well. In my experience I have found it to be a useful and at times a necessary tool. Humour has a way of de-escalating a tense situation; it can also lighten the mood during a serious moment and can help to build personal connections. Humour and laughter can also enhance an individual's overall well-being. The challenge in studying humour, however, is the lack of consensus on the definition of the term humour. Elliot (2013) explains how the individual nature of humor lies at the intersection of the objective, subjective, and definitional experience and reporting of humor (p. 204). As humour can be quite subjective, I will be outlining several definitions that represent how I view humour and how I am using the term within this research. My experience as an art therapy intern, working first with adults with developmental disabilities and then families and children at a community mental health clinic, will influence my research. A qualitative, theoretical methodology has been employed in this research and it is written using a reflexive stance, acknowledging my subjective viewpoint, biases and predispositions

In this research, I am interested in exploring the use of humour in therapy and specifically in art therapy. The literature on humour in therapy exists for all age groups,

however, for the purpose of this paper, the focus is on adults. My original intent was to research humour in art therapy within a wide range of client populations, however, the majority of the data I found was on adults, as it appeared that not much was written on humour in therapy with children or adolescents. I was also interested in the sophistication that adult humour often brings as opposed to the lack thereof in children's humour. Therefore, I narrowed down the research to humour in art therapy with an adult population suffering from a psychiatric disorder. This population is an area of interest to me as I plan on working with this clientele in the future. Moreover, I was initially interested in researching individual sessions, but in the end I have included information on some group sessions as I have integrated whatever I could find pertaining to the general topic of humour in art therapy.

Methodology

The Procrastination Methodology.
Storyline by Miguel Sorensen & Lindsay Ficara. Illustrations by Miguel Sorensen.

Statement of Purpose

The goal of this present research is to explore the theories and processes of how humour can and has been used in therapy, primarily with adults suffering from a psychiatric disorder, and how this information can inform the use of humour in art therapy. This research follows a theoretical methodology, where literature on the use of humour in therapy is collected, examined and summarized. As underlined by Randolph (2009) "the literature review is the primary source of the empirical research question" (p. 6). A large body of research has explored the use of humour in therapy and for this reason I believe that theoretical research is an appropriate method to help answer my research question. However, very few articles have been written on humour use in art therapy and therefore I can continue to expand upon this area, using the knowledge gained from the collected data. The final outcome is intended to be a comprehensive analysis of the literature related to humour in art therapy primarily with adults suffering from a psychiatric disorder. This will include appropriateness and disadvantages of the use of humour in therapy for the purpose of enhancing and adding to the literature.

Theoretical Research

Theoretical methodology falls under the qualitative approach to research. The following are descriptions of theoretical research that closely reflect how I will be directing the paper. Hesse-Biber and Leavy (2011) explain "qualitative approaches center on understanding the subjective meaning that individuals give to their social worlds. The social reality is multiple and not unitary; there is no single truth that is sought" (p. 33). Using a theoretical methodology, the type of data that can be collected is data that already exists. With a theoretical methodology approach the researcher

typically proceeds as such; thinking of a research question, then collecting data, analyzing the data, organizing the data as relevant to the research question, presenting the data and conclusions from the research. "There is a dynamic interaction between the research problem and the literature review. Research questions are tentative and most often not framed in terms of hypotheses (looking for cause and effect). The goal is one of theory generation" (Hesse-Biber & Leavy, 2011, p. 35). "Multiple types of data, researcher view-points, theoretical frames, and methods of analysis allow different facets of problems to be explored, increases scope, deepens understanding, and encourages consistent (re) interpretation" (Tracy, 2010, p. 843). Junge and Linesch (1993) explain, "with theoretical research theory is the data. The researcher first searches out limits and contradictions of the theories under study and then attempts to eliminate them, or critique them. Primary methods are logical analysis, evaluation and synthesis" (p. 66).

Tracy (2010) maintains that qualitative research credibility is achieved through practices including thick description, triangulation or crystallization, and multivocality and partiality. Throughout the research I will be using a post-positivist approach. Junge and Linesch (1993) describe a "post-positivist" approach to research as having the characteristic of; "understanding a concern while fully comprehending the unique features of an event, situation or organization, rather than attempting to draw some highly general conclusions that presumably enable one to make predictions about the future" (p. 62).

Data Collection and Data Analysis

The focus of my research is on the theories and processes of how humour can and has been used in therapy with adults suffering from a psychiatric disorder. I collected

data primarily from academic journals, case study illustrations, edited books and textbooks. The keywords and keyword combinations used in researching these topics include: humour and/or humor, humour in therapy, humour in art therapy, humour interventions, humour techniques, therapeutic humour, development of humour, humour and creativity and humour in treatment. The disciplines that I draw from include social work, occupational therapy, psychiatry, psychology, creative arts therapies, and psychotherapy. From these sources I identify patterns, draw common themes and various perspectives related to my topic as well as compare and contrast theories. Randolph (2009) explains, "the goal of the data collection stage is to collect an exhaustive, semi-exhaustive, representative, or pivotal set of relevant articles" (p. 6). In regards to this research, the goal is to collect a representative set of articles on the topic of humour in therapy during the data collection stage.

Definitions of Key Terms

Art therapy. The Canadian Art Therapy Association (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).

L'Association des art-thérapeutes du Quebec (1981) defines art therapy as "a human care service, which expands the psychotherapeutic process to encompass the client's visual, as well as verbal, expressions and reflections. Art therapy clients are able to deal with the same kinds of issues they would deal with in conventional talk therapies, however, they engage in the therapy by creating with art materials as well as talking with

the art therapist. Clients do not require any special art skills or abilities in order to benefit fully from art therapy. The creative process and artwork are considered in terms of their therapeutic significance rather than their artistic merit per se" (What is art therapy, para. 1-2).

Humour. The Oxford English Dictionary (1989) defines humor as "That quality of action, speech, or writing, which excites amusement; oddity, jocularity, facetiousness, comicality, fun…The faculty of perceiving what is ludicrous or amusing, or of expressing it in speech, writing, or other composition; jocose imagination or treatment of a subject. Distinguished from *wit* as being less purely intellectual."

Therapeutic humour. The Association for Applied and Therapeutic Humor (2000) defines therapeutic humor as "an intervention that promotes health and wellness by stimulating a playful discovery, expression, or appreciation of the absurdity or incongruity of life's situations".

Psychiatric disorder and/or mental illness. There are many different categories of mental illness and therefore, psychiatric disorder is used as an umbrella term under which specific diagnoses are classified. "Psychiatric disorders are estimated to affect 20 percent of the adult population in America in any given year. Psychiatric disorders exist along a spectrum from the very mild, with little or no evidence of disability, to the very severe, with profound disruptions in all areas of functioning, leading to severe, disabling consequences. It can profoundly impair individuals emotionally, interpersonally, and professionally" (Dove, 2006, p. 1304).

Within the context of this research the term client and patient are used interchangeably and represent an individual who is engaging in a therapeutic process.

Author Bias

Using existing theories and literature does have some issues with validity and reliability. The original source may have biases from the researcher of that source and then we, as researchers, have our own biases in reading and interpreting. "The existing literature and the assumptions embedded in it can deform the way one frames their research, which may cause one to overlook important ways of conceptualizing their data" (Maxwell, 2013, p. 51). Similarly, as I am a young, white, Canadian, female adult I come with preconceptions and assumptions of what humour means to me, which will effect the collection and interpretation of data. Stated otherwise, Maxwell (2013) explains that there is researcher bias in "the selection of data that fit the researcher's existing theory, goals, or preconceptions" (p. 124). I believe it is impossible for me to be completely objective by eliminating my beliefs, theories and perceptual lens. Therefore, it is important to be transparent about them as well as maintaining a critical stance when reading the literature.

Ethical considerations to be aware of when using a theoretical methodology include but are not limited to; misrepresenting the data, plagiarizing, or not providing adequate details related to the provenance of the data. Another concern would be to silently reject or ignore evidence, which happens to be contrary to ones beliefs, or being too selective in the data used (Walliman, 2011, p. 45). The theories we put forth may be harmful or even culturally biased. After all it is the researcher who is finding and choosing the data and therefore the data may be misrepresented or culturally limited.

Examining ethics in qualitative research, Tracy (2010) defines the concept of exiting ethics as ethical considerations that continue beyond the data collection phase to

how the researcher shares the results. Tracy points out that surely researchers never have full control over how their work will be read, understood and used. However, researchers can consider how best to present the research so as to avoid unjust or unintended consequences. In addition, researchers should take care that their representation style matches the goals of the project.

Limitations

Limitations, in regards to the topic of humour in therapy may pertain to how one defines humour. Humour is seen and defined differently from culture to culture. What may be funny in one country may be offensive in another. For example, Kuipers (2008) emphasizes that, "joke, as a genre, does not have the same connotation to different social groups…as well the joke is not a universal genre, and some cultures do not have jokes" (p. 387). To add to this, Adamle and Turkoski (2006) state that although humor is a universal concept, there are cultural variables or norms that determine the appropriateness of the timing, the content of humor, and who is present in the situation. Ethnic differences and backgrounds influence the kind of humor that is acceptable in a particular situation (p. 641). Humour is very individual; what is hilarious to one generation may not be understood or perceived as funny to another therefore generational differences also need to be considered. As I am gathering the majority of my sources from North American databases and journals I may be presenting a skewed representation of how humour is used in therapy. Lynch (1983) suggests that external validity is irrelevant to theoretical research because it is not as important as is internal, construct and statistical conclusion validities (p.110). I realize that the theories I will be discussing may not be generalizable to the larger population and that humour may work better with some clients

over others. The fact is that our biases and assumptions affect our research and so researchers cannot be completely objective. Thus, Walliman (2011) suggests, "honesty is essential in order to engender a level of trust and credibility in the outcomes of the research" (p. 43).

Delimitations

Space and scope limitations prevent the coverage of every aspect and topic related to humour. For example, I will be presenting theories on the use of humour in therapy and am not as concerned with evaluating the therapeutic effectiveness of humour use in therapy. As this is not an intervention research paper, I will not be presenting a humour intervention that could be used in art therapy. I will instead be focusing on how it has been used in the past. Since the primary focus is on humour use in therapy with individual clients, humour use in group therapy will only be mentioned as it comes up in case studies relevant to the research. Finally, I will not be going into details on the subject of laughter as well as the neuroscience of humour, although both will be briefly explored. In regards to my literature review, it is not meant to be exhaustive. I am using a representative sample of articles approach. Randolph (2009) describes this type of coverage approach as using a representative sample of articles to make inferences about the entire population of articles from that sample (p. 4).

Literature Review

"If more psychiatrists had a sense of humor, they would not have to prescribe so many pills to relieve tension in their patients"

- Greenwald (1977)

The following literature review is organized conceptually and divided into sections. The first section defines a broad view of humour and then narrows humour down into the

specific types of humour that I will be exploring. The second and third sections examine the neurological responses to humour and humour development starting in infancy. Therapeutic humour is presented in the fourth section using a historical format. In the fifth, sixth and seventh sections some positive and negative effects of humour use in therapy are portrayed along with a discussion on humour use in art therapy. In the final sections a short summary of humour and its role in countertransference and the relationship between humour and adults with a psychiatric disorder are reviewed.

Representations of Humour

Humour is a complex and multifaceted phenomenon. Given the many definitions, explanations and theoretical concepts in the literature, narrowing down what humour means has proven to be difficult. Rossel (1981) advises, "since humor itself is a form of metacommunication, its meaning and social function can ultimately only be understood in relation to the context within which it appears" (p. 196). In defining humour one also needs to take into consideration the cultural and generational aspects as well as the subjectivity. "The subjective aspect of humor plays a major part in the recognition, interpretation, and reception of humor" (Adamle & Turkoski, 2006, p. 640). To add to this, Kubie (1971) states that there are differences in the impact of humour from person to person; furthermore age differences also influence the effects of humor both in social and therapeutic situations.

In the following paragraph, I will draw on specific definitions and descriptions of humour of relevance to this research. In his literature review, Saper (1987) highlights a variety of theories and studies on humour use in psychotherapy. Saper states that humour dates back to the Greek philosophers Aristotle and Plato who described humour as a

response to the ugliness and incongruity of a stimulus. Other philosophers have seen humour as a way of mocking another while making oneself feel superior. Conversely, some philosophers have defined it as a process that produces release, catharsis, amelioration of stress, relief from tension, whether physical or psychological (Saper, 1987, p. 364). Freud saw humour as the highest of the defensive processes. To quote Freud (1905/1960):

> Humour scorns to withdraw the ideational content bearing the distressing affect from conscious attention as repression does, and thus surmounts the automatism of defense. It brings this about by finding a means of withdrawing the energy from the release of un-pleasure that is already in preparation and of transforming it, by discharge, into pleasure. (p. 299)

In the present context humour can be defined as "an approach to oneself and to others that is characterized by a flexible view enabling one to discover, express, or appreciate the ludicrous or absurdly incongruous" (Rosenheim & Golan, 1986, p. 110). Kopytin and Lebedev (2013) explain humour as a "complex psychological and interpersonal phenomenon involving emotions and cognitions, conscious and unconscious minds, and also the human body" (p. 21). Adamle and Turkoski (2006) define humour as "not an emotion, but rather a vehicle for expressing emotions; a universal phenomenon that occurs in all cultural groups and all settings" (p. 639). In psychology there are three general theories that explain how humour works. Restak (2013) attempts to outline these three theories. According to the most common explanation for humour, the tension release theory, for a brief period after hearing a joke or looking at a cartoon, we experience a tension that counterbalances what we assume

about the situation being described or illustrated against what the comedian or cartoonist intends to convey. The second most popular theory of humour, the incongruity resolution model, involves the solving of a paradox or incongruity in a playful context. Finally, the superiority theory emphasizes how mirth and laughter so often involve a focus on someone else's mistakes, misfortune, or stupidity. Using a psychodynamic lens, Barwick (2012) explores the relationship between humour and pain such as humiliation and shame. He argues that humour is used as a way of managing negative life issues. Barwick describes three forms of humour: reflective, deflective and projective, and that these forms of humour may fall under the category of psychological development as well as psychological defence. Barwick (2012) states:

> In 'the gap' that characterises this world, aspirations and creative acts are inevitably shadowed by frustrations, losses and myriad 'falls', and it is humour that is often used, developmentally and/or defensively, to lighten the shadow and to manage the psychic residue of these falls, that is, humiliation and shame… humour may be seen as vital to our capacity to manage our sense of inadequacy, of lack of worth. (pp. 164-165)

Leist and Müller (2012) studied the correlations between humour styles and well-being. Building from Martin et el. (2003) Humor Styles Questionnaire (HSQ), an instrument designed to assess habitual humor-related behavior patterns, Leist and Müller (2012) distinguish four humor styles. Of particular relevance to this research, they describe affiliative humor as reflecting a humor style that is used to enhance one's relationships with others in a relatively benign way. It is the tendency to tell jokes and funny stories, in order to amuse and laugh with others. Self-enhancing humor refers to

humor to enhance the self in a tolerant way and is the tendency to maintain a humorous outlook on life to cheer oneself up (p. 552).

Franzini (2001) lists forms of humour that can be used in therapy. Some of which include: "a formal structured joke or riddle, a pointing out of absurdities, an unintended pun, behavioral or verbal parapraxes, examples of illogical reasoning, exaggerations to the extreme, statements of therapist self-deprecation, repeating an amusing punchline, illustrations of universal human frailties, or comical observations of current social and environmental events" (p. 171). Aho (1979) defines a joke as a brief story that describes a situation and, like the cartoon, has a facetious meaning. The forms of humour listed in this paragraph are the types of humour being focused on in this research.

Laughter.

Although laughter as a behavioral event is not always synonymous with humour, it must be considered when studying humour as it plays a significant role. A lot has been written on the subject of laughter. The following are a few descriptions of laughter that I find interesting. Askenasy (1987) describes laughter as being a primitive communication medium understood by all human societies. Laughter frequency increases in direct proportion to social agglomeration for instance the collective laughter at parties. Askenasy gives a noteworthy interpretation of the roots of April fool's day. Askenasy (1987) explains:

> The traditional date of April 1st for merriment may be interpreted as a preventive mass therapy, offered by human culture against stress and fear. The roots of this custom can be found in the Roman Empire period where every March 25th of the vernal equinox, Hilaria was celebrated. (p. 330)

Freud (1905/1960) has argued convincingly that psychic or emotional energy is released through laughter:

> In laughter, the conditions are present under which a sum of psychical energy, which has hitherto been used cathexis, is allowed free discharge…Laughter is among the highly infectious expressions of psychical states. When I make the other person laugh by telling him my joke, I am actually making use of him to arouse my own laughter. (p. 209)

Gelkopf (2011) believes, "laughter can reduce excessive anxiety and facilitate the expression of emotions such as feelings of hostility. Laughter can also be a mind relaxing tool, helping to reach emotional content that the patient is neurotically protecting" (p. 3). Askenasy (1987) discusses laughter dysfunctions and disorders. "Exaggerated amount of laughter is encountered in mania and hypomania. Depression is usually associated with suppression of laughter and decreased motor activity. Hysterical laughing spells with no clear motivation are well known usually following trauma, shock, and anxiety states" (p. 323).

Hostile humour.

One of the major distinctions that is common when describing humour is between positive and negative forms of humour. Leist and Müller (2012) define types of negative humor as including aggressive and self-defeating. Aggressive humor is a hostile form of humor to enhance the self at the expense of others and includes sarcastic or criticizing humor. Self-defeating humor is used to enhance relationships with others at the expense and detriment of the self. A self-defeating use of humor is to make fun of oneself for the enjoyment of others, that is, to use humor in a self-disparaging way, or laughing along

with others when being made fun of (p. 552). Garrick (2006) explores black humour and dehumanizing humour. He describes black humour as a means of allowing negative or maladaptive stress responses to become positive or adaptive and to facilitate survivors' progress in the recovery process. "Humour can do more than expose and unmask, it can help the oppressed cope and survive" (Stroobants, 2009, p. 8). An example of this would be Jewish humour during the holocaust in the Nazi concentration camps. Garrick (2006) also describes dehumanizing humour. "The racist or the oppressor makes fun of what he does not understand or fears, in spite of its negative impact on others. When an abuser treats someone as if he or she is funny or is not to be taken seriously, then the individual is no longer dangerous and frightening. The power balance is altered and the ridiculer gains more control" (p. 177).

Neurological Responses to Humour

In order to better understand the effects that humour has on us, whether positive or negative, we need to understand how our body and mind responds to humour. "Our brains are hardwired for laughter. The enduring mystery is understanding how" (Restak, 2013, p. 27). "The mood elevating effect of laughter is assumed to be based on a biochemical mechanism involving various neurotransmitters. During laughter the subject feels released from present cares and worries and a mood of joy prevails. For its duration, laughter inhibits a depressive preexisting mood, hence a norepinephrine elevation was suggested" (Askenasy, 1987, p. 322). Berk expands; "when a person laughs, the pituitary gland produces hormones called endorphins, which act as natural pain killers. Endorphins, when released into the system, create an effect similar to taking morphine, heroin, or some other type of opiate" (as cited in Garrick, 2006, p. 172).

"Laughter and humor have been hailed as good for the body because they restore homeostasis, stabilize blood pressure, oxygenate the blood, massage vital organs, stimulate circulation, facilitate digestion, relax the system, and produce feelings of well-being" (Fry & Salameh, 1987, p. 11). Additionally, Garrick (2006) observes, "When oxygen is flowing better, the respiratory system benefits, resulting in less yawning and lower levels of sleepiness. Once endorphins have been released and blood is flowing to the brain and muscles, individuals begin to feel better, have more energy, and feel less stressed. Concentration also becomes easier..." (p. 172). Amongst authors it is generally agreed that in addition to enhancing our immune, endocrine, and cardiovascular system, laughter also provides a workout for the muscles of the diaphragm, abdomen, skeletal and face (Restak, 2013; Sultanoff, 2013).

Additionally, laughter may increase the body's ability to fight infections. Berk (1994) studied effects of laughter on the body. He found five significant neuroendocrine and stress hormone changes that occur during laughter. In particular, Berk's findings demonstrated an increase in immunoglobulin A antibodies in the upper respiratory tract during laughter, which allows this system to fight infection. Norman Cousins, who was an American political journalist, author, professor and world peace advocate, had been diagnosed with different illnesses throughout his life. Some of which included heart disease and collagen illness. Norman attempted to cure himself of a mysterious and rapidly progressive inflammatory illness of the spine by engaging in hours-long laughing sessions while watching funny shows and movies, such as Marx Brothers films. He documented his experience in his *Anatomy of an Illness* (1979) book. Restak (2013) writes, "Though Cousins' claims could not be scientifically confirmed, even the most

skeptical researchers agree that humor provides an antidote to some emotions widely recognized to be associated with illness (p. 20).

Goel and Dolan (2001) have isolated two components of humour. They justify that successful jokes involve a cognitive juxtaposition of mental sets, followed by an affective feeling of amusement. A common component of humor is expressed in activity in medial ventral prefrontal cortex, a region involved in reward processing (p. 237). Restak (2013) explains, "Humor is associated with brain networks involving the temporal and frontal lobes in the cerebral cortex. Located near the top of the brain, these cortical areas are related to speech, general information, and the appreciation of contradiction and illogicality" (p. 21).

In regards to the role humour plays in emotion regulation there are different trains of thought on this issue. Samson and Gross (2012) name a few: "The first focuses on the possibility that humour might serve as a form of distraction. The second suggests that humour-related positive emotions directly undo negative emotion. The third and fourth perspectives both suggest the possibility that humour changes the way a person appraises or evaluates a potentially stressful event, thereby changing the meaning it has, and hence the person's emotional response" (p. 377).

Though much is known about the brain structures involved in humour, several questions remain. Further studies would need to be conducted in these areas. The exact location in the brain and the neurotransmitters that are involved in humour and laughter would need further exploration.

Humour Development

Smiling is regarded as an innate human reaction developing gradually to laughter.

In infants the tendency to throw their body backward when sitting marks the start of laughter (Askenasy, 1987). "Infants smile and laugh months before they babble, gesture or speak" (Mireault et al., 2012, p. 339). Believing that humour is closely related to play, Loizou (2005) provides evidence that children who have imaginative play skills in the pre-school years will develop a sense of humour along with flexibility and creativity in the later years (p. 99). Infants in the first year of life exhibit a surprising capacity for humour, laughter and play. For example, infants between 7 and 12 months of age can detect 'perceived incongruities' such as silly faces and voices and will laugh in response. Infants in this age range will also actively work to elicit laughter in their caregivers and try to maintain the humorous interaction (Mireault et al., 2012). Hoicka and Akhtar (2012) suggest that humour may be a good index of socio-cognitive development, as a successful joker must use their understanding of incongruity in social interaction. Different types of humour may reflect stages in cognitive development. For example, once children understand that objects can be used in multiple ways, they can misuse objects as a joke (p. 587). Similarly, as pointed out by Loizou (2005), when children are being humourous it means that they have already explored the different possibilities of using materials and/or their bodies and are now in the process of discovering alternative uses (p. 105).

Some studies suggest that *Theory of Mind* (ToM) and humour are related. ToM refers to the ability to infer mental states, such as beliefs, desires, intentions, imagination and emotions, that cause actions. An individual with a ToM is able to reflect on the content of his/ her own and others' minds (Baron-Cohen, 2001). Reddy (2008) has observed three types of teasing in infants as young as 8 months (e.g. provocative

noncompliance, offer and withdrawal of an item and provocative disruption of others' activities), all of which suggest an understanding of others' minds and intentions. Thus, humour research may reveal that infants are maturing towards developmental milestones like a ToM at a much earlier age.

Wolff's descriptive study of smiling and laughing in the first year of life resulted in a developmental timetable beginning with social smiling (5– 9 weeks), followed by laughter in response to physical stimulation (3 months), social games (5 months), visual events (7– 9 months), and finally humour creation (9– 11 months) (as cited in Mireault et al., 2012, p. 339). During early humorous interactions parents provide affective cues that guide infants' interpretation of what are initially ambiguous behaviours. In addition, parents' efforts at clowning are quickly rewarded as infants come to understand the humorous nature of these behaviours and reinforce parents' absurd behaviour by staring, smiling and laughing in response (Mireault et al., 2012, p. 345).

Hoicka and Akhtar (2012) conducted a study with parents and their children aged 3 years and under. Through parent reports, they were interested in knowing whether children produced copied or novel jokes. They found that humour can be learned through imitation. During play sessions, copied humorous acts and variations followed parents' jokes, therefore, caregivers help initiate and direct children's humour. However, they also found that the children were rather creative in their abilities to produce humour, and are also able to produce humour without being shown how. "Altogether, children's ability to produce novel humour, and to cue it, suggests that from 2 years children have a socio-cognitive understanding of humour" (p. 599).

Although some believe humour's source to be biological, instinctive and

evolutionary, others say play is the social learning place where children learn about humour (Gibbon, 1988). Loizou (2005) argues that children's development and learning, and more specifically children's humour, is better understood within the context of their daily interactions. At the same time, every joke or cartoon is said to require some minimal level of cognitive development for comprehension of the humour depicted. The incongruity of jokes, for example, creates a "problem" in the mind of children and when they are capable of solving that problem, thus using cognitive mental processes, they can enjoy the humour created in the situation. Aho (1979) states that by ages six and a half to seven years, the age of concrete operations (Piaget as cited in Aho, 1979), children begin to appreciate jokes on their cognitive level. Gibbon (1988) notes that children of preadolescence age are especially susceptible to what others in their own age group find funny (p. 204). Levesque (2012) notes that between the ages of 11 and 12 research shows a significant increase in the use of humor in uncertain situations.

From a developmental perspective little has been researched on how humour develops past childhood. Levesque (2012) states that research reports that a good sense of humor is associated with increased communicative competence in adolescence. When used as a defense mechanism, humor may allow adolescents to face challenging or threatening situations without being overwhelmed by negative emotions. A consistent finding in research about adolescent humor reveals that boys use aggressive and sexually related humor strategies more than girls (p. 1352). Führ (2001) observed a stage of destabilization, in adolescence, as the child's total conditions of life change (ex: parents attitudes and expectations). The author questions to what extent the individual person's use of humour is redefined during adolescence, as the adolescent is attempting to find

themself, takes time for reflection, turns inwards to self, and perceives life in a new, more reflexively chosen perspective. Führ (2001) states, "It probably occurs during this period that in asking yourself what life is, you will also ask yourself what humor is" (p. 35). In this section I have only covered humour development until adolescence. Unfortunately, it does not seem that very much has been written on humour development in adulthood. However, research suggests that development occurs across the lifespan (Erikson, 1959). Like other developmental stages in later life, I believe that it is safe to infer that humour development happens across the lifespan. Further research would need to investigate humour development in adulthood.

Therapeutic Humour

The literature on the use of humour in a therapeutic context is expansive. Practitioners coming from a variety of backgrounds, and to a lesser degree, art therapists, have contributed to this investigation. However, there appear to be opposing views on the use of humour in therapy, and humour seems to be underutilized by therapists. From my interpretation of the literature the topic appears quite controversial.

Freud was amongst one of the first to discuss the use of humour in psychoanalysis. Freud noted that humour, like dreams, was related to unconscious content. Freud saw a joke as a playful judgment. "A favourite definition of joking has long been the ability to find similarities between dissimilar things- that is, hidden similarities" (Freud, 1905/1960, p. 41). Freud discusses the technique of jokes as using condensation by modifying, employing multiple use of the same material and double meanings. Freud described puns as "passing as the lowest form of verbal joke, probably because they are the cheapest as they can be made with the least trouble" (Freud, 1905/1960, p. 80). Freud

postulated that humour disguises aggressive impulses. Humour, as a technique, can be used to redirect misguided aggressive energies. "A joke will allow us to exploit something ridiculous in our enemy which we could not, on account of obstacles in the way, bring forward openly or consciously; once again, then, the joke will evade restrictions and open sources of pleasure that have become inaccessible" (Freud, 1905/1960, p. 147). When humour is used to obscure a real problem then humour becomes a defense mechanism. However, humour can give the client "a means of expressing charged feelings in a camouflaged and safe way" (Dewane, 1978, p. 509-510).

Dr. Hunter Doherty Adams (also known as Patch Adams) incorporated humour in the medical field. Patch Adams was a social activist and began clowning in public places to promote peace and love. He founded the Gesundheit Institute in 1971 after completing medical school. The Gesundheit Institute was a pilot hospital model, promoting alternative health care, and was operated out of his home. The Gesundheit Institute ran as a free community hospital for twelve years. Adams believed that the health of the staff was just as important as the health of the patients. He then began touring the world and gave presentations and performances on his medical methods to educate people. Adams and his team raised money to build teaching centers and clinics, which enabled Gesundheit to see patients and teach health care designs. He sees humour and play as essential to physical and emotional health. In speaking of clowning Adams (2002) explains:

> It easily calms stressful situations and comforts countless griefs. My experiments have shown me that public love and fun are so important that I have chosen to wear only clown clothes publicly every day for over 20 years, to do my part. When I

began to see patients (of any age) I insisted on being funny with all of them, even the profoundly ill…clearly knowing it was also wonderful for my own health. I was a stranger to that burnout which is endemic in modern hospitals. (p. 447)

Not too long ago David Granirer (2000) a counselor, stand-up comic, mental health keynote speaker, and author founded *Stand Up For Mental Health* (SMH). SMH is a program that teaches stand up comedy to people with a mental illness or a mental health issue as a way of building confidence and fighting public stigma. Granirer uses stand-up comedy, including training and public performances to enhance self-competence, sense of control and self-worth, as well as reducing self-stigma. He uses the performances to educate the public about the stigma surrounding mental health. "The idea is that laughing at our setbacks raises us above them. It makes people go from despair to hope, and hope is crucial to anyone struggling with adversity. Studies prove that hopeful people are more resilient and also tend to live longer, healthier lives." Additionally seeing people with a mental illness doing stand-up comedy forces the audience to re-evaluate their perceptions of and prejudices against people who have a mental illness.

So what makes humour therapeutic? To this question Sultanoff's (2013) answer is: when a skilled practitioner chooses to use humor with intention, when the "ways of being" are an integral part of the health practitioner's being, when the receiver "gets" the humorous experience, and when the relationship is connected and a bond exists between the practitioner and the client, then the humor has the greatest potential for being therapeutic (p. 395). In speaking of the "ways of being" Sultanoff is referring to Rogers (1957) concepts. Rogers describes that all therapists must have conscious intent and embody three central core conditions or "ways of being". These ways of being are:

empathy/compassion; genuineness/congruence; and positive regard/acceptance (p. 97).

In addition to research mentioned above, I believe that certain factors to consider when using humour in sessions would include the client's cultural background, the timing, and further, that the therapists should have specific objectives in mind when using humour.

Positive Effects of Humour Use in Therapy

A growing body of literature has demonstrated the importance of humour use in therapy. Psychoanalysts such as Sigmund Freud to practitioners such as Albert Ellis and Harold Greenwald have advocated the use of humour to promote therapeutic change (Saper, 1987). For example Ellis (1977) supports the fact that humour can be used to shift negative, self-defeating thinking. In speaking of the benefits of humour Elliot (2013) maintains that humour enhances a person's well being. Elliot highlights a number of studies that have shown that similar psychological benefits emerged from a physical exercise and a laughter session of the same duration (p. 203). Freud saw humour as a valuable tool for the maintenance of sanity (Murgatroyd, 1987, p. 225). Saper (1987) describes humour working on three basic levels:

> Cognitively, it presents new ideas to the absolutistic, rigid client in an insightful, hard-hitting way. Emotively, it brings enjoyment and mirth, makes life seem more worthwhile, and dramatically intrudes on gloom and inertia. Behaviorally, it encourages radically different actions, it constitutes an antianxiety activity in its own right, and it serves as a diverting relaxant. If clients can even briefly experience amusement, it can serve as an antidote to their sadness. (p. 361)

From a caregiver and nursing perspective Adamle and Turkoski (2006) discovered

a lot of literature in regards to caregiver-initiated humor as an intervention in healthcare settings. However, by comparison, they found little has been written about patient-initiated humour. Adamle and Turkoski (2006) argue that humor initiated by a nurse or caregiver and humor initiated by a patient can provide relief from stress, provide an outlet for emotions, serve to break down communication barriers, reinforce the patient's control of his or her situation, and strengthen the therapeutic relationship. "This use of humor by patients is not to "make light" of the situation, but rather a way to reduce their feelings of dehumanization" (p. 638). Therefore, in their article, Adamle and Turkoski (2006) outline some guidelines on how caregivers can respond to patient-initiated humor. Mango and Richman (1990) have also criticized the literature on humour in therapy as being one-sided, where the therapist is seen as initiating the use of humour to affect the patient but the patient is seen as passive. They propose that humour in therapy should involve more collaboration between patient and therapist. "We laugh most at what frightens us most" (p. 111). Therefore, therapists can also learn a lot about their clients when the client initiates humour, for example, by sharing a joke.

According to Ziv (1984), humour is closely connected with the following functions: expressing aggression and sexuality, providing defense, supporting the intellectual digesting of information, and promoting inclusion in the social context. Psychological integration is an additional significant function of humour when deployed in therapy. Humour allows a person to tolerate ambivalence and see the positive and negative sides of a situation. Franzini (2001) explores intentional use of humour in therapy and how it can help "to establish rapport, to illustrate the client's illogical or irrational thinking, and to share a positive emotional experience with the client. Humor is the best gift we can

offer our patients because it demonstrates constructively that with a newly acquired positive view, their problems become solvable" (p. 172). Barwick (2012) asserts that in the context of group therapy a humorous engagement in a burst of wordplay and/or boisterousness may not only be pleasurable but can also suddenly open up multiple perspectives and multiple meanings. In a similar fashion, Garrick (2006) asserts that humour should be introduced in the therapeutic process because it can be a powerful healing tool. It does not minimize the significance of a lived trauma, but it can allow the survivor to see how she/he can cope and thrive in her/his environment (p. 169). Mann (1991) came to these same conclusions as well. He shares that humour does not make the therapist's work less serious, but may, if used appropriately, enable patients to develop the capacity for a richer experience of themselves and others, enhance their capacity to play and have a complete human experience and to become more integrated and spontaneous in their relationships (p. 161). Saper (1990) suggests, "psychologically, positive emotions (including humor) tend to provide a sense of confidence, a lightened coping style in the face of stress and adversity, a technique for combating helplessness and hopelessness, and a device for letting off the steam of pent-up emotions" (p. 267). Overall these articles mentioned above present a consensus around the positive effects that humour may have on clients in therapy. Humour appears to help in establishing the therapeutic alliance, specifically with the initial engagement and to strengthen already existing relationships, and it can help in the overall therapeutic process.

Negative Effects of Humour Use in Therapy

Evidently there are moments in a therapeutic relationship when humour is not only inappropriate but can be destructive. In discussing some pros and cons of using humour

in psychotherapy, Corey (1986) mentions that it is important that the therapists recognize that laughter or humor does not mean that work is not being accomplished. However, the author goes on to explain that there are times when laughter is used to cover up anxiety or to escape from experience of facing threatening material. Therefore the author advises that therapists need to distinguish between humor that distracts and humor that enhances the situation (p. 380). Garrick (2006) gives an example:

> If a client is smiling and joking while reporting a particularly painful childhood memory, it is likely that the client is not sure how close s/he wants to get to the memory and is attempting to obtain distance from the associated emotional pain. This distancing is similar to denial in that it provides for a comfort zone. However, if not properly handled in treatment, such denial impedes the therapeutic process. (p. 177)

In regards to clients using humour in sessions, Moran and Hughes (2006) express that "people who use humour exclusively may not allow themselves to develop other coping strategies, may become tedious, or they may hurt others" (p. 513). Sultanoff (2013) warns of the possible risks a therapist runs in using humour in therapy. He explains that because the client places trust in the therapist and is, therefore, more vulnerable to emotional harm, the risk when using humour in psychotherapy is greater than the risk of using humour in other relationships. The purposeful intention of using humour in psychotherapy must clearly be for the benefit of the client and not for the therapist's personal gratification or pleasure. By using humour, the therapist may risk alienating the client. The therapist may be perceived as not taking the client's issues seriously, and/or may be perceived as less competent and, therefore, less capable of

helping (p. 394). While distinguishing between therapeutic and harmful humour, Saper (1987) indicates that harmful humour "exacerbates client's problems, thwarts cognitive-emotional equilibrium, undermines personal worth, leaves a deleterious bitterness and so forth" (p. 363). Nothing funny about that!

Believing there is no place for humour in the therapeutic process, Kubie (1971) makes it clear that humor has a high potential for destructiveness, that it is a dangerous weapon, and that the mere fact that it amuses and entertains the therapist and gives him a pleasant feeling is not evidence that it is a valuable experience for the patient. Kubie lists the significant drawbacks of using humour in therapy. He describes that the patient's stream of feeling and thought is diverted or blocked from spontaneous channels by the therapist's humor (p. 861). Kubie also describes how the patient may realize how easy it is to use humor as a mask for hostility. Additionally, patients may be confused about whether the therapist is serious about what he/ she is saying or only joking. Kubie expands that for the beginning therapist these dangers and reservations for incorporating humor are doubly loaded. "The young psychiatrist, new to the therapeutic situation takes up his responsibilities with a tense combination of masked terror and anger, from which humor is an escape and against which it is a defense" (1971, p. 865). Rossel (1981) advises that humor itself can be disruptive by reinforcing regressive tendencies in interaction and introducing a lot of thinly veiled hostility into interaction that can potentially flip into more overt forms of conflict (p. 206). In exploring the disadvantages of humour use in therapy, Schnarch (1990) mentions the following clientele that he feels would not benefit. Patients who readily feel misunderstood or disqualified by authority figures may respond negatively to therapist humor. Further, patients with hearing

difficulties or cognitive deficits are more likely to miss the point of the joke and feel diminished in the process (p. 80).

In setting some guidelines for practice in responding to patient-initiated humour, Adamle and Turkoski (2006) recognized that; "It is generally permissible for a person to make fun of himself/herself and his/her culture, ethnicity, or family; but it is not acceptable for someone else to do so (this is considered ridicule, slamming, or mockery and is a harmful use of humor). Inappropriate humor, especially with demeaning overtones, may indicate attempts at belittling self or others, or vindictiveness that needs to be addressed" (p. 641-642).

Humour in Art Therapy

> The art therapist set the client up with paper and drawing materials. She asked the client to go ahead and get started on the art process as she went down the hall to get him a container with water. Upon her return she had noticed that he had left the page blank. She immediately began interpreting his work. Pondering if perhaps he may be feeling empty, discouraged and lonely. "This must be a very difficult time for you" she said. The client exclaimed "What? I haven't even started yet!"
>
> -Lindsay Ficara, 2014

Several studies have examined the use of humour in art therapy. In the following section I will be covering some of these studies and articles. "Through art and humor, a person can express thoughts, attitudes, and feelings that are usually concealed or taboo" (Mango & Richman, 1990, p. 112). While battling cancer, Heath (2000) an art therapist, took an interesting approach in order to lighten her situation. Heath began keeping notes of humorous things that happened to her and began turning her notes into cartoons using

watercolors and ink. She called them "cancer comics, the humor of the tumor" and shared them with others who were also battling cancer. Heath explains "Even in the worst of times humorous things do happen, especially if you're alert to the possibility" (p. 47).

Mango and Richman (1990) found that much of the literature on humour in psychotherapy is incomplete or one-sided. The therapist is too often the dominant figure who initiates or utilizes humor, while the patient is subordinate. In their study Mango and Richman (1990) report the use of both verbal and graphic expressions of humor in an in-patient art therapy group. They encouraged patients to create verbal and visual humor. The subjects in their study were patients with a psychiatric disorder seen in art therapy, ages ranged between 17-76. Each session was organized into three periods: a warm-up period for telling jokes, a drawing period, and a period for the group and group leader to discuss the drawings. For the drawing period they instructed the patients to draw something funny that happened to them (p. 113). The authors' working hypothesis was that each joke and drawing was an expression of its creator's emotional state and current struggles. For example, ethnic jokes were not necessarily seen as expressions of social prejudice but as metaphors for the joke teller's needs, relationships, identifications, and current situation. During the art therapy groups almost all the participants, including the therapist, enjoyed and were interested in the task. Humorous drawing also appears to be a pleasant way to establish therapeutic rapport. In this mixed group, while it may be socially more acceptable for men to tell jokes than for women, the authors reported that the women were equally able to draw something humorous. The patients enjoyed sharing their drawings with other group members and receiving acceptance for their work.

Topics that were shared by the patients during the humor art therapy sessions were usually topics that were kept hidden and seen as shameful in other situations. Both the art and humor productions expressed the patients' isolation, impaired interpersonal relationships, and the pain associated with mental illness. To conclude Mango and Richman (1990) found that their clinical experience demonstrated that combining art therapy with humor is a promising therapeutic procedure

Silver (2007) created the Silver Drawing Test and the Draw A Story Assessment. Silver's assessments use stimulus drawings to bypass language disorders in assessing cognitive skills, and to provide access to emotions and attitudes. The Silver Drawing Test has three subtests: drawing from imagination, drawing from observation and predictive drawing. In her assessments, Silver identified several distinct types of humour: lethal and morbid humor, lethal but not morbid humor, disparaging humor, self-disparaging humor, ambiguous or ambivalent (neutral) humor, resilient humor, and playful humor. The following paragraph illustrates a study that incorporated the Silver drawing assessments in order to identify types of humour.

Kopytin and Lebedev (2013) studied the therapeutic effects of group art therapy in a psychotherapy unit of a Russian hospital for war veterans. The emphasis of the study was on the use of humour by incorporating Silver's drawing assessments, The Draw A Story assessment and the Silver Drawing Test, with respect to cognition, emotions, creativity, and self-image. War veterans are among the many client groups in which art therapy is used to reduce stress-related symptoms and to improve social adaptation. In the Russian Federation many combat veterans of military campaigns in different regions of the country and abroad suffer from mental disorders as a result of their service (p. 20).

The authors described how the men's art and verbal commentaries, which were full of self-irony and humor, helped to release tension and express powerful feelings. Results from the study confirmed the authors' hypothesis that humor serves as one of the therapeutic factors linked to creative and cognitive resources. The authors' conclusion is that art therapy does not necessarily develop one's sense of humor as much as it enables a considerable number of war veterans to more freely express humor in their art and verbal communications during sessions. However, it is possible that the participants' frequent use of humor is connected to the high resistance many patients have to art therapy. In this situation humor could be deployed to exert a heightened self-control while at the same time enabling a more secure emotional self-expression in the group. The study findings also showed very high rates of humorous responses before and after treatment, with considerable increase in such responses in the art therapy group. Interestingly, men tended to produce more negative humor than women. As for the presence of different types of humor, ambivalent or ambiguous humor was most common, whereas lethal, morbid humor was least common (Kopytin & Lebedev, 2013, p. 25).

Humour and Countertransference

For the therapist humour can exacerbate the complex entanglements of countertransference. Gabel and Bemporad (1994) define countertransference as "ranging from a highly specific situation involving only the therapist's unconscious reactions to the patient's transference to a more general notion of any feeling, conscious or unconscious, of the therapist that occurs in the therapeutic situation" (p. 113). In regards to countertransference Kubie (1971) states that humor often serves as a defense against our own anxieties as therapists and also against those of the patient, either of which may be

hard to tolerate. Indeed, it may be used as a defense against all forms of psychological pain. For example, the patient may use humor as a defense against accepting the importance of their own illnesses. They may mock their own symptoms in their efforts to evade the acceptance of help. If the therapist steps into this trap by echoing the patient's humor, he will reinforce the patient's neurotic defenses (p. 862). Additionally, Dewane (1978) mentions, "a client's ability to joke with the therapist may indicate the level of the client's psychological development or an attempt to seek approval from the therapist- the surrogate parent" (p. 508). A therapist who employs humor as a technique should also be prepared to be the target of some humor. However, as the therapist may be the focus of the joke, the therapist may assist the client in uncovering what the client's humour may represent through an exploration of the therapeutic relationship including transference. Conversely, Kubie (1971) expands, "Sometimes the joke is on the therapist, who cannot allow himself to appear angry when the tables are turned in this way. He cannot always laugh along, because if he does he will lose an invaluable opportunity to help the patient to gain more insight into the latter's use of humor as a weapon" (p. 865).

Humour and Adults with a Psychiatric Disorder

In focusing in on humour with an adult population suffering from a psychiatric disorder, the following articles on this topic are explored. Gelkopfl (2011) reviews the use of humor in "serious mental illness" (SMI). By SMI the author is referring to severe and long lasting mental disorders such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder and borderline personality disorder. SMIs are conditions that disrupt a person's motivation, thought processes, emotions, mood, interpersonal relationships and behaviors

(p. 2). Challenges for these individuals can be very encompassing and range from a wide variety of issues. Distorted cognitions and obsessive rumination are some of the features of many SMIs. Humour can foster self-observation by initiating the reorganization of attitudes, and by temporarily suspending taboos and distancing oneself from obsessive thoughts. Humour can offer a sense of proportion as well as promote different perspectives towards problems. Humour can also facilitate a pleasurable and hedonistic approach to problems, in stark contrast to depressive or suicidal thinking (Gelkopf, 2011, p. 3).

Ortiz (2000) discusses a case example where he used humour with a client struggling with obsessive-compulsive disorder (OCD). Ortiz explains that for many clients with OCD, laughing at their fears is an important step in being able to conquer them. However, the author warns that during exposure therapy the humour should not distract the client from the task at hand as this could reduce the effectiveness of the therapy. Additionally, clients with OCD are often embarrassed and ashamed about their disorder, making them highly sensitive to the reactions of others. There is a danger that they may feel that the humour is in some way meant to disparage them (p. 195). Ortiz (2000) describes a session:

> In one set of scenarios we focused on Bill's fear of associating with people whom he considered to be ''unclean'' or ''shady.'' Bill believed that such an association would begin a vicious cycle whereby he would become shady himself. When we were in the process of constructing the anxiety provoking scenarios to battle this particular obsession, I would say to Bill with a smile, ''OK, let's think of the shadiest, slimiest, corniest people you can possibly imagine.'' He would smile

> back wryly and start describing these characters in great detail. For Bill the ability to laugh at what made him anxious was a major step in mastering and coping with his anxiety in a way that was less destructive than were his compulsions. (p. 195)

Salameh (1987) provided specific guidelines on how to introduce humour with different patients who may reveal their negative past experiences with harmful humour. Some patients may exhibit symptoms such as depression or paranoia, which are likely to be associated with misinterpretations of a therapist's well-intentioned humor interventions. However, as clients suffering from a mental illness may feel alienated and alone, Garrick (2006) suggests that a therapist can educate clients on gallows and black humour and that this type of humour can help to relieve such feelings of isolation and separateness. Though, when it comes to working with an adult population suffering from a psychiatric disorder, we cannot generalize whether humour would be therapeutic or not. Saper (1990) points out that patients at the same developmental stage with the same DSM diagnosis may have different personalities, temperaments, coping styles and appreciations of humour. Furthermore, some patients may be too gravely disturbed, too depressed, too much in pain, too intensely in anguish to respond positively to humour or to engage in humorous interactions (p. 265).

Further Thoughts

How many psychotherapists does it take to change a lightbulb?

Just one, so long as the light bulb *wants* to change.

-Burton, 2013

There seems to be agreement among researchers that practitioners who are interested in applying humour interventions in their work should seek formal humour training (Franzini, 2001; Saper, 1990; Sultanoff, 2013). Lack of agreement about what is

funny can be problematic. For this reason Saper (1987) advises that therapists know themselves as well as their clients as thoroughly as possible before incorporating humour into therapy. As I believe humour is not only one-sided, initiated by the therapists, we can learn a lot from our clients by the type of humour they use. Schnarch (1990) notes; "It is always appropriate for the therapist to consider the systemic and dynamic meaning of patients' joke telling, just like any other event in the course of treatment" (p. 78).

Of the articles reviewed in the context of this research I found a lack of definitional clarity around the term humour. Instead a general definition of humour was provided as opposed to narrowing down what types of humour, such as riddles and puns. In reference to Freud's theories of humor I find the divisions he identifies such as tendentious jokes, mimetic and comics, to be too artificial and unclear. However, these are older theories and come from a time where psychoanalysis was much more rigid. Since Freud's time, therapy has altered immensely.

Franzini (2001) lists the reputed benefits of humour appearing across multiple domains. Medical, physiological (e.g., an increase in released endorphins and improvements in natural killer cell activity), social (e.g., becoming a more pleasing social stimulus and expanding one's network of friends), and psychological (e.g., providing an effective coping device to modulate stress and enhancing an appealing personality trait). Is a sense of humour a skill that can be enhanced? If so this may be a skill that art therapists may consider working towards given the current state of understanding of the benefits humour has on a person's overall well-being, while also keeping in mind the potential negative effects. In this respect, Crawford and Caltabiano (2011) conducted a study that investigated the concept that sense of humour is a skill that can possibly be

enhanced so that individuals are able to manipulate their own experience and frequency of daily positive affect and thus be in control over their own emotional well-being (p. 240). Based on the results of this study, it appears that a sense of humour can be taught and therefore clients can have a better, more positive outlook on their situations. Middleton (2007) explains that a key stated or unstated goal of therapy for many patients is the growth or enhancement of a sense of self, of which the growth of more mature or adaptive defense mechanisms including the use of humour, is such an important part (p. 152). Therefore, I believe it is important for the therapist to demonstrate a sense of humour in order to teach the client how she/ he may grow in the same way. As Haddock mentions "modeling humour is an effective way of teaching emotional management and self-nurturing" (as cited in Middleton, 2007, p. 153).

This research has reinforced my belief in the benefits of incorporating humour into art therapy sessions. However, this is not to say that it is a technique that every therapist should utilize. For instance, in situations where therapists are not comfortable using humour then it might be counterproductive and therefore not advisable. With therapists who have a good sense of humour and feel at ease with the idea of employing humour techniques in their practice, it may be a good idea to incorporate humour, which can benefit both the therapist and the client. In initiating humour, the therapist is showing the client that it is alright to bring it into sessions. By using humour the therapist is showing the client that the therapist is also human. Dewane (1978) argues "When employing humor in therapy, the therapist takes the risk of appearing imperfect, fallible, and human. But he also gives the patient license to behave imperfectly, fallibly, and humanly" (p. 510).

A therapist can incorporate puns, exaggerations, absurdities, light banter, and teasing as a way of communicating in the therapeutic relationship. This is especially appropriate if the therapist has explored this with the client and knows the client is comfortable using humour. As Adams suggests, therapists must initially recognize how important it is to have a sense of humor and be open to seeing humor in themselves and their own lives before they can use it in the therapy process. Then, they must find out what humor means to the individual clients with whom they are working (as cited in Garrick, 2006, p. 178). In an older article, Dewane (1978) explains that humour in therapy must be differentiated from sarcasm and ridicule. Humour cannot be used in a condescending manner, nor can it be used to express the therapist's feelings towards the client. Instead humour should be used as a way to look at the client's problem from a different perspective, and can be normalizing (p. 508). As seen from the literature humor can be used as a defense mechanism and as a coping strategy. In terms of using humour as a defense mechanism, somehow the therapist needs to address this concern without scaring the client away from using humour. Garrick (2006) explains "the therapist needs to address these underlying emotions by sensitively peeling away at the comical mask that covers them. The therapist must also be able to reflect back the inconsistencies between the client's behavior and what is being reported or recalled" (p.177).

Within the reviewed literature, I found that the use of humour was most often debated upon in the fields of psychotherapy and psychoanalysis. As Roustang (1987) jokes: "Psychoanalysts seem so entrenched in certitudes concerning their trade, their practice, their Lacanian or Freudian theory that it is impossible to see where there might be an opening for laughter about themselves" (p. 708). Perhaps humour is not used as a

tool in psychoanalysis often because psychoanalysts take themselves too seriously! Seriously speaking, this may apply more to traditional psychoanalysts as opposed to current analysts. Traditionally, the profession itself was designed to treat psychopathology and therefore may have been seen as bleak. Humour was also discouraged as part of the psychotherapeutic practice, which may complicate the matter of incorporating humour in practice even more, according to Roustang (1987) as he believes that some therapists may still hold onto these values or have been taught in this way.

In regards to Kubie's (1971) article on the destructive potentials of humor I find that although he is very radical in his stance, some of his ideas and concepts are sensible within psychotherapy. According to Kubie (1971) "humor has its place in life. Let us keep it there by acknowledging that one place where it has a very limited role, if any, is in psychotherapy" (p. 866). This article comes from an older school of thought. Further, Kubie refers to humor such as poking fun of the patients, their symptoms and mockery. I find this humor to be very different from the humor I would employ in therapy such as affiliative and self-enhancing humour. Kubie does not seem to give the therapist the benefit of the doubt by trusting the skills of the therapist. For example the therapist can make sure to try and select appropriate humor, or at least be able to respond accordingly when he/she observes that the client is uncomfortable or reacts negatively to humour. In contrast with Kubie's views of humour being potentially dangerous, especially when used by beginning therapists, Ortiz (2000) found humour to be a useful tool in his early years as a psychotherapist. He describes a case example with a client, Bill, suffering from OCD. Ortiz describes:

> The tenor of these sessions, as well as Bill's humorous examples, helped him with his OCD and also helped me with my own anxiety. I was able to let go of my rigid efforts to remember all the ''rules'' of therapy, as I was learning to be myself. I was better able to connect with Bill and empathize with how difficult constructing these scenes was for him. Using humor facilitated a decrease in my nervousness, which proved to be liberating for both myself and my client. (p. 196)

Additionally, the views on humor use in psychotherapy have changed over time and are looked at through a more positive perspective. To quote Sultanoff (2013) "Clinicians use their clinical knowledge, sense of themselves, and sense of the client to create interventions" (p. 395).

Humour and the Therapeutic Alliance

Research has supported the strength of the therapeutic alliance as the primary factor for client change in psychotherapy (Lambert & Barley, 2001). Sultanoff (2013) believes that humorous interventions help build the therapeutic alliance and have great potential to deepen the relationship because they can result in positive accepting, empathy, cohesion, and belonging (p. 392).

To my surprise, many authors and clinicians had contrasting opinions of when to incorporate humour in the therapeutic process. Some mentioned waiting after establishing a strong therapeutic relationship before attempting to incorporate humour (Thomson, 1990), while others mentioned an advantage in its use at any time in therapy, so long as the therapist is aware of its possible risks. Further, some mentioned the advantages of using it in the beginning to help establish the relationship. I believe that all of these suggestions are valid. Gelkopf (2011) explores humour use in working with

clients suffering from a mental illness. Humor in the therapeutic relationship may help deepen the therapeutic alliance. Therapists can show their humanness and break down barriers that often exist within the therapeutic context—especially if working in a psychiatric institution. The therapist's spontaneous laughter can improve the patient's trust in the therapist and therapeutic process (p. 3).

Sultanoff (2013) discusses a case where he incorporated humor with a client:

> During her first therapy session she explained that "bad things" happened to her because she was "stupid." This client was treated with a traditional cognitive therapy approach, helping her to restructure that belief system. On her tenth visit, she reported that another "bad thing" had happened, but she could not explain why it had occurred. I insisted that she knew why, but she insisted that she did not. Finally, I looked directly into her eyes and exclaimed, "It happened because you are stupid!" After a brief moment of shock (startled by the unexpected), the client burst out laughing. (p. 391)

The client's ability to perceive the absurdity of the "bad event" being associated with her "being stupid" triggered her laughter. She perceived that her belief that bad things happened because she was "stupid" was, indeed, ludicrous, indicating a shift in thinking from the first session to the tenth session. This is an informative example of how humour incorporated into therapy can change a client's cognition of an event. This case example also shows the importance of establishing a strong therapeutic alliance in order to proceed with making a joke such as this one!

The Role of Humour in Burnout Prevention

There is much agreement on the benefits of the use of humor as a professional tool to prevent possible burnout amongst practitioners (Franzini, 2001; Malinowski, 2013; Mann, 1991; Schnarch, 1990). Ortiz (2000) expands on this subject by adding that humour may help to reduce the self-doubt and anxiety that is common, especially amongst beginning therapists (p. 191). I think that, at times due to the challenging nature of our work as art therapists, laughter can really help us cope. As Schnarch (1990) notes, "Humor, and the capacity to see the meaningfulness and folly of human existence, is a requisite capacity, and burnout antidote, for caring and involved therapists" (p. 86). Leist and Müller (2012) studied the correlations between types of humor and well-being. Results showed that affiliative humor was positively associated to measures of well-being and self-esteem, and negatively related to anxiety and depression. Self-enhancing humor showed the same, and was also significantly associated with optimism (p. 553). Erickson and Feldstein (2007) found that "self-defeating humor was uniquely predictive of depressive symptoms above and beyond coping and defense contributions" (p. 268). Kopytin and Lebedev (2013) explain that it can be difficult to differentiate between healthy and pathological or morbid humor due to the significant role that context plays. Nonetheless, the distinction is important if we are to predict humor's effects on individuals and groups and use its therapeutic and regulative power properly (p. 21). Overall I believe that using humour in therapy is an effective way to take care of yourself, as a therapist, and to provide comic relief for the client. Additionally, humor can help weather and support sensitive topics in therapy, and can help approach challenging affect such as anger and sadness.

Humour in Art Therapy with Adults Suffering from a Psychiatric Disorder

I believe humour is closely related to creativity and therefore incorporating humour into art therapy sessions may help adults with a psychiatric disorder loosen up and to expand their creative potential. In particular, Mango-Hurdman and Richman (1994) view creative arts therapies as engaging the patient and touching upon deep and often unconscious thoughts, fantasies, and life tasks in an accepting and relatively nonthreatening manner. The authors note that humor is one such form of self-expression, and the graphic arts another. When used in combination, they help patients feel free to bring up material, which otherwise might remain unexpressed. For example, in their study Mango-Hurdman and Richman (1994) observed that ethnic material surfaces in the patients' art and humor especially when there are unresolved issues of identity. Therefore the ethnic humor provides the therapist with an opportunity to explore the patient's self-esteem and self-identity (p. 215).

I believe that playful contexts facilitate humour and humour development and vice versa. Humour may also expand a client's capacity for play. I found that this topic was not addressed much in the reviewed literature with the exception of Loizou (2005), who explains that the ability to move from reality to the imaginary, from seriousness to funniness, are elements of "cognitive playfulness", which are essential to creativity and humour. The relationship between play and humor can be further researched. Within humour development, Fromberg and Bergen (2006) express the need to "explore systematically the development of children's sense of humor within the context where it might be most likely to flower, that of play" (p. 141).

I have noticed some contradictions in the literature in regards to self-defeating humor in therapy. On the one hand, some authors have argued for the benefits of therapists and clients using self-defeating humor in a session (Franzini, 2001). On the other hand, others have described self-defeating humor as having a negative effect (Adamle & Turkoski, 2006; Erickson & Feldstein, 2007). In the case illustrations from the humour and art therapy sessions conducted by Mango and Richman (1990), the client's expressions of humour in their drawings include a lot of self-deprecation (p. 113). While the research reported positive results overall, I found these self-deprecating examples uncomfortable and hard to imagine how it can be useful for the client. I personally do not find this humour positive or empowering for the client. I would advise therapists to use this form of humour with care and apply sensitivity in receiving and supporting self-deprecating humour.

Conclusion

"Compassion, joy, love, and humour are essential to build healthy and peaceful societies"

–Patch Adams (2002)

Many times in my own therapy sessions where I am the client, my counselor and I have incorporated humour. I know that using humour has helped to lighten the mood and to expand my perspective on certain topics. However, I consider myself to have a good sense of humour and fortunately, I am not suffering from any mental health issues (as far as I am aware..). "Humour and laughter, by awakening us to new perspectives and underlying patterns, and by making us laugh at ourselves, help us put things in perspective. This gives us a new, more coherent way of seeing things" (Stroobants, 2009, p. 11).

Future Research

How do therapists create humorous interventions in their practice? I found the answer to this question was lacking from the literature. While many therapists discuss incorporating humour into their practice and find it beneficial, few discussed how they specifically used humour, what types of humour and so forth. To my dismay in writing this paper, there was not much written on the application of humour use in art therapy. As mentioned earlier, much of the literature was on humour use in talk therapy. However, in art therapy, a whole other layer of humour can be incorporated in sessions through graphic representations. My assumption is that like me, there may be many art therapists who use humour in their practice, but simply haven't documented this aspect of the sessions. Aligned with my research methodological approach, this paper was not meant to be exhaustive, nor conclusive. Further, I did not develop a humour intervention that could be incorporated into art therapy. Future avenues of research could investigate an intervention approach to research on the use of humour in art therapy by documenting and discussing activities that could incorporate humour. Therefore, this research could further guide any art therapists who are interested in incorporating humour into their practice. Other topics that were not explored in depth would include; differences in appreciation and use of humour that arise due to culture, age and gender. Further developing research on the topic of humour use in therapy from a multicultural perspective would also be beneficial for art therapists and their clients.

> "How are you getting along?" The blind man asked the lame man. "As you see," the lame man replied to the blind man."
>
> (Freud, 1905/1960, p. 68)

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