Laughing in the Face of Stress: A Humour-based Group Drama Therapy Intervention to Improve Resilience for People in High-Stress Situations

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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

Concordia University

Montreal, Quebec, Canada

CONCORDIA UNIVERSITY

School of Graduate Studies

This is to certify that the research paper prepared

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Entitled: Laughing in the Face of Stress: A Humour-based Group Drama Therapy Intervention to Improve Resilience for People in High-Stress Situations

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

Master of Arts (Creative Arts Therapies: Drama Therapy Option)

Complies with the regulations of the University and meets the accepted standards concerning originality and quality as approved by the research advisor.

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September 1st, 2022

ABSTRACT

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Humour has been viewed as an adaptive strength and a valuable coping mechanism. Over the past three decades researchers have studied the use of humour as an intervention for dealing with different challenges. The following research paper aims to document the reasoning behind creating a drama therapy intervention that enhances the sense of humour to improve resilience for people in high-stress situations. The theoretical intervention research is based on literature highlighting the need for resilience, especially in stressful situations, the benefits of humour, and its beneficial impact on persons living with extensive stress.

The first two steps from Fraser and Galinsky's (2010) will be used to complete the intervention's design. The exercises in the drama therapy intervention are inspired by the 7 Humour Habits Program (7HHP) developed by Paul McGhee (2010). The suggested intervention will focus on key humour habits and skills including establishing a playful attitude, looking for humour in everyday life, laughing more often, laughing at oneself, and, finally, finding humour amid stress.

ACKNOWLEDGEMENTS

To all the professors, supervisors, and wonderful therapists that I have met through the Drama Therapy program at Concordia University, I appreciate your wisdom, insights, and continuous support. A special thanks, to my research advisor, Stephen Snow, for the encouragement, patience, and guidance. I would also like to express my gratitude to PERFORM Center for believing in my work and granting me the Student Award in Preventive Health Research.

To imagination and art for making my life tolerable.

To absurdity, sensuality, and humour for making my life pleasurable.

To my playmates, for the connection and the special moments.

And finally, to myself for the laughter, the play, and the excellent company.

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CHAPTER ONE: INTRODUCTION

Over the past three decades, researchers have witnessed an increase in research highlighting the benefits of humour. Recently, humour interventions have grown in popularity. Humour interventions have been applied in the medical and educational fields. It has been used in nursing education and nursing practice (Ziegler, 1998), in treating hospitalized children to reduce pre-surgical stress and anxiety (Dionigi et al., 2014), in addressing trauma (De Jong, 2018; Landoni, 2019), and to promote psychological wellbeing (Crawford, & Caltabiano, 2011; Mbiriri, 2020). These humour interventions took different forms such as clown doctor visits (Dionigi et al., 2014), watching humourous content (Rudnick et al., 2014) and teaching stand-up comedy (Davila, 2021; Rudnick et al., 2014). In 2010, Paul McGhee, an internationally known contributor to the field of humour research published two books entitled "Humour the Lighter Path to Resilience and Health" and "Humour as Survival Training for a Stressed-Out World." In these two books, McGhee advocates humour and laughter as a skill that can be taught in the promotion of health and well-being. He developed an evidence-based humour intervention program called the "7 Humour Habits Program" (7HHP) that was tested in the USA, Switzerland, Australia, and Germany (Goldstein & Ruch, 2018). The studies showed that the humour training was effective with participants of all ages, and it improved overall mood, boosted optimism, and improved the ability to cope with stress (Goldstein & Ruch, 2018).

The following research paper will document the process of the creation of a group drama therapy intervention aiming to strengthen the participants' sense of humour to bolster their resilience amid stressful situations. The intervention is inspired by my lived experience, my educational background, my career path, and the 7HHP. In the following paragraphs, I will start by situating myself, then share some background on the reasoning behind the intervention.

I was born at the end of the civil war in Lebanon, and I witnessed the succeeding Lebanese wars. Then, I immigrated to Canada in 2010. Before arriving in Canada, I lost friends to bombings, my father to heart problems, and my community in Lebanon to immigration. Then, I had to adapt to my new country, create a new network and community, and more recently, deal with a pandemic while completing my studies. There was no shortage of challenging situations. I have experienced many traumas, but I also had the luxury to attend therapy and experience healing.

My playful imagination often goes ahead of me to perceive and initiate humour, especially in uncomfortable situations. Laughing wholeheartedly has become natural to me. Humour helped me temporarily detach from the challenging situations allowing me to look at the bigger picture instead of fixating on the discomfort at hand. Humour allowed me to make meaningful connections, take things lightly and play even in times of distress. Humour was and still is one of my sources of strength. I have learned to use humour to tame life.

Before I continue, I will touch on my academic background and work experiences that have shaped my use of humour and my research focus. I completed a Bachelor of Arts in Theater, a diploma in recreation and leisure studies, and an Honours Specialized Bachelor of Arts in psychology. Currently, I am finishing my master's in drama therapy at Concordia University for which I am submitting this research paper. I was also trained as a therapeutic clown. I have worked in four different Lebanese hospitals with children and youth in oncology and pediatric units. I have also worked in life enrichment with older adults in retirement homes and with patients in palliative and end-of-life care in nursing homes. In these settings, I was surrounded by people dealing with diverse challenges, acute or chronic illnesses, pain, and death. I gathered hands-on experience in using humour appropriately in these settings and witnessed its

positive impact on myself, the patients, their families and my colleagues. The reaction to my work only strengthened my belief in the power of humour and the promise of an intervention that enhances one's sense of humour to improve their resilience.

The following research paper will include an introduction and a literature review on resilience, its necessity in times of stress, humour, its benefits, its use in therapy, and the multi-directional relationship between humour and resilience and drama therapy. This will be followed by a chapter on research methodology discussing intervention research design, and a chapter suggesting the practical application of the proposed intervention. This will be followed by a discussion about the risks, the protective factors, the limits, the strengths of the intervention, future recommendations, and finally, the conclusion.

CHAPTER TWO: RESEARCH METHODOLOGY

The primary research question of this study is: How can the sense of humour be fostered, in the context of group drama therapy, to improve the participants' resilience amid stress? This research paper proposes a model for a group drama therapy intervention to enhance the participants' sense of humour consequently improving their resilience in high-stress situations. The research methodologies used in this study are drawn from theoretical research, specifically the integrative literature review (Whittemore & Knafl, 2005) and intervention research (Carroll & Nuro, 2002; Fraser & Galinsky, 2010).

Integrative literature reviews aim to synthesize related research using diverse methodologies. For this study, a systematic literature search was conducted using the databases provided by Concordia University Library electronic resources, Google Scholar, and creative art therapy journals including PsychArticles (APA PsychNET), *Drama Therapy Review*, and *The Arts in Psychotherapy*. The following search terms were used to guide the selection of the literature "humour and therapy," "benefits of humour," "humour and resilience," "impact of resilience," "stress," "group drama therapy," and "The 7 Humour Habits Program," "humour interventions." The articles collected were used to evaluate, summarize and synthesize research outcomes to generate a comprehensive understanding of resilience, humour, humour-based interventions, and drama therapy.

Intervention research is a systematic approach to designing, developing, and evaluating innovative and evidence-based interventions that foster clinical and social change (McBride, 2016). Fraser and Galinsky define it as "purposely implemented change strategies" (2010, p.459). It is a five-step process including 1) the development of the problem and intervention theories, 2) specifying the intervention structures and processes, 3) refining and confirming the

intervention components 4) testing the effectiveness of the intervention in practice settings, and finally 5) disseminating the intervention findings and materials (Fraser & Galinsky, 2010). In this research project, only the first two steps will be addressed.

In the first step, the literature will be examined to define the problem, the circumstances, and the targeted population, as well as, to identify the "risks" and the "protective factors" pertaining to the development of the proposed humour-based intervention (Fraser & Galinsky, 2010). In the second step, the literature review will inform the preliminary outline of the pilot intervention, specifying its goals, its exercises, and its overall process. In addition, Paul McGhee's book "Humour as Survival training for a stressed-out world" (2010) will be used as a model to give direction to some of the proposed exercises for the pilot clinical intervention. The preliminary outline developed refers to a manual that includes the necessary components to create change (Fraser & Galinsky, 2010). In pilot intervention research, the goal of a manual is "to define the treatment in broad strokes for preliminary evaluation of feasibility and efficacy" (Carroll & Nuro, 2002, p. 397).

As mentioned, the goal of this study is to develop a group drama therapy intervention that builds different humour habits for participants living in high-stress situations. The proposed intervention as a whole has not been tested, but the theoretical research provides the foundation for experimental research using humour and dramatherapy to reinforce resilience.

CHAPTER THREE: LITERATURE REVIEW

We are living through exceptionally stressful times. According to statistics from the American Psychological Association and the American Institute of Stress, stress and mental health in the US are worsening mostly due to the uncertainty caused by the Covid-19 pandemic, rising inflation and the unstable political environment, especially in light of the Russia-Ukraine crisis (2022). Statistics Canada reports that 50% of Canadians consider that their stress levels have drastically worsened in the last two years (2021). The Canadian Social Survey (CSS) introduced between April and June 2021, shows that Canadians are living through a time of social and economic disruption. A quarter of Canadian women reported being extremely stressed most days. More than 50% of the Canadians in the workforce reported their mental health to be extremely impacted by the pandemic, finances, and world events. In addition to these worldwide events, scientific literature explored a variety of life experiences that have a considerable impact on personal stress. These include the death of a loved one, migration between and within countries, urban conditions that result in unpredictability, lack of control, and loss of work– among other daily stressors (Lazarus, & Folkman, 1984).

Increased stress has negatively impacted different aspects of life including health, relationships, society, and finances. Stress is challenging the population's physical and mental well-being. It can lead to problems at individual, relational, social, and organizational levels (Lazarus, & Folkman, 1984). Stress negatively impacts emotional and psychological well-being. Exposure to long periods of stress has serious negative effects on all body systems including the musculoskeletal, respiratory, cardiovascular, endocrine, gastrointestinal, nervous, and reproductive systems (Larzelere, & Jones, 2008). Stress contributes to a broad range of illnesses

including cancer, cardiovascular diseases osteoporosis, arthritis, and type II diabetes (McGhee, 2010b).

In these stressful times, being able to cope with stress is critical to our well-being. Recent research in mental health advocated for the importance of resilience, as it is pivotal to coping with these extraordinarily stressful situations (Vinkers et al., 2020; Webster &Neil, 2021). Webster and Neil (2021) underlined the importance of building resilience for individuals, organizations, and societies, which, in practise, translates to developing a combination of skills and capabilities to cope better with adversity while protecting their health and well-being.

Resilience

The concept of resilience has been widely studied by behavioral, social, and health scientists. It has become an umbrella term to cover different aspects of dealing with, adapting to, and overcoming adversities. A large body of mental health research defined the concept of resilience as a process and/or characteristic (Ayed, Toner & Priebe, 2019). The American Psychological Association (2014) describes resilience as the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress such as family and relationship problems, serious health concerns, or workplace and financial stressors. More precisely, resilience is described as a process when it fosters a sense of immunity, where the individual is undisturbed due to protective factors in the face of life stress and adversity (Um et al., 2014). It is also described as "bouncing back" when the individual is negatively impacted by the adversity but can return to their former mental stability (Amering & Schmolke, 2009). Personal growth is another trajectory of resilience, expressed when individuals thrive in face of adversities, capture positive life changes and do better than before (Tusaie & Dyer, 2004). On the other hand, resilience is conceptualized as a characteristic of personal and social resources

utilized by the individual to cope efficiently with adversities. Personal resources are traits, attributes, skills, and talents such as self-determination, hope, motivation, and humour, whereas social resources include supportive networks, positive relationships, and meaningful and affectional bonds (Ayed, Toner & Priebe, 2019). For this study, all reference to resilience implies the combination of factors supporting individuals to cope and thrive in spite of hardship.

In short, resilience is the ability to "roll with the punches." Coping is the effort put toward constant change in cognition and behaviors to manage specific external and/or internal situations that are taxing for the person (Lazarus & Folkman, 1984). The ability to cope and adapt to change is viewed as an important step toward achieving and maintaining well-being (Mayordomo et al., 2016). Adaptive coping strategies can positively predict resilience, and resilience can positively predict psychological well-being and quality of life (Mayordomo et al., 2016; McGhee, 2010b). Higher levels of resilience predict lower levels of mental illness and a high degree of mental health (Wu et al., 2020).

Moreover, resilience is enhanced by increasing the experiences of positive emotions. Positive emotions can build lasting intellectual, social and emotional resources which can consequently prepare the individual to cope effectively with future adversities (Fredrickson, 2001). The daily ratio of positive to negative emotions predicts happiness, life satisfaction, experiences of psychological growth, and better physical health (Diener, 2000). This also increases cognitive flexibility, creativity, receptivity to new information, improves planning abilities, thinking and judgment while allowing for greater trust, increased social responsibility, and easier bonding with others (Isen, 2003; McGhee, 2010b). Some of the tools suggested by McGhee to enhance the experiences of positive affect in daily life are practising gratitude, meditation, finding positive meaning within negative events, and building more humour into

one's life. This can be achieved by immersing oneself in the humour of others or by finding, using, appreciating and producing more humour in one's surroundings (McGhee, 2010b).

Humour

Defining Humour

Humour has been defined operationally and theoretically in different ways considering its diverse aspects. It involves emotional, cognitive, physiological, and interpersonal elements. Although it is often defined in terms of its effect on people (whether something is funny or humourous because it made people laugh) humour is much more complex and multidimensional. Martin, et al. (2003) list six different conceptualizations of having a sense of humour: 1) an intellectual ability to create, understand delivering humourous material such as jokes and comebacks, 2) an appreciation of humourous material, 3) a habit or pattern of telling jokes, amusing others and laughing frequently, 4) an emotion-related temperament trait such as joyfulness or cheerfulness, 5) a positive attitude toward the world, 6) a defense mechanism or a coping skill such as having a humourous outlook in difficult situations. These different conceptualizations represent the multidimensional phenomenon of humour and the different implementations and expressions of humour. They also help differentiate between the functions, forms, and styles of humour.

Martin, et al. (2003) distinguished between four prevalent forms of humour. They identified two benign forms of humour which are self-enhancing and affiliative humour and two harmful forms of humour which are self-defeating and aggressive humour. Self-enhancing humour is used benevolently to enhance the self, regulate emotions and cope with difficult situations. Affiliative humour is used spontaneously to amuse and connect with others, enhance

relationships and minimize interpersonal tension. Aggressive humour is used to enhance the self at the expense of demeaning or manipulating others. Self-defeating humour enhances the relationship with others at the expense of deprecating the self. Benign and harmful humour are different, but they cannot be viewed as opposite. Rather, they represent degrees of humour that can sometimes overlap. It is important to note that these distinctions are not exclusive, as they don't fully capture the personal, contextual, and cultural perspectives of different forms of humour.

Menéndez-Aller et al. (2020) noted that all forms of humour, benign or harmful, can be used positively or negatively. Research shows that humour can have a positive or a negative effect on health (Kuiper, 2012; Martin et al., 2003). Viktor Frankl, mentioned in his book *Man's Search for Meaning* that, "humour, more than anything else in the human make-up, can afford an aloofness and an ability to rise above any situation, even if only for a few seconds" (1959). Frankl considered the ability to find humour in the grimmest circumstances a survival tool and a trick that can be learned as part of the art of living. For him, humour was an act of creativity, and a statement of spiritual freedom wherein the person chooses their attitude and their way of dealing with their circumstances. Thus, when humour or having a sense of humour is used positively (adaptively), it is viewed as an adaptive coping skill and an important facet of personal resilience. It is suggested that individuals can draw upon their sense of humour when dealing with high levels of adversity and stressful circumstances (Kuiper, 2012). Conversely, people who use humour negatively (maladaptively) towards themselves or others, are more likely to experience interpersonal difficulties, pathological symptoms, poor judgment, and lower self-esteem (Kuiper, et al., 2004). In extremes, humour could lead to an inflated ego, hostile

relationships with others, or even predispose the individual to depression and anxiety (Menéndez-Aller et al., 2020).

For this research paper, we will focus on the positive, adaptive, good-natured sense of humour, and all references to a sense of humour will signify humour as per the definition of Martin (2007):

> anything that people say or do that is perceived as funny and tends to make others laugh, as well as the mental processes that go into both creating and perceiving such an amusing stimulus, and also the affective response involved in the enjoyment of it (p.5).

Benefits of Humour

Within the past decade, researchers from the field of psychology have shown particular interest in exploring and documenting the positive impacts of adaptive, good-natured humour on the individual. Research shows that having a good sense of humour can add a degree of richness and fullness to one's life, including enhanced enjoyment of positive life experiences, greater positive emotions, a more balanced perception of challenging life events, a healthier self-image, and greater psychological well-being and quality of life (Crawford, & Caltabiano, 2011; Kuiper, 2012; Houston et al., 1998). It improves coping abilities and resiliency (Kuiper, 2012; Tan & Schneider, 2009) and facilitates dealing with grief (Cox, 2014; McLachlan, 2013). For example, Lipman (1991) describes humour as a psychological necessity used by concentration camp survivors during the Holocaust to release repressed rage, anxiety, and depression.

Similarly, having a sense of humour is considered a character strength and a valuable trait. Humour improves productivity, heightens interest, reduces boredom, and encourages divergent thinking (McGhee, 2010a; 2010b). On a social level, humour is considered a mode of social communication and influence (Martin, 2001). People who have good humour skills tend to be more comfortable in social situations. Research shows that they are better at initiating and maintaining positive social interactions which consequently enhance interpersonal closeness, connectedness and strengthen social support (Martin, 2007). They are considered more attractive and desirable as friends and potential mates (Peterson & Seligman, 2004).

On a psychological level, humour boosts positive emotions which then improves social behavior and cognitive abilities (Isen, 2003). Humour helps with emotional regulation. One does not examine the benefits of humour without examining the physical benefits caused by laughter. Laughter reduces physiological arousal which relieves tension and anxiety (Samson & Gross, 2012). On a neurophysiological level, laughter promotes relaxation, pain reduction, a strengthened immune system, stress mitigation, decreased levels of stress hormones, and elevation of the mood (Van der Wal & Kok, 2019). Laughter Yoga practice is based on movement and breathing exercises to provoke deliberate laughter. It was based on the fact that the body doesn't differentiate between fake and genuine laughter, hence, it reaps the benefits of laughter regardless of the reason (Laughter Yoga International University, 2012). Dr. Kataria, the founder of Laughter Yoga, states that it can help lift the mood, reduce stress, strengthen the immune system, increase energy levels and manage life's hardships (Laughter Yoga International University, 2012).

Humour and Resilience

In line with Viktor Frankl's conception of the use of humour as a survival tool in the grimmest circumstances, researchers suggested that humour is used adaptively as a coping mechanism to ensure efficient action in adverse situations. Kuiper (2012), for example, suggests that humour can help individuals detach or distance themselves from traumatic circumstances. Humour used in such circumstances can have immanent and transcendent qualities making it a deep spiritual experience with transformational properties. For example, death workers in cemeteries seem to regularly use gallows humour (black humour, dark humour) as a specific coping mechanism to deal with second-hand grief (McLachlan, 2013). The deep engagement with the natural aspects of humanity, such as death, contextualized by the use of responsible gallows humour provides the death workers with an experience of worldly transcendence. In like manner, Peterson and Seligman consider humour "the playful recognition, enjoyment, and/or creation of incongruity, and the ability to make others laugh or smile" (2004, p.584). In these situations, humour involves a social element of connectedness, cohesion, and support.

Positive, good-natured humour, such as self-enhancing or affiliative humour, has a protective capacity and can foster resilience and emotional regulation, as suggested by positive psychology. Coping humour can be viewed as a composed cheerful position on adversity that allows the individual to sustain a good mood by focusing on the light side of adversities (Peterson & Seligman, 2004). Since humour can distance individuals from the source of stress, it may influence them to perceive the situation in a less threatening way, resist the negative impact of the stressors, and consequently lower the levels of post-traumatic stress and reduce the expression and repercussions associated with negative emotions. (Kuiper, 2012). Individuals

who used humour in coping with conjugal bereavement were better able to separate their negative emotions from their positive ones resulting in fewer depressive symptoms (Kuiper, 2012). Healthcare workers who use adaptive humour at work are better prepared to deal with a difficult situation because of their alternate response to threats that distance them from the stressor which consequently translates to greater workplace well-being (Bhattacharyya et al., 2019).

Humour in Therapy and Therapeutic Humour

Examining humour in the context of therapy is as old as the early works of Freud (1928) who viewed humour as a defense mechanism that has a comforting and protective purpose. He pointed out the psychological advantages of the use of humour in gratifying the sexual and aggressive drives instead of oppressing them. Similarly, Allport (1961) regarded the use of humour as a marker of health and maturity. Greenwald (1975) suggested that humour can allow the patients to gain perspective on themselves, their behaviors, and their defenses which can spark change and dismantle defensiveness. Haig (1986) emphasized the importance of empathy and respect towards the client and the therapeutic goals when employing humour in therapy.

With the development of humour studies, research about the use of humour in therapy became more nuanced. Researchers started differentiating between the various forms and functions of humour and its contextual use. They began looking at effective and ineffective uses of humour in therapy, highlighting the benefits and advantages of appropriate humour. Franzini (2001) alluded to different purposes of humour in therapy such as building rapport, revealing the client's illogical or irrational thinking, and promoting a client's self-efficacy for dealing with difficult situations. Likewise, humour is used effectively in sessions to encourage further

exploration, regulate strong emotions, relieve tension, reorient to reality, ease rigid defenses, break stereotypes, allow clients to express hostility and frustration, broaden perspectives and provide new problem solving or coping skills (Dziegielewski 2003; Vereen et al., 2006). Humour in therapy would be considered ineffective or improper when it is used at irrelevant or inappropriate times, when it avoids the client's anxiety, and when it is used to insult or put down in group therapy (Dziegielewski, 2003). Therefore, humour should be used in therapy only to benefit the client and the therapeutic process, and the therapist should be mindful of the type of humour and how it is used in sessions to ensure said benefit.

Mindess, in 1971, defined therapeutic humour as deep, genuine humour, that can be instrumental in people's lives where it extends beyond jokes, wit, and laughter to a particular frame of mind. She considered it as an inner condition and an attitude to life (as mentioned in Franzini, 2001). More precisely, therapeutic humour can be explained as involving "both the intentional and spontaneous use of humour techniques by therapists and other health care professionals, which can lead to improvements in the self-understanding and behavior of clients or patients" (Franzini, 2001, p. 171).

Several theoretical approaches supported the use of humour in therapy. Accordingly, specific humour-based interventions were proposed for treating specific psychological problems. For example, "Paradoxical intention" was a humour technique developed by Frankl (1960) to treat people with anxiety, depression, obsessive-compulsive symptoms, and agoraphobia. Frankl asked his patients to exaggerate the frequency and the severity of their symptoms which helped them to laugh, detach and recognize the absurdity of their behavior. Ventis et al., (2001) used humour in systematic desensitization to reduce fear. They believed that pairing the feared

stimulus with muscle relaxation and the positive emotional experience created by humour could change the cognitive appraisals of the patients. Richman (2003) explored the use of therapeutic humour with depressed and suicidal elderly people. Comparably, research shows that humour interventions can reduce preoperative stress and anxiety in children undergoing surgical procedures (Dionigi et al., 2014). Nowadays, similar humour interventions are accepted as an appropriate, cost-effective and complementary strategy to reduce the effects of stress that slow down the healing process even in serious and terminal conditions (Van der Wal & Kok, 2019).

Enhancing the Sense of Humour

In addition to using humour in therapy, some researchers went beyond that, developing interventions that are specifically humour-based. For example, Lehman et al. (2001) noted that training participants to create and use humour led to greater production of humour, implying that humour production can be trained for use during stressful situations. In these situations, training humour would be the goal of the therapeutic intervention. Most of the interventions that seek to train, develop, foster, cultivate or improve the sense of humour view humour as a skill that can be learned through modeling, cognitive restructuring, and reinforcement (Peterson & Seligman, 2004).

One example of a humour-based intervention is the "Humour Workshop" developed by Lowis (1997). The intervention aimed to train participants to use humour as a coping tool for stress and depression. It included five sessions: four of which were structured learning, and one was a reflection and discussion. In this intervention, participants learned about humour construction, the link between humour and creativity, reverse role-play exercises, and homework assignments. Although it was a pilot project, the initial findings supported the goal of helping participants learn to use humour effectively as a coping mechanism with life stress. A more

recent intervention was examined by Zhao et al. (2020) where they trained a group of older adults on the appreciation and the use of humour to release their emotions. The goal of the intervention was to improve their physical and mental health and social function. The results showed effectiveness in reducing symptoms of depression and anxiety and in increasing subjective well-being, cognitive function, and sleep quality in older adults.

7 Humour Habits Program (7HHP)

In 1994, Paul McGhee deconstructed the "sense of humour" into a set of habits that can be learned and acquired. He later developed the 7 Humour Habits Program (7HHP) as a training program to improve the foundational skills of a sense of humour to use them to cope with stress (McGhee, 2010b). The 7 habits include surrounding oneself with humour, establishing a playful attitude, laughing more often and heartily, creating verbal humour, looking for humour in everyday life, laughing at oneself, and, finally, finding humour amid stress. The habits are ordered hierarchically with increasing difficulty. The training program is represented in the book "Humour as Survival training for a stressed-out world." The program can be done alone, with a partner, or in a group. The intervention uses two main methods "humour log exercises" and "home play assignments," The humour log contains cognitive exercises that encourage the participants to think and reflect on things related to each of the humour habits. The "home play" contains behavioral exercises and suggestions to practice related to each of the humour habits.

Goldstein & Ruch (2018) documented the effectiveness of this program in boosting sense of humour in studies conducted in the USA, Switzerland, Australia, and Germany. The results support the hypothesis claiming that the program improves daily mood, boosts optimism, and improves the ability to cope with stress. The 7 Humour Habits Program was also used as a tool to

reduce clinical depression and anxiety, which inspired the creation of a German manual for therapists treating people with those conditions (Falkenberg et al. 2013). For instance, Andress and Matsumoto (2015) documented the results of a 10-week 7HH training period with older adults. The results at the end of the training period showed a significant increase in a positive mood and a reduction in stress level using the positive vs. negative mood scale.

The proposed clinical intervention in this research paper is inspired by the 7HH, focusing on five of the seven habits to be facilitated through the context of group drama therapy sessions. The first habit proposed by McGhee (2010a) is to surround oneself with humour. This habit will not be included in the intervention as it is more a daily practice than a drama therapy goal. The other habit that will not be included in the goals of the proposed intervention is creating verbal humour as it is highly intellectual and centered on language. Instead, the proposed intervention will focus first on developing a playful attitude which is the foundation from which the sense of humour emerges (p.14). Secondly, it will delve into the habit of laughing more often and more heartily. This habit is more related to physical and emotional expression. Thirdly, finding the lightness in everyday life will be explored. This is a skill that will encourage the participants to notice the humouristic potential of the mundane. Fourth, the humour habit of laughing at oneself will be developed. This portion will encourage the participants to stop taking themselves too seriously. The last habit is finding humour amid stress. In this phase of group therapy, the participants will get to apply all the acquired habits amid simulated stressful situations.

Group Drama Therapy

Drama therapy is a flexible, experiential, and creative mode of therapy that allows the participants to connect with different aspects of their being. Renée Emunah (1994) defines it as "the intentional and systematic use of drama/theatre processes to achieve psychological growth

and change." (p.3). Drama therapy offers the participants a framework to tell their stories, set goals, solve problems, express feelings, and achieve catharsis (Jones, 2007). It facilitates the learning of new coping and interpersonal skills (Emunah, 1994). Drama therapy uses creativity, play, humour, masks, puppets, miniature objects, embodiment, projection, role play, storytelling, metaphor, empathy, distancing, witnessing, performance, and improvisation to help people make meaningful change (Emunah, 1994; Johnson, 2009; Jones, 2007).

Acknowledging the possible emergence of participants' sensitive and delicate stories emanating from their stressful circumstances, drama therapy is a convenient framework to offer this clinical intervention. It is an appropriate approach to hold space for the participants, to contain their experiences, and to enhance their sense of humour because of its tenets of play, drama therapeutic empathy and distancing, embodiment, transformation, and life-drama connection. In the following paragraphs, I will point out and explain some of the aforementioned core therapeutic processes and factors pertaining to drama therapy and support the suggested humour-based intervention.

Play and the play space

As per Phil Jones (2007), play and the play space are central factors in drama therapy. The play space is also referred to as "dramatic reality" (Pendzik, 2006). It is a space of imagination and make-believe which has its own specific rules and ways of being. Johnson (2009) defines the play space as a "mutual agreement among the participants that everything that goes on between them is a representation or portrayal of a real or imagined being. It is the container of the entire therapeutic action" (p.8). Clients enter the play space with playfulness or a playing state, which is an attitude that is more creative and flexible towards ideas, situations, rules, and boundaries. This space and state encourage the client to be experimental in their

outlook on themselves and the world around them. This experimentation can be therapeutic because it can provide insights and opportunities for change (Jones, 2007). In addition, Emunah explains in her Integrative Five-Phase Model that in the first phase of group drama therapy, playfulness and humour are encouraged to help the clients become more comfortable with each other and with the therapist (1994). It is through these playful exercises that trust is built in the group and the group alliance is strengthened. She adds that humour can be used to diffuse emotionally charged moments and to combat resistance (Emunah, 1994). In a similar way, the first habit to develop in the suggested intervention is developing a playful attitude. The benefits of this playful attitude extend to the remaining phases in group drama therapy and the suggested intervention.

Dramatherapeutic empathy and distancing

Jones refers to drama therapeutic empathy and distancing as the different ways participants may respond to the world around them through roles, objects, and other dramatic materials (2007). A response of emotional involvement and resonance is considered a state of empathy, whereas a response of thoughts, reflection, and analysis is considered a state of distancing (Jones, 2007). Depending on the need of the participants, the drama therapist can use techniques to achieve greater empathy, greater distancing, or a balance between the two. This balance is called the aesthetic distance (Landy, 1994). Aesthetic distance is an emotionally adjusted place where the participants can reach both their thoughts and emotions. This spectrum of distancing allows the drama therapist to choose the appropriate distance of the exercises to hold participants in a safe space to delve into the therapeutic process without harming themselves emotionally or psychologically, or even re-traumatizing themselves. Humour and exercises that may generate humour can be used as a dramatic distancing technique. Emunah states that

through the most playful and humourous dramatizations, real feelings and needs can be expressed (1994) as they can act as a protective factor to the participants in regards to their ability and tolerance for emotional expression (2020).

Embodiment: dramatizing the body

Embodiment refers to the way the participants realize themselves "by and through the body" (Jones, 2007). It facilitates the acquisition of knowledge by engaging both body and mind in the process of creative discovery (Jones, 2007). Jones states, "Embodiment in drama therapy is the client's physical encountering of material through enactment and combines the knowledge to be gained through sensory and emotional feeling with the knowledge to be taken from more abstract reflection" (2007, p.114). This physical and emotional experience allows for a more intense encounter with the participant's material. In embodying different materials, the body experiences a transformation that can result in gaining insights, new perspectives, and release (Jones, 2007). This will be particularly beneficial for the first and second habits of the proposed intervention, which are establishing a playful attitude and laughing more often. Embodying these habits will allow the participants to wholly experience them physically, emotionally, and psychologically.

Transformation

This process implies the therapeutic potential of change and transformation to the participants or their material through drama therapy. Jones (2007) notes that through exploration within the drama exercises, participants can create and rearrange their thoughts, values, and emotions and they can respond to themselves and the world. This transformation can not only involve new developments, but it can also disintegrate and dismantle old restraints, patterns, and ways of responding and reasoning. Likewise, humouristic drama offers the participants the

opportunity to create, rearrange their material, and respond to it humourously and more lightly. This will transform their perspective on their material, which will in turn transform their response.

Life-drama connection

Jones references Solomon (1950) in suggesting that the drama therapy spaces must feel sufficiently removed from reality so that the participants can find gratification for their unconscious motivations without the anxiety and risks that are associated with real-life consequences. This permissiveness allows the participants to be freer and more flexible in expressing themselves and exploring different material. However, the connection between life and drama is essential for the therapeutic process. Jones (2007) states that "in drama therapy, there is an intimate connection between life and drama. This is intentional and essential to the process of change in drama therapy. If the connection did not exist, then the client might be able to create and maintain a separate drama therapy world. This would be counter-therapeutic" (p.117). In other words, if the participants are not able to make this life-drama connection, they will not be able to bring their life experiences into the play space, and they will not be able to take the work done in the play space and apply it to their life outside the sessions. In situations like this, the participants are stuck in the process. This is not to be confused with the participant's awareness of the direct representation between life and drama. Some participants will have a clear understanding of what they would like to explore from their life in the drama space and others will not. Instead, they will enter the drama space, explore, and then figure out the connection to their life. Furthermore, in the suggested intervention, the participants will use the work done with humour in the therapy space and connect it to their lives. They will take the skills acquired in the play space and transfer them to real-life situations.

Models of Humour in Drama Therapy

In addition to the elemental presence of humour and playfulness in the drama therapy space and process, recent research in the field of drama therapy explored humour-related specificities. For example, Hill explored humour through the role of the fool or the clown, in history and theatre and its comparison to the role of the drama therapist. He states, "My role as a drama therapist occasionally manages to weave a little colour, creativity, humour, and serendipity into the work regime. This creative spark somehow brings something intangible, a potentiality if you like, into this work environment' (Hill, 2005). Hill suggested that parts of these roles are useful in the therapeutic environment. Other research also highlighted the importance of the role of the clown in group drama therapy sessions (Baer, 2008; Roy, 2009), the role of medical clowns in hospital settings (Grinberg, Pendzik & Kowalsy, 2012), and the freedom, permissiveness and play associated to the role of the clown.

On the other hand, Tauber (2008) highlighted the use of humour in drama therapy particularly as a bonding tool between the participants in the group and as a protective factor when dealing with triggering material. Another example would be De Jong (2018) who focused his research and performance on the use of dark humour in his life to cope with major medical challenges. He also underlined the negative potential of dark humour on self-esteem and mental health when used inappropriately. None of these studies explored facilitating the sense of humour as a therapeutic goal in group drama therapy sessions, except Davila in 2021, who proposed incorporating stand-up comedy as a narrative model in drama therapy. He suggested an intervention that would "allow the participants to explore how humour plays a role in their life, how they can enhance its benefits to their life, what aspects of their life are they secure about and can joke about, and what aspects of their life allow them to connect with others when presented

in a humourous and connective manner" (p.28). Davila's intervention aligns conceptually at the core with my suggested intervention as it intentionally uses humour as a medium and a goal in therapy.

CHAPTER FOUR: THE INTERVENTION

Purpose and Design

The proposed group drama therapy intervention has three main purposes. The first and most immediate purpose is to offer a group drama therapy intervention that will allow the participants to play, de-stress and tackle some of their stressors. The second purpose is to develop skills that will foster, build and strengthen participants' sense of humour. The third purpose, which will have long-term effects, is to improve participants' resilience by equipping them with an adaptive coping tool to be used in stressful times.

This intervention design can be adapted and offered using different frameworks depending on the needs of the participants. The following section will present this intervention in a phase-based framework, where each phase will include two to four sessions, or even more. Each phase would focus on one of the humour habits. These phases are similar to Emunah`s Integrative Five Phase model (2020) in terms of their gradual unfolding, progressiveness, and easing participants into the next phase. The phases don't have a set formula. They are flexible and overlapping. They are used as guidelines to support drama therapists in facilitating the flow of the sessions while identifying the participant`s needs, evaluating progress, and choosing suitable exercises and techniques.

Intervention Goals

The long-term goal of this intervention is to boost participants' resilience by building and strengthening their sense of humour. It is inspired by Paul McGhee's 7 Humour Habits program; however, it focuses only on 5 of these habits, which are: cultivating a playful attitude, laughing

more often, finding humour in the quotidian, finding humour in oneself, and finally finding humour in misery. Through drama therapy exercises, each of these habits will be cultivated. Each drama therapy phase will focus on one of these goals, in the order mentioned.

The Therapist

This intervention calls for drama therapists who have an extensive understanding of the use of humour as a tool in therapy and are familiar with the 7HHP. Training in clowning, hospital clowning (clown doctors), and laughter yoga could be an asset for the facilitators. As for the characteristics of the drama therapist, they must be skilled in making proper, well-thought out "choice points" to guide the sessions (Emunah, 2020). They need to be culturally sensitive and congruent, take risks, and properly assess the behaviors and emotions of the participants (Vereen et al., 2006). They must be competent in holding space for the emotional baggage of the participants while keeping the appropriate aesthetic distance. Also, they need to be able to address inappropriate humour and microaggressions firmly and gently while caring for all the parties involved.

Population and Recruitment Procedure

The suggested intervention aims to work mainly with participants in high-stress situations. Stressful situations can include major life changes in one's life such as divorce, loss of a loved one, and loss of work. They can include highly demanding expectations and responsibilities at work such as caregiving for chronically ill patients. Nursing and teaching are examples of stressful and demanding careers. High-stress situations are situations that carry higher levels of pressure on the individuals' body, mind, and spirit. Wars, natural disasters,

environmental crises, and pandemics are traumatic events that are considered high-stress situations.

Through presentations and proposals, the intervention can be put forward to clinical institutions, community organizations, workplace environments, and private organizations. Based on the interest of the parties, participants within the organizations will be recruited using the appropriate promotional material used by the organization such as flyers, emails, or social media. The interested participants can follow up to learn about registration, requirements, and expectations.

The number of participants recruited is suggested to be a minimum of 8 and a maximum of 12. Having a larger number of participants might make it harder to achieve intimacy in the group. Participants need to be consenting adults and able to understand and communicate in the language used to offer the intervention. They will be asked to sign a consent form prior to beginning the intervention. Participants with a history or current diagnostic of psychiatric illnesses will be excluded to reduce complexity at this early stage of the intervention's development.

One example of a suitable population was illustrated through my practicum at Concordia University, where I got the opportunity to test parts of this pilot intervention in the context of a program to support the mental health of front-line health workers at a local community centre. Because of COVID-19 restrictions, the sessions were offered online to three different groups of eight participants. The participants were mainly social workers, psychotherapists, psycho-educators, psychologists, and sexologists working with the Montreal community. For confidentiality purposes, the location of the community centre will not be disclosed. These

frontline workers were going through exceptionally stressful times due to the challenges caused by the pandemic.

The Space

This intervention can be adapted for in-person or online. If it is offered in person, the space can be in the organization itself or a community center. The space must be private and free from noise and interruptions. The space should be large enough for the participants to move about freely. It should be well-lit, ventilated and uncluttered, equipped with chairs, mats, and a table. As for props, the drama therapist can decide whether to bring in art supplies, hats, masks, bubble soap, scarves, and funny gadgets depending on the exercises they choose.

Time and Duration of the Sessions

The time and duration of the sessions will be dependent on the number of sessions in each phase. It goes without saying that the longer the time spent on each of the goals, the more in-depth they will be explored through additional exercises. The sessions could be 1.5 to 2 hours in length. At least 3 to 4 hours should be spent on each of the intervention goals. For example, if we are offering this intervention to employees with high-stress jobs, it is suggested to offer the intervention through 10 to 12 sessions of 1.5 hours on a Monday morning or a Friday evening, to start or end the working week on a fun note. Another example would be offering this intervention at a community centre for at-risk young adults. Each of the phases would take up to four sessions. They can be offered on the weekend to facilitate attendance.

Practical Application of the Intervention

As mentioned earlier, this drama therapy intervention uses the phase model to support the participants in exploring humour habits that will help them improve their resilience and better deal with stress. Each of the phases will focus on one humour habit. McGhee's humour log and

exercises will serve as the theoretical guide for the main ideas and concepts tackled in each phase. These ideas will be concretized experientially through drama therapy exercises and techniques. Emunah (2020) provides a list of techniques and games that can be used to attain specific goals. They can be modified and adapted to different populations and situations. The drama therapists can also use interventions from their creative repertoire like sociodrama, improv exercises, clown work, laughter yoga or games. The drama therapy sessions will prepare the participants to gradually deepen their therapeutic work.

Since this suggested intervention will be tailored to the needs of each group of participants, the following section will briefly explain the usual structure of a drama therapy session and the main components of each of the phases. Then, a few suitable exercises will be proposed for each of the phases. This part is not prescriptive, instead, it provides guidelines and recommendations to the drama therapist offering the intervention.

Session structure

Drama therapy sessions usually have four basic parts to their structure. It starts with a brief check-in, followed by warmups, the main activity, and then a closing activity. However, the structure of the session is always flexible and open to necessary modifications and improvisations.

Check-in

Check-ins are short and simple exercises where each of the participants share how they are feeling in the moment. This allows the drama therapist to assess the emotional and energetic state of the participants individually and as a group. This information helps the drama therapist to guide the group based on the emerging needs of the participants. It also acts as an opening ritual that announces the beginning of the drama therapy session and entering the play space. Dramatic

projection is used frequently in check-ins. Dramatic projection is "the process by which clients project aspects of themselves or their experience into theatrical or dramatic materials or enactment, and thereby externalize inner conflicts" (Jones, 2007, p.84). Externalizing personal material allows the participants to take a moment and connect with their bodies, their emotions, and share their inner experience with the group. It would allow them to start thinking creatively, as they are transitioning from their everyday life to a more permissive space.

One check-in that I used with the healthcare workers was asking them to choose one projective device to describe how they were feeling in the moment. Projective devices can be a colour, weather forecast, a piece of art, a fruit, an animal, an object, a sound, a movement, a laugh, etc. For example, I would ask each of the participants "if you were a laugh that represented how you are doing or feeling right now, which laugh would you be?" Participants would authentically state or embody their current emotion through a laugh. These check-ins not only gave me an idea about the participants' lived experiences, but also informed the rest of the participants about the general energy of the group and primed them for entering the play space. In the early sessions, I would choose more common concepts as a projective device and choose more eccentric concepts as the sessions advanced.

Warm-up

Warm-ups, as their name indicates, warm up the participants and prepare them for the main theme or activity of the drama therapy session. Warm-ups are usually fail-proof, simple, and engaging. They help the participants detach from the outside world, switch focus to the inside and become more present in the play space. Depending on the needs of the group and the session, warm-ups can be physical, emotional, or mental. They can be individual or involve all group participants. Physical warm-ups get the participants active, mobilize energy and increase

comfort in their bodies. Emotional warm-ups would focus on the participant's somatic experience of emotions and embodied emotional expression. Mental warm-ups would constitute generating ideas individually or brainstorming collectively.

Main Activity

Main activities are where the bulk of the therapeutic work can happen. These activities usually take more time. This part of the session is directly related to the main goal of the session. Jones proposes that the main activity might take the form of one or more participants dealing with a certain issue, a group of participants working together with a specific theme or focus, or all the participants working on their material alone, in small groups, or all together (Jones, 1996).

Closure

Closure indicates the ending of the main activity and the transitioning back to the real world from the play space. The drama therapists need to be actively involved in this part to support the participants to fully disengage from any role, situation, or dramatic activity that was rendered in the play space. In this part, participants take the time to reflect upon and assimilate the work that has been done during the session (Jones, 1996). Closures can provide the participants with a great deal of information, insight, and awareness about the self. This is loaded with therapeutic potential. Afterward, the participants reunite, share and discuss their findings. It is also appropriate to reflect on ways to transition and implement the work that was done in the therapy session to the world outside of the session. Closures also act as closing rituals, announcing the end of the drama therapy session.

Main Components of Each Phase

This section will discuss the goal of each phase, appropriate exercises, suggestions, and recommendations. The phases represent a developmental course of treatment, where each phase paves the way for the next phase in a scaffolded and progressive manner (Emunah, 2020). The phases unfold toward deeper levels of play, intimacy, and self-revelation (Emunah, 2020). The drama therapist needs to be sensible in making choices to move from one phase to the other. Each of the phases will contain two to four sessions or more, if time permits.

Phase One - Establishing a Playful Attitude

"The human need to play is a powerful one. When we ignore it, we feel there is something missing in our life." – Leo Buscaglia

McGhee states that rediscovering child-like playfulness is the basic foundation to improve one's sense of humour. He argues that being more playful leads to more spontaneity and greater enjoyment in life. In this habit, McGhee invites the readers to contemplate their meaning of playfulness and adopt a playful attitude while addressing barriers, challenges, and negative views related to playfulness, early influences on their play style, and the association and perceived incompatibility between play, fun, and work. Then, he invites the readers to engage in more play while working on this humour habit.

Phase one builds the foundation for all the following phases. In this phase, participants get to know each other and build group culture, connection, and trust (Emunah, 2020). Kindness, empathy, respect, support, and openness are good values to establish in the group norms. Trust is critical to the later emotional work, as it will allow the participants to bring in more personal materials, take more risks, and dig deeper into the therapeutic work. Offering psychoeducation about humour and playfulness can assist the participants in understanding the

theory behind the work, recognizing its importance, and engaging in it. As humour is highly personal, talking about individual and cultural factors and differences is imperative. The dramatherapist can guide the participants to brainstorm convenient ways to deal with unintentional offenses and micro-aggressions that might occur in sessions.

In the first phase of exercises, expressiveness, playfulness, creativity, spontaneity, humour, and aliveness are nurtured to consequently promote the participants' self-confidence, self-esteem, and ego strengths (Emunah, 2020). The exercises are simple, fail-proof, and fun. *Mirror exercises* and variations, *sounding the movement*, *fast-speed Handshake*, *trust falls* and variations, *body connections*, *circle ball throw*, *people puppets* are all convenient exercises to begin in this phase (Emunah, 2020). These exercises will allow the participants to slowly get to know each other and start to play together as a group. They also introduce the medium of drama therapy to the participants. They gradually bring the participants back to their bodies and guide them toward using their bodies as expressive mediums.

An example of a game I use at this stage is *Zip, Zap, Zoom, Boom*. Borrowed from theatre games, it is an energizing exercise to engage participants in play, spontaneity, and celebrating mistakes. The exercise requires participants to stand in a circle and pass around a mix of a clapping and movement, an imaginary object, or an instruction that is associated with the respective, agreed-on sounds "Zip", "Zap", "Zoom" and" Boom." Each change in sound indicates a change in direction around the circle. Participants must make eye contact with another participant before passing on their sound and movement. The receiving participant will then need to react quickly to the other person and decide how to pass it on and to whom. As the participants get comfortable with the exercise, the pace is gradually picks up, and other combinations are added to the exchanges. This activity calls for the participants to be in their

bodies as they will actively be using it as a device to play. They also need to be focused and act and react quickly, which helps them be more present in the moment. Usually, this game generates lots of laughter as the participants make a lot of mistakes. However, since the stakes are low, it is an opportunity to model celebrating mistakes and taking them lightly instead of too seriously.

Phase Two - Laughing More Often

McGhee added laughing more often and more heartily to the humour habits because he acknowledged the benefits that come from the act of laughing. He describes laughter as a "stress deodorant," that activates pleasure centers of the brain and a "stress-reducing and resilient-inducing" (p.39). In this phase, McGhee explains the benefits of the physical act of laughing. He encourages the reader to consider their habits, current attitudes and beliefs established early on about expressing themselves through laughter.

In alignment with McGhee's approach, this phase focuses on affect and embodied emotional expression. Its goal is to develop the ability to notice, identify and name feelings, in addition, to ease and expanding the range of emotional expression. The participants get to play and act out different emotions and experiment with intensity, nuance, and subtlety. Emunah's techniques (2020) centred on emotional expressions such as *emotional greetings*, *group mood*, *join the emotion*, *guess how I feel*, *emotional statues*, *emotional sculpting*, and *emotional orchestra* are all appropriate for this phase.

Exercises from Laughter Yoga practise are suitable for this phase. The drama therapist can share some information about the history and philosophy behind Laughter Yoga (Laughter Yoga International University, 2012). One of the main Laughter Yoga lessons is the differentiation between happiness, which is a conditional response, and joy, which is an

unconditional commitment to have fun from within. Laughter Yoga exercises are playful and silly. They activate the body and have the potential to elevate the mood. Below, I will share a few popular Laughter Yoga exercises:

- Hold an imaginary cellphone to your ear and have a conversation using laughter instead of words.
- Walk around the space and greet others with different laughs.
- In pairs, have a heated argument using laughter instead of words.
- Open an imaginary credit card bill and laugh in shock at the amount you need to pay.
- Walk around while taking your pockets inside out looking for money that isn't there and laugh.
- Pain laughter: touch parts of your body that hurts and let out laughs.
- Find your evil, shy, scary, sad, …, angry laugh.

One of the exercises that I used in my practice with the front-line health workers was reflection and a visualization of a satisfying hearty laughter experience from the past. The instruction goes as follows, "*after finding a comfortable place to sit and relax, take the time to connect back to a moment where you have experienced a good satisfying hearty laugh, a laugh that felt like a shower to your soul… Try to remember your surroundings… where were you? were you alone or did you have company? When was that? What lead to the moment of laughter?... Try to recapture your feelings at that moment… How did your body feel? Stay with those feelings… When you are ready, use the colors and the paper on the table to depict that moment*." I have facilitated this exercise with four groups of participants, and in every group, I

had at least one participant who expressed feelings of sadness when the exercise ended. Their experiences were different, but they all agreed that remembering these good moments made them realize that things have changed, and that they have missed or lost these moments or elements thereof. Hence, early in this phase, I learned that I should probe the participants to ponder their experiences with mixed and seemingly contradictory feelings. This will prepare the participants to receive and tolerate the negative emotions as well.

Phase Three - Looking for Humour in Everyday Life

You can't be strong until you see a funny side to things – Ken Kesey

The goal of this phase is to sensitize the participants to daily opportunities for humour. McGhee (2010a) motivates the readers to start taking an active role in finding or creating their humour (p.74). He emphasizes that this skill needs to be built in non-stressful situations first. He explains that acquiring a "humourous perspective" is the result of ease in switching from a serious frame of mind to a playful one, and a joy in playing with unusual associations. He encourages toying with crazy ideas, incongruities, absurdities, ironies, and ridiculous aspects of life. This intellectual play nurtures a high level of creativity and mental flexibility. This is to say, cultivating a "humourous perspective" is a skill built through practice.

In parallel to the third phase of the integrative phase model (2020), where the participants start exploring situations in their lives, this phase also explores material brought from the participants' daily life. These exercises utilize the participants' current real-life stories in the play space where they are magnified, elucidated, and transformed into humourous situations. Simple scene work will be introduced in this phase. Participants will re-enact different roles and parts from their own stories or the other group members' stories. Usually, when asked to bring personal material, participants bring what they are currently processing which can include

unresolved issues, losses, and choices (Emunah, 2020). This phase is rich in opportunities of gaining perspective on one's thoughts and feelings, and their connection with themselves and others, as well as opportunities of transforming the narrative into something more playful and humourous. Since the exercises will ridicule actual real-life stories, the drama therapist must be vigilant in ensuring that the humourous play or the ridiculing of the stories occurs safely and with mutual respect.

One example of an exercise to introduce early in this stage is looking up different headlines from the news, and adding the story to the following statement:

"_____ thing happened today. If this happened to me, or if I did that, then _____"

This exercise offers the participants an opportunity to practice making associations with material that is distant to them before delving into more personal material.

Another exercise, used in improv theater, the integrative 5-phase model and Laughter Yoga, is gibberish. Gibberish is a technique in which people speak using sounds instead of recognizable words. The drama therapist can ask the participants to share or re-enact a story from their day using gibberish and ask another participant to translate what they are understanding into words. This exercise does not put pressure on the participant to use words and share details about themselves, keeping the participant at distance from the story. The use of gibberish is fundamentally entertaining, especially with the addition of the translation that usually holds an abundance of incongruity.

Phase Four - Laughing at Oneself

"to make mistakes is human; to stumble is commonplace; to be able to laugh at yourself is maturity" – William Arthur Ward

The focus on phase four is the habit of laughing at oneself, in other words, taking oneself lightly. McGhee (2010a) expounds that taking oneself lightly does not mean having a low opinion of oneself, putting oneself down, being incompetent, unprofessional, immature or irresponsible, or never serious. Rather, it means, 1) recognizing that they are not the center of the universe, 2) recognizing that one's perspective is nothing but one perspective among many, 3) actively refusing to carry a sense of heaviness when one makes mistakes, and finally, 4) seeing the funny side of one's behaviour and circumstances (pp. 86-87). He emphasizes that being able to laugh at one's own mistakes is a way of admitting ownership of weaknesses, without the ego being threatened.

As the phases advance, the intimacy and the sensitivity of the participants' material increases. Directing humour at the self is a double-edged sword. If used negatively, it will lead to putting oneself down and lowering self-esteem. However, when used positively, it grants a sense of acceptance and peace. Also, Sultanoff (1994) counsels that humour intended to attack a person's situation, traits or characteristics might sometimes be confused with a personal attack which might lead to alienation and hostility. The drama therapists can encourage the participants to start playing with what seems comfortable to them. They must guide the participants to find the balance in joking about themselves in a way that is fun, accepting, and positive, and devoid of bitterness, rejection, and negativity.

An exercise that I introduced early in this phase with the mental health workers was *"Complete the following sentences without overthinking or trying to be funny:*

I hate…

I love…

I'm annoyed by…

The best is when…

I'm proud that…

I'm terrified of…

I'm embarrassed by…

I'm obsessed with…

You should totally be my friend because…"

Once they have completed these sentences and shared some of them in the group, I asked them to *repeat this exercise, while using "because" with the given answer, and add a statement after "because"*. Lastly, I would ask them to *mix and play with the answers and explore the incongruities and absurdities that could be created*. The participants could also *pick one of the prompts and look at different short answers that could eventually make a list of funny statements*. This exercise offered the participants an opportunity to contemplate parts of themselves without the pressure of being funny at the beginning. Progressively, they start seeing the possibility of humour and play about themselves.

In this phase, I also share a few funny stories from my work experience in long-term care. One specific vignette that I enjoy sharing at this stage of the process is the story of a patient who had advanced Parkinson's disease. I used to love visiting and conversing with him at work. The story offers a strong example of the power of laughing at oneself, which can encourage the participants to do the same.

Vignette:

One day, as I was visiting Mr. X, he was putting significant physical effort to talk to me about his motorcycle adventures. While in his room, the nurse brings him juice. So, I offer to help him drink the juice with a straw. Mr. X was more jittery than usual, making the task of

catching the straw very challenging. He noticed my disappointment in failing to help. So, he commented "at least the mosquitoes don't bite me", in reference to his continuous movement. We both laughed so much.

After telling this story, I offer another exercise introduced by McGhee, wherein he asks the participants to make a list of things that they don't like about themselves, then categorize the findings into items that are heavy and minor, then in items that can be changed and items that can't be changed. McGhee explains that this exercise is full of insight and potential in asking the individuals to take note of the sensitive areas where they lose their sense of humour, what this loss means, and in realizing the things that they can work on and the things they need to live with. In my work with frontline mental health workers, I have used this list created by the participants to ask the following instructions:

- Choose an item on the list and find five benefits to it.
- Choose an item on the list and imagine exaggerated disastrous events that will happen if this item was any different.
- Choose an item on the list and announce yourself as the queen or the king of it. Then, share what changes you will make in the world once you acquire this power.

Phase Five - Finding Humour Amid Stress

"Perhaps I know why it is man alone who laughs; he alone suffers so deeply that he had to invent laughter" – Friedrich Wilhelm Nietzsche

The focus of this phase is on applying the acquired habits in stressful situations. McGhee (2010a) explains that the key to success in this phase is to find humour in connection to minor stressors first, then move on to bigger stressors. The exercises encourage the participants to

integrate what they have been practicing in earlier phases and to transfer and generalize it to their life outside the therapy group. In alignment with McGhee's suggestions for this phase, the drama therapist can guide the participants in exercises exploring first, the lighter side of other people's problems, second, humour in a stressful situation in one's own past, and third, humour in minor hassles such as traffic, spilled food, or conflict at work.

For this phase, I have designed a guided visualization exercise that walks the participants through emotional milestones in everyone's life, starting from the moment of birth until the moment of death. The instruction of the exercise goes as follows "*in pairs, find a comfortable place in the space and sit in front of each other. Take a deep breath together. If you are comfortable, look at each other's eyes, and connect without talking. Imagine the moment this person was born, the way they looked, cried, moved. Imagine their first bath. First giggle. First toy. First time attempting to walk. Falling, standing up, and trying again. …".* In this exercise, I name moments about first experiences, connections with others (i.e. family, friends, lovers, partners), excitements, achievements, heartbreaks, hardships, perseverance, etc. The exercise continues as follows, "*imagine how well you know this person, and how close you have become. Think about all the moments you have shared together. Now, imagine how old they have become. Their wrinkles. The hair. The slow movement. The heaviness. Their facial expressions. The tiredness. Yet, they still have a sparkle in their eyes. Imagine that you are visiting them for the last time. Reminiscing about the life you have lived. Imagine their last words. Last breath. Breathe together. Close your eyes. The other isn't here anymore. Sit with the feelings of emptiness that they have left. Take a deep breath. Now, you realize that you don't exist anymore. Sit in the stillness of non-existing."* Here, I would give the participants a couple of minutes of silence, then add "*and now, you hear a weird sound… you start smelling the worst smell ever…*

was that sound a fart? Did your friend just fart?... Did this fart just bring you back to life?". This exercise is emotionally charged. By the time people get to the old age part of the visualization, they are already loaded with emotions, as they can imagine what is to come. The moments of silence exacerbate this build-up of tension. Hearing the word "*fart*" would act like a permission to release the tension, allowing a cathartic experience.

In the times when I have facilitated this exercise, I have witnessed participants bursting with laughter, crying, and tearing up. Consequently, I noticed that the energy changes in the space, and a lightness appears in the participants' behaviour. Due to the emotional charge of this exercise, I suggest introducing it early on in the last stage. By this time, participants are comfortable with each other, more at ease with their emotional expression, and more proficient in self-regulation. I have received feedback describing the impact of this exercise on the participants' general outlook on life and their perception of what is most important to them.

Other exercises suggested for this phase are improvisations inspired by my experience as a clown and my work as a medical clown in the hospital. The drama therapist can discuss briefly the spirit of the clown, highlighting firstly the celebration of failures: the clown's failure is a mark of success and secondly, the infinite possibilities of the absurd: making sense of the non-sense (Proctor, 2013). The clown has a fresh innocent eye and is ready to play with anything in the world. This richness in the possibilities is a fertile ground for individual transformation (Proctor, 2013). Wearing the clown nose offers permissiveness to play with the unplayable. This would ease the participants to play in more serious situations. A prompt for an improvisation exercise would be "*while wearing the clown nose, share with us the saddest news you heard last week*", "*while wearing the clown nose, improvise a serious scene of conflict at work*", or "*while wearing the clown nose, take the role of a doctor who needs to explain to his patient that he*

forgot his watch in his stomach during the operation". It is also appropriate to brainstorm difficult situations with the participants and re-enact them while wearing the nose.

Later in this phase, the drama therapist can guide the participants toward choosing one challenging personal story and help the participants transform it into a funny one, to perform in front of each other. In line with Emunah's Self-Revelatory Performance (2020), and Davila's Stand-up Comedy Performance (2021), this can help the performer connect to the audience (the other participants) through their shared reactions to events. This can help validate the emotions, reactions, and experiences of both parties. It is also a symbolic way to celebrate the entire therapeutic process.

Since this is the last phase, exercises to review, integrate and celebrate, focusing on the interconnection, collective creativity, reflection, and intergroup perceptions are necessary (Emunah, 2020). Emunah offers a list of appropriate techniques to use in this phase, specifically in the last session. The drama therapist must stay aware of time limitations when closing the last sessions, as some new material might emerge. With delicacy and care, the drama therapist can create a meaningful and containing ending, even within a very brief time period (Emunah, 2020, p.236).

CHAPTER FIVE: DISCUSSION

These synthesized findings of the intervention design research resulted in a five-phase group drama therapy program aiming to improve participants' sense of humour for increased resilience in high-stress situations. The proposed intervention outlines a guide including the main goals of each of the phases, in addition to several tailored exercises and recommendations for the sessions. This guide is available to every drama therapist interested in offering such interventions. The intervention is flexible and highly adaptable to the needs of each drama therapy group. The drama therapist can adjust and modify the suggested exercises while respecting the goals of each phase. The role of the drama therapist is to determine the suitable pace at which to advance based on the unique needs of the participants. Like every intervention in its early phases, this intervention has some strengths, weaknesses, concerns, limitations, recommendations, and future developments that will be discussed in the following section.

Strengths

This intervention aims to offer a tool to improve resilience for people in high-stress situations. It takes a fun, playful, and humourous approach to dealing with difficulties. This intervention not only models humour habits to the participants but also allows them to experience and practice them during the sessions. This means that, within the sessions, the participants will get to instantly reap the benefits of humour and play. Also, this intervention might impact the participants' personal approach and outlook by sparking a change toward a lighter and more playful perspective. The humourous perspective is beneficial not only in the initiation of humour but, simply in the enjoyment of humour. This can benefit creativity, mental

flexibility, and problem-solving. This acquired resilience acts like a preventative health agent as it will avert the impact of stress and avoid disease caused by it on the short and the long run.

Weaknesses, concerns, and limitations

Due to the multidimensionality of the construct of humour, cultural and individual differences must be taken into consideration when using humour. These differences can lead to possible misinterpretations, unintended insults, and microaggressions by either the drama therapists or the participants. Drama therapists must be cautious, tactful, and sensitive in their use of humour, especially, if the group is culturally diverse (Garrett et al., 2005). They should put forth the effort to learn about each participant's sense of humour to establish a base for their therapeutic work. Cultural humility, openness, and respect should be promoted as group norms. Also, considering the high-stress situations they have experienced, participants' sensitivity may be heightened, and they could become easily triggered. Humour aimed at their situation may sometimes be confused with a personal attack, which can lead to feelings of isolation and hostility (Sultanoff, 1994). It is up to the drama therapist to hold space for all the participants and ensure they all feel respected and included.

Similarly, due to the nature of humour and play, some participants might ridicule and judge the approach, leading to resistance to the medium and the process of therapy. The drama therapist should address the resistance through drama therapy techniques. Offering psychoeducation, asking questions, and including the participants in the decision-making process are key to addressing the participants' concerns and to improve the therapeutic alliance.

This intervention is purely theoretical. Only the first two steps of Fraser and Galenski (2010) were carried out. There was no implementation to practically evaluate the efficacy of the intervention. Hence, the efficacy of this intervention cannot be determined at this stage.

It is also important to consider my personal biases and assumptions related to humour and play. I have shared in the introduction what lead me to believe in the benefits, usefulness, and value of humour. However, reviewing my own assumptions, and being aware of generalizations is essential, as well as analyzing potential risks and negative impacts of humour. At the stage of the implementation, humour should be used only to benefit the therapeutic process. The therapist should be mindful of the type of humour and how it is used in sessions.

Recommendations

To avoid some of the risks mentioned earlier, the drama therapist can recruit participants with no historical or current psychiatric diagnosis. Clear communication, and setting clear expectations and limitations for the drama therapy group is necessary to avoid misunderstandings. The drama therapist must repeatedly emphasize the cultural and personal nature of humour, and the importance of respect, humility, and openness. Franzini (2001) advises that humour should be controlled by "dosage" guidelines for certain participant struggles and delivered by qualified practitioners. It is therefore essential that the drama therapist be interested in offering such interventions and seek out training opportunities that will allow them to use humour effectively and respond appropriately to the participants in the therapy sessions.

In the early sessions, the drama therapist can introduce several grounding techniques to the participants. Then, the participants will be encouraged to be aware of their emotional and physical reactions throughout the sessions, and to take care of themselves. Promoting a culture of self-care during the sessions can teach the participants to do so not only within the confines of a therapy session. For example, the participants are advised to use the grounding techniques on their own as soon as they notice their reactivity. Sometimes, setting up a tea and snacks area can help with emotional regulation.

When offering this intervention to individuals who have professional and/or personal relationships, the participants might feel vulnerable to sharing stories from their past and personal lives. In similar situations, the drama therapist can name this challenge for the participants and encourage them to take ownership of their decision to share. Also, they can suggest the participant change details in the story to gain some distance.

In case any of the risks mentioned above materialize, depending on the situation, the drama therapist will use cultural humility approach to address micro-aggressions, resolve the conflict using drama therapy techniques, use emotional regulation techniques to support participants, and provide a list of resources.

Future development

Any proposed new therapeutic intervention must be empirically verifiable, and its efficacy must be tested by controlled research (Franzini, 2001). Since this research paper is purely theoretical, different research methodologies can be used to determine its effectiveness. For example, a test/re-test approach administrating the 10-item Connor-Davidson Resilience Scale (2003) can offer a quantitative methodology to test the impact of the intervention on the participants' resilience.

Another option would be a qualitative methodology, in the form of a participatory approach pre-and post-intervention through individual and group interviews. These interviews can investigate the participant's sense of humour, self-care habits, coping skills, reactions when they are rarely offended, their daily use of humour, and their understanding of appropriate and inappropriate humour. To evaluate the intervention, questions can focus more on meaningful moments from the sessions, favourite exercises, impact on perspective and attitudes, noticeable experienced change, and things they would change in the exercises offered.

If further research supports the efficiency of this intervention, creating a standardized manual of the process can lead to examining reliability and validity. Then, different aspects of the intervention could be examined more closely such as the longitudinal impact of the intervention on the participants, or differences related to the different forms and functions of the employed humour.

CHAPTER SIX: CONCLUSION

The unprecedented uncertainty brought on by the Covid-19 pandemic, rising inflation, and the unstable geopolitical environment has caused stress to spike around the world. Stress has negatively impacted different aspects of life including health and well-being. Building resilience is important when dealing with, adapting, and overcoming adversities. Increasing experiences of positive emotions increase resilience. One tool suggested by McGhee (2010) to enhance experiences of positive emotions is through building more humour into one's life. Humour is a multidimensional phenomenon that has different forms and functions. It can be used positively to connect, cope and regulate emotions, and it can be used negatively, to demean the self and others. Positive, good-natured humour has physical, psychological, emotional, and intellectual benefits. It is considered a character strength, a social connector, and for some, a survival tool. The advantages of humour have been studied about its use in therapy. Humour is appropriate in therapy work as long as it serves the therapeutic process. Studies have shown that humour is a protective factor that can benefit the therapeutic alliance, self-examination, emotional regulation, tension release, perspective transformation, change, and working through difficult material. When used to hide real emotions, to self-deprecate, or manipulate others, humour is then considered a risk factor.

Enhancing the sense of humour is one way to strengthen coping skills and improve resilience. Group Drama Therapy is a flexible, humour-welcoming approach to working with people in high-stress situations. This research paper proposed a group drama therapy intervention inspired by the work of McGhee (2010), who designed a humour training entitled "The 7 Humour Habits Program" (7HHP). The 7HHP's ultimate goal is to train the humours habits of individuals, so, they can use them to cope with stress. The proposed intervention used five of the

seven habits proposed by McGhee to guide a phase-based model of group drama therapy. Each of the phases has a goal of acquiring one of the habits. The phases develop gradually and progressively in terms of the depth and difficulty of the therapeutic work. The intervention's five phases correspond to acquiring the following habits: establishing a playful attitude, laughing more often and heartily, looking for humour in everyday life, laughing at oneself, and finally finding humour amid stress. Each of the phases includes goals, suggested exercises, and some recommendations and cautions to guide the drama therapist interested in offering such interventions. It is important to note that it is up to the drama therapist to mitigate the risks of using humour in therapy and to continue to ensure the respect and emotional safety of the group.

Finally, humour is the medium and the goal of this intervention. I hope that the therapeutic process will be pleasurable as it relies mainly on play and humour and that the intervention will offer people in high-stress situations an efficient coping tool and a playful perspective to lighten up the burdens and the challenges of life.

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