Humor within the Therapeutic Relationship:

Mental Health Therapists' Experiences and Understandings

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Abstract

Humor is a common phenomenon in social interactions and interpersonal relationships. Although humor research has grown extensively in the last 30 years, there is still minimal research studying humor within the therapeutic relationship. This study explored mental health therapists' experience of humor within the therapeutic relationship and their understandings of this experience. In order to explore these experiences and understandings, I conducted in-depth interviews with mental health therapists. Phenomenological research methods were used to analyze the data in order to obtain common themes and descriptions. Themes discovered from the data were humor use, humor within the therapeutic relationship, humor as a sign of mental health, communicating with humor, humor provides balance, genuineness, and therapeutic risks. The findings indicated that humor is present in the therapeutic relationship and is used in a number of ways by therapist and client. Therapist humor generally occurred naturally, yet mindfully. Humor created connection and balanced the emotional heaviness of therapy. Client use of humor could signify healing or a healthy aspect of their being. Therapists also expressed a number of potential risks when using humor. Strengths and limitation of this research project are included, as are suggestions for future research.

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Dedication

To all the critters at the Two-Bits Ranch

You keep me laughing

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"Therapy is not so serious that laughter need be excluded from it" (Middleton, 2007).

Chapter 1

Introduction

Humor is one of the few human qualities present among all cultures throughout the world. While a specific culture's mores define what is and is not appropriate humor, the laughter produced from humor cannot be recognized as originating from a member of a certain culture (Martin, 2007). Humor is a social phenomenon (Martin). Generally, people desire to share a humorous event or experience with others (Freud, 1905/1960). Provine & Fischer (1989) found laughter occurred approximately 30 times more often in social contexts compared to solitary contexts. Humor can enhance interpersonal relationships and sharing humor within such interactions typically increases the enjoyment felt (Sultanoff, 2003).

Humor is generally dependent on the context (Cundall, 2007) and the given interaction between people (Nelson, 2008). It is dependent on the personal experiences of the individuals who are sharing the humor. Often, humor must be experienced because the retelling of this same experience leaves the listener smiling politely and the speaker saying that often heard phrase, "I guess you had to be there" (Ortiz, 2000). Humor can be viewed as a paradox as it can build the ego of one person and destroy the ego of another. It can insult and create joy. A statement is hilarious to one person, but rude to another (Kuhlman, 1984).

Humor has cognitive, emotional, behavioral, physical, and social aspects that effect people (Buxman, 2001; Ellis, 1977; Martin, 2007). Ellis suggests that since problems may impact an individual cognitively, emotionally, and behaviorally, humor could be a beneficial part of mental health therapy since it can influence these different areas of personal distress. Many writers have offered ideas and theories as to the role of humor in mental health therapy. Strong arguments have been made for the perceived therapeutic benefits of humor as well as precautions

for its use in mental health therapy (e.g. Dziegielewski, Jacinto, Laudadio, & Legg-Rodriguez, 2003; Goldin et al., 2006; Goldin & Bordan, 1999; Kubie, 1970; Kuhlman, 1984; Salameh & Fry, 2001).

Significance of the Study

There have been a number of approaches to the use of humor in psychotherapy. Some therapists have designed therapies where humor is central to the therapy (Ellis, 1977; Farrelly & Matthews, 1981; O'Connell, 1987). Other therapists have used humor as a specific technique (Frankl, 1984). Finally, humor has been identified as an interpersonal skill comparable to empathy or genuineness (Dziegielewski et al., 2003; Martens, 2004; Martin, 2007; Nelson, 2008). Humor use may be intentional or spontaneous (Franzini, 2001). One entreaty given by many writers is humor should always be used to help clients achieve the changes they desire (Killinger, 1987; Martens, 2004; Saper, 1987). The role of humor within the therapeutic relationship is not clear. More research is needed to understand how humor can be used to move mental health clients forward to a preferred way of living (Martin, 2007; Ventis, Higbee, & Murdock, 2001).

Purpose

The purpose of this qualitative study was to explore mental health therapists' experiences and understandings of humor as it is present within the therapeutic relationship. Interest into the use of humor within mental health therapy is growing because of the perceived benefits of humor for mental health (Martin, 2007). There is a present need to understand mental health therapists' lived experience of the phenomenon of humor within their work.

Statement of the Problem

I was interested in how humor was viewed by mental health therapists. Humor has such a strong presence in our daily lives and relationships and I was curious if humor has a role in the therapeutic relationship. Assuming it does have a role, I wanted to explore the meanings attached to humor use in the therapeutic relationship. Specifically, I was interested in mental health therapists' experiences of the phenomenon of humor and their thoughts and understandings around these experiences. Therefore, I explored the meanings mental health therapists attributed to the presence of humor within the therapeutic relationship. Questions considered within this project were:

- How do mental health therapists understand humor within the therapeutic relationship?
- What are ways in which humor is perceived as therapeutic or not therapeutic?
- How is humor used by both the therapist and the client within the therapeutic relationship?

Research Approach

Research investigating the use and benefits of humor within therapy sessions is limited (Martin, 2007; Ventis, et al., 2001). One possible reason for the limited research may be because humor is most often spontaneous and is therefore difficult to research in a controlled manner (Ventis, et al.). In addition, humor is a complex construct, which has cognitive, physiological, philosophical, and psychological aspects (Dziegielewski et al., 2003). This complexity makes humor difficult to capture in research. Humor use often has many layers and is often dependent on context for full understanding and appreciation. This fact makes it difficult to research humor as often researchers will not be part of the complete experience (Ortiz, 2000).

This research project employed a qualitative research methodology. Specifically, it used phenomenological research theory to guide the research process. Qualitative inquiry was chosen

for this research project because the goal of this project was to discover the detailed meanings of humor as understood by mental health therapists. I was interested in exploring the multiple meanings of humor use within the therapeutic relationship. Qualitative research created the opportunity to discover the elaborate descriptions of multiple perspectives of how humor is perceived (Creswell, 2007).

Phenomenology seeks understanding though inquiry into the essences of an experience or phenomenon (Creswell, 2007 Moustakas, 1994). Description is valued rather than explanations (Moustakas). Phenomenology seeks first person accounts of the phenomenon (Giorgi & Giorgi, 2008). Therefore, data was collected through face to face interviews with mental health therapists. Data was then explored to discover common themes.

Definition of Terms

Humor. "An affective, cognitive, or aesthetic aspect of a person, stimulus, or event that evokes such indications of amusement, joy, or mirth as the laughing, smiling, or giggling response" (Saper, 1987, p. 364). Types of humor may include "cartoon, clowning, comedy, farce, jest, joke, parody, pun, riddle, ridicule, sarcasm, satire, and slapstick" (Kuhlman, 1984, p. 9).

Therapeutic humor. Any intervention that promotes health and wellness by stimulating a playful discovery, expression, or appreciation of the absurdity or incongruity of life's situation. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social, or spiritual. (AATH Board of Directors, 2000)

Therapeutic relationship. A "collaborative and affective bond between therapist and [client]" (Martin, Garske, & Davis, 2000, p. 438) that develops as they work towards achieving client therapy goals (Corsini & Wedding, 2008).

Assumptions

Since humor is a common phenomenon within our society and often occurs as people interact, it was assumed that the therapists interviewed have experienced humor in the context of some, if not many, therapeutic relationships. The therapists may produce humor, listen to the clients' humor, or both may listen to and produce humor within one humorous interaction. Regardless of whether the therapist, the client, or both produce the humor, both are participants in the experience. Participation does not necessarily mean the individual hearing the humor responds in the typical way of laughing or smiling. There are many potential ways of responding and these were explored in the research study.

Chapter 2

Literature Review

For the past 30 years, interest and research in the study of humor has been expanding (Gelkopf, 2009). However, research studying the use of humor in mental health therapy remains limited and many empirical studies that have been conducted have methodological issues (Gelkopf). Much has been written about humor and psychotherapy from a conceptual and anecdotal framework including a number of texts on the subject (Fry & Salameh, 1987; Kuhlman, 1984; Martin, 2007; Salameh & Fry, 2001).

A discussion of humor and its relationship to psychology dates back to the turn of the century when Freud (1905/1960) wrote *Jokes and Their Relation to the Unconscious.* Freud distinguished between jokes, the comic, and humor. Jokes were categorized as either innocent or tendentious. Innocent jokes bring a person pleasure through cognitive processes. Tendentious joke satisfy either a hostile or lustful instinctual drive that has been repressed. The comic involves the mental process of comparison, such as comparing a mime's movements to our own or a child's innocent statement to our own understanding. Parody, mimicry, and practical jokes are also discussed in the realm of the comic. Freud considered humor one of the "highest psychical achievements" (p. 228) and wrote that humor counters, in fact displaces, distressing emotions. Freud did not discuss the use of humor in psychotherapy however.

Moving through the 20th century to the present, a number of discussions, theories, and research on humor and mental health therapy can be found. Some therapists have developed therapies where humor provides the foundation that supports different therapeutic techniques (Martin, 2007). Other therapists have devised specific humorous techniques (Martin). Finally

many writers and therapists embrace the idea of humor as a communication skill (Martin). Stated another way, humor is viewed as a quality of the therapist comparable to empathy or genuineness (Martin). Franzini (2001) lists these possible methods of humor use by the therapist: "jokes, unintended puns, pointing out absurdities, parapraxes, examples of illogical reasoning, extreme exaggerations, therapist self-depreciation, and comical observations about the world" (p. 171).

Humor as a Therapy

Rational-Emotive Therapy. Ellis (1977) used humor as an integral part of his theory of emotional disturbance and Rational-Emotive Therapy. He believed that people who were too serious about life are prone to distress. Clients, who seek psychotherapy, generally want more fun and less suffering in their life and humor is able to serve this purpose. Ellis recognized the problems and distress experienced in life affect people cognitively, emotionally, and behaviorally. Therefore, therapy should include cognitive, emotional, and behavioral interventions. Humor impacts these aspects of an individual thereby allowing humor to be potentially very effective in psychotherapy sessions (Ellis).

In Rational-Emotive Therapy, therapists use humor to confront clients' irrational and ineffective cognitions. In order to achieve this goal of confrontation, the humor often used is formed by exaggeration. This type of humor takes the client's irrational idea to the extreme and reduces it to absurdity (Ellis, 1977). The style of humor used is confrontational and forceful (Martin, 2007). Ellis emphasized that the humor is used to confront ineffective thinking and not the client because one important premise of Rational-Emotive Therapy is that it is "unconditionally accepting [of] people with their mistakes" (p. 264).

Provocative Therapy. Concepts and assumptions within Provocative Therapy began to be developed by Frank Farrelly in the 1960's (Farrelly & Lynch, 1987). The foundational assumption for this therapy is "people change and grow in response to a challenge" (Farrelly & Lynch, p. 82). Humor plays a central part in this therapy and is used to challenge or provoke clients to move in the direction of positive change (Farrelly & Matthews, 2001). The type of humor used takes a rather aggressive form (Martin, 2007). By using humorous exaggeration, therapists challenge clients to continue to resist change (Farrelly & Matthews).

In Provocative Therapy, clients tend to move through four stages. First, clients are likely to be bewildered or shocked by the humorous provocation. Next, clients tend to see some legitimacy in the therapist's challenges. Clients may fight back or resist the therapist's humorous statements in the third stage. Finally, detachment occurs for clients and they are able to laugh at their former selves (Kuhlman, 1984). Farrelly & Matthews (1981) maintain that the aggressive humor is directed toward clients' problematic behaviors and not the clients' themselves. Farrelly and Brandsma (in Farrelly & Lynch, 1987) state, "if the client is not laughing during at least part of the therapeutic encounter, the therapist is not doing provocative therapy and what he is doing may at time turn out to be destructive" (p. 90).

Natural High Therapy. Walter O'Connell developed Natural High Therapy in the 1970's (O'Connell, 2001). As its name suggests, Natural High Therapy emphasizes a positive approach to life with the goal of self-actualization through the development of the Adlerian concepts of self-esteem and social interest. A core element of the self-actualization process is the development of a sense of humor (O'Connell, 2001). Developing a sense of humor is the goal of self-actualization (O'Connell, 1987). O'Connell (2001) believed there were three levels that clients must work through in order to develop self-esteem and social interest. As these two

qualities are enhanced, a humorous attitude develops. A sense of humor gives people a "distancing perspective" on problems and issues (O'Connell, 2001, p. 432).

In Natural High Therapy, therapist humor is used to "diffuse the self-defeating purposes of guilt, seen as the product of one's ego-identity" (O'Connell, 1987, p. 60). As guilt is relinquished, clients are able to expand their self-esteem and social interest, which culminates in a humorous outlook on life (O'Connell, 1987). The therapist models having a humorous outlook within therapy and encourages clients' use of humor. Humor is incorporated into techniques such as psychodrama and role playing (Martin, 2007).

Humor as a Technique in Therapy

Paradoxical Intention. Victor Frankl was one of the first psychotherapists to actively promote the use of humor in a therapeutic setting. He developed a technique known as "paradoxical intention" (Frankl, 1959/1984). By increasing the attention on that which the client is trying to avoid through exaggeration and frequency of symptoms, clients will come to see the absurdity and humor in their behavior (Martin, 2007). The ability to see the humor in their actions allows the client to gain a certain amount of detachment from the behavior (Frankl). As a survivor of the Nazi concentration camps, Frankl truly understood the benefits of humor for a person. He wrote, "Humor was another of the soul's weapons in the fight for self-preservation" (p.63).

Witztum, Briskin, & Lerner (1999) used humor in the form of paradoxical scenarios to evaluate if humor would have a positive effect on the Brief Psychiatric Rating Scale of 12 individuals who had been hospitalized for at least eight years with a diagnosis of schizophrenia or schizoaffective disorder. The individuals first received three months of logical persuasion therapy, which was a modified form of Rational-Effective Therapy. Then, they participated in

three months of humor therapy. Psychopharmacological therapy remained as it had been before the study began. The results showed no noticeable improvement and actually show four cases of deterioration of mental status after the logical persuasion therapy was complete. By contrast, the humor therapy showed positive changes including five individuals who showing unusual improvement. Deterioration of these gains was not evident after three months.

Irreverence. Dialectical Behavior Therapy (DBT) employs irreverent communication, often referred to as irreverence, as one communication strategy (Linehan, 1993). Humor is one way a therapist may apply irreverence. The communication style of irreverence has been described as "offbeat", "matter-of-fact", and "deadpan" (Linehan, p. 393). Linehan specifically mentions humor use by the therapist when sensitive client issues are being addressed. Other writers have referred to irreverence as the "judicious use of humor" (Palmer, 2002; Slee, Arensman, Garnefski, & Spinhoven, 2007). Irreverence is used when the client or the client and therapist are stuck and no movement toward therapy goals has occurred for a time. The purpose of irreverence is to create imbalance in clients in order to move them toward a healthier balance. Irreverence may gain clients' attention, shift their emotional response, or present a different perspective (Linehan). Imbalance is created by a therapist exaggerating or minimizing clients' assumptions in an unemotional, objective manner. The therapist may also present in an intense emotional manner if the client is being unemotional or aloof. Extreme statements or paradox may also be used by the therapist. Finally, Linehan (p. 394) warns that if irreverent communication is being used in the following ways, it is not following the philosophy of DBT:

1. Irreverent communication is used in a mean-spirited way.
2. Irreverent communication is used without awareness of effects on the client.
3. Irreverent communication is used in a stilted or rigid manner.

Systematic Desensitization. Humor has also been used in systematic desensitization. Ventis et al. (2001) studied an adaptation of systematic desensitization that used humor. Three groups were established from 40 college students who reported a genuine fear of spiders. One group received traditional desensitization, one group received humorous desensitization, and one group served as the control. The Behavioral Approach Test (BAT) was used to determine level of fear both pre- and posttest. Ventis et al. found both treatment groups completed more items on the BAT than the control group. The two treatment groups did not differ significantly from each other.

Group work. Humor has been used as the primary technique in some therapy groups. A humor group for forensic psychiatric inpatients was established and studied by Minden (2002) to evaluate whether or not a humor group could promote health. Health was defined as "a dynamic process affecting quality of life and encompassing physical, mental, social, and spiritual dimensions (p. 75). The group sessions were led by Minden and nursing students. The nursing students had received prior instruction on the use of humor in therapy. The 66 researched group sessions involved 129 patients and 64 nursing students. The students were each responsible for planning the session they would lead following this standard outline for the groups: 1) call for rules, 2) introductions, 3) call for jokes, 4) humorous activity 5) discussion, and 6)enlightenment. Data was collected by means of questionnaires, researcher observation, researcher notes, videotapes, student notes, and 13 patient interviews. Results found that 83% of the patients wanted to participate again. Of those interviewed, 100% stated they benefited mentally, 77% stated they benefited socially, 46% stated they benefited physically, and 46% stated they benefited spiritually. Positive statement by patients included "relax[ed] and open[ed] up to who I really am", "a part of [group members] humanity was acknowledged" and "[the group was] a

medicine. A pick-me-up" (Minden, p. 81-82). The researcher concluded the group was therapeutic and "did have meaning for their health" (Minden, p. 82).

Another study utilized professional clowns in a group therapy setting on a psychiatric ward of a general hospital (Higueras et al., 2006). The researchers were interested in whether a humor-based group could positively affect the disruptive behaviors of patients on this acute care ward. The study took a quasi-experimental design and compared the number of disruptive behaviors during an 83 day time period when the humor based activity was offered to an 83 day period when the humor based activity was not offered. A checklist of 10 disruptive behaviors was completed three times a day by nursing staff. The humor based group was offered twice a week for 90 minutes. Humor was an element in all the different activities incorporated in the group. For the baseline time period, results indicated there were a total of 1666 inpatient days with 293 recorded disruptive behaviors. For the humor based activity time period, a total of 1916 inpatient days with 220 disruptive behaviors were recorded. Six of the 10 disruptive behaviors decreased significantly during the humor based time period with attempted escapes, self-injury, and fighting being most significant. Two disruptive behaviors, shouting and refusing to cooperate, increased during the humor based activity period. These two disruptive behaviors were considered minor in relation to the decreases observed in attempted escapes, self-injury, and fighting.

Humor as a Communication Tool

Humor has been called a “social lubricant, meaning that it tends to bring people together (Sultanoff, 2003, p. 107). Therefore, it is not surprising that humor and laughter naturally and spontaneously occur during mental health therapy sessions. Humor, occurring in such a manner,

would be viewed as a therapist skill and therapists need to be mindful of how to use it in a way that is therapeutic (Martin, 2007).

Araoz, (cited in Goldin et al. 2006), suggested therapists consider the timing when using humor and recommended they avoid humor use until the client first uses it. According to Araoz, therapists should also be concerned with the appropriateness of humor use in relation to the topic being discussed. It is the client's expressed emotions about a situation that dictates the appropriateness of humor use by the therapist. Finally, Araoz determines a client's receptivity to humor before using it.

Humor is often used to point out the client's illogical thinking. This is often accomplished with exaggeration (similar to paradoxical intention) to the point of being nonsensical with the goal that clients may come to the realization that their thinking is irrational (Martin, 2007). This method is often successful with individuals who struggle with perfectionism (Borcherdt, 2002). Therefore, greater self-awareness is fostered and different ways of perceiving life circumstances are realized (Gladding, 2002). Borcherdt summarized this idea by stating, "When you can laugh at a problem, it implies you will prevail against it" (p. 248). It is a way to assist clients in becoming "unstuck" from their problems (Borcherdt). By learning to find humor in such situations, an individual's life is enriched (Goldin et al., 2006).

Humor within mental health therapy may promote movement toward clients' goals by opening up new ideas or perspectives on the problem (Martin, 2007). Martin suggests this occurs because humor often is produced because incongruous ideas are recognized. As the humor is shared, absurd or unrealistic thoughts may be stated. The unrealistic ideas may lead to more realistic ideas. The realistic thoughts may be shared within the humorous exchange, as well. These ideas open up possible ways of reaching therapeutic goals.

Humor frequently occurs within daily conversations. Therefore, as the counselor models humor within the therapeutic conversation, clients may expand their communication skills (Dziegielewski, et al. 2003). The use of humor creates a more natural therapeutic conversation, which assists in putting the client at ease. Clients, who are guarded in their disclosures during the conversation, may be more willing to open up as a response to the therapist's use of humor (Martens, 2004) This is especially true with children in therapy (Zall, 1994).

Humor may also be used to regulate distressing emotions being brought up in therapy sessions. Humor may bring a more positive mood to sessions. This use may be accomplished by therapists' modeling such an outlook and encouraging clients experience and utilize this lightness of mood (Martin, 2007).

Humor and the Therapeutic Relationship

The therapeutic relationship is the main component of therapy that promotes client change (Lambert & Barley, 2001). Just as humor creates a bond among people and promotes relationship development in everyday life, it can have a similar effect in the therapeutic relationship (Martens, 2004) and support rapport development (Goldin et al., 2006). Humor has a way of breaking down the defenses of clients who are not interested in therapy (Brooks, 1994).

When therapists incorporate humor in therapy, the client, should remain foremost in the therapist's mind. The humor used must always be relevant to the current discussion and support client change (Franzini, 2001). It must also be genuine and communicate empathy (Martin, 2007) as these are two qualities that should be present during the therapeutic conversation in order for the best chance for therapy success (Lambert & Barley, 2001).

A greater sense of equality within the therapeutic relationship is created when a therapist uses mildly self-depreciatory humor. It enhances the therapist's sensitivity and humanness

(Ortiz, 2000). Rather than seeing the therapist as an expert who has the skill to "fix" their problems, clients may come to see the therapist as a person who has the ability to work with clients to effect the change they desire. Such humor communicates the message that the client and therapist are "both in this together and neither is better than the other" (Borcherdt, 2002, p. 249).

Whether clients are feeling anxiety related to entering therapy or because of other situations, humor may be helpful. According to one study, individuals with a greater sense of humor were found to experience less stress and anxiety when compared to individuals with a lower sense of humor. The individuals used humor as a coping strategy and generally perceived less stress within their lives. This study suggested humor was used to reframe a situation so it was less stressful (Abel, 2002). Therefore, the therapist may find it beneficial to use humor to increase the client's comfort within the therapeutic setting (Haig, 1986; Martin, 2001; Zall, 1994).

Research has suggested a correlation between humor and hopefulness. In a study by Vilaythong, Arnau, Rosen, & Mascaro (2003), this relationship was examined. They found that individuals hopefulness increased after watching a humorous video compared to the control group who watched a neutral video. While this study did not specifically analyze the hope-humor relationship within a therapeutic context, it indicated an important potential benefit of the use of humor in psychotherapy. Often, an individual attends therapy looking for hope, an emotion that becomes significant during the process of client change (Irving et al., 2004). If humor positively influences the client's feeling of hope, the progress towards client goals is supported. Borcherdt (2002, p. 249) alluded to this idea when he wrote, "Laughter at self send the message that you will prevail over hard times." Hope is about prevailing when life is hard.

It is a gift therapists strive to give their clients and humor can be one means of accomplishing this task.

In his study, Scott (2009) asked five research questions. Two of the questions are of note. These questions asked "whether or not using humor strengthens the therapeutic alliance" and "whether or not the use of humor in therapy enhances the effectiveness of therapy" (p. 58). Of the 549 participant surveys, 99% answered 'yes' to these two questions.

Meyer (2007) investigated "the relationship between the use of humor within couple therapy and the therapeutic alliance" (p. 2). Forty couples and their therapists participated in the study. Each participant (clients and therapists) completed the Working Alliance Inventory (WAI) after the first and third session. The first session was also videotaped and then coded using the Humor Rating Scale devised by Salameh (1987). An analysis of the therapists' WAI responses found the frequency of humor (taken from ratings from the HRS) was significantly related to the overall therapeutic alliance. There was no correlation found between frequency of humor and therapeutic alliance from the clients' perspective. A final result found the frequency of humor in the first session was associated with less client drop out. The clients that did not drop out of therapy were exposed to almost twice as much humor in the first session compared to clients who did drop out of therapy.

Marci, Moran, & Orr (2004) studied laughter occurring in psychotherapy sessions. They looked at who produced the laughter and the role (speaker or non-speaker) of the producer of the laughter. They also measured physiologic responses to laughter as measured by skin conductivity. In this study, the clients laughed 119 times. The clients were the speakers 76.5% of the time when they laughed. In contrast, the therapist laughed 48 times and was a speaker only 10% of the time. Assumptions could be made as to why there was a rather large difference

in laughter production by both participants in the therapy sessions. However, without a detailed study as to the meanings behind the laughter production or lack thereof no conclusions can be reached.

An interesting part of this research was the skin conductivity. The changes in skin conductivity scores were significantly larger when the laughter was shared by both the client and the therapist (Marci et al., 2004). This finding supports the theory that humor and laughter is a social construct and may suggest a reason behind the contagious effect of laughter (Marci et al.).

Precautions

A discussion of precautions or risks of using humor in psychotherapy sessions must begin with the frequently cited article by Kubie (1970). Written from the standpoint of a psychoanalyst, Kubie argues that humor should be left out of mental health therapy sessions. He states that clients free associations may be altered, slowed, or blocked by therapist humor. He believes that therapists would use humor to mitigate their own anxieties and anxieties felt toward clients. When the therapist employs humor, clients may feel unable to express resentful feelings and may be pressured into reluctantly accepting the humor. Finally, Kubie states that because "it is never any fun to have a neurosis, nor is it ever fun to be in treatment…no matter how consciously well intended the therapist's humor may be, the patient usually perceives it as heartless, cruel, and unfeeling" (p. 863).

The editors of *The American Journal of Psychiatry* received many letters of rebuttal to Kubie's (1970) article. The authors of these letters offered arguments supporting the use of humor by therapists. Friedman (1971) replied that the use of humor depends on the nature of the therapeutic relationship and Schaengold, (1971) believed humor may "provide an intimacy achieved in few other ways" (p. 118). Letter writers noted Kubie did not separate psychoanalysis

from other methods of psychotherapy (Schakne, 1971; Schaengold). One final sample of the arguments refuting Kubie suggested that since psychotherapy's goal is to help clients with problems of living and since humor is a frequent part of individuals' experiences, it is almost necessary for humor to have a place in psychotherapy (Rapp, 1971).

The majority of writers support the use of humor in mental health therapy, but many include cautionary notes (Kuhlman, 1984). Humor cannot be used indiscriminately without consideration for clients and their goals for therapy. The basic premise regarding humor use mandates that humor not be used if it does not contribute to the therapeutic process or client development (Goldin et al., 2006). Certain types of humor are not appropriate for the therapist to use during a psychotherapy session. Any humor that is cynical, sarcastic, or disrespectful should be avoided (Goldin et al.) and it must not trivialize the client's emotions, thoughts, or experiences (Martin, 2007).

Humor is not beneficial when clients are experiencing certain emotional states such as depression or grief (Goldin et al., 2006). A therapist must be vigilant to refrain from supporting clients' humor if they joke about their destructive behaviors (Goldin et al.). Simply laughing along with clients at such jokes may demonstrate support of such behavior, which opposes client change. As well, some clients may believe that therapy is solely a serious endeavor and would not accept a therapist's use of humor (Goldin et al.).

Therapists should reflect upon whether they are using humor as a defense mechanism. It is possible a therapist may be uncomfortable with the topic of the session and, therefore, uses humor to cover this feeling instead of addressing it directly. Within such a scenario, the therapist may use humor to distract the client or to subtly move the conversation in a different direction and away from the topic causing discomfort (Martin, 2007). Countertransference issues may

also cause of therapist discomfort. Humor may be used by the therapist to cover such issues (Martens, 2004).

Just as humor may be used to shift clients' perspective, poorly timed humor may shift the client from the problem which needs to be addressed. Poorly timed humor may also shift clients' emotions at a time when the expression of such emotions is therapeutic (Kuhlman, 1984).

Relevant Research

Since Norman Cousins published a journal article and a book documenting how he used humor and laughter to combat the effects of a debilitating disease, research into how humor may affect the physical health of a person has grown (Cousins, 1976; Cousins, 1979). Research has also expanded in to the effects humor has on a person's mental health (see Martin (2007) for a more complete review of the literature in these two areas). There is much less research studying humor within mental health therapy (Ventis, et al. 2001). One possible reason for the limited research may be because humor is most often spontaneous and is therefore difficult to research in a controlled manner (Ventis et al). In addition, humor is a complex construct, which has cognitive, physiological, philosophical, and psychological aspect (Dziegielewski et al., 2003). This complexity makes humor difficult to capture in research. Humor use often has many layers and is often dependent on context for full understanding and appreciation. This fact makes it difficult to study humor using research methods as often researchers will not be part of the complete experience and may have been subjected to the "I guess you should have been there" phenomenon (Ortiz, 2000). Below are descriptions of relatively recent studies, which have not been discussed previously, that have looked at humor in mental health therapy.

Wilkens (2001) wanted to study the attitudes of marriage and family therapists towards humor use in therapy sessions. Responses to a number of devised statements provided interesting information. The statements and results follow:

1. I adequately understand the phenomenon of humor in psychotherapy (p. 93). Ninety percent of respondents answered agreed or strongly agreed to this statement. One respondent disagreed.
2. I think that humor was adequately addressed in my training as a marriage and family therapist (p. 93). Forty-five percent of respondents disagreed with this statement, 14% strongly disagreed, and 20% agreed or strongly agreed.
3. I find that spontaneous humor and/or episodes of humorous levity occur on average in my clinical practice (p. 94). Most respondents answered frequently to this question.
4. I feel comfortable in my ability to understand and interpret humor as it spontaneously develops in the therapeutic setting (p. 94-95). Eighty-five percent of respondents agreed or strongly agreed with this statement. Ten percent of respondents were not as comfortable as they would like.
5. I use humor deliberately as a rapport building tool (p. 95). Forty-seven percent of respondents answered frequently and 28% answered occasionally.
6. I use humor deliberately in my clinical interventions (p.96). The majority of the respondents answered either occasionally or frequently.
7. Humor can be appropriate to use in (not any/specific/occasional/most/all) clinical situations (p. 97). Fifty-one percent of respondents answered most and 44% answered occasional or specific.

8. I could see where humor might be used in counseling a family who has lost a child to suicide (p. 98). Seven percent of respondents answered definitely, 46% answered perhaps, 36% answered probably not and 12% answered definitely not.

The results of this research show that humor is frequently present within the therapeutic relationship. Many of the therapists, who were the respondents, used humor with deliberation and thought. Also, a small number of respondents added comments to the survey. These comments demonstrated a "positive attitude toward the topic of humor" (p. 104).

Using qualitative research, Gregson (2009) sought to provide a description and an understanding of humor in psychotherapy. Clinical, conversation, and humor theory analyses were used on data taken from actual therapy sessions. Of the 50 utterances of humor analyzed, clients produced approximately two-thirds of the humor. Gregson also found that one instance of humor was apt to produce more humor. When humor was produced, it was often accompanied by cues that signaled intent of humor production. Some of these cues were laughter, tone change, volume change, and announcing something as funny. These cues were important in identifying humor. Even with cues, Gregson noted occasional misunderstanding of the humorous intent. Sometimes, during emotional or stressful times in the session, clients tried to use humor. Interestingly, Gregson found that the humor style of the therapist tended to change when they were with different clients. Finally, an observer of the session would not have understood most of the humor used. Context was needed for understanding and demonstrated the "you had to be there" phenomenon of humor.

Jeffry (2009) used conversation analysis to discover how humor was used by the therapists and clients and the function of the humorous utterance. Three audiotapes were randomly selected from pool of 53 audiotapes. Fourteen excerpts for use in the analysis were

identified through speaker laughter. Therapist humor was identified six times and client humor was identified eight times.

Based on the conversation analysis, humor functioned in a number of different ways. Therapists used humor to communicate empathy, offer interpretations, counter resistance, express disagreement, reconnect with the client, and protect the therapeutic environment. Clients used humor to express incongruence as they worked to change, communicate confusion over the direction of the therapy session, and describe a disagreement with another person.

Chapter Summary

From the literature, it is apparent that humor is present within mental health therapy. While some humor may be preplanned or used as a specific technique, it most likely occurs spontaneously and naturally. The challenge for the mental health therapist is to ensure humor is used in a therapeutic manner focusing on the achievement of client goals. As with any therapeutic intervention, there are risks associated with the use of humor. Thus, therapist humor must be presented in a mindful manner.

Research studying the use of humor in mental health therapist is currently limited. Humor has had a positive impact on hospitalized and forensic individuals with mental health concerns. Therapist responses in a number of studies indicated a positive attitude to using humor in mental health therapy. There is limited data on clients' perspective of humor use outside of hospital and forensic units. The research presented above showed that clients do use humor in therapy and more frequently than therapists. The one study did not find a correlation between humor present in therapy and clients' view of the therapeutic relationship. Yet those clients exposed to almost twice as much humor were less likely to terminate therapy early.

Chapter 3

Methodology

This research project employed a qualitative research methodology. Specifically, it used phenomenological research theory to guide the research process. Qualitative inquiry was chosen because the research goal was to discover the comprehensive descriptions of therapists' experiences of humor in the therapeutic relationship and the meanings attributed to those experiences.

Qualitative research

Qualitative research is a legitimate form of inquiry for researchers who desire to understand and discover the meanings and understandings of the world experienced by people. The different perspectives, worldviews, realities, and meanings of individuals create the substance for qualitative inquiry (Creswell, 2007). It is an inductive process whereby the researcher works with the data to establish a set of themes which demonstrate the essence of the phenomenon (Creswell).

Another important facet of qualitative research is to approach reporting the data in a transparent manner. Part of the transparency includes an understanding and sharing with readers the worldview which guided the research process (Creswell, 2007). A worldview is "a basic set of beliefs that guide action" (Guba, as cited in Creswell, p. 19). I espoused a social constructivism worldview, where understandings were sought from the world of work. This worldview holds that people create their own personal meanings of their experiences (Loseke, 2007). Loseke described how this worldview applies to objective truth. "The truth *does not matter* in the social problems game. What matters is what audience members *believe* is true" (italicized words in the original text) (p. 35). The goal of this research is to discover the

meanings regarding humor in the therapeutic relationship as participants have come to understand them.

Phenomenological Approach

Phenomenology seeks understanding though inquiry into the essences of an experience or phenomenon (Moustakas, 1994; Creswell, 2007). Phenomenology explores the lived experiences of individuals and meanings ascribed to those experiences. Description is valued rather that explanations (Moustakas). The goal is "to remain as faithful as possible to the phenomenon and to the context in which it appears in the world" (Giorgi & Giorgi, 2008, p. 28). The discovery of the essence of the phenomenon is the intended outcome of the phenomenological research method (Creswell; Moustakas).

Data collection and data analysis are approached with intentionality to preconceived notions about the phenomenon being studied. Such prejudgments, biases, and preconceptions are set aside as much as possible. This process is called epoche or bracketing (Moustakas, 1994). By having knowledge of epoche, the researcher would remind and examine self throughout the research process to strive for a fresh, open perspective towards the data. Complete bracketing is difficult to attain (Creswell, 2007), but by intentionally engaging in introspection about prior understandings and preconceptions of the phenomenon, the research process can be approached in a receptive and curious manner. Creswell (2007) suggests epoche could be viewed "as suspending our understandings in a reflective move that cultivates curiosity (p. 62).

Credibility

Validity in qualitative research is determined in a different manner from quantitative research because each has different purposes. Through qualitative research, the meanings that

individuals attribute to a situation or experience are explored rather than causal relationships (Creswell, J., 2007). Value is placed on context and individual differences rather than generalizations (Yardley, 2008). These philisophical differences have inspired some writers to define validity using different frameworks and terms (Creswell, 2007). Examples range from credibility and authenticity to paralogic validity and rhizomatic validity (see Creswell (2007) for a further explanation of various terms). Yardley (2008) states that "objectivity, reliability, and (statistical) generalizability," which are important for quantitative research validity are not appropriate for qualitative research.

There are a number of ways to ensure validity in qualitative research:

1. Triangulation – the use of different sources, methods and theories to inform the data (Creswell, 2007; Yardley, 2008).
2. Negative or disconfirming case analysis – as themes are identified from the data, the researcher analyzes the data again to identify any meanings that do not fit into the established themes (Creswell, 2007; Yardley, 2008).
3. Participant feedback – participants review the analysis and themes and provide further comments to ensure accuracy.
4. Acknowledgement of "researcher bias from the outset of the study" (Creswell, 2007, p. 208).
5. Provide rich and thick descriptions of the participants' experience. This allows readers to be able to generalize the meanings and understandings to other experiences, settings, or individuals (Creswell, 2007).

6. Peer review – "provides an external check of the research process." The peer would analyze the "methods, meanings, and interpretations" (Creswell, 2007, p. 208).

To ensure validity, Creswell (2007) recommends incorporating at least two of these methods.

Rationale

Phenomenological inquiry was chosen for this research project because it was the method by which I could explore humor in the therapeutic relationship as understood by those mental health therapists who conduct therapy on a regular basis. My interest was to hear descriptions about the participants' experiences and to discover the meanings of humor use in the therapeutic relationship as understood by these front line professionals. Qualitative research created the opportunity to discover the rich descriptions of multiple perspectives of how humor is perceived (Creswell, 2007).

Another reason phenomenology was chosen as the research method is because humor is most often spontaneous and is therefore difficult to research in a controlled manner (Ventis et al., 2001). In addition, humor is a complex construct, which has cognitive, physiological, philosophical, and psychological aspects (Dziegielewski et al., 2003). This complexity makes humor difficult to capture in quantitative research. Humor use typically has many layers and is often dependent on context for full understanding and appreciation. In order to gain a deeper understanding of the phenomenon, a qualitative research method is required (Giorgi, 2009). Humor is a part of the humanness of individuals and should be researched with this idea at the fore. To apply a reductionistic approach to humor would result in limited understanding (Giorgi). Giorgi states that in order to study such human concepts "an approach to human phenomena that respects the essential characteristics of humanness" is needed (p. 70).

Participants

Eligibility for a participant required only that the individual was currently working as a mental health therapist and was licensed or registered with the appropriate professional governing body. I posted invitations (see Appendix A) requesting participation from mental health therapists at Sheldon M. Chumir Health Centre, Calgary, Alberta. My colleague also distributed the invitation via email at the Calgary Counselling Centre, Calgary. Alberta. Two recruited participants offered to distribute the invitation via email to their colleagues. Thus, participants were also recruited through word of mouth or the "snowball" approach as described by Creswell (2007). Eight mental health therapists participated in this research project.

Data collection and Procedures

Initial contact with participants was made through email. Participants were again given the title of the project and reminded that the interview would take approximately one hour. The dates and times of the interviews were mutually agreed upon by each of the participants and myself.

Each of the interviews was conducted at the participants' work place. After initial rapport building conversation, the informed consent form (Appendix B) and the demographic information sheet (Appendix C) were completed and signed by each participant. Consent for audio recording was included on the consent form. All participants agreed to be audiotaped. The interviews followed a semi-structured, conversation style format to allow participants the freedom to contribute as many descriptions of humor use within the therapeutic relationship as possible. The interviews were guided by the research questions stated in chapter one. Supplementary questions (Appendix D) were also formulated and used as required to draw out the descriptions and meanings of participants' experiences.

The audio recordings were sent to a professional transcriptionist. Confidentiality for the participants was adhered to by the transcriptionist signing a Transcriptionist Confidentiality Agreement (Appendix E). When the transcription service was complete, the transcriptionist destroyed her copies of the audio recordings and the transcript documents.

Data Analysis

Within phenomenological research, there are a number of steps to follow for data analysis:

1. Once the interview has been transcribed, the entire description should be read again in order to gain a sense of the meaning as a whole (Moustakas, 1994).
2. The researcher reads through the transcript again, pulling out "meaning units" (Moustakas, 1994, p. 14; Giorgi & Giorgi, 2008, p. 34). Each time there is a transition in meaning, new meaning unit is indicated (Moustakas, 1994). These units may include ""significant statements," sentences, or quotes that provide an understanding of how the participants experienced the phenomenon" (Creswell, 2007, p. 61). This step is rather spontaneous and arbitrary as the rationale for identifying meaning units is to make the data more manageable Giorgi, 2009).
3. Each of these units of meaning is then grouped into different emerging themes (Creswell, 2007).
4. Further reflection on the units of meaning and the resulting themes is undertaken in order to create a description of the essence of the participant's experience and the context surrounding that experience (Creswell, 2007).

Data analysis began by comparing the completed transcripts with the corresponding audio recording to ensure accuracy of the transcripts. Any changes required were completed.

The transcripts were then read to gain a sense of the flow of the interview conversation and to begin to understand the intent and meanings of the descriptions of the participants' experiences. The transcripts were then read to identify meaning units as described by Giorgi (2009). The meaning units were then reread carefully and significant statements within each meaning unit were extracted. Notes of my initial ideas regarding meanings and themes were also included next to the significant statements. Care was taken to continue to bracket my beliefs and experiences. If a question arose regarding my beliefs or experiences on emerging themes, these thoughts were noted and the meaning unit was reread until I was certain that my beliefs and experienced did not influence initial ideas.

Next, each of the significant statements was analyzed to determine the meaning within. This meaning was noted next to the significant statement. If there was uncertainty as to the meaning of the significant statement, the transcript was reread and some instances required listening to the audio recording again in order to hear the intonation, pauses, and other verbal cues that may have contributed to the meaning.

The meanings were reread and then grouped into tentative themes. Solidifying the themes required a number of trials in order to ensure the experiences and understandings of the participants were fully represented. Finally, a thorough description of the participants' understandings of the phenomenon was developed. The voices of the participants were included through the use of many quotations. In a number of instances, selected quotations were emailed back to that participant due to ethical considerations. Once the participant approved of the use of the quotation under consideration, it was included in the description. The description was emailed to each of the participants so they would have an opportunity to provide feedback and

make clarifications if necessary. Any changes requested were included in the final description. This final description is the essence of the phenomenon researched.

This research process was not linear (Creswell, 2007). Creswell used a spiral figure to conceptualize qualitative research data analysis. There was a sense of working with the data, reflecting, taking preliminary notes, going back to the data, describing, categorizing. All the while, there was the constant checking and rechecking with the data as I moved toward a final account (Leedy & Ormrod, 2010).

Chapter 4

Findings

This chapter presents the descriptions discovered in the semi-structured interviews with the eight participants. Seven themes and five sub-themes emerged from the data. These themes are summarized in Table 1. While the themes are categorized, in reality there is overlap. Each theme and sub-theme contributes to the essence of the others and it is with this understanding that the essence of humor within the therapeutic relationship was discovered.

One of the research questions queried how humor was used by therapists and clients. Although one theme is called "Humor Use", the descriptions pertaining to this question can be found throughout all themes. The "Humor Use" theme was developed to capture experiences and descriptions that did not readily fit within the other three themes, yet these descriptions contribute to the essence of the phenomena.

Introduction to the Participants

All participants were working in the capacity of mental health therapists. The professional backgrounds were varied and included three social workers, two psychologists, one occupational therapist, one pastoral counselor, and one registered nurse. All participants were licensed with the professional licensure body of their particular field. They had been licensed from one year to 15 years. As well, participants had worked in the mental health field from one year to 15 years. Work settings included community mental health, hospital, day treatment, and the community at large. All participants worked with adults and two participants also worked with adolescents. Participants saw clients with a variety of mental health issues. These issues included relationship problems, complex PTSD, grief, trauma, depression, anxiety, eating

disorders with co-occurring mental illnesses, other Axis I disorders, and personality disorders with Borderline Personality Disorder being the most common.

Table 1

Themes and Sub-themes

Themes	*Sub-themes*
1. Humor Use	- Broadens perspectives - Mindful Use - Irreverence
2. Humor within the Relationship	- Connection - Balancing power
3. Humor as a Sign of Mental Health	
4. Communicating with Humor	
5. Humor provides balance	
6. Genuineness	
7. Therapeutic risks	

Humor Use

Participants described a number of ways that humor was used in mental health therapy. Some of these applications had a more intentional goal. At other times, the result of natural humor use may not have been recognized until the specific interaction had ended.

Humor was used as a way to normalize an experience or emotion for clients. It was a way to let clients know that everyone makes mistakes. Shannon shared an example of this:

> I would say something like 'I'm so glad you said that because that's EXACTLY what I do.' And then I'll say something like 'yeah, so many times I'll have safe places and then I can't remember where the safe places are.' And then we laugh about how we're getting old together.

Marci also used humor to normalize clients' experiences. She stated, "It's [humor's] also to normalize things for clients; that it's okay to mess up or it's okay to make a mistake."

There were also times when the participants did not intend for a comment to be funny, but it was perceived as such. Stacey shared this experience:

> If you take them very literally and ask if that's what they really mean, they'll end up laughing because when somebody else does it, it kind of sounds… however it sounds. So, sometimes that ends up being humorous, getting them laughing….A particular client came in saying that they didn't have anything left to live for, that they just wanted to die. And so as we were talking; to kind of get an idea of her train of thought throughout the session, [Stacey said] 'okay, so then this happens and then, you know, this might happen. So then you went [out] and then the next thing that happened was you needed to die. And so in me saying that she started laughing and said, 'hearing you say that just kind of really sounds ridiculous.' So initially it wasn't intended as humor, but it was received as humorous. So then it was used throughout.

This experience occurred in the first session and provided Stacey with some valuable information. She explained, "That kind of actually showed me that the relationship is developing…I think it tells me that she's able to be attentive in the sessions and she could actually hear it for what it was and she was actually very present."

Katherine also shared a story when a comment was made that was not intended to be humorous, but when it was said it accidentally came out in a humorous way:

> [I] accidentally, in a sentence…I accidentally said the word stealing, like a Freudian slip, like instead of saying you're going to get more comfortable or something…it was just a wrong word and all we could do was laugh. [The client] too sort of made light of a few things as [the client] was realizing that [the client] could overcome this, [the client] started to joke about it a bit more.

Katherine sums up this experience by saying, "A good joke is not to be wasted even if it's at your own expense."

When a client shared a humorous story with Garrett, he incorporated it into future sessions as a way to refocus on the goals of therapy:

> I would re-use that story a few different times in our time together, which would kind of make us both laugh again after maybe a little bit of tension or something - not the tension between us. But, if I was finding it was getting harder for him to think things through or something like that, I'd use those funny stories…to help him get back on track with his thoughts about [the issue].

When a client uses humor, it may be appropriate to explore the humor further. It is a way to gain a greater understanding of the client. "If they crack a joke in the middle of something really serious when they really probably shouldn't be joking, I'll definitely ask them about what that was about and go back to the serious spot with them."

Humor was also used as a way to ease the delivery of a comment or suggestion that needed to be stated. Shannon explained it as "a gentle way to mirror back discrepancies." Christine also touched on this use of humor:

> Just saying it in a lighter way, a humorous way, they kind of smile or laugh or just [say] 'sure, yeah, right.' That bit of laugh helps them to say yeah, you're right or yeah, and I'm sorry about that. [It makes it easier] for them to accept that's something that I need to say. But if I just go dead on, without humor then, the defense just goes right up.

When first meeting clients, participants may have used humor as a way to invite clients to join in on experiencing lighter, more positive emotions. It was also used to communicate that it is acceptable for humor to occur in the therapy session: "My reasons at the beginning will be to have them experience a bit of enjoyment, and that this doesn't have to be incredibly heavy to be work." "I think there's been times where clients have been surprised that there's been laughing, which I find not necessarily a bad thing 'cause we also do a lot of work."

When humor was used by a therapist "it models… a flexible way to live. A shift...for them to learn to move faster and change position faster. That's what the humor does, or one thing it does." This means using humor is a way a therapist can model how to view something differently or how a person is able to refocus when a problem occurs.

One participant emphasized that her course of action regarding humor was to always wait for clients to invite her to join with them in sharing humor and laughter. She stated that she never initiated humor use regardless of whether the therapeutic relationship was developing or whether it was a more established relationship. She waited for the client to use humor first in each session:

> Normally, I wouldn't start off anything humorous. I'd wait for my client to choose that it's okay to laugh and they would laugh first. Where they think it's funny themselves and then invite me to laugh along with them. They have to be the ones to initiate it and to cue me [that] it's okay. Even the ones who I've been seeing for awhile; I still wait for them

> to initiate it. [The client is] laughing because this is funny and you can join along with me kind of thing. Because some of the clients are still very vulnerable.

Irreverence. Three of the participants spoke of irreverence as framed within Dialectical Behavior Therapy. Humor used in this way was applied more strategically. These participants used irreverence with intention. "It's done with the specific intent to knock them out of their rut of what they're in." "[Irreverence] shake's them off their train of thought that they're going on. Sometimes it's used kind of strategically. It actually takes thought and you just can't do it whenever." When clients seemed to be rigidly focused on the problem and seemed unable to move forward toward the therapy goals, irreverence was a way to get their attention and cause them to stop perseverating on the problem. Christine described it as "actually puts things directly in their face."

It was acknowledged that irreverence is not always funny, but it could be perceived or intended that way. Care was taken when these participants used irreverence. Timing and intention were carefully considered as irreverence could be perceived as mocking or sarcasm. Katherine put it this way:

> I'm going to be irreverent here with this client but I'm going to do it in a relaxed way and then it lands better – intentional…So, it's partly done intentionally for the shock. It's also done [to suggest] it's a possibility. If it lands right, they'll actually stop and look at you but they won't be ashamed or disconnected. It's quite technical the way they lay it out actually.

Katherine also provided an example of the use of irreverence:

> So he's worried that from his crimes he's going to end up in jail and then he's mad at you for always bringing up his habits. Yet he wants you to help him. So one time in the

> middle of his ramblings all over the place about what do I do to stop this…[Katherine then stated] 'Well, I mean jail might be kind of fun!'

Broadens perspectives. Another use of humor identified from the data was that humor often opens up new ideas or new perspectives for the client. It may lighten the mood, which then opens up possibilities for the client, who may be constricted by the problem. On two different occasions during the interview, Stacey succinctly described a broadening of clients' perspectives: "It lightens the mood of it [issue] and then they can kind of work through whatever it is that they were bound and determined on thinking and to see it kind of in a different light." "[Humor can] just kind of helps them take a couple of steps back so they can see the situation rather than being so close that they can't see." Christine was also aware of humor's capacity to create new ideas: "So the really big insight often comes after like we laugh about something." Garrett experienced humor opening up new possibilities and ways for him to work with his clients: "Well it helps me from the point I guess that I have a few extra avenues now to you know to approach [the client] with." In this context, it seemed that humor not only broadens the perspective for clients, but it can also broaden therapists' perspectives.

Some of the participants facilitated psychoeducational groups and found humor also allowed clients to process the information in an easy manner. "Even in groups and stuff, I always think that the groups that are lighter – that they're able to joke or laugh or use humor - that it relaxes them enough so that they can hear more information." Just as it does within individual work, humor also created a space for new ideas to emerge. Garrett described his experience:

> Someone will make a funny comment or we're watching a video say, and we all laugh about a situation and it just...a new idea is opened about [the topic] that nobody even

> considered. Especially from the point of view that people usually think of it as more of a serious thing, and soon as you hear the word serious, they think it's hard – too hard to deal with or understand. But as soon as you put some humor around that hard concept, all of a sudden it seems much easier to understand and deal with.

Mindful use. All of the participants spoke about humor occurring spontaneously within sessions. With the exception of irreverence, humor was not considered a technique to be employed. Humor was seen as a part of the therapeutic relationship and the conversations that took place in therapy sessions. While humor was spontaneous, participants recognized the need to be mindful of the humor they used in therapy because of the uniqueness of the therapeutic relationship and the potential detrimental effects. Katherine emphasized that she does "a little check at the door before it [humor] comes out." Christine compared the humor she used in everyday life in her relationship with friends to the humor she used within the therapeutic relationship: "In the session, I'm more purposeful. So it's a bit different from just totally being myself. It is a part of repertoire I have as a therapist because I'm inclined to it. She also acknowledged the fact that it can be both spontaneous and mindful: "It feels like I'm doing it almost like it's just naturally, but there's a lot of thought [that] go[es] into it."

Participants also recognized the need to know their clients and were aware of how clients are feeling the day of their session. Marci commented that "it's knowing what your relationship can handle" and Amanda was cognizant that:

> Some people come here with a very heavy heart and are very serious about things and so I'm gonna try to meet them there. I'm not gonna throw in humor when I'm tuned into them or where they would be at.

Christine emphasized that humor must be for the benefit of the client: "So the humor all has to be in service of...are they getting closer to solving their problems and living differently."

Marci was aware of humor's impact on the relationship, yet she found the humor that she used in therapy was not as intentional as other interventions used: "Everything else you're quite intentional about, but your own humor you're not necessarily that intentional."

Humor within the Therapeutic Relationship

Different phrases were used by participants as they described how they viewed the therapeutic relationship as they explained their thoughts. These phrases included:

- Having a relationship
- A developing relationship
- Building a relationship
- Established relationship
- Tentative relationship
- A built relationship
- Knowing someone longer

These phrases implied the passage of time from when the therapist and client first meet to when they have met a number of times. These phrases also suggested that the therapeutic relationship is not static, but changes over time. It was suggested that the therapist and client learn more about each other with the passage of time. The use of humor was used differently at different stages of the relationship. When the relationship had a solid foundation, humor could be used in more ways. Christine stated, "I can use humor about more serious things." Stacey elaborated:

> Well, I think you can use it more. And then the clients kind of bring it in and the clients get used to, you know, if there's some quirkiness or [they state] 'I know what you're gonna say.' [That] kind of thing. I mean sometimes you can use humor just with kind of a facial expression right and they actually [have to] know you well enough to know what your facial expressions are.

She continued to elaborate:

> As you get more and more comfortable with a client and the client gets more comfortable, I think it gives you more freedom to use humor either more frequently or in ways you haven't tried it before.

Stacey also found that if the relationship is established there is more knowledge about the client and more shared experiences, which gives both individuals more content to use. "Well, I think the longer you know somebody the more you have to draw on."

Before the relationship is established, participants were cautious in their use of humor. Concern for how it would be received by the client was paramount. "I can't use too much [humor] until I establish relationship without worrying about a client taking it as offensive or criticism." "Absolutely, you have to have the relationship. The relationship has to be in place or it's not received as humor at all." "People don't know how to take humor if they don't have a relationship with you because they don't know where it's coming from."

Shannon viewed this concept as safety for the client. Limiting humor use at the beginning stages of the therapeutic relationship allowed the client time to develop trust and feel respected:

> The relationship needs to be built before you can safely use humor. So, I often find humor certainly occurs as a result of the comfort that we build with each other. Some safety so the client knows that I like her or I respect her – I mean her no harm.

Katherine also spoke directly about safety. She has come to understand that if clients begin to use humor in the therapeutic relationship, they are feeling safer in the relationship and in life:

> If people are wanting to play, it means they feel safe. If we think of humor as being a form of play…'cause a lot of kids grow up never playing because it was never safe. And so, if as an adult, they start to want to giggle or laugh or play by using humor or being a little goofy, it shows that they're finally experiencing what safety feels like.

Marci was concerned about therapeutic relationship itself: "If we have a really tentative relationship, even though therapeutically I think we could work well together, humor isn't appropriate."

Four participants spoke of humor in a cultural context. "If I were to broaden humor, I would say humor is very contextual within the crucible of relationship - language, culture…. What's funny for you is certainly not funny for me because maybe I've never been exposed to that." Dawn counsels people from her own culture and she this sharing of culture added another dimension to the humor used in the therapeutic relationship. "There's cultural humor that clients and I share. I can understand them more at a culture level, I guess. A deeper level because we would kind of have similar experiences." When I asked, "In your culture, how much is humor valued in general?" She answered, "It's right up there. If we didn't have a healthy dose of humor I don't think we'd have made it this far."

Some participants acknowledged that some clients have a more serious personality and may not have an affinity for humor: "I also think part of humor is also recognizing that some people are serious. They don't enjoy humor and that just as much. We haven't really talked about that. But that's just as much a part of the spectrum."

Connection. Connection was placed as a sub-theme within the Humor in the Relationship theme because it is inextricably tied to the therapeutic relationship. A connection may be the beginnings of a relationship and plays a part in deciding if a continued relationship is warranted. A connection may also be present within a more established relationship. A specific experience may create a stronger connection. Participants spoke of humor within both of these contexts. Katherine explained this as she was discussing the meaning of clients' humor to her: "You know, reading - is it the kind of joking that's wanting to be connected or is it the kind of joking that IS being connected." Shannon actually spoke of humor being "a human exchange of connection." Marci saw humor as a way to connect that spoke to the humanness of humor: "It's (humor's) more of a human connection than a therapist/client connection."

Humor was used to develop a rapport with clients, to create a connection. "I think I use humor most in building a relationship." "It did open the doors more for further counseling. So that's a good thing for sure." Two participants, who worked with adolescents, believed that humor is often drawn upon to begin the therapeutic relationship. Participants also recognized that it is not only therapists who use humor to connect. Clients also used it as a way to engage.

Amanda spoke of an experience of shared humor and laughter when she and the client already had an established relationship. After the experience, the relationship developed even further:

> It felt like a connection and I felt like we're in this together a little bit and that we actually enjoyed each other's company in that moment. It felt like a true enjoyment and enjoyed each other….We were able to work together a lot more closely on certain issues and it built up the trust more between us.

Balancing power. A number of participants saw humor as a way to reduce the power imbalance felt within the therapeutic relationship because of the roles of professional and client. The participants recognized the power they could have within the relationship, but prefer to have, and strive to create a relationship of equality. Shannon described this succinctly: "It [humor] reduces that imbalance of power…So, it's a way to reduce that idea that I'm the expert and they are the client who you know, for whom I'm going to do things or fix it."

Humor is seen as a human quality and when it was experienced participants within the therapeutic relationship, they saw themselves as appearing more human to the client. "I think she was a person that was really attached to the mental illness label and all of that too….The power, maybe the power thing....I was not the expert person. I was sort of human like her."

> Christine described this experience as creating a sense of informality for the client: Especially if a person…is very anxious. I want to loosen it so I want to make it a little bit funny so they can feel relaxed and they can feel that I'm not here to question them or examine them or judge them…so to create a sense of informality.

Humor as a Sign of Mental Health

When clients were able to share humor and share in humor and laughter, they demonstrated healing and movement toward mental health. Amanda saw humor as a way to move from the problem and the heaviness associated with it. She stated, "It's kind of the

opposite side of the hard stuff, that yucky, yucky stuff that sometimes we have to fall into or the heaviness or the heartbreak stuff. You can kind of go into the sort of healing side."

Katherine told of a success experience she had with a client and how humor emerged from this success:

> She had this success experience and then she was, I think, a lot more – 'hey, I might be able to be normal.' She was just more relaxed and then jokes kind of came…. Healthy people use humor. So, if I'm enjoying myself, then there's something normal about me.

Humor use was a way for clients to say that there was more to who they were as people other than just as individuals with a problem or mental illness. Marci saw this in a very real way with one client:

> [A client] would come in with jokes on paper or would tell me jokes and it was important for [the client] to do that and it was constant. It was something that I saw as important 'cause it was a piece of [the client's] identity that connected as good and healthy. 'Cause there's so many other parts, there's so much shame and 'I'm not a good person' that this part of, that's what [the client] did really well, that I can make people laugh.

Katherine also saw humor as one characteristic of clients, which demonstrated a healthier side. She would remind clients of this characteristic that she observed in them:

> You're just kind of going - hey, you're cool and what you say is funny and you have pain and we're gonna deal with that and you have the strong, confident funny part and that's big too. You're not just a blob of sickness sitting here.

Amanda viewed humor as a sign of resilience. Clients would experience horrific trauma and yet be able to find humor. It symbolized strength and was something they could draw upon

in distressing times. She also recognized the grave nature of those who were unable to see humor:

> I see it [humor] as a sign of extreme strength and resilience that they got through like horrendous things you know. It's quite amazing…. I just see it as such a sign of overcoming, overcoming and dealing with difficulties and really awful things that people experience. It's quite amazing actually that people keep their humor… So I think it's really indicative if you've gone beyond humor, then it's not good you know. Like humor is so necessary.

When clients used humor in sessions, Dawn saw it as a sign of hope and that these clients were working at and succeeding at avoiding becoming overwhelmed by the problem:

> I noticed in my clients that physically they look a little bit lighter. They're not carrying a big bag of burden – that's what I call it. And they look a little bit lighter and you know it's just - it would exude hope, the conversation at the end. It would just be like there's hope you know. They do see a light at their, at the end of the tunnel kind of thing. And you know they're really trying to not be so lost in the problem. Not to be controlled by the problem.

Communicating with Humor

Humor communicates messages. Included in this theme are descriptions of the messages it may be used to communicate and the reasons humor was chosen or used as a method to communicate a message. Within every theme in this analysis, humor was used to communicate. This theme emerged as a way to present some of the messages that emerged from the data.

Humor was a way for people to communicate a feeling of discomfort or anxiety. "I'm thinking it's a natural response when we're uncomfortable - for some of us -for both therapist and client."

Humor was a way for clients to let the therapist know that they were not ready to take on a certain aspect of the problem. "For clients, it's probably a way of letting [therapists] know that [they're] not ready for that without being able to say that."

When the therapist used humor at the beginning it may have been an invitation to clients to use humor if they wanted. "At the beginning, I want to say your humor is welcome here."

It was used by participants to communicate a strong request or suggestion. "Sometimes it [humor] is just really direct way to convey that you – I don't want you to do certain things."

Finally, "it's [humor] really trying to communicate acceptance and co-humanity."

Many of the participants recognized that part of communicating with humor and understanding someone else's humor included body language, intonation, pitch, and facial expression. By using these characteristics in a humorous way with the words, there was a greater likelihood that the message was received as humorous. "Definitely tone, body language, um – that's because they're so perceptive to anything. That's huge – using a tone that's kind of light hearted." "It's never just the language, it's also the intonation of the way you said something you know, a particular pitch you use."

As a way to understand what clients are trying to communicate through humor, Katherine observed their body language and breathing:

> If their breathing is kind of shallow and tense and they're joking, I'm gonna be far more likely to take what they're saying seriously and kind of bypass their joking or kind of go….'yeah, that might be funny and I wonder if there's some truth to that.' But, if

> they're really kind of breathing deeply and feeling settled and joking, then I'll join with them.

Humor Provides Balance

A prominent theme throughout the interviews described humor as a way that therapists and clients balanced the intensity and seriousness of mental health therapy with a lighter mood or atmosphere. Christine described it this way:

> I think it is a neat way to convey that it is a serious issue. However, it doesn't cause unnecessary heaviness. So what I think is, often what ends up happening is the talking about it or discussing it - it's making it heavier than it is, right The humor is kind of like at the other end. Pulling, pulling to the other end.

Therapists witnessed clients using humor to offset heavy emotions, such as sadness, loneliness, despair, and depression. Whether this use of humor was seen as a positive occurrence in therapy or not depended on the client and the goals of therapy. Marci spoke of one client who used humor in this way:

> He would get to the point where he'd cry actually a few tears and it was probably about something that had happened in his life – and I think it would get to the point when he couldn't stand that emotion any more, he would crack a joke. And I kind of let that happen because I knew that this is a person that's never really talked about any of these things in his life.

Dawn had a similar experience:

> It kind of creates a balance because this individual comes in with a very heavy story, very heavy problem. I think when this person brings in the, the humor part…he's trying to

balance it out and trying to make it where 'yes, I have this big issue but I can make light of it this.

Stacey viewed client use of humor in this way positively because it was a sign for her that clients were able to experience emotions other than the heavy ones:

> They're able to kind of let you see another side. And they're also seeing another side. Everything isn't so dire or negative or you know. They are able to let some of those other emotions in that aren't all…..sadness, depression and fear, anger. It definitely lightens anger.

A number of participants suggested that by balancing the heaviness and seriousness of a session with lightness actually moved the therapeutic work to a deeper level. "If they're using kind of a light, easy manner, sometimes [it] helps to be able to do the really tough stuff or talk about it." "I think you need humor sometimes during the counseling time to keep things serious almost." "Using humor helps you take people more seriously."

Christine believed viewing the problem with a sense of balance so important that she would explain the concept to clients in this way:

> I often teach that, your stance [on the problem is like this]. So, if you hold your pen, you don't want to hold too tight. This is getting too serious. But you don't want to loosen it too much so that the pen falls. You just want to learn how to put that just a little bit of pressure enough, right? When people deal with the problem [they] tend to be this tight [she demonstrated by gripping the pen in an overly tight manner]. It [humor] is a way to loosen it and so that they can learn how to put the appropriate pressure on the problem.

Some participants described how a lighter touch in therapy sessions was actually more effective than maintaining a serious atmosphere throughout the session. "I can still have a bit of

a lighter touch on it…which actually I think makes you more effective than grinding away with them at their problem." "It's [humor] useful and since they are in a very dark and uh lonely place…actually getting serious and trying to shake them doesn't work."

Humor used to balance heavy emotions can be viewed as a time for clients to breathe or to feel a sense of relief. "If you just trigger negative emotion after negative emotion without giving client an opportunity to switch over, they don't have relief." Another participant stated, "Sometimes humor is needed in a counseling session for tension relief."

As an individual session neared completion, participants found it important to ensure clients were not carrying intense emotions when they left for the day. Stacey stated:

> I just see it as having a very beneficial place in therapy especially since everything is so serious and it triggers a lot of negative emotions. So, I think being able to counter that sometimes, especially in a session where it's really serious, it's actually important to be able to send them on their way, for them to kind of balance out the stuff, otherwise you're just leaving them in a kind of gloom.

Amanda stated:

> Sometimes at the end, after an intense kind of heavier talk or you know like where you're discussing heavy stuff. Sometimes I find that when humor is used or happens, humor seems to happen it sort of shifts, it kind of is like kind of balances it so they're not walking out with all those say deep emotions right at the surface. I think it's one way of kind of containing the experience actually. "

Dawn saw this use of humor as a way to bring in hope at the end of a session:

> I noticed in my clients that physically they look a little bit lighter, you know what I mean? They're not carrying a big bag of burden – that's what I call it. And they look a

> little bit lighter and you know it would exude hope, the conversation, at the end, like it would just be like there's hope.

Genuineness

Many of the participants felt humor was a part of their character, a part of who they are as people. They truly appreciate it. By using humor in therapy sessions, it brought a genuine part of who they are to the therapeutic relationship. It naturally occurs in everyday life and it naturally occurs in their role as mental health therapists.

Amanda stated, "It's just part of who I am and I can't hide that and I don't want to hide that because then I wouldn't be being myself."

Garrett stated, "This is who I am and I believe it's a good thing in that respect but I can't be somebody I'm not. And I love humor…and so it'll come out whether I try or not."

Marci stated, "It's not something I use as a psychologist. It's something that a natural part of my personality that I would use to connect with people….It is a genuine piece of me."

Christine stated, "It's more like bringing my own self. I'm like this. I like humor as a person… So it's part of my repertoire as a human being."

Therapeutic Risks

Every participant spoke of the possibility that humor may be detrimental to therapy or the therapeutic relationship. For some participants, humor they have used may not have been beneficial to the client because it was ill timed, misunderstood or should not have been said. All participants were concerned about the possibility of clients' seeing therapist humor as mocking or not taking their problems seriously. Rob related his experience:

> Bad timing would be there, but it probably didn't even need to be said at all. I was hearing something from the client that I thought I could respond back with a maybe a

> satirical joke or something like that. I can think of a couple of times it just died you know. Other times [the client asks] 'what do you mean by that?' You know that kind of a response. So then I'd have to explain myself which always kills the joke when you have to explain it and then realized that it wasn't the best thing to say anyway.

Other participants spoke of humor that had "bombed". They emphasized that if this happened the best course of action was to apologize directly rather than overlooking the fact that the humor was not well placed:

> If it falls flat, if you've bombed, then you just apologize. Actually, let them know that was intended to be a joke and you just come clean – absolutely. Well, I think what they see is you modeling that you can mess up. You can apologize, you can come clean, you can kind of just say, no, that was actually meant to be a joke. I think that does more for the relationship than if you just kind of brush it off.

Participants have witnessed humor reducing the intensity of sessions. This use of humor could have been either beneficial (if it served as a balance) or be detrimental to the work the client needed to do. It was dependent on the client, the session, and the work being done. The only way to truly know was through the therapeutic relationship. Marci spoke of a client who used it as emotional tolerance, but she also knew clients who needed to stay with the uncomfortable feelings being brought to the surface. She referred to this as avoidance:

> Some people use humor as an avoidance tactic. I find that humor comes up the most from the client end when they are talking about something really sensitive and really emotional. There's some embarrassment around what they are talking about or they don't quite feel comfortable with those emotions that are coming out, so they might make a joke.

Marci also acknowledged that she had likely used humor in a similar manner: "I'm sure as a therapist I've used it to lighten the intensity and that's not always a good thing." When the intensity was lightened, it was possible that the session could not return to the seriousness that was necessary. "I think it [humor] derails it [the session] sometimes." A therapist can also derail a session. Katherine explained it this way: "If you, for a second, depersonalize and just go, 'oh, that's a funny way that they phrased it', you might just sort of have a little chuckle and it disrupts their process."

> Marci described how one of her clients used humor to mask her true feelings: Sometimes it's an avoidance. What did my one client say 'cause she does it a lot in sessions, but she's feeling absolutely horrible and smiling and laughing on the outside and recognizes that this isn't normal and it's not good and she walks around showing the world that it's okay and people aren't believing her. She knows that. But she also says it's just, it's kind of her wall, her protection I think. If I can walk around and be above me and joke and, then no one knows that, no one will ask me what's really going on.

Summary

For these mental health therapists, humor naturally occurred in the therapeutic relationship. In some cases, it was used intentionally with a specific goal in mind. At other times, it was shared spontaneously as the therapeutic conversation flowed. The participants were mindful of how they used humor and the effect it would have for the client. Clients were always the primary concern. Misunderstandings may have arose, however. If a client misinterpreted or felt offended by therapist usage of humor, participants agreed that the best course of action was to apologize directly, to "come clean."

Clients also utilized humor within the therapeutic relationship. Their humor use could be interpreted in a number of ways. Participants recognized that clients may use it to avoid discussing a sensitive topic or to mask difficult emotions. Humor was also utilized as a means to regulate emotions. It was a way to balance difficult, intense emotions brought up in therapy sessions. In a similar manner, participants may have shared humor as a way to assist clients in feeling more positive emotions or to lighten the heaviness of a session. This use could be construed as opening a time to breathe or bringing relief.

The need for an established therapeutic relationship was vital for the participants' utilization of humor. A stable relationship meant there was greater understanding between therapists and clients, which reduced the possibility that humorous comments would be misconstrued. Humor was used as the therapeutic relationship was developing as a way for both therapists and clients to connect and build rapport. Humor used for this purpose was offered tentatively and cautiously.

When the therapeutic relationship was established, it allowed therapists to use humor in different ways. Humor could broaden clients' perspectives on the problem. It was a way to help clients shift their focus, to create movement toward their therapeutic goal, and to help them become "unstuck". Participants also used humor as a way to equalize power within the therapeutic relationship. Participants valued equality in the relationship and humor was a way for the therapists to humanize themselves.

Some therapists believed humor made them appear more human to clients because it was an integral piece of some of the participants' personalities. By using humor, they brought genuineness to the relationship. Clients also used humor in such a manner. By using humor,

clients disclosed a healthy piece of their identity. Humor use by clients demonstrated that there was more to them than just the problem or illness.

Shannon aptly encapsulated the essence of the phenomenon of humor within the therapeutic relationship. She said, “I think humor is a much, much richer concept and experience than what we give it credit for.”

Chapter 5

Discussion

This research project explored humor in the therapeutic relationship as it pertained to three research questions. These questions were:

- How do mental health therapists understand humor within the therapeutic relationship?
- What are ways in which humor is perceived as therapeutic or not therapeutic?
- How is humor used by both the therapist and the client within the therapeutic relationship?

In actuality, the findings merge together to answer the research questions simultaneously. A specific finding cannot be assigned to a specific question. One description by a participant generally had aspects that answered each question. This result spoke to the richness and meaningfulness of the participants' experiences and descriptions.

Participants interviewed

Eight participants were interviewed for this research project. All participants worked within the role of mental health therapists and were licensed by the appropriate professional licensure body. These participants worked with a range of client problems, including most Axis I and Axis II disorders, giving the participants different contexts in which to experience humor in the therapeutic relationship.

Summary of results

Humor as a phenomenon within the context of the therapeutic relationship occurred naturally and spontaneously during therapeutic conversations. A number of participants felt the humor they used was a genuine part of their personality, which they shared with clients. They believed this made them appear more human to clients rather than as an expert mental health

therapist. These understandings by the participants aligned with the literature. Martin (2007) recommended humor use be genuine. Borcherdt (2002) also discussed the role humor plays in equalizing the therapeutic relationship. He suggested humor use by therapists reduces the perspective that they are experts who fix client problems. Rather, humor use suggested a collaborative relationship with both parties participating equally.

Humor was also seen as a part of some clients' identities. It signified resilience and mastery of the problem. Their humor use also demonstrated a healthy aspect of their being. Participants saw this use of humor as a sign that these clients were not completely overwhelmed by the problem.

Humor use by clients signified their healing or movement toward greater mental health. One participant felt humor use by clients "exuded hope". This statement aligned with research by Vilaythong, et al. (2003). While the literature review in this thesis did not discuss humor and mental health generally, an extensive review can be found in Martin (2007). In his conclusion to the literature review, Martin states, "a healthy sense of humor is an important component of overall mental health" (p. 306).

Participants also witnessed clients using humor for emotional regulation. Humor served as a balance counteracting the difficult or intense emotions often felt in mental health therapy. This use was generally seen as positve, but participants also stated humor could be used to mask or avoid such emotional intensity. Participants also utilized humor as a way to balance the heavy, serious mood of therapy sessions with a lighter tone. This usage could be viewed as providing relief or allowing a time to breathe. As well as providing relief, balancing the heaviness in a session with humor afforded the opportunity for clients to experience positive emotions.

Another predominant theme discovered from the study related to humor and the therapeutic relationship itself. Participants agreed that a strong therapeutic relationship was necessary if humor was to be used in any way other than very tentatively. Humor was used tentatively at the beginning stages of the relationship as a means of establishing a connection. Martens (2004) and Goldin et al., (2006) respectively discussed creating a bond and rapport development.

Participants did not use any of the "humor therapies" described in the literature review. The only specific humor technique discussed by participants was irreverence. The three participants who used irreverence employed it strategically, but naturally as a way to create movement in therapy sessions or as it was aptly described "move them out of the rut they're in."

Most of the humor used by participants could be categorized as a communication skill, which is explained by Martin (2007). Humor was a way to communicate discrepencies and suggestions in a way that would be more readily accepted by clients. Shared humor by the therapist and client brought forth new ideas or perspectives about the problem. Martin (2007) refered to this use as "gain[ing] insight and alternative perspectives" (p. 343).

One topic discovered in this research, which was not addressed in the literature regarding humor in the therapeutic relationship, was the role of cultural humor in the relationship. One participant stated that humor used with clients in this way moved the relationship to a deeper, cultural level. It suggested a deeper bond and understanding.

Both participants and the liturature discussed potential dangers of using humor in therapy sessions. A primary concern voiced was the possibility that clients would misconstue therapists' use of humor as mockery. There was also the concern that clients would feel therapists were not

taking their problems or issues seriously. Humor could be a way for clients to avoid the primary issue or intense emotions that need to be expressed.

Implications of the study

This study allowed the voices of individuals working on the front lines of mental health therapy to be heard. They shared their experiences of humor occuring in therapy sessions and their understandings of humor contributes to the liturature. Mental health therapists need to participate in more conversations about humor in the therapeutic relationship in order to expand therapists' understandings of this phenomenon. This study creates an opening for those converations to begin.

Strengths and limitations

This research project had a number of strengths. Five different programs were represented in this study. Thus, the participants had worked with clients who were dealing with a range of mental health issues and illnesses, making their collective experience extensive.

This study also included participants with different professional backgrounds and education working in the role as mental health therapist. Therefore, this study allowed a number of different voices to be heard.

I used a number of different methods to increase the validity of this study.

1. Comprehensive descriptions of the participants' experiences were presented in the analysis. Numerous participant quotations were used to ensure that the reader had the opportunity to hear their voices.
2. Transcripts and the analysis report, including themes were emailed to the participants with a request for their feedback. In this way, the accuracy of the analysis was increased.

3. I presented the worldview I held for this research project. This transparency gives the reader a clearer understanding of how the data and analysis were approached.
4. The data was checked and rechecked to ensure the themes encompassed all meanings discovered in the data.
5. Bracketing was undertaken prior to and during the research project.

Limitations of this research project include the following:

1. Female participants outnumbered male participants by a ratio of 7:1. Therefore the understandings from male mental health therapists were under represented.
2. This study explored humor in the therapeutic relationship, yet only the voices of therapists were heard. Participants spoke respectfully about clients, honoring their experiences, but the voices of the clients were not directly represented.
3. The sample size was relatively small.
4. Although I endeavored to bracket prior knowledge and experiences, it is possible this knowledge and these experiences had a bearing upon the results.

Future research

From this research project, a number of future areas of research emerged. A qualitative research project which would explore the meanings that clients have come to understand through experiencing humor in mental health therapy would give clients a voice on this topic. If approached from a social constructivist worldview, with the understanding that clients are the experts in their own lives, this type of research would open client understandings to mental health therapists.

Research exploring the role cultural humor has within the therapeutic relationship would be very beneficial and lend knowledge to the ever expanding multicultural theories and therapy.

It would be valuable to understand the significance and perceptions of humor for different cultures. Research could be endless on this interesting topic. Two questions that arose for me are: (a) If client and therapist were from the same culture, how does this affect the use of humor? (b) If client and therapist are from different cultures, how does this affect the use of humor?

Closing remarks

Humor is a social lubricant. It occurs naturally and spontaneously in many human interactions, so it is not surprising that it occurs within the therapeutic relationship as well. This study explored this phenomenon and discovered many understandings and meanings, many which point to positiveness, mental health, and connection. Humor shifts the focus from the problem to strengths and solutions and therefore fits nicely into a strengths-based practice.

Some of the participants admitted that they had not considered the role humor has and can have in mental health therapy. One of the goals of this project was to encourage thoughtful exploration of this phenomenon by mental health therapists working daily with clients. This study is generalizable in the sense that readers can use the information to consider how they use humor. Some of the meanings may fit for them and others may not. This project may persuade therapists to begin to consider their own meanings and understandings of humor within the therapeutic relationship. In turn, this could lead to a more mindful use of humor, which can only benefit clients. As one participant stated:

"I think that laughing you know, experiencing joy, having a sense of positive emotions that come with humor – I think [that] can't not benefit anybody."

Appendix A

HUMOUR
IN THERAPY

Participants, who work as mental health therapists, are needed for a Prescott College, Arizona research study exploring humour in the therapeutic relationship.

You are invited to participate if you:

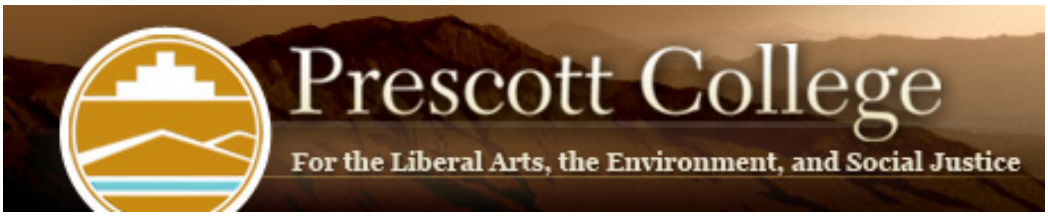
- Currently work as a mental health therapist
- Are registered/licensed with the appropriate professional association. E.g. College of Alberta Psychologists, Alberta College of Social Workers.

This is a qualitative research study exploring mental health therapists' experiences and understandings of humour within the therapeutic relationship. The researcher is looking for volunteers who would be willing to participate in open-ended, in-depth interviews of approximately one hour in length.

All information provided by participants will be kept confidential.

If you are interested in participating or would like more information, please contact:

Rhonda Wolf-Wasylowich
403-556-9270
rwolfwasylowich@prescott.edu



Appendix B

Informed Consent

Humor within the Therapeutic Relationship:
Mental Health Therapists' Experiences and Understandings

Introduction
You are being invited to take part in a research study. The information in this form is provided to help you decide whether or not to take part. The Principal Investigator, Rhonda Wolf-Wasylowich, will be available to answer your questions and provide additional information. If you decide to take part in the study, you will be asked to sign this consent form. A copy of this form will be given to you.

What is the purpose of this research study?
This qualitative research study will explore the phenomena of humour within the therapeutic relationship. The purpose is to understand the experiences of participants and the meanings they attribute to those experiences. An analysis of all interviews will be conducted to discover common themes.

Why are you being asked to participate?
You are being invited because the experiences you have had as a mental health therapist are a valuable source of knowledge. The meaning and understandings that you have discovered can contribute to our profession's understanding of humor within the therapeutic relationship.

How many people will be asked to participate in this study?
Approximately 6-10 persons will be asked to participate in this study.

What will happen during this study?
This qualitative study will use open-ended interviews to gather data regarding the stated topic. During the interview, you will be encouraged to share your experiences and your understanding of the experiences. After the interview is completed, the Principal Investigator will analyze the data to discover common themes among all participants. Should you choose to do so, you will have the opportunity to review the transcript of your interview and the final results.

How long will I be in this study?
About 1 hour of time will be needed to complete this study.

Are there any risks to me?
The things that you will be doing have no apparent risks. Although the Principal Investigator has tried to avoid risks, you may feel that some questions asked will be stressful or upsetting. If this occurs you can stop participating immediately. The Principal Investigator can give you information about individuals who may be able to help you with these problems.

Are there any benefits to me?

While you may not receive any direct benefit from taking part in this study, the findings from this study may contribute to the growing interest and knowledge of humour use within mental health therapy.

Will there be any costs to me?

Aside from your time, there are no perceived costs for taking part in the study. If necessary, you will be compensated for travel.

Will video or audio recordings be made of me during the study?

The Principal Investigator will make an audio recording during the study so that the Principal Investigator can be certain that your responses are recorded accurately only if you check the box below:

☐ I give my permission for audio recordings to be made of me during my participation in this research study.

Will the information that is obtained from me be kept confidential?

The only person who will know that you participated in this study will be the Principal Investigator. Your records will be confidential. You will not be identified in any reports or publications resulting from the study.

May I change my mind about participating?

Your participation in this study is voluntary. You may decide to not begin or to stop the study at any time. Also, any new information discovered about the research will be provided to you. This information could affect your willingness to continue your participation.

Whom can I contact for additional information?

You can obtain further information about the research or voice concerns or complaints about the research by calling the Principal Investigator, Rhonda Wolf-Wasylowich, at (403)556-9270. If you have questions concerning your rights as a research participant, have general questions, concerns or complaints or would like to give input about the research and cannot reach the researcher, or want to talk to someone other than the researcher, you may call Paul Smith, Thesis Committee Faculty for this study at 877-350-2100 ext. 2250. If you would like to contact Paul Smith by email, please use the following email address: psmith@prescott.edu.

Your Signature

By signing this form, I affirm that I have read the information contained in the form, that the study has been explained to me, that my questions have been answered and that I agree to take part in this study. I do not give up any of my legal rights by signing this form.

_____

Name (Printed)

_____ _____

Participant's Signature Date signed

Statement by person obtaining consent

I certify that I have explained the research study to the person who has agreed to participate, and that he or she has been informed of the purpose, the procedures, the possible risks and potential benefits associated with participation in this study. Any questions raised have been answered to the participant's satisfaction.

_____
Name of Principal Investigator

_____ _____
Principal Investigator Signature Date signed

Appendix C

Demographic Questions

1. Professional affiliation? ie. psychologist, social worker etc.

2. How many years have you been licensed/registered in your profession?

3. How long have you been working in the mental health field?

4. Type of work setting? (community mental health, in-patient, private practice, day treatment, etc.)

5. General age of clients? (adults, adolescents, children, geriatric)?

6. Types of client presenting problems?

Appendix D

Supplemental Interview Questions

1. Does humor occur often in your therapy sessions?
2. Do you ever plan to use humor in therapy sessions or is it more spontaneous use?
3. Who tends to use humor more – you or clients?
4. Could you describe for me a time (that stands out for you) where humor was used by either you or the client in therapy? What are your perceptions of the humor use in this situation?
5. What are some other ways in which humor is used in your therapeutic relationships?
6. Has there been a time in therapy sessions when you have perceived humor to be detrimental to the therapeutic relationship? How was it detrimental?
7. How have you found humor to be beneficial to the therapeutic relationship? to achieving client goals? Or therapeutic?
8. If the use of humor changes as the therapeutic relationship grows, how does it change?
9. What is your view of your humor use when you are counseling clients?
10. What meanings do you attribute to your use of humor with clients?
11. What is your view of client use of humor in your counseling sessions?
12. What meanings do you attribute to your clients use of humor?

Appendix E

Transcriptionist Confidentiality Agreement

I, _____ agree to maintain confidentiality of all data transcribed for the research project by Rhonda Wolf-Wasylowich entitled *Humor within the Therapeutic Relationship: Mental Health Therapists' Experiences and Understandings.* After transcription service is complete all audio files and transcription documents will be destroyed.

Signed:_____ Date:_____

Witnessed:_____ Date:_____

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