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"Make 'em Laugh" The Interaction of Humor in the Therapeutic Treatment of Trauma: A Narrative Review

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The Interaction of Humor in the Therapeutic Treatment of Trauma: A Narrative Review

by

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Acknowledgments

At the age of seven, my dad lost his mother to polio. As a late teen, he enlisted in the military and was sent to protect our country in the Vietnam War as a Navy Corpsman stationed with the marines. As a family, in February of 2018, we celebrated the 50-year anniversary from his swift exit from Vietnam, injured and near death, as he was flown out of the warzone on a “Huey” helicopter. “Fifty Years since God spared my life” is what he called that celebration. As a child, I had no idea that he was battling a daily war of posttraumatic stress inside himself. The dad I saw, even through sometimes explosive anger, was a man that desired little more than to bring joy to anyone and everyone he crossed paths with. I watched my dad exchange jokes and ironic or lightly sarcastic remarks with the kid bagging our groceries, the pastor at our church, his in-laws, or the bank teller. Wherever my dad went, he made it his goal to get the crankiest looking person to smile or laugh. Dad, thank you for teaching me to find joy in the little things and for teaching me, first and foremost, how to laugh at myself and to laugh with others. I would not have found this road to social work without you. I love you!

As a twenty-year-old and on winter break from college on January 2, 2004, I was startled awake by my mom dropping a front page newspaper on my bed with large colored photos of my best friend since kindergarten, Krista Mayer, and her two younger sisters, Nikki and Jessica, along with the title “Three Sisters Killed Days Before Brother’s Wedding” plastered across the top. In that moment and in the ~~days~~, ~~weeks~~, ~~months~~, years to come, the daily joy and relentless laughter I experienced in my friendship with Krista and my sister-relationships with Nikki and Jessica seemed lost forever. In the 10 years following the car accident that claimed my closest confidant, I functioned from a place of avoidance and distance. I had gotten married, and had three children, Natalie, Emma, and Noah, that slowly helped me experience laughter again. Later in the spring of 2014 and living near the cemetery, I went for a run, it took me close to an hour of being in the cemetery to even walk close to the headstones. I cried, I screamed, I yelled like the accident had just happened. In that release, I began to find peace. I remembered Krista’s catch phrase, “Carpe Diem” (Seize the Day!) and experienced a flood of memories of being so silly and laughing for hours with Krista, her sisters and her brother Joey. Laughing and bringing out laughter in others is what Krista did best. Trauma hurts, pain is real AND there is joy, humor and laughter available to anyone, anytime to bring peace, healing, and togetherness. I love you Krista and will forever miss your smile and laugh.

Abstract

Like oil and water, humor and trauma would seem to be as opposite as can be. This systematic narrative review set out to discover if and how humor interacts with the therapeutic treatment of trauma. Peer reviewed data was collected, analyzed, and organized in four levels; humor in trauma therapy, humor in therapy promoting behavior for the client, humor in therapy sustaining behavior for the clinician, and humor in trauma work outside of a therapeutic setting. Using conceptual models of Trauma-Informed Care and Resiliency Theory, each level of articles were analyzed for similarities and differences through identifying; the use of humor, physiological, cognitive and psychological, behavioral and relational effects of humor, connections of humor and trauma, connections of humor and culture, limitations of humor, and implications for the use of humor. Findings indicated that humor is an integral and unique part of the whole-person approach to health and well-being and was identified as a key element in promoting healing for individuals that have experienced trauma. Effects were shown to be most beneficial when the level of humor used and the bond and depth of the therapeutic relationship were aligned and were intentionally focused on helpful, not hurtful, interactions. Future empirical studies should focus on assessing specific types of humor interventions and/or longevity studies focusing on a specific population or shared experience. In a therapeutic capacity, focus should be given to initiating and maintaining an open dialogue about individual humor styles and how to incorporate them into a therapeutic setting as well as utilizing humor for on-going assessment of levels of psychological distress. Additionally, the use of humor should not be overlooked in its ability to offer a status assessment of the clinician and for its value in supporting healthy coping skills and resilience.

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The Interaction of Humor in the Therapeutic Treatment of Trauma: A Narrative Review

“We need not fear expressing humor in pain.
Sometimes a hint of normalcy is exactly what we need.”
- Author unknown

The great Charlie Chaplain said it best, “a day without laughter is a day wasted.” Yet for an individual experiencing the effects of trauma, laughter may seem far out of reach. While trauma has been studied and identified as a whole body experience that effects physiology, cognitive and psychological functioning, along with impacting behavior and relationship adaptations (Chaikin & Prout, 2004; Courtois, 2008; Pearlman & Courtois, 2005; Scott & Copping, 2008; Solomon & Heide, 2005), the application or use of humor in a therapeutic setting has not frequently been the basis for empirical studies yet humor has often been recognized as supplementary to most therapeutic interventions (Franzini, 2001; Fry & Salameh, 1987; Schnarch, 1990). This study was developed to identify gaps in existing research and is offered to inform clinical social workers on the potential interaction of humor in a therapeutic setting in capacities that are less driven by intuition and more driven by evidence based practices.

Therapeutic humor is defined as “any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life’s situation” (Association for Applied Therapeutic Humor, 2017, p. 1). Humor in therapeutic interactions has been shown to take on forms ranging from mild and reflective amusement to loud shared laughter. Used intentionally or spontaneously by therapists and other supporting professionals, therapeutic humor has been shown to offer opportunities for improving self-understanding as well as to improve the behavior of clients (Ehrenberg, 1991; Franzini, 2001; Fry & Salameh, 1987). When used with care and intentionality, the exchange of humor in the

therapeutic process, can provide a positive emotional experience that both the client and therapist can share (Franzini, 2001; Goodheart, 1994; Schnarch, 1990). Humor, including laughter, have been noted in several health and mental health related studies as an instrumental factor in the healing process as it supports physical and emotional healing (Fox, 2016; Franzini, 2001; Gladding, 2016; Hart & Rollins, 2011; Martin, 2010; Robinson, Smith, & Segal, 2017). As it relates to the field of clinical social work, in the National Association of Social Workers’ Code of Ethics (2017), social workers are committed to valuing and promoting human relationships. Humor has been identified as instrumental in increasing positive relationships (Robinson, Smith, & Segal, 2017) and offers a beneficial and supportive tool to the role of the clinical social worker in building rapport and promoting human relationships.

This narrative review aims to focus on the interaction of humor in the therapeutic treatment of trauma and implications for clinical social work practice.

Literature Review

The following literature review creates a framework of therapeutic treatment of trauma, offers an overview of humor in therapy including its benefits and concerns, and establishes the groundwork for a systematic narrative review seeking to identify existing interactions of humor in therapeutic treatments of trauma.

Trauma Effects and Therapeutic Treatment Methods

In order to set a foundation for exploring the interaction of humor within the therapeutic treatment of trauma, it is essential to identify how trauma is conceptualized for the purposes of this review. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies individual trauma as the result of “an event, series or events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and

that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (SAHMSA, 2017). Additionally, Courtois (2008) refers to complex trauma as “a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts” (p. 86). Due to the varied and brief overviews of therapeutic treatment of trauma presented in this review, the word “trauma” will be used to reflect the experiences and effects of acute and/or complex traumatic experiences. Attachment, biology, cognitions, affect regulation, dissociation, and behavior control are greatly affected because of a traumatic experience (Green & Myrick, 2014). Symptom presentations of complex trauma can include “depression, anxiety, self-hatred, dissociation, substance abuse, self-destructive and risk-taking behaviors, revictimization, problems with interpersonal and intimate relationships (including parenting), medical and somatic concerns, and despair” (Courtois, 2008, p. 87). The following review will identify the physiological, cognitive and psychological, and behavior and relational effects of trauma as well as therapeutic treatment options designed to address these corresponding effects.

A trauma-focused therapeutic framework incorporates structured, evidence-based clinical techniques to offer opportunities for the individual seeking treatment to accept and grow from their painful experiences in a therapeutic environment (Chaikin & Prout, 2004; Courtois, 2008; Pearlman & Courtois, 2005; Scott & Copping, 2008; Solomon & Heide, 2005). Trauma’s effect on an individual can be engraved in the body in a variety of ways; physiological effects, cognitive distortions, and maladaptive behavior (Courtois, 2008; Scott & Copping, 2008; Solomon & Heide, 2005). Therapeutic treatments of trauma have been designed to focus on at least one or more than one of these elements (Chaikin & Prout, 2004; Courtois, 2008; Green & Myrick; Pearlman & Courtois, 2005; Scott & Copping, 2008; Solomon & Heide, 2005) and

treatment opportunities for trauma can be successfully completed in individual therapy as well as in group processing (Chaikin & Prout, 2004). Many treatments designed to address trauma utilize a relational framework (Pearlman & Courtois, 2005) which can offer a corrective experience as a foundation for processing and healing from trauma. Individual mastery and control of symptoms can be gained through participating in “therapeutic strategies that consider both the biological and psychological roots of human development” (Solomon & Heide, 2005, p. 58). This limited review offers a brief identification of the effect of trauma on physiology, cognitions and psychology, and behavior and relational adaptations as well as correlating treatments in order to establish the broad range of opportunities available for growth and healing from trauma and sets a precursor to how humor may have the potential to interact with them.

Physiological effects of trauma. Human development itself is a biologically driven mechanism starting with the physiological development of the body and brain then moving into the cognitive activities taking place within the physical brain and then leading to the behavioral and relational connections extended outside of that (Courtois 2008; Solomon & Heide, 2005). When traumatic experiences take place, the trickle-down effects can be astronomical and have significant implications on each level of the pathways of human development.

At simply a physiological level, trauma disrupts homeostasis and causes short and long-term changes in the brain along with many organs and systems of the body (Solomon & Heide, 2005). Effects include “abnormal concentrations of certain neurotransmitters, changes in EEG patterns, and a decrease in integration between right and left hemispheres and measurable size decreases in the cerebral volume, the corpus callosum, amygdala, and hippocampus” (Solomon & Heide, 2005, p. 56). Trauma sufferers experience the cycles of damage to brains and bodies many times which leaves numerous neurological effects (Green & Myrick, 2014). Physiological

responses connected with stress are directly affected due to the neural and structural changes within the brain after experiencing trauma while regulating the autonomic nervous system becomes a difficulty due to neurological pruning (Green & Myrick, 2014). Trauma has been found to have a significant impact on neuro-physical development and increases somatic and emotional dysregulation (Pearlman & Courtois, 2005). Traumatic experiences have short and long-term effects on the endocrine system that regulates physiology within the body including metabolism and neurophysiology (Solomon & Heide, 2005). A traumatic experience “causes the adrenal medulla to increase its output of epinephrine and norepinephrine” (Solomon & Heide, 2005, p. 53) which leads to the commonly understood reaction of a fight, flight, or freeze response. Chronic stress and trauma also impact cortisol secretion which directly impacts the body’s ability to function in a healthy capacity and heal itself (Solomon & Heide, 2005). After experiencing trauma, the body goes into a full “self-protection” mode which halts opportunities for growth and development as part of a typical growing process.

In terms of therapeutic treatments, physiological homeostasis can only be restored through processing and integration of the traumatic memory (Solomon & Heide, 2005). Biologically informed treatments for trauma offer opportunities to “process episodic memories, resolve physiological hyperarousal, and help clients connect with their bodies and their feelings” (Solomon & Heide, 2005, p. 56). When episodic memories are processed, the information “transfers from the limbic system to the neocortex and is filed away with other narrative memories” (Solomon & Heide, 2005, p. 57). This reprocessing of memories allows the individual to gain cognitive and emotional distance from the effects of trauma and, in most cases, a drastic reduction in physiological, cognitive, and behavioral symptoms caused by the traumatic experience.

Eye Movement Desensitization and Reprocessing (EMDR) is a treatment model developed by Shapiro in 2001 that offers a combination of body-focused (bottom-up processing) and cognitive-behavioral (top-down processing) to support the transition of changing experiential memories of trauma into narrative memories to be filed in the brain as a long-term memory. Similarly, sensorimotor approaches developed by Levine in 1997 and Rothschild in 2001 offer treatment approaches for complex posttraumatic stress disorder (CPTSD) that focus on the lasting effects of trauma held within the physical body itself (Courtois, 2008). Additionally, Seeking Safety is a treatment model developed by Najavits in 2002 and addresses the unique needs of sufferers of complex trauma while addressing the physiological interruptions of healing due to addictions and substance use disorders (Courtois, 2008). The important element in biologically informed treatment is the intentional focus to address the effects of trauma on the body primarily or at least in tandem with other models of process healing.

Cognitive and psychological effects of trauma. Traumatic experiences can produce numerous effects on an individual’s brain. Trauma noticeably effects cognitive functioning which includes memory, focus and attention, concentration, and language development (Green & Myrick, 2014; Solomon & Heide, 2005). The Orbitofrontal cortex regulates emotional states and responses through its connections with the hypothalamus and limbic system (Solomon & Heide, 2005). These systems set the trajectory of a response to surrounding situations and allow an individual to be emotionally attuned to their environment which also allows the individual to understand the emotional experiences of others, respond empathically, and use moral judgment (Solomon & Heide, 2005). When trauma ignites disruption to these systems, cognitions within the brain become primarily focused on staying safe instead of typical functioning and cannot regulate individual affect. An individual that has experienced trauma often presents as “pre-

occupied, fearful-avoidant, or disorganized-disoriented-dissociative” (Pearlman & Courtois, 2005, p. 452). An individual that has experienced trauma struggles to maintain positive “cognitions about themselves, their worth in relationships, and the motivations of others” (Pearlman & Courtois, 2005, p. 450). Cognitive hyperarousal can interfere with a trauma sufferer’s skills in perspective-taking or the ability to understand another person’s perspective or the ability to remain objective while obtaining new information. These effects of the traumatic experiences and distorted cognitions leave little room for an individual to function in all areas of life without difficulties.

In terms of therapeutic interventions, cognitive-based treatments offer opportunities to manage intense feelings through learning about the thought process and incorporating containment strategies (Courtois, 2008; Pearlman & Courtois, 2005; Solomon & Heide, 2005). Cognitive-Behavioral Therapy (CBT) is one such example of using a top-down processing approach to manage problematic thoughts, feelings and behaviors (Solomon & Heide, 2005). Additionally, motivated change and thought processing can be experienced by complex trauma sufferers through the treatment model of Dialectal Behavior Therapy (DBT) developed by Linehan in 1993 where issues directly related to trauma can be addressed through narrative-based techniques (Courtois, 2008).

Similar to DBT, examples of more formalized and specialized approaches to treating trauma in a therapeutic setting are Guided Imagery, Imagery Rescripting, and Narrative Telling/Writing (Courtois, 2008). Guided Imagery developed by Naperstek in 2004, is a mind-body intervention allowing the individual to identify and focus on mental images that can distract from the intrusiveness of negative symptoms resulting from the traumatic experience. Imagery Rescripting developed in 1995 by Smucker and Niederee allows individuals to re-live distressing

images and then transform them into imagery that can be self-soothing. Narrative Telling/Writing developed by Pennebaker in 2000 is a treatment option designed to allow the trauma sufferer to write narratives of difficult experiences in order to express and organize complex emotional experiences.

Another treatment model, Risking Connection (Saakvitne et al., 2000), seeks to create a “therapeutic relationship as an opportunity to rework attachment difficulties” (Pearlman & Courtois, 2005, p. 453). This model utilizes a helping relationship in order for the individual to alter negative self-perceptions. Cognitive-based treatment models function to provide process opportunities and increase containment capacities to impact a trauma sufferer’s day to day functioning.

Behavioral and relational effects of trauma. Along with many of the identified effects of trauma on individual physiology and cognitions, traumatic experiences effect behavior control, often manifested as under-controlled or over-controlled behavior (Green & Myrick, 2014). Researchers identified that disruptions to the amygdala interfere with an individual’s typical inhibition of rage responses and can exaggerate commonly understood “fight-flight-freeze” responses (Solomon & Heide, 2005). These reactions can be viewed by others as behaviors like “hostility, defiance, impulsivity, aggression, and high-risk behaviors” (Green & Myrick, 2014, p. 136). Because the physiology and cognitions effected by trauma cause difficulties in understanding emotions expressed by others and perspective-taking, developing empathy, and healthy relationship interactions become a great difficulty (Solomon & Heide, 2005). Additionally, an individual’s sense of self can be diminished due to the impact of trauma on the brain which can lead to a high likelihood of disconnection from other people (Solomon & Heide, 2005). Increased emotional dysregulation perpetuates the likelihood of maladaptive

coping, often observed as a “lack of emotional awareness, difficulty managing impulses, and inadequate strategies to regulate emotions” (Green & Myrick, 2014, p. 135). Additionally, these behaviors often tend to be misconstrued and responded to in a negative or increasingly harming way, often leading to a perpetuation of symptoms.

Relationships with others are markedly effected by trauma (Pearlman & Courtois, 2005). After exposure to “physical and emotional harm, rejection, neglect, and violations of personal safety and integrity, individuals may come to experience themselves as helpless, worthless, and unlovable” (Green & Myrick, 2014, p. 137). Trauma sufferers frequently learn maladaptive ways of relating to others often out of instinctual self-preservation techniques (Green & Myrick, 2014; Pearlman & Courtois, 2005). Trauma and its residual effects hinder an individual’s capacity for mutually receptive relationships and can create challenges for healthy conflict resolution and problem-solving in relationships. Due to brain rewiring from exposure to trauma, healthy relationship skills often need to be relearned.

In terms of therapeutic treatments focused on behavior and relational adaptations due to complex trauma, the following treatment models allow the therapeutic relationship to act as the primary method for processing and healing through building a collaborative alliance that increases overtime and allows the client to experience an empathic relationship that may be different than their background of trauma (Courtois, 2008). Risking Connection, as mentioned previously, incorporates fundamental elements aligning with the acronym RICH (respect, information, connection, and hope) (Saakvitne, Gamble, Pearlman, & Lev, 2008) which provides a framework for all therapeutic and relationally driven interactions. Similarly, the Intergenerational Trauma Treatment Model (ITTM) (Scott & Copping, 2008) identifies phases for treatment to attend to the effects of complex trauma. A distinction with ITTM is the focus

placed on utilizing parents as the “mechanisms for change for their child” (Scott & Copping, 2008, p. 276). This model offers a manualized system of addressing effects of intergenerational trauma on attachment, regulation and opportunities for “safe expressing and processing of trauma experiences and the development of parents’ competencies and self-efficacy” (Scott & Copping, 2008, p. 281). Additionally, a treatment program developed for trauma in women and one that is frequently used in community settings is OPAL (Overcoming Pain and Adversity in Life) (Chaikin & Prout, 2004). The goal of this treatment model is to “promote each woman’s efforts to attain her optimal level of functioning” (Chaikin & Prout, 2004, p. 169). Highest successes in this model are observed as women “demonstrate empowerment, boundary setting and establish and maintain healthy relationships” (Chaikin & Prout, 2004, p. 169). Regardless of the phases and structure of relationally focused interventions, the opportunity to offer a corrective emotional connection to others is incorporated with high intentionality.

Therapeutic process for healing from trauma. Though this review only offers a minimal overview of a small number of treatment models, it is important to note that interventions focused on treating trauma are most often successful when the therapist sets a foundation of safety, security, and affect regulation (Courtois, 2008). Treatment offerings that pursue a “whole-person philosophy” identify the value of the complex trauma experiences and keeps the individual needs as the forefront (Courtois, 2008). Courtois (2008) identifies the stages of therapeutic treatment of trauma in this way,

> “The early stage of treatment is devoted to the development of the treatment alliance, affect regulation, education, safety, and skill building. The middle stage of treatment is an appropriate place to move toward processing of traumatic material in enough detail and to a degree of completion and resolution to allow the individual to function with less

> posttraumatic impairment. The last stage of treatment is targeted toward life consolidation and restructuring, in other words toward a life that is less affected by the original trauma and its consequences.” (p. 92)

Additionally, through the therapeutic process focused on trauma, an important element to include and a method for evaluating successful programs and treatments for trauma is the experience and needs of the helper (Chaikin & Prout, 2004). When the therapist or helper is emotionally healthy, they are most apt to be able to offer the relational and empathic consistency most needed in the healing process for trauma sufferers.

Humor in Therapy

Prior to the 1970s, little research specifically identified humor as utilized in clinical treatment and therapeutic processes (Curtis, 2001; Franzini, 2001). Since that time, research has shown movement in identifying the physiological, cognitive and psychological, and behavioral and relational effects of humor in treatment, including some precautions, and offering evidence that proves its relevancy for counseling (Able, 2002; Gladding, 2016; Millicent, 2001; Schnarch, 1990) yet studies have also struggled to show empirical evidence directly correlating specific humor techniques with quantitative outcomes (Franzini, 2001). The use of humor in therapy is also a skill that, in most settings, has not been universally taught because of the nature of its subjectivity and inconsistency in techniques used (Franzini, 2001; Schnarch, 1990), making short- or long-term studies that much more difficult to complete and thus difficult to draw specifically connected uses in the therapeutic settings. Additionally, a difference exists between humor as a construct and laughter as a behavioral event (Franzini, 2001) that adds to the difficulty in research implications. Each term is individual and thus outcomes are not interchangeable. Laughter, most often can be described as a symptom of humor. Humor may or

may not include laughter. For the sake of this research, the term “humor” will be used to conceptualize the experience in finding pleasure in, being amused by or experiencing an increase in mood or state of mind. It should be understood, this conceptualization may or may not include laughter even if not identified separately.

To many lovers of William Shakespeare’s writings, the concepts of comedy and tragedy are somewhat interchangeable. Many of Shakespeare’s plays demonstrate the existence of both comedy and tragedy. Pauline Boss (2016), offers this clarification, “if the clown falls, it’s a comedy; if he doesn’t get up again, it’s a tragedy. Both comedy and tragedy can stimulate the discovery of hope” (p. 68). Though initially the idea of using humor in a therapeutic setting for the treatment of trauma may seem uncomfortable to some, humor has been shown to offer a modality for probing difficult subject areas, diffusing anger, and limiting resistance (Curtis 2001; Gladding, 2013; Goodheart, 1994).

Physiological effects of humor. In the classic 1952 film, *Singing in the Rain,* a lead character sings of the need for laughter in the world, *“make ‘em laugh, make ‘em laugh, don’t you know everyone wants to laugh,”* while demonstrating frequent uses of comedic falls and spills and eliciting laughter from the audience. Though the presentation is over the top in its effort to prompt laughter, it supports the experience shared by most, that *everyone wants to laugh*. As evaluated research attests, humor and laughter have profound effects on the physical experiences of humans (Able, 2002; Curtis 2006; Fry & Salameh, 1993; Robinson, Smith, & Segal, 2017). Positive impacts of humor and laughter offer support to encourage the professional to incorporate elements of humor into clinical treatment (Able, 2002; Fry & Salameh, 1993). Gladding (2016) describes some of the physical impacts of laughter as easing physical pain, strengthening immune function, decreasing stress, increasing relaxation, elevating mood and

feelings of well-being, decreasing feelings of depression and anxiety, and releasing endorphins. Humor and laughter have demonstrated at least short, if not long-term increases in positive cell activity supporting the immune system (Payne Bennett & Lengacher, 2009). Additionally, dopamine has been shown to be released in the reward process experienced as an individual engages in laughter (Mensen, Poryazova, Schwartz, & Khatami, 2014). These physiological responses experienced when an individual experiences humor, amusement, and laughter demonstrate the positive sense and well-being that takes place even for only a few moments.

Cognitive and psychological effects of humor. In addition to the physiological impacts of laughter, the cognitive and psychological effects of humor can support increases in perspective-taking, making challenges seem more surmountable, increasing problem solving, allowing one to take themselves less seriously, triggering creativity, and increasing a sense of control or mastery over circumstances that initially seemed distressing, threatening and all-consuming (Gladding, 2016; Robinson, Smith, & Segal, 2017). Humor also has the ability to distance clients from too much subjectivity and allows them to enhance a vision of themselves and their environments, providing an “*aha* moment from their *haha* moment” (Gladding, 2011, p. 158). Igniting the frontal lobe, humor also correlates with the skill of problem solving and can offer opportunity to probe into difficult areas, stifle anger, lighten resistance, and build resilience (Adams, 1974; Gladding & Kezar, 1978; Haig, 1986, as cited in Gladding, 2013). Humor is a human experience that allows individuals, both client and therapist, to switch gears and provides an opportunity to lighten the mood, even for just a moment (Gladding, 2013; Schnarch, 1990). In both the acts of laughing and problem solving, the frontal lobes of the brain are significantly utilized (Brain, 2000), when therapists promote humor, it allows clients to move from the fight or flight mode of the amygdala and activate the important frontal lobe area to continue the process

of building resiliency. A very important note is that humor is *not* the absence of sadness or hurt (Stevenson & Cox, 2017), an individual can be *both* hurt *and* engage in laughter (Boss, 2013). Humor and laughter allow the individual to gain perspective in the midst of their difficult experiences.

The use of humor in a clinical setting demonstrates the increase of perspective taking for each individual (Able, 2002; Ehrenberg, 1991; Goodheart, 1994). When used carefully, humor replaces criticism while drawing attention to possible absurdities in a client’s typical or unsuccessful responses to solving problems or meeting self-needs (Fox, 2016). When the therapeutic relationship supports the use of humor, helplessness and despair can be overcome with renewed thought and perspective over a specific situation (Gladding, 2013). Offering humor as a mode of perspective taking for individuals allows for positive interactions to replace negative views of self and others.

Additionally, relief for difficult situations has been shown to often be experienced through laughter when clinicians use humor as a means of pursuing hope (Boss, 2016). As part of the human experience, humor allows the individual to find entertainment or enjoyment in the unexpected, expected, predictable, and unpredictable moments of life. Remaining humorless stunts individuals from an opportunity to experience and hold hope (Boss, 2006). Laughing allows the individual to build capacity to find even a glimmer of hope (Boss, 2006).

Behavioral and relational effects of humor. Along with finding relief and hope through humor, laughter has been shown to provide opportunities to share a common experience (Gladding, 2013), build connection with others (Franzini, 2001), and build resiliency (Boss, 2006). In a study on grief in the workplace, Mary Tehan (2007) acknowledges the value of humor as a specific connection between individuals as laughter is shared *with* one another as

opposed to *at* one another. When individuals are able to be united in laughter, more positive views of problems and potential solutions are frequently brought to the surface (Franzini, 2001).

In terms of social and behavioral impact as described by Gladding (2016), humor and laughter can increase bonding among family and friends, enhance teamwork, help diffuse conflict, and boost morale. When individuals laugh, especially with other people, catharsis can be found in the therapeutic process (Hooyman & Kramer, 2006). Resistant children have been shown to be especially benefited through laughter as they are able to develop self-efficacy, increase healthy coping skills, and continue building meaningful relationships (Fox, 2016).

Humor has also been used with individuals to build connection with others outside as well as inside of the therapeutic relationship (Curtis, 2001; Robinson, Smith, & Segal, 2017; Schnarch, 1990). Even with light or simple humor, the therapeutic relationship can be strengthened and deepened (Franzini, 2001). When used appropriately, humor offers the use of strengthened relationships to support individuals in coping and enhancing rapport and the potential to build trust between the therapist and client (Gladding, 2013). Intentional use of humor in the therapeutic setting provides opportunities for individuals and families to become more aware of self, others, and situations (Gladding, 2013). Additionally, individuals can gain a sense of empowerment and empathy through the use of humor in a clinical setting that can offer opportunities to constructively interact with others within appropriate social boundaries (Gladding, 2013). This initial step of building connections with others through humor has served as a successful foundation for continued conflict resolution and proactive relationship building that has been shown to be beneficial in the long term. In discovering and discussing an individual’s response to humor, coping and deflective behavior can be broken down and reframed to more accurately portray underlying emotions taking place (Fox, 2016). During the

therapeutic interactions, humor allows for the disclosure of specific needs of the individual and allows for assessing how a client relates to oneself and others (Henderson & Rosario, 2008).

When used in appropriate manners, humor has been observed to offer an opportunity for the client and therapist to join together in a shared experience and a response which can aid in the breaking down of emotional walls (Ehrenberg, 1991; Gladding, 2013; Goodheart, 1994). Clinical social work can be greatly impacted by the shared experience in setting a mutual foundation for therapeutic work.

Therapeutic process for healing through humor. When seeking to incorporate the use of humor in clinical treatment of children, adolescents, or adults, clinicians can use many forms. Some of these modes for humor can include storytelling, and the use of puppets and word games (Gladding, 2013). For children and adolescents, humor can transcend cultures and closely associate with the most apparent environments like school or home (Gladding, 2013). Adults are more likely to respond to higher level play on words due to increased cognitive development. Humor can be incorporated in specific ways like songs, absurd actions, structured activities, jokes, and stories. Additionally, Gladding (2013) identifies this list as an appropriate starting place; drawing, exaggerations, unexpected riddles, jokes reflecting impossible and improbable facts, word play and double meanings, non-verbal and slapstick humor, and retrospective humor are other options. Additionally, made up skits portraying concerning subjects in a humorous way can foster open and honest conversations and challenging of ideas (Gladding, 2013). In a group dynamic, using more traditional “summer camp” style activities that may allow individuals to experience gentle embarrassment that can provide opportunity for individuals to laugh at themselves, find perspective, and build a sense of community with others. Even activities such as miming or clowning can offer non-verbal opportunities to draw out emotion while maintaining a

sense of lightheartedness and can uncover important and unresolved issues (Gladding, 2013). For adults, many of these same techniques could be fitting when brought to an appropriate level, along with even more structured and facilitated activities, like Laughter Yoga, that can allow for self-reflection and relief.

In a therapeutic environment, humor has been used very successfully as a diagnostic tool to gauge an individual’s ability to experience feelings and responses to humor (Bernet, 1993; Ehrenberg, 1991; Fox, 2016; Schnarch, 1990). Additionally, humor can be used in continuous assessment and processing if the client is assigned to identify specific shows, books, or other forms of media that make them laugh (Gladding, 2013). Therapeutic results for a client can be gauged through initial and ongoing use of humor when care and intentionality are practiced consistently.

Outside of the therapeutic benefit to the client, it is also important to emphasize the supporting and healing effect humor can have on the therapist individually. Finding humor and laughter *with* clients, not *at* them, offers opportunities to minimize professional burnout (Franzini, 2001; Schnarch, 1990) and can lead to positive self-care when found or used inside or outside of the therapeutic environment.

Intentionality of humor in therapy. While offering several benefits, humor and laughter in the therapeutic environment must be pursued only after several intentionalities have been considered (Franzini, 2001). Not unlike the use of human theories from Rogers (1961) or Fankl 1988), an individual experiences deep longings and likenesses while also representing a culmination of unique experiences, cultures, and character qualities. While a sense of humor seems to be a somewhat basic concept, it has been more specifically identified to have two major components: being a humor *initiator* and/or being a humor *appreciator* (Franzini, 2001). In the

use of humor in therapy, the clinician must be aware of their own strengths in sense of humor and refrain from assuming that because they may be a humor appreciator, they are a skilled humor initiator. Unless a therapist is seasoned or strengthened in humor techniques, or if humor is forced or used in poor timing, the session can become uncomfortable and counterproductive (Ehrenberg, 1991; Franzini, 2001; Schnarch, 1990). Another significant caution when using humor in the therapeutic process is maintaining professionalism and sensitivity to cultural impacts and relevancy (Gladding, 2013; Schnarch, 1990). Foundationally, it is also with high importance that the therapist is aware of personal needs behind laughter, both of their own and of the client’s (Boss, 2006). It is important to pay close attention to the use of humor as a defense mechanism used to hide hostility or shame, a cover for anxiety, or an act to control or hurt others (Boss, 2006; Goodheart, 1994). The need for laughter can also come from a need of connection with others and is most meaningful when that connection leads to hope (Boss, 2016).

Prior to incorporating an intentional use of humor in the therapeutic treatment of trauma, it is important that professionals consider “prerequisites” of sorts. Humor is very unique and experienced by each individual differently. Professionals intentionally using humor in treatment must practice a high level of skill in reading verbal and nonverbal messages and heed to appropriate timing with witty responses (Curtis, 2001; Gladding, 2013; Schnarch, 1990). It is also important for the professional to be attuned to the individual’s laughter. For example, is it forced or natural? Is it an appropriate level of response to the humorous statement? Other cognitive, chemical health, or mental health disorders may directly affect the core human behavior of laughter and thus can interact uniquely in the therapeutic environment (Henderson & Rosario, 2008). A professional will find the use of humor more successful when close attention is paid to the reactions and emotions of the client as well as their own experiences outside of that

environment (Curtis, 2001; Ehrenberg, 1991; Rayle, 2013). Above all else, the point cannot be stressed enough that using humor in a therapeutic environment *must* be used to laugh *with* the client, never *at* the client.

Regardless of the mode or activity utilized in a therapeutic environment, it is crucial and important for the therapist to heed to the cautions and prerequisites in order to maintain the goal to “do no harm” for the individual. When used skillfully, humor truly can be “the best medicine”.

Research Question

Further research is needed to study the existing interaction of humor in the therapeutic treatment of trauma. Additionally, the practice of clinical social work in areas utilizing a perspective of Trauma Informed Care would benefit from an increased understanding of how humor interacts, offers benefits, and requires intentionality in treatment along with potential opportunities for longer term studies. The preceding reviews of literature demonstrate existence of humor in therapy and clinical treatment of trauma as individual entities as well as offer opportunities for more intentional correlations between the two while using social work theories and perspectives to inform practice.

This narrative literature review will attempt to draw widespread themes from individual writings regarding interactions of humor and the therapeutic treatment of trauma. Though existing research and writings offer insight on the use of humor in the therapeutic treatment of trauma to varying degrees, a more comprehensive merging of information offers a more organized effort to inform clinical social work practice. This review will seek to answer how humor interacts with therapeutic treatment of trauma.

Conceptual framework

When individuals, children, adolescents, or adults, experience an instance or multiple

instances of trauma the resulting effects can have dramatic repercussions on the physiology of the body, cognitive and psychological distortions of the brain, and lead to maladaptive behavior and relational adaptations. Humor in general and humor used in a therapeutic environment have been shown to offer positive effects on the body, mind, and relational dynamics. With this basis of knowledge, it is crucial for clinical social workers to be informed with the benefits and cautions available when seeking to merge humor and the therapeutic treatment of trauma and to be skilled in creating a tool base to increase opportunities for individual growth and healing from the traumatic experiences.

Many theories and models have proven appropriate to application in research and services for the therapeutic treatment of trauma. A main model offered from this work is of Trauma Informed Care. This model, however, leans itself more appropriately to understanding, recognizing, and responding to the effect of trauma on individuals and groups. For the sake of this research, a lens of Resiliency Theory will be used as a strengths-based approach to offer opportunities to foster positive development. Resiliency itself is identified as the dynamic system that allows an individual or a group to adapt to difficulties. In evaluating the use of humor in the therapeutic treatment of trauma, Resiliency Theory will offer the most direct description of potential positive or negative effects of humor in growing and healing through trauma.

Methods

Research Design

A narrative method analysis was used to gather and review information in order to assess how humor interacts with the therapeutic treatment of trauma. A narrative analysis reviewed any literature pulled with specific search terms that offered information for interaction. A search of professional literature offered content to be used in this narrative analysis. The professional

literature was obtained by using a combination of the following key words in the literature search: humor, trauma, therapy. The hypothesis was that humor would show as an effective and complementary tool for offering strength in resilience building for individuals who have experienced trauma. A Data Analysis Form was used to track information gathered and can be found in Appendix A. Findings are categorized and interpretations of findings are discussed. The interpretation of the findings answers the question, “how does humor interact with the therapeutic treatment of trauma?”.

Sample

The professional literature used in this narrative analysis was found using the Psych Info and Social Work Abstracts databases. After the literature was collected, it was reviewed for inclusion criteria. Articles were initially assessed for inclusion if the full text was available, were published between the years 2000 – 2017, were published in English, and identified humor or laughter in reference to work with individuals or groups that have experienced trauma.

Data Collection

A narrative review was conducted with a total of 252 articles meeting initial criteria collectively. Articles were then reviewed based on title and abstract for proximity to the research question. After initial articles were excluded, 21 articles were included for data analysis based on a direct or indirect connection to the research question. An Article Form can be found in Appendix B and is provided to identify articles used, type of research, and proximity to research question.

Data Analysis Plan

The Data Analysis Form used for this research was developed by this researcher and was conceptualized to offer identifications of seven main elements: how humor is represented, if

humor is addressed or incorporated intentionally or unintentionally, how humor is represented in connection with trauma treatment, how humor is projected to be used in future work, if humor is identified in terms of a cultural connection, any distinguishing characteristics of the article, and limitations or concerns about the study or review. The Data Analysis Form template can be found in Appendix A. Core elements emerged through the data in identifying the interaction of humor in the clinical treatment of trauma: The Use of Humor, The Effects of Humor, Connection of Humor and Trauma, Limitations of Humor, and Implications for Social Work Practice.

Findings

Findings from the data analysis naturally separated into four categories or circles of proximity in their closeness to answering the research question directly: Level 1: Interaction of humor in the therapeutic treatment of trauma (one article), Level 2: Interaction of humor in resiliency and therapy promoting behavior of the client (13 articles), Level 3: Interaction of humor in resiliency and therapeutic skill development for the clinician (five articles), and Level 4: the Interaction of humor in a high-trauma but non-therapeutic environment (two articles). Themes for each of these categories are offered below to answer the question “how does humor interact with the therapeutic treatment of trauma.

Level One – Humor in Trauma Therapy

From the 21 articles included and evaluated in this study, only one article specifically and directly addressed the interaction of humor in the therapeutic treatment of trauma. This article utilized a review of the literature surrounding humor and its connection to experiencers of trauma in order to identify humor styles used by trauma survivors and how humor is used to maximize healing and challenge negative thinking (Garrick, 2006). The following themes were observed and evaluated to inform the long-term use of humor in therapeutic trauma work.

The use of humor. Humor was identified to appear in-practice through gallows humor (using light-hearted or ironic statements in the midst of death/tragedy filled environments), black humor (using light-hearted or ironic statements in the “face of oppression and prejudice but not necessarily annihilation, mostly from man-made difficulties and used as a passive aggressive means of circumventing their oppressors without risk of retaliation”) (Garrick, 2006, p. 176). Humor was also noted to appear through funny or ironic stories or possibly absurd childhood memories.

The effects of humor. Through the review of literature completed and the case studies presented, a number of physiological, cognitive or psychological, and behavioral or relational effects were observed in the research. Below is a breakdown of the themes and observations.

Physiological effects of humor. Also acknowledged as an element requiring more systematic research, Garrick (2006) identified observations of humor as promoting physiological healing for sufferers of trauma significantly in response to endorphins (or natural pain killers) released during the activity of laughing. Laughter was also identified to support a body’s ability to fight infection through this same release (Garrick, 2006). Observations were also noted in case examples that trauma sufferers appreciated the healing effects of laughter whether in the immediate moment of release or in the long-term physical lightening (Garrick, 2006).

Cognitive and psychological effects of humor. In the case examples provided, Garrick (2006) noted the greatest cognitive or psychological effect on sufferers of trauma was the opportunity humor carried in mitigating the intensity of the traumatic stress reactions. Additionally, individuals that experienced trauma noted that humor in therapy provided an ability to take new perspectives in order to cut through conflicted emotions (Garrick, 2006).

Behavioral and relational effects of humor. In connection with behavioral or relational

effects of humor, Garrick (2006) noted opportunities for the clinician to identify an individual’s “brand of humor” quickly in order to create the most opportunity to increase group bonding, and allow for the reward or reinforcement of others. Additionally, the use of humor in reflecting on situations carrying trauma responses provided opportunities to minimize the abuser’s power over a victim while simultaneously maximizing on a victim’s growing power apart from an abuser (Garrick, 2006).

Connection of Humor and Trauma. This article directly addressed the use of humor in therapeutic work with experiencers or sufferers of trauma including the observed individual effects, support for the therapeutic milieu, and connections to future work. Humor was observed as a therapeutic and beneficial tool when confronting traumatic experiences (Garrick, 2006).

Connection of Humor to Culture. The main connection between humor and culture presented by Garrick (2006) was observed as humor is conducive to the typical human experiences of desiring connection and cutting through tension, aiding forgiveness and letting go of worries, and using one’s one culture to help define individual use of humor.

Limitations of humor. The greatest limitation of using humor in trauma therapy identified in this article was found in the need but personal difficulty in acknowledging humor’s traditional *faux pas* within the psychoanalytic community and agreeing on terms of use within the therapeutic environment (Garrick, 2006).

Implications for the use of humor. Aside from noted opportunities for significant and systematic research assessing the direct effects of humor in therapeutic work with trauma experiences, especially in terms of physiological support through healing and increases in quality sleep, Garrick (2006) identifies a number of potential opportunities for the clinical use of humor when working with individuals or groups that have experienced trauma in three main categories:

structured intervention methods, assessment and psychoeducation, and best practices.

Humor experienced as part of Rational Emotive Behavior Therapy provides opportunity to find peace in difficulties of experiences by reducing irrational beliefs through irony and wit experienced through humor (Garrick, 2006). Stress Inoculation Training focuses on increasing coping skills to manage anxiety symptoms through education, relaxation, breathing exercises and self-dialog (Garrick, 2006). Humor was observed in this intervention as a method to integrate corrective information and modify or begin to modify elements of traumatizing memories that could become pathological (Garrick, 2006).

When used in assessment and psychoeducation, Garrick (2006) identified value in being in-tune with the individual and the group in order to identify humor styles presented, discover meaning of humor to the individual or group, as well as to help identify things that bring enjoyment or amusement in order to confront negative thinking. Maintaining a consistent focus of assessment and identifying the use of humor was noted to support the clinician’s ability to educate on other potential uses of humor to aid in the recovery process as well (Garrick, 2006).

In order to offer a helpful and supportive framework for incorporating humor in therapeutic work with trauma, Garrick (2006) instructs clinicians to be comfortable with humor themselves, allow humor to show up in the clinician’s daily life as a stress management technique, be intentional on the use of reflection of these humorous experiences to aid in the therapeutic process with the individual or group in order to build cohesion and connection while normalizing humor styles. Additionally, humor is beneficial in interventions through validation and acceptance of the individual or group humor style.

Level Two – Humor in Therapy Promoting Behavior for the Client

As this research sought to assess the interaction of humor within the therapeutic treatment

of trauma, 13 of the 21 articles aligned themselves a step away from the bullseye of the research question assessing humor, trauma, and therapy. These 13 articles, did however, demonstrate specific connections between humor and therapy supporting behaviors and resiliency. The following themes were observed and evaluated for similarities and differences as well as to inform the long-term use of humor in therapeutic interactions even if trauma is not the main focus.

The use of humor. Throughout these articles, humor was addressed in several different ways and was expressed and assessed through shared humor (both/all individuals amused/engaged), unshared humor (an individual’s own humorous response), and internal or external laughter (Frisby, Horan, & Booth-Butterfield, 2016; Kashdan, Yarbro, McKnight, & Neziek, 2013). Humor was also identified through the use of categories; affiliative (bringing amusement to others or facilitating relationships), self-enhancing humor (coping with stress or maintaining a positive outlook even during difficulty), aggressive humor (sarcastic, manipulative, or damaging put-downs), self-defeating humor or self-irony (excessive self-disparagement or defensive denial) (Bos, Snippe, de Jonge, & Jeronimus, 2016; Cheung & Yue, 2011; Fabian, 2012;). In three of the studies reviewed, the Humor Styles Questionnaire was used to assess those four categories of humor as the initiator or the receiver (Bos et al., 2016; Frisby et al., 2016; Veselka, Aitken Schermer, Martin, & Vernon, 2010).

From a review of interventions, a model used in one study assessing the use of humor with older patients with depression used a model designed by McGhee (1996) (cited in Konradt, Hirsch, Jonitz, & Junglas, 2012) that identifies the following factors in the use of humor: enjoyment of humor, laughter, non-verbal humor, verbal humor, finding humor in everyday life, laughing at yourself, and humor under stress. In the interventions, humor was experienced

through amusing jokes, music, stories, memories, and more. Humor was used as a conversation starter to be transparent and open about negative feelings, moods, or conflicts and how to deal with them in a humorous way (Konradt et al., 2012). Humor was also observed in the use of Rational Emotive Therapy (Sultanoff, 2013).

Humor was noted as verbal and non-verbal cues, communication, and responses such as a “cool pose” at just the right time, as well as assessed as positive or negative (Bonanno, 2004; Bryant-Davis, 2005; Veselka et al., 2010). It appeared as joking, teasing, physical play, light tones, irony, sarcasm, and mocking or parody (Cameron, Fox, Anderson, & Cameron, 2010). Additionally, Anzieu-Premmereur (2009) noted “young children use preverbal symbols, deliberate finger and body movements, clowning, exaggerated movements, and vocal sounds to initiate humor with their parents. Toddlers expand this repertoire of humor by adding verbal humor such as mislabeling, puns, and nonsense verbal productions” (p. 137).

The effects of humor. As humor was present and assessed in a variety of ways, the effects observed aligned in three categories; physiological, cognitive or psychological, and behavioral or relational. The term resiliency and coping was referenced several times in observing humor’s interaction in a therapeutic environment. Though greater studies would likely align “resiliency” and “coping” to reflect all three areas of an individual, for this evaluation, the terms “resiliency” and “coping” are assessed for behavioral and relational interactions due to its ability to be observed and assessed by a third party.

Physiological effects of humor. The physical effects of humor and laughter were very minimally addressed in the articles represented at this level. Mention was made to the positive impact humor demonstrated on individual’s “well-being” but did not offer more descriptors than that (Bos et al., 2016). In the study assessing humor interventions among older adults with

depression, humor group members acknowledged experiencing less distressing physical symptoms by the end of the eight-week intervention (Konradt et al., 2012). Frisby et al. (2016) observed a reported increase in distressing physical symptoms when self-defeating humor was used in a study group of divorced individuals. Sultanoff (2013) demonstrated how humor influences biochemistry by equating laughter to increased energy, decreased levels of stress hormones, increased level of antibodies, and as a method for activating body systems such as the cardiovascular, muscular and skeletal systems.

Cognitive and psychological effects of humor. Emotions, thought patterns, and attitude serve as the three main categories of the cognitive and psychological effects of humor as noted in the 13 articles aligning themselves in this layer of the evaluation. Though there is overlap between the three categories, the separation offers an in-depth view.

In terms of emotions, humor impacted a number of affective states. Humor was noted to have relieved emotional distress (Sultanoff, 2013), reduced feelings of depression (Bos et al., 2016), reduced stress (Bos et al., 2016; Bryant-Davis, 2005; Cheung & Yue, 2011), increased emotional control (Cameron et al., 2010; Fabian, 2002; Veselka et al., 2010), and activated positive change in emotions (Kashdan et al., 2013; Sultanoff, 2013).

Thought patterns were shown to demonstrate a positive effect from humor. Researchers theorized that humor increased in distance from intensity of negative thoughts (Fabian, 2002; Sultanoff, 2013), increased attentiveness (Sultanoff, 2013; Veselka et al., 2010), reduced anxious thinking (Sultanoff, 2013), loosened rigid thinking (Cameron et al., 2010; Sultanoff, 2013), a shift in distorted thinking (Fabian, 2002; Sultanoff, 2013), a reduction of a poor sense of self from trauma (Anzieu-Premmereur, 2009), increased mental toughness as perceived as commitment, control, challenge, and confidence (Cameron et al., 2010; Kidd, Miller, Boyd, &

Cardena, 2009; Veselka et al., 2010), and created a vehicle for self-expression (Cameron et al., 2010; Frisby et al., 2016).

Attitudes were observed to be affected by humor. Changes noted included, decreased seriousness (Kashdan et al., 2013; Konradt et al., 2012), shifts in negative moods (Anzieu-Premmereur, 2009; Bonanno, 2004; Sultanoff, 2013), increased awareness of moods and improved moods (Kidd et al., 2009; Konradt et al., 2012), changes in distressful states (Kidd et al., 2009; Sultanoff, 2013), increased perception and perspective (Bryant-Davis, 2005; Fabian, 2002; Sultanoff, 2013), increased cheerfulness and warmth (Kashdan et al., 2013; Konradt et al., 2012), and increased satisfaction of life (Konradt et al., 2012). As attitudes were evaluated, a note of interest was found as the use of humorous irony allowed for hidden meanings to be revealed to the individual or group.

***Behavioral and relational effects of humor*.** Behavioral changes, personal resilience, and interpersonal development are the three broad categories that encompass the behavioral and relational effects of humor in a therapeutic environment.

There were a number of different behavioral changes that researchers observed. These alterations included reduced suicidal tendencies (Konradt et al., 2012), increased interest and engagement in services (Kashdan et al., 2013; Konradt et al., 2012), increased positive and healthy behavior (Kashdan et al., 2013; Sultanoff, 2013), increased use of healthy coping strategies (Anzieu-Premmereur, 2009; Bryant-Davis, 2005; Frisby et al., 2016; Kidd et al., 2009), increased positive decision making (Sultanoff, 2013), and increased creativity and inventiveness (Sultanoff, 2013; Veselka et al., 2010).

Humor was noted as a factor in building and maintaining personal resiliency in a number of studies (Bonanno, 2004; Bos et al., 2016; Cameron et al., 2010; Cheung & Yue, 2011; Frisby

et al., 2016; Konradt et al., 2012). Additionally, Bos et al. (2016) noted humor showed distress-buffering effects in its population-based study in the Netherlands. Bryant-Davis (2005) observed humor allowed African American adult survivors of childhood violence an ability to hold and contain pain through laughter, smiling and the use of humorous wit.

A positive effect from humor was also noted frequently in terms of interpersonal development and relationships. Specifically, humor was observed to provide normalizing of experiences (Fabian, 2002; Kidd et al., 2009), reduced panic from shyness (Anzieu-Premmereur, 2009; Kidd et al., 2009), built or maintained rapport and connection to others (Bonanno, 2004; Cameron et al., 2010; Fabian, 2002; Frisby et al., 2016; Kashdan et al., 2013; Kidd et al., 2009; Sultanoff, 2013), increased self-confidence and willingness to be outgoing (Veselka et al., 2010), increased social competence and assertiveness (Bonanno, 2004; Cameron et al., 2010; Kashdan et al., 2013; Kidd et al., 2009; Sultanoff, 2013) Additionally, within a therapeutic relationship, humor was noted to build and strengthen the therapeutic alliance (Fabian, 2002; Kidd et al., 2009; Sultanoff, 2013), reduce transference and countertransference experiences (Fabian, 2002; Kidd et al., 2009), and can be utilized for assessment of therapeutic progress (Fabian, 2002; Frisby et al., 2016; Kidd et al., 2009).

Connection of Humor and Trauma. Humor was most often indirectly identified in this level of evaluation. Several articles drew a connection from humor and its ability to increase personal resiliency factors (Bos et al., 2016; Fabian, 2002; Cameron et al., 2010; Cheung & Yue, 2011). Anzieu-Premmereur (2009) observed humor used by children as a defense against fears of traumatic feelings. Additionally, Frisby et al. (2016) identified shared humor as a support for individuals that had experienced a divorce except for in the case of self-defeating humor which had poor effects on individual resiliency.

Connection of Humor to Culture. As Kidd et al. (2009) evaluated humor among persons with severe mental illness, it was noted that “humor is the reflection of local culture in experience and expression…it is culture-bound and highly subjective” (Kidd et al., 2009, p. 1421). Additionally, it was observed that African American adult survivors of childhood violence often shared similar jokes, ironic statements, and other humorous shared meaning in reference to similar experiences (Bryant-Davis, 2005). Cheung & Yue (2011) observed similar humor styles used by exchange students from China even though they attended different universities. Other cultural groups that observed trends in humor styles that encouraged shared meaning were older adults with severe depression (Konradt et al., 2012), the general population of the Netherlands (Bos et al., 2016), young children (Anzieu-Premmereur, 2009), at risk teens (Cameron et al., 2010), and adults that had been divorced (Frisby et al., 2016). Additionally, Sultanoff (2013) noted humor as a defining element in the culture developed within a therapeutic relationship.

Limitations of humor. The most significant limitation evaluated in these articles was a significant gap in empirical research in terms of interventions and communities researched especially in terms of longevity (Kidd et al., 2009; Konradt et al., 2012; Sultanoff, 2013; Veselka et al., 2010). Additionally, in many of the studies available for this evaluation, limitations existed in the inability to randomize trials or a narrow scope of data (Cameron et al., 2010; Frisby et al., 2016; Konradt et al., 2012). Bos et al. (2016) only incorporated self-reported assessments of humor use and style rather than observed behavior. Fabian (2002) acknowledged difficulty in breaking through long-held beliefs about maintaining separation between humor and psychotherapy. Additionally, cautions to the clinician presented in this evaluation focused on intentional assessment of an individual’s humor style and respecting that personal or cultural

quality for what it is (Bos et al., 2016; Cameron et al., 2010; Cheung & Yue, 2011).

Implications for the use of humor. Due to the lack of empirical research, professional testimony is relied upon to assess the value of the use of humor in a therapeutic environment. When seeking to incorporate the use of humor into the therapeutic environment, clinicians are encouraged to maintain a goal that works to reinforce and recover the sense of humor that each individual possess to a different degree (Cheung & Yue, 2011; Konradt et al., 2012) and maintain use of clinical knowledge, sense of self, and a sense of the individual in order to create appropriate interventions with the use of humor (Fabian, 2002; Sultanoff, 2013). Bonanno (2004), Bos et al. (2016), and Cameron et al. (2010) identified humor provided great value in its contribution to a person’s overall well-being and utilized the therapeutic relationship to help the individual connect more deeply with their humor styles and their internal working provided a successful foundation for continued and helpful therapeutic interventions. Anzieu-Premmereur (2009) charged the clinician to create a space where playing becomes possible and silliness can be experienced even in the midst of difficulties from trauma. Additionally, Fabian (2002) identified a therapeutic benefit when the use of humor and the level of rapport between client and clinician moved forward at the same rate to maintain confidence and openness in the therapeutic relationship. For individuals experiencing serious mental illness, pre-existing stigmas may interfere with the benefit of the use of humor in the therapeutic environment. In a qualitative study by Kidd et al. (2009) evaluating this population, several interviewees noted that simply participating in the study and being asked about personal humor styles was experienced as highly beneficial and an explorative positive experience and the interview process was even referenced by participants as “just as therapeutic as Cognitive Behavior Therapy interventions” (p. 1424).

Level Three – Humor in Therapy Sustaining Behavior for the Clinician

As the articles naturally separated into levels in proximity to the research question, it was clear that a significant element to assessing how humor and the therapeutic treatment of trauma interact is addressing the use and effect of humor on the clinician as one portion of the relationship. Five articles analyzed in this study contributed to this level. The following themes were observed and evaluated for similarities and differences as well as to inform the long-term use of humor from the lens of the clinician.

The use of humor. Humor was identified in four main categories; respectful, running gags, sarcastic or demeaning, and dark humor (Maxwell, 2003; Valentine & Gabbard, 2014). Respectful humor was identified as spontaneous and not attached to a traumatic experience whatsoever. This was frequently observed in “exit lines” or a safe and quick drop of humor when exiting a therapeutic exchange where vulnerability was displayed. A running gag refers to a frequent return to items of amusement that return in the same or similar fashion within the therapeutic environment and was experienced through hyperbole, wit, irony, light sarcasm, or satire. Sarcastic, demeaning or self-defeating humor (Panichelli, 2013), was experienced on a number of levels from mild to cutting. Dark humor, including sick or gallows humor used wit to related desperate things to illuminate or amuse in the presence of emotionally or physically difficult situations.

The effects of humor. In the studies aligning themselves with using humor for sustaining behavior for clinicians, humor was identified in specific intervention models, in crisis response, psychotherapy, theoretical applications, and in education and training programs for psychiatric students (Gibson & Tantam, 2017; Maxwell, 2003; Panichelli, 2013; Schulenberg, Nassif, Hutzell, Rogina, 2008; and Valentine & Gabbard, 2014). Physiological, cognitive and psychological, and behavioral or relational effects of humor were identified in reference to the

clinician's experience.

Physiological effects of humor. The effects on the clinician's physical body were very lightly addressed within these studies. Maxwell (2003) identified humor as a tension reducer. Valentine & Gabbard (2014) identified when the right brain is being used for humor, it is not conducive to the neurological processing of the left brain used during manualized intervention methods suggesting difficulty in mixing the two processes.

Cognitive and psychological effects of humor. Humor was identified to promote several factors in connection to the clinician's cognitions and psychological wellbeing when participating in and following a therapeutic interaction. Humor was noted to act as a tool to reduce or counteract anxiety (Schulenberg, Nassif, Hutzell, & Rogina, 2008) through self-distancing, perspective taking, entertaining paradoxes, discovering alternative meanings, and even attitude change (Panichelli, 2013; Schulenberg et al., 2008). Humor was shown to allow for a balance in cognitions about conflicting motives in the therapeutic interactions (Panichelli, 2013). Additionally, humor was noted as a tool to increase capacity for empathy (Gibson & Tantam, 2017) which also connects to the therapeutic relationship itself.

Behavioral and relational effects of humor. Change, alliance, and coping were identified as the three main categories in demonstrating humor's effect on the behavioral and relational actions of the clinician. A variety of types of change were identified through the use of humor: potential change, part of the change process, adaptive and change capacities, behavior change, and increasing the capacity to face a problem (Panichelli, 2013; Schulenberg et al., 2008). As an element available to increase a therapeutic alliance, humor was shown to reduce interpersonal tension or conflict, increase ability to confront clients in a playful way about difficult topics, incorporate joining and reframing in the relationship, maintaining modesty in power

differentials, increase social bonding, build therapeutic rapport with connectedness and belonging through shared moments and shared meaning (Gibson & Tantam, 2017; Panichelli, 2013; Schulenberg et al., 2008). Additionally, humor was demonstrated to increase coping abilities of clinicians with difficult or traumatic situations (Maxwell, 2013) and was noted as the highest of eight most effective coping mechanisms which include anticipation, affiliation, altruism, self-assertion, self-observation, sublimation, and suppression (Panichelli, 2013).

Connection of Humor and Trauma. In this level of evaluation, humor in connection with trauma was directly referenced by three articles and indirectly referenced in two. In the three articles that referenced humor and trauma directly, the use and effect of humor on psychotherapy professionals was a key element of the original study. These studies noted that in spite of difficult and traumatic situations, humor was shown as a cognitive or behavioral coping strategy (Maxwell, 2003), an element to align and reframe the therapeutic environment (Panichelli, 2013), and to describe humor theories (Gibson & Tantam, 2017). Indirectly, humor was noted in the other two articles as a tool for increasing adaptive constructs while working through the use of logotherapy (Schulenberg et al., 2008) and in an evaluation for how students training to be psychiatrists are taught or not taught to use humor in psychotherapy interventions (Valentine & Gabbard, 2014).

Connection of Humor to Culture. No other specific cultural factors in the use of humor were noted in this grouping of articles except for the style and timing of the use of humor is somewhat consistent among the culture of crisis and emergency responders (Maxwell, 2003).

Limitations of humor. Without question, the greatest limitation noted in this set of studies was, again, that of a gap in systematic research assessing the use of specific humor techniques in the therapeutic environment (Valentine & Gabbard, 2014). Additionally, these

studies noted specific cautions in terms of two main themes: destructive potential and motivation. Many factors are at play that offer success of the use of humor in a therapeutic environment however there are also many factors that can play into the demise of the use of humor in a therapeutic environment. In more extreme humor styles like dark or gallows humor, there is a potential that humor could be construed to be attached to disrespect for the injured, deceased, or their survivors (Maxwell, 2003) or a number of other misinterpretations increasing distance in the relationship (Panichelli, 2013). Additionally, perils of the use of humor can include laughing with vs. laughing at, using humor as an escape, and using humor to quell beginner’s anxiety (Valentine & Gabbard, 2014). A check for motivation in the use of humor assesses the awareness of the clinician’s own response to client’s humor or use of humor (Gibson & Tantam, 2017). The effect of humor in therapy was noted to depend entirely on why, when and how it is used (Panichelli, 2013). Humor is a high-risk, high-gain intervention and learners or users of humor need to conceptualize it as such (Valentine & Gabbard, 2014).

Implications for the use of humor. As observed in this set of articles, a variety of potential opportunities for the use of humor in therapy were noted. The main themes for implications were identified as educational opportunities, intervention opportunities, and reflective practice opportunities. A variety in type of educational opportunities were noted as knowledge on appropriateness (why, when, how) (Maxwell, 2003), technique or choice of humor used (Panichelli, 2013), and using humor as a lens in sophisticated teaching on attachment theory, neuroscience, and right hemisphere learning (Valentine & Gabbard, 2014). In terms of intervention, logotherapy is a specific model that incorporates and recognizes humor as a significant element of the whole person (Schulenberg et al., 2008). Maxwell (2003) proposed a model including the use of progressive steps of humor from respectful to sarcastic in which

respectful humor (soft and spontaneous), dark humor (wit and irony relating to seemingly desperate things), and sarcastic humor (mild to strong irony most often times relating to behavior) are used to bring awareness, increase connection, and promote change. Valentine and Gabbard (2014) noted an importance on the user of humor to maintain status as a learner and to be frequently assessing the motivations and techniques of use implying a reflective practice. The clinician is directed to “use caution in humor but be open to the liberating and creative capacity that humor uniquely carries; remain vigilant and all the while human” (Gibson & Tantam, 2017, p. 285). Valentine and Gabbard (2014) encouraged the utilization of supervision and seminar coursework to reflect and educate on the presence of humor in the therapeutic environment. Additionally, Gibson and Tantam (2017, p. 273-275) offered four main theories of humor for the clinician to reflect on when utilizing humor in the therapeutic environment.

1. superiority theory: enjoyment is derived from other people’s misfortune
2. relief theory: a means by which nervous energy is released
3. incongruity-resolution theory: amusement as arising from defeated expectations in an audience
4. play theory: humor as a form of play

Reflecting and having the dialogue is the first step in incorporating beneficial humor into a healthy practice.

Level Four – Humor in Trauma Work Outside of a Therapeutic Setting

In both of the articles falling into this category, humor was the direct focus of the research, specifically on how humor is used in non-therapeutic settings; with case managers working with high-risk families and their children as well as with Internet Crimes Against Children task force personnel. The following themes were observed and evaluated for

similarities and differences as well as to inform the long-term use of humor in trauma work outside of a therapeutic setting.

The use of humor. Humor appeared in these studies as the use of laughter in response to a situation either initiated by the professional or by the individual/family, putting a humorous spin on a situation, gallows or dark humor, light hearted humor, humorous remarks, and light sarcasm (Craun & Bourke, 2014; Gilgun & Sharma, 2011). Specific definitions of vocabulary used to identify humor types were not identified but styles of humor were inferred through research findings.

The effects of humor. In the study evaluating case managers’ use of humor, it was noted that regardless of the type of humor used, the intentional or unintentional choice to use humor resulted in diffusing the situation in some capacity, either the case manager’s anxiety or to release tension (Gilgun & Sharma, 2011). In the study evaluating task force personnel, humor was connected to coping strategies needed in order to counteract the difficult and lasting effects of secondary trauma when being exposed to highly graphic images of crimes against children (Craun & Bourke, 2014). Regardless of the non-therapeutic setting, humor was employed to counteract difficult experiences and emotions and to increase case manager or task force personnel coping skills.

Physiological effects of humor. Three main themes presented in this level of data analysis is in the form of tension relief for both service users and professionals and a felt renewed commitment to well-being (Craun & Bourke, 2014; Gilgun & Sharma, 2011). No significant effects to specific body functions were noted in either study.

***Cognitive and psychological effects of humor*.** The main themes presented in terms of cognitive and psychological effects of humor were identified as igniting rational thinking and

moving out of flight-fright-freeze (Gilgun & Sharma, 2011), regulating negative emotions (Craun & Bourke, 2014; Gilgun & Sharma, 2011), relieving or regulating anxieties (Craun & Bourke, 2014; Gilgun & Sharma, 2011), and assessing timing of use and types of humor to show the level of psychological distress by professionals (Craun & Bourke, 2014). Both studies analyzed in this level implied cognitive and psychological effects on professionals rather than service users.

Behavioral and relational effects of humor. Themes identified in terms of behavioral or relational effects of humor in a non-therapeutic setting aligned closely in both studies; humor allowed for increased or continued coping that allowed professionals to continue physically engaging in their work, to express frustration, practice and promote creative problem solving, express liking and admiration, tolerate job stress, increase enjoyment of incongruity, and increase group cohesion (Craun & Bourke, 2014; Gilgun & Sharma, 2011). Each theme identified lends itself to a healthy professional growing process.

Connection of Humor and Trauma. Neither article referenced at this level made a direct connection between humor and trauma. However, both articles made indirect reference. Gilgun and Sharma (2011) referenced trauma as an implied element that significantly added to the stress and intensity of the cases observed. Craun and Bourke (2014) referenced trauma only indirectly by identifying humor was a tool that lent itself to increasing coping skills and resiliency among task force personnel to prevent or counteract the effects of Secondary Trauma Symptoms (STS).

Connection of Humor to Culture. No direct cultural connections were present in either article. Craun and Bourke (2014), however, identified group cohesion as a benefiting factor of the use of humor implying shared elements among the group of task force personnel or an

implied created culture among the group.

Limitations of humor. Gilgun and Sharma (2011) noted that some observed uses of humor by case managers could have been easily construed as expressions of superiority which could create significant distance between the professional and the service users. Additionally, the findings of the same study create the need to evaluate the ethical imperative to do no harm when working with individuals and families. Craun and Bourke (2014) identified a missed opportunity to separate types of gallows humor used in order to assess severity of source of humor and its effect on STS.

Implications for the use of humor. When evaluating the use of humor in working in a non-therapeutic setting with individuals or families experiencing trauma, both articles promoted the use of humor primarily for longevity of social workers and secondarily for well-being of service users (Craun & Bourke, 2014; Gilgun & Sharma, 2011). Additionally, the work of Craun and Bourke (2014) promoted the significant impact light-hearted humor had on the prevention of STS along with reduction of symptoms.

Discussion

In the traditional Navajo Indian culture, the child is viewed as the ultimate gift. The first laugh ceremony ensures that an infant is constantly watched over and kept in a cradleboard until the infant laughs for the first time. This moment marks the child’s birth as a social being. The member of the family who makes the baby laugh must then provide for a celebration in honor of the child (Anzieu-Premmereur, 2009).

Regardless of the focus or style of study evaluated in this research, universally, humor is identified as an individual and personal experience not unlike spirituality. Often times, those individual experiences will align with others due to a shared culture, a shared experience, or simply in shared amusement. The hypothesis for this study rested in that humor would show as an effective and complementary tool for offering strength in resilience building for individuals

who have experienced trauma and would include supporting information for all categories of an individual; physiological, cognitive and psychological, and behavioral or relational. Although cautions for use were presented to the clinician in these findings, overwhelmingly, humor was shown to offer positive effects in all categories. The nature of the humorous interactions demonstrated connection to the effects of the use of humor and in order for humor to be utilized in a therapeutic capacity, the relationship between the initiator and the receiver must be frequently assessed and humor allowed to progress in tandem with the depth of the relationship.

In order for humor to play a therapeutic role, the findings suggest the humor initiator (clinician) must first be skilled in identifying the motive and style of humor to be used and must act in a conscious and purposeful way. Secondly, the humor initiator should embody the use of empathy and compassion, genuineness and congruence, and unconditional positive regard or acceptance as noted by Rogers (1961) as these elements are central to therapeutic interpersonal interactions. Additionally, the receiver of the humor (client) must first hear and perceive the humor and the bond between client and clinician must guide the “tone” of the humor used in a therapeutic capacity, utilizing the mechanics and meaning of humor as “the right amount of wrong” (Mankoff, 2014 as cited in Gibson & Tantam, 2017). Throughout these findings, general themes of alliance, trust, and safety could be found in the exchanges between client and clinician where humor is present in the therapeutic relationship and is used as a tool for deeper knowledge and awareness of a traumatic experience and the lasting negative effects an individual may be experiencing.

An element that was not directly studied initially but showed great value was the use of humor for the clinician’s own ability to cope with difficult situations while maintaining job satisfaction and care of self. Clinicians who modeled a light-hearted view of even harsh realities

were shown to offer great value in the therapeutic relationship. Humor is a tool easily accessible to individuals, groups, locations, and settings and can have a positive effect on mental health and trauma symptoms or prevention of secondary traumatic stress.

Implications for Social Work

Without a doubt, as clinical social work represents a whole-person approach to health and well-being, it is instrumental that more empirical research be performed in any capacity from incorporating minor humor intervention strategies to larger general population studies. The support of professional testimony has laid a solid foundation for a large increase in formal studies.

As a practice intervention, clinicians should feel empowered to take the risk in assessing one’s own humor style and motivators for the use of humor. Knowledge and awareness is the first step to using humor in a helpful capacity for the therapeutic environment.

In a therapeutic capacity, clinicians should feel empowered to open the dialogue with clients to identify personal qualities of humor and how it can be woven into interventions and how to recover from humor that precedes the bond of relationship.

Lastly, assess, assess, assess. The use of humor in a therapeutic environment offers a key to the lock of the internal world of an individual. Keep a willing foot into the interaction and use of humor even when trauma symptoms are present while keeping one foot out and staying clinically grounded for what can be learned about the individual through the observed use of humor and which self-revelations can be expanded on with a light-hearted, perspective taking experience. Incorporating questions on what a person finds amusing or entertaining can be a crucial next step as part of a comprehensive bio-psycho-social-spiritual diagnostic evaluation and basis for therapeutic interventions when working with trauma.

Limitations of Study

Limitations presented in this study fell most specifically in the area of lack of empirical research in order to formulate a systematic narrative review. In order to respond to the original research question posed, researchers were required to draw from higher level themes than specific points of research. Additionally, the term *humor* was shown to be quite overarching in itself and data was extracted based on repeated use of terms in describing elements of humor.

This study sought to understand the interaction between humor and the therapeutic treatment of trauma. Researchers used thematic data to establish concepts crossing four levels of interactions found in working with trauma in a clinical social work capacity.

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Appendix A

Table 1: Data Analysis Form

Article title	
Author/s & year of publishing	
Type of article	
How is humor represented within the article?	
Is humor addressed/incorporated intentionally or unintentionally, how?	
Is humor represented in connection with trauma treatment? If so, how?	
How is humor projected to be used in future work?	
Is humor identified in terms of a cultural connection? If so, how?	
Any distinguishing characteristics of the article?	
Limitations or concerns about the study or review?	

Appendix B

Table 2: Article Form

Author/s	**Year**	**Research Type**	**Proximity to Research question**
Garrick	2006	Literature Review/Case Study	Level One
Konradt, Hirsch, Jonitz, & Junglas	2012	Feasibility Study	Level Two
Sultanoff	2013	Intervention Review	Level Two
Box, Snippe, de Jong, & Jeronimus	2016	Population-based internet Study	Level Two
Bryant-Davis	2005	Qualitative Study	Level Two
Veselka, Aitken Shermer, Martin, & Vernon	2010	Phenotypic Study	Level Two
Anzieu-Premmereur	2009	Case Study	Level Two
Fabian	2002	Literature Review/Case Study	Level Two
Bonanno	2004	Literature Review/Case Study	Level Two
Cameron, Fox, Anderson, & Cameron	2010	Ecological Research	Level Two
Cheung & Yue	2011	Quantitative Study	Level Two
Frisby, Horan, & Booth-Butterfield	2016	Quantitative Study	Level Two
Kashdan, Yarbro, McKnight, & Nezlek	2013	Sampling Survey	Level Two
Kidd, Miller, Boyd, & Cardena	2009	Qualitative Study	Level Two
Schulenberg, Nassif, Hutzell, & Rogina	2008	Theoretical Model Review	Level Three
Maxwell	2003	Qualitative Study	Level Three
Panichelli	2013	Literature Review/Case Study	Level Three
Gibson & Tantam	2017	Literature Review	Level Three
Valentine & Gabbard	2014	Literature Review	Level Three
Gilgun & Sharma	2011	Exploratory Case Study	Level Four
Craun & Bourke	2014	Quantitative Study	Level Four