THE IMPLEMENTATION OF HUMOUR AS DEFLECTIVE TECHNIQUE IN CONTACT BOUNDARY DISTURBANCE

by

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Submitted in part fulfilment of the requirements for
the degree of

MASTER OF DIACONIOLOGY
(DIRECTION: PLAY THERAPY)

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR C H M BLOEM

NOVEMBER 2007

ACKNOWLEDGEMENTS

I wish to express my sincere thanks and gratitude to the following persons who helped to make the completion of this research possible:

- To my supervisor, Dr Retha Bloem, for the assistance, guidance and encouragement that she gave me during the conducting of the research and the writing of the thesis
- To my husband for his technical help, continued support, encouragement, and unselfish assistance
- To my dear children, Clarissa and Bianca, for being my soundboard and for their unconditional love and encouragement
- To UNISA for study leave and support
- To Jean Mitchell for proofreading and editing this thesis
- To my parents, family and friends for their ongoing support and encouragement
- To Bramley Childrens Home for the use of their facilities
- To the children in Play therapy that inspired me
- To my colleagues for their support
- To Almighty God, who is the source of all knowledge

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I declare that THE IMPLEMENTATION OF HUMOUR AS DEFLECTIVE TECHNIQUE IN CONTACT BOUNDARY DISTURBANCE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE

(S JACOBS) Date

SUMMARY

THE IMPLEMENTATION OF HUMOUR AS DEFLECTIVE TECHNIQUE IN CONTACT BOUNDARY DISTURBANCE

One potent, yet little recognized tool in therapy is humour. As the desire to be entertained through humour is near universal the establishment and return of a positive sense of humour may be considered a goal of therapy. The goal of Gestalt exploration is awareness. From its origin Gestalt theory includes addressing body experiences such as laughter and emotional expression through humour.

In Gestalt Theory a contact boundary disturbance such as deflection refers to the ways in which individuals may refuse contact with their environment in order to avoid awareness.

The goal of this study was to explore the implementation of humour as a deflective technique where contact boundary disturbances occur, to bring about change. Aspects of humour, namely the ability to perceive the comic as well as the ability to produce it, aid therapy and relationship building, and help the client to deflect in a way that enhances emotional well-being.

Key terms:

Humour; Incongruity; Gestalt; Gestalt Play Therapy; Children's play therapy
Awareness; Resistance; Contact; Boundary; Contact boundary disturbances;
Contact avoidance; Deflection; Play therapy techniques

OPSOMMING

DIE IMPLEMENTERING VAN HUMOR AS DEFLEKTIEWE TEGNIEK IN KONTAKGRENSVERSTEURINGS

Humor, geringskat in terapie, is ‘n uiters sterk hulpmiddel. Aangesien die behoefte om vermaak te word deur humor universeel is, is die terugkeer van ‘n positiewe sin vir humor ‘n deurdagte doel vir terapie. Die doel van die Gestalt eksplorasie is bewuswording. Van die begin af sluit Gestalt teorie liggaamservaringe soos lag en emosionele uitdrukking deur humor in.

In Gestalt Teorie verwys ‘n kontakgrens versteuring soos defleksie, na die wyse waarop individue kontak met die omgewing vermy, om sodoende bewuswording te vermy.

Die doel van die studie was om die implementering van humor as deflektiewe tegniek, waar kontak grens versteuringe en weerstande voorkom, as verandering teweeg kan bring. Aspekte van humor, naamlik die moontlikheid om die komiese waar te neem, sowel as om dit te produseer, versterk terapie and vehoudings-bou, beide aspekte help die klient om te deflekteer op so ‘n wyse dat emosionele goedvoel bevorder word.

You cannot be angry at someone that makes you laugh – it is as simple as that

(Edgar Watson Howe: In Van Eeden, J. 2006. HaHaHaHaha… *In Beeld* Thursday 20 April 2006)

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CHAPTER ONE

GENERAL INTRODUCTION

1.1 INTRODUCTION

This study will focus on the implementation of humour in the therapeutic setting in order to establish awareness. The central theme was to focus on humour as deflective technique in settings where contact boundary disturbances occurred. According to Ludick (1995:78), in Gestalt theory a contact boundary disturbance refers to the ways in which individuals may refuse contact with their environment. In Gestalt theory deflective behaviour refers to the interruption or "turning aside from contact" with the environment. According to Ludick (1995:85) deflection is experienced through a *temporary* sense of the environment, and could be characterized by behaviour such as avoidance.

Just as deflective behaviour can be described as a contact boundary disturbance in order to avoid awareness, the researcher wanted to investigate whether deflection could be used as a powerful instrument in order to establish awareness or maintain awareness long enough for therapeutic change to occur. This process refers to the paradoxical theory of change often used by Gestalt therapists (Zinker, 1994:102).

Humour can be described as the process of "been amused" or "being amusing". It is the process of making people laugh and the ability to enjoy comical things. In order to use humour the individual needs a *sense* of humour. This *sense* refers to the ability to feel or appreciate something, or in Gestalt terminology, the ability to be aware. The ability to experience humour is expressed through laughter.

The human being is the only organism on earth that has the ability to laugh. No other living being or animal has this capacity. Furthermore, it has often been said that it is the relatively mature and emotionally healthy individual who laughs frequently and enjoys it. Mental health professionals tend to agree that an absence of a sense of humour indicates that the person is suffering from emotional conflicts and is probably depressed. Schaefer (1993:22) confirms this by saying that the inability to laugh is a sign of severe emotional disturbance.

One extremely potent, yet apparently little recognized tool in therapy is humour. Olsen (1994:125) is of the opinion that by referring to humour is to refer to something positive that brings about mutually shared enjoyment and pleasure, that which is philosophic rather than belitelling. According to Chapman and Foot (1976:306) the urge to laugh is a basic human need. The desire to be entertained through humour is strong and near universal. Olsen (1994:27) continues by saying that humour, as a therapeutic tool must build instead to knock down, and therefore excludes sarcasm and cynicism.

The polarity of humour is sadness and unhappiness often expressed through crying, the other emotional response that is uniquely human. The absence of tears when they are expected, like the absence of laughter also indicates unconscious emotional conflict. It was important for the purpose of this study to identify the polarity as an emotional response because it would direct behavioural change from unhappiness to happiness.

1.2. RATIONALE AND PROBLEM STATEMENT

The choice of a topic of research is never made in a vacuum. Personal values often determine a researchers' choice of a topic. The personal interest ensures that the researcher will have commitments and motivation to complete the project (Collins, 2000:20). From this personal interest, a problem needs to evolve. The author further states that the formulation of the problem engages the reader in

the specific focus of the study and views it as the point of departure from which clarity about the issue is sought.

According to Strean (1994:xi), although laughing and crying are two basic inborn emotional relations, psychoanalysts and psychotherapists have been much more interested in the phenomenon of crying than laughing. In contrast to the many clinical papers in the professional literature that deal with the patient's inability to cry and mourn, there are very few that discuss the dynamics of the patient's inability to laugh, a patient's use of wit, humour and laughter. Most professional commentators on the subject point to this behaviour as a means of acting out, a way of resisting, a sign of a regressive transference, a maladaptive response, and frequently a disguised way of expressing hostility.

Shapiro (2002:24), on the other hand, asks the question with regard to the counsellor: *"Why are counsellors so serious? Certainly, we have a right to be serious, if not downright depressed, when you think about all the heart rending problems we see in a day: but paradoxically our serious natures may not be in our client's interest".* Olson (1994:196) agrees that the establishment or return of a positive sense of humour may well be considered a goal of psychotherapy. It seems to follow that the degree to which the sense of humour becomes established may be considered one criterion of the success of therapy. The author further points out that many studies show that humour is an important emotional intelligence skill.

As McGhee (1980:301) notes, children who are "skilled at humour" may be more successful in social interactions throughout their childhood, for "it is difficult not to like someone that makes you laugh". Olson (1994:197) says that those who laugh together soon forget their differences as humour provides a common bond for mutually shared experiences, where the participants momentarily drop their guard and relate authentically. Humour can thus be seen as a universal means of relationship building. Olson further stresses that humour can also be an

important curative force for children, both psychologically and physically. A variety of studies have shown that humour strengthens the immune system and often speeds recovery from illness (Kaduson, 2004:222; McGhee, 1980:143, 303; Saul, 1994:167; Schaefer, 1993:342 & Van Eeden, 2006:16).

According to Shibles (2002:16) one can learn humour just as one can learn typing. Unfortunately, humour is not taught in schools, but is rather suppressed. The author suggests that the therapist can improve the humour of any client. Nobody goes for therapy to improve their humour skills, which is a mistake as humour is one of the most significant aspects of life and our relationships with people. It is a form of “mental hygiene” in preventing depression, needless worry, hatred and frustration (Shibles, 2002:17). The researcher agrees with this and is of the opinion that therapists, clients and in fact the general public, do not recognise the value of humour in situations that are serious.

Since the researcher has been involved in the social sciences and caring profession, she has become aware of unhappiness in life. For a long time the researcher has been aware of the reactions of audiences when they listen to presentations, of whatever kind, being delivered in a humourous fashion. The researcher’s interest in this issue was further generated during many years of involvement in education and the teaching profession. She has become convinced that teaching leads to true learning when it is fun, because when learners are having fun the element of fear is removed. In addition, she has personally been aware of a “lighter feeling” when in the presence of a humouristic person, or by chance being involved in a situation where some laughter has occurred. It seems as if people are always drawn to the zestful and joyful, thus are drawn to the joys of sharing laughter, as it seems to remove distances.

The question arose whether the use of humour could be **taught**, especially after reading the comment Shibles (2002:16) made on humour that can be learnt, whether it could be taught as a vehicle for an intervention skill, especially as a

coping mechanism for clients, as well as for therapists. The researcher further wondered if people could be made more aware of the positive impact humour could have on a situation, involving the teller as well as the listener, in individual and group situations. In addition, the question to be asked was if clients and therapists could be made aware of their own humouristic capabilities. Since people tend to hide behind their feelings, as well as hide their feelings in various ways in order to try to escape pain, the possibility to explore the use of humour as a directive skill when "deflection" as resistance presents itself during therapy, arose.

As previously stated, in Gestalt Therapy, "deflection" is seen as a contact boundary disturbance where the client avoids connection, by shifting the contact to some other topic that provokes less anxiety (Zinker, 1994:124). In the present research it needed to be determined if humour could be implemented positively, and thus become a positive tool or technique to help the client address deflection. Some may argue that in its true sense humour may also be a form of deflection. For the purpose of this study, the researcher used humour particularly for its attributes as a deflective mechanism in order to address deflection as a contact boundary disturbance. Furthermore, the researcher wanted to investigate if the experience of pain, avoidance of connections, could be turned into enrichment, the creation of clearer boundaries, in order to create more interpersonal comfort instead of discomfort.

Another aspect of the research was to investigate whether awareness of the environment could be increased through humour and if the individual would be able to stay in a state of awareness in order to bring about emotional change.

Gestalt theory argues that if the process of awareness can be increased (Yontef, 1993:30) then the client may receive feedback from him/herself and others and the environment more efficiently. On the grounds of everything mentioned thus far, the following research questions arose:

Does the use of humour as deflective technique in Gestalt therapeutic work improve self-awareness and personal well-being?

The researcher considered the question to be particularly relevant to the therapeutic environment. She considered that research to establish answers to the question would probably contribute to the establishment of theories of humour in therapy.

The therapeutic as well as scientific value of an answer to this the research question would contribute and improve practice for

- therapists (Gestalt play therapists, as well as other therapists) who constantly deal with emotionally damaged people who show resistance and contact boundary disturbance in therapy;
- therapists' own feelings of well-being and achievement, during and after therapy sessions which will in turn combat fatigue and burnout;
- clients, empowering them to recognize, become aware of and handle deflection when not in therapy; and
- councilors and any one in the caring sciences, such as social workers, occupational therapists and teachers dealing with stressful events in their work environment.

1.3 AIM AND OBJECTIVE OF STUDY

The creation of the research problem gave rise to the formulation of more concrete research objectives, questions and hypotheses.

The aim of this study was to use a variety of carefully selected techniques in order to explore the implementation of humour as a deflective technique where **contact boundary disturbance and resistance occurs in order to bring about a change in emotional well-being.**

In order to reach the aim of this research the following critical objectives were formulated. These would enable the researcher to determine the needs and formulate steps to be taken in order to achieve the desired research goal.

- To collect and identify the phenomenology of humour, the process of how humour can be used and illustrated for enhancing self-awareness and personal use
- To gain knowledge by collecting and identifying the implications of contact boundary disturbance and deflective behaviour in order to isolate the relevant indicators that identify deflective behaviour as part of the Gestalt perspective. Through this information the question “Can humour be used to overcome/address contact boundary disturbance?” could be answered.
- To collect and interpret data through a single case study in order to answer the following sub-questions:
    a. Is humour accompanied or followed by indications of a positive shift in the client’s self-concept or self-perspective?
    b. Alternatively, is there a therapeutic change through the axis of heightened feeling?
    c. And, is the use of humour conducive to the Gestalt therapeutic situation?
- To describe an approach that will provide conclusions regarding the utilisation of humour as deflective technique in a therapeutic intervention to heighten awareness levels and well-being.

A hypothesis refers to a positive statement made about the relationship between variables. Once the researcher empirically tests or evaluates the research problem, it becomes a hypothesis. The hypothesis statement contains two or more variables that are measurable and specify how the variables relate to each other (De Vos, 2005:33).

The following hypotheses will guide this study:

- **Hypothesis 0:** The therapeutic use of humour has no effect / does not illustrate value / is not an effective tool / when it has been implemented as a modality in the case where contact boundary disturbance occurs.

- **Hypothesis 1:** The therapeutic use of humour illustrates value as an effective tool to address contact boundary disturbance if implemented as a modality in the case where contact boundary disturbance occurs.

1.4 THEORETICAL FRAMEWORK AND PARADIGM FOR THIS STUDY

Social science research entails more than merely gathering facts to describe phenomena (Puttergill, 2000:41). Theory provides inquiry with a focus, by suggesting what evidence is needed, since the evidence is specified. Theory provides a sifting mechanism making the evidence generated more manageable and thus preventing stimulus overflow.

In addition, theory explains actual situations in social reality, not imaginary ones (Vithal, 1997:17). In fact, theory is a way of systematically thinking about the phenomena we observe and experience, it also provides a framework for interpreting and organizing information we have collected (De Vos, 2005:263 & Collins, 2000:19).

According to de Vos (2005:265), theory and literature review in a case study guide the study in an exploratory way (before data collection), or is employed towards the end of the study to compare and contrast it (after data collection).

The point of entry for this study was the holistic approach used in Gestalt Theory as interpreted by Perls, Hefferline and Goodman in 1951, as referred to by Zinker 91994:94), based on the Phenomenological Existential perspective, Phenomenology is a discipline that helps people stand aside from their usual way

of thinking so that they can tell the difference between what is actually being perceived and felt in the current situation and what is residue from the past (Yontef, 1993:2), and can be seen as viewing the world from the inside to the outside (O'Dessie, 1994:145).

Existentialism is based on the phenomenological method and focuses on people's existence, relations with each other, joys and suffering as directly experienced (Yontef, 1993:3 & O'Dessie, 1994:137). O'Dessie states that fundamental beliefs about dualism and personal responsibility are central to the existential philosophy. Furthermore this theory declares that humans and the world in which they live are not mutually exclusive. According to Yontef (1993:3) and Oaklander, (1994:143) Gestalt Therapy treats what is "subjectively" felt in the present, as well as what is "objectively" observed as real and important data. Therefore, the goal of Gestalt phenomenological exploration is awareness or insight. The Gestalt approach is based on the assumption that the whole is greater than the parts presented.

Oaklander (1994:43) maintains that in the emerging human, the child is unable to understand where separation of the self or boundary and the world begins: until the child develops a sense of separateness, the child will not be able to develop the potential strength that hides within.

While boundary disturbances exist, the child is forced to use coping strategies that are oftentimes not functional, in order to fit in with those whom the child is in contact with. She concludes that a goal of therapy is to assist the child to develop a sense of boundaries between self and others, which Oaklander calls the *point of contact.*

Thus it becomes clear that the purpose of Gestalt Therapy is to address the needs of the child to become self-supportive; and is the focus of a Gestalt play

therapist. Self-support implies self-knowledge and making choices that will bring the client in contact with his positive energy.

1.5 LITERATURE REVIEW AND VIABILITY OF THE STUDY

The first step of narrowing a topic of interest into researchable questions is to examine what the literature says about it. This introduces the researcher to the debates and arguments surrounding the topic, and enables him/her to gain insight into the topic, and to identify the key issues that need to be explored (Puttergill, 2000:61).

A literature review further offers a synthesis of what has already been written on the topic and what has not and what is inadequate, as well as how the researcher's proposal addresses the gap, silence or weakness in the existing knowledgebase (Vithal, 1997:14). According to Puttergill (2000:59), social scientists are sometimes confronted by contradictory research findings that challenge existing explanations, and thus require further research.

In the literature review conducted for the present research it was found that the existing research on humour in psychotherapy pertains to its effectiveness with regard to its healing power, its destructive power, innovative applications for practice, as well as it being a function of creativity. Some mention is also made of humour as a form of resistance and metaphor for negative feelings (Strean, 1994:169, 15; McGhee, 1980:100, 288-290, 96-98, 99-104 & Schaefer, 1993: 223-239). Mostly humour is used for developmental assessment and as a diagnostic tool (Schaefer, 1993:22; McGhee, 1980:302 & Chapman, 1976:3).

Literature was found to be limited for the present study in that it fails to link humour to resistance as contact boundary disturbance. In Gestalt Play Therapy many references refer to the use of games in order to create pleasant and safe surroundings namely: Cattanach, 2003:92,142; Kaduson, 2004:352; Schaefer,

2004:336-337; Kottman, 2001:12-14; Lubimiv, 1994:65, Mahrer, 2002:199, McGhee, 1980:11, 299; McMahon, 1992:5, 22, 39, 77, 83, 139-142, 186; O'Dessie, 1997:81; Saul, 1994:157; Schaefer, 1993:331 and Van Fleet, 2004:51.

However, it fails to link the concept of humour to play, fun and games. In many instances in Gestalt Play Therapy literature mention is made of fantasy, imagery techniques as well as metaphoric teaching to create a safe environment for internalizing behaviour (Schaefer, 1993:94 and Kaduson, 2004:350).

The researcher found no reference that addresses techniques for addressing contact boundary disturbances such as deflection. Deflection is regarded as a contact boundary disturbance (Zinker, 1994:124 & Oaklander, 1994:61). The value of making use of humour as a technique for deflection has thus not yet been researched. According to McGhee (1980:28), the only prerequisites for humour are the capacity for play and the ability to detect incongruities. According to the researcher, this is very good news, as it means that many clients can be reached.

1.6 RESEARCH APPROACH/DESIGN

As the design involves the drawing up of a plan for the research, research design is usually done early in the research process, and should be coherent. The research conducted for this study followed the qualitative research paradigm. This approach is applied in nature focusing on the functional approach where answers for research questions can be found through recommendations.

According to Collins (2000:84), researchers using applied research try to solve problems or, if necessary, try to make specific recommendations. Applied research is generally descriptive in nature and its main advantage is that it can be applied immediately after having obtained the results. The criteria for applied research are that results should be presented in such a way that they can be

accessed by practitioners and can actually be used by them. Collins further defines this type of research as “the process of establishing value judgments based on evidence” which can be answered summatively, as the emphases is on the outcome or the result, and is therefore a reflective process.

Single case study forms part of applied research and was incorporated into this study because the characteristics of a single case study fit the aim of the present research. The research strategy implemented to explore the phenomena was the intrinsic case study (also known as an in-depth case study) bounded by time, place and activity (Creswell, 2003:15). The case can refer to a process, event, individual or group of multiple individuals. The design used for this qualitative research consisted of a series of therapeutic sessions with one single participant. The result of the research process forms a detailed description of the case study.

For the purpose of this research the case study as part of the single-systems design was used. The basic experimental design (A-B-A design) was used where the case study focused on intervention. The problem the researcher addressed was that in many cases, children do not possess the ability to use humour as a deflective technique in order to manage emotions, they also do not know how to deal with humour in a therapeutic relationship in such a way that it has positive consequences for the therapeutic process. In fact, children and therapists feel uncomfortable using humour as a positive outcome in therapy. The hypothesis of the researcher was that the therapeutic use of humour illustrates value as an effective tool to address contact boundary disturbance if being implemented as a modality in the case where contact boundary disturbance occurs. Baseline behaviour such as vague boundaries, emotional unstability and the continious changing of the topic of the participant was the negative deflective behaviour. The A represents the evaluation before and after therapy – this includes the observations done by the persons referring the child for help, the projection techniques used by the therapist and the self evaluation of

the child after the therapeutic process – where the B represents the therapeutic intervention using humour as deflective technique.

The case study represented a qualitative approach in which the point of departure is to study an object, namely man, within unique and meaningful human situations of interaction (Grobbelaar, 2000:89).

The following general characteristics of qualitative research are also applicable in this case, and are mentioned by Borg and Gall (1989:385-387), who state that qualitative research has the following general characteristics:

1. It allows a holistic investigation to be executed in a natural set-up. The set-up is studied as a whole in order to understand the realities involved. For this reason, the researcher tries to understand a phenomenon within its social, cultural and historical context.
2. Man is the primary data-collecting instrument. As such the researcher can adapt to a complex situation as it develops, and differences in values and preferences can be taken into account. Additional data can be obtained through other more objective instruments, such as questionnaires.
3. A wide variety of subjects are selected in a purposeful way, rather than in a random manner.
4. The researcher makes use of inductive data analysis, so that unexpected results will come into the fore. First, the researcher will collect the data, and then he/she will try to understand the situation and make deductions.
5. The subject plays a role in the interpretation of the results. Qualitative research tries to reconstruct reality from the subject's frame of reference.
6. Intuitive insights are used (the subject's experience of the situation)
7. The emphasis is on social processes and the meanings attached to such social situations by the participants.

All of the mentioned categories can be applied to the research questions, posed as critical questions that this research aims to answer, thus focusing this research to a structured and schematic plan of completion.

In Qualitative research the researcher is more involved in the phenomenon than in quantitative research. Sometimes they are even prepared to be part of the phenomenon that is studied (Grobbelaar, 2000:90). This provides the opportunity to give their own experiences from their own observations. Qualitative researchers are therefore open to observation and to pinpoint behaviour accurately.

Due to this, this research study was be of a descriptive nature, as it aimed at giving specific details of a situation. The “how” and “why” of the phenomenon was determined, and who was involved in the case study research.

According to Cattanach (2003:164) and De Vos (2005:272), case study research is a method that uses systematic observation and data collection. The research takes place in a specific environment, and information about the case comes from a variety of sources. Each individual case study consists of a “whole” study, in which facts are drawn from various sources and conclusions are drawn from those facts.

Case study research falls under “time dimension”. According to Grobbelaar (2000:99), in case study research the researcher tries to make an in-depth investigation into various characteristics of a small number of cases over a specific period. This means that data that are collected are more detailed, varied and comprehensive in nature. Cases can include individuals, groups and organizations, and can be compared with one another. This suits the manner in which the researcher hoped to answer some of the critical questions.

Grobbelaar (2000:99) continues by claiming that what is of importance is that the researcher focuses on various factors. Case studies constitute an in-depth investigation into interaction among factors that influence explanations or change. These factors are then analysed with the use of logical or analytical induction. A researcher will study one case or a specific number of cases regarding a specific topic and will then analyze the information obtained in detail, in order to determine how the different aspects are taking shape. This is also a way of organizing data with a view to taking stock of social reality.

Case study research is not sampling research; however, selecting cases must be done to maximise what can be learned in the period available for the study (Tellis, 1997:1).

Grobbelaar (2000:99) is of the opinion that case study research is also used to link the micro level to the macro level. On the micro level the behaviour of individuals is studied, so that it can be applied to social structures and processes on a large scale (Macro level).

In the case studies used in this research, data was collected by means of various techniques such as:

- Observation of social qualities or conducting therapeutic intervention using humour as deflective technique.

- Questionnaires (De Vos, 2005:107, 144, 159, 206 and Rossouw, 2003: 127-140) as selected or developed after the most important indicators were identified.

The researcher is of the opinion that the major limitation of single case study research is that results cannot readily be generalized and their extension of an

instrumental study to several cases was made use of, as the researcher believed that understanding these cases would clarify issues of theory.

To summarize: in this research, use was made of applied research; the approach was qualitative, with the aim to be descriptive, over a period of time by making use of case-study research. By making use of the case study, some flexibility could be developed as a strategy.

1.7 RESEARCH METHODOLOGY

As in all research, consideration must be given to construct validity: internal validity, external validity, and reliability (*construct validity* using the single case *exploratory* design, and *internal validity* using the single case *explanatory* design (Tellis, 1997:1)).

In this research, the experiments were with regard to whether*: the use of humour does not illustrate value; or whether the use of humour illustrates value.* The researcher created a condition or changes in an existing situation, called a treatment. Treatments included counseling, showing videos and using specific strategies and techniques. The researcher manipulated the treatment condition and thus decided who would receive which treatment.

The research context needs to be controlled. In so doing internal and external validity will be considered. Internal validity is achieved when the research into whether one of the factors is contributing towards the dependent variable is investigated, thus excluding other possible influences such as maturation, instrumentation and selection of subject, mortality, and the testing effect. In external validity, the implementation of control is omitted, as it tends to result in an artificial situation. Particular care should be taken to evade the reactive effect (Hawthorne) where subjects respond because they know they are being observed and researcher expectancy, where expectations cause a researcher to

behave in a manner that makes the expected event more likely to occur (Collins, 2000:131).

As part of the qualitative designs the decision on what specific data collection and analysis techniques to use are an important part of the research (Collins, 2000:134). The framework needs to be broad, but should allow the researcher flexibility while preventing the researcher from losing his/her way later. The outcome focuses on understanding rather than predicting general patterns of behaviour. In the present investigation the researcher planned to be involved in participant observation, which she hoped would prevent participants “holding back” during interviews, as she hoped this study would bring certain forms of information together across a broader front.

Triangulation was used, as data was collected from different sources, by making use of different techniques. The data was analysed using more than one type of analysis (De Vos, 2005:346, 360). According to Collins (2000:135), approaching a problem from several different angles increases the chance of “homing in” on correct or useful findings. Room needs to be let for “emergent design”, that is, the researcher discovering what he/she is doing as he/she goes along because new issues may arise as the study proceeds.

The limits of the flexibility pertained to time constraints, and the intended outcomes of this research were continuously reviewed. The intended outcome was interpreted and the phenomenon against the theory of existentialism and holism and the gestalt perspective was reflected upon. It was intended that research findings can also be actively used to change a therapeutic situation. Such action was implemented as it might have involved a continuous cycle of implementing interventions, evaluating their impact and modifying the intervention.

To summarize: The methods that were used in this qualitative study were:

Description: the researcher conducted in-depth, open interviews (therapeutic interventions) with a single participant to understand the subjective experience of humour as a positive technique for reflection on therapy after its implementation.

Scope: the main focus was on understanding the experiences of the particular individual interviewed, as well as the empowerment strategies that resulted from the intervention. A structured thematic content analysis was used.

Flexibility: the general area of concern was determined in advance by means of critical questions, but further specific questions could have arisen later. The interview format was naturalistic and open. The analytic technique was a phenomenological analysis that focused on private experiences and subjective perceptions that were specified in advance.

Relationship: the relationship was intense and empathetic, with the researcher playing the role of an interested and concerned listener and therapist.

Outcome: A conference paper could be presented in which the researcher "brackets" her theoretical and other preconceptions and attempts to let the data "speak for itself".

1.8 SAMPLING

A sample is a part of the whole, or a subset of measurements drawn from the population, thus being a selected group of elements from a defined population (Collins, 2000:149 and De Vos, 2005:194). A representative sample means a sample that resembles the population in as many ways as possible and that allows the researcher to accurately generalize results. A population that consists of people who are similar to each other is known as a homogenous population. In this research, the similarity lay in the fact that people who came for therapy are in some or other way not in touch with themselves or emotionally injured and

saught therapy in order to restore the imbalance experienced. This was the criteria for inclusion of the subject in this research. Therefore sampling in this research can be described as non-probability sampling with a purposive or as Collins, (2002: 158) describes it, convenience sampling (also called accidental or availability sampling), as the researcher selected those elements that he or she could access easily, until the sample reached saturation.

1.9 DATA COLLECTION: SUMMARY OF THE RESEARCH PROCEDURE

In this research, the researcher collected data by using the steps indicated by single-systems design (Strydom, 2002:154).

1.9.1 Formulation of the problem

The researcher reviewed relevant problem areas that were identified by the social worker who referred the child for therapy.

1.9.2 Review the literature

In preparing to conduct this research the researcher saturated herself in the literature as indicated in chapter two and three of this report. The researcher also attempted to find the most productive means of dealing with the indicated problem by using the theoretical framework stated in this report.

1.9.3 Development of goals and objectives for the study

The researcher developed the aim and objectives as indicated in 1.3 of this chapter. Specific goals and objectives were also developed for the intervention. These goals and objectives guided the researcher in proceeding with the intervention programme and in estimating when she had reached her goals

1.9.4 Development of Hypotheses

The researcher developed hypotheses about the ways in which certain variables were affected by the problem. The following hypotheses were stated:

- **Hypothesis 0:** The therapeutic use of humour has no effect / does not illustrate value / is not an effective tool / when it has been implemented as a modality in the case where contact boundary disturbance occurs.
- **Hypothesis 1:** The therapeutic use of humour illustrates value as an effective tool to address contact boundary disturbance if being implemented as a modality in the case where contact boundary disturbance occurs.

1.9.5 Development of the design

This refers to the researcher's plan for collecting and analyzing data.

The Data collection plan, in relation to the critical question "Can Humour be implemented as therapeutic tool in contact boundary disturbance?" was directed according to the measuring instrument used to determine base-line behaviour. The following structure directed the process of data-collection in order to develop the measuring instrument for base-line behaviour.

Questions for developing a data collection plan	**A data collection plan**
WHY is the data being collected?	To determine how a therapist intends to use humour as intervention strategy
WHAT is the research strategy?	Interviews, observations , intervention techniques
WHO (or what) will be the sources of data?	Literature, clients, social workers, therapists
HOW MANY of the data sources will be accessed?	Case study and a therapist until saturation has been reached
WHERE is the data to be collected?	The client will be interviewed in consultation rooms where therapy takes place.
HOW OFTEN will data be collected?	Client will be interviewed once after a therapy session to collect data on experiences and base-line responses, and once after a week has lapsed/before next session, to collect data about intervention effectiveness.
HOW will the data be collected?	Data will be collected through structured, and semi-structured interviews, observations and questionnaires as well as the measuring instrument to be selected and developed as part of the investigation
JUSTIFICATION for this data collection plan	This is the best way of collecting data as the interview will provide the most direct evidence of humour as intervention strategy. The interviews will be structured and semi structured to allow the researcher to probe initial responses.
Organizing the data	Describing: sequence of events, interactions, responses Comparing: responses from different clients Categorizing: by identifying patterns, responses on a question or embedded themes

To summarize, data collection was triangulated with a multi-method approach, including the views of the therapists, the clients (including the child and adults in his life), as well as the researcher.

1.9.6 Practical implementation

Once the dependent and independent variable, as well as the baseline behaviour has been defined, the intervention process and intended therapeutic helping aids can be impelented.

As stated above, after base-line behaviour was determined, the intervention was implemented. The following methods and instruments were used:

- Videos/DVD recordings
- Games (Problem-solving, "chance" and communication games (Kaduson, 2004, 352 and Schaefer, 1993:338), for identification of comical aspects of client's play, the process and base-line responses
- Board games
- Metaphors
- Storytelling
- Co-therapist, Panther
- Deflection as a Gestalt therapeutic principle.

1.10 LIMITATIONS OF THIS RESEARCH

The constraints of this research include the following:

- Not all clients that came for therapy during the research period had contact boundary disturbance. The clients had to be identified during therapy. This could not be anticipated beforehand.
- The researcher had only a theoretical framework with regard to Gestalt Play Therapy, and limited experience with regard to practical applications.

Thus, the researcher was not able to foresee pitfalls. However, as the research progressed, she identified problems. These limitations are noted in Chapter 6 of this study.

1.11 TRUSTWORTHINESS STRATEGY

The following are guidelines to determine trustworthiness, developed by Schumacher and McMillan (1997:110). The researcher has omitted a few, and adapted a few to suit the research project. Tactics that were used to ward off biases were:

- Lengthy data collection period: Research was conducted between four and six months
- Low inference descriptors: concrete precise descriptions from field notes and interviews are a hallmark for qualitative research. As far as possible the descriptions were literal, and the terms used by the participants were documented
- Mechanically recorded data: Tape or video recorders may increase reliability and were used
- Participant researcher: It was intended to obtain the aid of an informant to corroborate what was observed and recorded, the interpretation of participant meanings, and explanations of the overall processes. Participants were allowed to keep dairies or records to share with the researcher
- Participant review: The researcher who interviews asked the participant to review a synthesis of data obtained by him/her, in order to modify misrepresentation of meaning from the data
- The researcher's role: the researcher was unknown to the site and the participants who were being investigated
- The following quotation was taken to heart and supported by the researcher: *Collection of better data from fewer participants is a wise choice for virtually any study…* (Strydom, 2002:154).

1.12 ETHICAL ASPECTS

Ethics is that which is morally justifiable. The core issue is integrity. As researchers, we must be honest, because collecting data objectively and accurately, in a socially responsible way is basic scientific research. Ethics applies to every step of the research process.

It is the researcher's responsibility to ensure that the rights of those being studied are protected while conducting scientific research. The researcher undertook to:

- Have ongoing and appropriate supervision with an approved supervisor
- Carefully select settings: Working in settings other than private offices or university settings presents variables that the therapist cannot control. According to O'Dessie (1994:73), counselor ethical guidelines of the therapist and schools/institutions are often in conflict.
- Avoid any harm of an emotional nature or physical discomfort. Negative behaviour of the past might be recalled to memory during therapy and could be the beginning of renewed embarrassment (Strydom, 2005:58).
- Obtain informed consent: adequate information about what is intended was supplied, as is applicable to each case, and freedom was respected.
- Maintain confidentiality
- Consider the clients' needs when determining the goal of the treatment
- Ensure that the client was voluntarily involved in the therapy process
- Learn from her mistakes.

1.13 DEFINITIONS OF MAIN CONCEPTS (important theoretical constructs)

In order to understand a theory we need to grasp **concepts** used. For scientific purposes, concepts are tentative, based on agreement, and useful only to the degree that they capture or isolate some significant and definable item in reality (Collins, 2000:45).

- **Humour**

A number of theoretical approaches towards the studying of humour and laughing, as well as the causes thereof, exist. The concept can be defined in different ways. In most cases, something is perceived as humouristic when it contains an element of surprise (McGhee, 1980:158), and takes an unsuspected twist at the end, all of which cause a pleasant feeling. According to Van Fleet (2004:77), humour can be viewed as a set of developed psychological and physiological skills.

McGhee (1980:281) distinguishes between humour as a characteristic and as a state or condition. The expression of humour refers to a qualitative reaction on humouristic stimuli, while the creation of humour indicates a capability to understand humour in a funny context.

The necessary elements for a humouristic situation would have to include the following elements:

- Suddenness and unexpectedness;
- Increasing pleasure, due to a
- Perceived incongruity/absurdness/strangeness.

- **Gestalt Play Therapy**

Gestalt Play Therapy is based on concepts from Gestalt Therapy, which is a humanistic, process-oriented approach to therapy that is concerned with the healthy functioning of the total organism, including senses, body, emotions, and intellect (Oaklander, 1994). Play Therapy pertains to working therapeutically with young people by using various play mediums and techniques as means of communicating and providing healing and treatment.

- **Wholeness/holism**

For the purpose of this research, if there is a reference to wholeness the following quotation will be applicable: "The whole influences all the individual parts and is larger than the sum, no one is absolutely alone" (Zinker, 1994:293).

- **Awareness and experience**

Children who suffer from a weak sense of self have limited awareness of their own experiences (Kottman, 2001:62, referring to Oaklander 1994). Through experiences and experiments in the play therapy process the Gestalt play therapist helps the children involved to become more aware of themselves in play sessions, which can lead to an increase in their general level of awareness of themselves, others, and the world around them (Kottman, 2001:62). Awareness thus pertains to the deliberate consciousness about what is happening on physical, sensational and emotional levels.

- **Meta-theoretical assumptions of Gestalt Therapy:**

I/thou Relationship

The I/thou relationship involves a meeting of two individuals who are equal in power and entitlement, both parties fully bringing themselves into the interaction (Perls, 1969:7).

Organismic self-regulation

Each organism seeks homeostasis as a way to maintain health as change occurs in the environment. The needs of the organism change because of development; the organism seeks ways to satisfy needs and achieve equilibrium. Human beings use the organismic self-regulating process to get their needs met and to

integrate experience. This process results in learning, growth, and fulfillment of the potentialities of the child. When children encounter problems, they react in different ways, trying to get their needs met. The coping strategies that they choose may not work to return balance, but they will continue to seek ways to do so (Zinker1994:227).

Contact boundary disturbances

Contact boundary disturbances can also be referred to as “types of resistance”. (Zinker, 1994:119) According to Blom (2004:21), children with contact boundary disturbance are incapable of actualization and try increasingly to involve other people to tell them how they must be. Contact boundary disturbances are regarded as descriptions of processes and not character traits.

Resistance

For the purpose of this research resistance refers to the proposition that all movement engenders resistance. According to Zinker (1994:118) inner resistance is experienced as reluctance to change our ways of doing things. Our own experience is that we are acting to preserve, maintain and enhance ourselves.

Types of resistance

People make contact with other and their environment at the boundary of the self. People are often afraid to make contact. They feel a need to protect themselves from others and the environment and are afraid that they are not able to get their needs met if they make contact. In the process of trying to protect themselves, children may inhibit, block, repress, or restrict various aspects of their organism – the senses, the body, the emotions, and or the intellect. When children block any aspect of their organism, it causes contact boundary disturbances, which can lead to the development of adversarial behaviours and/or

manifestation of psychological, emotional, or physical symptoms (Oaklander, 1994:118).

Contact boundary disturbance can include

- *Retroflection*: pulling in energy that needs to be directed outward. In other words, doing to themselves what they would do to others, (Zinker, 1994: 122 & Blom, 2004:27).

- *Deflection*: turning away from feelings of grief and anger. Zinker (1994: 124) suggests that instead of making solid connections, messages ricochet off each other. According to Blom (2004:28), deflection refers to avoidance of direct contact with other people, for instance, by not making eye contact. They attempt to avoid the impact of stimuli from the environment. By not noticing deflection, the system collaborates to accept unfinished business. One experience melts into the other and disappears. There is little developmental or solid resolution of issues. Boundaries between persons are vague and ill defined and so interpersonal discomfort is avoided. Deflection thus implies diminished contact.

- *Confluence*: merging with others to the point of the denial of self and the need for individuation and separation (Kottman, 2001:63 and Blom, 2004: 25).

- *Projection*: denying personal experiences and responsibility, projecting personal feelings onto others, or holding the environment responsible for that which happens in the self (Blom, 2004:25). By projection, people deny their own personal experience and do not accept responsibility.

- *Introjections*: incorporating the negative of conditional messages from others about the self into the self-image (Kottman, 2001:62). Introjections

take place when children take in contents from their environment without criticism and awareness, the contents are not assimilated, and remain unprocessed and foreign (Blom, 2004:25 and Zinker, 1994:120).

Transference and counter transference

All people bring patterns of response into a relationship; it is called transference (Lubimiv, 1994:40). The person “transfers” his/her experience from the past into the present. In some situations, a person’s reflex actions predominate and control actions without his/her awareness. An indication of the need for therapy is the child’s’ response that is incongruent with the situation (i.e.”Would you like to play with something else?” The child shouts, “Leave me alone, you are always picking on me”). According to Zinker (1994:278), a person finds one side more attractive than the other. Lubimiv (1994:41) further contends that transference/counter transference is not an issue initself in therapy, as it is a natural process enabling people to survive the world. What is of importance is how to help those who have become ‘imprisoned’ by their references and are thereby unable to respond appropriately to situations.

The researcher concludes by stating that much of therapy focuses on these unaware forces. A goal of therapy is to bring these resistances to awareness so that the client can choose to transform him/herself into a more aware person. The therapist’s job is to invite a client to a curiosity about how they manage these experiences, what is avoided in the way of difficulty, and the price paid for staying safe.

Because we are optimists, and believe in the potential of every client, we hope that such awareness will produce change for the better.

1.14 STRUCTURE OF THE RESEARCH REPORT

CHAPTER I: OVERVIEW AND RATIONALE OF THE STUDY

CHAPTER 2: THEORETICAL CONSIDERATIONS ON HUMOUR AND THE USE OF HUMOUR IN THERAPY

CHAPTER 3: THEORETICAL CONSIDERATIONS ON GESTALT AWARENESS AND CONTACT BOUNDARY DISTURBANCES AND THE USE OF HUMOUR AS TECHNIQUE FOR INTERVENTION

CHAPTER 4: METHOD OF ENQUIRY AND FINDINGS: INTERVENTION STRATEGIES AND TECHNIQUES

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

1.15 CONCLUSION

This chapter serves as an introductory orientation with reference to the rationale and broad views on the problem being investigated, from which the aim and objectives of the study were formulated. The researcher's perspectives on which the research was grounded, as well as core concepts are defined. The research approach and the work procedure which was implemented during the execution of the research project are detailed. In Chapter 2 and 3 the theoretical assumptions which form part of this study will provide an in-depth background to the study as a whole.

CHAPTER TWO

THEORETICAL CONSIDERATIONS ON HUMOUR AND THE USE OF HUMOUR IN THERAPY

2.1 INTRODUCTION

In a very simple explanation, humour can be seen as the ability or quality of people, objects, or situations to evoke feelings of amusement in other people. The term encompasses a form of entertainment or human communication which evokes such feelings, or which makes people laugh or feel happy. The purpose of this chapter is to provide a brief and yet thorough introduction of relevant components that form part of the theoretical assumptions relevant for this study. In this chapter the phenomenon of humour will be investigated in more detail.

2.2 AN ANALYSIS OF THE PHENOMENON OF HUMOUR: CO-DETERMINANTS AND DEFINITIONS

It is difficult to determine the true nature of humour, as various human types of expressions, concepts and ways of operating are linked to humour. Concepts that correlate with humour could be: laughing, smiling, playing, creativity, fantasy, festiveness, irony, satire, comedy, and many more. When looking closer it becomes clear that the essence of humour is not represented in the concepts that correlate with humour. The mentioned concepts show a type of superficiality where knowledge on what humour really is, is absent. An obvious problem that interferes with the definition of humour is: is humour a stimulus, a response, or an attitude?

What the essence of humour is will be described further on, once the phenomenology of humour has been discussed. How then, should humour be defined?

According to the Oxford Advanced Learners Dictionary (1995) the term ‘humour’ is: “the quality of being amusing or comic; the ability to appreciate things, situations or people that are comic; the ability to be amused, happy and content; a person’s state of mind, a mood”. The English Penguin Dictionary (1998) recognizes three possibilities of what humour seems to be:

- A stimulus (that which causes a good mood and merriment)
- A response (an enjoyment of that which is entertaining and witty) and
- The nature of the attitude (the capacity to recognize humour in situations).

Koestler (1992:42) adds an important aspect to this by defining humour “in all its many splendid varieties… as a type of stimulation that tends to elicit the laughter reflex”. According to Jacobs (1992:119) a search of several dictionaries reveals three aspects of humour:

- The mental experience of the discovery and appreciation of the laughable or absurd
- Incongruent ideas, events or situations
- Those characteristics that lead to the perception that an event, idea or situation is laughable and therefore humourous.

The following terms can be included in a definition of humour and determine the essential characteristics of humour: absurdity, incongruity, ridiculousness, laughable, funny, amusing and pleasurable.

Billig (2005:43) describes the “noun” and the “verb” humour thus:

The **noun** humour has four identifiable *characteristics*:

1. The quality of being laughable or comical: comedy, comically, drollery, farcicality, funniness, ludicrousness, ridiculousness, wit, zaniness
2. A person's customary manner of emotional response: complexion, disposition, nature, temper, temperament
3. A temporary state of mind or feeling: frame of mind, mood, spirit, temper, vein
4. An impulsive, often illogical turn of mind: conceit, freak, impulse or whim.

The *noun* humour thus has four *meanings*, which are

1. A message of which ingenuity or verbal skill or incongruity has the power to evoke laughter (wit, humour, wittiness)
2. A trait of appreciating (and being able to express) the humourous (sense of humour)
3. A characteristic (habitual or relatively temporary state of feeling (temper, mood)
4. The quality of being funny.

The *verb* humour has only one meaning: to put into a good mood. Furthermore, some requirements for the humour formulae (http://.answers.com/humoandr=67) would be

- Some surprise/misdirection, contradiction, ambiguity or paradox
- The appeal to feelings or to emotions
- Similarity to reality, but not real, through the methods of
  - Metaphor
  - Hyperbole
  - Reframing
  - Timing

Rowan Atkinson explains in his lecture *Funny Business* (Shibles, 2002:2), that an object or a person can become funny in three different ways. They are by

- being in an unusual place
- behaving in an unusual way
- being the wrong size

Humour can thus be defined as a pleasurable experience of a wittiness of which the foundation is the ability to elicit laughter. Koestler (1989:24) supports this by stating that: "In all its many splendoured varieties, humour can be simply defined as a type of stimulation that tends to elicit the laughter reflex".

The polarity of "humour" lies in antonyms for comedy and funniness, which are: depression, drama, sadness, seriousness, tragedy, unhappiness. This is where the question arises, whether humour could be used in therapy where people often present with sadness, seriousness and depression. The question will be investigated in this chapter, but at this stage it can be speculated that there is nothing that is potentially funny for everybody, whereas everything is potentially funny for somebody.

Besides the definitions and co-determinants of humour it seems as though researchers often study the phenomenon of humour to gain insight into the diversity and variety of the occurrence of humour. According to Verwoerd (1989:49), there are eighty different theories on the origin and basics of humour. Researchers distinguish between anthropological, physiological, philosophical, psycho-analytical and sociological theories and come to the astonishing conclusion:

"… That much work needs to be done in the field of humour because no theory has yet evolved which offers an adequate solution to the problem".

The researcher will refer to a few theories.

2.3 COGNITIVE THEORIES ON HUMOUR

A variety of theoretical approaches towards the study of humour and laughing and their causes exists, and can be defined in various ways. In most cases something is humourous when it contains an element of surprise (Hill, 1988:13; McGhee, 1997:10), as well as an unexpected twist towards the end, that can cause a feeling of pleasure (De Munnik, 1988:229).

A closer look needs to be taken on what constitutes humour and laughter, and what humour consists of. One can start by asking the following questions:

- When do we find something funny?
- Why do we find something funny?
- What makes us find something funny?
- What prevents us from finding something funny?

2.3.1 Theory on Psychoanalysis

Freud (1960), as quoted by Verwoerd (1989:24) distinguishes between two broad categories of humour: those in which the essences are voiced in thoughts, and those in which the essence is contained in words. In the beginning of the 20th century Freud argued that apart of the pleasure that is derived from it humour is the result of the intellect that tries to understand a joke. An outcome of this view is that laughing is seen as the most economic mechanism for the releasing of energy of the psyche (Verwoerd, 1989:28).

2.3.2 Theory on Gestalt psychology

In Gestalt Theory, the significance of the parts is dependant on the whole. A holistic understanding of man brings the functioning of his physical body, his emotions, his thoughts, his culture, and his social expressions into a unified picture. They are all aspects of the same client – man. The whole is greater than

the sum of its parts. “Greater” means the difference in quality form; it also refers to the entirety of the object or event. It is apparent from his, according to Harman (1996:140), that the whole is a new event. The author continues that the holistic approach espouses the belief that normal, healthy man reacts as a whole, not as a disorganized organism. The statement by Straus (1963), as quoted by Harman (1996:14): “Man thinks, not the brain,” appropriately reflects the Gestalt Therapy point of view.

2.3.3 Theory on Biological Instinct

When the senses are stimulated, nerves are “awakened”, and then the human being laughs out of pure pleasure (Hill, 1998:36). (Also see laughter as language of humour in 2.5.3 (b).)

2.3.4 Theory on Release and Relief (Psychodynamic Characteristics)

The psychoanalytic viewpoint on humour is that its pleasure is partly derived from already mastered anxiety. “What was feared and mastered yesterday is laughed at today” (McGhee, 1972:19). Thus the child enjoys humour about actions only after he/she has mastered them. As an adaptive process, humour provides the child with an opportunity to re-experience the gratifications of motoristic, linguistic, cognitive, and interpersonal mastery at his/her age-appropriate development. It is accepted that laughing, as a response to humour, releases tension and can thus serve as a “coping mechanism”. Furthermore laughter and crying are regarded as human expressions in which the heart and soul of a human being is revealed (Verwoerd, 1989:34).

2.3.5 Theory on Superiority

An important characteristic of humour is that the degree of pleasure is dependent on the humiliation of others, and who the other party is (Goldstein & McGhee,

1972:6; Ventis & Ventis, 1988:183). In research conducted with children, the most common humour techniques were incongruity and disparagement of others.

2.3.6 Theory on Social Characteristics

According to Moursund (1976:383) laughter is simultaneously a strong feeling of companionship between members of a group, as well as a joint aggression against outsiders. As laughter is contagious, a feeling of exclusion is created if one does not join in the laughter. Although humour is part of daily interaction, it is a complex social psychological and communicative event.

Consequently it can be deducted that the implications of humour are the following: humour provides pleasure and therefore man seeks humour and situations that provide humour. McGhee (1979:19) states that it is noticed that the affective aspect of humour, for instance cheerfulness and joyfulness, are some of the first emotions that are observed in babies. One can thus conclude that the affective aspect of man is inborn and is therefore potentially there. Bleedhorn (1982:35) adds that to be playful is an essential element in the process of self-actualization.

The theological aspect of humour lies in knowledge of God being master over all powers. In this sense, humour becomes a key towards a meaningful attitude towards life and not as a natural inborn asset, but as grace from God. Therefore laughter of Christian humour is a sign of the acceptance of life as an award (Jacobs, 1992:39).

2.4 THE PROCESS OF HUMOUR

To be able to move toward a more comprehensive description of the term humour, it is necessary to investigate the process of humour. Researchers such as Barron (1980:2), Goldstein & McGhee (1972:82); Chapman & Foot (1976:12)

and Mulkay (1988:35), are of the opinion that the process of humour can be divided into two phases:

- The findings of elements of surprise and;
- Making sense out of incongruities (Shibles, 1978:2).

2.4.1 The findings of elements of surprise

The characteristic that has been accentuated mostly through the centuries and was seen as fundamental is “incongruity”, in conjunction with surprise or amazement, thus the deviation from the usual. The element of surprise is thus a stimulus that leads to humour (Goldstein and McGhee, 1972:13).

The necessary elements for a humouristic situation include the following elements:

- Suddenness (unexpectedness)
- Increasing pleasure, as a result of a
- Perceived incongruity (absurdness).

2.4.2 Making sense out of incongruities

According to McGhee (1997:14), humour is regarded as the result of a discrepancy between two thoughts, of which one is anticipation and the other an idea or perceptions. The funniness depends on the degree of divergence of the expectations. To be able to understand “humour” and “incongruities” better, one also needs to look at other constituents, such as laughing and smiling, which can be seen as the “language” of humour; what a joke is, what types of humour there are, and what their functions are.

2.5 TYPES OF HUMOUR AND THEIR FUNCTIONS

The significance of humour is derived from the uses of humour. The more we know about the possible uses of humour, the more we can do with it. "Use" refers to actual usage or the doing of humour, as well as the purposes of humour. This section deals with the uses or practical applications to which humour may be put.

2.5.1 Types of humour

There are many types of humour, but for the present purposes only the following types are listed:

- *Conflict humour* (with its function to use as a weapon, for instance in aggression – comic strips)
- *Control humour* (with its function to maintain order where people would otherwise be antagonistic towards each other)
- *Consensus humour* (promotes solidarity, comradeship and friendship, where people tend to dare and take risks easier, here the element of pleasure can be recognized most strongly)
- *Concealment humour* (its value lies not so much in what it gives but in what it allows people to avoid). Chapman and Foot (1976:201) state that humor"… saves us from a moral dilemma and permits us to be malicious, and vent negative sentiments with dignity, and this may well characterize what precisely humour can do for us". In chapter three this characteristic will be linked to deflection, as a contact boundary disturbance.

According to Wormer and Boes (1997:87-92), *five varieties* of humour have been identified as valuable in *stressful emergency situations*:

1. Tension-relieving nonsense
2. Play on words
3. Sense of the preposterous and incongruous
4. Gallows humour
5. Foolish jest

Most types of humour, such as the following, are based on or provide insight. These include satire, allegory, connotation, context deviation, contradiction, deviation from the familiar, expanded metaphor, free association, unexpected honesty, exposing hypocrisy, informal logical fallacies, juxtaposition, irony, taking literally, metaphor, misclassification, paradox, and personification, reduction to absurdity, reversal, simile, substitution, value and deviation. The idea is that by creating a model or metaphor, a hypothesis is created. By reducing an argument to absurdity, an argument is refuted. By juxtaposing, switching contexts and substituting one concept for another, new perspectives are disclosed. It is in this relation to deflection that the researcher wished to investigate the question “can humour be used as a deflective technique, to evoke change?” This is because deflection presents itself as a contact boundary disturbance.

2.5.2 Functions of humour

In the previous paragraph some of the functions of humour have been mentioned in conjunction with the types of humour that exist. The need exists to elaborate further.

Chapman and Foot (1976:49) argue that humour and metaphor both explore the limits of language and thus the limits of our reasoning. One could say that the limits of our humour are the limits of our understanding. Humour allows us to avoid taking our views too literally in order not to become captivated by them. It allows us to better describe occurrences by means of metaphor and similarity. It exposes falsity, contradictions, inconsistencies, hypocrisy, nonsense, illogic and

defense mechanisms. The authors continue by saying that humour questions beliefs, values and prejudices. Besides the mentioned functions, humour also questions society, institutions, language, meanings, concepts and even our own personalities, actions and beliefs.

Taboo humour or value deviation humour involves the apparent contradiction of saying the unacceptable, or expressing a dislike in an acceptable way. We laugh at what we disapprove of because it is put in a humourous or approved-of way. We say something good about what is bad. Thus, humour might allow one to say the unacceptable things one would like to say. Dysfunctional people may show their negative emotion too clearly, thereby causing the humour to become anger, a direct expression of hostility. Humour, however, cannot be taken as hostile and still be humourous.

A totally different type of human attitude, which can also be seen as humour, is encountered in irony, which is, according to Kritzinger (1980:358), covered ridicule, where the opposite of what is meant, is said. In humour there is seriousness behind the joke, in irony a joke behind the seriousness (Verwoerd, 1989:53). In contrast to the warmth that humour provokes, irony is cold and loveless.

Another function of humour, according to Shibles (2002:7), is that humour lets us escape into a world of contradiction and paradox, an impractical, purposeless world, a world where all the rules are broken, a world where what appears true is false, and what appears false is true, where good is bad, and bad is good. There is sense in nonsense, and nonsense in sense. It is an accepted, happy world which we may escape into. We leave behind hardship and an often too cruel reality. We escape from serious or fearful rationality to new and pleasurable sorts of rationality.

Shibles (2002:10) is of the opinion that humour may be used to express frustration, hostility, fears, or be used to “react” instead of “act” intelligently. When used in such a way it becomes a defence mechanism. The researcher is of the opinion that humour is used to say “something”.

The more understanding and the wider the range we have of humour, the more conscious we are of it, the better and more deliberately we will be able to use it for our purposes, such as to cope better, solve problems, gain insight and to enhance therapy, amongst others.

Koller (1988:18) has given the following uses of humour (thus also encompassing its functions): Humour allows us to:

Accept our mistakes; attack existing standards and values; avoid conflict; balance power; defend against attack; demostrate familiarity; entertain; express hostility; get atttention; keep the conversation going; move deep emotions; use it as a powerful tool of critical thinking; provoke thought; reduce axieties; reduce hostility; reinforce or undermine stereotypes; relieve stress and pain; replace anger; secure group membership; self-reflect; show abilities; socially bond; socially control; socially correct; soothe people; survive; symbolise close ties; turn negative emotions into positive ones and uphold honesty over shame.

2.5.3 Expressions of humour

(a) *The joke*

A joke can be defined as something that is intended to cause amusement or laughter, for example a humourous remark or a story with a funny ending. Kritzinger (1980:284 and 247) defines a joke as something told to create the desire for laughter, or a comic way of saying something that elicits laughter. Palmer (1984:25) states that the theme of a joke is only one of its dimensions.

The occasion on which it is told, the identity of the teller, as well as the audience, constitute other dimensions of the joke.

Getting the point of a joke is in itself a point of pleasure. However, it does reflect the awareness that there are multiple sources of pleasure in the enjoyment of humour. The fact that there is pleasure in successfully responding to the challenge of getting the point of a joke serves to account for, among other things, the importance of the perishability of a joke. The first hearing of a joke is funny. From then on the pleasure gain is from sharing it with others. Once the incongruity is resolved, the surprise is gone, the puzzle is solved, and the gratification comes from the recall of its resolutions (McGhee and Chapman, 1980:258).

Humourous material is coded as a joke if it consists of a relatively short prose build-up followed by a punch line (Bryant, 1979:112). It is also argued that the body of a joke serves deliberately to lead the listener astray, so that the punch line comes as a surprise which sets the listener back on the right track (Baron, 1980:35). We expect one thing to happen, and the unexpected happens instead. This is the element of surprise and difference, giving meaning to an apparent absurdity. Mulkay (1988:35) adds that the end of a joke does not logically follow on the previous text. Verwoerd (1989:20) also mentions in this regard: “a situation is undoubtedly comical when it simultaneously contains two separate ranges of events, which simultaneously are interpreted in two separate meanings”. Shibles (1978:14) adds that humour is based on something that is mostly not understood (contradictions, nonsense, meaninglessness) and the reaction is to laugh: “We expect one thing to happen and the unexpected happens instead”. Collins (1986:22) adds that the value of language exists in the fact that it can be manipulated to let others laugh, and so the true pleasure of humour lies in the words. It is supported by Kiken (1977:20) who says that the possibility to misuse words purposefully is “… an awakening joy, a sort of triumph over the words themselves!”

However, the author warns that when such a “mistake” is seen as bad or harmful, it is no longer humourous. Thus to be regarded as humourous, the incongruities should not be considered as being too serious. The function of humour can thus be regarded “to put us in a state of pleasurable instability that welcomes and craves the impact of another joke!” (Nash, 1985:13). Moursund (1975:382) concludes by stating that “whatever processes produce humour, including any perceptual or intellectual processing and any shifts of arousal level, are generally abrupt and over within a few seconds”.

On conclusion, Freud said that “A good joke is worth looking for on a daily basis”. The researcher agrees with Freud.

(b) ***Laughing and smiling as language of humour***

Although various theories on humour exist, the one point of conformity is that it has something to do with laughing, or at least a smile. There are several ways in which people react towards a same comical situation which indicates that the comical develops from a certain approach or interpretation of the situation. Such a message gets transferred in the most effective way and is carried over by laughing (Verwoerd, 1989:39). In this sense laughing can almost be regarded as the language of humour.

Because we are accustomed to experiencing laughter as an automatic, spontaneous response, we are seldom consciously aware of what a complex activity it is physiologically. “To laugh” means making sounds and movements of the face and body that express amusement or happiness. Sometimes laughter is a kind of language in itself. Anxiety, fear, embarrassment, concern, hope and joy are all emotions frequently expressed through laughter. Funes (2000:22) explains that laughter is a way of dealing with that which we cannot explain. Laugher gives us distance, and Koestler (1998:56) points out that laughter disposes of emotional tension which has become pointless.

The physical and emotional experience of laughing produces a feeling of arousal that quickens the heartbeat and breathing, and raises levels of oxygen in the body. This process is brief and is mostly considered as a pleasurable experience. In this regard Verwoerd (1989:30) refers to humor as a mechanism in service of psychic-economical pleasure.

In contrast to this opinion, Goldstein & McGhee (1972:19) regard laughing not as an expression of pleasure, rather as stimulation thereof: We laugh because we feel bad, and now we feel better. However, Hill (1988:17) holds another point of view: laughing and smiling are less descriptive than talking, and can thus leave space for misunderstandings; therefore it should be looked at in conjunction with language, and body language, as well as contextual factors.

According to Riggins (2001:1), there is widespread recognition of the value of laughter and humour to physical health and psychological well-being – valuable preconditions for spiritual devolvement. Humour, through laughter, is recognized as valuable for: increasing muscular and respiratory activity, stimulating the cardiovascular system and the muscular skeletal systems, increasing antibodies, increasing pain tolerance, decreasing levels of stress hormones and decreasing heart rate.

The intensity of the humour reaction, once the basis for humour is understood through bi-associations, is considered by Koestler (1964), as quoted by Jacobs (1992:39) to depend on the amount of emotional tension present. He has suggested that every humourous situation must contain one ingredient whose presence is indispensable: an impulse, however faint, of aggression or apprehension: it is this “aggressive-defensive” element which produces the emotional arousal released through laughter. Once our intellect has achieved the insight necessary to understand the humour of a joke, cartoon, etcetera, our emotions are left in an aroused state.

According to Livingstone (2006:152), there is ample evidence that humour, as it elicits laughter, heals. It makes sense that the internal chemical changes brought about by laughter have a salubrious (healthy, wholesome) effect. The mind/body interplay is at the heart of every theory of how we can influence recovery by the ways in which we think and feel about whatever afflicts us.

It can thus be concluded that laughter serves the necessary function of removing redundant tension “along physiological channels of least resistance” enabling the client to return to a normal more relaxed state of mind.

2.5.4 Sense of humour as personality characteristic

A sense of humour is easily identified. Most people own a sense of humour. It is easy to laugh but difficult to explain why. According to Billig (2005:82), a sense of humour is the ability to experience humour, a quality which all people share. However, the extent to which an individual will personally find something humourous depends on a host of absolute and relative variables, including, but not limited to geographical location, culture, maturity (developmental level), level of education and context. For example, young children (of any background), particularly favour slapstick, while satire tends to appeal to more mature audiences.

Humour is seen as a basic part of the personality structure. Indeed, as far back as Plato, contemporary humanistic theorists believed that a good sense of humour can be been linked to a mature, well-adjusted adult. To be able to laugh at one’s self and the absurdity inherent in the world constitutes a fundamental human quality associated with personal adjustment.

According to Chapman and Foot (1996:78) everybody is convinced that a sense of humour does exist. The possession of a sense of humour means that the

person observes incongruent or conflicting aspects of life and can extract pleasure (merriment) from them.

It can be deduced that a sense of humour is a personality trait, as it can be described as a relatively enduring aspect that underlies a variety of behaviours in a variety of situations. According to De Munnik (1988:229) aspects that characterize a sense of humour are:

- The appreciation of humour (most people possess the ability to recognize a humouristic situation), and
- The production of humour (only a few people possess the ability to let others laugh and to create humour).

Hehl (1985:707) also distinguishes between humour as a characteristic and a state (excitement and merriment). The expression of humour refers to a qualitative reaction on humouristic stimuli, whereas the creation of humour reveals the capability to place situations into a funny context.

Rogers (1984:48) identifies 6 characteristics of a humourous frame of mind:

- Flexibility
- Spontaneity
- Non conventionality
- Shrewdness/cleverness
- Playfulness
- Being humble

Being humble and being capable to laugh at oneself, are closely related (Shibles 1979:2). This involves a capability to stand away from the self and to understand the self better. Moursund (1976:68) joins in by stating that when social relationships are mastered, as well as a peaceful relationship with the self, then the

person possesses this valued character trait, a sense of humour, which can be regarded as the final integration of all the levels of development.

In conjunction with this, is a willingness to be amused. Baughman (1974:52) says that “A man who can laugh at himself will always be amused”, and, “humour makes the educated mind a safer mind, as the world is a comedy to those who think, and a tragedy to those who feel”. Prerost (1994:139) adds that when humour is significantly diminished in a person’s functioning, the path toward psychological growth is slowed. The losing of ones sense of humour signals the retreat from social exchange and a blocking of feedback from others. From a gestalt perspective it could be regarded as contact boundary disturbance.

To be able to be in a humourous frame of mind one must feel master of the situation and not be overcome with fear. Humour cannot overcome strong emotional states like depression, rage and terror as a person is then not master of a situation. Besides the ability to experience humour, as stated earlier on, to be in possession of a sense of humour means to be able to realize and be aware of the dissonant (inharmonious) and to find pleasure therein. The possession of a sense of humour means that the person observes incongruent or conflicting aspects of life and can extract pleasure (merriment) from them.

The researcher is of the opinion that a person’s outlook often shows through his sense of humour and that a person’s sense of humour reveals how he thinks and feels.

2.5.5 Humour and cognition

The root of the cognitive developmental theory of humour is that an individual’s comprehension and application of ludicrous (absurd, comical) situations will depend to a great extent on the match between the individual’s existing developmental level and the cognitive demands placed upon him/her by the humourous

event. One must be mentally challenged by the stimulus before one will perceive it as being funny (McGhee and Chapman, 1980:188).

Researchers such as Goldstein and McGhee (1972:66) are of the opinion that conceptual thoughts, based on cognitive expectations, are necessary cognitive attributes for the experience of what humour is. A high level of cognitive control is thus a prerequisite. Barron (1980:1) says that the role of cognitive processes and imagery are linked. When an object or picture is seen, the visual image becomes a word code for that image. The more concrete the stimulus the easier it will be recognized. In this sense the funniness of a joke or comic strip increases through the level of surprise and imagery.

It is clear from naturalistic observations that children learn to laugh and joke about all areas of functioning over which they have just achieved mastery. These include body functions, language and verbal fluency, motor skills and finally interpersonal interactions, children's jokes about excreta, play-on words, riddles, puns, clowning and pratfalls, all reflect these steps in the development.

In closing, it can be stated that the comprehension and appreciation of humour must be a totally individual affair. Possessing the cognitive prerequisites (McGhee and Chapman, 1980:296) to understand a joke is no guarantee of comprehension, and comprehension is no guarantee of appreciation. Full comprehension of a joke or cartoon, an individual's prior developmental history, current physical, biological and social needs, and general frame of mind are combined to determine funniness at that particular moment.

2.5.6 Humour and creativity

A characteristic of a creative person is his sense of humour (McGhee and Chapman, 1980:119). "Creativity" can be regarded as the possibilities of each person with something that is for him, the creator thereof, new and valued (Chapman

and Foot, 1976:246). De Munnik (1988:239) is of the opinion that humour "instigates" thoughts for creativity.

De Bono (1985:33) says that learning occurs most effectively through the process of humour, citing humour as the most evident example of how the brain works as a thinking tool – with learning occurring when a jump in perception occurs. The result is a new idea or insight. The process of creative thinking (generating from nothing) is therefore exemplified in humour.

2.5.7 Humour and intelligence

According to research, a definite connection exists between humour and intelligence (McGhee and Chapman, 1980:186-187, 189, 230-231, 256-258). The most excellent humour is found with the most intelligent people, and a shortage of humour reveals mental weakness. The level of humour is related to the level of the cognitive ability. If the situation or joke is too simple, the complex thinker will not be amused. According to Bleedhorn (1982:35) the appreciation of humour is a sign of being highly intelligent.

2.5.8 Humour and social dynamics

The most common form of laughing is social laughing, which takes place in a variety of situations as part of the normal communicative processes. Group members feel at ease and communication is enhanced, as it is enjoyed more. Moursund (1976:378) puts it that to laugh is to invite those present to come nearer.

Some individuals, even as children, have the talent for detecting and teasing out humourous possibilities in commonplace events and then utilizing them for the enjoyment of others.

Funes (2000:39) makes the point that humour is highly subjective and a matter of personal taste. Therefore it is important to remember that what is funny to one person is not necessarily funny to another, as issues of generation, culture and gender come into play.

On the other hand, laughter can also be socially contaguous. In a classroom, for example, if one or two persons start giggling, all the learners will soon start doing the same. There are few ways of stopping a mini-epidemic of this type; the laughter must be allowed to “wind down” and stop of its own accord. In this “safety valve” thesis, Palmer (1984:56) observes that humour operates to release inhibition. The contagious effect of the laughter of the child engaged in active make-believe cannot be minimized. Popularity through evoking laugher can be reinforcing and can begin to establish a pattern of playful engagement that can become a humourous style of social interaction later on.

Laughing is thus enjoyed in the company of others. Humour is also a form of sharing, an interpersonal exercise. To share laughing is to affirm that we are all in this lifeboat together (Livingstone, 2006:161).

2.5.9 Humour and play

Both play and humour are activities whose primary purpose, essentially, is to obtain pleasure, whatever other purposes may be involved. To obtain the pleasure in these activities they must be carried out by a detachment from reality (McGhee and Chapman, 1980:265). In the context of playfulness and being “in humour” all things are accepted as possible, even the impossible. As in play, in humour a psychological condition or state is thus created in which the real world is ignored. The creation of a therapy situation in which play and humour are media or communication, offers both therapist and child communicative intimacy in which they share common freedom from the constraints of a painful reality.

2.5.10 Humour and therapy

The beneficial aspects of humour in the psycho-therapeutic process have been identified by numerous therapists (Prerost, 1994:141). In this regard, the following question can be asked: How is it possible to maintain a relationship in which mutual trust and acceptance are essential but where the hierarchical nature of the relationship allows one party to give orders and binds the other to obey? Humour is the answer. With humour we are capable of encouraging people to perform serious tasks, as will be seen in the opinions of various researchers that follow.

In 1905 Freud already pointed out that humour often serves as a mechanism for dealing with intra-physic conflicts. Subject areas such as sexuality, aggression, and death are often too anxiety-laden for the individual to deal with directly (Prerost, 1994:140). Consequently, the individual's thoughts, wishes and feelings concerning these areas are expressed indirectly through joking. As such, humour can serve as a psychological window through which the clinician may gaze in search of the individual's conflict areas. In fact, clinicians often go a step further, and use humour as a therapeutic medium for exposing their clients to their basic conflicts, thus helping them to confront and resolve them (McGhee & Chapman, 1980:183).

It can thus be concluded that the use of humour during therapy can serve two significant functions: first the enjoyment of humour during therapy could lift a depressed mood state and alleviate the anxiety present. Second, humour can assist in resolving the threatening aspects or conflicts surrounding a stressful circumstance.

This section dealt with co-determinants of humour, looking into definitions, theories, the process, types of humour, functions of humour, laughing and smiling

as language of humour, humour and cognition, creativity, intelligence, play and social dynamics, and the role humour can play in therapy.

Since various aspects of humour are identified as co-determiners, the need arises to analyze the phenomenon thereof.

2.6 PHENOMENOLOGY OF HUMOUR

The concept phenomenology holds that a phenomenon is revealed to the researcher, and that the researcher will discover, discuss and argue this phenomenon with the help of certain methodological procedures, so that contents may become accessible to others. According to Yontef (1989:1) phenomenology is a discipline that helps people stand aside from their usual way of thinking so that they can tell the difference between what is actually being perceived and felt in the current situation and what is residue or excess.

describes three steps that need to be followed when the essence of a matter needs to be discovered:

2.6.1 Steps in phenomenological reduction

1) Phenomenological reduction
2) The enlightening of essential characteristics in context, and
3) Transcendental reduction

Step One: Phenomenological reduction

Phenomenological reduction implies the removal of research impediments and obstructions, and is described by Zinker (1994:33) as a descriptive analysis of the phenomena under consideration. This step is further divided into 3 sections, namely

1) Relevance
2) Clear perimeter setting and
3) Predispositions (stance of researcher)

1) *Relevance*

Smith (1988, 14:240) continues that Relevance of therapy and psychotherapy (a way of treating an illness of the mind or the body, are usually without surgery or artificial medication). In the context of this study one has to look at the relevance of play therapy.

Play in itself is not therapy (Schaefer, 1993:22). For play to be therapeutic it needs to have definite qualities. Play varies on a continuum from unstructured to structured. Exactly where play falls on the continuum depends on the following factors: the setting (office vs. playroom), the therapists role (passive vs. active), the limits (none vs. many), and goal directedness (no goal vs. specific goal). In terms of resistant children, a structured play setting is necessary in the most cases. The therapist needs to be an active participator who is goal directed and establishes necessary limits. Furthermore, the play activities must gain the attention and interest of the children, by luring them into the therapeutic process.

Relevance of humour

Humour is related to play and to therapy. Humour is a reality in the therapeutic setting. The critical question would be if humour could be left out of the therapy situation. In the light of the prominence of humour as “ideal” in the therapeutic setting, especially with regard to the play therapeutic setting, it cannot be excluded from the therapeutic situation. The total exclusion of humour in the therapeutic situation would reduce the effectiveness thereof to a great extent.

2) *Clear subject/theme perimeter setting*

Humour is used within the context of the therapeutic setting, more so in a play therapeutic setting, in relation to children presenting with contact boundary disturbance.

3) *Predispositions, competence and stance of the researcher*

The goal is to deliberately investigate the phenomenon objectively, without preconceived ideas. It is the objective to analyze and discover the phenomena with attentive probing as supported by the literature.

Step Two: The enlightening of essential characteristics in context

This step is subdivided into 4 stages, namely: the manifestation of knowledge sources, preliminary and provisional identification of the essences, confirmation of the essences and contextualization and meaning of build-up.

1) *The determining of manifestation and knowledge sources*

Humour can be witnessed in everyday situations, sometimes as a characteristic, sometimes as a condition, and is expressed through laughing. Humour is looked at from the perspective of the effects it has on the client; and a literature study, that informs significantly and extensively the revealing of the essential characteristics of humour.

2) *Preliminary and provisional identification of essence*

Table 2.1 Preliminary and provisional identification of essences

CHARACTERISTIC	CLARIFICATION
Double meaning	More than one meaning, unclear, unobtrusive
Incongruousness	Absurd, inappropriate, strange, meaninglessness
Irrationallity	No relation, irrational, incompatible,
Absurdity	Illogical, ridiculous, comical
Ridiculousness	Nonsensical, farcical, comical, foolish, hilarious
Amused	Funny, comical, witty, silly, entertaining
Laughter	Expression of human pleasure, smiling, pleased
Ludicrous	Nonsensical, preposterous, stupid
Incongruity	Strange, inappropriate, inept, unease, clash
Inspiration	Original, surprising, laughable expression
Fantasy	Creative imagination in conjunction with the meaning of something extraordinary, daydream, flight of the imagination

3) *Confirmation of the essences*

The question here is whether there is humour if the essences are eliminated. The objective is to determine the true essence of humour.

Table 2.2 Confirmation of the essenses

CHARACTERISTIC	ELIMINABLE
Double meaning	NO
Incongruous	NO
Irrational	NO
Absurdity	YES
Ridiculous	YES
Amusing	YES
Laughing	YES
Ludicrous	NO
Incongruity	NO
Inspirational	YES
Fantasy	NO

It thus seems as though the *essence* of humour is constituted by the presence of one or more of the following: dual meaning, incongruity, irrationality, ludicrousness and fantasy.

4) *Contextualization and connotation of meaning build-up*

When humour takes place, there is a notable increase in incidence since people involved need a frame of reference. Different levels of perceptions of humour exist. Humour can be applied any time, any place and by anybody with whom there has not necessarily been any interaction over a period of time, but who has a certain frame of reference. A cultural connotation does exist.

Step Three: Transcendental reduction

The researcher is exposed to the critique of co-researchers with regard to the study. The phenomenon of humour can be regarded from within the psychological, physiological, philosophic and social perspective.

The goal of Gestalt phenomenological exploration is awareness, or insights. According to Heidbreder (1933), as quoted by Harman (1996:23), insight is a patterning of the perceptual field in such a way that the significant realities are apparent, it is the formation of a gestalt in which the relevant factors fall into place with respect to the “whole” in Gestalt Therapy. Insight is clear understanding of the structure of the situation being studied.

Awareness without systematic exploration is not ordinarily sufficient to develop insight. Therefore, Gestalt Therapy uses focused awareness and experimentation to achieve insight. How one becomes aware is crucial to any phenomenological investigation. The phenomenologist studies not only personal awareness but also the awareness process itself. The client is to learn how to become aware

of awareness. How the therapist and the client experience their relationship is of special concern in Gestalt Therapy (Yontef, 1889:1).

In Chapter 3 a closer look will be taken at the concepts and their phenomenology necessary for this study: awareness, boundary and contact, contact boundary disturbance and deflection. The possibility of humour as a deflective technique in contact boundary disturbance will be discussed.

2.6.2 Synthesis

Humour does exist where the ambiguous, incongruous, laughable and fantasy cannot be excluded. However, something can be humouristic although it is not amusing, absurd, ridiculous or contradictory.

2.6.3 Summary

The phenomenon of humour was analysed in Chapter 2. After a concept analysis was made, the functions of humour were discovered and the following found: humour is characterized by a sudden and unexpected incongruity, accompanied by mounting pleasure as a result of a conceived incongruity. In a second exposure to the same context humour would lose its impact. To conclude on the complexity of the topic, the following can be said: before a simple joke can be understood, knowledge of language, the diversity and variety of social encounters and ways of thinking are necessary. Nothing is free of the spectrum of humour, and no two brains think alike.

CHAPTER THREE

THEORETICAL CONSIDERATIONS ON GESTALT AWARENESS AND CONTACT BOUNDARY DISTURBANCES AND THE USE OF HUMOUR AS TECHNIQUE FOR INTERVENTION

3.1 INTRODUCTION

The development of a theoretical frame of reference becomes necessary when doing research. In Chapter 2 a clear picture was established on the fundamentals and range of the phenomenon of humour. In this chapter the focus is on the explanation on how the researcher understands the functioning of the child as a whole within the Gestalt framework. The philosophical perspectives of Gestalt theory are outlined, followed by a discussion of theoretical and procedural aspects of Gestalt Play Therapy. Throughout the theoretical inquiry a link between the philosophical foundation in Gestalt Therapy and the theoretical frameworks guiding the use of humour as technique for intervention are exposed. Concepts such as awareness, boundary, contact, resistance, and deflection as contact boundary disturbance, are investigated in relation to the use of humour.

3.2 THE GESTALT APPROACH TO THERAPY

Latner (2000:13) defines Gestalt theory as a system that provides the context for concepts, techniques and applications that facilitate the structure and organization of living in terms of aware relations. The available literature presents a large body of theoretical concepts and principles that underpin this mode of therapy. The main theoretical foundations are grounded in field theory, phenomenology and dialogue (Clarkson, 2004:31) and serve as theoretical framework for this study.

Gestalt Therapy is described by Yontef (1989:1) as a phenomenological-existential therapy founded by Frederick (Fritz) and Laura Perls in the 1940's. It teaches therapists and patients the phenomenological method of awareness, in which perceiving, feeling and acting are distinguished from interpreting and reshuffling pre-existing attitudes. Explanations and interpretations are considered less reliable than what is directly perceived and felt. Patients and therapists in Gestalt Therapy dialogue communicate their perspectives (Yontef, 1989:4). Differences in perspectives become the focus of experimentation and continued dialogue. The goal is for clients to become aware of what they are doing, how they are doing it, and how they can change themselves, and at the same time, to learn to accept and value themselves.

Gestalt Therapy focuses more on process (what is happening) than on content (what is being discussed). Oaklander (1994:143) explains this mode of therapy as being concerned with the healthy functioning and the integration of all aspects of the total organism (the person) including senses, body, emotions and intellect. It is based on a belief that individuals are born with resources and the ability to be in rewarding contact with others, the environment and at the same time being able to lead a satisfying and creative life (Joyce & Sills, 2001:7). Lampert (2003: 8) perceives the Gestalt approach as being a deeply respectful and non-intrusive method, where individuals are accepted as they are and that there are no expectations of performance. Clarkson (2004:2) adds that the Gestalt approach is characterized by the use of "metaphor, fantasy and imagery, working with body posture and movement, enactment and visualization, time distortion and the full expression of feelings involving the whole body in action". This is supported by Totton (2003:106) who emphasises that from its inception, Gestalt Therapy included working with the body and addressing body experiences such as laughter and emotional expression through humour.

For the purposes of this study of the Gestalt approach the understanding and relation to the use of humour will be discussed. A description of applicable concepts within the Gestalt approach follows.

3.2.1 Awareness

According to Livingstone (2006:96), much, perhaps most, human behaviour is driven by intentions that are below the level of our awareness. Since we like to think of ourselves as rational people doing things for explainable reasons, it is disturbing to acknowledge that much of our habitual conduct is determined by needs, desires, and experiences of which we are only dimly aware and that are related to our past experience, often from our childhood (Livingstone, 2006:96).

The goal of Gestalt phenomenological exploration is awareness, or insights. According to Harman (1996:33), “insight is a patterning of the perceptual field in such a way that the significant realities are apparent, it is the formation of a gestalt in which the relevant factors fall into place with respect to the ‘whole’ in Gestalt Therapy”. Insight is clear understanding of the structure of the situation being studied.

Awareness without systematic exploration is not ordinarily sufficient to develop insight. Therefore, Gestalt Therapy uses focused awareness and experimentation to achieve insight. How one becomes aware is crucial to any phenomenological investigation (Zinker, 1994:34). The phenomenologist studies not only personal awareness but also the awareness process itself. The client is to learn how to become aware of awareness. How the therapist and the client experience their relationship is of special concern in Gestalt Therapy (Yontef, 1889:1).

Awareness is characterized by contact, by sensing, by excitement and by Gestalt formation (Zinker, 1994:66). In Gestalt Therapy an attempt is made to help the client to own that which he projects onto others in order to enhance his aware-

ness of himself, self-identity and promote contact with the environment in a self-nurturing manner.

Awareness is considered a primary therapeutic tool (Yontef, 1993:139) and a major cornerstone in Gestalt Therapy (Joyce & Sills, 2001:27). Information from the sensory systems leads to awareness, leading to figure formation. Full awareness is the process of being in vigilant contact with the foreground issue with full sensory, cognitive, emotional and energetic presence. It implies taking responsibility for sensations perceived, for feelings felt, for thoughts that were conceptualized and for directing action in accordance with conscious choices (Yontef, 1993:12).

Qualities of awareness

Latner (2000:18) states that awareness has five distinct qualities, which are:

- *Contact* – the meeting of difference, also seen as the flow of awareness (Joyce & Sills, 2001:33)
- *Sensing* – determines the nature of awareness. This includes close sensing such as touching or feeling; far sensing such as visual and auditory perception; and internal sensing called proprioception which will include thoughts, dreams, body sensations and emotions
- *Excitement* – including a range of emotional and physiological excitations
- *Figure formation* – is the manner in which awareness is shaped and developed
- *Wholeness* – defined as “the whole is greater than the sum of its parts” (Latner, 2000:19).

Humour is a process in which one needs a *sense* of humour; “sense” referring to the ability to feel or appreciate something, the ability to be aware (Höfner and Schlachtner, 1995:40).

3.2.2 Boundaries

"Boundary" means, in Gestalt terms, to make sense of experience that is part of a system. To attribute meaning to something or an experience is to furnish a boundary, and to differentiate what is experienced from other phenomena. Zinker (1994:145) adds that Gestalt Therapy states that the boundary is where you experience the difference: – where there is a "me" and a "you" or a "we" and a "they" – and that growth takes place when there is contact at the boundary.

According to Yontef (1989:7), this growth is called the "regulation of the boundary". The boundary between self and the environment must be kept permeable to allow exchanges, yet firm enough for autonomy. The environment includes toxins that need to be screened out. Even what is nourishing needs to be discriminated in accordance with dominant needs. The boundary between self and others is defined and experienced due to the influences of aspects such as value systems, familiarity, exposure and physical or bodily functioning or feeling. Essential functions of the contact boundary that are rooted in the body process have been described by Kepner, 1987:171 and Perls *et al.* 1951:230 as the

(1) maintenance of difference
(2) rejection of danger
(3) coping with obstacles,and
(4) selection and appropriation of the assimilable novelty.

Kepner (1987:168-172) proposes a model that describes how the body-self participates in maintaining, modulating, selecting and preventing contact. The body-self is described as consisting of a boundary layer and space which includes the physical body and part of environmental field. This is summarised as follows:

- Body as a *boundary layer* – here the skin surface, musculature and body openings are considered as a physical boundary, the place where contact is experienced as the "me" distinct from the "other". Boundaries are considered

more than a physical structure; they are formed by an ongoing process of modulation and change. From this perspective it is the capacity to regulate, by hardening or softening the musculature, and is a physical process by which the organism changes the permeability of self to contact and thus manages what novelty is selected and assimilated or rejected.

- Body as a *boundary space* – "is the buffer area of self, the place where *me* and *environment* diffuse into one another" (Kepner, 1987:171). The boundary space as process is constantly being adjusted or defined in order to (1) regulate the actual distance form others i.e. the pace and intensity of the contact, and (2) to manage the physical contact onto the body boundary layer. The amount of surrounding space changes according to the organismic needs, perceptions and the conditions of the environment. The organism regulates, modifies and communicates its body space through the body process, which is mainly nonverbal. This is further divided into two domains:

  distal boundary space – social distance, the space around the body outside range of touch. The actual distance that is required between self and environment can be regulated and communicated through body processes that involve (1) the sensing of the body signals that indicate being comfortable/uncomfortable, (2) gross motor activity such as movement through space and (3) use of verbal and body language including posture, gesture, voice tone and facial expressions (Kepner, 1987:172).

  proximal boundary space – intimate distance, the space around body within range of touch. This space is managed by gross motor actions such as adjusting body position by leaning back or moving away, use of hands such as pushing.

Boundaries do not have a fixed form neither is one organism better than another's. Healthy functioning is when an individual has the capacity to adjust his/her boundary and space according to the need and the context of the contact.

3.2.3 Contact

The Gestalt therapist believes that part of psychological health is having good contact with self and others. Contact means "the awareness of, and behaviour toward, the assimilable, and the rejection of the unassimilable novelty" (Harman, 1996:6). However, how we make contact will need to be modified according to the field circumstances in each unique situation. Seeing, hearing, touching, and talking, moving, smelling and tasting are sensory motor components involved singularly, or in some combination of contact, and form part of the awareness of the field. Acknowledging and coping with the "other", in our existence constitutes contact, and so the becoming aware of what is "me" and "not me". When we are able to maintain our awareness of this boundary that separates "me" and "not me", then excitement and growth are possible.

The dilemma of contact styles is influenced by the selection of what is the assimilable novelty and the rejection of the unassimilable novelty. One contact style leads to growth and development, the other to dysfunction. When a person introjects it can be described as a swalloing down without questioning (Kepner, 1987:174). An example of this can be seen in young children when their own needs and perceptions are displaced and intruded on by adults. Intrusion may be in the form of expectations for performance; constant rules and regulations for contact; or living out the parents' narcissist demands. A child can modulate his/her boundary (i.e. contact style) by giving up his/her own needs in favour of the introjected needs; or by closing boundaries to any contact .

Where no nourishment takes place it is called *underbounding and is a* result of *overbounding,* as there is little taken in to be assimilated, as high amounts of

boundary space is maintained (Kepner, 1987:175). When the boundary is too permeable and the sense of "I" is dissipated or not developed, as in younger children, this is called underbounding. A person cannot maintain his/her identity without intact personal boundaries (Kepner, 1987:178). Being aware of the personal body boundary allows the individual to communicate through his/her body language and posture what personal space is considered as acceptable. With overbounding the person creates a shell whenever his/her contact is threatened. This can be seen in the body structure where the muscle whose function is movement has been converted into acting like bone (Kepner, 1987:179). To become overbound requires more motor development to harden the body in order to remain more differentiated and maintain organismic integrity. Kepner (1987:179) states that overbound individuals often report of symptoms such as feelings of insulation, loneliness, being unloved, feeling rejected by others, fears of opening up which results in loss of control.

Intervention suggestions is use of 'I' statements; exploring separations, endings; similarities and difference (Joyce & Sills, 2001:121). On the other hand the polarity to *confluence* is *withdrawal*, like feelings of alienation or being invisible.

To summarize, in Gestalt Therapy, therapists are interested in how patients contact other people or how they avoid or resist contact.

3.2.4 Resistance

Resistance is an acceptable occurrence in the course of therapy, but varies in type, quantity and intensity (Kaduson *et al.*, 2004:320; Zinker: 1994:117). Resistance can be broadly categorized as externalizing or internalizing behaviours. Externalizing behaviours include aggression, destruction, non-compliance, and/or negativism, whereas, avoidances, passive-aggressive traits, and fearfulness are internalizing behaviours. The type of resistance reveals valuable information

about how the child copes and reacts to psychic conflict and distress. As indicated by Kaduson *et al.* (2004:320), it is even more crucial to analyze the amount and intensity of the resistance.

According to Zinker (1994:117), all movement engenders resistance. Our inner resistance is experienced as a reluctance to change our ways of doing things as we take comfort in that which has constancy. Zinker adds that "what appears to you, on your observing surface, as a casual reluctance to change, may be an inner crisis for me, a fight for my very life". As highly complex organisms, we learn to block our need satisfaction, also called "fixation". Fixation blocks the continuous development of the organism. What appears "sick" to us is actually a state of accommodation to blockage in the other person.

Resistance thus implies protection against risk of pain and discomfort. The implications of resistance are:

- listlessness
- a loss of humour; and
- a loss of playfulness.

In Gestalt Therapy children must be helped to show resistance, and be assisted to develop a strong sense of self, in order to counteract listlessness, a loss of humour and playfulness. These three implications are indicative of contact boundary disturbances, and, as can be seen later in the discussion, the price the individual pays for "trying to stay the same".

3.2.5 Contact boundary resistance and disturbance

Contact, as well as figure formation and destruction, takes place at the boundary (Yontef, 1989:8). The boundary between the organism and the environment are either objects in the environment or another person (interpersonal and interacting in nature). Allowing clear uninterrupted contact is a sign of healthy functioning

(Harman, 1996:230). According to Zinker (1994:95), the dynamic point at which we and this sensation meet is called the contact boundary. The phenomenological here and now, therefore, represents a highly personal sensory experience at this moment in time and place.

On the grounds of the factors mentioned, for contact to occur the boundary between the individual and the environment must be permeable and flexible so that nourishment may be allowed to enter (Harman, 1996:20 and Blom, 2004:24). Also, the boundary must be firm enough to keep out toxic material so that the individuals' integrity is protected. Contact interruption, interference, or prevention, which occurs at the boundary, is known as contact boundary disturbance.

Harman (1996:21) continues by saying that clients usually experience their boundary disturbance without awareness, their disturbances become their "habitual" ways of "being" in the world. These disturbances may occur with certain people, under certain conditions such as stress, or may be manifested in a fixed (stuck) way in all of one's interactions with others. Boundary disturbances may also be considered as energy diversions that reduce the possibilities for encounters with others (Polster and Polster, 1973) in Harman (1996:33).

Contact boundary disturbances are descriptions of processes, and not of character traits, and can be summarized as the following baseline responses:

- The boundary between the self and the environment gets lost and becomes unclear
- One experience melts into the other and disappears: the boundaries are vague, ill-defined, so that interpersonal discomfort is avoided
- The individual is out of balance; he is no longer capable of forming a sound balance between himself and the world
- The individual is not capable of suitable awareness, and can therefore not share

- The individual rarely works things out to everybody's satisfaction
- The implication is that it refers to a process where children satisfy needs of figure foreground (process of Gestalt completion and destruction).
- The individual can no longer respond to his real needs
- The individual appears listless, depressed, hurt, in pain and depleted of energy
- This disturbs contact awareness, and then the client tries increasingly to involve other people to show them how he/she must be
- It may lead to isolation, because it is fixed, and fails to allow close contact to emerge or boundary confluence if the need to withdraw is blocked.
- The neurosis impedes Gestalt completion.

Disturbances at the contact boundary usually take one of more froms: 1) projections, 2) deflections, 3) introjections, 4) retroflections and 5) confluence. For the purposes of this study a short description of retroflection and introjections will be offered in order to give a background for deflection where "deflection" will be discussed in detail.

Retroflection, a contact interruption is suggested to be characteristically occurring around final contact phase, and occurs when the individual holds back to take action (speech, expression or feeling and behaviour). Energy does not discharge or connect appropriately (Clarkson, 2004:57). If the energy is not naturally discharged or not acted out on the environment, it may be directed onto themselves, which is often held in the body in the form of tensions, cancer, somatic illnesses, depression and self-harm (Joyce & Sills, 2001:115). The other type of retroflection is to do to oneself what one would like another to do to one (Clarkson, 2004:63). An example of this is to stroke oneself. The polarity to *retroflection* is *impulsiveness*. Suggested interventions are grounding exercises and heightening awareness of body boundaries (Joyce & Sills, 2001:116).

Egotism is the capacity for self-reflection (Joyce & Sills, 2001:122). It is like watching oneself and becoming a commentator on oneself and the relationship with the environment (Clarkson, 2004:64). This dysfunction often occurs around the satisfaction cycle when the individual cannot derive a sense of completion or satisfaction and rushes into the next experience. There is a lack of spontaneity due to controlling and alienation from physical self and environment. Examples of this is excessive preoccupation with one's own thoughts, feelings, behaviours and its effect on others; or the inability to achieve climax during intercourse. The polarity to *egotism* is *spontaneity*. In unhealthy form it can appear as mania and anti-social behaviour (Joyce & Sills, 2001:123).

Once final contact ends through satiation or other withdrawal, the *what* that was experienced must be assimilated so that a new figure can emerge. This phase is called withdrawal from contact. The completion of the cycle requires the organism's energy and awareness to revert from the environment back to self. Kepner (1987:189) sees the withdrawal phase as a "rhythmic punctuation" to the cyclic human process of contact. The nature and intensity of contact influences the process of withdrawal and assimilation (Kepner, 1987:189).

Elements of the withdrawal phase include:

- *Disengagement from contact* – which involves certain tasks that shift the attention from the contact object towards the self. The shift of attention is usually signalled by some *bodily signal* of satiation involving sensations such as fatigue, a sense of fullness, dulling of perceptual intensity, or a sense of satisfaction; and *bodily movements* such as physically separating, shifting or breaking eye contact from the other; and a *slowing down.* Difficulties can occur in the disengagement when individuals are in a state of *confluence* or enmeshment (Joyce & Sills, 2001:120); feelings of anxiety and emptiness may occur when individuals have little sense of self or sense or physical sense of bodily boundedness (Kepner, 1987:193). This dysfunction originally

had a survival function which was necessary for an infants' development (Clarkson, 2004:65).

- *Re-forming self boundary* is a task necessary to reaffirm one's sense of self or defining the "I" after having separated from the contact object. It is a process of returning to "home ground", finding a bodily space to locate a sense of self. Without this clear sense of bodily self, withdrawal can be difficult. It should be noted that this process is part of child development (e.g. individuation) where the symbiotic bond between infant and primary caregiver start to separate. However, from a Gestalt perspective this is not seen as a development milestone but rather as a characteristic of an ongoing contact and withdrawal process (Kepner, 1987:195).

Assimilation and closure – The aim of contact is that the self boundary is recreated to include or assimilate the new experience or material that results in growth which in turn results in the emergences of a new Gestalt (Kepner, 1987:196). Every contact creates some emotional and/or body response impact which needs to be digested and assimilated. Each assimilation results in a new whole or Gestalt and an awareness of the impact of the contact in terms of what is completed and what is unfinished. Closure indicates the full turn of the organismic cycle and may be experienced as a sense of calm or a sense of loss and mourning i.e. mixed or ambivalent feelings. Common fears of losses such as loss of self; abandonment by others and possible feelings of grief, mourning, and anger may be experienced by the individual.

3.2.6 Deflection

A common way of reducing or avoiding awareness in the figure formation phase of the cycle is *deflection*. This is an active way of ignoring internal stimulus (feelings and impulses) and avoiding needs or demands of the environment (Clarkson, 2004:60). Examples include endless talking or laughing, avoiding eye contact, focusing on the need of others rather than self; or else a passive

aggressive person might stare out a window or sit sulking. Deflection, as described by Zinker (1994:123), is avoidance of enrichment in the contact phase of the interactive cycle. Here people avoid connection by shifting the contact to some other topic that provokes less anxiety.

According to Harman (1996:22) when a person deflects he/she turns aside or in some way diffuses possible contact. Words from others seem to have little effect; and they bounce off as from invisible shields. Zinker describes this as messages ricocheting off each other. By not noticing the deflection, the system collaborates to accept unfinished business.

Deflections serve to water down feelings. Not only deflections weaken the impact others have on us, they also sap the vitality of our own responses. As a boundary disturbance, deflections are used to interfere with contact by both receivers and senders of messages. Senders “scatter” their messages while receivers deflect contact, so that messages have little impact on them.

According to Yontef (1989:8), *deflecting* is the avoidance of contact or of awareness by turning aside, as when one is polite instead of direct. Deflection can be accomplished by not expressing directly or by nor receiving. In the latter case, the person usually feels “untouched”; in the former case, the person is often ineffective and baffled about not getting what is wanted. Other examples of deflection include not looking at a person, verbosity (long-windedness), vagueness, understating and talking “about”, rather than “to” (Polster & Polster, 1973:89-92).

To summarize, the following aspects are indicative of people who deflect:

Deflectors

- avoid direct contact
- reduce awareness with the environment
- avoid enrichment

- do not make solid connections
- avoid eye contact
- change the subject
- avoid connection by shifting the contact to some other topic that provokes less anxiety

Children who make use of deflection do not use their energy efficiently in order to receive feedback from themselves, others and the environment. Deflection is seen as a prime, irreducible boundary disturbance.

3.3 HUMOUR AS DEFLECTIVE TECHNIQUE IN CONTACT BOUNDARY DISTURBANCE

3.3.1 The implementation of humour in the therapeutic setting to establish awareness and change

For the purpose of this study it is important to identify the polarity of humour as an emotional response that will direct behavioural change: from unhappiness to happiness. In this research it needed to be determined if humour can be implemented positively, becoming a positive tool or technique to help the client address deflection.

The following questions guided the research:

- Can the experience of pain and avoidance of connections be turned into enrichment, the creation of clearer boundaries, in order to create more interpersonal comfort instead of discomfort?
- Can humour be taught as a vehicle for an intervention skill, especially as a coping mechanism?

- What is the possibility of exploring the use of humour as a **directive skill** when deflection as resistance presents itself during therapy?
- Can a particular intervention on the part of the therapist have positive consequences?
- Can people be made more aware of the positive impact humour has on a situation, involving the teller as well as the listener, in individual, or group situations?
- Can people be made aware of their own humouristic capabilities?
- Can awareness with the environment be increased through humour and can the individual then be able to stay aware in order to change emotionally?
- Does the use (implementation) of humour (by making use of carefully selected techniques), as deflective technique in Gestalt therapeutic work improve self-awareness and personal well being, thus change in emotional well-being?
- Can humour be used as an instrument in order to establish awareness long enough for change to occur?

3.3.2 Humour used as deflection

From the literature it has become obvious that even though they might be unaware, people do use deflection, and the following has become apparent:

When a person encounters stress that is not effectively dealt with, a withdrawal into the self might take place in what may be a protected retreat. The individual risks less and fewer humourous exchanges are made than before. The stressful circumstances and emotional isolation begins to solidify. Events and situations that were previously rewarding become potential sources of rejection and failure. Since humour is a basic social exchange, the sharing of humour diminishes as social interactions are limited.

As we look at deflection as contact boundary disturbance in order to protect against risk of psychic pain, hurt, discomfort, difficult confrontation and rejection, we also witness the price paid: listlessness, lack of intellectual spark, depleted energy, depression, loss of humour and playfulness and a sense of rarely working things out to everyone's satisfaction.

On the other hand, Harman (1996:23) is of the opinion that doing therapy with deflectors requires helping clients to establish contact in order to add zest and freshness to their interactions. Useful purposes may be served by deflection. According to Yontef (1994:125), deflection can be useful where, with awareness, it meets the needs of the situation for example where the situation needs cooling down.This can be done in many ways. Deflection can take the heat out of our responses, so that it is possible for us to remain in contact and not to withdraw, or, in extreme cases, not to attack. Deflection enables us to not respond to all the stimuli that impinge (invade) upon us. As deflection is sometimes considered healthy, the researcher intended to investigate the use of humour as a deflective technique.

Much of therapy focused on these unaware forces. A goal of therapy is to bring these resistances to awareness so that the client can choose to transform himself into a more "contact-full" unit. The therapist's job is to entice or invite a client to a curiosity about how they manage these occurrences, what is avoided in the way of difficulty, and the price that is paid for staying safe.

According to Harman (1996:23), the Gestalt therapist must be willing to ask, tease, cajole, persuade, entice, flatter, coax, sweet-talk, provoke or demand contact from clients. In responding the deflector begins to experience the contact boundary as an energizing, exciting place to be.

According to Friedman (1994:49), people reveal their unconscious both by the **jokes they tell** and by what they find funny. The author explains by saying that

emotional communication can be aimed at someone's unconscious by a well-timed and appropriate joke. He continues by stating that humour is no different from any other **technique:** to use humour effectively one needs the same safeguards against counter transference and resistances that one needs with any intervention: a good personal analysis, continuing self-analysis and continuous consultation with colleagues. When used responsibly, he finds humour to be an effective intervention where interpretation fails. He sees humour as subversive, insubordinate and rebellious. It might be argued that humour provides the most sublimated and constructive way of dealing with aggression.

There are reasons and purposes a person has for telling a joke. In understanding humour it is necessary to know what actual assessments of the humour are made by those involved. We can then find out what the humour does. There are two levels of humour, as seen before. One is the level of the joke itself as told in a particular situation and to certain people with their individual beliefs and values. The second level involves what the joke teller is trying to do in telling the joke. The person may wish to be sociable, seem clever, make a critical point, enjoy the pleasant feelings humour provide, and express something that could not otherwise be expressed.

Birner (1994:80) is of the opinion that if a patient tells a therapist a bad joke, he is speaking of his lack of inner connectedness and his ego conflict. The inappropriate joke can reflect feelings of personal inappropriateness. The bad joke can be the communication of a conflict in a particular area.

Also, in settings where the clinician is interested in influencing the child and his/her relationships, humour has proved to be helpful (Prerost, 1994:140-141 and Birner, 1994:84). The authors further contend that the humourous reaction to problem behaviour, through its tension-decontamination effect, is more efficient than any other technique. According to Shibles (2002:7), humour in

therapy aids to distance oneself from a painful event as well as lessen negative emotions. The researcher would like to agree with this point.

One of the most difficult things for many clients is to develop and maintain a truly positive, not bravado, sense of self-worth while finding out something about themselves that does not fit their self-ideal. The acceptance of self-worth must be learnt in therapy. In the interpretation phase (clarification and evaluation), humour becomes a marvelous technique for allowing the client to see some of the useless things he is doing. Without becoming offended again, humour takes the edge off and lessens resistance. When some of the strongest interpretations are presented with a glint in the eye or phrased in a humourous way, they have had better results with a higher degree of acceptance by the client. The therapist's message becomes, "this is what you are doing to louse yourself up, but I still like you anyway". Another way of saying the same while making use of banter could be: "Who can like you?" (Satow, 1994:190; McGhee & Chapman, 1980:275).

This technique carries implications of both good humour and ridicule. The use of banter is also an aid for use by insecure therapists in dealing with clients that tend to make them uneasy by their indirect or masochistic complaining, self-depreciation, and implied questioning of the therapists competence. The therapist is encouraged to exaggerate the self-belittling remarks of the client to the point of sounding ridiculous: "You're the worst patient I ever had" or "Who can like you anyway?" This is said in a friendly tone and tends to agree with the patients' self de-evaluative fears that he is unloved. It is obviously not felt as rejection by the patient when he responds by laughing and becoming visibly more relaxed. Actually the therapist is not addressing himself to the patient's feelings of worthlessness, but to his aggression. The patient is saying in effect: "You have to like me because it is your job and you have no choice". With his response, the therapist pricks the patient's pride in ugliness and gives the patient the opportunity to relax the pressure of his angry demands.

According to McGhee and Chapman (1980:277) the technique of humourous de-contamination is speculated as being effective as it is the result of a combination of factors:

- The adult's use of humour demonstrates his/her invulnerability and attitude of self assurance in his/her ability to cope with the situation
- The humour response reassures the child so that he/she is saved the guilt and fear by which he/she was about to be overcome in the attack and problem behaviour he/she was about to act out
- The possibility of face-saving as when the child has had to act tough and belligerent, and
- The humour diverts the child by the funniness of the moment from the strong emotions which threaten to overcome him/her and as such humour is used as a distractive tool to avoid the issue at hand
- It may be used to bring one out of depression, a bad mood, and a tense or embarrassing situation. It may be used to lessen the severity of blame, e.g. "I would have fed the cat, but it said it wasn't hungry"; "If you work, you make mistakes" (Jacobs, 1992:84)
- Humour is often used when there seems to be no direct or other way to communicate criticism. In this capacity, it serves as an invaluable tool. Kind, loaded humour can be the most pleasant or sugar-coated way of offering constructive criticism
- For seeking and gaining approval of others and making friends, humour is a central tool. It establishes intimacy and is seen as a type of love. A lively, humourous person is attractive. Humour is a gift. We often do not want to "waste" humour on people we do not like, or perhaps whom we are afraid we might like if we joke with them.

Other uses of humour to bring about change can be listed. Humour is used

- as a criterion of selecting a person for a job, choosing a spouse, etc.
- as a humanistic way of managing personnel and people
- for social cohesion in society

- to aid in solving political differences
- to bring about our desires and goals
- to cope with difficult or hopeless situations such as war, death, etc.
- to cope with oppression
- to create friendship and intimacy
- to criticize institutions and bring about social change
- to enhance motivation toward accomplishing tasks in any area
- to enrich marriage
- to help avoid, end, or prevent war
- to help make business run smoother, and work more enjoyable
- to motivate one to enjoy life and overcome negative moods such as depression
- to motivate students
- to persuade
- to persuade in advertising
- to present an argument effectively

To conclude, it can be assumed that awareness, as well as a simple, even miniscule shift can evoke change in human systems. When a client begins to experience his competence and creativity outweighing his troubles, he can experience affirmation and dignity that was not previously available to his awareness. This in turn gives him courage to look at what is missing in his system, and what his strengths are.

3.4 HUMOUR IN THE THERAPEUTIC PROCESS

At the most general level humour can be used to move clients to a particular level of feeling experience. Pierce (1994:109) makes a point about the relationship of humour with regard to the expression of feelings, that humour can be used to lighten as well as deepen client's involvement with their feelings. "Most of the time we work to deepen a client's experience of feelings, but at times, when the

client seems to be too immersed in a feeling, humour may be used to help the client lighten up." It thus follows that the right kind of humourous twist by the therapist or by the client, gives perspective in a way that is a particular gift of humour.

A second goal of therapy is insight, and in that sense humour is used diagnostically, presenting in the cognitive and emotional grasping of a connection that is personally relevant. It may be a connection between the past or present, between feelings and behaviour, or it may involve a transference connection between early caregivers. With humour, insight can be facilitated in a number of ways. What a person finds funny often tells the therapist, and sometimes the client, where the conflict is.

A third objective is to provide the client with a healing relationship. There is a moment in laughter when the laughers' eyes meet and for a moment they are not alone. There is a shared, sometimes very intimate message: "I know exactly what you mean, I have been there too". Because it is not overtly shared or consciously decided upon, but rather happens, it can be amongst the most spontaneous moments in therapy. In Gestalt, this spontaneous moment could be seen as the "facilitation" of the "I-Thou" moment and contributes to relationship building.

It can thus be argued that therapy represents a joint exploration, an inquiry into motives and patterns of thought and behaviour, trying always to make connections between past influences and present conceptions of "what" it is we want and "how" best to get it.

These writers agree that when appropriate laugher is triggered in a patient it usually signals therapeutic progress. Amongst others, humour helps to demonstrate acceptance and respect for the client, and helps put the course of therapy in a positive direction. Although the therapist takes the client and his problems

seriously, humour lets the client know that the therapist entertains hope and does not feel overwhelmed by the difficulties the client presents (Prerost, 1994:140). Humour is contagious, and usually the clients will respond positively to it. Prerost explains that humour allows the client to see that everything can be something else as well, that the clients' problems have more faces than he/she originally anticipated, and that problems may be "redefined opportunities for growth".

As the client begins to laugh with the therapist, he grows in his feelings of self-control over his problems. This is especially true in depression, as depression cannot survive a state of humour. When the client can bring himself to laugh, he vividly demonstrates to himself that he, not his symptoms or moods are in control of his life. A true realization of this fact is often the turning-point from which a clients' progress can develop.

3.4.1 Humour used by the therapist

The successful and well-considered integration of humour in the therapeutic situation demands first of all a humourous frame of mind. This includes flexibility, willingness to experiment, spontaneity and playfulness. It also includes an element of humility, a willingness not to take human imperfections too seriously, because "a man who can laugh at himself will always be amused" (Jacobs, 1992).

One must acknowledge that not every therapist is comfortable with the use of humour in therapy as a tool to relieve stress (McGhee & Chapman, 1980:267). Reactions of clients vary as well: Many are unaccustomed to finding anything funny, as they have lost the capacity for surprise which is one of the essences of humour. Others are simply unprepared for the idea that a counselor or therapist might try to amuse them (Livingstone, 1006:29).

The willingness of the child to join the therapist in the humourous frame of mind depends upon his or her feelings about the therapist and the notions about the therapist's intent. It is good for the therapist to laugh appropriately at the patient's humour as it is the only acceptable affect that can be readily shared in the treatment situation. The laughter is also a way for the therapist to express his own humanity to the patient (Birner, 1994:187).

According to Olson (1994:198), the use of humour early in therapy takes the "edge" off the client's anxiety regarding the awesomeness of the therapist and the therapy process. With the appropriate use of humour, the therapist demonstrates his humaness, that he is a "regular guy" who needs not be feared, after all, someone who jokes with you, can't be all bad.

Olson (1994:198) further mentions that what is also useful is to approach the child from the viewpoint of meta-conversation, "I am joking". This message about the message is an invitation to the child also to join the therapist in the humourous frame of mind.

McGhee & Chapman (1980:227) mention the importance of intuitively knowing when to make a humourous remark. The therapist should use humour throughout only with positive regard for the client, also stressing the positive successes of the client. The therapist must always be basically kind, warm and caring. In fact, the spontaneity, honesty and natural response of the therapist is always indicated throughout whatever technique is used.

A common ingredient for the use of humour in therapy would thus be a humourous outlook on life, spontaneous playfulness, an appreciation of the ridiculous and the tragic-comic, an ability to stand off and see oneself as silly and foolish, as well as the recognition of the absurd and the welcoming of caricature.

3.4.2 Oppositions and Resistances towards the use of humour in therapy

Some oppose the use of humour in therapy. According to some therapists the use of humour is unscientific and the therapist is expected to be serious. Kubie (1994:95) is of the opinion that humour is usually not appropriate in therapy. The problem refers to

- the perception that the therapist is not serious
- problems that are not to be taken seriously
- the masking of hostility
- different people reacting differently to different types of humour
- humour just covering one's embarrassment
- humour being inappropriate to the degree of suffering experienced
- humour used to hide denial, for seduction, to support one's egotism, to express the therapist's hostility, to abuse
- the fact that ridicule, aggression, mockery, being sardonic and sarcastic are negative evaluations and not to be regarded as humour.

Birner (1994:86) is of the opinion that humour should only be used by the therapist in the ethical sense of being helpful to the patient.

3.4.3 Rules of thumb

According to McGhee and Chapman (1980:274), the only general rule of thumb is that the therapist will intentionally use humour when he/she considers that it will facilitate the therapeutic relationship and process, and to combat resistances. Practically any human characteristic such as competitiveness, orderliness, even

kindness, thus also humour, when indulged to an extreme, can produce undesirable results (Livingstone, 2006:153).

The therapist may joke when he/she has the purpose to

- reduce the child's tension or anxiety
- create a more intimate communicative relationship
- dramatize a point that is too difficult to communicate directly
- create a less solemn, more playful climate
- communicate his/her empathetic understanding of the child's concerns
- deal with the difficulty of forbidden feelings or issues
- facilitate emotional expressiveness, and
- present an insight to the child effectively

Although humour is an effective therapeutic tool, the conditions that must prevail, according to Olson (1994:197), are that the therapist must be genuine. Secondly, humour must never be at the client's expense. This would be the antithesis to therapy. Thirdly, the therapist must know his client and must understand what kind of humour is appropriate. Common sense, clinical sensitivity, and skill are essential in the use of humour. Then, humour in therapy becomes a backdrop against which a variety of techniques are used. The researcher underwrites this opinion.

It can thus be deduced that the use of humour to promote the goals of therapy appears to be a skill which the therapist must develop. By creating a more relaxed and playful frame of mind the skillful introduction of humour by the therapist may increase the child's willingness to confront the source of his or her anxiety. The establishment of this frame of mind is more likely to produce a feeling of comfort and trust regarding the therapist, an essential step if therapy is to be successful.

3.5 USING HUMOUR IN GESTALT PLAY THERAPY WITH CHILDREN

Children lack adult verbal skills and cognitive abilities. The major accommodation to this fact has been the use of play therapy, in which the child's play behaviour is encouraged by a therapist and then used as a response to a projective technique to make sense of how a child experiences his world. Although the title, *Play Therapy*, might lead one to expect the playful inclusion of humour in the play therapy literature, journal accounts of cases are typically rather analytical (Ventis & Ventis, 1988:180).

According to McGhee (1980:264), just like play, humour is not necessarily an extraneous or distracting intervention in psychotherapy with children. Since humour is a form of play and has many of the significant characteristics of play, it is helpful to consider the use of play as well as of humour in child therapy. We know that play is the primary activity of childhood and is an essential to normal development. Children who cannot play or whose play is developmentally arrested have been found to be emotionally and intellectually handicapped. We may well find that children who have difficulty in enjoying humour may also be impaired in their development. It is because children have such an enormous need to play, and in their play express their pleasure by laughter and humourous-ness that they will relate readily to others, even strangers, who will play with them.

In studies conducted it was found that one of the two dimensions of major importance in children becoming socially and morally mature was the freedom of emotional expression (and thus being playful) and the lack of strictness with parents which controlled their children's behaviour (McGhee & Chapman, 1980: 259). A child was less apt to become emotionally and socially mature when his/her parents tolerated no noise, mess, or when they acted unkindly to the child's aggressiveness toward them. When parents were concerned with using

their powers to maintain an adult-centered home, the child was not likely to become a mature adult.

Authors such as Ventis and Ventis (1988:181) argue that other reasons for considering humour in therapy with children are implicit in the developmental literature on children's emerging abilities. In some ways, humour may be more easily integrated into psychotherapy. The child's normal mode of experiencing tends to be a playful perspective in which there is considerable vacillation between fantasy and reality, and the younger the child the more this tends to be the case. Thus, techniques using humour in play therapy with children use a mode of experience that the child is accustomed to and may well prefer.

There is evidence that playful, active, lively children are less aggressive than their less imaginative peers, particularly as they reach school age (McGhee & Chapman, 1980:259). By being able to respond with appropriate emotions to shifts in the incoming stimulation, they are more able to find alternate means of expressing their anger and frustration than through outright violence.

When humour is used in play therapy it may erupt spontaneously and naturally. When this happens, the sharing of a joke accompanied by laughter ordinarily reflects a climate of friendliness and perhaps of growing intimacy, even if it occurs in the context of a competitive game. Such spontaneous humour even intends to reduce barriers to communication by promoting mutuality and even intimacy. Humour in psychotherapy, whether it is spontaneous or intentional, reduces the psychic distance between patient and therapist, thereby affecting the professional relationship.

3.5.1 Resistance

As contrasted with the adult who voluntarily seeks treatment, the child is more typically brought to therapy by the parents, or is required to attend by an outside

agency. In this circumstance, the child is likely to begin therapy in a state of bewilderment, fear, or as an adversary to the therapist whom he or she feels forced to see. When this is the case, it can be a relief and a source of re-assurance if the therapist shows a playful of humourous perspective early on (Ventis & Ventis, 1988:180). Whatever else is to come, the relationship begins with a shared interest in playful fun.

3.5.2 Sensory contact making

The healthy uninterrupted development of the child's senses, body, feelings and intellect is the underlying base of the client's sense of self. A strong sense of self makes for good contact with one's environment and people in the environment. Oaklander (1988:57) emphasizes that themes children singled out as needing help have one thing in common: some impairment in their contact functions. The tools for good contact are: looking, talking, touching, listening, moving, smelling and tasting. Since a strong sense of self predisposes good contact, it is no wonder that almost every child seen in therapy does not think too well of himself, though he may do everything he can to keep this fact hidden.

The therapist must therefore work to build the child's sense of self, to strengthen the contact functions, and to renew the child's contact with his senses, body, feelings and use of intellect. Once this is being done, the behaviours and symptoms that the client used for his/her misdirected expression and growth often drop away. In this way the child's awareness is redirected to the healthy mindfulness of his/her own contact functions, his/her own organism, and thus toward more satisfying behaviours (Oaklander, 1988:59).

3.5.3 The child's process

The intentions of the child in using humour in therapy are different from those of the therapist. The child says something funny either as a defense or as a dis-

guised expression of hostility. The therapist tells a joke and makes a witty remark when he thinks it will promote the therapeutic process. The child, unlike the therapist, is unaware of and unconcerned with the purposes of humour when it occurs. It is a moment of playful amusement (McGhee & Chapman, 1980:268).

Children possess the outlook of the humourist before they are coerced to conform to the dictates of the adult world. The healthy child enjoys playing with the endless possibilities of nonsense and absurdity available in the world. McGhee (1979:107) describes how cognitive growth in childhood occurs concurrently with the basic nonsensical aspects of humour appreciation. The child or person who is punished or discouraged from maintaining a humourous outlook on life runs the risk of falling into a life of restrictive functioning and constricted psychological heath.

3.5.4 Projection

According to research conducted from 1954 to 1977 (McGhee & Chapman, 1980:269), healthier children often use “pretend” nature of humour to mention their problems, in the contexts of therapy, while more disturbed children are more likely to manifest the intrusive force of ongoing problems by rearranging and substituting humourous content, so as to destroy the point of the joke.

According to McGhee and Chapman (1980:288) probably the most extensive observational study of children’s humour was done by Wolfenstein in 1954, who observed and interviewed children between six and twelve years of age to find the kinds of jokes they liked to tell. She hypothesized that a basic motive of a child’s joking is a wish to transform a painful experience into a pleasurable one. The authors further mention that Wolfenstein has described in some detail what she considers to be developmental phases of joking and the use of the joke façade. According to her, the child must find ways to gratify his/her impulses while disclaiming responsibility for them. He/she does this by an increasing

indirectness of expression. He/she will attribute the performance of naughty deeds to other children rather than to him/herself and ultimately to an entire fictitious character. Frequently, even authority figures are made responsible for the deeds.

3.5.5 Self-maintenance (self-support)

A partial list of some of these purposes for which children have used humour may be helpful in demonstrating the range and depth. Children may express humour as

- a desire to create a friendly relationship and communicating intimacy
- a need to disarm the therapist whom he/she fears by making an amusing self-disparaging remark
- a wish to make the therapist laugh as signifying approval of affection
- indirect hostility towards therapist
- a defense against anxiety
- an attempt to transform fear into pleasure
- an attempt to provoke the therapist by teasing
- an attempt to be teased
- a relief from tension arising from the session
- self-contempt as a symptom of depression
- mastery of anxiety
- avoidance of anxiety-laden discourse

3.5.6 Synthesis

The most important conclusion to be drawn from clinical views and studies is that humour can be used effectively by therapists to assist children in dealing with their conflicts, although care must be taken in doing so.

In addition, the *aim* of Gestalt should always be kept in mind, and that is to help the client to become *aware* of processes, by helping the client to explore the following, namely:

- Who are you?
- What do you feel?
- What do you like? What don't you like?
- What do you need?
- What do you want?
- What do you do and how do you do it? Or, What are you busy doing?
- What do you expect?
- What do you evade?

Once the person is aware, changes can be made and new behaviours explored.

The importance of awareness, contact, boundaries and the use of deflection in Gestalt Play Therapy with children validates the inclusion of this paradigm of thinking as part of a realistic contextual reasoning before doing the empirical research. The Gestalt perspective as paradigm of thinking which underwrites the relationship in which these aspects were addressed, provides a suitable philosophical context within which treatment is to take place.

In Chapter 4 the methodology and empirical findings for this study are introduced. The reader is enlightened on how the process of inquiry was structured to deal with the objectives of this study.

CHAPTER FOUR

METHOD OF ENQUIRY AND FINDINGS: INTERVENTION STRATEGIES AND TECHNIQUES

4.1 INTRODUCTION

In previous chapters all applicable concepts for the exploration and description of humour, Gestalt awareness and contact boundary disturbances have been explored and described. The literature has indicated that within a Gestalt Therapeutic approach the use of humour offers a dynamic alternative to persons presenting with deflection as contact boundary disturbance. In Chapter 4 the literature will thus be explored and described within the framework of case studies. This description of the exploration of new knowledge offers the researcher the necessary support and confidence for successful utilization in practice.

4.1.1 The research process

Research activities that were carried out are summarized by means of the data collection cycle below (Creswell, 1998).

1. Locate site and identify selection criteria
2. Purposive sampling
3. Data capture:
    - Baseline responses of clients presenting with contact boundary disturbance
    - Data collection during participation in Gestalt Play Therapy

- Data capture post-treatment: Intervention applied: directive and non-directive experiment

4. Data analysis: Comparison between intervention and second baseline
5. Resolving field issues as they arise during process

In Chapter 4 the research focus is on the empirical process that is followed in order to evaluate the results in a scientific way that is appropriate to the research method followed in this study. The research was undertaken by making use of case studies (single systems design) through which empirical data was collected with regard to the implementation of humour in the therapeutic process. As described in Chapter 1, the study was undertaken within the qualitative paradigm in order to reach the overall objective of the study. The most important component for this part of the study is that the researcher needs to write down the observations, in this case the clients presenting with deflection as contact boundary disturbance, making use of humour to enhance self-awareness.

A dominant qualitative approach was followed, applied in nature (single systems design), thus focusing on the functionality, as specific recommendations are described. The emphasis is on evidence, as well as the reflection of the outcome which can be applied immediately.

For the gathering, analyzing and interpretation of the empirical data for this study use has been made of qualitative research. Furthermore, the utilization of a qualitative strategy according to Patton (2001:190) is described as a combination of qualitative empirical data, personal involvement and observation of the researcher in the research process and analyzing of the data.

In order to achieve the goal, repetitive measurement of the target problem (contact boundary disturbance) must be measured at regular time intervals in order to see if changes have occurred prior, during or after treatment The repetition of

measurement is undertaken to establish trends. It was undertaken through observation, questionnaires and personal interviews in which open-, unstructured-, and in-depth follow-up questions were used.

The measuring instrument was developed after the literature research was undertaken, when an informed idea of relevant indicators that could be tested as baseline behaviour could be formed. (*When, where, what, why, how.)*

Two comparisons are possible:

- Between first baseline and interventions, and
- Between intervention and a second baseline.

4.1.2 Selecting the participants

In qualitative research *man* is the primary data collecting instrument. Measurement was taken from a single case, over a specific period of time, both before and after manipulation (pre and post treatment), in a specific environment. The method sampling can be regarded as accidental and availability sampling. The subject was selected in a purposeful way. The individual case is a whole study. The subject plays a role in the interpretations of the results to establish if the reality is reconstructed. The emphasis is on social processes and meanings attached to such social situations by participants. The researcher forms part of the phenomenon.

4.1.3 Strategy and process for data-capture for case studies

By making use of a planned strategy through which data can be collected from case studies, the researcher attempted to comply with one of the components of qualitative research, namely the completion of research by making use of systematic procedures. The most applicable strategy for the collection of data is to make use of participating observation and analyzing the content.

Data was captured through baseline responses (needed as a control measure) before introducing intervention (using specific strategies and techniques) as a treatment. The researcher manipulated the treatment condition, thus deciding who received treatment.

Every intervention (structured or unstructured, directive or non-directive) that included humour was noted meticulously in report form where text, verbal and non-verbal behaviour, words and gestures by the respondent were analyzed in detail in relation to the literature, the goal of the study and the research question.

4.1.4 Trustworthiness and Rigour

In qualitative research the truth-value is ensured through different sources of data around the same issue. The accounts of different informants in different observations in different settings, using different methods to evaluate data strengthen trustworthiness. Findings from all the different sources are synthesized to project a true representation of the process under investigation.

To ensure trustworthiness and rigour in this study guidelines set out by Lincoln and Guba (1985:290) for a case study inquiry were followed. Rigour was enhanced through credibility, transferability, consistency and neutrality.

(a) *Credibility*

Credibility implies confidence in the truth. In this research, credibility was also enhanced by the fact that behaviour depends on the repetition of the same situations, as components of the phenomenon came to the fore continually. The use of triangulation through observations, semi-structured interviews, the taking of field notes and the use of questionnaires were applied in this research. The

continuous involvement of the researcher in the research process and the gathering of data over a period of 6 months increased the value and credibility of this study. A reflective process where the researcher shared her thoughts, ideas, observations and experience of the process with colleagues, social workers and fellow students was followed. As a result of the process of continued observation and reflection, the credibility was ensured. The use of audiovisual methods, repetitive field entry, triangulation, member-checking reflexivity and peer evaluation further enhanced credibility.

(b) *Applicability*

Findings can be applied to many Gestalt Therapy contexts. It was pertinent to ensure that the selection criteria accommodated *deflection* in contact boundary disturbance. Applicability is also the way in which information from a small sample can be carried over to the broader population, in order to gain knowledge from the concepts that are studied to be able to transfer it to other situations and to give meaning in other contexts. The goal is not to generalise, but to develop understanding for the “deflector”. By making use of step-by-step analysing of the research process, the applicability of this research is built on a chain of evidence. The one set of deductions made, logically gave rise to the next.

(c) *Consistency*

In order to facilitate consistency it was necessary that the research should indicate consistency in the results and conclusions. Data was checked on a continuous basis in order to determine whether conclusions reflected the true nature of the problem. Strong literature control and reflective conversations with regard to video recordings ensured that a probing quality was incorporated. Video/DVD recordings are a source of data that is a form of direct observation of the phenomenon to be analyzed by separate analysts and can be repeatedly

examined and were made use of. In addition, the precise methods that were used for data gathering were written down step by step to ensure consistency.

(d) *Neutrality*

Establishing personal biases upfront by rigorously adhering to the methodology and using strategies, which could easily be replicated, enhanced the degree of objectiveness which was adhered to during the research process. In addition, consultation with experts in the fields of Gestalt Theory added to neutrality and all-round reflexivity, which were further promoted by field notes.

4.2 INTERVENTION STRATEGIES AND TECHNIQUES AS PART OF THE SINGLE SYSTEMS DESIGN

4.2.1 Introduction

A simple but powerful three step intervention method as used by Zinker (1994:207) formed the basis of this intervention. These steps were only implemented after the relationship between the client and the therapist was established and the client's process was discovered.

1) **Observation during the collection of data**: the purpose was to highlight that humour, as well as contact boundary disturbances existed in this case focusing on deflection and gathering baseline responses.

   The therapist begins by encouraging the client to talk about something that matters to him. This gives the therapist the opportunity to observe the client's level of awareness within its boundaries. After obtaining enough phenomenological data, the therapist made some observations. This was the first intervention. The observations were based on real data. Their purpose was to support the client's competence, goodness and sense of

creativity, and to bring what exists to the client's awareness. The therapist allowed time during the therapeutic situation to enrich awareness.

2) **The uncovering of contact boundary disturbances:** The purpose was to uncover the incompetence and highlight the price that was paid for not being fully aware. This brought up major areas of difficulty, and the therapist expected to meet potential resistance in the form of denial, shame, guilt or just plain unawareness. The therapist supported the client as resistances surfaced.

3) **What can be done:** The third intervention used was the experiment and raised questions on what could be done to change the implicit disturbances into explicit behaviours that supported the loosening of boundaries between the client and the environment. When the client's awareness is enriched there are more choices and more possible actions to pursue.

4.2.2 Measuring instruments and techniques (experiments)

(a) *Directive and Non-directive use of humour*

For the purposes of this study the following were used in a directive and planned manner:

- Games
- Board games – decision making games

Types of games can be classified according to what determines who wins (Dunn, 2004:207). Three types of games can be distinguished: (1) Games of physical skill, in which the outcome is determined by the players' motor activities, (2) games of strategy, in which cognitive skill determines the outcome, and (3) games of chance, in which the outcome is accidental.

The following games were used to find out about the process and the sense-of-self of the client. These games were used in a directive way, but during the play of these games humour was “used” in a spontaneous manner, by the therapist as well as the client.

- Mensch, Ärgere Dich Nicht, (People, don’t get Angry!) In English this game is called LUDO, a game of strategy and chance
- Snakes and Ladders – a game of chance
- Pickup Sticks – a game of physical fine-motor skills, and chance
- Checkers – a game of strategy
- *The Talking, Feeling and Doing Game* (Gardner, 1989) – a game of chance, and mostly communication in problem solving, ego enhancement, socialization, with regard to the cognitive, psychomotor and affective domains.

(b) *Directive and non-directive (spontaneous) techniques used by the therapist/researcher for the purposes of this study*

The following humour instruments and techniques, that are regarded as a welcomed event in therapy, were used and fit in well with the Gestalt experiment.

<u>The Favorite Joke technique</u>

Wolfenstein (1954:262) also mentions the use of the favorite joke as psycho-diagnostic tool. It is based on the assumption that a person’s favorite joke is related to a central problem or emotional conflict, which can then be used diagnostically or in therapy. It is suggested though, that this technique be used only to support more reliable clinical evidence.

<u>Modeling</u>

Modeling is an important therapeutic responsibility and is one of the fastest ways for the client to develop a positive sense of humour. Like responsibility, humour cannot be taught didactically, but must be observed and personally experienced to be mastered.

Humour can be presented as a coping model, the modeling of overcoming fear for instance, as well as the reinforcing of joking behaviour. The therapist may also model some silly behaviour. The therapist should laugh after the child has done something funny. The main idea is to model the development of a positive sense of humour, observed and experienced.

Banter (intensification and exaggeration)

An effective technique for raising awareness is to invite clients to exaggerate how they are behaving. The rationale behind this is that our inner experience often shows itself in our body language and behaviour. Thus a chance gesture such as a frown or smile, shrug or a pointing figure, if it is attended to, exaggerated or enacted, can be a powerful indicator of what is on the edge of the clients' experience. Equally, the casual use of a verbal expression or the particular tone of voice can reveal feelings that a person may be disallowing or ignoring.

One of the ways in which to use banter is to stay at the impasse (paradoxical principle of change) by suggesting that the client do nothing, and stays with the experience of feeling stuck. In the same manner a client can be coaxed to reversing, exaggerating or minimizing the habitual response to invent a new response.

When clients present situations where they are stuck, the therapist can try to identify a central quality or attitude such as stubbornness, guilt or perfection, and then help the client to imagine what continuum this quality might fall into. For

example, what would the opposite of this quality be? Thus, what is the other end of this polarity? The options are: do the opposite, do more, do less…

Other techniques that were used deliberately, either in a directive or spontaneous manner were the following:

- Prompting
- Novelty humour
- Banter (teasing, mockery, joking)
- Pictorial absurdities
- Verbal absurdities
- Humourous rituals
- Playing a clown or a fool
- Tendentious jokes (jokes that have no point to make, and have the greatest intra-psychic importance for the listener and the teller and are more likely to lead to outbursts of laughter)
- “Pink Panther” as co-therapist (also as part of the ritual)
- Storytelling techniques
- Fantasy and Imagery
- Reframing
- Funny toys
- Direct instruction to look for funny situations, stories and jokes for the next meeting.

As was mentioned in Chapter 3, the Gestalt therapist must be willing to ask, tease, cajole, persuade, entice, flatter, coax, sweet-talk, provoke, or demand contact from clients. In responding, the “deflector” begins to experience the contact boundary as an energizing, exciting place to be. In the research the therapist/researcher was continually “aware” of the ways to entice, allure and attract the client, and “implemented” the mentioned ways on a continued basis, as seemed fit for the situation.

Once it had been established what the process of the client was, an adapted version of *The Talking, Feeling and Doing Game* was chosen by the therapist to enhance awareness of humour, and implemented at about the 4th session. The contents of the game were adapted to suit the process of the participant. For the purposes of this report the need arises to explain the game in more detail, and to describe the adaptations that were made with regard to humour as an intervention strategy.

4.3 THE BOARD GAME AS PLAY TECHNIQUE

4.3.1 Rationale

As children develop, their play becomes more interactive and complex. The increasing social nature of play requires a combination of physical-motor, interpersonal as well as cognitive skills. Through play children discover their capabilities. Various play techniques within Gestalt Play Therapy can be utilised in working with children. A board game is an example of a play technique. As children's physical and mental capacities and interests mature, the quality of their games changes. Game patterns change with cognitive development and children become more and more capable of handling complex rules and strategies. Games, and especially board games, have a vital role to play in aiding the child's multi-dimensional development. In this section the rationale behind the employment of games in the therapeutic setting, with regard to humour is discussed.

4.3.2 Communication board games

While traditional forms of therapy are effective with many children, there are children who find it difficult, for various reasons, to respond to traditional approaches that require self-disclosing to the therapist in a one-on-one relationship or a group therapy setting. The following discussion is based on the

work of Frey (1986:21). Children are acquainted with board games, and usually achieve a positive association with such games. Even the most reserved and negative child will usually play a game with the therapist, since such play is not necessarily viewed as being self-disclosing by the client and is usually seen more pleasant than sitting in silence and receiving direct confrontation from the therapist.

Communication board games enable children to project aspects of self, both known and unknown to the child. Often these projections involve the presenting problem which was the cause for referral and additional areas of concern which were not the initial focus of the therapist. This gives the therapist a plethora of information about the child. Board games provide both the child and the therapist with flexibility and variety for use with a multiplicity of childhood disorders. Whatever theoretical orientation the therapist has can be easily integrated into most communication board games. The researcher found this to be accurate for the use of humour as intervention strategy where the client tends to deflect.

Due to the flexibility of responding in board games, the therapist can focus on cognitive, affective, and/or behavioural dynamics of the child depending on the presenting of the problem. The goal, of course, is to help the child become aware of all three domains and how they influence each other.

4.3.3 The Taking, Feeling and Doing Game: A Psychotherapeutic Game for Children by Richard Gardner (1973)

(a) *Background*

The *Taking, Feeling and Doing* Game was developed by Dr. Richard A Gardner in 1968 and first published in 1973, and has enjoyed worldwide success as an extremely effective psychotherapeutic instrument. Most child therapists consider

it an indispensable part of their playroom equipment. However, 25 percent of the questions in the game have since been updated, modified and imported.

The *Taking, Feeling and Doing Game* is appropriate for children ages 7 to12. The game cards can be read to young children who will actively participate. The game can be played by 2 to 4 players. The object of the game is to accumulate as many reward chips as possible after all players have reached the finish point. This is done by responding to cards which cover the cognitive, affective, and behaviourual aspects of the child. Through the child's responses, underlying psychological processes are discovered. A representative sampling of the cards includes: "Name three things that could make a person happy" and "Make believe something is happening that is very frightening. What is happening?"

(b) *Description of the game*

The following description is by Richard Gardner (Gardner, 1986:41-45), and clearly describes how the game is developed and played.

The *Taking, Feeling and Doing Game* is similar in format and appearance to many of the board games with which most of the children are familiar. The game begins with the child and the therapist each placing their playing pieces at the *start* position. They alternate turns, throwing the dice and moving their playing pieces along a curved path of squares which ultimately end at the *finish* positions. If the playing piece lands on a white square the player takes a *talking* card, on a yellow square a *feeling* card, and on a red square a *doing* card. If the playing piece lands on a square marked *spin*, the player spins the spinner which directs the player to move forward or backward or to gain or to loose chips. In addition, there are *go forward* and *go backward* squares. The spinner and the latter squares are of little psychological significance. They merely add to the child's fun and thereby enhance the likelihood of involvement. It is the questions and the directions on the talking, feeling, or doing cards of course, that are of

primary importance and the child is given a reward chip for each response provided. The first person to reach the *finish* position gets five extra reward chips. The winner is the person who has the most chips after both players have reached finish, or after the game has been interrupted because the session is over. Active completion for the acquisition of chips is discouraged; rather, the therapist plays at a slow pace and tries to use each response as a point of departure for therapeutic interchange. Obviously, the greater the breadth and depth of such discussion, the greater the likelihood is that it will be of therapeutic value.

The core of the game is the questions and directions on each of the cards. As implied by their title, the *talking* cards direct the child to make comments that are primarily in the cognitive and intellectual realm. The *feeling* cards focus on emotional issues. The *doing* cards involve some kind of physical activity and/or play acting. There are 104 cards in each stack. The questions in each category range from threatening to very non-threatening to encourage any child to respond to moderately anxiety-provoking questions. If the child responds a token reward chip is given from the “bank”.

Examples of low-anxiety questions are: “What present would you like to get for your next birthday?”; “What is your lucky number?” the main purpose of the low anxiety cards is to ensure that the child will provide an answer to gain a chip, and so enhance the likelihood that the child will remain involved.

Moderate-anxiety provoking questions are the most important and make up 90% of the cards. Some typical questions are: “Suppose two people were talking about you and they didn’t know you were listening: what do you think you would hear them saying?”; “What things come into your mind if you can’t sleep?” The child’s responses are usually revealing of those psychological issues that are most important at the time.

The questions cover the broad range of human experiences, and issues related to the responses are likely to be relevant to the etiology of the child's disturbance. The symptoms can be viewed as the most superficial manifestations of underlying unresolved problems. The problems that are handled inappropriately via symptom formation are generally the same problems with which all of us deal. Accordingly, the topics raised by the cards are likely to relate to issues that are the foundation of the psychological process. Each response should serve as a point of departure for therapeutic interchanges. The therapist does well to get "as much mileage" as possible from each response. Merely providing the child with a reward chip and then going on with the game defeats the whole purpose of this therapeutic instrument. However, the thepist should use his/her discretion when deciding how much discussion is indicated for each patient.

The therapist plays similarly to the child and also responds to the questions, which should be randomized. The therapist's knowledge of the child's problems, as well as the responses that have been given to previous cards, can provide guidelines for his or her own responses. The game requires considerable judiciousness / good judgment / sense on the therapist's part regarding responses to her cards. The therapist should always be aware that a response should be selected that is in the child's best interests. Many of the cards ask personal questions of the therapist's life. This brings up an important question regarding self-revelation. It is suggested that a response could be answered as honestly as possible, and suggests relating the experience that occurred at the time of his own life what he/she was the same age as the child. Children usually enjoy hearing about the childhood experiences of significant figures.

Children also have the opportunity not to answer a question if they do not wish to. The researcher is of the opinion that this fact fits in well with the Gestalt approach, where the client is respected for the fact that he is given a choice (in Gestalt terms "Choices and Responsibility"); and when the therapist goes into

confluence with the child, (Paradoxical theory of Change). However, the child needs to be reminded that he will also forfeit a token.

(c) *Significance of the game*

Though the game facilitates the elicitation of the child's responses via token reinforcement, it is by no means a form of behaviour modification. The purpose of the token reinforcement is not to change behaviour at the manifest level, but to use such reinforcement for the elicitation of psycho dynamically meaningful material, material that is designed to serve as a point of departure for meaningful psychotherapeutic interchanges between the child and the therapist.

It is at this point where the researcher would like to bring in the humour aspect. After making use of the game in therapy as a pretest, the researcher used the same basis as Gardner and adapted questions, focusing on deflection, deflective behaviour, humouristic behaviours and interventions, and then combining them into questions on humouristic deflective behaviour. All the questions have the same base of talking, feeling and doing, and the game is played in the same manner as the original one. The only difference is that questions are asked at the beginning of each game that are based on sensory awareness, also based on talking, feeling and doing, so as to ground the clients into the here and the now. Then the questions on humour and deflection follow.

The adapted game is called "A Game of Learning about FUN, while talking, feeling and doing: A Challenge to Change"

4.4 MODIFICATIONS ON THE APPLICATION TO GESTALT

4.4.1 Gestalt and Sensory Modalities

(a) *Rationale for inclusion of questions on sensory modalities*

Good contact making skills (through sensory modalities) are necessary for a good sense of self. By focusing on children's sensory and bodily contact making they can be made more aware of the emotions they experience at a specific moment. If children shut themselves off sensorially in respect of one or more of the senses, they will find it difficult to come into contact with their repressed emotions. Every emotion has a link with the body (Blom, 2004:100). Children who are troubled restrict their bodies and become disconnected from them (Oaklander 1997:297). Some educational games can also be used positively to promote some of the child's sensory contact making functions, and Blom (2004:101, 128) in particular makes mention of the *Talking, Feeling and Doing Game* of Gardner.

It is apparent that traumatized children make use of deflection in order to protect themselves from further hurt or pain: when contact making skills are used optimally they can start reacting in more playful ways and react towards humour initiated by the therapist. Humour provides possibilities for distancing or breaking an old set of patterns.

The Goal of therapy should always be kept in mind, and that is to assist the child to develop a sense of boundaries which is the point of contact and bring the client into contact with his/her positive energy; present a person with a challenge which forces him to change; and provoke clients into certain kinds of behaviour

The sensory modalities through which we make contact are our seeing, smelling, hearing, touching and tasting senses. On the grounds of the above, questions

that are aimed at sensory bodily contact making, which are placed at the start of the game (color coded blue) are the following:

(b) *Questions on sensory modalities as adaptation to game of Gardner*

Talking question on *touch*

- I like to touch silk because it feels….
- Where in the room does it feel warmer and then again colder?
- Tell about something that can hurt the skin

Feeling questions on *touch*

- I like to touch a baby because it makes me feel…
- I don't like the touch of… because it makes me feel…
- When my body aches it makes me feel…

Doing questions on *touch*

- Touch something in the room that has a tough surface
- Take off your shoes and walk barefoot for a couple of seconds: how does it feel?
- Massage your temples: How does it feel?

Talking questions on *seeing*

- Look at yourself in the mirror for 30 seconds without talking: describe what you see
- What is the funniest object that you see in this room; why is it funny?
- Tell the person on your left side what color you don't like looking at

Feeling questions on *seeing*

- Search for something made of glass in the room, look at it for one minute: what emotion does it make you think of?

- Imagine you are looking at the color “yellow”. How does it make you feel?
- Ask the person next to you about the colour he/she/likes most and ask them to tell you why

Doing questions on *seeing*

- Turn your head upside down, what do you see?
- Look at an object through a glass: what do you see and how does it make you feel?
- Stare at the person next to you for 30 seconds: how do you think that person feels? Ask that person how he/she felt

Talking and f*eeling* questions on *smell*

- Tell about a smell that you cannot stand, and say why not
- Tell about the food that smells most delicious to you
- Tell about a smell that you smelt that made you think of something funny
- Tell about a smell that makes you feel good

Doing questions on smell

- Everybody: Breathe through your nose, and then your mouth
- Smell any two objects in the room: what does it remind you of?
- Look at your nose in a mirror: what do you use your nose for?

Talking questions on *taste*

- Tell what the functions of your mouth and tongue are
- What sweets did you like when you were small? Describe an event that reminds you of this taste

Feeling questions on *taste*

- What do you feel like if you eat something you like very much?

- Tell how you feel if you must eat something you don't like, but don't want to be impolite

Doing questions on *taste*

- Which taste do you like most, bitter, sour, sweet and salty and say why you like it
- Tear off a piece of paper and chew it: what is it like?
- Stick out your tongue and look into a mirror

Talking questions on *hearing*

- Tell about a sound that makes you feel calm
- Tell about a sound that frightens you. Tell about a time it happened.
- Tell about happy and funny noises, sad noises, scary noises

Doing questions on *hearing*

- Sit quietly, eyes shut and listen to all the noises that you hear: tell about the most disturbing noise, and how it makes you feel
- Take two items in the room and bang them on to each other: what do you hear?

Feeling questions on *hearing*

- What are some of the sounds water can make? How does the sound make you feel?
- What noises do you think are funny and why?
- When you hear somebody laugh, how does it make you feel?

4.4.2 Gestalt and sense of self questions

Physical

- What is it about you that is lovable and interesting?

Intellectual

- Tell about something you can understand or do very well

Behavioural

- What skill did you master most recently? What can you do now that you could not do 3 months ago, a year ago?

Social

- What makes you different from other people?

Creative

- Are you a people pleaser, or do you do things in own way? How?

4.4.3 Gestalt and humour related questions based on *the talking, feeling and doing game*

General questions that can initiate responses (Coded as green)

- What makes you laugh?
- When do you laugh?
- Where do you laugh?
- Why do you laugh?
- How do you laugh?
- Whom do you laugh with?
- What are words associated with fun?
- Which words do you mostly use to express how you feel? Laughing, smiling, amused, pleased, happy, thrilled, cheery, jolly, merry, joyful, giggle, smirk, chuckle, grin, absurd, hilarious, comical, joy

Talking question on humour (Coded as light green)

- What types of funny situations do you normally enjoy very much?
- What types of jokes don't you enjoy listening to? What can you do about it?
- Do you wish that you could laugh more and why?
- Can you normally remember jokes that people tell you?

- What makes you laugh most?
- Why do you prefer being in the company of humouristic persons, or why not?
- Why is it not good to always be serious? What would the opposite be?
- Why do you think children enjoy playing so much?
- When you see something funny, do you like to tell others?
- Tell about a funny situation that you have seen recently
- How can a person learn to see things less seriously? What would you suggest?
- What do you think of people who can restore a tense situation with humour?
- How do you think people restore tense situations through humour?
- Do you tend to laugh when you are feeling serious, frightened or depressed?
- What do you think are the elements of a funny situation?
- Why do some people laugh once they have mastered a difficult task?
- What makes you different from other people?
- Tell of a situation where you experienced that laughter is contagious.

Doing questions on humour *(*Coded as florescent green)

- Drop dead!
- Hit the cushion in this room!
- Make the person next to you laugh!/make me laugh!
- Laugh out loud! What do you experience?
- Tell your favorite joke
- Tell a joke that you remembered for a long time
- Who can like you? You are the worst I have ever seen…
- You have one minute to name words that go with humour!
- Pretend an angry face/surprised/happy/scared/sad
- Act like a clown for 30 seconds

- You have one minute in which to name all the emotions you can think of: the one who gets most may have 2 more chips.

Feeling questions on humour (Coded as dark green)

- What feelings do you experience when you see people laughing at other people?
- Why do you enjoy laughing?
- What about telling a joke makes you feel good?
- How do you feel if people enjoy your joking?
- How do you feel when you are with other people that laugh and joke a lot?
- Why do you enjoy being with humourous people?

Talking, feeling, doing questions on *movies/animations* (coded as leaf green)

- What was the funniest movie you have ever seen? Discuss
- What animation movie do you like most? Which one do you find the funniest? Why?
- Which of the mentioned movies do find least funny? Why
- Which one would you watch over and over again? Why?

Shrek
Madagascar
Finding Nemo
Over the Hedge
Ice Age
Chicken Run
Flushed Away
Rattatoulie

4.4.5 Gestalt and questions on deflection (coded as orange)

General questions that can be discussed should the situation present itself

When somebody says, asks, talks about something that you don't like, what do you do:

- Look away
- Change the topic
- Pretend not to hear
- Prefer not to answer
- Say "I don't know"

What else could you have done?

Talking questions on deflection

- Why do you think people pretend not to hear some things? What can you do?
- Why do you think that some people prefer not to answer certain questions and why do you say so?
- Do you often have the urge to change the topic and why?
- Why is it that you often say "I don't know'? How would you like to change it?
- Explain why people walk away in the middle of a fight. What can you do?
- Why do people make jokes when they actually feel frightened?
- Why do some people start laughing when asked about an issue?
- Have you noticed people looking away when being talked to? What did you think?
- Do you make use of jokes when you feel stressed? How?
- How can joking help you avoid a painful situation?
- How can you ease off the tension in a painful/tense situation?
- What type of adult would you like to become one day?

- What type of questions do people normally pretend not to hear? Why do you think so?

Doing questions on deflection

- Make believe you can design a game: what would it be about?
- How do you feel when people often say ”I don’t know”, and what can you do to help them?
- What do you do when people talk about something that hurts you? What could you do instead? Can you try now?

Feeling questions on deflection

- How do you feel when you ask somebody a question and they look away?
- What does it make you feel like if somebody continually changes the topic?
- How does it make you feel if you get ignored when asking a question?

4.5 EMPIRICAL RESULTS: CASE STUDY

4.5.1 Progression of therapeutic sessions: sessions as process of data collection analysis

(a) *Baseline responses*

Capture and analysis of baseline data was a preliminary step, which needed to be completed before the intervention with humour was introduced.

Findings represented in this chapter relate to deflective behaviours and humour, as well as to findings pertaining to the clarification of the Gestalt Play Therapy process.

(b) ***Description of case study: Angelique***

- **Biographic details and background history**

Angelique has been living in a children's home since she was in grade 4, and 10 years old. She is now 13 years old. She was born on the 29th of June 1994. Her parents have been divorced for 7 years. Angelique only sees her mother once a year, since she lives in Port Elizabeth with her boyfriend and her father during school holidays. Her father is addicted to drugs, often jobless, and as a result, poor and unable to look after Angelique.

In addition, it needs to be mentioned that the intellectual development of a 13 year old child is marked by more independent thoughts and the ability to compare, reconstruct logically, increased memory and attention span as well as the ability to plan and reflect.

At this stage the researcher would like to mention some of the losses that a child experiences through divorce:

Loss of

- family unity
- a parent
- parental attention
- family
- trust
- parental involvement and physical contact
- own identity as existed prior to the divorce
- supporting relationships due to relocation
- social status
- economic security and quality of living

All of the mentioned losses have effects on the body, the affect, cognition and the behaviour of the child. The case study respondent comes from a divorced family, and as a result was placed in a children's home, as neither of the parents were able to support her. This experience of having to adapt to the home, intensified the trauma the client was subjected to. The initial reasons why the client was referred are now mentioned briefly, followed by the observations that were made by the therapist after seeing the client for the first time. After that, is a table that indicates interventions that took place over 14 sessions, followed by a description of what took place during the sessions is presented.

- **Initial reason for referral**

Angelique was found to be stealing, lying, manipulating other children to do the same, disobedient, throwing tantrums, "framing" other children, backstabbing, poor in school performance, showing aggressive behaviour.

Observation of the clients' process in the first session indicated the following: frustration, anger, helplessness, uncertainty, aggression, destructive behaviour, manipulation, loss of pleasure through playing, troublemaking, promiscuity, dis-interest in schoolwork, irritability, withdrawal, argumentative, blaming, confused, disassociate, egocentric, indecisive, irritated, negative, pessimistic, passive, reasoning, rebellious, resistant.

- **Data and capture**

TABLE 4.1 PLAYTHERAPEUTIC PROCESS USED FOR IDENTIFICATION OF CONTACT BOUNDARY DISTURBANCES OF THE RESPONDENT/ CASE STUDY

Nr	Goal and phase	Playform and Techniques For projection	Baseline responses	Observations
1	**PHASE: Building of Relationship** Childs process Contact making Layout of sessions and time, place Limit setting	Showing around where client stays, room, bed, view from window Sensory modalities Art: Drawing of name	Excuse to evade therapy ("I have too much homework to do") "I am not going to say..." "It is my secret" "I am not going to talk about it..." "I don't know" Dodges: "I can't do it…" Squinting Fidgeting, Talking non-stop and incoherently about numerous topics, continuous breaking of contact Does not accept responsibility Vindictive Blames "I know what to do" "Nobody understands me, "There is no use to change anything, I like it this way" contradictory behaviour within the self **False layer** Hyperactive, changing topic No responsibility, lies, believes lies strongly, everybody else to blame, terribly unhappy at home, mother of home is against her, always unfair to her.	Resistance Contact boundary disturbances Fragmentation Deflection Desensitization Incomplete gestalts Living in past and for future, not in here and now Introjects, and functions in terms of what is acceptable to environment Polarity Retroflection Projection Confluences: lack of boundaries, maintaining bad contact with others

2	**PHASE: CONTACT MAKING and SELF SUPPORT** Relationship Contact making Limit setting Foreground need Awareness Sense of self	Sensory modalities Feeling faces Scribbling	Therapy session = power struggle Only one interest, to escape to father: "Need" turns out to be worry about father, being with him means to take control of him, and to protect him Prefers to be loner at school Bluntly refuses any positive comments (received award previous day, never mentioned it) Feeling faces selected: angry, rebellious, bored, worn out depressed; AND Happy, thankful, excited Infantile body language **Phobic layer**	Unable to distinguish between need, wish, desire, pain Confluence (they share "everything" when they are together Deflection Lives for future only Believes own lies Rejects everything that is given, even love and attention Deflects, by blocking off through endless talking Impulsiveness Experiences pain from unfinished business
3	**PHASE: EMOTIONAL EXPRESSION** Childs process in board games Foreground need Limit setting Choices and responsibility Responses to competition Sense of self Introduction to humour awareness	Sensory modalities Board Game: Don't get angry! Checkers Snakes and Ladders	Took lead to teach me Glad that we would not talk, agreed to play games whole session Relaxed atmosphere Metaphor for life Bent and stretched rules Element of fun: client is discovering "what is me" and "what is not me"	Sense of self stronger Sensitivity Deflection Reception Patience Projection Intellectually strong Good strategy Choices and responsibility I-thou moments Started to take ownership

4	**PHASE: EMOTIONAL EXPRESSION** Limit setting Choices and responsibility Foreground need Sense of self Self-regulation Self-nurturing Humour awareness	Clay for Sensory modalities and Projection	Continually destroyed clay item before I could have a proper look, Refused to own Very daring, but smiling, teasing Therapist: banter, exaggeration, modeling Humour: Clay hot-dog **Impasse layer**	Rejection is habitual style, impulsive answering of "I don't know" Egotism Retroflection Deflection Projection that was owned (she is sausage inside)
5	**PHASE: SELF-NURTURING** Limit setting Foreground need To accept what she cannot change Expressions of feelings Sense of self Schoolwork is NB Humour awareness Self-nurturing	Feelings Chart: Color your feelings, and drawing thereof, making use of allocated colour	Unplanned humouristic intervention (spontaneous) as result of camera: "refusal" to speak, lots of mimicking, evoked lots of laughter Destroyed drawings Reward for good behaviour, at school! And at home, may go to dance **Impasse Layer**	Spontaneity Retroflection Denial Afraid of what she might feel and experience Desensitization Later showed her pride
6	**PHASE: SELF-NURTURING** Limit setting Emotional awareness Foreground need Humour awareness Self-nurturing	GAME "Talking Feeling Doing game" of R Gardner	Sits up straight, sits still, attention focused, enjoyed game thoroughly, opened up, answered almost all the questions, did not want to end session. Also told about two good friends, how they support each other, OWNS many of the options **Explosive layer**	Spontaneity Reception Rejection of bad qualities Acceptance of good qualities Sensitivity towards other people Use of "I" I-thou moments

7	Limit setting Awareness of deflection, and humour as positive intervention, for empowerment Self-nurturing	"A Game of learning about Fun: the Talking, Feeling and Doing way" (adapted)	Laughs, giggles, smiles, initiates joking, tells funny stories Reacts positively towards confrontations which are playful and humouristic	Shows insight into behaviours of other people, especially when they deflect, and admits that she has become aware of own deflection: distinguishes between healthy deflection and "evasive" deflection Much stronger sense-of-self
8	**PHASE: HANDLING OF PERSISTANT PROCESS** Limit setting To address relationship with father: the reality Self-nurturing	Collage making: associations with father, good and bad qualities	Avoidance of hurt about what her father does and who he is Sees herself as separate from father Request to play the humour game again next time	Very resistant Deflection Not in confluence anymore Self supportive Stronger sense of self Receptive
9	Addressing of areas that are not yet fully healed, directive choice of questions that respond to clients sensory awareness, process and DISC Limit setting Self-nurturing	"A Game of learning about Fun: the Talking, Feeling and Doing way"	Proudly showed me her art journal Humouristic: enjoys humour, and creates humour, and is aware of humour "outside" Her true self: tries to be an example	Senses of self all improved Own opinions Directive, Interactive, taking the lead Lives in "here and now"
10	**PHASE: TERMINATION** Preparation for termination Reflection on what has been mastered in 10 sessions Self-nurturing	Feeling Faces and "Writing: Be True To Thyself"	Chose faces: Full of confidence, hopeful, thankful, relieved, happy, relaxed, excited. Sometimes angry	Resistant towards reflection (dealt with unfinished business), Realizes her uniqueness Is aware of her humourous personality: that she can initiate and enjoy humour

11	Termination Self nurturing Assurance that therapy can take place should need arise	Went to drink a Slo-Jo Fruit Cocktail, as friends		Takes the lead at the children's home, children look up to her and follow her good example

- **Description of the playtherapeutic process and evaluation of the usefulness of humour in relation to the inner process of the child**

Description of sessions 1 - 10

In the report the researcher makes use of **"bold"** where the use of humour and its effect is described.

<u>Session 1</u>

The goal of the first session is to build a therapeutic relationship, and find out about the clients' process. It is primarily a process diagnosis, concerned with how the client is behaving in the present moment and thus an attempt to describe the "Gestalt". The very fist moment was marked by resistance, (a lame excuse to evade therapy), which became an immediate opportunity to set limits and boundaries, and so also the first opportunity to let the child know that the time is allocated especially for her, and only for her.

Drawing of the name was the main technique used for projection. This was met with extreme resistance ("I can't draw, I don't like drawing, I don't want to draw"). The client's first attempt took 10 seconds, and after explaining that the drawing should look like a poster, and that I wanted a better one another attempt was made. It was observed that when the client consciously put her mind to a task, it seemed to become enjoyment and a success. It was observed that the client discovered that she had a pretty name, and that one could create a beautiful picture without being an artist.

From the responses summarized in the table 4.1 the following can be deduced about the session:

In the life of this client processes have become static and fixed. It implies that adjustments were made previously to previous life circumstances which have become habitual and inappropriate in the present.

The client was not functioning as a whole. The Gestalt approach focuses on what is happening with regard to the healthy functioning and integration of all the aspects of the total organism, including the senses, the body, emotions and intellect.

It was observed that this client was functioning from incomplete gestalts, with contact boundary disturbances such as introjects, projections, retroflection and deflection all occurring at the same time. The client was functioning from the false layer of her personality.

The core beliefs that were communicated were: “I can do everything by myself, other people cannot be trusted”.

The following baseline responses are a summary of observed responses during the first session of the Gestalt Play Therapy process.

<u>Verbal deflectors</u>

- Did not want to come to therapy, made many excuses (“I must do my homework, I don’t have time now, if I come now, I will not be able to finish my homework and then I will be in trouble at school, can you see what I mean?”
- ”I don’t know”
- “Why?”

- Resistance (“I am not going to tell, its my secret”)
- “Maar tannie…”
- “I can’t choose-you choose for me”
- Most important “indicator”: Angelique was not able to be “here”, she only lived in the past and in the future – did not want to say “now”
- Very little awareness of behaviour
- Vague answers, open ended, hinting

Non-verbal deflectors

- Looking away
- Changing the topic every few seconds
- Not answering
- Ignoring of question
- Looking at me cross-eyed
- Slouching, half-lying in chair
- Fumbling and fidgeting to an extreme extent
- Sad look (extremely unhappy)

According to Joyce and Sills (2003:112) problems arise when habitual responses are not updated for new or changed field conditions. It may become a general style of contact across a range of situations which can pervade all aspects of the person’s way of making contact. The person is then not free to make new choices or adjustments and repeats the same response that was once useful (or seemed so at that time). The authors continue that a healthy person needs to be able to move along a continuum between completely avoided contact, modified contact and full contact, depending on each new situation. The client in this case did not realize that she deflected from any difficult emotion by changing the subject, and that she tensed her body every time she spoke about her father. She was also unaware of the options for self expression.

The client needed to be helped to find new, more creative ways to deal with situations which would probably become a major focus of therapy.

No "sense of humour" was detected or observed by the therapist, nor was humour utilized in any way by the therapist, although the therapist ensured a relaxed atmosphere, not being drawn into all the problems, and smiling when appropriate. During this session the therapist's co-therapist, a very pink, lame and tired looking and squinting soft toy, named Pink Panther, was introduced. The therapist mentioned that Panther goes along everywhere, and that he is there to keep an eye on both of us. The client had the option however, to tell Panther to sit up straight, or tell him what she did not want to tell the therapist.

Session 2

The technique for projection was making use of a sheet with "Feeling Faces", to try and identify the emotions the client was able to distinguish and describe. It became clear that the client was unable to distinguish between need, wish, desire and pain, since she claimed to experience the emotions of anger, rebellion, boredom, being worn-out, together with being happy, thankful and exited all at the same time. The client tried to block off her senses by endless talking. Later during the session the incessant fidgeting eased off a bit but was replaced by the client reverting to infantile body positioning as emotions were being explored on a deeper level (the experiencing of pain due to unfinished business).

The main theme throughout the session became the need to be with her father, no matter what. There was no insight as to the dangers that were involved and that conditions were not conducive towards her being safe, nor was there any insight about the priviledge of her attending a good school. Responses about her father were very evasive, and "her secret". There was no insight regarding that

she lived in the past, and for the future, and refused to live and experience the “now”. She completely ignored and refused to accept the compliment the social worker had given her on the reward she received at school (Rejects positive aspects, deflects stimulus from the environment in order to prevent full recognition or awareness). During therapy it was established that the clients’ need to be with her father actually was a need to protect him and to be able to control his behaviour).

The client has very little positive so say about her home, her school, her subjects, her mother, any friends: she saw me as a means to an end, that I would probably believe the lies she told, so that I could assist her with “getting out of that bad place”.

During this session the therapist brought in exaggeration, by exaggerating many of the problems the client claimed to have, in a playful tone of voice, which caused the client to pause for a moment and think, before carrying on with the conversation. The therapist also tried to make the client aware of the fact that all phrases used were in future or in past, not now, so the therapist called the client “the little spooky”, and kept on doing so for the rest of the session. The client seemed to enjoy the connotation. As mentioned in Chapter 3.4, a goal of therapy is insight, and is utilized in this case for the cognitive and emotional grasping of a connection that is personally relevant to the client. Also, the therapist was often said: “I am joking”, as this message about the message was an invitation to the child also to join the therapist in the humourous frame of mind.

Panther was present, and the client put Panther next to her on the couch, every now and then picking him up and stroking him.

Session 3

The client noticed that Panther was not there, and asked where he was, on which the therapist took Panther from her bag, and the client put him on her lap. Before a word was even spoken, Panther elicited a smile from the client, every time he was "seen".

The goal of therapy was to establish the child's process in board games, how she reacted to choices and responsibility, how she responded to competition, to enhance the sense of self and to introduce an awareness of humour. It was observed that she not only thoroughly enjoyed playing the three games, but also revealed much of her personality. The relationship was much stronger, and a relaxed atmosphere was present. The client accepted the therapist's presence, and started to enjoy the attention, and the time that was allocated especially to her. She took the lead to teach the therapist how to play checkers, as the therapist did not know how to.

It was a golden opportunity for the therapist to create awareness within the client of the strengths that were starting to show. The games were also an opportunity to talk about life, how one can sometimes choose what happens, other times not, and how one can get out of situations, by merely reflecting, and thinking before acting. In this way the habitual way of rejecting, and saying "I don't know" was also addressed, as the client was aware or did have the answer. The client started to become aware of choices and responsibility and was taking ownership of projections. The client did however, try to bend and stretch the rules all the time, but she did not express meanness by doing so, and appeared to be relaxed and a bit playful.

A marked difference with regard to humour came to the fore at this point. The games themselves left ample scope for introducing enjoyment and

laughter; and became a technique for the client to see some of the useless things she was doing.

The game became a metaphor for her way of living and experiencing, the bullying she experienced, and the wish to overcome her powerlessness in the situation of being at the children's home. The therapist was very subtly starting to tease, cajole and make fun of the game and reactions to loosing and making silly choices.

There was a moment of very strong and spontaneous laughter when the client picked up the dice that fell on the floor, hit her bum against the cupboard, as she misjudged her distance, and toppled over onto her chest. Here the therapist made use of "banter": "Wow, are you clumsy!" Both therapist and client could not stop giggling for the rest of the session, and it was safe to do so. The client did not feel offended at the therapist's laughter. Here humour was not consciously decided upon, and happened, and was a very spontaneous moment in therapy (Chapter 3.4). When appropriate laughter is triggered in a patient it usually signals therapeutic progress. In this case, the course of therapy was put in a positive direction. Although the therapist takes the client and his problems seriously, humour lets the client know that their therapist entertains hope and does not feel overwhelmed by the difficulties the client presents. The client requested the therapist to "please" come again next Thursday, and "Do you have more games? Can you please bring them? Can we please play games again?"

The therapist lent a game to her, although it is not good practice to do so-, in order to see what she would be doing with it and whether she could return it safely the next session (choices and responsibility). **Another reason was to establish if the group she would play the game with would have fun, and if the client could report back on humour (awareness). In this session the**

client was clearly discovering “what is me” and “what is not me”. The therapist gave the client a task, (directive assignment) namely to look out for funny situations, just being aware as they happen in daily life, and to come and share her experiences, as well as a joke she might pick up during the week.

Session 4

In this session the client waited for the therapist in the parking lot (The client was looking forward to being with me, and so it can be deduced that resistance to therapy was over and the relationship and trust had been established).

The goal of the session was to let the **client report back on the humour**, and to address feelings on the foreground need, enhance the sense of self and self-regulation. Clay was used for sensory modalities and for projection.

The client had witnessed a few funny situations that happened at school and she told me about them (Awareness of humour being established).

A good relaxed atmosphere existed, but rejection to complements and positive events was still the habitual style. The client continually destroyed the clay item before I could have a proper look. The client used the clay for expressing aggression; she intensely manipulated the clay, squeezed it, and pounded it. The tangible nature of the clay seemed to facilitate feelings in the here and now. She discussed how she hated school. She refused to own, was very daring, but **smiling**. She was testing her limits with me.

The client tended to deflect, but less than in previous sessions. She looked me straight in the eyes, did not avoid eye contact anymore, but still tended to say: ”I don’t know, and if I know I am not going to say, I will still decide if I am going to say...” It happened more and more that the client changed her mind, and then

decided that she would tell. The client then “owned” her being the sausage in the middle of the “hot-dog” she created with clay. **The “hot-dog” created ample room for laughter and she jokingly explored her feelings.**
Panther was present, as usual.

Session 5

The goal of the session was to help the client accept what she cannot change, which is being separated from the father and consequently living the children’s home. The technique used for projection was the “Color Your Feelings” chart.

This session was very unique, as the camera was introduced. The client categorically stated that she was not going talk in front of “that thing”, (resistance) on which the therapist agreed that she did not have to (Respecting the client’s wishes, and going into confluence). **The session was mimicked. The client “locked” her mouth with a key and threw the key away.** The therapist continued “doing therapy”, acknowledging the clients request. The client proceeded to draw her feelings with the colors she allocated to them. It was observed that more positive feelings were used with bright colors. **Later, once the therapist got tired of doing all the talking and having to guess what was going on she joined the client by also locking her mouth, and the session turned out to be very funny, as neither could keep their laughter after half an hour of showing hand signs and “acting” the whole “conversation”, especially making use of exaggeration. Humour evolved spontaneously. Both therapist and client initiated humour, and were able to enjoy the situation. Later the client begged the therapist to talk!**

The client was proud to tell that she had been rewarded to go to the school dance, as she was the only one from the home, and the reward was allocated because of her good behaviour!

At this stage the social worker reported that the change in the client was unbelievable. The client obeyed, had fewer fights with the mother of the home, helped the younger children, didn't have so many excuses for not doing her homework or helped with the dishes, and was awarded a prize at school for entrepreneurship.

Session 6

The goal of the session was to concentrate on emotional awareness, contact boundaries and humour awareness by introducing the "Talking, Feeling and Doing Game" of Gardner, thus making use of an intervention directive. The client sat in an upright position, still, without fidgeting, and was keen on playing the game. The researcher would like to refer the reader to 4.3.3 where the game is explained in detail.

The questions cover the broad range of human experiences, and issues related to the responses are likely to be relevant to the etiology of the child's disturbance. The problems that are handled inappropriately via symptom formation are generally the same problems with which all of us deal. Accordingly, the topics raised by the cards are likely to relate to issues that are the foundation of the psychological process. Each response serves as a point of departure for therapeutic interchanges.

Observation of the client revealed spontaneity, reception (as polarity of deflect-tion), insight into rejection of bad qualities and the acceptance of good qualities, sensitivity towards other people, and the use of "I". The client "owned" many of the options and revealed remarkable insight into the questions asked. Low and high anxiety questions were chosen to be answered, although the client had the option to "pass".

The reaction the client revealed towards the questions was very positive. Questions were answered with many examples being given in a spontaneous manner. The client showed insight into behaviours of other people, especially when they broke contact and admitted to her becoming aware of her own deflection. She **was able to distinguish between healthy deflection and "evasive" deflection.** Her sense of self was much stronger. What was also observed was that the client did not squint anymore, but was able to look the therapist straight in the eyes.

Session 7

The aim of the session was to introduce the adapted version of the "Talking, Feeling and Doing Game", named "A Game of Learning about FUN, the Talking, Feeling and Doing Way"

The researcher would like to refer the reader back to 4.4.2 where the questions used in the game, that focus on the recognition of humour, and deflection, based on the cognitive, psychomotor and affective domains are described in detail.

Some of the questions addressed in this session were:

***Talking* question on humour**

- Do you wish that you could laugh more and why?
- Can you normally remember jokes that people tell you?
- What makes you laugh most?
- Why is it not good to always be serious? What would the opposite be?
- Why do you think children enjoy playing so much?
- When you see something funny, do you like to tell others?
- How can a person learn to see things less seriously? What would you suggest?
- How do you think people restore tense situations through humour?
- Do you tend to laugh when you are feeling serious? Frightened/depressed?
- Tell of a situation where you experienced that laughter is contagious

Doing questions on humour

- Drop dead!
- Make the person next to you laugh! / make me laugh!
- Laugh out loud! What do you experience?
- Tell your favorite joke

Feeling questions on humour

- How do you feel if people enjoy your joking?
- How do you feel when you are with other people that laugh and joke a lot?
- Why do you enjoy being with humourous people?

QUESTIONS ON DEFLECTION (talking, feeling and doing)

When somebody says, asks, talks about something that you don't like, what do you do:

- Look away
- Change the topic
- Pretend Not to hear
- Prefer not to answer
- Say "I don't know"
- What else could you have done?
- Why do you think people pretend not to hear some things? What can you do?
- Why do you think that some people prefer not to answer on certain questions and why?
- Do you often have the urge to change the topic and why?
- Why is it that you often say "I don't know""? How would you like to change it?
- Explain why people walk away in the middle of a fight? What can you do?
- Why do people make jokes when they actually feel frightened?
- Why do some people start laughing when asked about an issue?
- Have you noticed people looking away when being talked to? What did you think?
- Do you make use of jokes when you feel stressed? How?
- How can joking help you avoid a painful situation?
- How can you ease off the tension in a painful/tense situation?
- How do feel when you ask somebody a question and they look away?
- What does it make you feel like if somebody continually changes the topic?
- How does it make you feel if you get ignored when asking a question?

The questions are designed to create awareness for deflection and the use of humour in a deflective situation. The client enjoyed talking about and discussing the various options.

Questions on humour formed part of the cards. The client revealed remarkable insight into deflective behaviour of people, and of her own deflective behaviour. The client mentioned being aware of the fact that people sometimes laugh when they are shy or try to evade a painful situation. In this session it was also addressed that problems have more faces than originally anticipated. The atmosphere of the game play inevitably meant that a light atmosphere existed.

Session 8

The goal of the session was to deal with the relationship with her father, to address the confluence between them, as well as the reality. The projective technique was the making of a collage, selecting pictures that reminded her of her father, in order to address his being a real person, with good and bad qualities, looking for elements of fun, funny situations they had enjoyed together, and for the identification of his deflective behaviour.

In this session the client seemed to regress, and did not want to speak or be reminded about her father, the very opposite from our sessions in the beginning, where her father was her everything. She often tried to deflect, using “I don’t know”. The client was reassured that she did not have to reveal painful memories or secrets, or bad behaviour her father might demonstrate. The intention was for her to find a solution she was comfortable with.

Joyce and Sills (2003:131) state that the anxiety that accompanies major shifts in self understanding is because the existence of the self is felt to be in jeopardy as

boundaries sag and reform while a new self is in the process of emerging. For the client this is emergence-cy.

It was observed that the client now saw herself as separate from the father, that she could support herself emotionally, and that she was able to guard her personal boundaries. The memories evoked through the collage were not easy to deal with. The client had moved out of the impasse.

Since the client was embarrassed about her father the therapist decided and knew intuitively that humour would not be appropriate in this session, as she took the problems the client is experiencing as serious. There was no purpose in joking. **However, the client was requested to reflect on moments of fun she might have experienced with her father. In this case, Panther was being held tightly by the client and helped to create a less solemn and more playful climate.**

Session 9

The goal of this session was to address areas that were not fully healed, and use was made of directive choice of questions not addressed in the previous session with the adapted game.

The client proudly showed the therapist her art journal. With this session it was clearly established that the client is a directive, as well as interactive person (DISC), who can take the lead and is fully grounded in the “here and now”. The selected questions differed from the questions in the previous session.

During this session the client often provoked the therapist by teasing. It can be stated that the client initiated the humour, due to a good relation-ship, and as a result her experiencing a much stronger sense of self.

The client was being prepared that the following session would be the last, to which she objected strongly.

Session 10

The aim of the session was to reflect on what had been done and mastered in the previous sessions, by making use of the “Feeling Faces”, in order to compare the emotions with those experienced earlier on, as well as writing “Be true To Thyself”. The activity requires of the client to write down 10 aspects of the self that the client does not like, and on the other half of the page 10 aspects that can be regarded as good qualities. In this session the therapist also let the client write down 5 observations of funny events that she witnessed during the previous week. The client does not share what is written, and destroys the bad qualities, and keeps the paper with the good ones and the funny events.

The feeling faces that were chosen were: proud, hopeful, happy, thankful, relieved, and relaxed.

The client was resistant to reflect on her qualities, and kept saying that that was part of the past, and that she had started new beginnings.

The therapist invited the client to a next meeting which would be an outing. The client accepted termination on the conditions that she could contact the therapist if she felt the need to do so. This arrangement is in order with the therapist, as children living in children’s homes have to share the attention with other children. In the client’s case, she had to share the attention from the home mother with 14 other children.

- **Synthesis for Gestalt therapeutic process**

The therapeutic work with Angelique centered primarily on the awareness of contact boundaries and enhancing her awareness continuum. This was congruous with the objective of Gestalt Therapy, where the goal is awareness (Yontef, 1993:16). Growth and autonomy are achieved through an increase in conscience. Awareness of sensations and feelings but also automatic mannerisms and habits are brought into awareness. The product of awareness is to discover the self, to get to know the environment, take responsibility for choices, self-acceptance and the ability to be in contact.

In the case of Angelique these processes were approached through engagement in Gestalt Play Therapy. Angelique became aware of sensory experiences, she discovered who she was, and related to objects and people (the researcher). In the playroom she learned to take responsibility for her choices. These processes took place within a secure relationship, maximized through structured handling strategies, making consciousl use of humour throughout the sessions.

4.6 SUMMARY OF FINDINGS

Comparison between baseline responses and responses after treatment

Observation of the clients' processes and behaviours in the first session indicated the following: satisfaction, anger, helplessness, uncertainty, aggression, destructive behaviour, manipulation, loss of pleasure through playing, troublemaking, promiscuity, disinterest in schoolwork, irritability, withdrawal, argumentative, blaming, confused, disassociate, egocentric, indecisive, negative, pessimistic, passive, reasoning, rebellious, resistant, cynical, listlessness.

During the last sessions only the following two of the above mentioned behaviours were observed: argumentativeness and reasoning. It can be deduced

that the clients' much stronger sense of self and insight into her own behaviour can be the reason for the argumentativeness and reasoning. Contact boundary disturbances were reduced to a point where the client felt free to "argue" and "reason" in a healthy way, also reflecting her developmental level. Changes have occurred during and after treatment.

The following behaviours and feeling experiences that the client displayed after treatment can now be added to the list of behaviours that emerged **(second baseline responses)**

The client seemed to be content, satisfied, calm, confident, inoffensive, constructive, playful, smiling, teasing, interested, in a good mood, present, challenging, enlightened, altruistic, proactive, accepting and trustful. The client has a good sense of humour and can enjoy humour, as well as create it. She did not cease to deflect altogether. Here the researcher would like to refer the reader to Harman (1996:23) who states that doing therapy with deflectors requires helping clients establish contact in order to add zest and freshness to their interactions and that useful purposes may be served by deflection.

According to Yontef (1994:125), deflection can be useful where, with awareness, it meets the needs of the situation (e.g. where the situation needs cooling down).This can be done in many ways. Deflection can take the heat out of responses, so that it is possible to remain in contact and not to withdraw, or, in extreme cases, not to attack. Deflection enables the client not to respond to all the stimuli that impose on us and in this sense can be regarded as healthy.

The price of deflective behaviour is listlessness, loss of playfulness and humour, and once addressed and gestalts are complete, a sense of humour comes to the fore, or if lost, returns.

A good sense of self is a prerequisite for good contact. When contact making skills are used optimally a person can start reacting in more playful ways, and can react towards humour initiated by the therapist, *and* initiate humour.

In Chapter 2, various types of humour are described. In this research it was found that the following types were spontaneously (non-directive) used by the participant:

- *Conflict humour* (used as a weapon to reveal aggression)
- *Control humour* (here the client maintained order where people would otherwise be antagonistic towards each other)
- *Consensus humour* (promoted comradeship and friendship, and elicited the client to dare and take more risks esily, here the element of pleasure was recognized most strongly)
- *Concealment humour* (It allowed the client to avoid/deflect in a healthy manner)

Other observations, besides the ones that are highlighted in the descriptions of the ten sessions are the following:

The stronger the sense of self, the more scope there is for humour, and a humourous personality, whether created and initiated, or enjoyed. This can be supported by the fact that during the same time that the sessions with Angelique took place, the therapist undertook therapy with two children who had lost their father. Prior to the loss their situation can be described as normal, as the mother reported no particular problems. During their bereavement the children (aged 8 and 10) came up with solutions to their mourning, which included jokes their father had told them, jokes that were their favorite ones, as well as setting time aside each day for reflection and sharing funny moments and situations they had encountered. These clients allowed themselves to mourn, as well as to deliberately experience the lighter side of life. The therapist observed that both boys had a strong sense of self.

In the literature it is stated that sadness and unhappiness can be seen as the polarity of humour. It is found that this is not completely true: humour does not “take away” the “unhappy” situation the client finds himself in, but it changes the “perception” of the situation. Adding a humourous atmosphere and quality to therapy, helps the client to feel uplifted, which then alters the perspective.

It was found that to help someone think through a problem is to tell them a joke. Laughing, like excitement, seems to help people think more broadly and associate more freely into interactions that might have eluded them otherwise. In addition, the intellectual benefits from a good laugh are most striking when it comes to solving a problem that demands a creative solution. Suddenly there is vision for an alternative creative use to solve a problem.

With regard to the “Talking, Feeling and Doing Game” of R Gardener, the questions had to be adapted, as many questions are not relevant to the situation of a child residing in a children’s home. Questions were selected directively and adapted carefully to maximize use and opportunity for sharing, making aware of deflection and talking about the use of humour.

It was found that humour sets the tone just by its presence.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The desire to be entertained through humour is strong and near universal. The focus of this study was the implementation of humour in the therapeutic setting in order to establish awareness. The central theme was to focus on humour as deflective technique in settings where contact boundary disturbances occur. Deflective behaviour as contact boundary disturbance is marked by behaviour such as avoidance and evasion.

The establishment of the return of a positive sense of humour may well be considered a goal of therapy. The degree to which a sense of humour becomes established may be considered one criterion of the success of therapy. The research was guided by the question whether humour could be taught as a vehicle for an intervention skill, especially as a coping mechanism. In addition, the aim was to investigate if people and clients could be made more aware of the positive impact humour could have on a situation, involving the teller and the listener, in individual or group situations, and if people could be made aware of their own humouristic capabilities. Humour is a gift. People often do not want to "waste" humour on people they do not like, or perhaps whom they are afraid they might like if they joke with them.

The goal of this study, therefore, was to explore the implementation of humour (by making use of carefully selected techniques), as a deflective technique where contact boundary disturbance and resistance occurs in order to bring about change. In order to achieve this goal the researcher made use of a literature study and observation as information technique for the research on humour in

contact boundary disturbances and deflection. The usefulness and applicability of Gestalt Play Therapy was also utilized during the therapeutic intervention. From the processing and integration of research results which were gathered in this research, guidelines for therapists, as well as other practitioners involved in the caring sciences could be described.

5.2 REACHING OF GOALS

The aim, namely to explore the implementation of humour as deflective technique in contact boundary disturbances and resistance in order to bring about change in emotional well-being, could be reached in order to disclose the applicability of this study. By studying the existing research on humour the researcher could form a clear picture of the applicability within the borders of the research and thus reach the goal.

The researcher made use of descriptive research in which it was attempted to construct a picture of the usefulness of the application of humour, using it as an intervention strategy, in Gestalt Play Therapy, for professional use.

The choice of a qualitative research design was applied successfully in this study since the success of the case study is not measurable although the results are usable. The single systems design gave a structure and framework for the research and directed the research towards evaluative accountability.

5.3 USING SINGLE-SYSTEMS DESIGN IN THE RESEARCH

The following observations in the use of the single systems design were made by the researcher.

The single-systems design is a direct form of research and the results are immediately available.

In this study the single systems design did not disrupt the treatment process or the intervention. The method provided good feedback to the researcher in respect of the intervention methods, especially for those primarily problem-solving in nature. The researcher experienced the single system design practice based and therapist oriented. The design enhanced goal-directedness in both therapist and the client in therapy

5.4 CONCLUSIONS

This study illustrates one single case, where the client presented with contact boundary disturbance, and revealed a habitual way of resisting contact through deflection. The case data shows how the client moved to becoming aware through the use of humour techniques, and she moved from a denial state of making contact to a state of being fully aware, towards a state of emotional well-being.

The task of the researcher was to select the most applicable way of research in order to come to the most effective conclusions. The way in which the problem was addressed indicated the direction for the study and as a result, a structure for a goal could be determined via critical objectives, which are now mentioned.

Critical objective one: *To identify the phenomenology of humour: to describe the process of how humour can be used and illustrated for enhancing self-awareness and personal use, in order to direct a therapeutical outcome for the question: Is contact boundary disturbances addressed, if there is a better awareness of humour?*

A comprehensive literature study indicated that literature is limited in that it fails to link humour to resistance in Gestalt Play Therapy. Many references refer to the use of games in order to create safe and pleasurable surroundings, but fail to link the concept of humour to play, fun, games as well as techniques and techniques for intervention to address contact boundary disturbances.

Critical objective two: *To gain knowledge by collecting and identifying the implications of contact boundary disturbance and deflective behaviour in order to isolate the relevant indicators to identify deflective behaviour as part of the Gestalt perspective. In addition, the question "Can humour be used to overcome/ address contact boundary disturbance?", was asked.*

The increased awareness, awareness of sensory modalities, contact boundaries, deflection, awareness of sense-of-self, self-support as described within the Gestalt approach, could be integrated within the nature, scope and influence of humour, as discussed in detail in Chapter 2 and Chapter 3.

Critical objective three: *To collect and interpret data through a single case study in order to answer the following sub-questions: Is humour accompanied or followed by indications of a positive shift in the patient's self-concept or self-perspective? Alternatively, is there a therapeutic change through the axis of heightened feeling? And, Is the use of humour conducive to the Gestalt therapeutic situation?*

The question can be answered in the following manner:

The use of humour in Gestalt Play Therapy where contact boundary disturbances such as deflection are manifested can be successfully found that a client can be led to awareness levels, as described in the Gestalt framework, and the use of humor can give rise to increased sensory contact and awareness in the environment to enhance emotional well-being. The usefulness is further enhanced by the fact that the implementation of humour does not require advanced education of the therapist. The basic principles of humour in therapy can be applied in various ways that suit the personality of the therapist thus the mere use of humour becomes the therapy.

Critical objective 4: *To describe an approach that will provide conclusions regarding the utilisation of humour as deflective technique in a therapeutic intervention to heighten awareness levels and well-being.*

De Vos (2005:33) describes a hypothesis as referring to a positive statement made about the relationship between variables. Once the researcher empirically

tests or evaluates the research problem, it becomes a hypothesis. The hypothesis statement contains two or more variables that are measurable and specify how the variables relate to each other.

The following hypothesis guided this study:

- **Hypothesis 0**: The therapeutic use of humour has no effect / does not illustrate value / is not an effective tool / when it has been implemented as a modality in the case where contact boundary disturbance occurs.
- **Hypothesis 1:** The therapeutic use of humour illustrates value as an effective tool to address contact boundary disturbance if being implemented as modality in the case where contact boundary disturbance occurs.

During the empirical investigation it was found that hypothesis 1 is the outcome, thus, the therapeutic use of humour *does* illustrate value as an effective tool to address deflection as contact boundary disturbance.

The following questions guided the research and can now be answered:

Can the experience of pain and avoidance of connections be turned into enrichment, the creation of clearer boundaries, in order to create more interpersonal comfort instead of discomfort?	**YES**
Can humour be taught as a vehicle for an intervention skill, especially as a coping mechanism?	**YES**
What is the possibility of exploring the use of humour as a **directive skill** when deflection as resistance presents itself during therapy?	**It is possible**
Can a particular intervention on the part of the therapist have positive consequences?	**YES**
Can people be made aware of their own humouristic capabilities?	**YES**
Can awareness of the environment be increased through humour and can the individual then be able to stay aware in order to change emotionally?	**YES**
Does the use (implementation) of humour (by making use of carefully selected techniques), as deflective technique in Gestalt therapeutic work improve self-awareness and personal well being, thus change in emotional wellbeing?	**YES**

Can humour be used as an instrument in order to establish awareness long enough for change to occur?	**YES**
Can humour be taught as a vehicle or an intervention skill, especially as a coping mechanism?	**YES**

5.5 FINDINGS AND RECOMMENDATIONS

5.5.1 Recommendations on scientific evidence provided

On the scientific evidence provided the following recommendations can be made:

The play therapist needs to be made aware continually of the importance of a theoretical point of departure. This needs to be kept intact with regard to the implementation of the research as well as the use and practice of play therapy as field of specialization.

The play therapist in practice needs to be fully knowledgeable of all components within the field and the field of contact boundaries. The success of the intervention starts with the understanding of the method and the way of the functioning of patterns of behaviour within the system.

Change or moving forward can be generated by the individual from his/her reservoir of learned wisdom in line with his/her developmental age. The therapist therefore, plays a role to formulate and make clear to the child his/her strengths, competencies and abilities with regard to humour. The therapist was continually aware of making conscious interventions, thus to showing and confirming the humour that the client displayed.

Furthermore,

- The adult's (therapist's) use of humour demonstrates his/her invulnerability and attitude of self assurance in his/her ability to cope with a particular situation
- The humour response of the therapist reassures the child so that he/she is saved the guilt and fear by which he/she was about to be overcome in the attack and problem behaviour he/she was about to act out.
- The therapist carries over the possibility of "face-saving" when the child needs to act tough and belligerent.
- The humour diverts the child by the funniness of the moment from the strong emotions which threaten to overcome him/her and as such humour is used by the therapist as a distractive tool to avoid the issue at hand.
- It may be used by the therapist to bring a client out of depressions, a bad mood, and a tense or embarrassing situation. It may be used to lessen the severity of blame.
- Humour can be used by the therapist when there seems to be no direct or other way to communicate criticism. In this capacity, it serves as an invaluable tool. Kind, loaded humour can be the most pleasant or sugar-coated way of offering constructive criticism.
- For seeking and gaining approval of others and making friends, humour is a central tool for building relationship, as it establishes intimacy and is seen as a type of love and acceptance.

5.5.2 Recommendations with regard to implementation of techniques

The following recommendations can be made with regard to the implementation of techniques:

(a) ***The use of GAMES***

Games function to promote and enhance the process of change due to the game creating mini life-situations through which children can learn social rules and

procedures whilst developing new strategies for use in real life settings. Games may then help children feel more comfortable in strange situations and promote engagement with therapy through improving their ability to communicate thoughts and feelings. If therapy can be derived in a fun way children can learn that they can be part of a social experience of having fun and being fun to be with. This may then add to their feelings of self worth. Games help children to identify strengths and abilities and help to make ideas concrete and address the problem in the context of the here and now.

Board games can be utilized for a multitude of childhood problems and can easily integrate the theoretical knowledge of the therapist. Criteria for the selection of games for therapy are 1) familiarity of the game, 2) ease to learn, 3) appropriateness for age, and 4) clear properties related to goals of therapy.

In this case use was made of the adapted *Talking, Feeling and Doing Game*, named *A Game of Learning about FUN: The Talking, Feeling and Doing way…*This game enabled a competence and ability transfer where skills obtained in the therapeutic environment were moved to the problem context of deflection as contact boundary disturbance.

The overall analysis of the research conducted indicates that there are very few games that cannot be adapted to some therapeutic purpose. However, it seems critical to keep in mind that humour is a means to an end and not an end in itself in therapy.

(b) *The use of the favourite joke and funny story technique*

The telling of a joke by a child reflects a positive motivation of wanting to share an enjoyable experience with another person or persons. Many children's favourite joke is often related to underlying sources of conflict or distress points and can be aligned to the importance of the coping functions of humour. An

outcome of this is that humour helps children overcome conflict and anxiety. By playfully confronting stressful situations in the context of humour many children appear to be able to master the anxiety associated with those situations.

Similarly, recently mastered conflicts tend to be the source of joking because of the pleasure derived from re-experiencing mastery over a previously anxiety – arousing situation. Thus, the researcher concludes that humour should be considered both to assist in the coping process, and to reflect on mastery achieved over recent conflicts.

(c) ***Modeling***

Therapists must choose therapeutic pathways to suit the child's intellect and emotional development. Once the therapist knows the child's process, humour can be selected and modeled in a directive manner. The therapist needs to be aware of what is on the foreground of the child on that particular day, before implementing humour. Modelling can be regarded as the environmental process of influencing humourous behaviour, either purposeful or not and should be used.

(d) ***The use of banter***

The use of banter was found to be very effective. One of the most difficult things for many clients is to develop and maintain a truly positive sense of self-worth while finding out something about themselves that does not fit their self-ideal. The acceptance of self-worth must be learnt in therapy. During the interpretation phase, where the session is clarifified and evaluated, humour becomes a marvelous technique used by the therapist for allowing the client to see some of the useless things he is doing. Humour takes the edge off and lessens resistance without causing offence. When some of the strongest interpretations are presented with a glint in the eye or phrased in a humourous way, the therapist had better results with a higher degree of acceptance by the client. The

therapist's message becomes, "This is what you are doing to louse yourself up, but I still like you anyway". Another way of saying the same while making use of banter could be: "Who can like you?"

This technique carries implications of both good humour and ridicule. The use of banter is also an aid for use by insecure therapists in dealing with clients who tend to make them uneasy by their indirect or masochistic complaining, self-depreciation, and implied questioning of the therapists competence. The therapist is encouraged to exaggerate the self-belittling remarks of the client to the point of sounding ridiculous: "You're the worst client I ever had". This is said in a friendly tone and tends to agree with the client's self de-evaluative fears that he/she is unloved. It is obviously not felt as rejection by the client when he/she responds by laughing and becoming visibly more relaxed. Actually, the therapist is not addressing himself to the patient's feelings of worthlessness, but to his aggression. The client is saying in effect: "You have to like me because it is your job and you have no choice". With his/her response, the therapist pricks the patient's pride of ugliness and gives the patient the opportunity to relax the pressure of his/her anxiety.

The modeling and reinforcement of joking behaviour and humour appreciation can be a desirable inclusion in social skills training, as well as the facilitation of better peer relationships.

5.6 POSSIBLE SHORTCOMINGS

At this point it is deemed necessary to identify the limitations of this study.

This study is as a thesis/proposal is in partial fulfillment of the degree MDIAC, and as such is, due to the requirements thereof, of limited scope.

The importance of clearly delineating the role of researcher and practitioner is emphasized by Strydom (1998:29), as it is difficult for the same person to represent both roles objectively and could be a limitation of this study. While establishing the researcher's bias for this study it was ascertained that this very aspect was to be handled with circumspection. By adhering strictly to the methodology it was attempted to link theory and practice in ways which ensured a high degree of neutrality.

The researcher became cognizant of her lack of experience in terms of a client living in a children's home, as the situation differs remarkably from a client living with his/her parents, in terms of support, feedback, and availability of therapy venues.

The therapist herself was faced with a lack of energy, due to full schedules, and therefore not always in a humourous frame of mind. However, therapy does not require the therapist to be funny, games that initiate fun proved to help and, remarkably, resulted in the therapist herself entering into better emotional state of well-being.

5.7 CONCLUDING REMARKS

Humour takes many forms, ranging from the simple to the complex and from the crude to the subtle. The creative element comes from the ability to take this information from past experiences and apply it to new situations.

Humour consists of two aspects: the ability to perceive the comic and the ability to produce it. Both aspects can add to social acceptance, because they help to create the impression that one is fun to be with and is a good sport. With specific reference to the outcomes of this study these aspects aid therapy and relationship building, and contribute to helping the client to deflect in such a way that it enhances emotional well-being.

Children who want to be socially acceptable, especially if their acceptance is marginal, have a strong motivation to learn to produce humour as an aid to achieving this goal. They are willing to spend time and energy discovering what makes people laugh and creating humour that will win their approval. Considering that, making children aware of their own limitations to contact, seem to make humourous interventions even more appropriate.

Some forms of humour can be produced only by persons with a high level of intelligence, but most of the forms that have great appeal to children can be created by anyone of normal or even slightly below average intelligence. They require divergent thinking, which enables the producer to perceive new ways of combining previously learned material or patterns that others will regard as humourous. They do not require the production of completely new material.

The creation of humour also requires knowledge of the kind of situation that others perceive as comic and a motivation to turn one's creative energies into channels that will result in humourous patterns. As McGhee has pointed out, when a child acquires a high level of conceptual mastery over some content area, he may perceive any inaccurate depiction of it as "being funny". For example when he/she knows the socially approved roles for members of the two sexes, he/she will regard any deviation from these roles as "funny".

Individual differences in humour may be important in the design and effective-ness of therapeutic interventions. In the future, as we learn more about individual differences in humour, it may be beneficial to use different procedures for people with different personal attributes. With increasing knowledge of both humour and individual differences it becomes more important to know more about what kind of funny things should be done with whom.

In drawing a conclusion, it can be stated that humour can be taught and be made aware of, and only a miniscule shift can evoke change. Furthermore, a client who makes full contact is able to reveal liveliness instead of listlessness and an increase in humour, instead of a loss of it, as well as an increase in playfulness, instead of a loss of it

It seems that more extensive effort is justified to free humour ability and appreciation.

REFERENCES

Barron, W.L. 1980. *The Role of Imaginable Processing in Humor*. United States of America: University of Texas at Austin.

Baughman, M.D. 1974. *Baughman's Handbook of Humor in Education*. New York: Parker Publishing Company.

Billig, M. 2005. *Laughter and Ridicule: Towards a social critique of humor*. London: Sage.

Birner, L. 1994. *Humor and the Joke of Psychoanalysis. In Strean, H. 1994. The use of Humour in Psychotherapy*. London: Jason Aronson INC.

Bleedhorn, B.B. 1982. *Humor as an indicator of giftedness. Roper Review*, 9(4):33-34.

Blom, R. 2004. *Handbook of Gestalt Play Therapy. Practical Guidelines for Child Therapists*. South Africa: Fichartdpark.

Borg W.R. & Gall, M.D. 1998. *Educational Research. An Introduction*. 5th Edition. New York: Longman.

Bryant, J., Cominsky, P.W. & Zillmann, D. 1979. *Teacher's Humor in the College Classroom.* Communications Education, 28(2), May 1979:110-118.

Bryant J. 1988. *Using humour to promote learning in the classroom*. Journal of Children in Contemporary Society, 20 (1-20: 49-8).

Cattanach, A. 2003. *Introduction to Play Therapy*. Sussex: Routledge.

Chapman, A.J. & Foot, H.C. 1976. *Humour and Laughter: Theory, Research and Applications*. London: John Wily and Sons.

Clarkson, N. 2004. *Gestalt Counselling In Action*. London: Sage.

Collins, K.J. 2000. *Research in the Social Sciences.* Study Guide for RSC 201-H. South Africa. UNISA.

Cresswell, J.W. 2003. *Qualitative Inquiry and Research Design*. Thousand Oaks. Sage.

De Munnik, E.O. 1988*. Die gebruik van humor as didaktiese instrument in die onderwys. Uit: Opvoedkundevereniging van Suid-Afrika. Doeltreffende Onderwys*. Publikasie Reeks van OVSA 22. Pretoria: UNISA: 228-242.

De Bono, E. 1985. *Conflicts: A better way to resolve them*. USA: Penguine Books.

De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, C.S.L. 2005. *Research at Grassroots for the Social Sciences and the Human Sciences Professions*. Pretoria: Van Schaik Publishers.

Dunn, M. 2004. *The Development of a Board Game as Preventative Measure against the sexual abuse of grade 4 children in South Africa*. D DIAC. Doctor in Diaconiology (Direction Play Therapy UNISA).

Friedman. R. 1994. *Using humor to resolve intellectual resistances*. In Strean, H. 1994. *The use of Humor in Psychotherapy*. London: Jason Aronson INC.

Frey, D.E. 1993. *Learning by Metaphor*. In Schaefer, C.E. 1993. The Therapeutic Powers of Play New Jersey. Jason Aronson Inc.

Funes, M. 2000. *Laughing Matters: Live creatively with laughter*. Dublin: Newleaf: Gill and Macmillan Limited.

Gardner, R.A. 1983. *The Talking, Feeling, Doing Game*. In: Schaefer, C.E. and O'Connor, K.J. (Eds.). 1983. *Handbook of Play Therapy*. New York: John Wiley. 259-274.

Gardner, R.A. 1988. *The Talking, Feeling, and Doing Game*. New York: Cresswell and Child's Work / Child's Play. Creative Therapeutics Inc.

Goldstein, J.G & McGhee, P.E. 1972. *The Psychology of Humor (Theoretical perspectives and empirical issues)*. New York: Academic Press.

Grobbelaar, T. *Types of Research*. In: Collins, K.J. 2000. Research in the Social Sciences. Study guide for RSC201-H. South Africa. UNISA.

Harman. R L. 1996. *Gestalt Therapy Techniques. Working with Groups, Couples and Sexually dysfunctional men*. USA: Jason Aronson.

Hehl, F. 1985. *The location of sense of humor within comprehensive personality spaces: An explanatory steed*. Personality and individual differences. 6(6):703-715.

Hill. D.J.1988. *Humor in the classroom: A handbook for teachers (and other entertainers)*. Springfield: Charles Thomas Publishers.

Hurlock, E.B. 1978. *Child Development*. 6th Edition. McGraw-Hill International Editions.

Jacobs, S. 2007. *Teaching Science in the OBE classroom*. Johannesburg: McMillan.

Jacobs, S 1992a. *'Humor in Onderrig'.* Unpublished Masters Thesis. Johannesburg. Rand Afrikaans University.

Jacobs S. 1992b. *Humour in the Classroom*. *South African Journal of Higher Education*. Volume 6 no. 3

Jennings, S. 1993. *Play Therapy with Children. A Practitioner's Guide*. Oxford: Blackwell Scientific Publications.

Joyce, P. & Sills, C. 2001. *Skills in Gestalt Counseling and Psychotherapy*. London: Sage.

Kaduson, H.G. and Cangelosi. D., Schaefer. 2004. (Eds.), *The Playing Cure*. Individualized Play Therapy for Specific Childhood Problems. Northvale, NJ. Aronson.

Kepner, K. 1987. *Body Process: a Gestalt approach to working with the body in Gestalt Therapy*. New York: Gardner.

Kiken, M.E. 1977. *The Grammar of Humor*. Michigan: University Microfilms International.

Kottman, T. 2001. *Play Therapy: Basics and Beyond*. USA: American Counseling Association.

Koestler, A. 1998. *The Ghost in the Machine*. England: Arkana.

Kubie, L. 2005. *Embodying the sense of Self. Body-Mind Centering and authentic movement.* In: Totton, N. (ed.) 2005. New Dimensions in Body Psychotherapy. Maidenhead: Open University Press.

Kritzinger, M.S.B, & Labuschagne, F.J. 1980. *Verklarende Afrikaanse Woordeboek*. Pretoria: J.L Van Schaik Beperk.

Laetus in Praesens. 2005*. Recognized role of humor: in politics, leadership, religion and creativity.* http://www.laetuspraesens.org/musings/humourx.php

Latner, J. 1986. *The Gestalt Therapy Book*. New York: The Gestalt Journal Press, Inc.

Livingstone, G. 2006. *Too soon old, too late smart. Thirty true things you need to know now*. London.

Lubimiv, G.P. 1994. *Wings for our Children. Essentials of Becoming a Play Therapist*. Canada: The General Store Publishing House.

Ludick, D. 1995. *A Gestalt Programme for learning-disabled children*. Unpublished D.Phil dissertation. University of Pretoria.

Mahrer, A. 2002. *What Strong Laughter in Psychotherapy Is, and How it works*. In Strean, H. 1994. The use of Humour in Psychotherapy. London: Jason Aronson INC.

Markow. R. 1994. *Therapeutic Laughter: What therapists do to promote strong laughter in Patients.* In: Strean, H. 1994. *The use of Humour in Psychotherapy*. London: Jason Aronson INC.

McGhee. P. E 1979. *Humor: Its origin and development*. San Francisco: W.H Freeman and Company.

McGhee P.E. & Chapman A.J. 1980. *Children's Humour*. New York: John Wiley and Sons.

McGuire, D.K & McGuire, D.E. 2000. *Linking Parents to Play Therapy. A practical guide with Applications, Interventions, and Case Studies*. Philadelphia: Routledge.

McMahon, L. 1992. *The Handbook of Play Therapy*. London: Routledge.

McMillan, J.H. & Schumacher, S. 1997. *Research in Education: A Conceptual Introduction*. New York: Longman.

Moursund, J.P. 1976. *Learning the Learner*. California: Monterey/Cole Publishing Company.

Mulkay, M 1988. *On humor (Its nature and its place in modern society)*. Great Britain: T.J Press Ltd.

Nash W. 1985. *The Language of Humour. Style and technique in comic discourse*. London and New York. Longman.

Oaklander, V. 1969. (Second edition: 1988). *Windows to our children. A Gestalt therapy approach to children and adolelscents*. New York: Gestalt Journal Press, Inc.

Oaklander, V. 1994. *Gestalt Play Therapy*. In: O'Connor, K. & Schaefer, C. (Eds.), Handbook of Play Therapy (Vol.2, pp. 143-156). New York: Wiley.

Oxford Advanced Learners Dictionary. 1995. Fifth Edition. Oxford: University Press.

O'Connor, K. & Schaefer, C. (Eds.) 2001. *Handbook of Play Therapy*. New York: Wiley.

O'Dessie, O.J. 1997. *Play Therapy. A Comprehensive Guide*. London: Jason Aronson INC.

Olson, H.A. 1994. The use of Psychotherapy. In Strean, H. 1994. *The use of Humour in Psychotherapy*. London: Jason Aronson INC.

Palmer, J. 1984. *Taking Humour Seriously*. Great Britain: Cornwall.

Patton, M.Q. 2001. *Qualitative research and evaluation methods*. 3rd edition. Thousand Oaks, California: Sage Publication.

Perls, F. 1969. *In and Out the Garbage Pail*. Utha: Real People Press.

Perls, F. 1951. *Gestalt Therapy. Excitements and Growth in the Human Personality*. London: Souvenir Press.

Pierce, R. A. 1994. *Use and Abuse of Laughter in Psychotherapy*. In Strean, H. 1994. *The use of Humour in Psychotherapy*. London: Jason Aronson INC.

Poland, W.S. 1994. *The Place of Humor in Psycho Therapy*. In Strean, H. 1994. *The use of Humour in Psychotherapy*. London: Jason Aronson INC.

Prerost, F. 1994. *Humor as an intervention strategy.* In Strean, H. 1994. *The use of Humour in Psychotherapy*. London: Jason Aronson INC.

Puttergill, C. 2000. *Strategies of Discovery*. In: Collins, K.J. 2000. Research in the Social Sciences. Study guide for RSC201-H. South Africa. UNISA

Rossouw, D. (Ed.). 2003. *Intellectual Tools. Skills for the Human Sciences*. Second Edition. South Africa, Hatfield: Van Schaik.

Riggins, l. 2005. Adolescent Health. In: Rew, L. 2005. *Adolescent Health: A Multidisciplinary Apoproach to Theory Research and Intervention*. London: Sage Publications.

Rogers, S.C. 1989. *Comparative studies in Society and History*. Englewood Cliffs, NJ: Prentice Hall.

Saul, S. 1994. The Application of Joy in Group Psychotherapy for the Elderly. In: Strean, H. 1994. *The use of Humour in Psychotherapy*. London: Jason Aronson INC.

Satow. R. 1994. Classical, Object Relations, and Self Psychological Perspectives on Humor. In: Strean, H. 1994. *The use of Humour in Psychotherapy*. London: Jason Aronson INC.

Schaefer, C.E. 1993. *The Therapeutic Powers of Play*. New Jersey: Jason Aronson Inc.

Shapiro, E. *In the blink of an eye.*Journal Psychology. 153. 120-124. www.netwalker.co.uk/page Available.

Schaefer, C.E. & O'Connor, K.J. (Eds.). 1983. *Handbook of Play Therapy*. New York: John Wiley.

Sherrin, N. 1996. *Humourous Quotations*. New York: Oxford University Press.

Shibles, W, 1978. *Humor. A critical analysis for young people*. United States of America: The Language Press Wisconsin.

Shibles, W. 2002. *Is Beauty Power really the most important one?* http://facstaff.uww.edu/shibles/humourbook/hs.html.2002. Accessed on 15 January 2007.

Smith, D.P.J 1988: *Navorsingsmetodes van die filosofie van die opvoeding*. Johannesburg: Randse Afrikaanse Universiteit: 12-24.

Strean, H. 1994. *The use of Humour in Psychotherapy*. London: Jason Aronson INC.

Strydom, H. 2005. In De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, CSL. 2005. *Research at Grassroots for the Social Sciences and the Human Sciences Professions*. Pretoria: Van Schaik Publishers.

Tellis, W. 1997. *Application of a Case Study Methodology*. The Qualitative Report, Volume 3, Number 3, September 1997.
(http/www.nova.edu/sss/QR/QR3-3/tellis2.html)

Totton, N. 2005. *Emobied-Relational Therapy*. In: Totton, N. (Ed.) 2005. *New* Dimensions in Body Psycholtherapy. Maidenheiad: Open University Press.

Van Eeden, J. 2006. HaHaHaHaha… In: *Beeld* Donderdag 20 April 2006.

Ventis, W. L, & D G. 1988. *Guidelines for Using Humor in Therapy with Children and Young.* Journal of Children in Contemporary Society, Vol 20. no 1-2 pages 179-197

Verwoerd, W.J 1989*: Humor as hermeneutiese sinspel: 'n Hermeneuties Fenomenologiese besinning oor die sin van humor as laggende sinspel, met spesiale verwysing na die belang van hierdie interpretasiespel in lyding*. Stellenbosch: Universiteit van Stellenbosch. (M.A.-verhandeling).

Van Fleet, R. In Kaduson, H.G. and Cangelosi. D., Schaefer. 2004. (Eds.), *The Playing Cure*. Individualized Play Therapy for Specific Childhood Problems. New York. John Wiley

Van Heukelum, G. 2004. *Transformative Self-discoveries for a pre-school Child: From a passive to an Agentive Life Position.* In partial fulfillment of Master Diaconiologiae. South Africa. University of Stellenbosch.

Vithal, R. & Jansen, J. 1997. *Designing your First Research Proposal*. Cape Town: JUTA Co Ltd.

Weisberg, R. W. 1993. *Creativity. Beyond the Myth of Genius*. New York: W.H. Freeman and Company.

Welliver, D. 1986. *Laughing Together. The value of Humour in Family Life*. Illinois: Brethren Press.

Wormer, K. 1997. *Humor in the emergency room: a social work perspective*, Health Social Work 1997 May, 22 92):87-92).

Yontef, G.M. 1993. *Awareness, Dialogue, Process: Essays on Gestalt therapy*. New York: Gestalt Journal Press.

Yontef, G.M. 1989. *Gestalt Therapy: An Introduction. Current Psychotherapies*. Illinois: Peacock Publishing House.

Zinker, J.C. 1994. *In Search of Good Form. Gestalt Therapy with Couples and Families*. San Francisco: Jossey-Bass Publishers.