CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

THE ROLE OF HUMOR IN PSYCHOTHERAPY:
A WORKSHOP FOR THERAPISTS

A graduate thesis project in partial fulfillment of the requirements
For the degree of Masters of Science in Counseling,
Marriage and Family Therapy

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DEDICATION

This paper is dedicated to the friends I made in this program, both colleagues and mentors, who have helped me grow into a better person, deepen my understanding of this fascinating universe and its myriad forms, and become a more compassionate human being. Most of the time.
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I thank my parents, friends, teachers, and committee for their compassion and support throughout my education. I also thank my mentors, dead and alive, who have inspired me to pursue this line of work and enrich my understanding of people and the mechanics of well-being.
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ABSTRACT

THE ROLE OF HUMOR IN PSYCHOTHERAPY:
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The purpose of this thesis project is to create an introductory workshop for psychotherapists who are interested in learning about and incorporating humor into psychotherapy. The curriculum covers a survey of contemporary and classical theories of humor, the ways in which humor can be used to benefit clients, and the ways in which humor can harm clients. It looks at the research and issues surrounding therapist education and training in using humor, and presents specific exercises and examples for therapists to practice using and avoiding humor at different stages of psychotherapy. The workshop is intended to provide a starting point for therapists interested in expanding their understanding of humor and its role and to empower them to take measured risks in therapy for the benefit of their clients.
Chapter I

Introduction

“We do not take humor seriously enough.” -- Konrad Lorenz

Introduction

This is a projected guidebook for professionals wishing to incorporate humor into their psychotherapy practice. “Humor” is understood as “an affective, cognitive, or aesthetic aspect of a person, stimulus, or event that evokes such indications of amusement, joy, or mirth as the laughing, smiling, or giggling response,” (Saper, 1987). In the context of psychotherapy, humor takes on a therapeutic dimension. One definition of therapeutic humor proposed by the American Association for Therapeutic Humor (AATH) states that therapeutic humor is “any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life's situation. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual,” (Sultanoff, 2000).

Despite initial historical resistance, modern therapists have, by and large, advocated the use of humor in psychotherapy; however, the precise nature and benefits of therapeutic humor remain mostly understood. This is mostly due to the paucity of empirical research devoted to therapeutic humor. Anecdotally, mental health practitioners have proposed several benefits and purposes, in addition to risks, associated with therapeutic humor. These benefits range from medical
benefits, to assistance in assessment, improved client-therapist relationships, cognitive restructuring, expanded awareness, and more.

Statement of the Problem

Psychotherapists are living in a very exciting time. Our field, which has been home to many different paradigms, is seeing a proliferation of new treatment modalities, as well as the application of scientific rigor to existing theories. New theories, including post-modern theories, somatic-based theories and interventions, and mindfulness-based theories are taking root. Many therapists are abandoning the sterile, stoic conception of a therapist in favor of a relationship based on genuineness and sincerity.

With these changes, we have an immediate opportunity to reexamine the nature of the client-therapist relationship as well as its parameters. Humor is a central tenet of self-actualization as well as a marker of healthy interpersonal relationships (Sultanoff, 2003). Its application in psychotherapy has been met with mixed reactions (Saper, 1987). Some therapists continue to be skeptical about incorporating humor into psychotherapy. While most of these benefits have only been experimentally tested in a medical setting (rather than a psychological or therapeutic setting) many have attested to the positive effects of using humor in psychotherapy (Franzini, 2001).

Interventions, therapies, and techniques have emerged in the last 25 years that explicitly call for humor. Indeed, humor has been an important factor in the success of Rational-Emotive Behavioral Therapy, Dialectical Behavioral Therapy, Natural High Therapy, Provocative Therapy, and Logotherapy.
Therapists can benefit from learning about the benefits and risks of using humor in psychotherapy and decide for themselves whether it can help their clients achieve greater happiness in their lives. Yet there are still barriers to getting therapists to assimilate humor into their therapeutic skillset. Some of these barriers are cultural, and relate to the culture of psychotherapy, which is passed through supervisors and teachers who themselves may not be open to using humor, nor privy to its benefits. An additional barrier lies in therapists’ dependence and comfort in their expert role as therapists and the power it carries with it. For these therapists, humor can have the effect of dissolving the idealized conception of the therapist and humanizing them. While many would welcome such an opportunity, the prospect of being vulnerable or losing control within therapy is frightening for many therapists. Moreover, maintaining control of the session is a value that is praised by colleagues.

The question arises: if humor has a beneficial effect for clients and for their relationships with their therapists, is there a way to encourage therapists to use it? What benefits does it contain? What risks does it pose? And finally, what obstacles must be overcome?

**Purpose of Project**

The purpose of this project is to outline a workshop that will arm industry professionals with the basic information and rudimentary skills to use humor in the context of therapy in a safe, effective manner. Therapists will learn how humor can be used in therapy, how and when to apply it, and when to avoid it.
The workshop is designed to be held over a 4 hour period over the course of a single day. The workshop is designed for mental health professionals as well as students on their way to becoming professionals. It will be led by one or two mental health professionals, preferably therapists, currently licensed to practice. The presentation will include research information presented in a slideshow presentation, vignettes, and live role play.

**Terminology**

“Humor” is defined as “an affective, cognitive, or aesthetic aspect of a person, stimulus, or event that evokes such indications of amusement, joy, or mirth as the laughing, smiling, or giggling response” (Saper, 1987).

A “sense of humor” is a personality traits that spans 2 distinct but related dimensions: (1) the appreciation of humor, or the ability to perceive something as funny, and (2) the creative aspect of humor, or the ability to say or do funny things (Saper, 1987).

“Laughter” is understood to be a behavioral event where the muscles of the rib cage are rhythmically tensed and released.

A “joke” is a form of verbal humor which is often culturally linked (e.g., Jewish humor) (Fabian, 2002). Jokes require both appreciative and creative aspects of a sense of humor as well as familiarity with the nuances of language and cultural references and schema to which they may allude.

**Summary**

The following literature review will begin with a brief examination of the early conceptualization of humor. It then briefly reviews the historical reactions to
merging humor and psychotherapy. Next, it examines the modern theories of therapeutic humor and arrives at a definition of therapeutic humor, followed by a brief deconstruction of that definition and supplement from various other theorists. Next, it will explore the benefits, roles, and uses of humor at different points in the therapeutic process as well as the dangers and risks inherent in using humor inappropriately in therapy. Finally, this literature will examine the practicality and methods of teaching humor to therapists including some of the hurdles that must be overcome.
Chapter II

Literature Review

Conceptualizing Humor

What is humor?

Scholars have not arrived at a consensus regarding the definition of humor (Mooney, 2000). The word “humor” is thought to derive from Greek, and referred to the 4 different bodily fluids: blood, phlegm, choleric, and melancholy (black and yellow bile, respectively. Balancing each of these 4 humors led to a state of “good humor,” while an imbalance led to ill humor (Mooney, 2000). The German Brockhaus Encyclopedia (1969) defines humor as “a serenity not disturbed by thoughts. It may . . . achieve a harmonic reconciliation of the otherwise irreconcilable, playfully, from the distance of an aesthetical attitude. Humor encounters human weaknesses and the difficulties of human existence with a benevolent, understanding smile.”

Biologically speaking, humor tends to trigger a behavioral response called laughter. Laughter can elevate endorphin and enkephalin levels in the brain (Weeks, 2000). The mechanism for release of endorphins is mediated by the pituitary gland. Endorphins are the brain’s natural opiate, making us smile, forget our troubles, and feel happy (Mooney, 2000). Laughing is not the only behavior that triggers endorphins: running, chocolate, and even the smell of cinnamon can also stimulate the pituitary gland to release endorphins (Weeks, 2000).

Early Conceptualizations of Therapeutic Humor
Therapists have long advocated the use of humor in psychotherapy. Indeed, the benefits of humor have often been intertwined into the conceptualizations of therapeutic humor. Its early proponents have come from psychodynamic and rational-emotive schools of thought (Franzini 2000; Ellis, 1977).

Freud believed that humor could be used to discharge sexual and aggressive drives that would otherwise be stifled and even told jokes during therapy (Freud, 1938). According to Mooney (2000), humor is an unconscious, benevolent way to provide relief from psychic tensions in the form of a joke. They are a way to release tension over conflicts that are taboo, such as one’s dislike of their in-laws or resentments towards their spouse. Grotjahn (1949) believed that “the therapist’s own humor arises as a spontaneous reaction and should be expressed because humor signifies emotional freedom and maturity.” Thus, humor could help model emotional freedom for clients. Similarly, Kohut (1971) viewed the presence of humor as a sign of effective psychoanalysis.

Albert Ellis (1977, 1984) the founder of Rational Emotive Behavioral Therapy (REBT), routinely incorporated humor into his therapeutic practice. To this day, REBT therapists actively use humor to help their clients identify irrational beliefs (Yankura & Dryden, 1994). Humor is used intentionally and by design (rather than spontaneously) by REBT therapists.

Not all therapists invited humor into their therapeutic practice. Psychoanalysts viewed humor with skepticism and cynicism, believing that humor was a form of resistance that demanded interpretation of its defensive
function. Conversely, a therapist’s use of humor was viewed as “as best, a countertransference distraction from the therapy and, at worst, collusion with the patient’s avoidant striving,” (Reynes & Allen, 1987). This approach was rooted in the belief that a therapist should avoid acknowledging shared feelings in therapy, especially feelings of amusement and pleasure.

An early critic of therapeutic humor was Kubie (1971), who stated: “Let us keep [humor in life] by acknowledging that one place where it has a very limited role, if any, is in psychotherapy.” Others (Zillmann, 1983) went even further to characterize humor as malevolent, lumping together friendly humor and cynical, sarcastic humor.

Perhaps due to its early detractors or due to its difficulty in testing, research on therapeutic humor is scant. Surveying the literature on behavioral therapy, Kuhlman (1984) found no references to humor prior to the early 1970s. Similarly, in a survey of published research on the use of humor in behavior therapy, Franzini (2000) found only 2 references to humor, both of which were published in 1973.

One reason for the paucity of scientific studies on humor is the spontaneous nature of humor (Ventis, et al. 2001). This makes studies on humor difficult to replicate in a controlled setting. A second reason is the complexity of conceptualizing humor, which has cognitive, emotional, physiological, and philosophical dimensions (Dziegielewski et al. 2003).

Nonetheless, both the value and use of humor in the psychotherapeutic context has been widely acknowledged. In his sample, Franzini found that 98% of
behavioral therapists endorsed the intentional use of humor in therapy. They reported 3 key purposes for using humor: to assist in establishing rapport, to identify irrational cognitions, and to share a positive emotional experience with the client. (Franzini, 2000).

Wilkens (2001) conducted a recent survey of marriage family therapists and their views of therapeutic humor. A majority of respondents agreed to the following statements:

1. I adequately understand the phenomenon of humor in psychotherapy.
2. I think that humor was adequately addressed in my training as a marriage and family Therapist.
3. I find that spontaneous humor and/or episodes of humorous levity occur on average in my clinical practice.
4. I feel comfortable in my ability to understand and interpret humor as it spontaneously develops in the therapeutic setting.
5. I use humor deliberately as a rapport building tool.
6. I use humor deliberately in my clinical interventions.
7. Humor can be appropriate to use in (not any/specific/occasional/most/all) clinical situations. (most said “most”)

The survey results indicate that therapists are moving in the direction of using humor in the therapy session but are aware of the some of the risks inherent in that task.

In a similar vein, Gregson (2009) conducted a study using recordings of live therapy sessions. Gregson analyzed the recordings to determine who
produced more humor and the conversational patterns surrounding the joke. Interestingly, Gregoson found that clients produced two-third of humor. Gregson also found that humor in session was often accompanied by cues like stating “you’re going to think this is funny, but…”) or laughing, changing tone, or changing volume. These cues can be important in signaling to the therapist that the information need not be analyzed about that a joke was approaching. Also, that it would be okay to laugh along with the client. Therapists were observed changing their humor style depending on who their clients were. Finally, many of the jokes were inside jokes, not obvious to researchers.

**Modern Conceptualizations of Therapeutic Humor**

In the last 2 decades, we have witnessed a proliferation of interest in the incorporation of humor into psychotherapy. Websites, newsletters, conferences, and international society to study humor, and 4 handbooks about humor and psychotherapy have emerged recently (Franzini, 2001).

Various conceptualizations of humor have emerged throughout the years ranging from the concrete to the philosophical. The American Association for Therapeutic Humor (AATH) defines humor as “any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life's situation. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual” (Sultanoff, 2000). The AATH’s definition could be deconstructed into 3 basic elements:
1. An intervention: Using humor in the context of psychotherapy should be regarded as an intervention, tantamount to other interventions advocated in other modalities. It also suggests the possibility of using humor as a specific intervention for specific types of challenges presented by patients such as over-seriousness, obsessive thinking, or clinging to maladaptive narratives.

2. Promotion of health and wellness, whether cognitive, emotional, social, or spiritual. Humor in therapy is used only to help clients, never to put them down or simply for the amusement of the therapist. Also, humor can be used to enrich a client’s spiritual life. This is one of the defining differences between therapeutic humor and non-specified humor.

3. A focus on the absurdity of one’s life situation. Humor is a tool to help expose and find enjoyment in the incongruities of one’s circumstances. More importantly, the therapist must be able to adequately flesh out the client’s dilemma in order to expose the absurdities and paradoxes that are embedded in it. Thus, humor is therapy actually born out of a client’s suffering (i.e., their tense life circumstance), rather than outside material.

    Adding more existential overtones, Mindess (1971) proposed his own definition of therapeutic humor as “[d]eep, genuine humor…that can be instrumental in our lives extends beyond jokes, beyond wit, beyond laughter itself to a peculiar frame of mind. It is an inner condition, a stance, a point of view, or
in the largest sense an attitude to life.” Mindess’s definition recognizes the powerful way in which humor can affect one’s fundamental lifestyle and relationship to life itself, not simply a discrete issue or dilemma.

Other features of therapeutic humor appear throughout the literature:

1. “Humor is a natural and universal form of interpersonal contact that stands beyond cultural traditions,” (Fabian, 2002).
2. “The capacity for humor linked to wisdom about the world is available in varying degrees to all of us,” (Poland, 1990).
3. Researchers Fabian & von Bulow (1994) described humor as an ego function related to ego demarcation and curiosity, specifically with regard to people and one’s surroundings.
4. Therapeutic humor can be spontaneous or planned (Franzini, 2001).

Taking a more functional-behavioral approach to defining humor, Saper (1987) defines humor "as an affective, cognitive, or aesthetic aspect of a person, stimulus, or event that evokes such indications of amusement, joy, or mirth as the laughing, smiling, or giggling response.” While Saper’s definition focuses on behavioral responses to humor, rather than the mechanisms that provoke them, he succeeds in distinguishing between “humor” and a “sense of humor.” According to Sapir, a sense of humor is a personality trait that can be understood across 2 distinct but related dimensions: (1) the appreciation of humor, or the ability to perceive something as funny, and (2) the creative aspect of humor, or the ability to say or do funny things. This becomes a critical distinction in designing a
program to help therapists incorporate humor into therapy and even raises questions as to whether the creative aspect of humor can be taught or learned at all.

The construct of humor is distinguished from both laughter, which is a behavioral event, and a joke, which is a product of humor. Laughter can be triggered by humor and can be cathartic, but it is not necessary for humor to be therapeutic (Ventis, 1987). A joke is a form of verbal humor which is often culturally linked (e.g., Jewish humor) (Fabian, 2002). Jokes require both appreciative and creative aspects of a sense of humor as well as familiarity with the nuances of language and cultural references and schema to which they may allude. Although counseling is primarily a serious endeavor, humor has been shown to occur in it either through the “natural” interactions of its participants (e.g., Gladding, 1995) or by design (e.g., Ellis, 1973).

The particular uses of humor vary between client and therapist. Jeffry (2009) analyzed and coded conversions between therapists and patients. The researchers found that therapists used humor 6 times while the clients used humor 8 times (on average). The particular uses were also highly varied: therapists used humor to communicate empathy, offer interpretations, counter resistance, graciously express disagreement, reconnect with the client, and protect the therapeutic environment. Meanwhile, client used therapy to express incongruence as they worked to change, communicate confusion over the direction of the therapy session, and describe a disagreement with another person

Benefits of Uses of Therapeutic Humor
Generally speaking, the benefits of humor cut across multiple domains.

**Medical Benefits**

Humor has been shown to alleviate pain and increase quality of life in terminal patients. Socially, humor can expand one’s network of friends. Physiologically, humor has been demonstrated to release endorphins and assist in cellular health, and psychologically, humor can help combat stress. (Levinthal, 1988; Bennett, 1998; Fry & Salameh, 1987). In a recent empirical study, researchers interviewed bereaved participants 6 months post-loss. Those that displayed laughter in the interview also showed increased psychological distance from the loss, reduced anger, increased positive affect, and enhanced social relationships (Keltner & Bonanno, 1997).

**Assessment**

Greenson (1967) suggested the most effective therapists all shared a good sense of humor. Therapists can use humor strategically to achieve various goals within therapy. At the outset of therapy, humor can be used as an assessment tool. Reynes & Allen (1987) explain that in their own practice, they would ask new clients to tell their favorite joke during therapy as a means to gain insight into their anxieties and the obsessive themes in their lives. They cite examples in their work of individuals joking about impotence and cheating, only later to reveal that their neuroses centered around these 2 issues. Supporting this approach, McNary (1979) has stated that one good way to collect data about a client is to see what makes them laugh, since their humor provides clues about their anxieties.

**Dyadic Benefits**
The main component of therapy that stimulates change is the therapeutic relationship. (Lambert & Barley, 2001). One key benefit of therapeutic humor that I have directly observed over the course of my training as a therapist is in rapport-building. Humor and laughter can be used to share positive emotions in a therapy room where sadness and hardship prevail. Humor can also be used to discharge anxiety involved with disclosing shameful thoughts and behaviors. According to Fabian (2002), humor, whether verbal or nonverbal, can help the client establish confidence in the therapist. He goes on to state that “humor and playfulness are therefore welcome features of every psychotherapy and should be attributes of every psychotherapist, especially if he or she treats psychotic patients, children, or juvenile patients,” (Fabian).

Humor can also be used to help negate the formality of therapy and the rigid roles of therapist and patient that are embedded in therapy. Humor demonstrates to clients that the therapist is, after all, human, and gives clients permission to use humor in their own lives, (Salameh, 1987; Dreikurs (1967). In addition to combatting the notion of the perfect therapist, humor can also be used to challenge clients’ notions about the therapeutic process itself and its presumed formality and seriousness (Bloomfield (1980). Related to this, humor in therapy could also help erode beliefs that one is not allowed to laugh in therapy, fostering the client’s ability laugh in other areas of his or her life that also harbor taboos (Ericson, 1984).

Similarly, humor can demonstrate understanding and similarity, helping clients feel understood and safe. At the heart of therapy, according to many
therapists, is the relationship between the client and therapist. This relationship can provide the correction interpersonal experience required for a client to grow and form new relationship patterns in their lives. Thus, through humor, a therapist can strengthen the interpersonal bond and help clients form healthier relationships outside of therapy (Rosenheim, 1974).

**Cognitive Restructuring**

Cognitive and affective changes can be divided into two main categories: those affecting the client’s general outlook on life (i.e., influence core schemas) and those that target specific anxieties and issues (i.e., transient, immediate dilemmas). With regard to the former, humor can help individuals see the world differently and see their problems differently. Recall Mindess's (1971) definition of therapeutic humor as “a peculiar frame of mind…an inner condition, a stance, a point of view, or in the largest sense an attitude to life.” Using humor, clients can develop the capacity to both be clear about cognitions, feelings, and life situation while at the same time, finding a way to tolerate the stress by transforming the stress into joy. From this perspective, it is difficult to maintain the argument that humor is a distraction or defense mechanism, since the client is required to admit the hardship of the situation, rather than repress it, in order to find the humor in it.

An example of this might be a client who’s facing a dilemma at work such that his boss has propositioned him for sex and the client fears that if he doesn’t follow through, he’ll lose his job. Given a strong relationship, a therapist could say “well, it sounds like you’re screwed either way.” This particular form of humor (joke) acknowledges the client’s dilemma as well as the feelings involved.
Without these factors, the joke would not make sense and would not be therapeutic. This type of humor allows the client to admit his feelings while developing a different way of looking at the same situation. The client is later able to take this new approach and apply to other areas of his or her life, thereby increasing wellbeing and satisfaction in a global manner.

Further elaborating on this mindset, Heuscher (1980) states that the ideal relationship to life is one that views life as “a kind of game, a conviction that everything we do is a half-serious search [for] the elusive reality we can’t quite touch. If an individual finds a humor which serves him and keeps him whole, it will be a kind of tentativeness, a playfulness in the face of the world.”

The ability to alter schema is also central to the resolution of immediate conflicts and dilemmas. According to Epstein (1998), humor can also be used to broaden clients’ schemas. (Franzini, 2001) In altering schema, humor can help relieve tension surrounding specific anxieties. As Grotjan (1970) eloquently stated, “jokes grow best on the graves of old anxieties.” The psychological shift from tension to relaxation is also mirrored, if not galvanized, by changes to the physical body that occur along with laughter. The act of laughing, a rhythmic tensing and relaxing of the rib muscles, not only relaxes the muscles around the rib cage, but also releases endorphins, the body’s natural opioid.

*Expanding Awareness*

Yet another benefit of therapeutic humor is that it can facilitate awareness by overcoming resistance and denial. Grotjahn (1970) asserted that humor allows clients to admit to and listen to things they otherwise would not be open to. By
reframing situations and character traits in a humorous light, clients experience less shame tied to their maladaptive behaviors and thinking. This technique can be used to encourage awareness of thoughts, feelings, or situations.

Roncoli (1974) describes his process of using humor to foster emotional awareness. Through bantering, exaggeration, and playfully caricaturing clients, Roncoli was able to challenge their emotional denial, ritual, and grandiosity. Roncoli specifically caricatured the great lengths clients went to remain emotionally unaware and called attention to both the humorous and unfortunate consequences of such denial. Reyes & Allen (1987) relay the following story to illustrate this point:

“With patients whose hostility leads them to see hostility in those around them, the ‘Jack Story’ has often been effectively used. This is the story of the driver whose car suffers a flat tire, finds he has no jack, and walks back to a house he has passed to borrow one. As he walks back he muses that the occupant will consider him to be stupid and will certainly refuse to lend him the jack. When the doorbell is answered, the driver hits the occupant who has asked, ‘Can I help you.’”

In this exchange, humor is used to expose and caricaturize the client’s hostility. The joke creates an environment and mood that allows the client to acknowledge their own overreactions and their consequences.

Perhaps the least understood, but most fascinating function of therapeutic humor is in relation to catharsis. Therapists and psychiatrists have acknowledged the integrating function of humor in treatment (Deri, 1968). By this, Deri refers to
the ability of humor to allow individuals to accept parts of themselves that they otherwise deny. In my own practice, I have witnessed on several occasions the emergence of humor and laughter following cathartic events.

One possibility is that humor is being used to help discharge pent up tension and feeling, via laughter and the release of endorphins. Another aspect of this process which has yet to be researched is the ability for humor to serve as a bridge from a highly arousing cathartic event back to everyday life where emotionally charged states are not the norm. Humor, in this way, can help clients transition out of these highly charged states.

One reason therapeutic humor might be such an appropriate tool for helping clients transition is because it acknowledges the gravity of the situation while still finding something funny about it. However, by reframing it, clients can find a way to hold onto the experience in their daily life in a way that is less distressing and emotionally taxing.

Benefits for Therapists

Client can also benefit vicariously through their therapists through humor. One of the protective functions of humor is in its ability to prevent therapist burnout and reduce stress (Franzini, 2001). Therapists who are able to stay fresh and present are better able to treat their clients.

Interventions, Therapies, and Techniques

Provocative Therapy

Two therapy modalities have made humor a central part of their success. One such area is Provocative Therapy. Provocative Therapy attempts to foster
change through challenge. (Farrelly & Lynch, p. 82). Humor is used aggressively in Provocative Therapy to challenge clients to resist change (Farrelly & Matthews). The aggressive humor is directed at the client’s problems, not at the client himself or herself.

Clients go through 4 stages of humorous provocation. First, clients are surprised at the provocation. Next, they begin to see legitimacy in the therapist’s exaggeration and challenge. Third, clients may begin to resist the therapist’s attempt to provoke change. Finally, the client is able to detach himself or herself from the situation and laugh at their former selves (Kuhlman 1984).

Natural High Therapy

A second therapy using humor is Natural High Therapy. The goal of natural high therapy is to promote a positive approach to life to foster self-actualization via self-esteem and social interest (O’Connell, 2001). In Natural High Therapy, a sense of humor is seen as a core element of self-actualization. (O’Connell). Therapists use humor to help dissolve clients’ guilt and free them to develop their self-esteem and social interest (O’Connell). Humor is both modeled by the therapist and incorporated into other interventions such as role-playing (Martin, 2007).

Rational-Emotive Behavioral Therapy

One of the more staunch advocates of therapeutic humor was the founder of REBT, Albert Ellis. Ellis (1977) believed that humor was a good antidote to the seriousness with which clients took their lives. Ellis viewed humor as a good way
to offset the hardship of life. He understood it as a tool to affect a person’s cognitions, emotions, and behavior, hence a very effective tool.

One central tenet of REBT is the interplay and importance that thoughts have on emotions and behaviors. Ellis believed that irrational thoughts were the basis of maladaptive emotions and cognitions and could be logically disputed. One method Ellis used to dispute these irrational cognitions was humor (Martin, 2007). By exaggerating client’s illogical rationale and taking them to an absurd extreme, therapists attempt to assertively help the client realize the absurdity of maintaining such a belief (Martin).

Paradoxical Intention

Victor Frankl developed yet another use for humor in the therapeutic context called paradoxical intention. Paradoxical intention is a method whereby a therapist focuses attention, through exaggeration, on something the client is trying to conceal or deny. Through humor, clients are able to detach or depersonalize the behavior and see it through a new light (Martin, 2007)

Irreverent Communication

Finally, Lineham (1993), the founder of Dialectical Behavioral Therapy (DBT) developed a form of communication called irreverent communication to help confront clients and hold them accountable for their progress in therapy.

Irreverent communication is a deadpan, offbeat, matter-of-fact communication with clients. It is used when clients are at an impasse in therapy. The therapist exaggerates or minimizes a client’s assumptions in a stoic manner.
Conversely, the therapist might choose to react excitedly to a client who acts aloof. In this way, imbalance is created in the client which forces them to arrive at a new balance (Lineham, 1993).

**Therapeutic Risks**

One of the tenets of therapeutic humor is that it benefits the client. Therapists must be careful never to use humor in such a way that it “humiliates, deprecates, or undermines the self-esteem, intelligence, or well-being of a client,” (Saper, 1987). This is especially important given the therapist’s disparate power inside of the therapeutic dyad. Salameh (1987) warned that therapeutic humor should always take into account the specific sensitivities of the client as well as the gravity of the topic of discussion.

Some have cautioned against using humor with certain types of client. One type of client to use humor with caution is the psychotic individual who lacks abstract reasoning. Their concern is that these clients would experience the humor as insulting (Fabian, 2002), although this conclusion was based on anecdotal, rather than experimental evidence. A second type of client where therapeutic humor is cautioned is a client from a different culture. Here, the concern is that the style of humor might not register with a foreign client in the same way it would with a native client (Fabian).

A third type of client where humor should be cautioned is with clients the therapist dislikes (Brooks (1994). However, one could also argue the opposite position, namely, that humor could help dissolve rapport difficulties and facilitate the liking of a client through shared positive feelings.
Teaching Humor to Therapists

The possibility of teaching therapeutic humor to therapists presents several obstacles and issues. The obstacles to teaching therapeutic humor include:

1. The therapist’s seriousness;
2. A therapist dismissing the need for or value of therapeutic humor;
3. The fear of being criticized by other therapists or supervisors; and
4. Therapists may lack a sense of humor.

The first obstacle is that the therapist takes himself or herself too seriously. According to Ellis (1977), therapists are charged to take therapy very seriously, consistent with the gravity of the mental disorders they treat. This seriousness extends beyond the work they do to they themselves (Franzini, 2001). While the mission of therapy is an important and meaningful one, it is a mistake to conflate importance and seriousness. Doing so prevents the client from incorporating humor into their worldview and lifestyle.

A second obstacle is that therapist may resist incorporating therapeutic humor because they believe they already have all the requisite skills to treat their clients. Mindess (1971) points out that when therapists believe that their interventions are sufficient and valid, they fail to experiment with new interventions which may be equally beneficial or even superior.

Related to this, Jolley (1982) has pointed out that some therapists may eschew humor because of the closeness and intimacy it generates, and by extension, by the lack of power implied by a relationship that is not steeped in the rigid roles of client and therapist or patient and doctor. Jolley hypothesized the
fear of losing power really centers around a therapist’s fear of being judged by colleagues as failing to maintain power in the dyad. This is in stark contrast to modalities that emphasize genuineness and power equality.

Just as therapists avoid using humor to prevent criticism from their colleagues, it is equally likely, that therapists avoid humor to try and appease their supervisors. Especially during training, supervisors can have a profound effect on their supervisees, either through modeling or through subtle reinforcements. Supervisors who are uncomfortable with using humor in therapy, perhaps due to the norms and customs in which they were trained, can intentionally or purposefully discourage the use of therapeutic humor (Franzini, 2001).

Perhaps the most difficult obstacle to overcome is a lack of sense of humor on the part of the therapist. A therapist without a good sense of humor who attempts to use humor may end up coming across as awkward and generate discomfort instead of laughter. It is not clear whether one’s sense of humor can be developed where there is no prior foundation. Moreover, even if a therapist can appreciate humor, there is no guarantee that they can generate humor (Franzini, 2001). On the topic of learning humor, Olson (1994) stated that humor could not be taught but had to be experienced before it could be initiated successfully.

Components of Humor Training

Franzini (2001) has outlined the 3 components of humor training as follows: “(a) the modeling and reinforcement of therapist humor behaviors by clinical supervisors, (b) specific training in the variety of humor techniques, and (c) sensitivity to any humor attempts by their clients, which can become critical
transition points in the therapeutic process.” Some of the specific training
techniques for therapist could include: modeling, reinforcement, joke, storytelling,
and metaphor, overcoming resistance, psychoeducation about therapeutic humor,
cognitive restructuring, playful caricaturizing, exaggeration, and specific
techniques.

Salameh (1994) has proposed the idea of therapists reflecting on their own
lives and foibles help them create a humorous outlook and better generate humor
in therapy. Salameh even went as far as to recommend that therapists create a
humor-related room with funny posters, quotes, or cartoons to inspire laughter
and joking.

To test the effectiveness of humor training, Salameh (1993) has proposed
a 5-point Humor Rating Scale. The scale divides humor into 5 levels ranging from
destructive to outstandingly helpful. Each level is explained through a vignette.
As Franzini (2001) notes, the scale could be used to evaluate changes in clients
use of therapeutic humor before and after a workshop.
Chapter III

Project Audience and Implementation Factors

Introduction

This workshop is intended to introduce therapists to the concept of therapeutic humor and provide them with practical exercises to help build their skills in using therapeutic humor in their own practice. The workshop explores the history, definitions and conceptualizations, and benefits and risks of psychotherapeutic humor. It looks at specific interventions and uses of humor, and gives participants an opportunity to practice creating humor using vignettes and real-life examples.

Development of Project

In creating this workshop, I have scoured the literature of psychotherapeutic humor, including academic articles, news articles, and handbooks. More importantly, I became interested in this topic through my own experiences in counseling friends, and then transferring those skills while counseling clients. I have, for the most part, been successful in using humor, and have used with clients as young as 7 and as old as 48. I have used humor for many of the purposes outlined in the literature, including expanding awareness, caricaturizing extreme or obsessive behaviors, rapport-building, and most interestingly have noticed its emergence during and immediately after cathartic moments in therapy. The humor I create is spontaneous, rather than planned, and informs the way I view the world and the dilemmas that have challenged me over the years.
My education, practice, and life experience has provided me with an adequate foundation to teach a workshop, develop vignettes, and give real-world examples of therapeutic humor. It has also armed me with the knowledge necessary to teach other clinicians about therapeutic humor and help them develop humorous outlooks that can inform their therapeutic style.
**Intended Audience**

The current workshop is designed for all mental health professionals, but specifically targets marriage and family therapists. Attendees will be recruited through advertisements placed in CAMFT publications and related trade publications. Attendees need not have any special training or knowledge to attend the workshop, but should have an open mind to incorporating humor and challenging preconceived notions about what the therapy and the therapeutic relationship should look like.

**Personal Qualification**

The workshop facilitator should have a good sense of humor, able to both appreciate humor and create original jokes. A strong sense of humor can help foster a playful environment during the workshop, and help stimulate participants’ imagination. The leader should also be a marriage and family therapist who has used humor in the course of his or her therapy practice for at least a year.

**Environment and Equipment**

The workshop should be held in a room designed to hold at least 20 attendees. The room must have a projector to project the accompanying PowerPoint presentation can be shown. The room must have chairs and tables to allow everyone to sit comfortable. The workshop leader will distribute a hardcopy of the PowerPoint presentation at the conclusion of the workshop.

**Formative Evaluation**

To gain suggestions and obtain feedback, I consulted with professors within the Marriage and Family Therapy program at California State University,
Northridge as well as colleagues, supervisors at the Center for Individual and Family Counseling, as well as friends.
Chapter IV

Summary and Conclusion

Summary of Project

The current project is the curriculum for a four hour workshop about therapeutic humor, designed for marriage and family therapists. Attendees will gain both knowledge and skill in using therapeutic humor through a PowerPoint-assisted presentation. The presentations will include research findings, the theoretical basis for using humor, benefits and drawbacks, specific interventions, and vignettes to practice using humor. The goal of the workshop is to introduce therapists to therapeutic humor, to give them the confidence to apply humor in therapy, and to urge them to continue to explore humor and unorthodox interventions in therapy.

This project is divided into six sections which include four chapters and the curriculum for the workshop. The first chapter provides a brief introduction to the problem: that there is a useful intervention that can benefit clients in profound, global ways, and that this intervention is underutilized due to unawareness or irrational fears about using such an intervention. This chapter provides a brief overview of early conceptualization of therapeutic humor and outlines some of the historical reactions to therapeutic humor, both positive and negative. The next chapter examines some of the modern conceptualizations of therapeutic humor, and deconstructs one definition in particular. It also supplements this definition with ideas from other clinicians and researchers. Chapter three examines some of the benefits of therapeutic humor and divides the benefits into numerous sections,
including assessment, rapport-building, cognitive restructuring, expanding awareness, and preventing therapist burnout. The fourth chapter examines the risks involved in using therapeutic, spotlighting the types of clients where humor should be cautioned. The fifth chapter examines the challenges involved in teaching humor to therapists. Finally, the sixth chapter looks at the components of a training session, such as a workshop, designed to educate therapists about therapeutic humor and give them practical skills to use in their own therapy.

**Recommendations for Implementation**

It is recommended that the facilitator use the included PowerPoint presentation, or simply the notes within it, as a starting point. The facilitator should try to supplement the curriculum with their own examples and lessons from using humor in therapy, or from their own experiences as clients in therapy.

The presenter should feel free to modify or add vignettes as he or she may see fit. Personal stories are encouraged as they can provide richer dialogue. Facilitators should also ask attendees to share funny moments from their lives, from their experiences as clinicians, as supervisors or supervisees, and as therapists.

**Recommendations for Future Research**

Research on humor and psychotherapy presents challenges beyond traditional research on psychotherapy. First, humor works best when it is spontaneous, rather than planned, which makes any type of experimental testing difficult if not impossible. A second challenge is posed by the variability of
clients, their problems, and the variability in sense of humor, not to mention the different types of modalities and styles practiced by therapists.

A far majority of the quantitative (i.e., experimental) studies concerning humor come from the field of nursing, rather than counseling. This is one key area where future research can expand our understanding of humor. A second area where more research could help is in clearly understanding how clients shift from seeing a problem as burdensome to seeing it as humorous. Related to this question, research could help establish prerequisites for clients to make this cognitive shift. Third, research could be used to better understand the role of humor and laughter in catharsis, particularly, the nature of the relationship between catharsis and humor.

Finally, research could be used to see if watching humorous movies and listening to comedy shows can help individuals develop humorous schema and cognitive biases that could help inoculate them to stress. With modern technological developments, this could develop into an affordable, simple type of therapy with far-reaching benefits.

**Conclusion**

Over the past century, marriage and family therapists have recognized the value of laughing and humor in the context of therapy, but there has been a dearth of research on therapeutic humor. Most of the literature concerns anecdotal evidence and stories about the benefits and risks of therapeutic humor. I became interested in this subject over the course of my graduate studies at California State University, Northridge. I witnessed my friends discharging lots of emotion, and
saw them recover from these experiences with the help of a joke. It led me to the realization that humor could be used during catharsis to help ground clients and normalize their experience. Months later, I found myself introducing humor into my sessions with clients, as well as during supervision. I have witnessed it assist clients in accepting things about themselves and situations, and find humor in the challenges in their life. In this way, they’ve managed to transform their suffering into amusement. As a clinician with a strong interest in existentialism and Buddhism, I believe that suffering is an unavoidable part of our lives. Finding humor in our suffering is one way to improve the quality of our lives, and being able to teach others, whether therapists or clients, how to do the same is a precious gift.
References


Epstein, B. (1998, November). Humor in behavioral and cognitive therapies. Symposium conducted at the annual meeting of the Association for the Advancement of Behavior Therapy, Washington, DC.


Appendix A: Presentation Slides

Therapeutic Humor
A WORKSHOP
AGENDA

- Preconceptions about therapeutic humor
- Your experiences, good and bad
- Defining humor
- History of therapeutic humor
- Defining therapeutic humor
  - Benefits
  - Interventions
  - Risks
  - Vignettes
- Next steps
WHEN YOU THINK ABOUT USING HUMOR IN PSYCHOTHERAPY, WHAT THOUGHTS COME TO MIND?

BENEFITS?
TECHNIQUES?
FAILURES?
CONSIDERATIONS?
EXPERIENCES?
WHAT DID YOUR SUPERVISORS, COLLEAGUES, AND TEACHERS TELL YOU (DIRECTLY OR INDIRECTLY)?

WERE THEY IN FAVOR?
WERE THEY AGAINST IT?
DID THEY EVER EVEN TALK ABOUT IT???
WHAT PEOPLE SAY ABOUT THERAPEUTIC HUMOR...

NOPE, NOPE, and NOPE.
It doesn't belong in therapy.

It's naturally therapeutic and helps rapport.

Too risky.

It's safe and effective.

Therapy should be serious.

Therapists are too serious!
WHAT ARE SOME OF YOUR EXPERIENCES WITH HUMOR IN THERAPY?

HOW MANY HAVE USED IT?
DID IT HELP? HOW?
HAS IT EVER BACKFIRED?
DOES IT FEEL NATURAL?

HOW ABOUT IN YOUR OWN THERAPY?

C’mon, we all know you’re in therapy.
WHAT IS HUMOR?

The German *Brockhaus Encyclopedia* (1969) defines humor as “a serenity not disturbed by thoughts. It may. . . . achieve a harmonic reconciliation of the otherwise irreconcilable, playfully, from the distance of an aesthetical attitude. Humor encounters human weaknesses and the difficulties of human existence with a benevolent, understanding smile.”
WHAT IS LAUGHTER?

Biologically speaking, humor tends to trigger a behavioral response called laughter. Laughter can elevate endorphin and enkephalin levels in the brain (Weeks, 2000).
### OTHER ENDORPHIN TRIGGERS

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<thead>
<tr>
<th>Increases Endorphins</th>
<th>Decreases Endorphins</th>
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<tbody>
<tr>
<td>Laughter</td>
<td>Poor physical condition</td>
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<tr>
<td>Smiling</td>
<td>Poor posture</td>
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<td>Exercise</td>
<td>Poor finances</td>
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<td>Self-talk</td>
<td>Pain (chronic)</td>
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<td>Eating</td>
<td>Negative/drainning people</td>
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<td>Recognition</td>
<td>Stress (acute)</td>
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<td>Sight</td>
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<td>Nature</td>
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DEFINING THERAPEUTIC HUMOR

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

American Association for Therapeutic Humor (AATH)
DEFINING THERAPEUTIC HUMOR

“Any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life’s situation. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual.”

What do the highlighted words signify?
DEFINING THERAPEUTIC HUMOR

OTHER FACTORS

UNIVERSALITY
“Humor is a natural and universal form of interpersonal contact that stands beyond cultural traditions,” (Fabian).

WISDOM
“The capacity for humor linked to wisdom about the world is available in varying degrees to all of us,” (Poland).

TERRITORIALITY
Researchers Fabian & von Bulow described humor as an ego function related to ego demarcation and curiosity, specifically with regard to people and one’s surroundings.

TYPES
Therapeutic humor can be spontaneous or planned (Franzini).
DEFINING THERAPEUTIC HUMOR
A FUNCTIONAL DEFINITION

“An affective, cognitive, or aesthetic aspect of a person, stimulus, or event that evokes such indications of amusement, joy, or mirth as the laughing, smiling, or giggling response.”
DEFINING THERAPEUTIC HUMOR
“SENSE OF HUMOR”

A TRAIT, NOT JUST A CONSTRUCT!

2 distinct but related dimensions:

(1) the appreciation of humor, or the ability to perceive something as funny, and

() the creative aspect of humor, or the ability to say or do funny things.

LAUGHING AT A JOKE

MAKING A JOKE
Laughing is a behavioral event that results from humor... and other things, like tickling or nervousness.
1 Medical Benefits
BENEFITS OF HUMOR IN PSYCHOTHERAPY

1 Medical Benefits
2 Assessment

“Tell me a Joke”
BENEFITS OF HUMOR IN PSYCHOTHERAPY

1. Medical Benefits
2. Assessment
3. Dyadic/Rapport

Laughter Therapy
BENEFITS OF HUMOR IN PSYCHOTHERAPY

1. Medical Benefits
2. Assessment
3. Dyadic/Rapport
4. Cognitive Restructuring
BENEFITS OF HUMOR IN PSYCHOTHERAPY

1 Medical Benefits
2 Assessment
3 Dyadic/Rapport
4 Cognitive Restructuring
5 Expanding Awareness

Seeing Yourself Differently
BENEFITS OF HUMOR IN PSYCHOTHERAPY

1. Medical Benefits
2. Assessment
3. Dyadic/Rapport
4. Cognitive Restructuring
5. Expanding Awareness
6. Burnout Prevention
Paradoxical Intention
FRANKL

Increasing the attention on that which the client is trying to avoid through exaggeration and frequency of symptoms.

Irreverance
LINEHAM

“Offbeat”, “matter-of-fact”, and “deadpan” communication style; exaggerating or minimizing clients’ assumptions in an unemotional, objective manner or reacting emotionally if the client is being aloof.
INTERVENTIONS
2 of 2

Systematic Desensitization
VENTIS
Humor used with desensitization techniques for phobias

Group Work
MINDEN
Humor in groups with psychiatric patients produces better results in therapy
RISKS!

Rules to Abide By

I.  Humor should always benefit the client and never put them down.
II. Be careful with clients with a loose grasp of reality (e.g., some schizophrenics).
III. Use caution when using humor with a client you don’t particularly like.
Ms. Z is a 20-year-old female college student. She originally came to counseling because she was feeling lonely and isolated on her college campus. She is inclined to find lots of reasons to avoid making changes in her life. She reports a strong working relationship with her counselor, and this interaction is taken from her fourth counseling session.

Ms. Z: It just seems like everyone else is having fun all the time—hanging out and doing things. All I ever do is homework, and sometimes I talk to my family, but that just makes me sad because they are far away.

Counselor: Six, you’re feeling really lonely and maybe left out.

Ms. Z: Yeah, exactly. Like I’m not a part of it.

Counselor: Were you able to look at some of the campus organizations that you might be interested in, like we talked about last week.

Ms. Z: Well—I thought about it. But I had some papers to work on and lots of reading to do this week, so I didn’t get around to it.

Counselor: OK, so finding out ways to become a part of something was not your priority this week.

Ms. Z: Yeah, I had too much schoolwork.

Counselor: It’s great that you are really focused on doing well academically, but I wonder if there are any other things that might be keeping you from getting involved in activities.

Ms. Z: Um...I’m not sure. Like what?

Counselor: Well, it could be almost anything. For example, sometimes people have a hard time doing something new because they are afraid that it won’t work out the way that they want it to.

Ms. Z: But what if it doesn’t? What if I never make friends? It’s scary to think about that...I mean—you have to talk to me, but other people don’t...

Counselor: It is really scary to actually participate sometimes. Tell me some more about what’s scary about it for you.
Ms. Z: It just seems like everyone else is having fun all the time—hanging out and doing things. All I ever do is homework, and sometimes I talk to my family, but that just makes me sadder because they are far away.

Counselor: So, you’re feeling really lonely and maybe left out.

Ms. Z: Yeah, exactly. Like I’m not a part of it.

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Counselor: OK, so finding out ways to become a part of something was not your priority this week.

Ms. Z: Yeah, I had too much schoolwork.

Counselor: You are reminding me of Nick when we talk about this.

Ms. Z: Who’s Nick?

Counselor: Well, Nick lived his whole life being the best person he could be. He also wanted to please God. He was kind, loving, always doing good deeds—anything God asked of him. But Nick was poor—he sometimes had a hard time giving his family all they needed—so one day God was thanking Nick for all of his good deeds and Nick said, —God, I work hard to serve you and be a good person, and I am happy to do it, but my family is suffering. Why don’t you let me win the lottery?!? And God replied, —You are a good man. But Nick, you have to get a ticket!!!

Ms. Z: (smiles) Ah....you can’t win if you don’t play. And I can’t make friends if I don’t leave my room. But it’s kinda scary to think about that...I mean—you have to talk to me, but other people don’t...

Counselor: It is really scary to actually participate sometimes. Tell me some more about what’s scary about it for you.
Ms. X is a 24 year old teacher. She originally came to counseling because she was feeling under lots of pressure about her job and her relationship. She feels that her boyfriend demands too much from her, and she is inclined to try to keep other people happy all the time. She reports a strong working relationship with her counselor and this interaction is from their fourth counseling session.

Ms. X: Things have just not gotten any better. At school there are all of these budget cuts looming, and they may have to fire some teachers. Everyone says that I should be fine, but I can't help but be worried about it, at least a little. And even though I’m really stressed out about work, my boyfriend just doesn’t get it. He’s always wanting me to do things for him—like always picking something up or fixing dinner. It doesn’t sound like a big deal, but it ends up taking all my time, and if I ask him to do anything he never will. Not take out the trash, not fix dinner, nothing.

Counselor: So it sounds like you are really being pulled in several directions.

Ms. X: I am. And it’s like I can see that he is no good for me and the relationship is basically dead, but I am stuck in this rut of always doing everything for him and never saying no. It’s like a bad habit.

Counselor: Tell me more about what it’s like to be stuck.

Ms. X: Nothing ever changes. It just seems like he doesn’t even care about the relationship at all—he just likes to know that I’m always there. He never wants me to go out on my own or with friends from work and it is so annoying because I don’t want to just be with him all the time. So then we fight, and we both go out with our friends, and he doesn’t have a problem with it. I mean, I am fed up with it, and stressed out about work, and sure, I can act—together all the time, like nothing even bothers me... But the truth is that you are quite bothered.

Ms. X: I am. It’s like I spend all of my energy keeping everyone thinking that my life is—on track, or whatever, but inside I am breaking out.

Counselor: I wonder if there is something that you’d like to be doing with your energy instead?
Ms. X is a 24-year-old teacher. She originally came to counseling because she was feeling under lots of pressure about her job and her relationship. She feels that her boyfriend demands too much from her, and she is inclined to try to keep other people happy all the time. She reports a strong working relationship with her counselor and this interaction is from their fourth counseling session.

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Counselor: I've got a feeling if it's that bad, you'd like to kick the habit.

Ms. X: (Smiles) Wouldn't that be nice? Sometimes I think that I would like to...or at least know what's going on. It just seems like he doesn't even care about the relationship at all—he just likes to know that I'm always there. He never wants me to go out on my own or with friends from work and it is so annoying because I don't want to just be with him all the time. So then we fight, and we'll go out with his friends, and he doesn't have a problem with it. I mean, I am fed up with it, and stressed out about work, and sure, I can act—together all the time, like nothing ever bothers me...

Counselor: (Counselor smiles) With all that acting, it sounds like you deserve an Oscar.

Ms. X: (Smiles, nods in agreement) I totally did it's like I spend all of my energy keeping everyone thinking that my life is—on track—or whatever, but inside I am freaking out.

Counselor: I wonder if there is something that you'd like to be doing with your energy instead?
Karen was complaining about her boyfriend who had justifiably criticized her.

"He dared to say that I was self-centered, inconsiderate and defensive."

"Karen, I know how sensitive you are to criticism, but it's important to learn to take constructive feedback if you wish to have a healthy relationship."

"I told him that he was not my psychologist."

"Being your psychologist hasn't made it any easier for me."
Ms. X: They [her husband, children and parent] say they love and care for me. I appreciate it [here, points to her head], but I feel empty in my heart. Counselor: Intellectually, you know they are there for you. Somehow, it's just not convincingly getting through to you [here, points to heart].

Ms. X: And it makes me feel that maybe I'm really bad. Shouldn't I feel something?

Counselor: Like something's defective or just not good.

Ms. X: I know I'm not evil or something. I just want more and, honestly, they are all so needy. I sometimes think they are only there to get--I mean they're there, but they're really not there for me, or they're there as long as I keep giving, and that's not enough.

Counselor: Let me see if I've got this straight. It seems as if they're present in your life, but not really there for you, and maybe even if they're there, it doesn't make it, it's not enough for you.

Ms. X: Yes, they're really selfish in many ways.

Counselor: You know, this reminds me of a counselor who saw someone who felt the way you do. She felt that no one who was in her life was really there for her. The counselor meant to make her feel better, but it came out wrong. He said, "Well, at least you always have yourself."

Ms. X [laughing] But that's what it's like. They're not really there to give, and I don't feel I'm getting enough in my life.

Counselor: So, what do you think you need to get in order to feel that inside you were getting enough?
Ms. Y: I could never stand that he [her husband] never had the backbone to stand up to them [in-laws]. His father never felt that he would amount to anything, has never liked or accepted me, and they both expect to be treated like royalty when they come here to visit. Counselor: Then, how do you explain the power that your in-laws have held over you and your husband for all these years?

Mr. Y: My father has a lot of money.

Ms. Y: Although no one really knows for sure. And also, he is cheap, so we never see evidence of his wealth except when he has bailed us out.

Mr. Y: Who knows if he still has money?

Ms. Y: I've said to Mr. Y, sometimes I think we may be listening to the "sound of two-coins jingling" around in his father's pocket [she and Mr. Y smile].

Counselor: But, why are you both smiling at that thought? If that is true, it then isn't funny at all. It would be tragic that you have let the possible fantasy of his having money that you would inherit if you played your cards right sabotage your marriage for so many years. Especially if it turns out that he didn't have it.
Ms. A was a 45-year-old divorced, unemployed mother of two preteens, who sought counseling because of depression and substance abuse issues. She was particularly inclined to blame herself for all of her family’s and extended family’s problems. She had grown up in an alcoholic environment and found it difficult to find humor in life’s tribulations and events. At a specific time in the counseling session, the counselor used humor to aid her in appreciating that not all occurrences could be linked in a cause-and-effect way to her. The interaction was as follows:

Ms. A: My children are experiencing all kinds of school problems. The school is thinking of holding my younger son back. I don’t know what to do. I’m sure that it has to do with me. I have made it difficult for my son to do anything.

Counselor: You have made it difficult for your son to do all things personal and academic.

Ms. A: Yes, that’s right. They are nervous, because I am nervous, and I have caused them to not even be able to do their homework. Counselor: Let me try to understand this. You have caused them to be unable to do their homework. Have you broken their arms, not paid the electricity bills, or played loud music in order to distract them?

Ms. A: [Taking the question seriously, and without any humor implied in her response.] No, I haven’t done that. Counselor: Well, could you help me to understand exactly what you did or do to present them from completing their assignments?

Ms. A: Well, it’s nothing specific. They are probably just unhappy to have me as a mother, worried about my relationships. You know whatever. They are not the only ones. My whole family probably blames me for everything. It’s my fault that my brothers don’t like each other and that my mother is sick right now.

Counselor: Have you been watching television lately? The president just went on TV to discuss the economy. I should think that he would have mentioned you directly.

Ms. A: What do you mean by that?

Counselor: Well, it seems to me that you blame yourself. held yourself accountable for everything. Have you considered attributing any inflation worries or depressed economy or global warming or increased terrorist activities all to you? I am surprised that you left those out. [Author’s Note: The counselor used this particular humor in an interventionally rather establishing a strong “working relationship” with this client.]

Ms. A: [For the first time appreciating the humor in the question, he began to laugh and her facial expression lightened.] I guess you are right. I do tend to blame myself for everything. [She continued to laugh.]
VIGNETTES

Paradox

Mr. and Mrs. B had been married for 5 years. They were thinking about having children, but were hesitant to change their lifestyle so dramatically. Both were professionals and had demanding careers and hours to juggle. Recently, Mr. B had become quite suspicious that Mrs. B was being unfaithful to him. He presented alone at a session to explore these feelings. The interaction was as follows:

Mr. B: I don’t know why I think my wife is having an affair. I just do. Counselor: You have no indication, but yet you believe that she is having an affair.

Mr. B: That’s true. She lost a lot of weight recently and has been dressing better for work.

Counselor: You believe that this is unusual for a person to lose a lot of weight and then begin to dress better.

Mr. B: Well, if you put it that way, no but, there’s something else. I just can’t put my finger on it.

Counselor: I am getting a sense that there is something that you want to tell me, but haven’t so far.

Mr. B: I followed her the other Saturday. I followed her for almost the whole day.

Counselor: You trailed her for almost a whole day. That must have been a very difficult maneuver.

Mr. B: It sure was and I am not proud of what I did. As a matter of fact, I feel pretty crummy. I feel like a total cretin.

Counselor: Could you tell me about the experience?

Mr. B: [He then began to describe in detail how he had followed his wife on her Saturday errands. He had found it difficult and had been in “morbid” fear that he would be discovered. He also mentioned that he had followed her into a department store, watched her shop, and then went for a yogurt and to a public restroom facility.]

Counselor: So, you watched her for the entire time until she went into the bathroom. How do you know that she didn’t meet someone in there? I wouldn’t have stopped there—never known. Mr. B: That sounds pretty crazy to follow her into the bathroom. [He began to laugh. He seemed to find the paradoxical intervention humorous and was able to begin to examine some of his other, as he put it, “ridiculous assumptions” about his wife’s dress and demeanor.]
NEXT STEPS

1. Supervision
2. Identify clients who humor would be appropriate for
3. Take calculated risks
4. Add more humor into your own life (movies, books)
5. Think about how humor comes into your own therapy and life
6. Read and learn more!
Appendix B: Presenter’s Notes

1. SLIDE 1: TITLE
   
a. Introduction and credentials
   
b. “We do not take humor seriously enough.” Konrad Lorenz
      
i. Konrad Zacharias Lorenz was an Austrian zoologist, ethologist, and ornithologist. He shared the 1973 Nobel Prize in Physiology or Medicine with Nikolaas Tinbergen and Karl von Frisch.
   
c. Presenter’s interest in studying humor, based on observation, philosophical readings, experiences in therapy as both a counselor and a therapist
   
d. Presented gauges audience interest in therapeutic humor
      
i. What brought you here today?
      
ii. Do not ask about prior experience to avoid creating an “expert” in the group

2. SLIDE 2: AGENDA
   
a. Break before “Benefits” for 30 minutes

3. SLIDE 3: ASSOCIATIONS
   
a. Ask the audience what they associate with therapeutic humor; extract themes
      
i. Benefits?
      
ii. Techniques?
      
iii. Failures?
iv. Considerations?

v. Experiences?

4. SLIDE 4: SUPERVISOR MESSAGES

   a. What did your supervisors say or suggest?

   b. How is seriousness reinforced in supervision?

      i. What type of reinforcement and punishment is used?

      Smiles? Frowns? How do supervisors question your skill

      and judgment, and approve of it?

   c. Historical threads (Freudian) that made therapy such a serious

      process

   d. “Let us keep [humor in life] by acknowledging that one place

      where it has a very limited role, if any, is in psychotherapy.” Kubie

   e. Presenter talks about their own preconceptions, especially as they

      relate to the culture of therapy and supervision

5. SLIDE 5: OPINIONS

6. SLIDE 6: YOUR EXPERIENCES

   a. How many have used it?

   b. Did it help? How?

   c. Has it ever backfired?

   d. Does it feel natural?

   e. How about in your own therapy?

7. SLIDE 7: DEFINING HUMOR
a. German *Brockhaus Encyclopedia*: “a serenity not disturbed by thoughts. It may . . . achieve a harmonic reconciliation of the otherwise irreconcilable, playfully, from the distance of an aesthetical attitude. Humor encounters human weaknesses and the difficulties of human existence with a benevolent, understanding smile.”

b. Relief theory – humor discharged tension and anxiety

c. Superiority theory – we laugh at others misfortunes to feel better

d. Incongruity theory – we laugh when concepts and things don’t align correctly

8. SLIDE 8: LAUGHTER

a. Humor tends to trigger a behavioral response called laughter.

Laughter can elevate endorphin and enkephalin levels in the brain (Weeks, 2000).

b. Laughing is an involuntary, physical reaction in humans, consisting typically of rhythmical, often audible contractions of the diaphragm and other parts of the respiratory system.

c. Laughter is regulated by the brain

9. SLIDE 9: OTHER ENDORPHIN TRIGGERS

a. Endogenous opioid peptides that function as inhibitory neurotransmitters.

b. Produced by the pituitary gland and the hypothalamus in vertebrates during exercise, excitement, pain, spicy food.
consumption, love, and sexual activity, and they resemble the opiates in their abilities to produce analgesia and a feeling of well-being.

10. SLIDE 10: HISTORY

a. Early proponents have come from psychodynamic and rational-emotive schools of thought

b. Psychodynamic

   i. Freud: humor could be used to discharge sexual and aggressive drives that would otherwise be stifled and even told jokes during therapy.

   ii. Mooney: humor is an unconscious, benevolent way to provide relief from psychic tensions in the form of a joke.

      1. Think about jokes about your in-laws or your spouse

   iii. Grotjahn: “the therapist’s own humor arises as a spontaneous reaction and should be expressed because humor signifies emotional freedom and maturity.”

      1. humor could help model emotional freedom

   iv. Kohut (1971) viewed the presence of humor as a sign of effective psychoanalysis.

c. REBT

   i. Ellis: routinely incorporated humor into his therapeutic practice
ii. Still used to help their clients identify irrational beliefs

iii. Humor is used intentionally and by design (rather than spontaneously) by REBT therapists

d. Backlash

i. Psychoanalysts viewed humor with skepticism and cynicism, believing that humor was a form of resistance that demanded interpretation of its defensive function.

ii. Conversely, a therapist’s use of humor was viewed as collusion

iii. Rooted in the belief that a therapist should avoid acknowledging shared feelings in therapy, especially feelings of amusement and pleasure.

iv. Kubie: “Let us keep [humor in life] by acknowledging that one place where it has a very limited role, if any, is in psychotherapy.”

v. Zillmann: characterized humor as malevolent, lumping together friendly humor and cynical, sarcastic humor.

e. Very little empirical studies on humor. Most of what we think is based on anecdote. Some studies from the medical/nursing field.

11. SLIDE 11: THERAPEUTIC HUMOR

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

b. What dimensions does this definition carry?

12. SLIDE 12: BREAKDOWN

13. SLIDE 13: BREAKDOWN 2

a. An intervention: Using humor in the context of psychotherapy should be regarded as an intervention, tantamount to other interventions advocated in other modalities. It also suggests the possibility of using humor as a specific intervention for specific types of challenges presented by patients such as over-seriousness, obsessive thinking, or clinging to maladaptive narratives.

b. Promotion of health and wellness, whether cognitive, emotional, social, or spiritual. Humor in therapy is used only to help clients, never to put them down or simply for the amusement of the therapist. Also, humor can be used to enrich a client’s spiritual life. This is one of the defining differences between therapeutic humor and non-specified humor.

c. A focus on the absurdity of one’s life situation. Humor is a tool to help expose and find enjoyment in the incongruities of one’s circumstances. More importantly, the therapist must be able to adequately flesh out the client’s dilemma in order to expose the
absurdities and paradoxes that are embedded in it. Thus, humor is therapy actually born out of a client’s suffering (i.e., their tense life circumstance), rather than outside material.

d. How has humor served you, therapeutically, in your own life?

14. SLIDE 14: OTHER FACTORS

a. *Existential*: Mindess: “[d]eep, genuine humor…that can be instrumental in our lives extends beyond jokes, beyond wit, beyond laughter itself to a peculiar frame of mind. It is an inner condition, a stance, a point of view, or in the largest sense an attitude to life.”

b. *Universality*: Fabian: “Humor is a natural and universal form of interpersonal contact that stands beyond cultural traditions,”

c. *Wisdom*: Poland: “The capacity for humor linked to wisdom about the world is available in varying degrees to all of us,”

d. *Territoriality*: Fabian & von Bulow: an ego function related to ego demarcation and curiosity, specifically with regard to people and one’s surroundings.

e. *Types*: Franzini: Therapeutic humor can be spontaneous or planned

f. Which aspect renovates most with you?

15. SLIDE 15: FUNCTIONAL DEFINITION

16. SLIDE 16: SENSE OF HUMOR

a. 2 aspects

b. Which is more important for therapists? Answer: both
17. SLIDE 17: LAUGHTER
   a. Walk audience through diagram

18. SLIDE 18: MEDICAL BENEFITS
   a. Medical/General
      i. Medically, humor has been shown to alleviate pain and increase quality of life in terminal patients. Socially, humor can expand one’s network of friends. Physiologically, humor has been demonstrated to release endorphins and assist in cellular health, and psychologically, humor can help combat stress.
      ii. Recent empirical study, researchers interviewed bereaved participants 6 months post-loss. Those that displayed laughter in the interview also showed increased psychological distance from the loss, reduced anger, increased positive affect, and enhanced social relationships.

19. SLIDE 19: ASSESSMENT
   i. Reynes & Allen: in their own practice, they would ask new clients to tell their favorite joke during therapy as a means to gain insight into their anxieties and the obsessive themes in their lives
   ii. Examples in their work of individuals joking about impotence and cheating, only later to reveal that their
neuroses centered around these 2 issues. Supporting this approach,

iii. One good way to collect data about a client is to see what makes them laugh, since their humor provides clues about their anxieties.

20. SLIDE 20: DYADIC/RAPPORT

a. Think about your friends. Do you have any friends with whom you don’t laugh?

b. Improve rapport

i. The main component of therapy that stimulates change is the therapeutic relationship.

ii. Humor and laughter can be used to share positive emotions in a therapy room where sadness and hardship prevail.

iii. Humor can also be used to discharge anxiety involved with disclosing shameful thoughts and behaviors. (link to Relief Theory of humor)

iv. Fabian: humor, whether verbal or nonverbal, can help the client establish confidence in the therapist

c. Dissolve roles and conceptions of the perfect therapist

i. Humor demonstrates to clients that the therapist is, after all, human, and gives clients permission to use humor in their own lives

ii. Especially true for slightly self-deprecating humor
d. Dissolve preconceptions about therapy
   i. Challenge clients’ notions about the therapeutic process itself and its presumed formality and seriousness

e. Dissolve preconceptions about life
   i. Humor in therapy could also help erode beliefs that one is not allowed to laugh in therapy, fostering the client’s ability to laugh in other areas of his or her life that also harbor taboos

f. Corrective experience via the therapist relationship
   i. Humor as a social lubricant

21. SLIDE 21: COGNITIVE RESTRUCTURING

   a. Cognitive and affective changes can be divided into two main categories: those affecting the client’s general outlook on life (i.e., influence core schemas) and those that target specific anxieties and issues (i.e., transient, immediate dilemmas)

   b. Humor can help individuals see the world differently and see their problems differently

   c. Transforming stress into joy

   d. Humor requires understanding, which implies empathy, a curative factor for therapy

   e. Humor lets clients accept their situation in a humorous way

   f. Broaden schemas to see a tense situation differently.

   g. Example: a client who’s facing a dilemma at work such that his boss has propositioned him for sex and the client fears that if he
doesn’t follow through, he’ll lose his job. Given a strong relationship, a therapist could say “well, it sounds like you’re screwed either way.”

h. What does a humorous perspective on life look like?

i. What other ways can it be developed? (movies, television, reading, comedy shows)

22. SLIDE 22: EXPANDING AWARENESS

a. Tools: bantering, exaggeration, and playfully caricaturing clients

b. Shame cannot exist within the humorous field

c. In a humorous space, shameful facts become reinterpreted as funny or ironic

d. Humor allows clients to admit what they are denying to themselves because the cost of honesty is reduced as shame is abated

e. Jack Story “With patients whose hostility leads tem to see hostility in those around them, the ‘Jack Story’ has often been effectively used. This is the story of the driver whose car suffers a flat tire, finds he has no jack, and walks back to a house he has passed to borrow one. As he walks back he muses that the occupant will consider him to be stupid and will certainly refuse to lend him the jack. When the doorbell is answered, the driver hits the occupant who has asked, ‘Can I help you.’”

i. Humor is used to expose and caricaturize the client’s hostility
f. Catharsis
   i. Why do we laugh after we cry?
      1. Endorphins
      2. Discharging emotion
   ii. Humor is a good bridge between high-arousal states and normal life

23. SLIDE 23: BURNOUT PREVENTION
   a. Laughing helps prevent therapist burnout!

24. SLIDE 24: INTERVENTIONS
   a. Paradoxical Intention
   b. Irreverence

25. SLIDE 25: INTERVENTIONS 2
   a. Systematic Desensitization
   b. Group Work

26. SLIDE 26: RISKS
   a. “As with the case of copulating porcupines, such a union [between humor and psychotherapy] although potentially productive, should be consummated very carefully.” Bernard Saper
   b. What other risks abound?

27. SLIDE 27: VIGNETTE 1
   a. How could humor have been used?

28. SLIDE 28: VIGNETTE 1b
   a. How was humor used in this case?
b. What was the effect of the humor?

c. How did it help?

d. How could it have gone wrong?

29. SLIDE 29: VIGNETTE 2b

a. How was humor used in this case?

b. What was the effect of the humor?

c. How did it help?

d. How could it have gone wrong?

30. SLIDE 30: VIGNETTE 2b

a. How was humor used in this case?

b. What was the effect of the humor?

c. How did it help?

d. How could it have gone wrong?

31. SLIDE 31: VIGNETTE 3

a. How was humor used in this case?

b. What was the effect of the humor?

c. How did it help?

d. How could it have gone wrong?

e. How do you use humor to overcome resistance?

32. SLIDE 32: VIGNETTE 4

a. How was humor used in this case?

b. What was the effect of the humor?

c. How did it help?
d. How could it have gone wrong?

33. SLIDE 33: VIGNETTE 5
   a. How was humor used in this case?
   b. Who was it used by?
   c. What was the effect of the humor?
   d. What was it being used for?
   e. How did the therapist address it?

34. SLIDE 34: VIGNETTE 6
   a. How was humor used in this case?
   b. What was the effect of the humor?
   c. How did it help?
   d. How could it have gone wrong?

35. SLIDE 35: VIGNETTE 7
   a. How was humor used in this case?
   b. What was the effect of the humor?
   c. How did it help?
   d. How could it have gone wrong?

36. SLIDE 36: VIGNETTE 8
   a. How was humor used in this case?
   b. What was the effect of the humor?
   c. How did it help?
   d. How could it have gone wrong?

37. SLIDE 37: NEXT STEPS