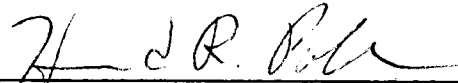


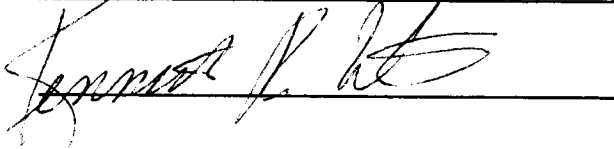
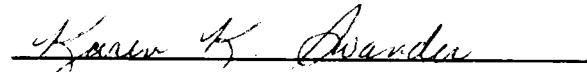
To the Graduate Council:

I am submitting herewith a dissertation written by Jacquelynn Ferguson Martin entitled "Humor in Therapy: An Observational Study." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.



Howard R. Pollio
Major Professor

We have read this dissertation
and recommend its acceptance:



Accepted for the Council:



Vice Chancellor
Graduate Studies and Research

HUMOR IN THERAPY: AN OBSERVATIONAL STUDY

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Jacquelynn Ferguson Martin

June 1983

ACKNOWLEDGMENTS

There are many people to whom I owe thanks for helping me with this project. Without their faith, encouragement, and playful teasing, this task would have been more burdensome.

First, I would like to thank the therapist who so warmly and freely gave of her time, energy, and expertise. I greatly appreciate both her and the client's willingness to let me observe their therapeutic endeavor. To Amal Barkouki, Janet Bach, Susan Barkhurst, and Valerie Zaidel, I would like to express my deep gratitude for their efforts in the massive undertaking of collecting, analyzing, and compiling the data. I am still amazed and thankful that they were willing to give so much.

My committee members were wonderfully understanding of the extra burden of completing a dissertation from so far away. Special thanks to Howard R. Pollio for introducing me to psychology, supporting all my academic endeavors, and tolerating my bitches and complaints; to Kenneth R. Newton for being my teacher, supervisor, and so much more: a very special friend; to Karen K. Swander for helping me keep sane during the final stages and providing for me an exciting example of what a woman in this profession can be; and to Robert Wahler for his easygoing thoroughness and genuine interest in the research.

With a sigh of relief, I toast my dear friends who went before me, then pushed, pulled, and teased me into joining them. Joyce Diftler, Johanna Mayer, Kitty Moore, and Terry Wissler, your concern and support has been wonderful, both through this endeavor and in my life in general. Also the same thanks to Tim Vettel, who additionally made this whole process more fun with his challenges and, who, when I lost the first time, gave me a second chance.

Last, but not least, I thank my parents, Nina and T. I., who started this whole thing. Thanks for giving me the raw material necessary, a belief in myself, the stubbornness to see it through, and your willingness to let me "do it myself."

ABSTRACT

The purpose of the present study was to examine the occurrence of humor in an individual therapeutic relationship. Empirically, humor has been studied in a variety of group settings and has concerned the following issues: frequency of targeted and nontargeted humor; choice of target; relationship of targeting to being targeted; and frequency and nature of "negatively" and "positively" toned humor.

To obtain data on the natural occurrence of humor in a therapeutic dyad, one complete, seven session, therapy was videotaped. Three raters independently viewed the videotapes and identified instances in which they thought someone had attempted to be humorous. For those instances, the same raters also independently judged whether the humor was targeted or nontargeted; positively or negatively toned; and targeted at self, other, or generalized other. They also determined the subject of the humor and impact of the humor on nine variables, including anxiety, intimacy, and defensiveness. The percentage of time talked and the occurrence of laughter by each participant were also noted. The therapist and client were also interviewed as to their perceptions of humor in this therapy.

The results indicate that humor was a frequent and important behavior. Although the client produced more humorous attempts than the therapist; when considering amount of time talked, the therapist produced about three times as many humorous attempts. The large percentage of targeted remarks seemed to indicate an intense and intimate relationship. The target and topic of humor, produced by both therapist and client were predominantly the client and his concerns. According to raters and participants, alike, the "negatively" toned humor was not destructive; rather it seemed to help establish rapport, facilitate new perspectives, and decrease defensiveness. The only humor not encouraged by laughter or smiling was some client initiated humor in response to which the therapist chose to emphasize the serious, underlying content. Finally, results indicate that humor can be useful therapeutically. However, because appropriate, successful humor is contextual and spontaneous, therapists should allow and encourage humor to emerge naturally rather than artificially injecting it.

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CHAPTER I

INTRODUCTION

It seems a pity that some psychoanalysts avoid the potentially valuable option of humor as a communicative device, especially in view of the fact that it can foster a parallel, constructive capacity in the patient as well.

John L. Schimel, 1978, p. 378

Psychotherapeutic schools of thought are multiple, as are the therapeutic approaches taught to and used by therapists. Numerous debates, some congenial and some not so congenial, have been argued about which approach is the most efficacious. For all these differences, however, most therapists agree that the basic aim of the therapeutic endeavor is to facilitate movement from constricted and rigid patterns of defensive operations towards more flexible, adaptive, and meaningful ways of living.

Psychological dysfunction can be characterized by defensive operations that so constrict the range of behavior that the individual becomes alienated from naturally occurring feelings and from other people.

The basic situation in neurosis is that of life lived in isolation; it is a state of being "narrowed in," working one's course within narrow confines, not daring to move out into the wider areas that could be encompassed by personal life. (Angyal, 1965, p. 76)

While the specific rigid modes of defense vary (e.g., the ritualistic behaviors of compulsives, the constant and pervasive distrust of paranoids, the continual attempts of hysterics to please others, and the habitual withdrawal of schizoids) the basic issue of inflexibility remains the same.

Singer (1965) describes the psychotherapeutic process as the facilitation of the person's movement from pseudo-activity, employed to maintain the illusion of life and growth, to genuine activity, the capacity to be open to new experiences, to be surprised, and to grow and develop from new experiences. Such genuine activity necessitates flexibility. To be open to new experiences requires the person to tolerate ambiguity and uncertainty, to modify schematizations and to allow new perceptions and behaviors. Thus an important aspect of the therapeutic process is the successful expanding of the client's narrow conceptualization of the world and the concomitant, restricted behaviors and interactions. While letting go of this stalwart, if narrow, view of reality, the client also needs to utilize a creative capacity to integrate new awarenesses and develop new behaviors.

If the aim of therapy is to broaden the person's capacity to integrate new experiences, to foster freedom from the self-maintained prison of an underdeveloped

potential, and to increase the capacity for genuine relatedness with others, it would seem that humor would be an obvious and natural agent for the therapist. Humor with its capacity to surprise, redefine one's "reality," and establish intimacy, can be a subtle and powerful interpersonal experience, one well worth exploring further as an ingredient in a successful therapeutic relationship.

Humor and laughter have been acknowledged as important interpersonal events since the time of Plato with innumerable theorists expounding upon different aspects, intents, and effects of these intriguing human behaviors. Bergler (1956) summarizes "a mere eighty" of these theories. Being magnanimous, he stopped short of a complete compilation as he did not ". . . wish to interfere with the countless Ph.D. theses of the future which will deal solely with their enumeration." Although grateful for his generosity, the present work will not attempt to enumerate theories; rather, it will focus on a specific aspect of humor in a specific context.

Although the subject of humor is intertwined with that of formal jokes, practical jokes, laughing, and smiling, this study will be limited to spontaneous, intentional attempts to be humorous in a therapeutic setting as well as to laughter occurring within that setting. The occurrence of such humorous attempts by both client and therapist has

been acknowledged and discussed by numerous therapists (Freud, 1916, 1928; Grotjahn, 1957; Kohut, 1971; Kubie, 1971; O'Connell, 1978; Orjanidis, 1972; Poland, 1971; Rosenheim, 1974; Whitaker, 1975; Zuk, 1963, 1964, 1966). Though many therapists have theorized about the meaning and usefulness of this event in the context of therapy as well as reporting anecdotal data, no one has systematically observed and described its occurrence in the context of an individual ongoing therapy.

Statement of Purpose

The objective of this study will be to look at the natural occurrence of laughter and humor production by both therapist and client in the course of a seven week therapy in order to describe this behavior and to gain an initial understanding of its therapeutic aspects. Using methods developed by Childs (1975), Peterson and Pollio (1982), Scogin and Pollio (1980), Swander and Martin (1975), and some, newly developed for this research, humor production and laughter will be observed from a variety of perspectives. Rather than look only at the behavioral, "objective" aspects or at the experiential, "subjective" aspects, this research will include both. Looking at both the directly observable and the experiential, or inferred, aspects will give a fuller and more useful description and understanding of this phenomena.

The directly observable occurrence of laughter and the slightly more subjective detection of attempts to be humorous will be identified by raters. These raters will also code such attempts at humor into categories. This information will be used to detect patterns of laughter and humor production.

Previous studies of laughter and humor in group contexts have reported relationships between various factors. There were differences between the type of humor produced by different types of groups with differing levels of intimacy and differing group functions (Scogin & Pollio, 1980). Another relationship was noted between the type of humor and the change in level of therapeutic interaction in a therapy group (Peterson & Pollio, 1982). Thirdly, there seemed to be a relationship between the frequency of making someone the target of a joke and the frequency of being made the target of someone's joke (Childs, 1974; Scogin & Pollio, 1980). The affective tone of targeted jokes was found to be predominantly negative in five of the six groups examined (Scogin & Pollio, 1980). These patterns will be examined to see how they relate to those found in this set of individual therapy sessions.

In addition to expanding the previous work done describing humor in groups to include the humor found in individual therapy, this study will also look at additional

aspects of humorous interactions. The relationship between content of the humor and the major content issues of the therapy. Raters will observe the extent to which humor is used to emphasize or distract from certain topics. They will also judge the impact of the humor on other variables important in the therapeutic process.

Finally, this study will take into consideration the participants' and researcher's understanding of the role humor played in their interaction. For this purpose, the therapist and client were asked their perceptions of and reactions to the humor that occurred in the therapy sessions. Specifically the therapist, client, and researcher described their understanding of the meaning and their perception of the impact of the occurrences of humor.

As has been indicated in previous studies reported by Pollio (1980, pp. 150-152), humor occurs in the context of interpersonal relationship and is context bound. Therefore, perceptions of, impact of, and usefulness of laughter and humor can vary from person to person; from situation to situation. This study looks at two people in the specialized context of a therapeutic relationship. Because of this fact, this study should be seen as an initial look at humor and laughter in therapy and an addition to the information gathered regarding the interactional and therapeutic aspects of humor.

CHAPTER II

A REVIEW OF THE LITERATURE

A flourishing sense of humor is fundamental to mental health. It represents a source of vitality and a means of transcendence second to none.

Harvey Mindess, 1971, p. 51

Adaptive Functions of Humor for the Individual

Humor is a significant aspect of human behavior. Numerous therapists have recognized the importance it can play in the psychological functioning of the individual. From Freud's (1928) description of humor as the ego's triumph over a painful reality without sacrificing sanity to Cousin's (1977) assertion that humor is a critical component of the healing process, humor has been acknowledged as a potentially powerful transaction related to a diversity of abilities, characteristics, and attitudes.

Generally theorists who have discussed the relationship of humor to psychological functioning think it is an important aspect of a healthy personality. As Levine points out, "The reason why the possession of a good sense of humor can be an important index of good mental health is that it implies certain abilities and attitudes" (1963, p. 789). These adaptive abilities and attitudes can be divided into four broad groups: coping with insoluble situations without

succumbing to hopelessness; clearly perceiving and accepting one's own characteristics, both positive and negative; enhancing creativity and problem resolution; and aiding in the healing process and the maintenance of health.

Coping with Insoluble Problems

The ability to cope with insoluble problems and painful situations is an extremely important function of humor. When faced with the inevitability of a grim situation, a person must have some way of coping to forestall feeling overwhelmed and giving up hope. This is epitomized in the uniquely human dilemma created by the foreknowledge of death. While comprehending the ultimate powerlessness with which we all face death, each person must maintain some sense of mastery of life and reason for living. Humor, with its capacity to suspend reality without denying it, is particularly well suited for this task.

In 1938 after terrifying harassment from the German government, Freud was allowed to leave Austria if he agreed to sign a document stating he had been treated with respect, been given full scientific freedom, and had found full support from the German authorities, particularly the Gestapo. Jones (1961) reports that Freud signed the document, making the request to add the following, "I can heartily recommend the Gestapo to anyone."

Such a ludicrous statement in the face of potential danger is an example of what Freud called gallows humor: the humorous attitude ". . . by means of which one refuses to undergo suffering . . ." (Freud, 1928, p. 3). In contrast to other ego defenses against suffering, Freud (1928) saw it as superior because it repudiated suffering ". . . without quitting the ground of mental sanity . . ." (p. 3). In other words, it repudiated suffering without denying or distorting the reality.

Other theorists concur with Freud's perception of humor as a means of maintaining a sense of self, a sense of integrity and a sense of hope when confronted with situations that seem intolerable. This capacity to transcend is, perhaps, best described by Victor Frankl (1963) in his discussion of the importance of humor in the Nazi concentration camps.

Humor was another of the soul's weapons in the fight for self-preservation. It is well known that humor, more than anything else in the human make-up, can afford an aloofness and an ability to rise above any situation, even if only for a few seconds. (p. 68)

Jourard (1963) also sees humor as supporting the assertion of human potential, when he writes, "When a person can laugh even in potentially grim situations, it implies some degree for freedom from the press of fate and circumstances" (p. 102).

This capacity to rise above the circumstances is no small matter. Such hope and transcendence creates the impetus to keep living, to keep trying, and possibly to live through or change the situation. Even if an external change of circumstances is never affected, humor may affect the quality of life. By a continual refusal to succumb to hopelessness or degradation one can maintain one's dignity and sense of self-worth. As May (1969) says, "Humor normally should have the function of preserving the sense of self. It is an expression of our uniquely human capacity to experience ourselves as subjects who are not swallowed up in the objective situation" (p. 54).

While distinguished as a defense capable of maintaining sanity and affirming humanity in heinous situations, humor is also recognized as an effective antidote for more typical yet grievous difficulties. In his longitudinal study of adult male psychological functioning, Valliant (1977) categorizes humor as one of the five mature defenses.

Humor is one of the truly elegant defenses in the human repertoire. Few would deny that the capacity for humor, like hope, is one of mankind's most potent antidotes for the woes of Pandora's box. (p. 116)

Levine (1963) maintains that humor is important in dealing with the frustrations of life.

To have a sense of humor implies . . . that the individual does not take the situation too seriously and is able to approach it with some detachment and playfulness . . . that the

individual can accept the incongruous and the ridiculous without being disturbed by it.
(p. 788)

There are multiple situations in life where an individual must tolerate ambiguity and act in spite of uncertainty. Humor's tendency to deflate the seriousness of a situation and approach it with a more playful attitude is crucial in creating a broader and more wholesome perspective. Without the levity humor provides, the tendency to become lost in the trivial increases.

. . . the ability to see the funny side of things and to laugh at ourselves and our troubles is an asset of the greatest magnitude. It can help us contend with adversity, derive greater joy out of living, and maintain our sanity. (Mindess, 1971, p. 10)

Perceiving and Accepting One's Self

Closely related to this increased capacity to tolerate painful situations, a humorous attitude affords the ability to look at one's self more honestly. With a humorous posture a person can look at faults without the usual accompanying pain and shame that makes self examination so difficult. Humor facilitates this in two ways: a change in perspective and acceptance.

By gently laughing at one's own foibles, a person can take comfort and support in joining with others in their perceptions. The act of poking fun at one's self moves the individual from being closely identified with a certain

personal and painful aspect to joining others in appreciating the humor in the whole situation.

This change in perspective, coupled with the acceptance offered by humor, takes the sting out of the awareness of personal faults. The individual is not only comforted by an alliance with others but also has achieved a more accepting attitude toward humanity. "Learning to laugh with others at one's self . . . helps to objectify one's characteristics . . ." (Allport, 1927, p. 580). Kaplan (1965) goes so far as to describe this role of humor as being the sine qua non of therapeutic progress. It allows the person to give up the illusion that perfection is possible and, thus, to relax from the serious struggle to achieve it. It is through such acceptance that people can afford to see themselves completely, good and bad, and thereby free themselves from maintaining a facade of perfection.

An example of the freeing aspect of humor occurred during a supervision session at the Palo Alto Veteran's Administration Hospital with Dr. Donald Nehr. In discussing the fear people experience during the self-exploration of therapy, he commented, "In my own therapy I was petrified that once I quit avoiding and distracting, I would discover that I was rotten to the core." "But you finally took the plunge and found out you were not so bad after all!" finished his supervisee. "Oh, no," he replied, "I took the

plunge and found out I was right all along. I am rotten to the core. But what a relief not to have to worry about it anymore!"

Enhancing Creativity and Problem Resolution

Humor is also related to the capacity to think creatively. Creative thinking necessitates the ability to relax the constraints of a situation or problem and to synthesize discrepancies in a novel manner. This freedom of thought involves the same process that occurs in producing a humorous remark or in comprehending a joke. Koestler (1949) says, ". . . an investigation of the specific type of mental activity involved in the creation of comic stimuli will lead us to the very core of the process of creative thought itself" (p. 15).

He attributes humor, as well as other forms of intellectual creativity, to a process he calls "bisociation." In this process, a situation or event is simultaneously perceived in two habitually incompatible contexts. This juxtaposition of two mutually exclusive fields requires an expansion of the habitual thought patterns to encompass these two independent concepts. It may ". . . signify a revolutionary departure from traditional patterns of thought, a creative synthesis between two fields, between hitherto unconnected aspects of the phenomenal world: in

other words it may enter the services of invention and discovery" (1949, p. 52).

Mindess (1971) concurs that humor is closely related to creative thinking. In describing humor, he observes, ". . . it pries us loose from encrusted ruts of thinking and invites us to skip along on novel pathways of the mind. It is in this respect that humor paves the way for originality on a wider scale" (p. 154). Thus, the freedom to enjoy and produce humor can be seen as both a creative process in and of itself, and a catalyst for unconventional and imaginative thinking.

In the psychoanalytic literature, ". . . creativity--the ability to meet life's demands with other than previously learned solutions--is the essence of adaptation" (Bellack et al., 1973, p. 180). This ability was first described by Ernest Kris (1936) as "regression in the service of the ego" and encompasses various creative processes, such as humor, productive fantasy, problem-solving, artistic creativity, imaginative processes, and the therapeutic process. Regression in the service of the ego is the partial, temporary, and controlled regression to a primary process level in order to enrich the individual's functioning by introducing less conventional material from preconscious levels of awareness.

Schafer (in Lindzey, 1958) enumerates six conditions in the personality that favor regression in the service of the

ego. Among these are a secure and well-defined sense of self, relative mastery of early trauma, a mild rather than severe superego, and a history of trust and mutuality in interpersonal relations. Thus, according to Schafer a psychologically healthy individual is more likely to utilize a creative and potentially humorous approach to life than is a person with less adaptive, more rigid defenses.

Needless to say, humor can also be utilized to distract from the dilemma at hand. By commanding attention, it may refocus an individual or group away from the problem to be solved, and thus hamper the creation of a solution. As with all behavior, the impact of humor in any given situation is dependent on many variables. This does not negate the fact that a humorous approach can facilitate creative thinking.

Pollio and Bainum (1980) looked at the effects of humor on two types of problem-solving tasks: a closed-system task defined by a finite number of solutions and an open-system task defined by the need for the problem solver to go beyond the information at hand. The first was an anagrams task and the second a NASA task requiring the participants to rank order 15 items as to their importance for survival after a crash on the moon. The results show that humor production per se had no consistent effect on problem solving for either task. The pertinent variable was the subject of the humor.

When the witty remark was directly related to the ongoing problem . . . it served to facilitate problem-solving. When, however, a witty remark did not relate to the task at hand its primary consequence was that of distracting the group: a condition serving to decrease problem-solving efficiency. (p. 20)

Several other empirical studies support the theory that humor can facilitate creativity. Ziv (1976) found that children who enjoyed humorous activity before taking a test that taps creative or divergent thinking manifested more creative thinking than those who did not. Smith, Ascough, Etting, and Nelson (1971) found that humor facilitated the learning process of students with high levels of anxiety.

Smith and Goodchilds (1963) and Goodchilds and Smith (1964) found that subjects in their studies who were deliberately humorous also demonstrated greater problem-solving efficiency. Being witty and being creative were also found to be positively correlated in research done by Smith and White (1965). They found that people who were intentionally witty scored higher on tests of creativity and did better on problem-solving tests than did people who were not intentionally witty.

Getzels and Jackson (1962) and Treadwell (1970) found in highly creative children and in highly creative undergraduate students, respectively, a better sense of humor than their peers had. As Ziv (1976) hypothesized ". . . laughter following humor has a liberating effect on the flow of ideas" (p. 319).

Aiding in the Healing Process

Recently the relationship between good health and humor has been rediscovered. Norman Cousins's (1977) best seller recounted his bout with a serious degenerative disease and was an example of the reawakening awareness of the importance of humor. Another is a book by Raymond Moody (1978), a physician who described the healing aspects of humor. Moody wrote that laughter and humor have been recognized as health-giving throughout the ages. He reported that Henri de Mondeville, a medieval physician who lived from 1260 to 1320, recommended that surgeons should foster their patients' joy and happiness by ". . . allowing his relatives and special friends to cheer him, and by having someone tell him jokes . . ." (1978, p. 29). Many other medical prescriptions for humor were enumerated in his book, including Proverbs 17:22, "A merry heart doeth good like a medicine: but a broken spirit drieth the bones."

Albert Schweitzer was another proponent of the importance of humor. He often used humor ". . . as an equatorial therapy, a way of reducing the temperatures and the humidity and the tensions" (Cousins, 1977, p. 82). Cousins reported that Schweitzer believed a good sense of humor and a job to do was the best medicine for any illness he might have.

Cousins personally testified to the efficacy of a good sense of humor as medicine. In 1964 his doctors told him

his chances of full recovery from his degenerative disease of the spinal connective tissues was one in five hundred. Reasoning that if negative emotions could produce negative chemical changes in the body then positive emotions should produce positive changes, he utilized his good sense of humor as an integral part of his treatment plan. Purposefully capitalizing upon his ability to enjoy and produce humor along with a regimen of large doses of vitamin C and a curtailment of aspirin, Cousins overcame his disorder.

Although there is no definitive answer to why or how humor can be instrumental in creating good health, the fact remains that humor is recognized as an aspect worthy of note. It seems quite logical to assume that humor, either appreciated or produced, can be a significant beneficial aspect of a person's sense of health and well-being.

Therapeutic Aspects of Humor

Although there is some sharp disagreement as to the appropriateness of a therapist's use of humor, psychologist's who have considered the role of humor in therapy concur that its production in a therapy session, by either therapist or patient, is an important and meaningful event. Numerous theorists have examined the various social/communicational functions of humor: including the management and resolution of conflict, (Stephenson, 1951; Hammond,

1964; Levine, 1963; Martineau, 1972; Radcliffe-Brown, 1952; Bradney, 1957), the release of tension (Miller, 1967; Levine, 1963; Zuk, 1966; Martineau, 1972); the indirect expression of hostility (O'Connell, 1960; Levine, 1963; Martineau, 1972), the denial of pain (Levine, 1963; Coser, 1959; Zuk, 1966; Grotjahn, 1957; O'Connell, 1960), and the promotion of interpersonal solidarity and intimacy (Miller, 1967; Coser, 1959; Levine, 1963; Kaplan & Boyd, 1965; Martineau, 1972; Davis & Farina, 1970; Klapp, 1950).

Although most of the interest in humor has been with regard to its social function in a group, it is obvious that these functions must also come into play in any interpersonal context, especially that of the therapeutic relationship. As Goodchilds (1972) stated, "Being witty-impromptu in situ, . . . is a form of human behavior . . . that has immediate impact in an ongoing interactive sequence . . ." (p. 174).

The role of humor in therapy can be divided into several different aspects. Humor can be used as a diagnostic tool to aid the therapist in understanding the patient, the therapeutic relationship and/or the progress being made by the patient. Humor is also used as a therapeutic tool to relieve tension and anxiety, to develop interpersonal closeness and trust between client and therapist, to circumvent the client's defensive and

unnecessarily limiting modes of coping, to help the client create a new and more functional perspective of himself and his problems, and to manage conflict and hostility in a productive manner. Each of these possible uses of humor in therapy will be discussed, as will some possibly destructive aspects of the therapist's use of humor.

Using Humor as a Diagnostic Tool

Examining the client's use of humor can be an extremely rich and illuminating source of information about the client's world. Psychoanalytic therapists view jokes and humor production as the symbolic or disguised expression of repressed material. As in dreams and slips of the tongue, humor production allows expression of that which is unacceptable to the ego and thus can be analyzed, in a manner similar to dream work, to gain access to unconscious motivations and conflicts. Rosenheim (1974), Coser (1959), Hes and Levine (1962), Freud (1916), Grotjahn (1957), and Zuk (1963, 1964, 1966) all discuss the use of the client's humor as a guidepost to defining the issues currently restricting the client's capacity to deal effectively with life. Even from a non-Freudian point of view, humor is still viewed as useful in defining problematic areas in a client's life by virtue of the fact that quite often joking and laughing are used to distract attention from a subject or redefine the attitude with which the subject is regarded

from one of seriousness to one of frivolity. Thus, the very issues joked about may be the ones that are hardest for the client to talk about directly.

Grotjahn (1957) also talks about the information available in the exploration of forgotten jokes. As with other lapses of memory, Grotjahn suggests that the forgetting of a joke or its punch line is indicative of latent unconscious conflicts aroused by the joke. Using the framework that jokes are appreciated due to their socially acceptable expression of unacceptable impulses, Zwerling (1955) used the client's favorite joke as an interview technique to ascertain areas of anxiety or conflict. In a more formalized but conceptually similar technique, Strother, Barnett, and Apostalakos (1954) used cartoons as a projective technique for defining inner conflict and problem areas. Redlich, Levine, and Sohler (1951) also used cartoons diagnostically. They see disturbances in the client's responses to the humorous cartoons as indicators of maladjustment and inner conflict. These disturbances can take the form of not understanding the point of the cartoon, of misperceiving details in the cartoon, or accepting and rejecting different types of cartoons as humorous.

O'Connell (1969) proposes a hypothesis to explain the relationship between appreciation of a humorous incident and the degree of conflict regarding the content of the joke.

Using a continuum from highly conflictual and repressed to resolved, he plots the level of overt enjoyment and laughter. The greatest amount of appreciation is found midway between those extremes in the area of awareness and working through of conflictual material. At either end of the continuum there is little enjoyment of the humor. In an earlier study, O'Connell (1960) found support for the idea that conflictual areas can be located through response to humorous stimuli. Specifically, he found that in a non-stressful situation maladjusted individuals appreciated hostile wit more than did those with a better level of adjustment. This implies that enjoying hostile wit more than most people could be indicative of some inner conflict with regard to their own experience of hostility and/or its expression. It is important to note, however, that this finding was reversed in the stressful situation, thus implying that well-adjusted individuals can make use of hostile wit in a stressful situation, whereas maladjusted individuals tend to lose this capacity for tension reduction in a stressful situation.

In this study O'Connell demonstrated what he failed to take into account: the interpersonal context. His 1960 work demonstrated that stressful, demeaning interpersonal experiences affect the level of conflict perceived with regard to hostile feelings and thus appreciation of hostile

humor. The stressful situation seemed to provide too much conflict for humor appreciation in "maladjusted" individuals. The "well-adjusted" individuals, who presumably perceived little or no conflict in the nonstressful situation, were more appreciative of the hostile humor in the stressful situation. The change in situation affected the level of perceived conflict regarding hostility.

Another study confirms the idea that the interpersonal context affects the appreciation of humor. Murphy and Pollio (1973) found that groups of strangers were less overtly appreciative of hostile humor than were groups of friends. The same research showed that whimsical, nonhostile humor was appreciated similarly by both groups.

Thus humor appreciation, particularly regarding hostile humor, may be an indication of the client's level of conflict regarding the content, level of interpersonal comfort with the therapist, or perceived appropriateness of laughter and humor in the therapeutic situation. Appreciation of humor, especially hostile humor, may connote interpersonal comfort in the therapeutic relationship.

A client's humor production and response to humor is also cited as a valuable indice of the potential for therapeutic progress. Nassbaum and Michaux (1963) used responses to cartoons to predict the depth of depression and to predict the client's progress, as well as to provide clues

to the underlying dynamics of the depression. Similarly Starer (1961) states that humor should be considered in predicting the likelihood for change and potential for success outside the hospital for schizophrenic patients. Changes in humor production and appreciation in the hospital seem to be reflective of simultaneous changes in their level of functioning. Harrelson and Stroud (1967) found that as schizophrenic patients improved their humor changed from hostile, distance-maintaining humor to warmer, more person-involved, and spontaneous humor. In discussing his work with narcissistic personalities, Kohut (1971) makes a similar observation. ". . . I wish to affirm my conviction that emergence of the capacity for genuine humor constitutes yet another--and welcome--sign that a transformation of archaic pathogenic narcissistic cathexes has taken place . . ." (p. 324).

Thus it seems that any irregular production of or response to humor, i.e., over-responding or producing, lack of responding or producing, misunderstanding, or forgetting, can be indicative of some anxiety or conflict associated with the content of the humor or the situation in which the humor occurs. For this reason the skillful therapist can use both the client's response to and production of humor as important information about issues for therapy and the client's level of functioning. As Zuk (1964) states it, "It

is hard to escape the conclusion that laughter and humor . . . is a sign of some degree of readiness to reveal the thoughts which it seeks to disguise" (p. 89).

Questioning the Efficacy of the Therapist's Humor

Turning to the issue of the therapist's use of humor the topic becomes more controversial. While a number of therapists endorsed the efficacy of humor as a therapeutic tool (for various reasons to be discussed later), Kubie (1971) made a strong statement about the potential dangers of the therapist's humorous comments. Although he recognized the potential for humor to relieve tension and facilitate the initial stages of communication, he emphasized the fact that, ". . . others [clients] are sealed off and frightened into silence even by a general impersonal atmosphere of joviality" (p. 861). Because of the frequent use of humor to communicate masked hostility and because most clients have negative self-perceptions, he contended that the use of humor by the therapist will usually be experienced as degrading, hostile, and distancing. Because of the indirectness of humor, Kubie felt it trapped the client into silence, for to treat it seriously and confront the therapist with the feelings it engenders is to run the further risk of being mocked or judged deficient because the therapist was "only kidding."

Kubie also points out the likelihood that the client has been teased or joked about by other significant people. The therapist, unbeknownst to him, probably ". . . inherits a patient's buried reactions to earlier humor" (p. 863). Although these reactions affect the therapeutic relationship, they will most likely remain buried and unresolved due to the client's pain and vulnerability to such humor.

Kubie goes on to comment that a therapist's humor with regard to clients is usually, ". . . a defense against our own anxieties as therapists . . . against all forms of psychological pain . . . and is self gratifying and exhibitionistic . . ." (pp. 862; 864). Kubie summarizes his position with the statement that,

It is never justifiable to make fun of patients or their symptoms no matter how strange or grotesque these may seem This serves only to increase the patient's pain, resentment, and defenses. (p. 865)

Although not as adamant as Kubie, other therapists have cautioned about the use of therapists' humor. Schimel (1978) stresses that therapists develop "a relationship of . . . concern and trust" before utilizing humor as an interpretive technique. Rosenheim (1974), Grotjahn (1957), Egan (1970), Poland (1971), and Greenwald (1975) have all warned of the potential counterproductive use of humor. Specifically they cite the possibility of using humor as an indirect expression of anger towards the client as well as

the client's using humor to avoid or distract from his problems. While such pitfalls are possible, Mindess responds to Kubies' admonitions by stating, ". . . that every other kind of so-called therapeutic interaction may be abused in identical ways" (1976, p. 333). As with any human interaction, it is neither useful nor destructive divorced from the context in which it occurs. The meaning and impact of the behavior is embedded in the interaction between two people in a specific situation.

Reducing the Tension and Anxiety

While no therapists maintain that it is therapeutic to "make fun of patients," many argue that a skillful therapist can use humor to facilitate the therapeutic process. One beneficial use of humor by the therapist is to relieve tension and anxiety. It is quite typical for a person in therapy to feel anxious during the initial stage of therapy as well as during periods of intense self-examination. During the initial phase of treatment, anxiety regarding the unknown predominates. Although most therapists agree that some degree of anxiety is necessary during therapy, too much anxiety can decrease the person's ability to absorb new information, think creatively, or learn new behaviors. Thus too high a level of anxiety can be countertherapeutic.

Humor affords an efficient way of decreasing unproductive amounts of tension. Although in some circumstances it

would be preferable to deal overtly with the fears generating the anxiety, at other points it is more productive to decrease the anxiety quickly through less overt methods. This is particularly true in the initial stages of therapy when the client's fears and ambivalence about engaging in the therapeutic endeavor could result in a premature termination of therapy. Later when the therapeutic relationship is stronger, greater amounts of anxiety may be tolerated.

Humor can serve to reduce the anxiety producing quality of a stimulus, be that stimulus the therapist, a significant person in the client's life, or the client's dread of his own internal enemy. In Children's Humor, Wolfenstein (1954) describes how children use silly or negative names to master their fears of seemingly threatening people or events. This use of humorous irreverence is an assertion of their power and the actual harmlessness of the threatening stimulus. Any type of irreverence, absurdity, or exaggeration can provide a humorous way of decreasing perceived threat. Either client or therapist can introduce this humorous perspective effectively.

McGhee (1971) summarizes the child development research which indicates that humor builds on the security of experienced competence. Only as there is some minimal experience of competence will an individual dare to treat a

subject humorously. As this humor is met with success, or at least lack of retaliation, the experience of mastery grows and anxiety is further reduced. As Freud (1928) observed,

The principal thing is the intention which humor fulfills. Its meaning is: "Look here! This is all this seemingly dangerous world amounts to. Child's play, the very thing to jest about."
(p. 5)

Developing Interpersonal Closeness

Poland (1971), Rosenheim (1974), and O'Connell (1978), all view humor as a method of establishing interpersonal closeness between therapist and client. By utilizing humor the therapist reveals a human being with a capacity for enjoyment, while inviting the client to join the fun. ". . . integrated, appropriate, spontaneous humor is indicative of a high degree of alliance between the patient and the therapist . . ." (Poland, 1971, p. 637).

Various observational studies support the notion that humor can be an affective means of establishing rapport. The sharing of a joke or laughter bonds those participating in a common, pleasant and involving experience. ". . . laughter always implies a kind of secret freemasonry, or even complicity, with the laughers" (Bergson, 1911).

Miller (1967), an anthropologist studying the Chippewa tribal council meetings, found that promoting group solidarity was one of the functions of humor. Coser (1959),

Goodrich et al. (1954), Levine (1963), and Howell (1973) have all observed the cohesive quality of humor in various group settings. The introduction of a humorous comment is an invitation to join the initiator in an enjoyable experience. The respondent's laugh or smile is an acceptance and thus momentarily bonds the participants in a mutual amusement. ". . . anything which introduces laughter, especially a comic episode, will increase its [the group's] cohesiveness and reduce the distance between the estranged individuals" (Rosen, 1963, p. 716).

In his description of his integration into the work group setting which he was studying, Lundberg (1969) recounts the major role humor played. First his presence was acknowledged in a playful joking way by one of the more socially dominant workers. Later, as some of the workers were joking around, Lundberg ventured an additional humorous comment which was responded to positively. Finally, he knew his acceptance was assured when he was invited to join in a practical joke being played on another fellow.

If well received, teasing or humor directed in a playful manner towards the other is especially indicative of a high degree of interpersonal comfort according to Howell (1973). "The teasing relationships are based on a potential closeness, even if that closeness has yet to be realized" (p. 17). Howell sees teasing as an advance into the

personal space or domain of the other. If the other is willing to receive this teasing it marks the closeness of the relationship and increases the strength of relationship, i.e., increases the area of mutually available interpersonal space. Conversely, when mutual confidence is lacking, teasing is likely to be seen as an unwelcome intrusion that may contribute to increased defensiveness and decreased interpersonal closeness. Teasing is simultaneously a barometer of the strength of relationship as well as an attempt to modify the nature of the relationship. As O'Connell (1978) describes the use of teasing to create a genuine relationship, "When the therapist plays in this way, he is insisting that the relationship be real and insisting on not being the non-person the patient wants him to be" (p. 5).

Circumventing Defenses

Humor has an exceptional capacity to intrude into the rigid, grave, and joyless style of many clients. Grotjahn (1971) discusses the importance of demonstrating emotional freedom to the client by reacting to them in a humorous manner when appropriate.

By showing our reaction to the patient, we give an example of emotional freedom, since laughter and humor are a sign of the freedom. We show that we are not afraid of losing control or discipline and restraint . . . (p. 236)

In an effort to aid the client in breaking out of these affective constrictions that are so often found in obsessive personalities, Rosenheim (1974) recommends, "The teaching of emotional modulation . . . by applying gradual 'doses' of humor in therapy" (p. 587). Such "doses" can be administered by sharing a joke or by the therapist self directing a humorous remark. Such modeling of the capacity to enjoy the lighter side of things can allow the client to realize that our seriousness and solemnity is not an unequivocal condition of maturity.

Client's come to therapy with relatively fixed views of reality and overly mechanical responses to life situations. Not only does the therapist's humor give permission for a lighter perspective and model a more adaptable viewpoint, but it also breaks into the pedantic style of blocking out any experience which does not confirm his world view.

Humor with its capacity to surprise, to catch the client off guard, can often facilitate the interruption of a deadly serious litany. ". . . Psychotherapy of the absurd can be a deliberate effort to break old patterns of thought and behavior" (Whitaker, 1975, p. 11). By psychotherapy of the absurd, Whitaker refers to the humorous exaggeration of a client's complaint or behavior. This move from the deadly serious stance of the client to a humorous caricature forces the client into a new position of joining with the therapist

in laughing at the absurdity rather than fighting off the world with dour griping. "Therapeutic humor departs from the more formal kind of clarifications and interpretations by virtue of the closer participation with the patient in an inner experience" (Rosenheim, 1974, p. 585).

Schimmel (1978) discusses why a humorous remark is often more effective than a direct interpretation. "The linkage of dissociated ideas and affects presumably comes about since the person is taken by surprise, a state which permits the dissociated material to circumvent the censor" (p. 372). He relates the following example:

Pt: (Complaining) You always point out the positive aspects of everything.

Psa: That isn't true.

Pt: Then what is true?

Psa: I simply point out the areas you habitually neglect.

Pt: (Laughter)

In the space of a single sentence, the therapist points out the client's habitual pessimistic stance in life. This unexpected, humorous comment allows the client an opportunity for pleasure, an interruption in his rigid view of the world, a genuine shared experience with another person and insight into how he creates a gloomy, negative life.

An additional benefit in utilizing humor rather than more direct interpretations is the increased requirement for

active participation on the part of the client in understanding the issue. As Whitaker (1975) puts it,

The use of deliberate obscurantism, makes it necessary for the audience [family in therapy] not only to recognize a body of thought but also to learn it. In contrast, direct presentation many times leads to recognition but results in a failure to learn. (p. 10)

As Bodin and Farber (1973) so aptly put it,

Jokes, like dreams, can be artful in representing, without quite revealing, disguising without quite concealing. The resultant subtlety makes the listener reach for the latent meaning . . . (p. 290)

Levine (1963) states,

In therapy very often certain insights and basic relationships can be brought home more effectively through humor. Humor can be an extremely effective instrument to help the patient accept an interpretation that would otherwise make him anxious. (p. 4)

Rosenheim (1974), Grotjahn (1969), O'Connell (1978), and Levine (1963) all concur that humor can convey insights that would be defended against or ignored if given through a formal interpretation. Even Kubie (1971), though carefully warning that it should never be therapist initiated, concedes that humor is a useful medium for facilitating self-awareness.

I have seen patients speak the true word in jest quite freely only to sit or lie in stunned silence as the realization slowly grew of the true implications of what they had just said. (p. 865)

Creating a More Functional Perspective

The capacity that humor has for allowing a change in perspective and perhaps some respite from suffering, discussed previously, can be used by the therapist for the client's benefit. Rosenheim (1974), Poland (1974), Sullivan (1954), O'Connell (1978), Freud (1928), O'Connell (1960), Frankl (1967), and Grotjahn (1957), all regard humor as a uniquely human capacity that allows people to look at extremely painful situations and parts of themselves without being overwhelmed. According to Freud (1928), the important difference between a humorous attitude and neurosis or psychosis is the aspect of volition:

. . . humor approximates the regressive or reactionary processes which engage our attention in psychopathology . . . without quitting the ground of mental sanity as happens when other means to the same end [triumphing over painful reality] are adopted. (p. 3)

The therapist's use of humor can expand the client's capacity to self-examine behaviors and attitudes. As Sullivan (1954) stated, humor provides ". . . the capacity for maintaining a sense of proportion as to one's importance in the life situation in which one finds one's self" (p. 182). To focus directly on the client's responsibility for the pain without the concurrent perspective afforded by humor can be overwhelming. The therapist can express acceptance and the knowledge that imperfection is the

natural state of human beings through the vehicle of shared humor.

A distorted accentuation of the gravity of one's condition, the severity of one's pain and/or the magnitude of one's deficits tends to immobilize a person. Conversely, a distorted denial of the above also reduces the likelihood of productive change. Humor can play an effective role in creating a more productive self-perception. Schimel (1978) recounts just such a humorous intervention with a woman who habitually overemphasized the pain and suffering she felt:

Pt: (Opening remark) Where would you hospitalize me if you had to?

Psa: What's this about?

Pt: I had a terrible weekend. John didn't call me. I called him dozens of times on Saturday; I spent the night in front of his building waiting for him to show up.

Psa: Yes?

Pt: I cried all day Saturday. I had many thoughts of suicide. I still think I might kill myself. I can't tell you how awful I felt, afraid he'd never talk to me again. I left messages for him every place I could think of.

Psa: Yes?

Pt: Well, it's serious and I'm worried. I want to know where you would hospitalize me. I have a right to know!

Psa: The Little Red Nursery School.

Pt: (Laughs) You don't take me seriously! I was awfully frightened. I guess you don't

want me to act out. I was better this morning. But don't you think it's serious? I am getting over these things more quickly than I used to . . . (p. 371-372)

The humorous remark stopped the relentless self-concern and highlighted the childish over-dramatics. Although in this case it did not seem to slow the client down, it did begin to help her refocus on to the improvement she was making in handling disappointments.

Humor can be a useful component of a psychotherapeutic relationship. It has diagnostic value for aiding the therapist in assessing the adjustment of the patient, defining the problematic issues in the client's life, and ascertaining the level of the relationship and trust between therapist and client. As a prognostic tool, humor has also been used to predict the success of therapy and level of adjustment a patient may be expected to attain. As a therapeutic tool, although somewhat controversial, humor is thought to reduce tension, engender trust and intimacy, encourage the expression of affect in a constricted individual, facilitate self-awareness and understanding, introduce perspective and a means of living with a painful reality, and productively manage conflict and hostility.

Managing Conflict and Hostility

In all intense interpersonal relationships, some conflict and hostility will arise; the therapeutic relationship is no exception. Often it is of great therapeutic

importance to deal with such feelings overtly by direct verbal expression, discussion, and mutual resolution. Sometimes this is not possible due to the current level of the client's self-esteem and sometimes it is not preferable due to the amount of time such a resolution would entail. In either instance, humor offers a potential answer. A client with low self-esteem can use humor to indirectly express hostility with a greater sense of protection, e.g., can "test the water" with a joke and disclaim any hostile intent if the feared retaliatory anger arises. After such an angry joke has been made, the client seeing that the therapist is not vengeful may choose to deal with the issue more directly or may feel satisfied with having expressed the feeling and ready to move on.

O'Connell (1978) describes such an encounter with an obsessive client:

. . . he asked about his diagnosis, in a very weighty fashion. After pretending to be serious, I said, "I think you're a kangaroo."

The patient for a second began to obsessively consider this possibility and then laughed, blurting out, "Yes, I'm a kangaroo and you're an asshole." We both laughed. (p. 4)

Using a humorous retort, O'Connell's client was able to express his anger at being caught off guard while joining with the therapist in enjoying the humor in the whole situation.

Several theorists recognize the importance of humor in expressing anger and conflict. Levine (1963), Kaplan and Boyd (1965), Miller (1967), and Zuk (1966) all concur that in the social context humor can express hostility without escalating the tension. Zuk (1966) states that humor can ". . . discharge feelings which if expressed outrightly might lead to a serious disruption of a relationship" (p. 100).

Empirical Research in the Role of Humor in Group Interactions

As a first step towards understanding any human interaction it is important to accumulate observational information about that interaction in a naturalist and/or quasinaturalistic setting. Scogin and Pollio (1980) have observed and analyzed such information on humorous interactions in groups from six different group settings. Unfortunately, no such information has been collected in a dyadic situation. Group data is the only base for comparison for the observational information gathered in an individual therapy setting.

The six settings of humor they compared were: Goodrich, Henry and Goodrich (1954), a participant-observer study of 13 weekly psychiatric staff conferences; Coser (1960), another participant-observer study of case presentations at a series of mental health staff meetings; Childs

(1975), a videotaped study of humor in both an outpatient therapy group and a university growth group; Scogin and Pollio (1980), a participant-observer study of 10 one hour sessions of pool-playing by elderly men at a community recreation center, and Kubo (1978), a videotaped study of 12 sets of brief, problem-solving groups in a university experimental psychology laboratory.

In compiling the data shown in Table 1, several interesting patterns became evident. In the first five settings, about 66% of all the humorous incidences were targeted, i.e., directed at a specific person, place, or thing. The target of this directed humor differed between groups depending on the nature or focus of the group. Thus, in the Coser (1960) study of a staff conference, where discussion centered around patients and others not in that group, the largest percentage, 32%, of targeted humor was aimed at others not in the group. In the recreational group where the focus was the activity at hand, and on the participants of that activity, 56% of the targeted humor was directed towards other group members. The patterns found in therapy and growth groups were very similar. The amount of humor directed towards self and other in the group were about equal (28% and 27% for the therapy group and 21% and 26% for the growth group) reflecting the interpersonal focus of those groups.

Table 1
Nature of Humorous Incidents in Six Different Settings
(From Scogin & Pollio, 1980)

Source	Number incidents	Self			Other in group			Generalized other			Nondirected	Unclassified
		+	-	Total	+	-	Total	+	-	Total		
Psychiatric staff conferences ^a	174			6%			← 49%* →				47%	
Mental hospital staff conferences ^b	90			20%			27%			32%	18%	
Elderly men playing pool	246	4%	4%	13%	13%	29%	56%			1%	16%	12%
Growth group	318	7%	14%	21%	5%	21%	26%	1%	8%	9%	24%	20%
Therapy group	301	7%	21%	28%	6%	21%	26%	2%	14%	16%	22%	6%
Problem solving groups	183	4%	8%	12%	3%	7%	10%	3%	11%	14%	61%	2%
Short-duration												

^aGoodrich and co-workers (1954).

^bCoser (1960).

*These figures cannot be separated from published data.

The problem-solving groups were the only setting without a predominance of targeted humor. While the other five settings had 53% to 79% of the humorous incidents falling into the category of humor targeted at a person, place or thing, only 36% of the humorous episodes in the short-term problem solving groups were classified as such. Considering that these groups were composed of strangers assembled for a specific task, and that they did not have a group interaction focus, it is not surprising that the majority of their humorous incidents were nondirected. Engaging in targeted humor with much frequency seems to require a level of intimacy not found in such a group of strangers. It is interesting to note that most of these incidents that were targeted were targeted at the experimenters; the most immediate shared focus that was outside of their group.

Looking at the relationship of targeting others to being the target, Scogin and Pollio (1980) found a natural parity to humorous interactions in the three groups they were able to consider: the pool-playing group, the growth group, and the therapy group. This analysis was not possible for the other three groups due to the short-term duration of the problem-solving groups and to the inaccessibility of appropriate data for the staff conference groups studied by Goodrich et al. and Coser. For the three possible groups

they calculated five indices: (1) number of self-directed remarks; (2) number of remarks directed at others (including generalized others); (3) total number of remarks directed towards others and self ("total gives"); (4) number of targeted remarks received from others ("gets"); and (5) total number of targeted remarks received from others plus those self-directed remarks ("total gets"). Excluding the five correlations per group that may be artificially inflated due to "double counting" of self directed remarks, eleven of the fifteen correlations calculated between these indices were significant at $p < .05$ or less. The other four correlations, though not statistically significant, were all positive. This suggests that humor, in a group setting, serves a natural checks and balance system. Individuals who produce large amounts of other directed humor are also the recipients of large amounts of targeted humor and vice versa.

Scogin and Pollio (1980) also report that humorous remarks tended to occur in temporally contiguous bursts. The problem-solving and pool-playing groups had the largest percentage of humorous remarks occurring in single episodes, 44% and 42%, respectively. The growth group had only about 30% and the therapy group had even fewer with less than 25% of all humorous incidents occurring in a single event. Scogin and Pollio suggest that "short episodes are a mark

either of a group of strangers assembled for a given short-term activity or of a continuing group engaged in a constantly changing ongoing activity" (p. 845). The therapy and to a slightly lesser degree the growth group had a majority of their humorous incidents occurring in longer episodes. These episodes seemed to be diversions from the therapeutic interactions or "rest periods" that helped reduce tension after periods of intense interactions.

As to the tone of the humorous remarks, deprecating or negatively toned humor was far more frequent than overtly appreciative or positively toned humor. Negatively toned humor was two to four times more frequent than appreciatively toned humor, with the highest ratios being found in those remarks aimed at another person in the group. When examining those remarks, aimed at the producer of the humor (self), it is noteworthy that the ratio of negative to appreciative humor was 3 to 1 as contrasted to 2 to 1 for the growth group and problem solving group and 1 to 1 for the recreational group. Unfortunately this information is not available for the two staff conference groups.

Focusing further on the group therapy setting, Peterson and Pollio (1982) looked at the relationship of therapeutic effectiveness and humor. Using the Hill Interaction Matrix procedure, the therapeutic value was rated for each 5-minute segment for each session. By examining the level of

therapeutic effectiveness in the five minute segments during and after a humorous episode, some interesting results emerged. Humor directed towards a target outside the group was accompanied by an increase in therapeutic effectiveness; humor directed at a target inside the group by a decrease; and humor that was self-targeted by a slight increase. Looking at the level of therapeutic interaction in the five minutes before the humorous incident in Figure 1, those targeted outside of the group were preceded by relatively low levels. Those incidents targeted within the group were preceded by relatively high levels of therapeutic effectiveness, and those self-targeted were preceded by levels that were high though a bit lower than those preceding the incidents targeting others in the group. The pattern emerged that targeting outside the group happens when the therapeutic effectiveness is low and that level increases after the humor. Targeting of others within the group tends to happen when therapeutic effectiveness is high and the level decreases. Self targeting occurs when the level of effectiveness is relatively high and that level then increases after a momentary drop. A closer look at these incidents revealed that the majority (8 of 9) of those targeted at another group member served to avoid or distract from the topic under discussion. In those targeted outside the group and self-targeted, the majority did not distract

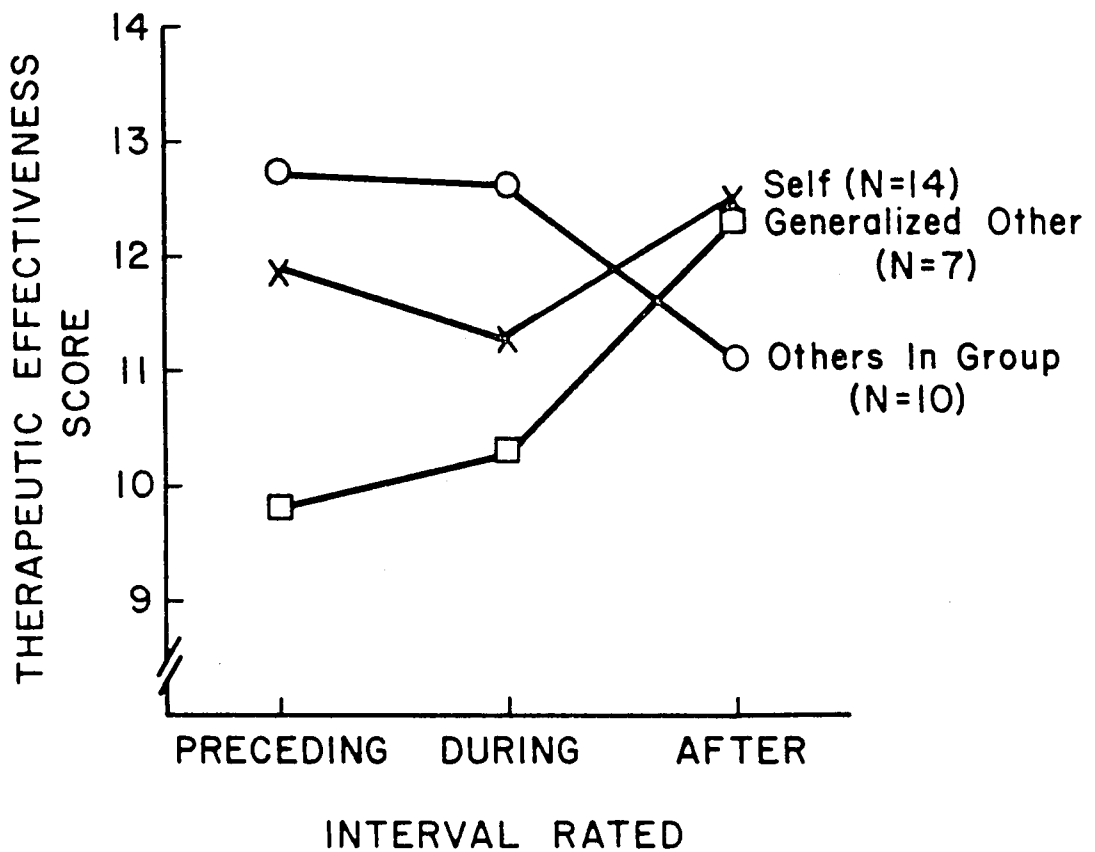


Figure 1. Therapeutic effectiveness of group process surrounding selected periods of peak laughter (from Peterson & Pollio, 1982).

from the topic, as only 2 of 6, and 4 of 8, respectively, were coded as distracting.

In summary, humor occurring in group settings is reflective of the focus of the group. Groups focused on discussion of people outside of the group have a higher prevalence of humor targeted at people outside the group than do groups focused on the participants and group interaction. Those groups tend to have a higher frequency of humor targeted within the group. Short-term, noncohesive groups tend to have the highest prevalence of humor not targeted at all. Furthermore, negatively toned humor tends to predominate over overtly positively toned humor. In the case of a therapy group, humor targeted at other group members tended to occur during points of high therapeutic effectiveness and reduced it, distracting from the topic at hand, while humor targeted outside the group tended to occur at lower points of therapeutic effectiveness and increased it by promoting group feeling; while self-targeted humor, though not as clear cut, tended to occur during relatively high points and to increase it slightly.

As indicted by this body of literature, humor is seen both theoretically and empirically as a frequently occurring, important, human interaction. Theoretically, various psychologists consider humor as a potentially adaptive human capacity that allows people to cope with insoluble

situations without succumbing to hopelessness, to perceive clearly and accept one's own characteristics, to resolve problems and enhance their creativity, and to expedite healing and maintain health. As a therapeutic agent humor has been described as being a way to determine issues, progress, and prognosis, as reducing tension and anxiety, as facilitating increased interpersonal closeness, as circumventing defenses, as creating a more functional perspective and as effectively managing conflict and hostility. Empirically, humor has been observed in several different group settings with the resultant findings that: (1) it was a frequent, spontaneous behavior, (2) it was frequently targeted at whatever was the group focus, (3) it was more frequently targeted in more intimate, ongoing groups than in short-term groups of strangers, (4) there was a parity between targeting and being the target, (5) humor targeted outside the group was accompanied by an increase in therapeutic effectiveness, while humor targeted at others within the group by a decrease and (6) it often occurred in bursts which allowed a rest or diversion from intense interactions.

This much discussed behavior, though observed and studied in group settings, had yet to be empirically examined in a therapeutic dyad. In order to look at the theoretical understandings in light of empirical data and to compare the findings in group settings with those in a

therapeutic dyad, an observational study of spontaneous attempts to be humorous was conducted in a seven session, individual therapy.

CHAPTER III

METHOD

Procedure

Data for this analysis were taken from videotape recordings of each therapy session that one individual had with a private clinical psychologist. This particular therapeutic endeavor consisted of seven, fifty-minute sessions. Both client and therapist knew that they were being taped and had given written permission for the taping and subsequent analysis.

The therapy was initiated voluntarily by the client who had no foreknowledge of this study. During his initial telephone conversation with the therapist and after arrangements had been made with regard to his first appointment, he was informed that the therapist was participating in a research study. He was further informed that the purpose of the study was to observe various processes that occur naturally during the course of therapy and to examine their effects on the therapeutic endeavor.

Being assured that agreement or refusal to participate would have no impact on his eligibility for therapy, he was asked if he would be willing to discuss it at the first session. Since he agreed, he received a copy of an

explanation of the study (see Appendix A), discussed it with his therapist, and signed the consent form (see Appendix B).

Apparatus

Each therapy session was recorded with a Sony camera and a Sony VHS videotape recorder. The recordings were made on RCA VK125 video cassette tapes and monitored on the same Sony VHS videotape recorder used to tape the sessions.

Subjects

Therapist

The therapist is a forty-one year old clinical psychologist who has been in private practice for seven years. She is also a professor at the Pacific Graduate School of Psychology, Palo Alto, California; a past president of the Santa Clara County Chapter of the American Psychological Association, and worked at the North County Community Mental Health Center for four years. She received her doctorate from the California School of Professional Psychology in 1973.

Because of her belief in the importance of observational and descriptive studies of the therapeutic process, she was willing to participate in this research. She was informed that the researcher was studying various processes that occurred naturally during the course of therapy.

Client

The client is a thirty-six year old professional man who voluntarily sought therapy. His presenting complaint was great difficulty in deciding whether or not to divorce his wife of twelve years. He also was experiencing feelings of anxiety, and guilt with regard to considering a divorce. He and his wife had been separated for the eight months preceding his therapy and he felt his wife was pressing him to make a decision.

After the first session, his therapist described him as a basically obsessive and anxious person who demanded self-perfection and was frequently self-recriminating. At that time he was experiencing increased discomfort, i.e., anxiety, self-recrimination, and obsessiveness, due to his current stressful situation.

Of the approximately ten clients who were asked to participate in this study, he was the second to agree. The first client to agree, a woman, was excluded from the study for three reasons: the therapist inadvertantly did not record one session; the therapist used a nontraditional, paradoxical approach in working with the client; and the client terminated therapy prematurely after five sessions without a final session.

Data Analysis

The raters were two masters level counselors who had recently completed the Marriage, Family, and Child Counseling program at the University of Santa Clara, Santa Clara, California, and one recent graduate of the bachelors level Psychology program at the same university. All were interested in observing an experienced therapist and learning more about the therapeutic process. They volunteered to work on this project for that reason. Using procedures developed by Childs (1975), Peterson (1975), Scogin and Pollio (1978), and Swander and Martin (1975), they rated and coded all seven tapes. These procedures are described in the following sections. They were informed of the importance of strict confidentiality with regard to all information concerning the client and signed an agreement to that effect (see Appendix C). None of the raters knew the client or had any mutual connection with him.

Identification of Humorous Attempts

Working independently, each rater viewed a complete fifty-minute session to become familiar with the general nature of the session. Then he/she watched the tape a second time; this time noting each instance where the therapist or client was attempting to be humorous. They were cautioned to respond to attempts to be humorous,

whether successful or not. Since laughing and/or smiling can occur without anyone attempting to be humorous and can be absent when an attempt at humor is made, the raters were also instructed not to respond to laughter and/or smiling. Notation included the initiator of the humorous attempt, the reading on the footage meter at that point, a brief description of the event (for ease in relocating the event), and a description of the subject matter of the humor, e.g., marriage, parents, therapy, etc. (see Appendix D for instructions to raters and Appendix E for data sheet).

After all seven therapy sessions had been rated independently by each of the raters, the researcher compared their data. Instances where two or more raters agreed that an attempt to be humorous was made was included for further analysis. Also, the subject matter of those instances was compiled. When a discrepancy occurred between the raters, that agreed upon by two raters was used. If all three raters disagreed with regard to subject matter, it was discussed among them. If they easily agreed on a common subject, it was used. If they could not, that instance was categorized as unclassifiable.

Classification of Humorous Incidents

When the instances of humorous attempts had been located, the raters were asked to classify each attempt. Again, they worked independently of each other. The

classifications are self-targeted, targeted toward the other person in the therapy session, targeted toward a generalized other (someone outside the therapy situation, an institution, an idea, etc.), self-aggrandizement, aggrandizement toward the other in the therapy session, aggrandizement toward a generalized other, nontargeted, and unclassifiable (see Appendix H).

As in the identification of attempts to be humorous, the researcher compared the classification data from the three raters. If there was any discrepancy in classification, the category agreed upon by two of the raters was used. In the event an incident received three different classifications, it was categorized as unclassifiable.

Identification of Laughter

After the humorous events were located, only one of the raters looked at the tapes a third time since previous research (Peterson & Pollio, 1982) has indicated that identification of laughter is a straightforward task with an interrater reliability correlation of .85. During this viewing she noted each instance of laughter. This determination was made independently of attempts to be humorous, thus laughter that occurred concomitantly with humor as well as laughter that occurred without a humorous incident was recorded. Notation included the reading on the footage meter at that point, the person who initiated the laughter,

the response of the other person, the duration of the laughter, and the subject being discussed when the laughter occurred (see Appendices F and G).

Determination of Time Spent Talking

Another rater watched the tapes a third time to determine the amount of time spent talking by the therapist and the client. Previous research (Peterson & Pollio, 1982) also found this behavior to be one easily identified with an interrater reliability correlation of .96. Using an event recorder, she indicated when each participant was talking for sessions one, three, five, and seven. Since the percentage of time for each individual was similar for all four sessions, the total time spent talking by each person for those four sessions was used to estimate the amount for all seven sessions.

Raters' Perceptions

Each rater was asked to independently rate each humorous incident as to its impact on the therapeutic endeavor. Nine dimensions that humor might effect were defined from the literature. They were: the level of tension and anxiety; the power differential between client and therapist; the client's feelings of defensiveness; the feelings of hostility and conflict; the client's self-perception; the client's perception of the therapist; the

client's perception of other people; and the topic being discussed. The raters judged each incidence of humor as to whether it increased or decreased the first four dimensions, changed or reinforced the next three dimensions, and highlighted or avoided the last dimension. They were also instructed to rate a dimension as not applicable if they thought that the humorous incident did not effect that dimension (see Appendix I).

These ratings were complied by the researcher. Occasions where two or more of the raters did not agree were categorized as unclassified.

Perception of Research

When the data collection and analysis was complete, the therapist was interviewed. The purpose of the interview was to determine what the therapist thought the researcher was studying and what impact, if any, she thought the videotaping had on the therapeutic process. Further, after a brief explanation of the research topic, she was asked how she views humor in the context of the therapeutic relationship, e.g., does she attend to the client's humor production and response to her humor as a diagnostic tool; does she intentionally use humor as a therapeutic maneuver; if so, for what purposes and in what ways does she use it, etc.

Then she and the researcher reviewed two tapes. At each instance of rater located humor, both discussed how

they understood this incident. They indicated what they saw as the meaning of the humor and what they saw as its effect (see Appendices J and K).

The client was contacted by his therapist and asked if he wanted to be informed regarding the nature of the research and if he was willing to answer some questions regarding his experience. It was stressed that the two questions are independent of each other, i.e., he could request information regarding the study whether or not he agreed to answer any questions.

He was agreeable to being contacted by the researcher to answer some questions and, thus, was contacted by telephone. He, also, was asked what he thought the researcher was studying and what impact, if any, he thought the videotaping had on his therapy sessions. After a brief explanation of the research topic, he was asked if he remembered any reactions to or feelings about any humorous instances that occurred during his therapy, initiated by either him or his therapist.

CHAPTER IV

RESULTS

Humorous Incidents

Across all seven therapy sessions, the raters identified 172 incidents of attempts to be humorous by either the therapist or the client. Of these incidents, 81% (139) were independently identified by two or more raters and, thus, were included for further analysis. The majority, 62% (86), of the 139 incidents observed were initiated by the client; the therapist initiated the other 38% (53).

The actual amount of time spent talking by the therapist and the client, respectively, was 10 minutes and 40 minutes for Session I, 11 and 39 for Session III, 12 and 41 for Session V, and 9 and 46 for Session VIII. Since the percentage of time talked for each was relatively consistent across these four sessions, it was used to estimate the total time spent talking for all seven sessions of the total 373 minutes of therapy, the client talked an estimated 298 minutes (80%) and the therapist, 75 minutes (20%). Although the client produced 62% of the humorous attempts, he produced fewer humorous remarks per minute talked than did the therapist. He averaged .29 incidents per minute talked, while she averaged .71 incidents per minute talked.

Looking at the number of incidents per session, the first contained the most per session with 30 incidents (22%) and the sixth had the least with 11 (8%). The remaining incidents are distributed fairly evenly across the other five sessions with 20 (14%), 22 (16%), 20 (14%), 18 (13%), and 18 (13%) occurring in Sessions II, III, IV, V, and VII, respectively (see Table 2).

The number of humorous incidents contributed by the therapist during each session was fairly consistent (see Table 2). She initiated 10, 8, 8, 7, 8, 7 and 5 in Sessions I through VII. The only slight variations occurred in Session I where she produced a few more than average and in Session VII where she produced a few less.

The client's production of humor was also fairly consistent across sessions with the exception of Sessions I and VI (see Table 2). During Sessions II through V and VII he produced 12, 14, 13, 10, and 13, respectively. In Session I he produced a larger number, 20, and in Session VI, a smaller number, 4. Session VI was the only session in which his absolute production of humor dropped below that of the therapist.

In order to understand the client's decrease in humor production in Session VI, the therapist and researcher reviewed that tape. Both agreed that the client was not as engaged in the therapeutic process as he had been in

Table 2

Number of Humorous Incidents Produced Each Session by Each Initiator

Initiator	Sessions							Total
	I	II	III	IV	V	VI	VII	
Therapist	10	8	8	7	8	7	5	53
Client	20	12	14	13	10	4	13	86
Total	30	20	22	20	18	11	18	139

previous sessions. Although he talked a typical amount about his previously recognized concerns, he seemed to be less explorative and less interested in what he was saying. His voice quality was monotonous and droning. The therapist said she had extended the therapy past what she thought the client desired. She felt that he had obtained symptomatic relief and probably was ready to terminate after Session V, but had rescheduled with him to be sure he did not want to engage in a further exploration of issues. His behavior in Session VI was an indication to her that she was correct in assuming he was finished, at least for the time being. Session VII was a finishing session in which they reviewed his progress and said goodbye.

Looking at the distribution of humorous incidents within sessions, the incidents were tallied for each ten minute segment of the sessions for both therapist and client. A chi square analysis ($\chi^2 = 2.06$; $p > .10$) indicated that there was no significant difference in the occurrence of humor among any of the six, ten minute segments across both therapist and client (see Table 3).

Classification of Humorous Incidents

The vast majority of humorous incidents were targeted, i.e., had a specific person, institution or idea as the target of the humor. Ninety percent of the incidents were

Table 3

Number of Humorous Incidents Initiated by Therapist
and Client per 10 Minute Segments
Across All 7 Sessions

	10 Minute Segments						Total
	1-10	11-20	21-30	31-40	41-50	51+	
Therapist	9	9	9	6	10	10	53
Client	12	15	19	11	20	9	86
Total	21	24	28	17	30	19	139

targeted, while 6% were nontargeted and 4% were not classified due to lack of interrater agreement. This breakdown of targeted, nontargeted, and unclassified was similar for both therapist and client. Their individual incidents were classified as follows: therapist, 91% targeted, 4% nontargeted, and 6% unclassified; client, 90% targeted, 7% nontargeted, and 3% unclassified (see Table 4).

Of the total 139 incidents, 3% were overtly, positively toned humor and 97% were overtly negatively toned. Looking at their humor production individually, the therapist had 6% positively toned humor whereas the client only had 1% (see Table 4). Specifically, this represents three incidents of the therapist positively targeting the client and one of the client positively targeting his wife.

The majority of the differences between therapist and client are found within the category of targeted humor. A chi square analysis completed across the three categories of self, other, and generalized other for both therapist and client indicated that these cell values differed significantly ($\chi^2 = 51.0$; $p < .01$). As can be seen in Table 4, the vast majority of this effect is due to the negative relationship between targeting self and targeting the other. Thus, the therapist targeted the client (other) most frequently (55%) whereas the client targeted himself most frequently (57%). Although the majority of incidents by

Table 4

Classification of Humorous Incidents

Initiator	Number of incidents	Self		Other		Gen. Other		Nontargeted	Unclassified	Total targeted					
		+	-	+	-	+	-			+	-	Total			
Therapist	53	--	15% (8)	15% (8)	6% (3)	49% (26)	55% (29)	--	21% (11)	21% (11)	4% (2)	6% (3)	6% (3)	85% (45)	91% (48)
Client	86	--	57% (49)	57% (49)	--	2% (2)	2% (2)	1% (1)	29% (25)	30% (26)	7% (6)	3% (3)	1% (1)	88% (76)	90% (77)
Total	139	--	41% (57)	41% (57)	2% (3)	20% (28)	22% (31)	1% (1)	26% (36)	27% (37)	6% (8)	4% (6)	3% (4)	87% (121)	90% (125)

both therapist and client were targeted at the client, the therapist targeted herself more frequently (15%) than did the client, who targeted her only 2% of the time. Both of them targeted people outside the session or institutions (generalized others) with approximately the same frequency: therapist, 21% and client, 30% (see Table 4).

A further correlational analysis of the relationship between pairs of five different categories of targeted humor was done for both the therapist and the client (see Table 5). These categories are: (1) number of self directed remarks; (2) number of remarks directed at others, including both other and generalized other; (3) total number directed at others and at self (this is referred to as "total give"); (4) number of remarks directed at the individual from the other; and (5) total number directed from the other plus those directed at oneself ("total gets").

Excluding the five correlations that would be artificially inflated due to double counting of self directed remarks, Table 5 presents five separate correlations. Those correlations were computed for the therapist and the client to examine the relationships between those five categories. As can be seen, none of the correlations were statistically significant at a .10 level of confidence.

Table 5
Relationship of Targeting and Being Targeted

	1	2	3	4	5
			<u>Client</u>		
1. Self-directed	x	-.25	-- ^a	-.08	-- ^a
2. Gives to others		x	-- ^a	-.40	-.41 ^a
3. Total gives			x	-.31	-- ^a
4. Gets from others				x	-- ^a
5. Total gets					x
			<u>Therapist</u>		
1. Self-directed	x	-.44	-- ^a	-.41	-- ^a
2. Gives to others		x	-- ^a	.23	.36 ^a
3. Total gives			x	-.12	-- ^a
4. Gets from others				x	-- ^a
5. Total gets					x

^aThese correlations not computed in that they would be artificially inflated due to a "double counting" of self-directed incidents.

-- $r \geq .669$ is significant at .10 for 5 degrees of freedom.

Nature of Humorous Episodes Bursts

An episode or "burst" was defined by the occurrence of two or more incidents with the same general topic and temporal proximity. Table 6 contains the number of episodes that occurred within each burst size for each session and for the total sessions.

The majority of incidents (56%) occurred individually, i.e., occurred without a burst of humorous activity. Of the remaining incidents, 26% occurred in bursts of two, 9% in bursts of 3, and 9% in bursts of more than five. The 9% occurring in bursts of more than five represents only two episodes, one of six incidents in Session II and one of seven incidents in Session IV.

The incident in Session II was primarily a series of humorous comments by the client about his difficulty in simplifying his relationships. For example, using a comic understatement, he commented "I tend to make things more complicated than they are!" It was not until the fifth incident that the therapist joined him. After the client had remarked, "That's any of two million people [that fit the therapist's description of the kind of woman he wanted to meet]" the therapist remarked, "See what happen's when you get simple?" This episode seemed to be a way for the client to slow down the process of looking at his approach

Table 6
Number of Humorous Episodes Occurring
in Each Burst Size

Session	Number of Incidents	Burst Size			
		1	2	3	>5
I	30	15	6	1	0
II	20	10	2	0	1
III	22	18	2	0	0
IV	20	9	2	0	1
V	18	9	3	1	0
VI	11	7	2	0	0
VII	18	10	1	2	0
Total	139	78	36	4	2

to relationships and to regain a sense of control of the situation.

In Session IV the burst was comprised of incidents produced by both client and therapist, four and three, respectively. The client started it with a comment mimicking his mother, "Oh, she's [referring to his wife] a wonderful person!" From there, both client and therapist engaged in an exchange of humorous remarks about their parents. The therapist built on the client's levity to expand the discussion. By also making humorous remarks about her own parents, she indirectly demonstrated that frustration with parents is a ubiquitous human experience. The episode moved the client from anger at his parents to a position of commenting, "My father has some awful attributes and I like him." The change in perspective allowed the client to access his positive feelings about his father rather than seeing himself as blighted by having the "world's worst parent."

Ninety-two percent of those incidents occurring within a burst of two or more were negatively toned. The remaining were 6% nontargeted and 2% positively toned. This is reflective of the 87% negatively targeted, 3% positively targeted, and 6% nontargeted of the total 139 incidents (the remaining 4% were not classified).

Topics of Humor

The raters specified the topic of each of the 139 incidents of humor. In the few instances where there was not agreement when independently defined, the raters discussed the incident and agreed on a topic. These topics fell naturally into six major categories, topics related to the client, to the therapist, to the client's relatives, to therapy in general, to other people, and to general issues (see Table 7).

Clearly the majority of the humorous remarks (63%) had some quality, characteristic, or feeling of the client as topic. Most of these were in some way related to his obsessive/compulsive character, e.g., his struggle to control others, his intolerance of ambiguity, his desire for superiority, and his obsessive thoughts. The next largest topic of humor was the client's relatives, who comprised 17% of total. Therapy-related topics made up 6% and topics related to the therapist, 7%. The remaining 7% were Other People and Issues, e.g., marriage, divorce, and relationships.

Of the total 139 incidents of humor, only 19 were not topics directly related to therapeutic issues, such as marriage, the client's feelings about himself, the client's qualities, his wife or family, etc. These topics were:

Table 7
Topics of Humor

Specific Content Categories	Session							Total
	I	II	III	IV	V	VI	VII	
I. Topics Related to the Client								87
A. Obsessive/compulsive qualities								51
1. Struggle for control/perfection		8	1		1	1	1	12
2. Ambivalence towards divorce			1		6		1	8
3. Obsessive thought			4	1		2		7
4. Difficulty changing	2		2	1				5
5. Desire for superiority/self satisfaction	1		1				2	4
6. Need for closure/intolerance of ambiguity	1					3		4
7. Desire for "right" answer*			1	2				3
8. Similarities to father*	1				2			3
9. Complication of life							2	2
10. Confusion	2							2
11. Fear of failure							1	1
B. Reaction to feelings about								
1. Wife	2	2	1					5
2. Dad	4							4
C. Depression/fear of depression/current adjustment	3	1			1		1	6
D. Naivete			2	2				4
E. Positive changes			1			1	1	3
F. Relationships/affairs	1		1		1			3
G. Possible schizophrenia	2							2
H. Reaction to men or women*	2							2
I. Skill with words				1			1	2
J. Desire to flee problems*						1		1
K. Guilt			1					1
L. Humanness*			1					1
M. Reaction to camera/research		1						1
N. Vulnerability						1		1
II. Topics Related to Client's Relatives								23
A. Father	4			4	1			9
B. Wife*	1	1	1		5		1	9
C. Parents*			1	2				3
D. In-laws				1				1
E. Mother				1				1

Table 7 (continued)

Specific Content Categories	Session							Total
	I	II	III	IV	V	VI	VII	
III. Topics Related to the Therapist			1					10
A. Perception of relationships/friends		2	1					3
B. Ignorance/ineptness*	1			1				2
C. Relationship to her father				2				2
D. Constancy*							1	1
E. Vulnerability*						1		1
IV. Topics Related to Therapy								9
A. Next appointment*		1	1			1		3
B. Therapy in general*	1				1		1	3
C. Kaiser (a potential provider of therapy)	2							2
D. Therapists in general							1	1
V. Topics Related to Issues								6
A. Relationships		2						2
B. Divorce*		1						1
C. Marriage*		1						1
D. Research/Camera	1							1
E. Schizophrenia*	1							1
VI. Topics Related to Other People								4
A. Client's friend							2	2
B. Therapist's father*				1				1
C. Homosexuals							1	1

*These topics were first introduced humorously by the therapist.

therapist's ignorance of U.S. military ranks (1), the research or videotape camera (2), the time of the next session (4), Kaiser Medical Center (a potential agency to provide therapy to the client) (2), the therapist's surprising amount of organization (1), the therapist's ineptness at sports (1), therapist's father and her relationship to him (3), the client's skill in using words (2), the therapist's age (2), the client's sexual preference (1), and a formal joke about therapy.

Looking at who was the first to address a topic humorously, the client introduced most of the topics relating directly to himself and the therapist introduced most of those relating directly to herself. Of the 24 topics about the client, he was the first to address humorously 19 of them. The therapist introduced humorously four of the five topics that related to her. After these topics had been introduced in a humorous manner the other person would often join in humorous remarks about that particular subject, at that point or in later sessions. It seemed both participants respected the other's prerogative to determine what topics were available as humorous topics.

Episodes of Laughter

The raters identified 145 episodes when one or both of the people laughed. Of these, 94% (136) were independently

identified by two or more raters and included for further analysis. These 136 episodes were composed of 24% (33 occasions) when the therapist laughed alone, 49% (66 occasions) when the client laughed alone, and 27% (37 occasions) when they both laughed. Thus, the therapist laughed on 51% of the occasions and the client on 76% of the occasions. Counting each time a person laughed as an independent event, there were 172 times when someone laughed with 74 of those occurring simultaneously and thus counted as only 37 episodes (see Table 8).

The majority of these episodes of laughter occurred simultaneously with an attempt to be humorous. A total of 62% (84 of 136) occurred with an attempt to be humorous. The largest percentage of laughter concurrent with humor per session (75%) occurred during Session II and the smallest (46%) occurred during Session V (see Table 8). The therapist produced 37% (31) of the humorous incidents that occurred with laughter, while the client produced 63% (53) of them. This is roughly equivalent to the proportions of total humor produced by therapist and client, whether or not they were accompanied by laughter (38% and 62%, respectively).

Table 9 presents the number of times the participants laughed simultaneously with incidents of humor initiated by the therapist and by the client, as well as when there was

Table 8
Episodes of Laughter

Sessions	Episodes of laughter			% Episodes per session Concurrent with humor
	Therapist only	Client only	Both	
I	4	14	8	72% (18)
II	2	13	5	75% (15)
III	4	9	7	60% (12)
IV	6	8	9	61% (14)
V	5	15	4	46% (11)
VI	4	3	0	57% (4)
VII	8	4	4	63% (10)
Total	33 (24%)	66 (49%)	37 (27%)	62% (84)
			136 (100%)	

Table 9
Initiator of Humor by Laughter Respondent

Initiated humor	Laughter				Total
	Therapist alone	Client alone	Both	No one	
Therapist	14	3	14	22	53
Client	4	34	15	33	86
No one	15	29	8	--	52
Total	33	66	37	55	191

no humorous incident. A 3×4 chi square analysis ($\chi^2 = 28.78$; $p < .01$) performed over who laughs (therapist only, client only, both, or no one) by who initiated the humorous incident (therapist, client, or no one) indicates there is a significant difference in frequency among these conditions. Both therapist and client laughed about the same proportion of times when there is no humorous incident identified (31% and 36%, respectively). The major portion of the significance is produced because they both tended to laugh more often concurrently with humorous incidents they, themselves, had produced than they did with incidents the other person had initiated. In other words, only rarely would either individual laugh at the other's humorous attempt if the initiator did not laugh.

After examining 18 incidents out of a possible 34 in which the client initiated and laughed at a humorous attempt without the therapist laughing and 7 of a possible 14 in which the therapist initiated and laughed at a humorous attempt without the client laughing, a pattern became clear. In the majority of those cases initiated by the client and not laughed at by the therapist (13 out of 18), the therapist was attending to the message contained in the client's remark without responding to his intended humor by laughing or smiling. For example, while he was talking about his sister's schizophrenia the therapist asked if he

worried about having the same tendency. He replied jokingly, "My feeling is, if it was going to surface it would already have surfaced (laughs) . . . I'll just live my life (laughs some more) and keep my fingers crossed." Rather than laughing with him, the therapist continued in a serious vein explaining that almost all people in his situation wonder about the possibility of their becoming schizophrenic and reassuring him that it was not probable.

A further examination of these instances indicated that occasionally (5 out of 18) when the client initiated humor that the therapist did not laugh at and usually (6 out of 7) when the therapist initiated humor at which the client did not laugh, a different picture emerged. In these instances, the noninitiator responded to the humor with a smile and joined in the appreciation of the humor without breaking into audible laughter.

In those instances when only the noninitiator laughed (4 of 4 for the client and 2 of 3 for the therapist), it was very clearly an appropriate and joining response. Each time, the noninitiator of the humor was either already laughing and the initiator simply added another humorous remark without laughing, or the initiator indicated appreciation by smiling. On one occasion, the therapist made a serious comment that the client reacted to as funny. In response to his friends "helpful" advice, she said, "Your

friends are always trying to save your soul." He seemed surprised, was silent, then chuckled, saying, "Isn't that what friends are for?" She smiled and replied, "Friends often have a lot of extraneous advice, mostly aimed at making their decisions sound right." Then she laughed. In this situation, it seems that the client used humor to deflect the therapist's comment. Rather than immediately joining his laughter, the therapist took his cue and continued in a more humorous vein while still presenting her alternative way of understanding the comment made by the client's friend.

Rater's Perceptions of Impact of Humor

Raters were asked to examine the impact of each humorous incident with respect to nine aspects depicted in the literature as important roles humor may play in interpersonal interactions. These aspects were: the level of tension or anxiety experienced by therapist, client, or dyad (Zuk, 1966; McGhee, 1971; Wolfenstein, 1954), the amount of intimacy experienced by the members of the dyad (Poland, 1971; Rosenheim, 1974; O'Connell, 1978; Martineau, 1972), the experience of a power differential between therapist and client, i.e., the increase or decrease of interpersonal power by either client, therapist, or both, (Kubie, 1971), the level of the client's defensiveness (Whitaker, 1975; Schimel, 1978, Grotjahn, 1971; Rosenheim, 1974), the amount

of conflict or hostility between client and therapist or other person being discussed (O'Connell, 1960; Levine, 1963; Martineau, 1972), the client's perception of himself, the therapist and other people (Kuplan, 1965; Sullivan, 1954; Schimel, 1978) and the topic being discussed (Rosenheim, 1974; Egan, 1970; Poland, 1971; Greenwald, 1975). More specifically, raters were asked to judge if the humorous incident increased or decreased the level of the first five aspects, changed or reinforced the next three aspects, and highlighted or avoided the last aspect (see Table 10). Additionally they could also indicate that the incident had no impact on the aspect being considered, i.e., was not applicable. Those occasions where there was no agreement by two or more of the raters were coded as unclassified. Interrater reliability between each pair of raters for each category was computed (see Table 10). The average interrater reliability for any given category varied from a high of 70% for the client's perception of the therapist (they primarily agreed that there was not any impact) to a low of 37% for hostility and conflict. Most categories produced values for interrater reliability in the 50% range (see values in the last column of Table 10).

The most striking finding is with regard to the topic being discussed. With agreement in 91% of the incidents (only 9% unclassified) and an average 57% interrater

Table 10

Raters' Perceptions of Impact of Humor

	Increased		Decreased		Not applicable	Unclassified	Average interrater reliability ¹
Tension/anxiety	5%		63%		20%	12%	46%
Intimacy	45		15		37	4	55
Power differential	17		15		58	10	45
Client's defensiveness	8		53		22	17	40
Hostility/conflict	4		16		66	14	37
	<u>Changed</u>		<u>Reinforced</u>				
Client's self perception	29		29		29	14	46
Client's perception of therapist	6		2		85	6	70
Client's perception of others	12		16		60	13	58
	<u>Highlighted</u>		<u>Avoided</u>				
Topic being discussed	84		1		6	9	57

¹These values were obtained by averaging the interrater reliability for the three possible pairs of raters.

reliability, the raters found only 1% of the humorous incidents served to avoid the topic under discussion, 6% neither avoided or highlighted it, and 84% served to highlight or emphasize the topic.

The majority of incidents were judged to decrease the level of tension and anxiety (63%) and the client's defensiveness (53%), to increase the level of intimacy (45%), and to have little or no impact on the power differential (58%) and the level of hostility or conflict (66%).

With regards to the judged impact of humor on the client's perceptions of self and others, it had little effect on his view of others. His perception of the therapist and of other people were judged not to be effected by 85% and 60% of the humorous incidents, respectively. Only 29% of the incidents were judged not applicable to his self perception. The 58% that were judged relevant were evenly distributed as to changing and reinforcing his current perspective of himself.

Therapist's Perceptions

Perceptions of Research

After data collection was complete, the therapist was interviewed to determine what effect she thought the research had on the therapeutic process. She was also asked her hypothesis regarding what the researcher was studying.

She reported that in her opinion it had very little impact on the treatment. The only impact she described experiencing was a slight tendency on her part to try to expand the scope and length of the therapy. Checking to see if a client is willing to deal with more than the presenting problem is a standard practice with her. In this case she said she saw him one to two sessions more than she ordinarily would have to be sure that he did not want to pursue the broader difficulties of his characterological style of handling problems.

As to the impact on the client, she thought it probably increased his interest and level of participation. Since he is an individual who feels comfortable and enjoys talking about himself and his concerns, she felt the research only served to enhance his sense of importance and motivation to participate.

The therapist stated that she had no specific guesses as to what the researcher was studying. Her only hypothesis was that it was regarding an interactional process in therapy. This was information that had been provided to her by the researcher before the study began.

Perception of Humor in Therapy

The therapist reported utilizing and enjoying humor in therapy. She spontaneously described many different ways she used humor in this therapy. Diagnostically she used it

to determine the client's level of functioning and prognosis for improvement. Since it takes an integrated sense of self to appreciate humor, she believes that the capacity to produce or appreciate humor is a good prognostic sign. Since that capacity was available, she knew that the individual had a strong enough self definition to be able to view feelings and impulses in a broader, more functional context; that is, to see himself as others might see him. Humor is also indicative of the capacity to enjoy and to resynthesize a set of facts in a new way, both of which are important in the therapeutic process as well as in life in general.

Commenting on her use of humor as a therapeutic tool, she identified several facets. She saw it as a way to build rapport, particularly in the initial stages of therapy. Sharing a smile or laugh can develop a feeling of consonance and safety. By joining him in laughing about his father, the therapist, his situation, or most anything, she could make a connection with him. "If I can get him laughing and we can both laugh together, I can find this guy." In other words, the act of laughing together tended to break through the client's initial, superficial presentation and thus allow the possibility of developing a genuine therapeutic relationship.

Another way in which the therapist used humor was to emphasize the absurdity of a particular belief or behavior.

With a sufficiently strong relationship, she could help the client laugh at seemingly insurmountable situations and, thus, begin to develop a sense of mastery rather than defeat. "Humor helps to make light of personal difficulties, to portray the fact that nothing is as catastrophic as it seems, without being patronizing." When the client accepted this change of perspective by joining her with a laugh or smile, she saw it as a willingness to "create a space," to allow room to continue exploring a difficult topic.

Humor can also be "the best reframe in the world." By using humor to change the context in which a certain feeling, thought, or behavior was seen, she facilitated the client's emergence from a negative or restrictive perspective to a more positive, adaptive one. For instance, when the client was critically and intensely describing how his wife did not meet his standards because she was not, at all, like him, the therapist replied, "Like Rex Harrison said, 'If only a woman could be more like a man!'" Suddenly his personal struggle was redefined as an age old issue, not without its humorous aspects.

Additionally, humor was a permissible way for her to support the client. In those areas where direct support would threaten his defensive presentation of "having it all under control," she was able to provide support he could

accept through a humorous remark. An example of this occurred when he called his obsessive thought process regarding whether or not to divorce his wife a "forensic debate." At that point a direct supportive remark regarding the difficulty and pain he was experiencing in making this decision might have resulted in his backing away from both the issue and the therapist. The client was not ready to acknowledge to himself or the therapist the extent to which this was disturbing him. Rather than pushing him to experience his ambivalence, she said playfully, "Forensic debate! What a wonderful way of putting it. Can I quote you some day? Anonymously, of course." He seemed to respond to her humorous compliment, relaxed, and continued talking about his internal struggle. By highlighting his eloquent and vivid description, she was able to provide him support, while humorously allowing him the freedom to continue downplaying the intensity of his feelings as he resumed his exploration of the issue.

Telling the client about himself in a way he could accept was another function that humor served. Rather than making direct comments about him, the therapist would sometimes use a humorous interaction to highlight dysfunctional behaviors or beliefs. This allowed him to accept the information without having to publicly or immediately to concur. They could both laugh because it was a joke; and

yet he could take the information with him and integrate it into own beliefs later. Without this approach, he may have been more likely to challenge or reject the same information to keep from being surprised and/or feeling stupid.

The therapist also used humor for her benefit in two types of situations. When the situation called for her to present herself as less powerful, less authoritative, or less knowledgeable for therapeutic reasons, humor allowed her to do so while maintaining her integrity. For instance, when the client talked about his father's rank in the military, she made a joke about her ignorance of military hierarchy. This allowed him great latitude to respond with his view regarding the importance of his father's rank, while allowing her to maintain her sense of self respect. Also, she used humor to deal with her feelings of boredom during therapy. At points where the discussion lapsed into a repetitious or tedious monologue, she introduced humor to restimulate both her and the client's interest. This humor additionally served to disrupt nonproductive, defensive platitudes, allowing for a return to productive exploration.

Client's Perceptions

Perception of Research

The client was contacted by the therapist after data collection was complete. He consented to being contacted by

the researcher for an interview. During the interview he said his guess as to what was being studied was the relationship of body language to interpersonal interactions, i.e., "evaluating emotional postures." As to the impact of the research on his therapeutic experience, he reported that after the first couple of minutes of the first session and the first couple of seconds of the other sessions, he would completely forget about the research.

Perception of Humor in Therapy

When told that humor was the subject being studied, he replied, "Was there any?" Rather than receiving an immediate answer, he was asked what his recollection was regarding humor in the sessions. He reported that he remembered no humor as his therapy was "a fairly sober experience." He went on to say, "I'm typically a jocular kind of person, but I don't remember telling any jokes. I do remember her [the therapist] commenting on my clever usage of words." He went on to describe how difficult that period of time was and how surprised he was that he had so much emotional difficulty with a decision that was so easy to make on an intellectual level.

CHAPTER V

DISCUSSION

Humor obviously played a significant and relevant role in this therapeutic endeavor. Both therapist and client produced and laughed at humorous incidents in each session. In fact, on an average, a humorous incident was produced approximately each three minutes. Such frequency makes this event one worthy of note.

It is clear that both therapist and client utilized humor to facilitate rather than to distract from the topic being discussed. Ninety-three percent of the topics of the humor pertained to the client, his relatives, therapy, or the therapist and 84% of the incidents were judged by the raters as highlighting rather than avoiding the topic of discussion. Finally, the therapist reported experiencing the humor as an integral and meaningful aspect of their interactions. No case can be made from this study to support those therapists (Kubie, 1971; Greenweld, 1975; Egan, 1970) who view humor as a bothersome diversion or potentially destructive behavior, for here is at least one exception.

In light of previous studies of humor in group settings (Coser, 1960; Goodrich et al., 1954; Scogin & Pollio, 1980; Peterson & Pollio, 1982), several interesting patterns are

reaffirmed. Although the therapist contributed a smaller absolute number of humorous incidents, she produced about two and a half times as many incidents per minute talked as the client did. This is consistent with previous observations (Coser, 1960) that the more powerful or higher in status a person is the more humor that person will utilize. Humor can be influential in interpersonal interactions and, as such, is frequently employed by the therapist. It is also interesting to note that she was the first to introduce humorous comments in the first session. After two such remarks, she was then joined by the client.

The amount of targeting is also not surprising given previous studies. The amount of targeting seems to increase with the intimacy of the group, i.e., short-term groups of strangers targeted only 37% of the total while staff groups, growth groups, and therapy groups targeted about 66% (Scogin and Pollio, 1980). In this setting, the focus was one of developing an interpersonal relationship within which the client could explore his intimate concerns. Since an individual therapy relationship is often more consistently interpersonally intense, the increased proportion of 90% targeted humor is understandable. Almost none of the humor in this setting was nontargeted, whimsical humor that would serve to distract the focus from a person or topic.

Again, the particular target of the humor is consistent with previous findings. Given a hierarchial structure, the

target is most frequently one of lower status (Coser, 1960, and Goodrich et al., 1954). In this situation, the therapist targeted the client and the client targeted himself. Both target others approximately the same amount, apparently joining or sharing in their humor directed at people not in the room. The fact that the therapist is rarely the target of humor, either the client's or her own, makes sense in another light as well. She is not, nor should she be, the focus of their interactions; he is. Because their agreed upon concentration is the client and his concerns, it follows naturally that the primary target and topic of their humorous incidents would be the client and his relatives.

This also explains why the correlation found in other research between targeting others and being the target is not found in this case. Scogin and Pollio (1980) report that in therapy, growth, and pool-playing groups, those individuals who directed a great deal of humor tended to be the recipients of humorous remarks. That this was not the case in this instance makes sense in light of the aforementioned facts: that the participants are of unequal hierarchial status and that the focus of the discussion is primarily unidirectional. Without other group members, of equal status and equal focus, the opportunity for a natural balance to develop did not exist. In other studies, the group composition of primarily equal members did allow for

this balancing process. Closer examination of the relationship of targeting to being targeted for the therapist or group leader of the therapy and growth groups would probably reveal that for these higher ranked members the correlation would not exist.

Although the therapist was not often the target in this study, it is interesting to note that she made herself a target somewhat more frequently than the client targeted her (she self-targeted eight times, while he targeted her twice). Through humor she would occasionally move out of the role of an authority and allow the client greater freedom in exploring or expressing his thoughts and feelings. She also utilized humor to model comfort with her fallibilities. As the client struggled for perfection, she sometimes would challenge his implicit assumption that she, too, strove toward or had achieved such a level. This acceptance and enjoyment of her human frailties intruded into his world view and allowed him to reevaluate his severe judgment of himself.

With regard to "bursts," or episodes of more than one humorous incident occurring in a short period of time and having the same topic, the majority of incidents did not occur in such groups. Unlike the therapy group described by Scogin and Pollio (1980) where 70% of all incidents occurred in bursts, only 44% of those in this individual therapy

occurred in bursts. The major difference in number of participants in each setting probably accounts for the decreased proportion of bursts. With only two participants, the 44% constitutes a relatively large percentage of interactive humor. Unlike the pool-playing group (the other setting with a low percentage of bursts), this therapeutic dyad frequently responded to each other's humor or carried their own initial remarks further when receiving acceptance. Scogin and Pollio (1980) also reported that in the therapy and growth groups, bursts of humor seemed to serve as a diversion from therapeutic interaction or a rest from an intense interaction. This is not the pattern found in the 2 or 3 incident bursts in this therapeutic dyad. Rather than a diversion or rest, humor seemed to serve as a means to continue with a difficult issue or subject without the client needing to withdraw from or avoid the topic. As was indicated by the raters, the humor often served to decrease the tension and anxiety while allowing the client to continue focusing on the anxiety arousing subject. They agreed that the humor served to decrease the level of anxiety in 63% of the humorous incidents. Concurring that humor often facilitated the continued exploration of a difficult subject, the therapist reported that she often used humor to check to see if she could help "create a space" for movement into the threatening topic. No clear pattern emerged

regarding larger episodes, as only two had more than three humorous attempts. One of these was almost exclusively a series of comments by the client (the therapist made only one of the six recorded) and seemed to be an effort on his part to slow down the discussion about how he complicated his relationships. The other was more an interactional exchange of seven attempts in which the therapist capitalized on the client's humor to facilitate a change in his perspective regarding his relationship with his parents.

As with other observations of naturally occurring humor (Scogin & Pollio, 1980), the majority of those found in this setting were negatively toned, at least in an overt sense. In fact, in this setting the humor was almost exclusively negative. While this has been seen as possible support for the view that humor is an expression of or control mechanism for aggressive behavior by Scogin and Pollio (1980), this understanding does not seem appropriate in the present case. Only 20% of the incidents were seen by raters as having any impact on the dimension of hostility and conflict. Also neither the therapist nor the client reported this dimension as playing a major role in the effect that humor had on their interactions.

The humor, though defined as negative when placed on a negative-positive bipolar dimension, was not primarily derogatory. The client's self-targeted humor was often a

humorous look at his current situation, behavior, or feelings. The negative tone reflected a dissatisfaction with some aspect but was rarely a disparaging rejection of himself. In fact, to be able to make a joke about this aspect seemed to provide him with some dignity: an ability to acknowledge this bothersome quality without being defined by it. The effect, when the humor was appreciated by the therapist, was one of joining with her beyond the experience of being caught in the confusion or pain that he had felt moments before.

When the therapist targeted the client in an ostensibly negative tone, again the impact was not depreciating. Though often quite confrontive, the therapist's humorous comments seemed to be supportive and to provide him more latitude of response than would a humorless confrontation. First, he was invited to participate in an enjoyable perspective that recognized his capacity to expand his current viewpoint. Second, her lighter approach to the topic reassured him of its manageable proportion. Third, if he was too threatened by her perspective, they could "laugh it off." This left him in a better position to reconsider at a future point since he had not felt required to argue the point. The raters reported that 53% of the humorous events seemed to decrease the client's defensiveness. This supports the understanding of "negative" humor as not

necessarily derogatory. It can demonstrate a level of trust, mutual respect, and relationship.

In the case of humor targeted at someone outside of the therapeutic dyad, the general definition of negative seems more appropriate. In these instances the therapist and client seemed to join around being somewhat disparaging towards others. Their attitude was still not totally discounting. Although some of the remarks seemed caustic, many of them were a recognition, though indirect, of the importance that individual had for the client.

Laughing also played an important role in this interaction. The majority of humorous attempts were responded to with laughter which seemed to signify an acceptance and support of the person producing the humorous incident. Even those instances when a participant laughed alone, the other usually responded with an encouraging smile and/or nod. There was one notable class of exceptions that usually occurred on those occasions when the therapist ignored the client's humorous affect and responded to the serious statement embedded in the humorous remark. This behavior may account for the fact that only a few humorous remarks served to avoid the topic at hand. In other words, the therapist's selective response to client humor may have encouraged therapeutically productive humor while discouraging humor that was not.

One problem involved in examining the data produced by rater perceptions regarding the impact of humor is that although it is possible to get agreement among two out of three raters in a given interaction, the picture regarding specific pair-wise agreements between raters is much less clear. Here values range from a high of 70% to a low of 37% with most falling around 50%. These findings would seem to indicate a good deal of disagreement for specific instances. The use of a 2-out-of-3 procedure may provide an overly generous method for defining interpersonal impact. By the same token, average reliability scores may be too stringent, since there was no systematic pattern of disagreement or agreement between any two raters. That is, Rater 1 would just as often agree and disagree with Rater 2 as with Rater 3. The same pattern applied for Raters 2 and 3. In any case, it would seem wise to use both procedures to provide a range of reliability indices and leave the final decision to the reader.

Thus in this therapeutic endeavor, humor played a useful role for both therapist and client. It highlighted the topic under discussion, often allowing further exploration by breaking the tension or reassuring the client of his capacity to handle the situation. Following the patterns of humor in other settings, it was primarily targeted at the individual with a lower hierarchical status. The person

targeted more frequently was also the agreed upon focus: the client. The large proportion of targeted vs. non-targeted humor is consistent with previous observations of more targeted humor in situations where the participants have an ongoing intimate relationship.

The majority of humor was seen by raters, therapist, and client as decreasing tension and anxiety, and client defensiveness. In this instance it seemed not to play a large part in the control or expression of hostility. As with humor found in a therapy group (Peterson and Pollio, 1982), humor targeted at others outside the group or dyad tended to build cohesiveness thus fostering therapeutic effectiveness. Self-directed humor on the client's part was by and large a useful way of coping with the potentially shameful and painful task of self-examination. Humor directed at him by the therapist was often simultaneously confrontive, supportive, and freeing. The client's potentially nonproductive or distracting humor seemed to be limited by the therapist's lack of laughter in response to it. Rather than supporting that humor she would attend to the serious meaning it carried.

The implications of results provided by the present analysis for therapists are complex. Though it is apparent that in this instance--with these two individuals--humor was both enjoyable and useful, it does not mean that all

therapists with all clients should set out to be more humorous. Humor is not a rote behavior that can be injected into everyone's therapeutic style with every client. Appropriate, successful humor is contextual, intuitive, and spontaneous, thus not able to be introduced at will. Rather the implications for therapists are to allow humor to emerge from both the client and therapist. To encourage a respectful yet playful approach to life and people, to "hold lightly" those concerns that threaten to skew one's perspective to a dull and deadly seriousness, that is the option of the therapist. From that, humor can appear and once it appears can often elicit a like response and grow.

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APPENDICES

APPENDIX A

EXPLANATION TO PARTICIPANTS OF THE RESEARCH PROJECT

This research project has been developed to investigate the impact and usefulness of a specific type of interaction between therapist and client in the therapeutic process. The goal is to better understand the nature of this interaction and to ascertain how this interaction can be utilized therapeutically.

This study is being conducted by Jacque Martin, a doctoral candidate in clinical psychology at the University of Tennessee, under the supervision of Howard R. Pollio, Ph.D., a faculty member of the Psychology Department at that university. Ms. Martin is currently working in Santa Clara County as a family therapist and coordinating a program for adolescents and their families who are experiencing difficulties.

Participation in this study will consist of the videotaping of your next ten therapy sessions and answering a few brief questions about your experience in therapy, after the ten sessions are completed. Your participation is completely voluntary. After the study is completed, Ms. Martin will be glad to talk with you and your therapist about the specifics of the study, i.e., what was looked at and what the results were. At no time will your name or other identifying information be reported. Only six people involved in this study will be permitted to view the tapes and they will be carefully reminded about their responsibility to protect your privacy.

Thank you for considering to participate in this study. If you have any questions please tell your therapist and we will arrange to have them answered.

APPENDIX B

CONSENT FORM

Researcher: Jacque Martin, 884 Lafayette St., Santa Clara, Ca. 95050

Faculty Adviser: Howard R. Pollio, Ph.D., University of Tennessee

Before agreeing to participate in this research project I have been informed of the following:

1. Participation in this study is completely voluntary and refusal to participate will have no effect on my eligibility for therapy nor on my treatment.
2. I can at any point terminate my agreement to participate in the study by notifying my therapist or Jacque Martin. At that point information collected with regards to me will be excluded from the study and any video tapes of me will be erased.
3. The purpose of this project is to study various processes that occur during therapy sessions including nonverbal behaviors, communication content and patterns, and the effects of these on the therapeutic process.
4. In order to study these phenomena, therapy sessions will be videotaped. The tapes will be viewed by only the principle researcher, two therapists, and three undergraduate or graduate students who will serve as research assistants to aid in the analysis. Each will be required to sign a statement that they have been informed of their responsibility and have agreed to protect my privacy.
5. No identifying information will be used when this research is summarized and reported.
6. After the sessions have been recorded and analyzed, I may have an explanation of what specifically was studied and what results were found, if so desired.
7. After the sessions have been recorded, I will be asked to answer some questions about my experience in therapy. I may refuse to answer any or all of the questions.
8. At the completion of this research project, the tapes will be erased unless some other agreement has been made between me and my therapist.
9. I have been given the opportunity to ask questions and they have been answered to my satisfaction.

I hereby grant permission for you to use video tapes and my answers to questions regarding my experiences in therapy for the dissertation research described.

Witness: _____

Participant: _____

Date: _____

Date: _____

APPENDIX C

RESEARCH AGREEMENT

Information concerning the individuals taped for this research project is strictly confidential. I understand that in order to protect the privacy of the people involved I am not to disclose to anyone outside the project any identifying information about the participants in this study. I may discuss the research and general findings as long as such information in no way jeopardizes the participants' privacy. At no time will I view tapes nor obtain any information regarding any person I know, with the exception of the therapist. If I become aware at any point that I know an individual or any person being mentioned, I will immediately stop the tape and inform Jacque Martin that I cannot participate in analyzing any tapes concerning that person.

Witness: _____ Participant: _____
Date: _____ Date: _____

APPENDIX D

INSTRUCTIONS FOR IDENTIFYING HUMOR

1. Rate only one therapy session at a time.
2. Watch the entire therapy session to familiarize yourself with the general nature of the session.
3. Watch the session a second time carefully, picking out each instance that you think someone was trying to be funny, that is attempting to be humorous. Do not let other situational variables influence your identification of humorous instances; i.e., laughter, or the lack of laughter. Don't look for a specific form of humor, for example, a formal joke or story, verbal or non-verbal. Rather, look for any behavior that you see as someone attempting to be humorous, successful or not. It is your impression that is important. Try to react as if you were there during the session.
4. When an instance has been identified, use the form provided to record:
 - a. footage on the tape meter
 - b. person initiating the humor, therapist or client
 - c. a brief description of the incident to aid in relocating the humorous attempt and to determine if raters have seen the same event
 - d. specific subject matter of the humor; i.e., wife therapy, parents, etc. (if an instance seems to include more than one subject, please include all relevant subjects).
5. You may want to stop the tape, rewind, and review a particular segment before making a decision. This is permissible and you may review a section of tape as many times as you desire.
6. Be sure to zero the videotape meter before engaging the play button. If you are unsure if the tape has been fully rewound, please try to rewind it. Even if the therapy sessions does not begin immediately (if there is some blank tape), please start the tape meter at the beginning of the tape.

APPENDIX E

HUMOR DATA SHEET

Session Number _____

Rater _____
Date _____

Situation Number	Person Initiating	Footage	Brief Description	Subject
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APPENDIX F

INSTRUCTIONS FOR IDENTIFYING LAUGHTER

1. Watch the session, picking out each time someone laughs. Do not let other situational variables influence your identification of laughter, i.e., the presence or lack of something funny occurring. If anyone laughs for any reason, please record it.
2. When laughter has been identified, use the form to record the following:
 - a. footage of the tape meter
 - b. person who laughs first
 - c. whether or not the other person joins in the laughing
 - d. amount of time spent laughing by each person, using the stopwatch provided to time the length of laughter
 - e. subject being discussed when the laughter first occurred
3. You may want to stop the tape, rewind, and review a particular segment before making a decision. This is permissible and you may review a section of tape as many times as you desire.
4. Be sure to zero the videotape meter before engaging the play button. If you are unsure if the tape has been fully rewound, please try to rewind it. Even if the therapy session does not begin immediately (if there is some blank tape), please start the tape meter at the beginning of the tape.

APPENDIX G

LAUGHTER DATA SHEET

Session Number _____

Rater _____
Date _____

Situation	Person	Length			
Number	Laughing/Joined?	Footage	Therapist/	Client	Subject

[illegible]

APPENDIX H

INSTRUCTIONS FOR CLASSIFYING HUMOR

1. Using the list of humorous instances, locate each instance and classify it according to the following categories:
 - A. Targeted humor: This is humor which has some object or focus and can be considered poking fun at, being sarcastic about, or being aggressive toward that object.
 - (1) Self-targeted (Self)--humor which is at the expense of the humor initiator; the initiator or his own behavior is the object.
 - (2) Targeted toward the other (Other)--humor targeted toward the other person in the therapy session.
 - (3) Targeted toward generalized other (Gen. Other)--humor directed toward other persons not in the therapy session, things, institutions, etc.
 - B. Aggrandizement humor: This humor has an object or focus and can be seen to be indicating positive regard, raising the esteem, or supporting by positively connoting the object.
 - (1) Self-aggrandizement (AGR-Self)--humor with the initiator as the object.
 - (2) Aggrandizement of the other (AGR-Other)--humor directed toward the other person in the therapy session.
 - (3) Aggrandizement of generalized other (AGR-Gen. Other)--humor directed toward persons not in the therapy session, things, institutions, etc.
 - C. Nontargeted humor (NT): This is humor with no object or person targeted. It is an attempt to be humorous without directing the comment toward any person, place, or thing.

- D. Unintelligible (Unint): There may be instances when you are unable to understand enough from the tape to allow you to make a classification. If this occurs use this classification.
 - E. Unclassifiable (Unclass.): There may be instances when none of the provided categories appear to be appropriate. If this is the case, do not hesitate to use this classification.
2. Watch each tape from the beginning. Using the information provided on the list of instances (footage, person initiating, brief description, and general subject matter), locate the instance on the tape as you view the session. At the end of the humorous instance, stop the tape and code it according to the above mentioned categories. You can review any instance as often as desired.
 3. When you have decided on a classification, place the appropriate notation (found in parentheses for each category) on the list of instances.
 4. If classifications other than those used here occur to you, make a notation on the list and call them to the attention of the researcher.
 5. IMPORTANT: Be sure to zero the counter when starting the tape. DO NOT wait for a picture to appear before zeroing the counter.

APPENDIX I

RATER'S PERCEPTIONS CODING SHEET

[illegible]

APPENDIX J

INSTRUCTIONS TO THERAPIST AND RESEARCHER

Please look at each instance of humor listed on the sheet given to you (see Appendix K). Describe the meaning of this humorous occurrence, i.e., what lead to or helped create this humorous incident. Then describe the effect or impact you see this incident as having on the therapeutic endeavor or relationship.

APPENDIX K

DATA SHEET FOR PERCEPTIONS OF HUMOR INCIDENTS

Session Number _____

Name _____

Date _____

Incident # _____ Footage _____ Person Initiating _____

Meaning:

Impact:

Incident # _____ Footage _____ Person Initiating _____

Meaning:

Impact:

Incident # _____ Footage _____ Person Initiating _____

Meaning:

Impact:

VITA

Jacquelynn Ferguson Martin was born February 27, 1951, in Richmond, Virginia. After attending many different primary and secondary schools due to the frequent moves of a military family, she entered The University of Tennessee, Knoxville, in 1969. In 1973 she graduated with high honors, obtaining a Bachelor of Science in Marketing Administration.

Entering a new field, she spent the next two years in the graduate study of psychology. She then entered the Clinical Psychology Program at The Univeristy of Tennessee in 1975. In 1978 after finishing all requirements except her dissertation, she did a one-year internship at the Palo Alto Veterans Hospital in California. She spent the next four years directing a short-term residential program for adolescents in crisis and their families. In June 1983, she completed her dissertation and received her Ph.D. in clinical psychology.