To the Graduate Council:

I am submitting herewith a dissertation written by James M. Koelln entitled "A Phenomenological Investigation of Humor in Psychotherapy." 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:

Charles P. Cohen

Robert G. Wahler

F. Stanley Lusky

Accepted for the Council:

Lew Minkel
Vice Provost
and Dean of The Graduate School

A PHENOMENOLOGICAL INVESTIGATION OF HUMOR IN PSYCHOTHERAPY

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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James M. Koelln

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ABSTRACT

The purpose of this study was to develop a thematic category system, which described the phenomena of humor and laughter in psychotherapy as experienced by the psychotherapist. In order to accomplish this, an empirical, phenomenological methodology was utilized. Ten articulate and experienced psychotherapists were interviewed about "funny or humorous" incidents that occurred in psychotherapy.

Data analysis was accomplished by clustering similar thematic content into a smaller number of more inclusive themes. This ultimately resulted in a thematic category system consisting of two major and eight minor themes. These included:

I. Therapeutic Qualities of Humor in Psychotherapy
   - A. Intimacy and the Therapeutic Relationship
   - B. Diagnostic and Prognostic Aspects of Patient Humor
   - C. Using Humor for Psychotherapeutic Change

II. Specific Qualities of Humor Occurring in Psychotherapy
   - A. Figure Ground Reversals and Other Odd Figures
   - B. Spontaneity
   - C. Playfulness
   - D. Bodily and Affective Experiences
   - E. Temporal Aspects: Brevity and Rate

Particular methodological issues of this study were explored. Specific issues discussed included: phenomenological methodology, the semistructured nature of the research interview, characteristics of

participants in this study, as well as the use of this particular methodology with narrative data. The results of this investigation were also discussed in terms of their relevance to the existing clinical, theoretical and empirical literature on humor in psychotherapy. It was discovered that the existing literature seemed to emphasize the psychotherapeutic aspects of humor in psychotherapy, rather than of humor per se. Interestingly, the participants of this study also maintained a similar focus. Hence aspects of the first major theme were found to be more easily related to the existing literature than aspects of the second major theme were. Finally the clinical implications of this study (i.e., such as the advantages and dangers of using humor) were discussed.

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INTRODUCTION

Humor and laughter are pervasive phenomena which are an aspect of all human relationships. In this particular research project the place of humor and laughter in psychotherapy was explored. These phenomena were investigated from the perspective of one of the co-participants, namely the psychotherapist. A number of therapists were interviewed regarding humorous incidents which occurred in therapy. The goal of the research project was to provide an "exhaustive description of the investigated phenomena" (Colaizzi, 1978) and to identify emerging themes.

In the first chapter the literature on humor and psychotherapy was reviewed. As Levine (1977) has pointed out "the paradox of humor is the extraordinary diversity of purposes it serves. In fact some are diametrically opposite to one another" (p. 132). For instance:

> We may laugh in scorn and derision or in sympathy and affection. We may tell a joke to convey hostility or to share intimacy. Humor both exposes hypocrisy, and hides unpleasant truth. If you laugh without reservation you are considered to be either mad or mentally healthy. We may laugh to allay anxiety, like "Whistling in the dark", or our laughter may express the opposite, relief from anxiety. A joke is "one man's meat but another man's poison", or as William Hazlitt put it, "sport to one but death to another". Viewed one way humor is regarded as a trifling, destructive and degrading force to morality, religion and art; viewed another, it is a liberating and socially constructive force by exposing sham and hypocrisy. (Levine, 1977, p. 132)

The literature review presents what has already been said about these seemingly contradictory and paradoxical phenomena.

It is important to note that in the process of developing categories for the literature review, that the investigator had a strong sense that these categories were all intimately related and that the divisions between them were somewhat arbitrary and artificial. Hence these divisions are perhaps best viewed as variations in emphasis, or shifts in figure/ground, rather than as sharply divided, mutually exclusive categories.

The emphasis in the literature review was on humor and laughter as it occurs in individual psychotherapy with adults. Humor and laughter in child therapy (Domash, 1975; Loewald, 1976; Orfandis, 1972) and family therapy (Zuk, 1955, 1963, 1966) were only mentioned insofar as they relate to individual adult psychotherapy. The literature review also primarily dealt with humor as it occurs in the context of traditional psychotherapy. Hence theoretical approaches which heavily emphasize humor such as Provocative Therapy (Farrelly & Matthews, 1981, Farrelly & Lynch, 1987) and Natural High Therapy (O'Connell, W. E., 1981, 1987) were not discussed. Most of the literature reviewed was either descriptive and/or theoretical in nature (Bloomfield, 1980; Boorstein, 1980; Dewane, 1978; Ellis, 1977; Frankl, 1963, 1965, 1967; Fry & Salameh, 1987; Greenwald, 1967, 1977, 1987; Grossman, 1977; Killinger, 1977; Kubie, 1971; Kuhlman, 1984; Levine, 1977; Mindess, 1976; O'Connell, M. J., 1978; Poland, 1971; Rasch, 1978; Reik, 1948; Roncolli, 1974; Rose, 1969; Rosen, 1977; Rosenheim, 1974, 1976; Salemeh, 1983; Spiegel, 1969). However, empirical studies were also examined (Brown, 1981; Buckman, 1980, 1984; Burbridge,

1978; Childs, 1976; Golub, 1979; Kaneko, 1972; Killinger, 1978; Labrentz, 1974; Martin, 1983; Magdell, 1982; Nies, 1982; Peterson, 1980; Peterson & Pollio, 1982; Pollio & Bainum, 1983; Schienberg, 1980; Scogin & Pollio, 1980). The literature review also dealt rather specifically with humor in psychotherapy. Although numerous theories regarding humor have been postulated (for an excellent survey see Keith-Spiegel, 1972), the literature review dealt specifically with humor as it emerges in treatment. Theories of humor were only discussed in this capacity. Since psychoanalytic theory (Freud, 1905/1960, 1928/1960; Kline, 1977; Kris, 1952; Simon, 1977; Wolfenstein, 1954) has had the most pervasive impact in this area, this theory was the one most frequently discussed.

In the final section of the literature review the phenomenological approach to research was examined (Colaizzi, 1978; Giorgi, 1971; Idhe, 1977; Jones, 1984; Pollio, 1982). This review of the phenomenological research literature was not exhaustive but was rather aimed at giving the reader some understanding of this alternative approach to conducting research.

The second chapter dealt with the particular methodology used in this investigation. The methodology utilized in this study was phenomenological, with an emphasis on description rather than hypothesis testing. Demographic data regarding the ten participants--all of whom were practicing psychotherapists--was provided. Their background and training as clinicians was also reviewed. After this, the investigator then when through the exact

procedures utilized in this research project. Next, the steps taken in data analysis were reviewed. Finally, the process of obtaining interrater reliability was described.

In the third chapter, the specific results of this investigation were reviewed. The narrative form of the data obtained was discussed. In addition, the thematic category system developed, was described in detail. Basically there were found to be two major and eight minor themes. These included:

I. Therapeutic Qualities of Humor in Psychotherapy
   - A. Intimacy and the Therapeutic Relationship
   - B. Diagnostic and Prognostic Aspects of Patient Humor
   - C. Using Humor for Psychotherapeutic Change

II. Specific Qualities of Humor Occurring in Psychotherapy
   - A. Figure Ground Reversals and Other Odd Figures
   - B. Spontaneity
   - C. Playfulness
   - D. Bodily and Affective Experiences
   - E. Temporal Aspects: Brevity and Rate

The fourth and final chapter began with a discussion of methodological issues. After this, the specific themes and subthemes noted above were examined in terms of their relevance to the existing clinical, theoretical and empirical literature on humor in psychotherapy. In addition, the clinical implications of this study were discussed.

CHAPTER I

LITERATURE REVIEW

Humor and Psychotherapy

The Relevance of Humor for the Psychotherapeutic Relationship

There are those theorists who postulate that humor is crucial to the relationship that develops between therapist and patient (O'Connell, M. J., 1978; Poland, 1971; Rosenheim, 1974, 1976). Of all those describing humor M. J. O'Connell (1978) more than any other therapist sees humor as being vital to the psychotherapeutic relationship. He speaks most directly about the relationship between humor and psychotherapy. O'Connell's position on the place and importance of humor in the therapeutic relationship is that humor "allows, encourages and establishes genuine human object relatedness, which is the main goal of treatment and without which treatment can only make superficial progress" (p. 2). He is heavily influenced by the Object Relations theorists Fairbairn (1954) and Guntrip (1969, 1971) and views "human object relatedness" as the main goal of treatment because he believes, as do Guntrip and Fairbairn that all ego development can only occur through the medium of good personal (object) relationships. As Guntrip so succinctly puts it "good object experience leads to good ego development." O'Connell agrees with Guntrip's position that "psychotherapy at any level but particularly at the deepest can only occur as a result of a personal object relationship" (Guntrip, 1969,

p. 310). Furthermore that "what the patient brings to analysis is at bottom, behind all his defenses, a need for a relationship with someone who in loco parentis will enable him to grow, a need which must be met by what the therapist brings to analysis" (p. 350). If the patient can only undo the damage done to him and experience ego growth and development through his object relationship with the therapist, then humor becomes important because it promotes a therapeutic (object) relationship which is necessary for therapeutic change to occur.

O'Connell (1978) also sees humor as being vital to the therapeutic relationship as the natural adversary of the antilibidinal ego. This aspect of the personality is described by Guntrip (1971) as "an underdeveloped, childish conscience, negative and hostile, self-persecuting, inducing fear and guilt, the main source of resistance to psychotherapy" (p. 98). According to O'Connell (1978) the antilibidinal ego is totally humorless and has as its goal "a cold encapsulated pristine perfection with no needs and no weaknesses" (p. 1). In Freudian metapsychology the antilibidinal ego would be analogous to a harsh sadistic superego. According to Fairbairn and Guntrip the antilibidinal ego attacks the libidinal ego, a split off aspect of the self which craves personal (object) relationships. It is beyond the scope of this investigation to delve into the reasons for this attack; we can see, however, that the antilibidinal ego does interfere with the establishment of object relatedness so necessary for psychological growth and development. This is another reason O'Connell believes that humor in therapy is so important, since it can be utilized

to attack and weaken the hold of the antilibidinal ego. This will facilitate object relatedness, which in turn will promote psychological growth and development.

It is important to note that O'Connell (1978) speaks of humor both as a "therapeutic enemy of the anti-libidinal ego" and as a means of promoting "human object relatedness." The therapist's use of humor, as a weapon against the antilibidinal ego, does promote "human object relatedness." In using humor to establish and promote a therapeutic (object) relationship, the therapist also battles the antilibidinal ego since "object relatedness is the only successful means of combat against the anti-libidinal ego" (p. 2). Humor also indirectly combats "the anti-libidinal ego by strengthening the patient's capacity for object relatedness" (p. 12). The above statements make it clear that these two perspectives are intimately related. In fact, O'Connell implies that their relationship may be an inverse one when he writes that "from the early humor of bantering through transcendance humor [stages of humor postulated by O'Connell] object relatedness is ever increasing, and the domain of the antilibidinal ego is continuously being reduced" (p. 12).

Another theorist who views humor as a significant factor in the psychotherapeutic relationship is Rosenheim (1974, 1976) who describes humor in terms of an "interactive experience." Unlike O'Connell (1978) who emphasizes the importance of humor for the establishment of a real and personal object relationship, Rosenheim (1974) views humor as "a tool for overcoming resistance and more substantivally, as a

corrective emotional experience" (p. 591). According to Rosenheim (1974, 1976) humor is a special form of interpersonal interaction that can enhance ego development by increasing the patient's self awareness, facilitating insight and encouraging more open affective reactions in the patient.

It is interesting to note that Rosenheim (1974, 1976) does not stress the importance of humor in the development of personal (object) relationships to the same degree as O'Connell (1978). Rosenheim does believe, however, that the "unique value and potency of humor in psychotherapy derives mainly from its intrinsic attributes of intimacy, directness and naturalness" in that "it draws patient and therapist into a closer alliance than is often possible through a more formal, purely rational modality" (1974, p. 591). In fact, Rosenheim (1974) believes that a therapist who is going to take a "humorous approach" with a patient must have a "certain readiness for mutuality with the patient" (p. 585). He sees humor as departing from "the more formal kind of clarifications and interpretations by virtue of the closer participation with the patient in an inner experience," for "humor is characterized by a measure of warmth and affectivity which demonstrates to the patient that the therapist can tolerate naturalness which so many patients have yet to learn to tolerate. Humor is intimate" (p. 585). Hence Rosenheim and O'Connell seem to differ more in emphasis than in content.

Humor as a Diagnostic Tool

Psychiatric patients are frequently described as being rather humorless. Rosenheim (1974) writes that "all too often one encounters in therapy people whose affective tone is excessively gloomy, either temporarily as in reactive depression or permanently as in the schizoid or obsessive personality. The latter who are characterologically 'dry' experience life as a grave, joyless affair" (p. 587). McKinnon and Michaels (1971) concur with this viewpoint when they describe the paranoid patient as someone who "thinks of himself as having a good sense of humor" but "in actuality lacks the ambiguity required for true humor" (p. 288). They believe that the "sardonic laugh" of the paranoid "reflects his pleasure in the sadism or aggression of a situation" but that "more complex types of humor are beyond his grasp" (p. 288). Perhaps O'Connell (1978) puts it best when he suggests that "the first issue of humor in treatment is no humor. In the early stages of treatment, more often than not, the situation is oppressively serious" (p. 4).

Both Rosenheim (1974, 1976) and O'Connell (1978) suggest the introduction of humor by the therapist early on in treatment may be useful for diagnostic purposes. Rosenheim (1974) believes that the:

> careful introduction of a humorous remark as a "trial ballon" may be of some diagnostic value as well as assessing the patient's capacity for spontaneity and his preparedness for active self exploration. (p. 587)

In a similar vein, O'Connell (1978) writes that during the opening phase of treatment:

> the therapist needs to pay attention to what might be called

> "recognition humor." In other words, when the therapist initiates humor he is attempting to see if the patient can "get it." The questions are: Can the patient see? Can he see at multiple levels? If the patient can see, can he join in the humor and play with the therapist. (p. 4).

Hence both theorists believe that by examining a patient's reactions to a humorous intervention one can obtain a great deal of significant information. For example one can assess a patient's capacity for spontaneity and interpersonal relatedness, his preparedness for active self exploration as well as his ability to view world and self at multiple levels. The patient's initial capacity for humor also gives a clue as to how adaptively he deals with life problems such as separation, illness and death; as well as destructive aspects of himself. O'Connell (1978) and Rosenheim's (1974, 1976) position is lent some indirect support by the empirical work of Nussbaum and Michaux (1963) who examined the responses of depressed patients to riddles, jokes and funny stories. Their "results offered tentative support for the significance of the humor response as a predictor and evaluator of change in depressed patients" (p. 538). These researchers believe that a patient's response to humorous stimuli can be used to assess the depth of a depression; which can have implications for later response to treatment.

The content of jokes and other humorous remarks made by the patient can also be of diagnostic significance. Psychoanalysts believe that jokes and other humorous remarks provide an outlet for the expression of repressed "instincts" and wishes in disguised or symbolic form. As Kline (1977) states "the joke, like the dream, makes possible the satisfaction of an instinct that would otherwise be banned" (p. 9).

According to the psychoanalytic perspective, jokes and other humorous productions can be analyzed in a manner similar to dreams and slips of the tongue. In fact psychoanalysts essentially believe that jokes, like dreams, can provide information regarding a patient's unconscious conflicts and motivations.

The importance of the actual content of jokes and other humorous productions has been discussed in terms of diagnostic usefulness. Zwerling (1955) believes that a patient's jokes can be utilized to determine areas of anxiety related to central conflicts. Although Zwerling (1955) does not think that jokes necessarily provide us with "information undiscoverable by other means, such as the analysis of dreams or of early memories," he does believe that "jokes are concise and pointed, and may be particularly useful when a light touch is valuable for a tentative approach to a troubled area" (p. 105). In a similar vein, Grossman (1977) believes that his work on the diagnostic and therapeutic significance of jokes has "experimentally and clinically demonstrated that both general personality factors and problems of personal significance find their means of expression through jokes" (p. 149). Spiegel et al., for instance, in an examination of the favorite jokes of suicidal patients likewise found that "suicidal subjects told significantly more jokes with a self-punishing theme than did nonsuicidal controls" (p. 504).

The diagnostic significance of a joke is illustrated in the following vignette by Grossman (1977). In this particular instance the joke alerted Grossman "to a specific problem area and the prognosis for the

patient in treatment" (p. 151). The joke was told by a 23 year old male paranoid patient with persecutory delusions. The joke goes as follows:

> This man comes to a doctor, complaining that his voice was too deep and his penis too long. He tells the doctor that his wife complains of the way he sounds and that he would like to be able to speak in a softer and higher-pitched voice. The doctor examines him and tells him that he can help him by cutting off several inches from his penis. The man agreed and the operation is a success. Soon after the operation he returns to the surgeon, and speaking in a well-modulated voice tells him that although his voice is everything he wanted it to be, still his wife was not happy. She would like him to have his long penis again. The doctor replies, in a very deep voice, "that would be a very difficult operation." (p. 151)

Grossman describes this patient as being very difficult to motivate for treatment. He believed that this paranoid young man's "constant fear was that, in curing him, the doctor would take something away from him" (p. 151). According to Grossman the patient soon thereafter left therapy "with the feeling that he would rather keep his problem than change" (p. 151). Hence, in this instance, the patient's joke was very revealing of his fears regarding the therapeutic relationship.

Although a patient's favorite joke may at times provide some very useful information, both Zwerling and Grossman recognize the limitations of this diagnostic technique. As Zwerling (1955) points out:

> The technique has several limitations. Some patients fail to report a favorite joke. A joke may be a favorite simply because the patient has elicited a favorable response by repeating it to others. Some jokes may arise from the social problems of a cultural group rather than from the conflicts of the individual. Some patients have so great a variety of problems that virtually any joke seems to be related to some essential conflict. The technique is limited to certain types of therapy. (p. 113)

Grossman (1977) agrees when he writes that:

> the favorite joke is not always connected with a patient's problem: on many occasions it may merely be a joke that was heard and repeated with success. The reward of laughter . . . is what makes the joke a favourite and not its personal meaning. It may also be that some jokes that are reported as favourites are more a function of social learning and may reflect problems of cultural groups, not specifically those of the individual who repeats them. . . . In addition some people's problems may be so complex that many kinds of jokes reflect some aspect of their personality. (p. 151)

Although not dealing specifically with humor in treatment, it is interesting to note that humor has been used diagnostically in other capacities. Strother, Barnett and Apostolakos (1954), for instance, conducted empirical research indicating that "objectively scored judgements of cartoons have potential value as a projective technique" (p. 42). In fact Redlich, Levine and Sohler (1951) actually developed a psychological test, the Mirth Response Test (MRT), consisting of 36 cartoons selected from well known magazines. The responses and preferences of their subjects to the cartoons were examined for their diagnostic value. One of Redlich et al.'s major findings was that "disturbances in humor behavior are associated with disturbances in other areas" (p. 721). According to Redlich et al., disturbances in humor "were manifest in five primary ways: (1) disturbance in mirth and other expressive behavior, (2) characteristics of cartoon preferences and rejections, (3) failures and misunderstandings of specific cartoons, (4) perceptual errors and distortions of cartoon details, (5) personal references and associations" (p. 722). These researchers also found that in analyzing test results that they could make "inferences about the subject's aggressive, sexual and dependent needs and the defenses

mobilized against their expression" (p. 732). They also utilized results to make "diagnostic and dynamic formulations" regarding each subject. Although Redlich et al.'s work does not directly address the issue of humor in psychotherapy, it does attest to the usefulness of humor as a diagnostic tool.

In addition to the issues already discussed, changes in humor can indicate that major changes in therapy are taking place. Harrelson and Stroud (1967), for instance, observed humor in chronic schizophrenics involved in a "resocialization-remotivation group." They found, as the group progressed, "a decrease in regressive distance maintaining, and hostile humor responses and their replacement by healthier forms of warmer more involved and spontaneous humor" (p. 460). M. J. O'Connell (1978) postulates that humor may indicate a readiness to enter the "heart of therapy" where the patient "moves into the interior and surveys the impoverishment and damage" (p. 7). According to O'Connell, patients are very ambivalent about moving into the interior and "one of the signals that the ambivalence is coming to a resolution is a form of humor where the patient laughs at his need to see his problems as simple and easily dispatched" (p. 7). This type of humor is portrayed in the following vignette by O'Connell:

> A patient came into my office in full flight towards health. He talked rigorously about his problems being solved but rapidly began to wind down. Then he attempted to reinstate his optimism by saying "I see the light at the end of the tunnel, I really do." He paused, looked depressed and added, "No, not really, I think a train is coming." (p. 7)

Both Kohut and Reik also view the emergence of humor as indicating progress in treatment. Kohut (1971) discussing "the course

of the analysis of narcissistic personalities" writes "that the emergence of the capacity for genuine humor constitutes yet another important--and welcome--sign that a transformation of archaic pathogenic narcissistic cathexes has taken place" (p. 324). In a similar vein, Reik (1948) states that "laughter at one part of the ego . . . indicates that the patient is capable of looking at something he has hidden away for a lifetime and acknowledging it as something familiar" (p. 250).

Humor as a Form of Interpretation

Humor has also been considered as an effective means of circumventing a patient's defenses in order to make an interpretation (Grossman, 1977; Grotjahn, 1971; Levine, 1977; Poland, 1971; Rose, 1969). In his discussion of laughter in group psychotherapy, Grotjahn (1971) suggests that jokes are an excellent means of making an interpretation because they often are able to bypass resistance and hence become more acceptable to a patient. According to Grotjahn, an additional advantage to jokes is that in the final analysis it is left up to the patient to understand the message being conveyed to him. Grossman (1977) believes that jokes are particularly useful when a "light touch . . . may be valuable for approaching a patient in a non-threatening fashion when some of the more traditional means are not adequate or appropriate" (p. 151).

The utilization of humor as a means of interpretation has been discussed in detail by Rose (1969). He believes that a humorous interpretation "may transmit reality across ego boundaries in the right blend of distance and closeness" (p. 936). In Rose's estimation

humorous interpretations may be particularly useful with preoedipal conditions where the boundaries between self and object representations are often blurred. With these types of disorders, interpretations may be "too readily spit out" or "swallowed whole" and hence experienced as an invasion of the ego which leads to a subsequent fear about loss of self. Rose sees humor as being particularly useful in the treatment of these disorders because:

> its form provides enough distance and similarity to the unconscious fantasy, or the feared reality, that its content may be taken in without fushion and not spit out automatically. Its form provides enough palatable texture that its content registers on the ego boundaries without blurring the distinction between inside and outside, self and not-self. When successful, humor is like the lens of transference which leads to increased appreciation of reality. Like transference or a work of art, humor may represent a literal lie, but it conveys a truth larger than itself. (p. 937)

The use of humor as a form of interpretation is well illustrated in the following vignette by Poland (1971):

> The patient was a 40 year-old professional man who had what I call a "Yes, but" character. He was initially extremely enthusiastic to the point of being almost hypomanic as he bubbled over about all that was good in the world Evil, at this point, was centered in his wife as he saw her.
>
> The initial phase of the patient's relationship with me was also one of extreme enthusiasm. He was pleased with all that I had to say, even though I had no impression that it in any way altered his view of the world or his behavior. He was even happy when I interpreted the projective nature of some of his manic defenses, but this too left the mechanism itself seemingly untouched.
>
> After about two months the patient's delight in me changed to the direct opposite. For several weeks it seemed as if our work were dedicated to his analysis of my flaws, malevolence and character defects. Every intervention I made was further evidence for his recognition of my problems. Naturally, in each instance there was some validity to what he saw, yet this was distorted and magnified in his attempt to condemn me. Efforts at intervention seemed of no

> avail as I tried to point out the transferential nature of his views and to re-establish a therapeutic alliance.
>
> At one point in the patient's discourse on my flaws he reflected "I used to hang on your every word." With a laugh I spontaneously erupted, "and now I hang on my every word." (p. 128)

According to Poland his humorous intervention was well timed and came at a point when the patient was rather reflective. The patient laughed in response to the interpretation and was able to use it in order to "effect an ego split" and join the therapist in objectively observing his (the patient's) own behavior.

Therapeutic Techniques Utilizing Humor

The use of humor in psychotherapy seems to cross the boundaries between various psychotherapeutic schools of thought. Therapists of different theoretical persuasions have all devised therapeutic techniques utilizing humor (Boorstein, 1980; Ellis, 1977; Frankl, 1963, 1967, 1969; Greenwald, 1967, 1977; O'Connell, M. J., 1978; Roncoli, 1974; Salameh, 1983).

Boorstein (1980), for instance, adhers to a Transpersonal perspective and has outlined six techniques utilizing humor which are part of his therapeutic "armamentarium." These include:

1. de-emphasizing, when it is appropriate or necessary, the impact of a particular personal life story or crisis by attempting to view it in the context of the larger cosmic drama;
2. the use of certain teaching stories from major spiritual traditions (the Hasidic and the Buddhist usually, since these are the ones that I am most familiar with), both as a diagnostic tool and also to encourage new points of view on the part of the clients;
3. the use of the concept that on some level we choose all of our experience and, to that degree, cannot hold onto the idea that we are solely "victims" of our past

experience or need to continue to be victims of our current experience;

4. the use of an aspect of mindfulness meditation practice, nonjudgmental witnessing, as a technique to develop the "watcher" aspect of ourselves;
5. the presentation of myself and the room in which I work in a more relaxed and cheerful way than is traditionally associated with psychotherapy;
6. the attempt to have the people I work with see each new crisis or stressful situation as a challenge rather than just another crisis that has befallen them. (pp. 105-106)

The founder of Rational-Emotive Therapy, Albert Ellis (1977), also makes frequent use of humorous techniques. He does so in order to help patients become less perfectionistic, increasingly responsible and more accepting of themselves and the world in which they live. M. J. O'Connell (1978) has suggested the use of various techniques--such as bantering, name calling and expansion--in his work with patients. In fact, Salameh (1980) has devised a classification system of "therapeutic humor techniques." The classification system consists of the following categories: surprise, exaggeration, absurdity, the human condition, incongruity, confrontation/affirmation humor, word play, metaphorical mirth, impersonation, relativizing, the tragic-comic twist and bodily humor. A table developed by Salameh (1983) with definitions and clinical illustrations of each of these humorous techniques is included in Appendix A, Table A-1.

To provide a better sense of the use of humorous techniques in treatment, the techniques of bantering and exaggeration are discussed below in detail. The latter technique is included in Salameh's (1983) classification system, the former is not. The use of bantering by the therapist will be discussed first. In M. J. O'Connell's (1978) system,

bantering is the first stage of humor in treatment. As mentioned earlier, in the discussion of humor as a diagnostic tool, O'Connell believes that most patients who come to therapy are "oppressively serious" and generally demonstrate an absence of humor. As O'Connell put it: "the first issue of humor in treatment is no humor" (p. 4). Initially the therapist wants to know if the patient can understand humor initiated by the therapist--can he get the point? At this stage the therapist is dealing with "recognition humor" on the part of his patient.

O'Connell (1978) sees bantering as the therapist's initial attempt to establish "object relatedness" with the patient. When the therapist banters with a patient he is insisting "that the relationship be real", and "on not being the nonperson the patient wants him to be" (p. 5). In using this type of humor the therapist is actively defying the antilibidinal ego by first of all refusing to go along with its policy of "cold-isolation" and by asserting that the patient can be more than a "stilted problem broadcaster." In addition, O'Connell insists that this type of humor "sets the stage for a superficial but actual alliance between the therapist and the patient's central ego" (p. 5).

An example of bantering can be seen in the following interaction between O'Connell and one of his obsessional patients. The patient asked O'Connell very seriously about his diagnosis. O'Connell initially pretended to be serious but then told the patient "I think you are a kangaroo." Apparently at first the patient seriously considered this possibility but then laughed and retorted saying "Yes I am a kangaroo and you're an asshole." Both therapist and patient laughed after this

exchange. Apparently O'Connell felt that bantering was helpful for this patient since it provided him with an outlet for his hostility and disrupted his "oppressive, deadening, interpersonal tempo."

Many therapists recommend bantering as a treatment strategy with obsessive-compulsive patients. Roncoli (1974) in particular describes the use of bantering with such patients to help them gain insight, become participant observers of their behavior and "begin to appreciate the comic and the tragic . . . the laughable and lamentable aspects of their obsessional way of life" (p. 172). Roncoli sees the obsessive patient as having ambivalent and aggressive feelings towards his therapist. Apparently an obsessive patient will often doubt the integrity of his therapist and insist despite all evidence to the contrary that he the patient is truly worthless. According to Roncoli these patients will often provoke anger, anxiety and rejection from their therapists. By using "irony, humorous depreciation, exaggeration, and impersonation" (p. 173) the therapist can dramatize the patient's complaints, momentarily interrupt his obsessional doubting and provide an outlet for his aggression through laughter. The former vignette by O'Connell illustrates clearly the use of bantering for these purposes.

In the use of bantering the therapist may appear to the patient as both a benevolent and ridiculing authority. According to Sullivan (1956) obsessional patients tend to have parents who are overtly benevolent and covertly hostile. In bantering the therapist shifts the pattern by being overtly ridiculing and covertly benevolent. Roncoli (1974) feels that the patient will recognize this pattern (even though it

is reversed) and that the bantering will bring the patient's ambivalence closer to awareness. This is a positive step because it provides the therapist an opportunity to help the patient become more aware of his aggressive feelings. This aggression must be released before affectionate feelings can be shown towards the therapist and a stronger patient-therapist relationship established.

The second humorous therapeutic technique to be discussed is exaggeration. Salameh (1983) defines exaggeration as an "obvious overstatement or understatement regarding size, proportion, numbers, feelings, facts, actions" (p. 76). Exaggeration can be utilized to achieve a number of therapeutic goals including helping a patient gain a sense of proportion and perspective on his problems, as well as helping the patient maintain an inner focus. There are clinicians, such as MacKinnon and Michaels (1971), who caution against the use of humor with paranoid patients. However, Greenwald (1967) demonstrates the successful use of exaggeration with a patient who he describes as "overly suspicious":

> When such patients used to ask me if an innocent electric socket was a concealed microphone for taping their remarks, I used to explain carefully the real purpose of the socket and they still remained suspicious. When a suspicious woman recently asked me that question I told her that not only was it a microphone but that even as she spoke to me her remarks were being broadcast over a national radio network and millions of housewives were letting their dinners burn on the stoves while they listened to her problems. (p. 45)

According to Greenwald this intervention had a positive effect on the patient. She laughed and replied "I really believe you [Greenwald] are more disturbed than I am, but I've realized that my suspicion is

really a wish to be the center of attention. When I worry about people talking about me really I would like them to" (p. 45). In this instance the patient was able to gain some understanding and perspective on her paranoid delusion.

O'Connell (1978) has also used exaggeration--"the expansion technique"--in work with clients. He believes that by using expansion the therapist can help the patient maintain an inner focus by humorously demonstrating how the same negative patterns occur over and over again. It is his contention that by "expanding how often these tragic situations happen and how predictably they happen a certain comic effect can take over" (p. 6). As an example O'Connell tells us that "to be abruptly rejected by a bountiful woman can be tragic; however to be abruptly rejected by 116 bountiful women begins to sound like a Hollywood extravaganza" (p. 6). Hence the expansion technique helps the patient accept that the destructive aspects of himself are the common denominator of his difficulties.

Frankl (1963, 1967, 1969) has devised a therapeutic technique called paradoxical intention, which also makes use of exaggeration. In this technique "the patient is encouraged to do, or wish to happen, the very things he fears" (Frankl, 1969, p. 102). Frankl (1969) believes that in paradoxical intention "the pathogenic fear is replaced by a paradoxical wish . . . (and) the wind is taken out of the sails of anticipatory anxiety" (p. 103). This technique is especially recommended in the short term treatment of phobic and obsessive-compulsive

patients. The use of paradoxical intention is illustrated in the following vignette by Frankl (1969):

> The patient refused to leave his house because every time he did he had attacks of fear that he would collapse on the street. Every time he did leave his house he returned after a few steps. He ran away from his fear. He was admitted to my department at the Poliklinik. My staff gave him a thorough checkup and made certain that there was nothing wrong with his heart. One of the doctors told him that. Then he suggested the patient should go out on the street and try to get a heart attack. The doctor told him, "Tell yourself that yesterday you had two heart attacks, and today you have time to get three--it's still early in the morning. Tell yourself that you will have a nice, fat coronary and a stroke to boot." For the first time the patient was able to break through the cocoon in which he had enclosed himself. (p. 106)

Frankl strongly believes that "paradoxical intention should always be formulated in as humorous a manner as possible" (p. 108). In his estimation "humor allows man to create perspective, to put distance between himself and whatever may confront him. By the same token, humor allows man to detach himself and thereby to attain the fullest possible control over himself" (p. 108). He also believes that "to make use of the human capacity of self-detachment is what paradoxical intention basically achieves" (p. 108). Hence we see that Frankl places a great deal of value on the use of humorous exaggeration.

Outlet for Hostility

Humor has also been described as an outlet for hostility (Freud, 1905/1960; O'Connell, 1978; Wolfenstein, 1954). Freud (1905/1960) in his work Jokes and Their Relation to the Unconscious discussed the use of jokes in this fashion. Basically Freud distinguished between two types of jokes: the "innocent" and the "tendentious." Whereas

innocent jokes derive their pleasure simply from technique--for example condensation of words, multiple meanings--tendentious jokes also provide an outlet for our sexual and aggressive "instincts." According to Freud tendentious jokes can be of two types: "either a hostile joke (serving the purpose of aggressiveness, satire or defense) or an obscene joke (serving the purpose of exposure)" (p. 97). In this discussion only hostile tendentious jokes will be considered. Freud believed that the "joke work" or actual mechanism of the tendentious joke provided a distraction which allowed for the indirect expression of aggressive (and sexual) feelings in disguised, derivative form. In this fashion jokes bear a marked resemblance to dreams. It is important for this discussion to note that Freud believed that hostile jokes were particularly useful with authority figures, who he viewed as being protected from direct disparagement by "internal inhibitions and external circumstances" (p. 105).

Wolfenstein (1954) is another psychoanalytic theorist who has extended the work of Freud. In her investigation of children's humor, Wolfenstein outlined the ways in which the joke facade changes and develops over time. She discovered that "as inhibitions against the direct expression of hostile motives increase with age, increasingly complicated disguises are elaborated on the joking treatment of these themes" (p. 21). In other words, as the child internalizes his society's norms, the joke work or joke facade becomes more complex and the expression of hostility (and sexuality) more indirect. Essentially in the development of the joke facade "two processes keep pace with

one another: the child's increasing scruples about simple release of impulse, and his progressive acquisition of techniques for circumventing these scruples" (p. 191).

Neither Freud (1905/1960) nor Wolfenstein (1954) directly addressed the use of humor in therapy as an outlet for hostility. Their work is crucial in this regard, since both theorists view humor as an indirect means of expressing hostility. Obviously anger is a common experience in relationships, including psychotherapy. This may be even more true in therapy, when one considers the intense feelings typically evoked in the transference relationship. Certain factors, however, mitigate against the patient's direct expression of anger in treatment. For instance psychiatric patients typically have a poor sense of self esteem and frequently experience difficulty asserting themselves and their needs. Also they often have difficulty expressing negative feelings such as anger, especially against authority figures. Since the therapist is frequently viewed as some sort of authority figure, it may be difficult for the patient, at least initially, to express his anger towards him. Hence it seems that at certain points in treatment, such as in the early stages, joking and laughter may be an ideal way for the patient to indirectly express his hostility without fear of retaliation or loss of relationship. As Zuk (1966) stated in a different context "laughter . . . may be used to disguise feelings which if expressed directly might lead to a serious disruption of relationship" (p. 100). These indirect expressions of hostility through humor can be explored in therapy and the patient helped to become

more aware of and responsible for his "negative" feelings. As therapy progresses the patient can also be encouraged to learn how to express these feelings more directly.

Humor as a Coping Device

Numerous theorists have discussed the use of humor as a means of asserting freedom and ego mastery as well as coping with life's problems (Boorstein, 1980; Ellis, 1977; Frankl, 1963, 1965, 1969; Freud, 1928/1960; Greenwald, 1967, 1977; Levine, 1977; Mindess, 1976; O'Connell, M. J., 1978; Pollio, 1983; Wolfenstein, 1954). This is clearly evident when we examine the writings of some of these theorists. Freud, for instance, in his 1928 paper "Humour" discusses some of humor's protective capacities. According to Freud (1928/1960) humor has:

> something liberating about it, but it also has something of grandeur and elevation. . . . The grandeur in it clearly relies on the triumph of narcissism, the victorious assertion of the ego's invulnerability. The ego refuses to be stressed by the provocation of reality, to suffer. It insists that it cannot be affected by the traumas of the external world; it shows in effect that such traumas are in fact no more than occasions for it to gain pleasure. This last feature is a quite essential element of humour. (p. 162)

Freud further asserts that "humour is not resigned" but "rather rebellious [since] it signifies not only the triumph of the ego, but also of the pleasure principle, which is able here to assert itself against the unkindness of the real circumstances" (p. 163). Essentially Freud believes that by adopting a humorous attitude a person: (1) "refuses to suffer" (2) "emphasizes the invulnerability of his ego by the real world" (3) "victoriously maintains the pleasure principle" and

(4) manages to do all this "without overstepping the bounds of mental health" (p. 163). Wolfenstein (1954), who examined children's humor from a psychoanalytic perspective, sees joking as "a gallant attempt to ward off the oppressive difficulties of life, a bit of humble heroism, which for the moment it succeeds provides elation" (p. 11). Finally Pollio (1983) also emphasizes the freedom producing qualities of humor. In a discussion of the explosive quality of laughter, Pollio writes that when one laughs:

> What is "breaking up" is the person and what is being "broken up" is the person's experience of his or her body in some specific situation, in some specific society, in some specific period of history; in short the person has "exploded" or "broken out" from the psychological limits imposed by the contemporary situation and for a moment is afforded the experience of what some philosophers (such as Sartre) might term radical freedom. On an experiential basis laughter provides a continuing body metaphor for freedom in which the person experiences himself as free of constraints imposed by others, society, time and even his own body. (p. 215)

Now considering the protective power which humor bestows, at least temporarily, one can understand how it might be advantageous for patients to adopt a humorous attitude towards the world. As Frankl (1963, 1965, 1969) has often stated, one may not always be able to change the causes of one's suffering, but one can change one's attitudes towards them. We might also add parenthetically "and sometimes a humorous attitude does this the best." Greenwald (1977) humorously makes this point when he writes that "if they [patients] want to laugh at some of their problems we [therapists] try to help them see that if you're stuck with a lemon it's a good idea to make lemonade" (p. 161). Greenwald (1977) and Mindess (1976) advocate

that therapists actively help their patients develop their sense of humor. They propose this be accomplished by having therapists serve as models for their clients. Both therapists believe that this nonserious attitude should extend to the therapists not taking their own profession too seriously.

Viewed from a certain perspective, humor can be seen as a means of coping with "external" life problems such as war, catastrophe, illness/impending death of self and others. Freud (1928/1960) illustrates this capacity with his now classic example of the "criminal who was being led to the gallows on Monday" and remarked "'well the week's beginning nicely'" (p. 161). In addition Freud demonstrated the adaptive capacity of humor by the way he dealt with difficult situations in his own life. Simon (1977), for example, tells us that during the Second World War, Freud was continuously harassed by the Gestapo. Freud was eventually provided with an opportunity to leave Austria, on the condition that he sign the following statement:

> I Prof. Freud hereby confirm that after the Anschluss of Austria to the German Reich I have been treated by the German authorities and particularly the Gestapo with all due respect and consideration due to my scientific reputation, that I could live and work in full freedom, that I could continue to pursue my activities in every way I desired, that I found full support from all concerned in this respect, and that I have not the slightest reason for any complaint. (p. 390)

Simon, quoting Ernest Jones, tells us that:

> Freud had of course, no compunction about signing it, but he asked if he might be allowed to add a sentence which was: I can heartily recommend the Gestapo to anyone! (p. 390)

We see that for Freud the adaptive capacities of humor were more than idle theory!

The use of humor as a means of coping with life difficulties has been explored in various contexts. Numerous authors (Boorstein, 1980; Freud, 1928/1980; Greenwald, 1977; Levine, 1977) have discussed the ways in which humor can be utilized in the face of death. In fact Greenwald (1977) believes that this is one of humor's major functions since all "human beings suffer from the knowledge that we are about to die and humor is one of the few aspects, one of the few ways of dealing with that knowledge. That's why there are so many jokes about death" (p. 162). Robinson (1983) has discussed the role of humor in coping with physical illness, while Obrdlik (1942) has shown how humor helped an entire nation under seige. The ability to use humor as a coping device in difficult life situations, is perhaps best illustrated by Frankl (1963), who describes its use in facing the many horrors of 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)

In addition to dealing with difficult life problems, humor can also be viewed as a means of coping with more intrapsychic issues such as fear and anxiety as well as with the destructive aspects of the self. Previously we observed how O'Connell portrayed humor as the natural adversary of the antilibidinal ego or destructive aspects of the self. Rose (1969) agrees with O'Connell when he writes that humor "may be

directed against the archaic aspects of the superego" (p. 933). Wolfenstein (1954) who studied humor in children, believes that children of all ages use joking as a means of alleviating the pain and anxiety generated by the problems and conflicts of a particular life period. Although "the particular exigencies which jokes aim to alleviate vary with age, the basic motive of briefly triumphing over distress, of gaining a momentary release from frustration persists" (p. 12). According to Wolfenstein, this is true even for adults since "the adult never really attains the power which the child imagines he will have when he grows up. We are far from being masters of our world, and are lucky if we achieve a fraction of our desires. Thus humor remains a beneficient resource. Only complete omnipotence could dispense with it" (p. 12).

Developing Perspective

Closely related to the notion of humor as a coping device, is the idea of using humor as a means of developing perspective. Numerous theorists have discussed the use of humor in this fashion (Boorstein, 1977; Mindess, 1976; O'Connell, 1978; Rasch, 1976; Sullivan, 1954). Sullivan (1954) the founder of Interpersonal Psychiatry, for instance, believes that 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). Boorstein, a Transpersonal psychologist, concurs with this view when he writes that humor can reduce "the impact of a particularly difficult event or drama by attempting to place

the whole life in the context of a broader cosmic drama" (p. 106).

O'Connell (1978) describes humor as:

> a display of humanism (which) is necessary if one wishes to live a life of quality with a sense of proportion. It allows the individual to playfully see the self and the world at multiple levels. Its fluidity oils the human condition. This elusive human capacity helps maintain the perspective needed to function effectively under stress. Irreverance permits the individual to disengage when situations or the self are being taken too seriously. (p. 3)

One is here reminded of Freud's (1928/1960) description of humor as a benign aspect of the superego, which like a kindly parent tells a child "Look here is the world which seems so serious! It is nothing but a game for children--just worth making a jest about!" (p. 166). Here the superego helps an intimidated ego deal with a life situation which threatens to become overwhelming.

Usually humor facilitates the development of an adaptive perspective by helping a patient put his problems into a broader context. Through this means, the importance of any particular life problem is minimized. At times, however, this strategy can be reversed. Sometimes humor can be used to highlight the significance of a particular moment/decision/event. Mindess (1976) illustrates the latter point in his description of a colleague's therapeutic intervention:

> A psychiatrist of my acquaintance . . . once responded to a patient's proclamation that he intended to commit suicide by jumping off the roof of the hospital with "Oh that's exciting. How do you plan to do it? A double flip? In your pajamas or in the raw? After all, it's a once-in-a-lifetime experience, so you'll want to make the most of it." (p. 337)

According to Mindess, the psychiatrist believed that "his remarks . . . hit home, as the patient recognized in this verbal caricature the

histrionic attention-seeking quality of his behavior and was thus enabled to perceive himself in clearer perspective" (p. 337). Here the therapist choose to emphasize the importance and uniqueness of a single life choice.

One type of humor which clearly illustrates the development of an adaptive perspective is transcendence humor. This type of humor was first described by Rasch (1976) and later elaborated by O'Connell (1978). Rasch (1976) describes transcendence humor in dyadic psychotherapy as a:

> "private joke" in which much is taken for granted. The humor is understood between the two. An outsider would be puzzled by it. It occurs infrequently . . . [and] generally arises with patients who have been in intensive psychotherapy for a considerable length of time. This humor is gentle, but biting, and deals with absurdity, paradox, and particularly the isolation and separateness of the human condition. (p. 12)

This type of humor bears a marked resemblance to humor which Mindess (1976) believes deserves to be called therapeutic. According to Mindess such humor must

> extend beyond wit, beyond laughter to a clear awareness of our common absurdities. It must constitute a dimension of experience that lets us admit that whatever we profess is only partially true at best that lets us know that we are all more unreasonable, corrupt and pretentious than we openly acknowledge, and that lets us feel that this is no great cause for concern and indignation. (p. 338)

Transcendence humor is beautifully illustrated by O'Connell (1978), in a description of an interaction between himself and a very disturbed adolescent boy. Here they are talking about his fortress, an analogy he frequently used throughout therapy:

> Therapist: Your fortress is a funny place. In some places the walls are 11 feet thick and made of brick, stone and steel, and, in other places it's made of paper-mache.
> Patient (to my surprise): Yeah, and there is a sign that says enter here. You could probably break in with a B.B. gun.
> We both laughed.
> Therapist: What would I find?
> Patient: Oh, some old guy in the basement with a can opener and a box of Cheerios.
> Patient paused and added, "Some big battle--you with a B.B. gun and me with a can opener."
> We both laughed gently and fell peacefully silent as he added, "The real bitch is that there isn't any milk to go with the Cheerios."
> We quietly and sadly laughed again. (p. 11)

In this vignette we see illustrated all the qualities of humor earlier described by Rasch (1976) and Mindess (1976).

Controversy Over the Use of Humor in Psychotherapy

Numerous therapists have examined the benefits and potential dangers of utilizing humor in psychotherapeutic treatment (Kubie, 1971; Levine, 1977; Rose, 1969; Rosenheim, 1974; Salameh, 1983; Mindess, 1976). Lawrence Kubie, a noted psychoanalyst, is perhaps the most extreme critic of the use of humor and laughter in psychotherapy. In his estimation humor should rarely be used in the psychotherapeutic process and then only by experienced psychotherapists. Basically he feels that the dangers of humor in therapy far outweigh its potential benefits. Salameh (1983) concisely summarizes Kubie's concerns regarding the dangers of humor and laughter in therapy:

> He (Kubie) noted that the therapist's humorous remarks can block patients' self disclosure and confuse them as to whether the therapist is "really serious or only joking." Patients

> could also perceive the humorous therapist as mocking them, to which they may subsequently react either by reinforcing their own defenses against accepting the importance of their symptoms or by depressively joining the therapist's perceived invitation to engage in self-flagellation. Moreover, Kubie proposes that therapists can use humor to mask their own hostilities or anxieties towards the patient, to gratify their exhibitionistic needs for self-display, to avoid dealing with patients' painful experiences, or to block deeper therapeutic exploration of patient's conflicts. On the other hand, Kubie interprets the use of humor by patients as a ploy intended to seduce therapists out of their therapeutic role and lure them into a nonproductive playful role. In conclusion Kubie argues that humor should be used in a limited fashion and only by experienced therapists during the later stages of the therapeutic process . . . he warns that the inexperienced therapist may be tempted to use humor too early in therapy, which would subsequently have detrimental consequences for clients. (p. 83)

It should be noted that few other theorists take such an extreme view on the use of humor as Kubie does. Most of these therapists (Levine, 1977; Mindess, 1976; Rose, 1969; Rosenheim, 1974, 1976; Salameh, 1983) would agree that humor, like any other psychoanalytic technique, if not used wisely can be dangerous and detrimental to treatment. Indeed several of these therapists (Mindess, 1976; Levine, 1977; Salameh, 1983) acknowledge that Kubie has adequately outlined the potential abuses of humor. However, all of the therapists mentioned above believe that humor, when judiciously used, can have a beneficial effect in psychotherapeutic treatment. As Rose (1969) so clearly points out the use of humor and laughter in psychotherapy depends "like all interventions on the analyst's tact, judgement and awareness in weighing the effects of making a particular remark at a given moment in the light of countertransference. Obviously one never uses humor self indulgently" (p. 932). "As is the case with any

other technique employed in psychotherapy, the legitimacy and efficiency of the use of humor will depend on the number of qualitative parameters; namely who does what with whom, why, when and how" (Rosenheim, 1974, p. 584). Levine (1977) essentially agrees with these views when he asserts "if a therapist's use of humor is destructive to the therapeutic process in any way . . . he is acting incompetently" (p. 133). Roncoli (1974) illustrates the sensitive and judicious use of humor when she tells us that the therapist must consider "the degree to which the obsessional defense interferes with productive living" (p. 174) before utilizing humor with the obsessional patient.

It appears that most therapists see humor in a more balanced way than Kubie does. Although acknowledging its destructive potential, most believe that when used appropriately, humor can be a powerful therapeutic instrument. This balanced view of humor is reflected in Salameh's (1983) Humor Rating Scale, which rates humor on five levels ranging from destructive to outstandingly helpful. A copy of this scale is included as Appendix A, Table A-2. Salameh also has differentiated some of the characteristics of therapeutic versus harmful humor which are summarized in Table 1. Perhaps Salameh describes the current state of affairs the best when he writes that:

> the question posed at this juncture is not whether humor is a viable therapeutic modality, but rather in what form and dosage it is most therapeutic, under which conditions, for which therapist in interaction with which patient, in conjunction with which other therapist personality traits, and how therapists can be trained in its effective use. (p. 85)

Table 1

Therapeutic versus Harmful Humor (from Salameh, 1983)

Therapeutic Humor	Harmful Humor
Concerned with impact of humorous feedback on others	Unconcerned with impact on others
Has an educational, corrective message	May exacerbate existing problems
Promotes the onset of cognitive-emotional equilibrium	Prevents the onset of cognitive-emotional equilibrium
May question or amplify specific maladaptive behaviors but does not question the essential worth of all human beings	Questions sense of personal worth, such as in racist jokes
Implies self- and other-awareness	Implies self- and other-blindness
Has a gentle, healing, constructive quality	Has a callous, "bitter aftertaste," detrimental quality
Acts as an interpersonal lubricant; constitutes an interpersonal asset	Tends to retard and confound interpersonal communication; constitutes an interpersonal liability
Based on acceptance	Based on rejection
Centers around clients' needs and their welfare	Reflects the perpetuation of personal dysfunctional patterns
Strengthens, brightens, and alleviates	Restricts, stigmatizes, and retaliates
Aims to reveal and unblock alternatives	Aims to obscure and block alternatives

Empirical Research

As Salameh (1983) has pointed out there has been a marked increase since the early 1970's in empirical research in the area of humor and psychotherapy (Brown, 1981; Buckman, 1980, 1984; Burbridge, 1978; Childs, 1976; Golub, 1979; Kaneko, 1972; Killinger, 1978; Labrentz, 1974; Martin, 1983; Megdell, 1982; Nies, 1982; Peterson, 1980; Peterson & Pollio, 1982; Schienberg, 1980; Scogin & Pollio, 1980). As he noted, a good number of these studies are unpublished doctoral dissertations. In this section, five of these studies will be reviewed; the first two of these deal with humor in groups (Peterson & Pollio, 1982; Scogin & Pollio, 1980); the third deals with humor as it occurs in a brief individual psychotherapy (Martin, 1983), whereas the final two studies deal with interview data (Buckman, 1980, 1984).

As noted earlier the first two studies deal with humor in groups. Scogin and Pollio (1980) examined naturally occurring humorous remarks in six different settings. The six settings were: (1) psychiatric staff conferences (Goodrich, Henry & Goodrich, 1954); (2) case presentations at mental health staff meetings (Coser, 1960); (3) a social group of elderly black men playing pool; (4) a University Counseling Center growth group; (5) a therapy group and (6) 12 sets of short-duration, problem-solving groups conducted in an experimental psychology laboratory.

Scogin and Pollio (1980) discovered that in the first five groups approximately 66% of the humorous remarks were targeted, that is directed at a specific person, place or thing. The major exception

occurred with short-term, problem-solving groups where only 36% of the humorous remarks were targeted. In this group participants did not know one another prior to the experiment and their focus was on problem solving rather than group interaction. In all groups studied deprecating humor far exceeded appreciative humor. Interestingly this occurred even in the short-term, problem solving groups. The ratio of deprecating to appreciative humor was found to be about 3:1 or 2:1. Scogin and Pollio also found that humorous remarks frequently occurred in sequences of two to five remarks. They discovered that more enduring groups, such as therapy groups, tended to produce longer and more frequent episodes. In general single item and more extended episodes were generally either appreciative or neutral in tone; whereas intermediate episodes tended to be more deprecatory in nature.

When cross-person targeting was examined, a relatively strong correlation was found between targeting and being the target of others. According to Scogin and Pollio (1980) this result "suggests that humor serves as a type of checks and balance system within a group; that is, a person who might be overly aggressive in terms of targeted humorous remarks is likely to get a greater number of remarks in return than would be true for a person who initiated a smaller number of remarks" (p. 843). Interestingly Scogin and Pollio do not believe that the external/objective viewpoint is the best way of understanding the function and significance of humor. Rather these investigators believe that humor is best understood from the perspective of the group.

They postulate that from this perspective even deprecatory humor can be seen as providing group support. First of all such remarks single out and pay special attention to the person being targeted; secondly these remarks provide an acceptable outlet for personal and group discomfort; and finally such humor strengthens the bonds within the group by evoking "the communal response of group laughter."

The second study to be examined was conducted by Peterson and Pollio (1982) who examined the therapeutic effectiveness of differentially targeted remarks in an ongoing therapy group. These researchers discovered that approximately 75% of the humorous remarks were targeted and that about 56% of all remarks were negative in tone. The ratio of negative to positive remarks was about 3.5 to 1.

These investigators utilized the Hill Interaction Matrix to evaluate therapeutic effectiveness during five minute segments of group therapy. They compared differentially targeted remarks (self, other, generalized other) by examining the level of therapeutic effectiveness before, during and after each humorous remark was made. The following results emerged: humorous remarks directed against other group members were preceded by high levels of therapeutic effectiveness. After such remarks were made, therapeutic effectiveness generally decreased. In contrast humorous remarks directed against generalized others (institutions or persons outside the group) were typically preceded by low levels of therapeutic effectiveness and were subsequently followed by an increase in therapeutic effectiveness. As Peterson and Pollio (1982) point out

> by targeting someone outside the group, a humorous remark served in Lorenz's . . . apt phrase, "simultaneously to draw a line and form a bond." The line drawn was obviously against the outside "other" while the bond formed was obviously a reaffirmation of the contemporary group sanctioned by the communal response of laughing together. (p. 49)

The final category, self-targeted humor, was generally preceded by a high level of therapeutic effectiveness (though not as high as the "other group member" category). Upon making such a remark there was a decrease in therapeutic effectiveness; however, this was subsequently followed by an increase. A close examination of self-targeted remarks indicated that such remarks served a multiplicity of functions and that their meaning and pattern were rather unique. These researchers found that their results supported:

> the conclusion that other-directed remarks reduce therapeutic effectiveness by distracting the group, that generalized-other remarks augment therapeutic effectiveness by promoting group feeling, and that self-targeted remarks have no unequivocal meaning or effect on group process. (Peterson & Pollio, 1982, p. 48)

Martin (1983) also examined humor as it occurred in a brief seven session individual therapy. This study is particularly interesting since it presents a more "objective/external" counterpoint to the present study. In her study, Martin found that humor was a frequent occurrence in individual psychotherapy. In fact a humorous event occurred approximately once every three minutes. The overwhelming majority (62%) of humorous remarks were produced by the patient; however, the patient produced fewer humorous remarks per minute than the therapist (.29 per minute in contrast to .79 per minute). The vast majority (90%) of humorous incidents were targeted, that is

directed at a specific person, institution or idea. Most of the targeted remarks were "negatively" toned. The most frequent target was the patient and his concerns. Although most of the humor was negatively targeted, Martin did not consider such humor to be derogatory in nature. As Martin points out:

> 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. (p. 96)

She also found that:

> 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 [the patient] more lattitude 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. (p. 96)

The raters in Martin's study also reported that humor frequently (53%) seemed to decrease client defensiveness. According to Martin (1983) this "result supports the understanding of 'negative' humor as not necessarily derogatory. It can demonstrate a level of trust, mutual respect and relationship" (p. 97). Humor was also frequently seen as reducing tension and anxiety (63%) and client defensiveness (53%) as well as increasing the level of intimacy (45%). It was found to have

little impact on the power differential (Not Applicable 58%) or the level of hostility or conflict (Not Applicable 66%). Martin discovered that the only humor not encouraged by the therapist was some client initiated humor to which the therapist responded by emphasizing its serious underlying content. In this study Martin found that the humor used was obviously therapeutic. Martin cautions, however, that "humor is not a rote behavior that can be injected into everyone's therapeutic style with every client" (p. 100). She believes that "because appropriate, successful humor is contextual and spontaneous, therapists should allow and encourage humor to emerge naturally rather than artificially injecting it" (p. v).

The final two pieces of research to be reviewed deal with interview data. Both of the studies to be discussed were conducted by Buckman (1980, 1984). In her initial study Buckman (1980) interviewed eight therapists (two psychologists, two psychiatrists, two social workers and two psychiatric nurses) regarding their use of humor in psychotherapy. Buckman described her research as "a qualitative study of the experiences and views of eight therapists reporting thoughts and beliefs about their use of humor during therapy sessions" (p. v). According to Buckman "the purpose of this study was to explore psychotherapists' conceptualizations of the use of humor as an intervention in the process of psychotherapy" (p. 1).

Buckman (1980) found that her sample self selected into two different theoretical groups: half of her subjects self selected into a more psychoanalytic/psychodynamic group, the other half, into a

humanistic/systems group. Buckman discovered that the psychoanalytic group was more cautious in their use of humor in treatment. They discussed their use of humor in terms of increasing therapist and client vulnerabilty and of interfering with transference. On the other hand, the humanistic/systems people tended to view their use of humor as a therapeutic use of self which helped establish a therapeutic alliance. In Buckman's estimation these two concepts (transference and vulnerability; self disclosure and alliance) served "as thematic connectors between the therapist's practicing frameworks and the resultant themes" (p. 66).

In her investigation Buckman found a number of major and minor themes emerged from the interviews. A major theme was one mentioned either explicitly or implicitly by five or more therapists. Eleven major themes were discovered. These included:

(1) humor as a diagnostic and assessment tool,
(2) types of humor,
(3) humor as a shared human interaction,
(4) cautions and abuses of humor,
(5) humor as a defense mechanism,
(6) humor as an indicator of self-esteem and observing ego,
(7) humor as a tension reliever,
(8) sharing one's use of humor with other therapists,
(9) humor as thoughtfully spontaneous,
(10) humor as being interpretive in nature, and
(11) humor as the therapist's use of self.

(Buckman, 1980, p. 72)

In addition to the major themes, four minor themes were elaborated. A minor theme was one mentioned by four or fewer therapists. Minor themes were most frequently mentioned by therapists with a humanistic/systems orientation. These themes included:

(1) the use of humor in therapy teaches the client about life;

(2) humor is an essential part of the therapeutic process;
(3) the uniqueness and ease of the use of humor with children, and
(4) the use of humor with adolescents as a tool "par excellence."

(Buckman, 1980, p. 104)

Buckman found that the existing literature was reflective of the themes which emerged in her study. She discovered that the literature was particularly supportive of the views of those who adhered to a psychoanalytic/psychodynamic perspective. Apparently this was less the case with those who adhered to a humanistic/systems perspective. In her estimation it seemed that the latter's views were either new or not reflected to any degree in the literature.

More recently Buckman (1984) expanded upon her initial research, by significantly increasing the number of therapists interviewed. In total, she interviewed thirty-two therapists including: eight psychologists, eight psychiatrists, eight social workers and eight psychiatric nurses. Her "purpose," in her most recent research project, was identical to that in her initial study: "to explore psychotherapists' conceptualizations of their use of humor as an intervention" (p. 1). Once again, Buckman "was only interested in exploring humor as a therapeutic dynamic and intervention used by the therapist"; she explicitly emphasizes how "social humor had no relevance within the context of this study" (p. 4).

As in her initial research, Buckman (1984) found that her therapists "self selected" evenly into "two theoretical/clinical frameworks"; and again, emphasized how she, as researcher, "did not screen for this development" (p. 12). Here again half of the therapists

interviewed were found to practice more "traditional analytic (psychodynamic) therapy"; whereas the other half operated from a more "humanistic/systems framework." In this more recent research, Buckman essentially differentiated the use of humor by these two groups, in a manner almost identical, to the way she had in her initial research.

As a result of this most recent investigation, Buckman enumerated nine themes which emerged for her, from her interviews with this larger group of therapists. These themes included:

(1) Humor as a shared human experience
(2) Humor as a reliever of tension and aggression
(3) Humor as interpretive in nature
(4) Humor is thoughtfully spontaneous
(5) Humor is the pun, wit, joke, banter, paradox, slips of the tongue, vignette
(6) Humor is a therapeutic use of self.
(7) Humor is indicative of self esteem and observing ego
(8) Humor when used has some attendant cautions
(9) Humor can be used as a diagnostic and assessment tool for levels of wellness.

(Buckman, 1984, p. 10)

It is interesting and important to note that even though Buckman (1984) did present this somewhat modified list of themes; that she still included two graph matrices recording the presence or absence of each of her initial themes (both the eleven major and four minor themes) across subjects. In discussing the presentation of her most recent results with Buckman (1986); she indicated that it would be reasonable to view her latter study as a substantiation (or replication) of her initial research, with a larger sample of subjects.

At this point the investigator would like to emphasize that he only became aware of Buckman's work, after outlining his own research in

considerable detail. This outline included the specific interview questions which would be asked. Although the research proposed here does overlap with Buckman's, it does differ significantly from Buckman's in a number of respects. Some of the more prominent differences will be discussed below.

First of all, in this investigation semistructured interviews were conducted, whereas Buckman's interviews were more open ended and less structured. She began each interview with an opening statement and conducted the interview "without a planned questionnaire so as to elicit only the information the interviewer considered relevant" (Buckman, 1980, p. 51). A copy of Buckman's (1980) opening statement to her subjects is included as Appendix B. Buckman's less structured interview had the advantage of allowing her subjects maximum latitude in structuring their answers for themselves. An advantage of the present research was that the semistructured interview provided a certain degree of consistency and structure to the investigator-participant dialogue (i.e., even in such simple ways as asking the therapist about the "context of the humorous incident"; or "what happened" after the humorous event, etc.), while still hopefully permitting each participant maximum latitude in structuring the interview for him/herself. Another major difference between the present research and Buckman's was that in this investigation therapists were asked about specific humorous occurrences in therapy, rather than for their "conceptualizations" or prior reflections on "the use of humor as an intervention in the process of psychotherapy"

(Buckman, 1980, p. 1). It was hoped that by designing the interview in this fashion, data would be obtained that was less reflective and more grounded in the therapist's experience. Also, in her research, Buckman was interested only in therapist initiated humor. In contrast, the present study was more open and broad based in that humorous incidents were investigated regardless of whether they were patient or therapist initiated; or if they were humorous events that serendiptiously occurred (i.e., as in, say, a funny accident). In addition Buckman's therapists, in both studies, were divided as to their theoretical orientation (half psychodynamic/psychoanalytic; half humanistic/systems); whereas the therapists interviewed in the present study largely adhered to a psychodynamic/psychoanalytic perspective. Finally, in neither of her studies did Buckman obtain interrater reliability in order to ascertain whether her themes or categories could be "seen" by others. In contrast, interrater reliability was obtained in the present study.

To the extent that the study proposed here is similar to Buckman's, it will serve, in some measure, as a replication of Buckman's research. In this sense, however, it will be particularly interesting because the interview questions were developed with no previous knowledge of Buckman's research. In essence this will mean that the same general area of interest, namely humor in dyadic psychotherapy, will be investigated by two independently developed "instruments" or methodologies. The precise methodology utilized in

this investigation is presented later, in detail, in the "Methods and Procedures" section of the dissertation.

Phenomenological Research

In this research project, an attempt was made to investigate the phenomenon of humor in psychotherapy, as experienced by the psychotherapist. To accomplish this goal, a phenomenological approach was utilized. At this point, a brief overview of the phenomenological research approach will be offered (Colaizzi, 1978; Giorgi, 1971; Idhe, 1977; Jones, 1984; Pollio, 1982), since this approach differs significantly from more traditional means of conducting research. This review will not be exhaustive, but rather will aim at providing some understanding of this alternative way of conducting research.

As Giorgi (1971) has pointed out, phenomenological research differs from traditional experimental research in that its primary fidelity is to the phenomena of the "life world" rather than to any particular methodology (i.e., the method of experimentation). In particular, phenomenologists are interested in studying experience, an area typically avoided in more traditional experimental research. Experience, for the phenomenologist, is not a subjective phenomenon inside the person, but rather is in and of the world. Pollio (1982), for instance, defines experience as an "active interchange between an individual and the world around her or him. It (experience) must be had by someone and be of something" (p. 19). Hence one's experience must always be directed towards some aspect of the world. Pollio further emphasizes

the first person quality of experience and goes on to describe it as "what I do whether or not I reflect on it as I do it" (p. 15).

Phenomenologists investigate human experience through the "phenomenological method of description as it has been articulated by the germinal phenomenologist Martin Heidegger (1962) 'to let that which shows itself be seen from itself in the very way in which it shows itself'" (Colaizzi, 1978, p. 53). Idhe (1977) has pointed out how in this approach "careful looking precedes classification and systematization, and systematization and classification are made to follow what the phenomenon shows" (p. 32). Hence careful description precedes any attempts at categorization. Unlike traditional experimental researchers, phenomenologists do not engage in hypothesis testing. As van den Berg (1972) states in a different (clinical) context:

> the phenomenologist never needs hypotheses. Hypotheses emerge where the description of reality has been discontinued too soon. Phenomenology is the description of reality. (p. 124)

Since the phenomenologist attempts to be faithful to phenomena rather than to any particular methodology, there "is no such thing as THE phenomenological method" (Colaizzi, 1978, p. 53). Rather:

> the phenomenologist employs descriptive methods, with emphasis on the plural. Each particular psychological phenomena, in conjunction with the objectives of a particular researcher, evokes a particular descriptive method. (Colaizzi, 1978, p. 53)

Hence in phenomenological research, the particular descriptive method utilized is tailored to the phenomenon under investigation.

Although there may not be such a thing as "THE phenomenological research method," Idhe (1977) has outlined a number of "hermeneutic

rules" which are extremely useful for conducting phenomenological research. The general strategy outlined by Idhe goes as follows:

> (a) attend to the phenomena as and how they show themselves,
> (b) describe (don't explain) phenomena, and
> (c) horizontalize all phenomena initially . . . . . (and)
> (d) look, not just at particularities, but delve into the essential features (essences) of phenomena . . . (referred) to as structural features or invariants. (p. 38)

The invariants in the present investigation will be themes or categories describing humor in therapy, as experienced by the psychotherapist.

CHAPTER II

METHODS AND PROCEDURES

Participants

The participants in this investigation were ten practicing psychotherapists. Therapists were interviewed until the data appeared to be redundant and no new information was being obtained. All participants met Colaizzi's (1978) criteria for participation in phenomenological research. In Colaizzi's (1978) estimation "experience with the investigated topic and articulateness suffice as criteria for selecting subjects" (p. 58). Overall therapists are a very verbal and reflective group and hence all the participants in this study easily met Colaizzi's requirement of "articulateness." Therapists were considered to have "experience with the investigated topic" if they ever had anything humorous or funny occur in therapy. They need not have extensively and/or actively used humor in treatment. The investigator made an active attempt to obtain the most experienced therapists possible. Therapists were not selected according to their theoretical orientation or by other demographic criteria (i.e., age, sex). Minimum professional/training requirements for participation in the study are described below:

Psychology: Ph.D. or Ed.D.; state license; 2 years postinternship experience.

Psychiatry: M.D.; state license; 2 years postresidency experience.

Social Work: M.S.W.; state license; 4 years postgraduate experience.

Of the ten participants, seven were male and three were female. Participants ranged in age from 37 to 65, with a mean age of 50. Eight participants were married, one was single and one was separated. All of the participants were known to the investigator prior to the study, and were individuals with whom he had some previous relationship (i.e., as a supervisor, professor, etc.). Nine of the ten participants were Ph.D. level psychologists. The final participant was considered to have at least the equivalent of the social work requirements cited above.

The theoretical orientation of the participants was predominantly psychodynamic/psychoanalytic. Six of the participants were practicing psychoanalysts. Two other participants were, at the time of the interview, involved in psychoanalytic training programs. One of these individuals was in a relatively advanced stage of training, being only three courses short of completion. A third participant had finished three of four years at an analytic training program, but left prior to completion. Hence nine of the ten participants were either analysts or had some psychoanalytic training. As noted above, participants were not selected according to their theoretical orientation. Rather the preponderance of participants with a psychodynamic/psychoanalytic orientation reflects the fact that most of the therapists of the investigator's acquaintance adhere to this viewpoint.

In terms of clinical experience the nine psychologists ranged from 8 years, 2 months to 33 years, 10 months of postdoctoral experience. The mean for this group was 17 years, 9 months. The six analysts ranged from 10 months to 25 years, 10 months of postanalytic experience. The mean for this group was 12 years, 4 months. Demographic data for the participants are summarized in Table 2.

Procedure

All of the participants in the study participated in a semi-structured interview on humor and psychotherapy. Two to three weeks prior to the actual interview an interview time was arranged and each participant was informed as to the general purpose of this investigation. Each participant was informed that the investigator would be asking her/him about humorous events/incidents that occurred during therapy. In addition each participant was also given the initial part of the first interview question: "Tell me about a time when something humorous or funny happened in therapy." The investigator decided to do this in order to give each participant an opportunity to reflect on and remember humorous events that had occurred in therapy. Also the investigator was concerned that if he were not to do this, that the participant might experience difficulty in recalling specific humorous instances. This might be of particular concern in this study, since all of the participants are professional psychotherapists who may only have set aside a limited amount of time to participate in the interview (i.e., having a patient scheduled immediately after their interview with the

Table 2

Demographic Characteristics of Participants

Category	Number of Participants	
	Male	Female
Age Interval		
36-40	2	0
41-45	0	1
46-50	2	1
51-55	0	1
56-60	1	0
61-65	2	0
Marital Status		
Single	1	0
Married	6	2
Separated	0	1
No. of Years Postdoctoral Experience		
06-10	4	1
11-15	0	0
16-20	0	0
21-25	1	0
26-30	0	1
31-35	2	0
No. of Years Postanalytic Experience		
00-05	2	0
06-10	1	1
11-15	0	0
16-20	0	0
21-25	1	1

investigator). In addition to the reasons already cited, the investigator wanted to facilitate the creation of an atmosphere in which investigator and participant would view themselves as "Co-Researchers" (Keen, 1975) investigating an interesting and somewhat elusive phenomena.

During the semistructured interview each of the participants will be asked a standard series of questions regarding their experience of humor in psychotherapy. The specific questions to be asked are outlined in Figure 1.

It should be noted that the interview originally proposed was simplified and refined in order to permit each participant maximum latitude in structuring their responses and the overall direction of the interview itself. However a number of follow-up questions derived from questions #2 and 3 of the original interview were used. The original interview questions are listed in Appendix C. In having follow-up questions, the investigator hoped to provide a certain degree of structure, while still permitting each participant maximum latitude in structuring the interview for him/herself. Also, for more pragmatic reasons the investigator decided to retain these questions since they appeared to generate a good deal of useful data during the pilot research. It should be noted that Question #4 from the original interview was dropped entirely, since the investigator believed that it was too leading and might thereby generate artificial categories (i.e., humor as being particularly helpful or destructive). In addition to the standard interview questions, clarifying questions were asked. The goal of the interview was for the

Interview Questions

1. Tell me about a time when something funny or humorous happened in therapy. Can you think of 1 or 2 other funny incidents that stood out for you? What made them stand out?

Follow-up Questions

   a. What was the context in which this humorous incident occurred?
   b. Do you remember what you were thinking at that time? (If so) tell me about it.
   c. (If patient initiated) What happened after the patient made his/her humorous remark?
   d. (If therapist initiated) Do you remember how the patient reacted? (If so) How did he/she react? What made you use humor instead of saying something serious?
   e. (If humor "emerges" between patient and therapist) What happened after the humorous event/incident occurred?

2. Is there anything else you'd like to say about what we've been discussing?

Figure 1. Interview questions.

investigator to obtain the clearest possible understanding of the participant's experiences.

The interviews were conducted in a place of the participant's choosing. All interviews were audiotaped. The tape recorder was kept in full view of each of the participants. All participants signed an Information and Consent Form prior to participating in the study. A copy of this form is included as Appendix D. This initial interview lasted approximately forty-five minutes to an hour and a half.

Some months after the initial interview a follow-up interview was conducted. Due to geographic and financial considerations, this follow-up interview was conducted by telephone. Prior to the actual interview, the participants were given written feedback regarding their initial interview. This feedback consisted of a summary (or reduced transcript) of the original interview. Accompanying this was a letter requesting that the participant take part in the follow-up interview, and explaining the general format utilized in the interview summary. In addition, the participant was also provided with the first two interview questions. A copy of the follow-up letter is included as Appendix E. During the follow-up interview the participant was asked (a) for his/her reaction to the written feedback, (b) if there was anything he/she would like to add or change, and (c) whether he/she considered the summarization to be a "faithful rendering" of the interview conducted. This part of the study took approximately 10 minutes to a half hour.

Data Analysis

During data analysis, an attempt was made to discover emerging themes or categories which describe the phenomenon of humor as it occurs during psychotherapy. The researcher found that these emerging themes or categories were able to be combined into a category system describing humor in therapy. In this manner, the "structure" of this elusive phenomenon was discovered. It should be emphasized that the "structure" which emerged describes humor as it is experienced by the psychotherapist.

The researcher used a method of descriptive research developed by Colaizzi (1978) in order to analyze the interview data. Variations of this basic methodological approach have been utilized by other researchers (Buddenhagen, 1984; Dapkus, 1982, 1983; MacGillivray, 1985) to explore various phenomena (cancer, time, the "lived body"). Modifications and elaborations made by these researchers were incorporated when deemed appropriate. This was especially true for Dapkus (1982), who frequently outlined, in her research, procedures only vaguely described by Colaizzi.

It should also be noted that no participant interview in its entirety (either verbatim or in summary form) was printed in this dissertation. This step was taken as a protective measure in order to protect the anonymity of patients discussed by participants in their descriptions of humorous events. This safeguard was specifically listed in the researchers' "Application for Review of Research Involving Human Subjects" (Form B). In this document, the investigator indicated that

only brief excerpts--in which it would be difficult if not impossible for a participant's patient (or someone who knew him/her) to recognize him/herself--would be utilized in the dissertation.

At this point, however, let us return to the present investigation, and review the various procedural steps followed during data analysis.

Colaizzi (1978) recommends that the phenomenological researcher begin by reading "all of the subjects descriptions, conventionally termed protocols, in order to Acquire a feeling for them, a making sense of them" (p. 59). In the present research project, all interviews were audiotaped. The researcher obtained a "feeling" for the raw interview data by listening to each of the audiotapes several times.

After the researcher has obtained a "feeling" for the raw interview data, Colaizzi (1978) recommends that the investigator begin a process he calls "extracting significant statements". The investigator, however, in conducting some pilot research, discovered that each participant, in describing humorous incidents, frequently provided a good deal of information about the case, which though obviously important, was not directly related to the subject under investigation. This data could not merely be eliminated, since it was, frequently necessary--or at least helpful--in understanding the humorous incident and significant statements. Hence, in order to reduce the voluminous raw interview data to more manageable form, the investigator, in consultation with Dapkus (1986), decided to divide each of the several vignettes given by each participant into the following three parts: (1) context, (2) humorous incident, and (3) significant statements.

In the context section the investigator concisely summarized all of the relevant context (i.e., major themes in therapy, patient diagnosis and other important information, session context, etc.) provided by the participant which was necessary and/or helpful in understanding the humorous incident and the significant statements. In this aspect of the research the investigator did not quote the participant verbatim, but merely summarized, in a concise fashion, the information provided. However the investigator did not make any inferences or go beyond the description provided by the participant. It should be noted that the context section was not examined for emerging themes per se, but rather was used to help understand the humorous incident and significant statements.

Next the investigator presented the humorous incident and subsequently began the process Colaizzi (1978) termed "extracting significant statements." Although the investigator chose to separate the humorous incident from the significant statements, this was done, somewhat arbitrarily for facility of presentation. In actuality the humorous incident could be considered to be a significant statement and was also examined for possible emerging themes. At this point the investigator formally began the process which Colaizzi (1978) has called "extracting significant statements." In this aspect of the data analysis, the researcher "return[ed] to each protocol and extract[ed] from them phrases or sentences that directly pertain to the investigated phenomena" (Colaizzi, 1978, p. 59).

In this particular study significant statements were extracted through careful listening to the audiotapes. Initially the investigator considered utilizing written protocols secondarily in order to help select significant statements. However in working with some pilot data, the written protocols were found to be minimally helpful and at times even counterproductive to the data analysis process. In actually attempting to utilize the written transcripts the investigator found himself continually forced to return to the audiotapes, since the tapes contained key cues and other important information that was not evident in the written protocols (i.e., changes in voice quality, inflection, tempo, pauses, etc.). Interestingly the researcher's experience in working with written transcripts was similar to Sproule's (1984) who "found that it was harder to determine where to begin eliminating things in order to reduce the transcript to something more manageable" and that indeed "the written text had a more seamless quality" to it (pp. 10-11). In short the investigator found the use of written protocols to be rather superfluous, since he needed to frequently return to the audiotapes in order to extract significant statements and "make sense" of the voluminous raw interview data (much of which, though important in providing a context within which to understand the subject matter, does not directly pertain to the humorous episodes). In addition, the investigator found that switching modalities--that is moving back and forth from listening to audiotapes to reading written protocols--to be a rather cumbersome process, and hence more of a hindrance than a help. Hence, for all of these reasons, the investigator chose to follow the tradition of

other phenomenological investigators (Dapkus, 1982; Buddenhagen, 1984; MacGillivray, 1985) and to extract humorous incidents and significant statements (as well as summarize important non-humor related material) via an active listening process, and to stop using written protocols as a supplemental means of data analysis. Upon reflection, it also appears that this approach was the best one for this investigator since it takes maximum advantage of skills the investigator has developed (i.e., careful listening, thematizing; "making sense" of the "other") during the course of his clinical training.

In the process of extracting significant statements the investigator once again made an attempt to reduce the raw data to a more manageable form. In selecting the "size" of significant statements the researcher essentially followed the guidelines set down by Dapkus (1982). In Dapkus' study "the 'chunk of meaning' that was finally chosen as the unit of study [significant statement] was what appeared to be the spoken equivalent of a paragraph" (Dapkus, 1982, p. 31). Dapkus (1982) found that "the beginning of a new item could be signalled by an answer to a new question, by what appeared to be a change in subject, by a long pause, or by a marked change in voice quality" (p. 32). She rejected the use of a single sentence as a basic unit because she found "the subject did not always explain his experience fully . . . in the space of one sentence" (Dapkus, 1982, p. 31). The entire answer to each question asked was also considered as a possible basic unit, but was subsequently rejected "since subjects would often elaborate on an answer to a question at great length, and, in the process, 'change the

subject' several times" (p. 31). It should be noted that Dapkus' choice for the "size" of the basic unit to be studied differed from that of other phenomenological investigators. Jones (1984), for instance, favored a more detailed breakdown (i.e., into phrases and sentences) of the raw data.

The present researcher also followed Dapkus (1982) and Buddenhagen (1984) in writing the significant statements in first-person form. This differed from Colaizzi (1978) whose significant statements are more like third-person descriptions of participant reports. In this manner the significant statements remained closer to the raw interview data. The significant statements also utilized, to the fullest extent possible, the exact language of the participants. An attempt was made, however, to write them in a more abbreviated form. During this stage "long vignettes will be shortened to their essentials" (Buddenhagen, 1984, p. 41). The present investigator also followed MacGillivray (1985) in that "redundancies and repetitions were eliminated, and interview questions were embedded into statements for increased clarity of meaning" (p. 82).

The next step recommended by Colaizzi is one which he calls "Formulating meanings." Initially the researcher intended to follow Dapkus' modification of Colaizzi's procedure. Dapkus (1982) described the process of formulating meanings as:

> an attempt to paraphrase, in a few concise paragraphs, what the subject had said about his/her experience (of time).

Dapkus reports that:

> Each paraphrase was formulated by keeping the entire interview in mind as much as possible (this was aided by laying out all the pages of the Significant Statements in an array in front of the experimenter) and then describing the subject's account of his or her experience. This was simply a description, with no attempt made to interpret. The description would, however, point out conflicting tendencies, at times drawing them together to form a single theme. (p. 33)

In this particular study, the researcher found the procedure described above to be untenable. Specifically the investigator found it impossible to paraphrase in a manner similar to the way Dapkus did. To a great extent, this appeared to be due to the fact that in this study there were a far greater number of significant statements than in Dapkus'. According to Dapkus, her interviews ranged from 12 to 25 significant statements. In contrast, the interviews in this study ranged from 24 to 50 items. In addition the data here was narrative in form. Each interview consisted of several funny or humorous stories. Each story, in turn, had its own relevant context. Though this context was not thematized, it was at times helpful in determining the meaning of the statement. The quantity and complexity of data necessitated that this researcher deal with the data in a more detailed and methodical way.

The investigator began by going through all of the significant statements, and for each statement selecting content that seemed theme like and conveyed the meaning(s) of that particular item. The analysis at this point was called a preliminary work-up.

Next the investigator clustered similar content within a story into a number of theme like statements for that particular story (Note: As indicated previously, each interview consisted of a number of humorous

or funny stories). These were called story themes/meanings. After this was accomplished the investigator then clustered themes/meanings across stories. At this point a number of themes or meanings for a particular protocol were derived. These were termed protocol themes/meanings. At this juncture, data analysis could be considered comparable to the step Colaizzi (1978) and Dapkus (1982) called formulating meanings.

The researcher also utilized a validation procedure similar to the one developed by Dapkus. In this study, each participant was provided written feedback regarding their initial interview. During a follow-up interview, conducted by telephone, the participant was asked (a) for his/her reaction to the written feedback, (b) if there was anything he/she would like to add or change and (c) whether he/she considered the summarization to be a "faithful rendering" of the interview conducted. Additional information obtained during this process was incorporated as part of the research data. It should be noted that this validation procedure differed from the one outlined by Colaizzi (1978), who recommended that a validating step be taken much later in the research process. Colaizzi (1978) conducted his validation procedure, after an "exhaustive description of the investigated phenomena" had been formulated and a thematic category system developed. Once again the present investigator chose to use Dapkus (1982) as a guide, since the validation procedure she advocated is conducted much earlier in the data analysis when the data is much closer to raw form.

Once the formulated meanings were obtained the researcher then began to "organize the aggregate formulated meanings [here called protocol themes/meanings] into a cluster of themes" (Colaizzi, 1978, p. 59). At this stage there was "an attempt . . . to allow for the emergence of themes which are common to all the subjects' protocols" (Colaizzi, 1978, p. 59).

Dapkus (1982) has outlined this procedure in some detail and the specifics of her methodology were followed here. Initially the researcher further reduced the formulated meanings into clusters of themes. Once all of the protocols were thematized:

> all of the themes from all of the protocols were collapsed into a tentative Master List of themes. This list was reduced to a number of general themes that seemed to the experimenter to be correct. (Dapkus, 1982, pp. 34, 35)

After this has been accomplished, Colaizzi (1978) recommends that the researcher:

> refer these clusters of themes back to the original protocols in order to validate them. This can be achieved by asking whether there is anything contained in the original protocols that isn't accounted for in the clusters of themes, and whether the clusters of themes propose anything which isn't implied in the original protocols. If the clusters of themes are not thereby validated, for example, if they contain themes which are alien to the original protocols, then the preceding procedures must be re-examined or conducted anew. (p. 59)

Dapkus (1982) has outlined this process in some detail, and once again her recommendations were followed. At this stage the Master List of Themes was used in an attempt to score all of the significant statements. Dapkus found that:

> at the beginning of this process virtually every attempt to score the Significant Statements led to a revision and recategorization of the Master List of Themes. With repeated

> examining of each protocol relationships emerged between the different experiences described, such that the original themes could be reduced to progressively fewer numbers of thematic categories. (p. 35)

Hence the Master List of Themes was continuously changing and evolving. Dapkus decided to accept her categories as final "only when she was able to score every Significant Statement according to those categories" (p. 35). This criterion was also utilized in the present research.

Colaizzi (1978) cautions that during this process:

> the researcher must rely upon his tolerance for ambiguity; he must proceed with the solid conviction that what is logically inexplicable may be existentially real and valid. He must refuse the temptations of ignoring data or themes which don't fit, or of prematurely generating a theory which would merely conceptually-abstractly eliminate the discordance of the findings so far." (p. 61)

In the next step of this research project, the investigator attempted to "formulate the exhaustive description of the investigated phenomena in as unequivocal a statement of its fundamental structure as possible" (Colaizzi, 1978, p. 61). Once again the researcher closely followed modifications and elaborations made by Dapkus.

This step only took place after the investigator was able to score all of the protocols according to the most recent Master List of Themes. At this point the themes were accepted as final and were organized into the thematic category system. This thematic system described the structure of humor as experienced by psychotherapists.

After the exhaustive description of the investigated phenomena was developed, the researcher then used this category system to score each of the significant statements from all of the protocols. The system did

not take note of the frequency with which each category or theme was utilized. It merely indicated whether or not a category had occurred.

Interrater Reliability

Once data analysis was completed, the investigator then obtained interrater reliability for his category system. This was done in order to determine whether others could "see" the categories or themes discovered by the investigator.

In order to facilitate this process the researcher developed a Scoring Manual for his raters to use. The manual was heavily based on previous manuals constructed by other phenomenological researchers--in particular Dapkus (1982) and Barrell (in progress)--with modifications made to accommodate the special content of this investigation. The Scoring Manual was largely made up of the exhaustive description of the investigated phenomena. Illustrative examples of themes and subthemes were provided. The Scoring Manual is included as Appendix F. The reliability raters were asked to utilize this manual to score a sample of 50 significant statements randomly selected from the protocols. The specific items included in this task are listed as Appendix G.

In addition to the investigator two reliability raters were utilized. Both raters were individuals with clinical training and experience. One rater was an advanced graduate student in clinical psychology, the other a doctoral level clinical psychologist. Each rater was provided a copy of the Scoring Manual and a number of practice items to score. The specific practice items are included as Appendix H. A review

session was conducted with each rater, during which the investigator reviewed the scores on all of the practice items. This session was useful both "to help clarify the category system for raters and to provide feedback to the experimenter regarding the comprehensibility of the Manual and category system" (Dapkus, 1982, p. 38). After the practice session was concluded, each rater then rated a sample of 50 significant statements selected from the protocols. The researcher obtained interrater reliability between both raters, as well as between each rater and himself.

CHAPTER III

RESULTS

Overview

In presenting the results of this investigation two main areas will be covered. This section will begin by briefly discussing the form the interview data took. Once this has been accomplished, the chapter will describe the thematic category system (or "exhaustive description of the investigated phenomena") which emerged for humor in psychotherapy as experienced by participating psychotherapists.

Narrative Form of the Data

It is interesting and important to note that the data obtained in this investigation, differed from other phenomenological investigators (i.e., Dapkus, 1982, 1983; MacGillivray, 1985; Meyers, 1985) in being, to a large extent, narrative in form. This tends to be especially true of the humorous incident proper and of the significant statements related to, and usually following, it. In reviewing the humorous incident and subsequent significant statements one gets a sense of the narrative (or story like) form of the data obtained. At times, the context of the case was spontaneously provided by the therapist prior to his or her relating of the humorous incident.

It should be noted, that the data obtained in this investigation--though largely narrative--were <u>not exclusively</u> so. At times,

participants provided information which did not take this form. This can perhaps best be illustrated by a specific example from the data. The interview of Participant 2 was one in which the "diagnostic" and "prognostic" aspects of patient humor were particularly figural. At the end of the interview--in response to the interview question: "Is there anything else you'd like to say about what we've been discussing?"--the participant stated how:

> I've also used it [humor] with certain patients, both inpatient and outpatient, to deal with very anxiety provoking issues in which you can dampen the anxiety by reframing the item in a humorous vein. Yeah. (I. Making it less serious?) Yes! No! Still serious! It's still serious, but for the moment we're almost talking about it as a tertiary equi[valent], as something else. Not directly connected with the person.

Here, the specific commentary of the participant was not narrative in form. It was almost as if the participant wanted to make figural for the investigator, an aspect of his experience of humor in therapy, which might not have stood out in the humorous vignettes he told. For this reason he specifically discusses the "use" of humor as an indirect communication to deal with "anxiety provoking issues."

A total of 36 humorous incidents were shared by participants in this study. This averages to 3.6 incidents per participant. The number of incidents per participant ranged from 2 to 5. The lowest value was provided by Participant 8; the highest by Participant 5.

Thematic Structure of Humor in Psychotherapy

A thematic analysis of all interview data resulted in the following overall structure. Two major themes emerged. They were:

I. Therapeutic Qualities of Humor in Psychotherapy.

II. Specific Qualities of Humor Occurring in Psychotherapy.

The first major theme deals with humor as it relates, or "maps onto," the therapeutic process. This theme is comprised of three subthemes: (1) Intimacy and the Therapeutic Relationship; (2) Diagnostic and Prognostic Aspects of Patient Humor; and (3) Using Humor for Psychotherapeutic Change.

The second major theme deals principally with specific aspects of a humorous event in dyadic psychotherapy as reported by the therapist. This theme deals, in part, with the question "What made it funny?" for participants. It also includes aspects of the participant's experience, that deal with humor, per se, rather than with how the humorous incident related to the process of treatment.

The second major theme is comprised of five subthemes: (1) Figure-Ground Reversals and Other Odd Figures, (2) Spontaneity, (3) Playfulness, (4) Bodily and Affective Experiences, and (5) Temporal Aspects: Brevity and Rate. These two major themes and their respective subthemes are presented in Figure 2.

Each subtheme could be viewed as comprised of a number of additional subthemes or variations. These have been termed "content areas" by other phenomenological researchers (i.e., Ross, 1987; Shell, 1986). In the present context, however, content areas do not need to be enumerated since such a treatment would create too much of a piecemeal or "list-like" quality to the phenomenon, and the "wholeness" of the phenomenon would be lost. In addition analysis was not

Theme I. Therapeutic Qualities of Humor in Psychotherapy

- A. Intimacy and the Therapeutic Relationship
- B. Diagnostic and Prognostic Aspects of Patient Humor
- C. Using Humor for Psychotherapeutic Change

Theme II. Specific Qualities of Humor Occurring in Psychotherapy

- A. Figure Ground Reversals and Other Odd Figures
- B. Spontaneity
- C. Playfulness
- D. Bodily and Affective Experiences
- E. Temporal Aspects: Brevity and Rate

Figure 2. The thematic structure of humor in psychotherapy as perceived by therapists.

continued beyond the subtheme level because at that point it seemed arbitrary and forced to make finer discriminations. This does not mean, however, that content areas will not be discussed. Rather than being given in list form, such content will be discussed in relation to the subtheme with which they are most closely associated. Such a strategy is meant to provide more of a sense of the various ways in which a particular subtheme, such as "Intimacy," was able to make itself manifest in the text.

In discussing the two major themes, and their subthemes, it should be kept in mind that they are not discrete pieces or parts but are varying aspects of a unified and undivided gestalt. One aspect may be more figural for Therapist A than Therapist B; in addition, different aspects may vary in how figural they are for the same therapist over time and across cases. It is important to remember, however, that all aspects are of a single experience. Divisions between themes should be thought of as fuzzy and indistinct (indicative of a certain fluidity), rather than as clear, crisp lines (indicative of discrete and mutually exclusive categories).

Theme I. Therapeutic Qualities of Humor in Psychotherapy

A. Intimacy and the Therapeutic Relationship

This subtheme deals with the relationship between therapist and patient. It concerns the realm of Mitsein, or the "we" of patient-therapist experience. It frequently involves humor which brings therapist and patient closer together and, at least momentarily,

closes the gap between them. At other times, it encourages a more authentic relationship between the two. This subtheme manifests itself in several ways, each of which will be discussed below.

1. The Sense of Relationship: The broadest aspect, of this subtheme concerns the sense of relationship which exists bewteen therapist and patient. This sense of relatedness is conveyed by the use of terms such as: "sharing," "feeling intimate"; "comradery"; "contact," "closeness"; "a bond"; interpersonal chemistry"; "connected" and "involved." It is also conveyed through such phrases as: "enjoying something together"/"sharing a joke together." This aspect of the subtheme "intimacy" may best be conveyed by presenting several illustrative statements.

Participant 4, when questioned as to what made a particular humorous incident "stand out," responded in a way which clearly conveyed a strong sense of relationship:

> The feeling of being in synch with him [the patient]. Enjoying something together. And that was what was special about that. It was that we were sharing a joke together and both of us were happy about it.

Participant 7 described a humorous incident with a female patient, and stated how through his use of humor:

> she [the patient] may feel more of a closeness. . . . Sort of like we're joking together. There's more of a bond there. And she may not feel that . . . with a distance--formality. So I think humor helps her to feel more wanted and liked by me . . . . She'll feel more of a warmth.

Finally, Participant 8 illustrated this aspect of "intimacy" when he reported how through humor he:

> felt very connected to this guy [the patient]. I felt, again through the humor, very understanding of his position . . . very identified with his position, with the Jewish guilt position.

2. Shared Laughter: Another aspect of the intimacy subtheme involves shared laughter that frequently occurs between therapist and patient. Participants noted that smiling also occurred, although this was not as frequent as a shared laugh. This aspect of "intimacy" was usually conveyed by statements such as: "And he laughed and I laughed," "we both laughed and giggled about it," "I sort of laughed and she laughed," and "we both smiled." Participant 10 explicitly described this quality of shared laughter when she stated how: "both my patient and I were amused by what she said and we were both laughing together about it."

It is interesting to note that one therapist, Participant 5, actually reported that her patients brought in funny stories, jokes and cartoons to share with her. Participant 5 related how she "can remember, various patients at various times coming in with funny stories. And telling me very funny jokes they heard at the office or in school that day. And sharing jokes with me." She also related how she has had patients who brought in cartoons, "and [how] we've laughed about some very funny cartoons." Interestingly, this therapist saw this occurrence as being related to her own character style; i.e., her patients perceived her as being "a person with a sense of humor" and as "nonjudgmental."

There were also instances in which the therapist saw some aspect of the therapeutic situation as being humorous or funny, and yet chose not to share this experience with the patient. Typically, these instances occurred when the patient did something odd or idiosyncratic, which the patient did not view as humorous or funny. The incident was only humorous from the perspective of the therapist. The quality of unshared laughter was conveyed through participant statements such as: "I [the therapist] didn't laugh . . . . No there was no laughter. He [the patient] was dead serious. And I was dead serious," and "I [the therapist] think the humor was I was laughing at myself . . . . It wasn't shared."

A more subtle example concerned the statement "I was laughing to myself, but not out loud . . . . A little bit maybe. Maybe I laughed mostly afterwards. I think I was preoccupied with what was happening." Instances of unshared humor were considered to still be within the realm of intimacy, because the intent of the therapist was clearly to further--or at least not disrupt--the evolving relationship between therapist and patient. The intent of the therapist was to preserve the possibility of intimacy or relationship, both in the present and the future. If the therapist was to laugh, the patient would not understand the joke, and the therapist's laughter would be perceived as "being laughed at" rather than "laughed with."

Participant 6, contrasted two instances in which his patient's did something odd or idiosyncratic where there was no shared laughter, and one in which there was.

> humor can be appropriate . . . if the therapist and patient can share something humorous. But if [P. chuckles] the therapist sees it as humorous . . . based on idiosyncratic events, then he may not necessarily want to share it. It may be very disruptive to therapy.

Participant 6 more specifically indicated that whether or not therapist laughter is shared, relates to the patient's ability to see the humor in his/her own behavior. It also relates to the level of psychopathology exhibited by the patient. In this regard the participant stated how:

> In the three cases I would guess that the first one--clearly a much more reactive transient disorder--that saw the humor in her own behavior . . . . The nurse. [How] That of course precipitated some humorous reactions on the part of the therapist. Where the other two were dead serious. And . . . in effect the therapist endeavored to keep the tone the same.

Closely related to this idea of whether the therapist should share his/her own humorous reaction, is whether the therapist should share or "participate" in patient laughter. Here, again, therapist participation is related to the level of health or pathology evidenced in the patient's humor. This consideration is clearly illustrated by Participant 2, who discussed his own freedom to "participate" in his patient's humor as the patient improved in treatment. He believed positive change was reflected by changes in patient humor. He discussed changes in key words used by the patient (i.e., "clown") and changes in the meaning of laughter as therapy progressed. The therapist stated how:

> I guess one of the big things if I try to focus on clown was really a sense of again my own participation in her change. And how again I could participate with her now in a real humor. Not this grim, suicidal, eleventh hour kind of thing. Where in the beginning of treatment I was also wondering "Is this someone who's going to suicide on me or

> whatever?" And so again a kind of participating in a genuine humor.

He later added how:

> One of the things that I think that forbid me to participate in the humor before, in a certain way would have been to reinforce the negative, sad sack . . . [Whereas] towards the end I would use her words [P. states with emphasis]. But also in a way that it was both logical and incongruous at the same time. So that if she wanted a kind of light session, we could have a light session. If she wanted to be serious, whatever. I didn't necessarily have to respond in a serious vein.

3. Knowing: Another aspect of the subtheme of intimacy involves a sense of "knowing" that exists between therapist and patient. It should be emphasized that "knowing," as discussed here, is warm and intimate. This contrasts markedly with the colder, more "clinical" type of knowing involved in making, say, a formal diagnosis. This knowing often involves a shared history of being together. It lies closer to the knowing that exists between intimate friends than between a research scientist and an object of study.

This type of knowing is illustrated by a humorous incident provided by Participant 3. The therapist was working with a patient who was living with an ex-addict "who has not been very responsible." The patient also was described as someone who "has a sense of being psychic and [that] sometimes it's true." During the session in which the humorous incident occurred, the patient came in stating how she had an irresistible urge to contact someone she had had an affair with many years earlier. The therapist stated how she "just looked at her [the patient] and said 'with anyone else I would analyze that and look

at it psychologically, but with you, I'm not sure! . . . And we both just sort of giggled." The therapist believes that through this remark she was saying:

> we'll have to talk about both [her urge to contact her ex-lover "in light of . . . her relationship with the man she's currently living with and this psychic 'stuff'"]. Cause I know you, we'll have to talk about both. Though my bent would be, with anyone else, not to talk about this other stuff. But knowing you we're going to have to do that. And it was somehow . . . acknowledging both.

Therapist 4 also illustrates this type of knowing in the following statement from a humorous incident where he "switched roles" with an oppositional adolescent boy. During the incident, the therapist played the role of the oppositional adolescent while the patient took on the role of therapist. The therapist indicated that he thought that:

> what was communicated [to the patient] was that I knew him well enough, that I could make fun of him in a way that wasn't hurtful . . . . [And] That also I knew him well enough! [P. states with emphasis]

The warmth and intimacy involved in this kind of "knowing" is revealed in Participant 3's subsequent statement that frequently humor "is an intimate moment. It's a way of both of us laughing at something, cause we know each other well." She also stated in her discussion of a different incident how:

> I [the therapist] hope it's understood, cause I think it's meant that way; that it's often caring and a sense of my knowing, and our feeling . . . intimate. You know that kind of stuff.

It should be noted that this sense of "knowing" can, at times, result in the development of a "shorthand" or "private intimate language" between therapist and patient. This development can best

be seen in a humorous incident reported by Participant 3. In this instance some context is necessary to understand the incident.

This incident occurred with the participant's first private patient. The therapist related how one night "she blew it" when this patient asked her something. Apparently the patient was "extremely tense and upset about something" and the session had just come to an end. At this point the patient said to the therapist "Oh! And I'm going to have to go home and live with this for the next few days 'til I can see you! And you haven't helped one bit! I'm just as tense as I walked in here and it's not solved! And how am I going to reduce all this!" The therapist reported how "without thinking" she replied to this saying "why don't you [the patient] go home and take a hot bath." The therapist believed that her remark "was countertransferential" and "was projecting how I [the therapist] would feel." According to the therapist, the patient's reaction to this was that "she blew up."

The therapist reported that the patient came in the next session "furious" and "ready to eat bear." The patient said "how dare I [the therapist] say anything like that! She hates baths. Why would I tell her to take a bath!; it was a punishment." Now the therapist replied to the patient by saying "Listen, I couldn't give you any great answer. And for me when I'm tense like that, a nice hot bath--soaking in it--would be fine. So I wasn't telling you anything bad. I was telling you what works for me." The patient replied by saying "Oh!" and was apparently calmed down by the therapist's explanation. The therapist continued to report how:

> thereafter, there would be times she [the patient] would come in and say "Listen, you know what I need tonight?" And we both would chuckle, cause it was saying we knew each other. She would say "have you got any hot bath remarks about this kind of thing? I really need something like that?

The therapist elaborated on the "shorthand" aspect of this phrase when she later said:

> So I mean, that's [the humorous remark] in some sense too saying: look we know each other. We've been through something, in that particular sense, which was: we ironed through your feeling misunderstood. My not getting defensive about it, but saying "My God I blew it but my intentions were honorable and good. And you were in some sense being cared for and you didn't hear that. And her being able to pick up on that and it being a shorthand for us, when she would say "Do you have any hot bath remarks?"

That this incident belongs in the realm of intimate knowing is revealed through the following remark by the participant:

> A "hot bath" remark would make us both feel we knew each other, and would be a way of touching.

4. Acceptance: Another aspect of intimacy deals with "acceptance," "acknowledgement" and "validation" of the patient by the therapist. This is illustrated in terms of a discussion of the humorous remark made by Participant 3 to her patient who believed she was psychic. The therapist reported that in reaction to her humorous remark:

> She [the patient] laughed! And sort of agreed with it. That for her, that was true and it was an acknowledgement of a piece of her that she considers important. That some places [and] people don't give credence to. And [it] was a shorthand for two of us who knew each other.

Interestingly, the therapist also indicated how the accepting attitude she conveyed prevented the loss of this woman as a patient. In her discussion, the participant likened challenging this patient regarding her belief that she's psychic, as similar to saying to a Catholic patient that thoughts and actions are distinct. The therapist reported how "the first time I pulled that one, I almost lost a patient," and that now she does this "much more gingerly."

Now the therapist believed that her humorous remark to this patient was:

> akin to that. [That] to try and say to this lady "this is a crock of shit," means I look for another customer. Cause I don't have it with her. And I think that's also in it.

Hence this participant obviously saw her accepting attitude, especially during the early phases of treatment, as preventing the loss of the patient and thereby preserving the therapeutic relationship (as well as the possibility of future relationship).

Acceptance is also well illustrated by participant 7 in a humorous incident involving a woman patient who "had been depressed and sort of was having all these superego onslaughts, self denegrating thoughts." During the session in which the humorous incident occurred, the patient "came in complaining that she was a terrible mother because at breakfast her children just sort of sit around . . . and don't seem interested, don't seem happy, and seemed very dissatisfied with her. Because they're not smiling and jumping around." The therapist reported that his response was to simply say

"something to the effect about . . . I didn't realize she expected a vaudeville show at the breakfast table." The therapist reported how:

> I became like a good object with this particular kind of remark. Which was in a sense, approving of her, and basically saying, "You're not doing such a bad job!"

5. Caring: Intimacy also manifested itself in participant descriptions of "caring" and "love." Though obviously belonging to this subtheme, this aspect is explicitly mentioned less than most others discussed. This manifestation of intimacy was illustrated in an incident discussed earlier where Participant 4 "switched roles" (the therapist played the patient role and visa versa) with an oppositional adolescent. The therapist stated how as he played out this role he did it "with a certain degree of love for him [the patient]."

In another incident, Participant 4 also illustrated intimacy. The humorous incident involved an adult male inpatient, in his 20s, and occurred on an inpatient unit. At the time of the incident, the therapist was in his "early 20s" (he is currently 37). The therapist described the patient as being "a very obnoxious and hostile patient"; yet also "very clingy, dependent and extremely psychotic." The humorous incident involved this patient as the therapist's baby, "sucking on the nipple" of the therapist's chest. The incident took place in the office of the participant's supervisor. Though the therapist did not use the words "love" or caring," he did describe how during the humorous incident he was

> thinking what . . . it'd be like to be his mother. And what it'd be like if he was my baby. So I felt sort of maternal [and] transformed sexually into being a woman with this

> baby. And I thought "Gee! It sort of might be nice to be a mother nursing a baby."

Later in the interview the therapist used the terms "compassion" and "shared love," in relation to the two incidents discussed above. He stated how: "There were moments of closeness there. Really. There was some compassion and shared love."

6. Being Genuine: The final aspect of this subtheme deals with the creation of a more genuine relationship between patient and therapist. A sense of this was conveyed by the use of phrases such as: "being genuine," "more real," and "more human."

Participant 9 began his interview by discussing an adventitious humorous incident, after which he "really shared some of my [the therapist's] countertransferential issues with the patient." The therapist indicated how in doing this:

> I [the therapist] shared an inner experience of my own. That apparently hit him [the patient] as being very real. That I became more real [P. states with emphasis] as a person. But suddenly he saw that I too could have clay feet.

Participant 4 in discussing the case mentioned earlier, where he reversed roles with an oppositional adolescent patient, stated how:

> I [the therapist] sort of knew him [the patient]. I knew what it was like to be that way and so I felt like it [the humorous intervention] was not artificial. I felt that I was sort of being genuine with him, and also in a satirical way that wouldn't be hurtful.

At times a patient may also use humor in order to determine if the therapist is open to having a more intimate, close, and authentic relationship with him. Participant 1, for instance, described an

incident where a patient began a session with a joke which is something he usually did not do. The therapist stated how:

> If you think about it now. I would say it was more an effort to test my waters. [To] see where I was . . . . To see how involved he could get with me . . . . Cause he does see me as different! As someone he can be free with, although . . . not always! There's still a great hesitancy.

The participant later elaborated on this stating how:

> Well . . . I think it said something about his testing the waters. It . . . has to do with his opening up a little more with me . . . . Being ready to mix it with me more. To see me as an authority that he can be . . . straight away with someone. Not just I'm the doctor and he's the patient. Bullshit!

B. Diagnostic and Prognostic Aspects of Patient Humor

This subtheme deals with humor as it reveals the state/status of the patient and/or of the therapeutic relationship. Incidents within this subtheme usually tend to be done by the patient. One of the major aspects of this category is the relationship between the presence/absence of patient humor, and the diagnostic category or level of health/pathology of the patient.

Both Participants 7 and 2 noted the absence of any "genuine" humor in very disturbed psychiatric inpatients. Participant 7, in a general spontaneous comment, noted how:

> The people I see here [a psychiatric inpatient unit of an inner city, municipal hospital] very rarely use humor. Quite often they're just so disorganized they may not be able to make use of it.

Participant 2, also a psychologist at an inner city municipal hospital, related how he:

> found very little humor in these very decompensated, hospitalized patients. I [the therapist] found humorous things . . . . You know. Funny sounding things . . . I worked with a couple of hebephrenic schizophrenics who were fantastically regressed. Baby talk . . . . And yeah, in quotes, there's a funny thing about that, but not really funny.

In addition to the absence of "genuine humor" being seen as an aspect of severe psychopathology, different types of patient humor were considered to reveal the patient's diagnostic state as well as level of health/pathology. To illustrate this, several types of patient humor are presented. These include: a patient doing something odd or idiosyncratic, pathological patient laughter and, finally, patient laughter accompanying "the key insight" of a psychotherapy.

Participant 6 discussed how "funny" or "humorous" incidents--where the patient does something odd or idiosyncratic--can provide a clinician with a great deal of psychodiagnostic information. It should be noted that this type of humorous incident was only funny from the perspective of the therapist. The humor here was not shared. As Participant 6 stated in the case to be discussed "I didn't laugh . . . No there was no laughter. He was dead serious and I was dead serious."

The humorous incident occurred during an initial interview described as "sort of an intake evaluation." It involved a 20 year old male, college junior, seen at a university outpatient setting. The therapist described the patient as an "obsessive compulsive personality with paranoid overtones." The participant is a professor of clinical psychology and decided to tape the interview for his "own personal

use" as well as "for educative purposes." The humorous incident occurred after the therapist began recording the session:

> He [the patient] looked me straight in the eye; he says "well," he says, "If you're going to record, I'm going to record!" [P. states with emphasis imitating patient; I starts to laugh]. And he whipped out his own tape recorder! [P. states laughingly] And set it right on the table . . . . And he proceeded to record.

The participant reported how when the patient whipped out the tape recorder, he:

> was thinking psychodiagnostically. But trying to keep it in a light touch. It came at . . . the beginning of the first meeting so . . . my thoughts were "this is really funny." I didn't really laugh! But I thought it was [funny] . . . that he would have a tape recorder too . . . and . . . my thought was "what does this mean psychodiagnostically?"

Immediately after this, the participant elaborated further by stating how:

> I [the therapist] was thinking that this is kind of a . . . a guy who . . . probably [is] hypervigilant and [has] paranoid like behavior. Guarding against self disclosure that might be used against him.

The therapist continued on saying:

> But it was a diagnostic thought that went through my mind that I thought was very funny. [P. states laughingly]. I didn't laugh . . . . No there was no laughter. He was dead serious. And I was dead serious. But . . . I thought it was kind of funny, that he would have better equipment than I did.

Significantly, Participant 6 also discussed the relationship between level of psychopathology/diagnosis and the ability of a patient to "see" humor. He did this in a comparative statement involving the patient in the tape recorder incident and a humorous incident with a much less disturbed patient where the laughter was shared. This latter patient

was a woman in her 40's, who was the nursing director of a "fairly large and prestigious hospital." This individual was suffering from "a reactive depression of some sort" brought about by the death of her chronically ill husband. In contrasting these two cases, the therapist stated how:

> The humor [in the case involving the patient with the tape recorder] was the humor from my vantage point. I'm sure he didn't see anything that was even remotely funny about this. No. Whereas my nurse did find her behavior [P. starts chuckling] sort of pungently humorous. There's a difference between the two. This was [the patient with the tape recorder] a much more . . . . I wouldn't call him Borderline, but somewhat more disturbed young man.

Participant 6 also talked about patient humor when "it's very self derogating" and the patient "is the object of his own self ridicule." In the following illustrative example, Participant 6 described this type of humor as "nonhumorous humor," that is, as laughter that "should be humorous but isn't." This case involved a male veteran who was separated from his wife, yet still pursued her. Apparently the patient "checked out her movements" and would "watch her at all times." According to the therapist, the patient would report on his own behavior laughingly:

> He'd [the patient] say "I don't know what's the matter with me. I have to get up in the middle of the night and see what Jane [a pseudonym] is doing." He'd say "that's really funny. I don't know." And he was laughing, you know, "I'm loosing sleep over this." But . . . he would do it." Get out of bed and . . . look for his separated wife, stating that he wanted to catch her in some sort of compromising situation; that was none of his business, at this point. He never did! But he was laughing all the time at "why was he a fool enough to do this." You know, a fair amount of say compulsive behavior, that sometimes a patient sees as inappropriate and laughs at, but . . . in no sense can stop doing.

The therapist continued to report how the humor in this incident:

> wasn't so much humor, obviously, [rather] it was being caught up in this compulsive webb, and trying to laugh off the seriousness of his behavior which is not working.

In addition, Participant 6 further reported how his own reaction to the patient's laughter:

> was that he [the patient] was in fairly bad shape. Not only was he caught up in his compulsions, but he had to laugh at them . . . . As possibly some undoing or dilution of them that wasn't working.

Obviously, here again, the type of patient humor--this time pathological laughter--revealed a great deal of diagnostic information regarding the patient.

This participant also stated that with this type of humor the clinician should not share or participate in the patient's humor, but that actually "there may be a need for the therapist to sort of move in and differentiate emotional tone from what the patient is saying. In the sense of, the incongruity there." The therapist should move in and "sort of redirect the therapeutic endeavor."

The emergence of humor/laughter can also be a "positive prognostic sign" and indicative of progress in treatment. This development is clearly illustrated in a rather dramatic case described by Participant 2. Here the emergence of laughter by the patient accompanied "the key insight" of his psychotherapy. The humorous incident involved a patient seen three times a week at a psychoanalytic institute. The patient was described by the therapist as a "posturally rigid, highly obsessive [and] fantastically cerebral patient; who was gifted intellectually." According to the participant the humorous

incident occurred at the "beginning of termination phase" during their 297th session.

The participant described the humorous incident as follows:

> When we had reached, you might say, the key dynamic of this person. This is intensive psychotherapy. And [he] began to realize almost as an insight what had been happening for the last 25 years of his life. . . . [A] person who very, very rarely laughed or smiled. Was a stereotypic, this is not his profession, [a] stereotypic research lawyer. And had this tremendous smile. For the first time his body became loose and relaxed. And he kind of said "is this all--there it is." I mean it was just this one little idea which unfortunately had been not in his consciousness for most of his life. And everything was hooked up with that one notion which hit him! And then he began to realize that all of his assumptions had fallen apart and it was no big deal. [There was] a tremendous wave of laughter and relaxation and incongruity of what he had thought might happen to him in future life, as to what he could do with his life. And that was a key issue in that particular treatment.

After the description of the humorous incident, the participant added how the patient's laughter accompanied

> the understanding, the posture of relaxation, his affect, everything. It was just like a ripple effect.

It should be noted that this incident was described by the participant as being indicative, or a "marker," of progress in a number of different ways. Some of these ways are conveyed by the use of the following phrases: "therapy's over," "like a tremendous hurdle had been bridged," the achievement of "a new gestalt" ("an affective total realization"), that the patient "began to realize again how foolish, in quotes, this whole thing was [his basic life assumption]," the emergence of "the part of him [the patient] that

very rarely shows," as well as "an ability to relax and laugh . . . and also be able to laugh at himself."

In addition to this dramatic incident, Participant 2 also noted how with many of the inpatients he saw how:

> Genuine humor was one of the signs that I [the therapist] used, about this person being able to get ready to mobilize. Not necessarily go home, but at least the patient is beginning to recompensate. Yeah.

Considering the three cases described above, it should come as no surprise that therapists reported that changes in patient laughter or humor can also be reflective of positive changes occurring in treatment. This was illustrated very markedly in a case presented by Participant 2. The patient involved in the humorous incident was a woman in her "late 30's," who was seen privately on an outpatient basis. This patient had attempted suicide multiple times and had been in treatment over a number of years. The therapist also indicated that he was this patient's sixth therapist, and how the patient had made "a lot of progress" in treatment with him.

The therapist noted how the patient's use of two key words--clown and raspberry--changed in meaning during the course of treatment. He specifically described changes in these two key words as reflecting progress in treatment. According to the therapist, it was the patient who found this development funny. The "same word [P. states loudly with emphasis] . . . pulling for fantastically significant meanings."

The first word "clown" was a term the patient frequently used in reference to herself. The therapist noted how earlier in treatment "clown" meant someone who was:

> a fool. Pejoratively funny. But to cover for the sad person. So the clown was really the envelope of the sad sack. . . . [And then later] clown was someone who really had a good sense of humor. Has a very good wit. Can see apparent incongruities between things. Who doesn't lose touch with the cognitive reality. . . . You can talk about regression in the service of the ego. That type of thing.

The second term, "the Raspberry," referred to the patient's fourth therapist. Participant 2 described "the Raspberry" as a "rather well known analyst" who worked with the patient at "a very exclusive, private facility not in New York City." According to Participant 2, the term, "the Raspberry" referred to the analyst's "somewhat ruddy complexion." Changes in the patient's use of this term are summarized in the following statement:

> But a very acid description of him as the raspberry [in the early parts of the treatment] . . . . It was apparent to me throughout the treatment, but not apparent to her--her resistance against that therapist. I think therapist 4 did most of the work that helped her. Towards the end of the treatment she was able to talk affectionately about "the Raspberry." And when she said that; recalling--using that same word, but in a very different way earlier in the treatment. And how now "the Raspberry" was a good person, a helpful person, a person who kept her alive, that type of thing. And again the contrast between "Raspberry" meaning almost the shit (P. states with emphasis) and the Raspberry who really helped her.

The participant emphasized how the patient:

> used these two words throughout the entire treatment . . . but they had two radically different meanings [P. states with emphasis] in the beginning of treatment, and in the end of treatment.

This participant also noted how towards the end of treatment the patient was able to "unleash the fantastic humor she had. About looking at things. Talking about things, laughing about things." He indicated how "the meaning of laughter had changed for this patient" during the course of treatment. How:

> The laughter before was a defense against crying. And laughter was a way to attract people. A way to be like flypaper, in a social setting. While towards the end, she could be "clownish and laugh" and not feel that that was needed necessarily to be a ploy to get something. But she could laugh because she wanted to laugh . . . just enjoying life.

This participant also described the patient as someone who would, at times, "come to the session, with make up, that approached that which a clown would wear in the circus." He noted how she "could sort of get by in the street with that, unless you really looked very closely. Particularly if you like stayed in the [Greenwich] Village type world . . . Which was the world she lived in." As treatment progressed the therapist noted how the patient's use of make-up changed. He stated how towards the end of treatment the patient:

> began to realize that part of her is a clown . . . . And that the kind of clown face that she always drew with the makeup was like a sad clown. A tearful clown. With almost like teardrops that she would put with some kind of make-up on her face. . . . [Whereas] towards the end. That now she can be a happy clown. And would sort of even describe herself as a happy clown. No longer would wear any kind of weird make-up or anything.

Another unusual variation of the Psychodiagnostic/Prognostic subtheme occurred in a case where the humorous incident was not merely revealing of the state or status of the patient, but where it actually served as a symbol or "metaphor" for "what was happening"

between therapist and patient. This variation was unusual and was only reported by one of the ten participants in this study.

According to Participant 9, the humorous incident occurred "many years ago" while he was in psychoanalytic training. The patient involved in the incident was a "low cost patient assigned by the institute"; who was seen on a three times a week basis. At the time of the humorous incident the therapy was not going very well. Apparently the patient had a strong negative transference towards the therapist. In a parallel fashion, the therapist had a strong countertransferential reaction towards his patient; the treatment appeared to be stalemated. According to the therapist, the patient "was resisting very forcefully. And instead of my dealing with the resistance of the patient; I was trying to placate him and be the good guy." He believed that he did this because he "was afraid to look bad and perhaps get a bad evaluation" from his supervisor (a prominent analyst and the director of the institute he was attending).

Essentially the humorous incident was a serendiptious occurrence in which <u>both</u> the participant and his patient came to an early morning session wearing one brown shoe and one black shoe. After describing the humorous incident, the therapist immediately noted how:

> It [the humorous event] was almost as though we had mirrored what we were both feeling.

Later while discussing this incident, the participant reported how:

> this event . . . was like the Rorschach ink blot . . . . The metaphor! [P. states loudly] for what was happening between us.

To which he subsequently added how:

> I [the therapist] don't really care now, or even when I thought about it in the past, of whether this had in fact a psychological causality, or whether it was pure accident. It served [P. states with strong emphasis] as the metaphor and had meaning to both the patient and myself at that time. (I. Regardless of whether it was an accident) That's right (I. or there was some unconscious) That's right (I. mirroring) Yeah. Right exactly.

The exact meaning of the metaphor was revealed through the following dialogue between the investigator (I) and the participant (P):

> (I. I had one question that I wanted to ask you about the first incident. I just wanted to ask you in a very explicit way. You said that you felt like the incident where you were both wearing a different type of shoe was a metaphor) Yes. (I. And I just wanted to make sure I understand what you were thinking it was a metaphor for. And was it sort of the stalemate) Yes (I. the mutual resistance.) Yes. Right. (That's what you saw it as a metaphor for?) Exactly. . . . And the nonintegration . . . in terms of what was happening. (I. You mean in terms of your relationship?) Yes (I. That it wasn't clicking?) Right. (I. It wasn't going?) That's right.

Another aspect of subtheme 2 occurs when the therapist sees the humorous incident as having a meaning representative of the overall content or context of the session. This is clearly illustrated in the following excerpts from an incident described by Participant 2.

The patient involved in the humorous incident was described by the participant as a "health professional," who is "very competent" and not a person "who gets turned around." The humorous event occurred after the patient's session had ended. The therapist had begun seeing another patient. During the incident the patient, who is very familiar with the office set-up of the therapist, rushed out of the bathroom and up the stairs to the second level of the therapist's brownstone. The therapist described the patient as "being sort of

tremendously embarrassed [about this]. Felt that he was going into my private world. The second floor of my house."

Since the incident the patient had been asking himself "How could it just happen? How could he have made a mistake?" The therapist reported that he knew the patient went up and down the stairs, because he heard the wind chimes, in the stairway. During the session the patient's wife was waiting outside for him. They were going to a medical appointment for the wife "who has a chronic illness [which] could be terminal but isn't." The therapist noted how during that session the patient was fumbling about "what to do with his wife" and "wanting me [the therapist] to do something about it."

Now the therapist saw this incident as being related to the patient and his wife's "fumbling" regarding the latter's illness and the discussion he and the patient had regarding this during the session just prior to the incident. The therapist reported:

> And part of the thing is they're fumbling. He's fumbling and they're fumbling [P. states with emphasis!] So they're fumbling individually and together about what to do with his wife's illness. . . . And part of that is what we're talking about prior to the end of the session. So that's why I [the therapist] don't have to do much thinking about it. I just said, "Well yeah. Go ahead. We've got a physical confirmation of what we've been talking about verbally? And just store it away and we'll get back to it next time.

The therapist saw a parallel between how he handled the patient during the incident and how he dealt with the patient in session. After he noted how "it's impossible to get to the top of the steps. Cause I have a gate there which can only be opened from the second

floor . . . . So I know there's nowhere to go." He continued on to state:

> And so . . . I don't feel, given I'm working already with someone else [the therapist was with another patient], that I got to go and pull him down the stairs. OK. As I didn't feel I had to pull him out of the wanderings around the sessions about what to do about the wife's illness. Yeah.

This subtheme may also manifest itself when the therapist is focused on his own questioning of the meaningfulness or "diagnostic-prognostic" significance of a humorous event. This aspect is illustrated in the following humorous incident by Participant 1. This incident involved a patient starting a session with a joke. When the patient made the joke, the therapist thought:

> I wonder what it's got to do with what he's going to be talking about . . . Generally with these things I don't just listen to the joke and say "Ha, ha--now, what's on your mind?" The joke is part of the process of treatment. It's not separate . . . we're not being entertained [P. states with emphasis] (I. So it sounds like you were curious about its significance) Yeah. Yeah.

It should be noted that the therapist's focusing on his own diagnostic functioning was usually far more subtle and evidenced in statements such as:

> And [I was] just assessing this bit of behavior . . . What does it mean? [Participant 6]

> Is this out of place? Or [P. states with emphasis] . . . is this the inner person. Which is it? [Participant 2]

> That I wondered if there was not something deeper going on since I had felt [P. states with emphasis] in the morning some unease about, [and] had even thought about cancelling the session. [Participant 9]

C. Using Humor for Psychotherapeutic Change

This subtheme primarily deals with the process aspects of psychotherapy in which the therapist is particularly focused on "doing." In their descriptions of use, participants' primarily focused on what they and their patients do. In their discussion of change, participants' descriptions primarily deal with and revolve around what the humor does--that is its perceived consequences or results. In short, use and change are both aspects of a single process: transformation in psychotherapy. Sometimes participants focus on use, and change is ground. On other occassions change is figural, and use is ground. Participants also made some statements in which it was not clear whether use or change was being emphasized, although such statements clearly concerned the larger subtheme dealing with use and change.

In describing this subtheme, aspects principally related to use will be discussed first, followed by a discussion of aspects principally related to change. Since use and change are so intimately related and frequently co-occur, some illustrations involving both also will be provided.

Aspects Primarily Related to Use

In discussing change, the therapists generally focused on change in the patient and less frequently on how they, as therapists, were changed. In contrast to this, in describing the use of humor in psychotherapy, therapists focused primarily on themselves as the "user" of humor and much less frequently on the patient's use of

humor. It seems understandable that therapists focused on their own use of humor, since the therapist is the professional or "expert" who is responsible for effectuating effective treatment. It seems appropriate, and not surprising, for these therapists to be primarily focused on the patient in terms of change or perceived consequence, since being of help or assistance to the patient is the major focus of therapy.

1. Humor as a Tool: In describing their own use of humor in treatment, some participants used the words "intervention" or "tool" instead of "use." Participant 8, for instance, clearly emphasized how, "humor is an intervention. It is not an indulgence for the therapist. It is an intervention." After discussing her successful use of humor in the treatment of an older teenage girl, described as "very trying" to work with, Participant 10 related how prior to this case she "had never thought of humor as a real tool, and [how] . . . after working with her [this patient] I decided it was a real tool. It was very effective." Since the terms "use," "intervention" and "tool" are used interchangeably by the participants, they will be used in a similar fashion in this section.

2. Types of Humor: Numerous types of humor were described: exaggeration, mimicry, role reversal, metaphor, indirect communication, humorous interpretation, humorous confrontation, puns as well as the use of a single word or brief phrase (almost like a "shorthand") in an interventive manner. Typically participants did

not give a name to the humorous intervention utilized. The above listing is intended to be heuristic and to give some sense of the range of interventions utilized. It is in no sense to be considered exhaustive. Participants described humorous incidents which were clearly interventive and yet could not easily be placed into one of the above categories. Participant 8, for instance, described an eloquent and elaborately staged psychodrama which involved various aspects of the types of humor noted above (in particular exaggeration and indirect communication). In fact the differences between these "types" of humor were not usually clear. For instance, the use of humorous exaggeration, mimicry, or the use of a single word or brief phrase interventively, can all be ways of indirectly communicating something to the patient.

2. Intent: Another instance of use occurred when the participant spoke of his/her use of humor as if it had an "intent," "goal" or "purpose." Here the therapist essentially described the anticipated impact the intervention would have upon the patient. This was conveyed through the use of such terms as: "strike," "startle," "jolt" and "get an immediate visceral reaction." Therapists also spoke of intent in terms of helping to make salient for the patient what were core conflicts and issues. This was illustrated in the following two successive statements related by Participant 7:

> Well I [the therapist] wanted to . . . clearly [P. states with emphasis] point out his [the patient's] conflict and anxiety over good things occurring to him. So that's basically why I said that . . . to really highlight it! You know! And make it absurd! . . . Present it in an absurd way. [So] it was something that could really strike him!

> And I felt that I wanted to clarify with him just what the real issues are in terms of what was going on. So I though that using humor would help [P. states with emphasis] initiate that.

On other occasions, a participant might speak of "intent" in a more narrow or focused sense as in the following statements from three participants:

> I [the therapist] tend to use humor both as a release of tension and sometimes as a way of focusing and getting something in there fast. [Participant 3]

> Well sometimes I [the therapist] might use humor to underline [P. states with emphasis] . . . and again it's really more addressed to the ego, to underline the preposterousness of what someone is saying. [Participant 7]

> I [the therapist] do know that she [the patient] found it difficult to laugh at herself. And that was really what I was trying to get her to do. Cause she was able to laugh at other people and especially her mother . . . . Even that was good; instead of just being angry. But . . . what I really wanted to do was to help her laugh at herself, and be amused by the things that she did. [Participant 10]

At times therapist discussions of the "intent" of a humorous remark was followed very closely by a description of positive "change" apparently effectuated in the patient. This is illustrated in the following statement by Participant 1, where he used humor: "To break the tension . . . [And] I think it had that effect." In a similar vein, Participant 7 describes how:

> I [the therapist] wanted to sort of jolt her [the patient] a little bit. Have more impact on her. And I guess I felt some gratification that I was able to do that in a therapeutic sense. So afterwards I felt a sense of satisfaction that she was able to use that . . . and it did help her.

3. Advantages: Closely related to the prior discussion of "intent" were the participants' descriptions of the various "advantages"

the use of humor had. In speaking of these advantages, the therapist was abstractly describing its possible positive consequences. Advantage differs from positive consequence, however, in that the latter deals with something that has already transpired and is the perceived result of a humorous event. As with "intent," therapists did not themselves usually use the word advantage.

The advantages cited by participants included the use of humor: (1) as an indirect communication; (2) as a way of avoiding patient pain, anxiety, and lowered self esteem; (3) as a way of increasing the probability of the patient accepting the therapist's message and seeing aspects of themselves and what they do; (4) as a way of avoiding patient resistance; (5) as a way of avoiding a negative transferential reaction on the part of the patient; (6) as a way of "cutting through" a patient's pathological mode of relating to self or other (i.e., the therapist), and (7) as a way of increasing clarity on the patient's part in "seeing" pathological aspects of themselves and of their mode of interpersonally relating.

Perhaps the most common, and frequently mentioned, advantage was as a means of avoiding pain and anxiety. The use of humor by the therapist to avoid eliciting pain and anxiety in the patient was illustrated by the following successive statements by Participant 8.

> And also it [the use of humor] allowed me [the therapist] to make interpretations in a way that were not painful to him [the patient].

> One of the uses of humor is to say something in a funny way . . . . (a) it sort of soothes the wound as the knife enters and (b) the person [patient] doesn't know the hook is in until it's in [I. and P. laugh]. They're busy looking

> at the humor and all of a sudden they're faced with the truth. But it's just not quite as painful. It's just not quite as painful to them.

Participant 5 also stressed the advantage of humor in the following description of the laughter which accompanied the discussion of issues that were very anxiety provoking for the patient:

> And there was a lot of laughter going on, with all the anxiety. Because we [therapist and patient] would laugh about his [the patient's] penis. Maybe it would come off. And then we talked about the vagina dentata that was going to snatch the penis and he wouldn't be able to withdraw it. He wouldn't be able to keep it, and what that meant. Why he couldn't maintain his erectile potency. Was that damaged? It was very productive . . . And this is one instance where humor can be used to great advantage in an analytic situation.

It should be noted that humor can also be used to deal with therapist conflicts and anxiety as they emerge during the course of treatment. This was illustrated in the following incident related by Participant 3. To understand the pertinent statements, some background regarding the patient needs to be provided. The patient involved was described by the therapist as someone who "has a sense of being psychic" and that "sometimes it's true." According to the therapist "there have been so many incidents in her [the patient's] life where she had . . . for whatever reasons, I [the therapist] think it was because of other clues . . . needed to call people, etcetera, when there were crises going on in their lives."

The therapist also described the tension between her traditional analytic training and the experiences this woman had shared with her as well as various readings she (the therapist) had done on psychic

phenomena. In discussing her reasons for making a humorous remark, as opposed to a more serious intervention, the therapist reported how:

> My [the therapist's] hunch is because it makes me uncomfortable . . . this conflict. And it's [the use of humor] a way my dealing with that kind of anxiety and discomfort (I. Your conflict of your traditional training versus the data this woman's given you) Yeah. (I. And the things you've read) Yeah. I think that's probably true. That it was my anxiety and discomfort that made me do it.

The therapist continued:

> in this particular situation when I look at it more carefully, it [had] to do with my own discomfort about this [the patient's belief that she's psychic] and how it's not totally resolved for me. And so that's why I've quipped with it. You know.

Though not a frequent occurrence Participant 6 noted how a patient's use of humor helped in dealing with potentially painful and anxiety provoking issues.

> if you [the therapist] can work with the humor in therapy generally, and the patient has a sense of humor of his own behavior . . . to some degree and can lighten some of his own more serious concerns with a little humor, in being self analytic, to some degree. I [the therapist] think being able to use humor is helpful.

Patient use of humor is also alluded to in the following statement by Participant 8:

> Well it's [the humor] a defense against the intensity of the pain. He [the patient] still gets to the issues but he gets to them in a somewhat insulated way. That it [the humor] says "Ok. These are terrible issues. These are horribly painful issues. On the other hand we don't have to be totally pained about them. We can have a little fun with them too."

To which, immediately thereafter, he added:

> So it's [the humor's] like gallow's humor in a way. But it does tend to soften things.

4. Patient and Therapist Characteristics: Another way in which humor may be used is in therapists' descriptions of the relationship between humor and therapist and patient characteristics as suggested in the following statement by Participant 3. The "Hi mom" refers to a term used by the therapist to help the patient become aware of her tendency to "mother" others including the therapist. The statement made by the therapist was as follows:

> And I could be much more straight laced . . . . And sometimes I will be . . . But for who she is and who [italics added] I am I'll say "Hi mom." That get's to it. And she will sometimes stop dead in her tracks and think "Oh my God! Why? What's up that I'm in that role again? Or sometimes she won't and I will have to go "Ok. Look. What is it that's up tonight? Why do you come in here taking care of me? What are you trying to avoid? What's going on? Whatever? . . . It's my style [italics added].

The relationship between "use" of humor and therapist character style was suggested in the following statements made by Participants 3 and 5, who stated:

> It's [the use of humor] my manner . . . as you know. And it's the way I think. And it's not something that I would want to give up using in therapy [Participant 3].

> I didn't know [how come I used humor] . . . . It probably had to do with my sense of humor, that comes out at the weirdest times. It's totally unpredictable. But I seem to have the happy faculty of finding joy and humor in life . . . And it has helped me through many a difficult period in my own life [Participant 5].

Interestingly, the character style of the therapist also related to his/her not using humor. This was illustrated in the following statement made by Participant 10 after describing her successful use of humor with a "very trying" and "atypical" patient:

> I [the therapist] suppose if I had a better sense of [humor]. I mean I have a good sense of humor. But if I didn't take this all so seriously, I could use humor with even the less disturbed patients in a more effective way. I think. I could make humorous interpretations, which would be very memorable! It might be very helpful! But it's not my style and I don't do that with ease [italics added].

There also appears to be a relationship between a therapist's training, talent, experience and knowledge regarding the use of humor and its use in treatment. Participant 8 stated how humor:

> should only, frankly, ethically, be used by those who know how to use it. Cause some people's attempt at humor will end of being sadism.

He continued to state how therapists should:

> use the humor as an appropriate intervention only with those patients where it is indicated, based on your [the therapist's] own experience and training and ability to manage the tool. And if you can't manage the tool don't pick it up.

As alluded to earlier, the use of humor by the therapist was also viewed by participants as being related to various characteristics of the patient. One important patient characteristic was that certain patients appear to be "more receptive" and "amenable" and less "defensive" to a therapeutic intervention when the therapist takes a humorous approach. Participant 7, for instance, described his use of humor with a patient who he does not consider "to be analyzable right now given . . . her current state." He described this patient as someone "who is very resistive to engaging in the analytic task . . . looking at just what's happening and trying to understand it. So [that] usually more serious interpretations are warded off by her which she finds more as assaults than not." The participant viewed this woman as being "extremely sensitive; hypersensitive to anything

that she might feel is rejecting or condemning of her." He also found that "humor is also less threatening with her" and "has a softer feel to it." So that "humor is more readily, shall we say, digested. It's easier for her to swallow that."

Another important patient characteristic related to therapist use of humor is the perception that the patient has a "good sense of humor." Participant 8 stated, after describing an elaborate psychodrama involving humor, how:

> most of the other funny incidents are not as extensive as this [the psychodrama]. They're more one liners . . . hit and run things. And they're very often with patients who are given to punning and humor.

Perhaps Participant 7, more than any other, emphasized most strongly how therapist use of humor was related to the patient's sense of humor. He mentioned this in three of the four humorous incidents described by him. The first statement involved a female patient who he saw as being depressed and self deprecating:

> This was a woman who was able to, use humor--I mean prior to this--to some extent. So it wasn't as though it [the therapist's use of humor] came out of the blue. I mean she had a certain humorous, self deprecating, quality. So I mean she would use it in a sadistic way. But there was humor there. And so . . . I felt she would be open to it. (I. Because she had used it before?) She had used it. And she had a good sense of humor, whenever it did show itself.

The second humorous incident involved a patient, discussed earlier, who was described by the therapist as someone who would not "be analyzable right now."

> This is a patient who does have a very good sense of humor. When she's relaxed enough to let it come out. So she's more receptive to humor. And a little less receptive to

> maybe a more serious approach at times, which she finds more as an attack on her.

Statements such as these indicate how patients with a sense of humor "would be open," "more receptive" and "more amenable" to the use of humor by the therapist. It may be that a patient's "sense of humor" is perhaps just a special instance of certain patients being more open and receptive to therapist humor.

Another important relationship between therapist use of humor and patient characteristics involved the use of humor and the diagnostic state of the patient; that is, the patient's level of health or pathology. This is illustrated in Participant 7's statement that he thought:

> that she [the patient] wasn't that depressed that she wouldn't respond to a humorous interpretation of what she was doing.

Participant 8, similarly, stated--in his discussion of his orchestration of a humorous psychodrama with a depressed patient--how:

> this guy's [the patient] pretty sound psychologically. He was a depressive, but . . . really no major psychopathology, just somewhat depressed. And otherwise [a] generally functional guy. So that he was able to take the humor and not feel it as a denigration or an attack. With somebody with somewhat more severe pathology you have to be much more careful with the humor.

Later in a discussion of the same humorous incident the therapist added how a humorous intervention:

> always has to be done with a healthy respect for the state of the patient's defenses, whatever their overall state is, but the state of their defenses <u>at that moment</u> [P. states with emphasis]! And how their <u>reacting to your</u> <u>at that moment</u> [P. states with emphasis]! Cause the sanest <u>people can get</u> flaky at times. I've had that happen too [P. laughs, I. joins in].

This participant summed up the importance of the relationship between therapist use of humor and patient diagnosis when he stated that a humorous intervention:

> has to be done in view of who's there. That just cause one uses humor doesn't mean one uses humor with everybody, in all situations.

5. Criteria for Use: Closely related to the issue of patient diagnosis, was the therapist's description of criteria for his/her use of humor. Perhaps the broadest criteria for therapist use of humor was that it be done with the best interests of the patient at heart. This is illustrated by Participant 8's statement:

> That it's really important to recognize that the humor is an intervention. That it's not just because one has a humorous stance or one likes humor. I mean it helps to like humor. But it is an intervention and it must be done for the benefit of the patient, even if you happen to have fun with it. But it's got to be first for the benefit of the patient.

The importance of using humor for the benefit of the patient can also be seen in the following statement by Participant 4. This statement is from a case in which the therapist switched roles with a late adolescent boy who was very oppositional and at times even refused to talk. The participant described how at the time he began mimicking the patient how:

> part of me thought "Jesus Christ! another session of silence!, and this stuff. That feeling passed and I said "Well let me try something new. It certainly can't be worse than what I've been doing in the past week or so" . . . I felt a certain degree of guilt or shame. "My God! I'm acting out something for him." Then I said "Fuck that!" This is a kid who you've been knowing and working with for a long time. You're not going to do anything that's shocking or hurtful. So try it out [italics added].

After weighing the possible risks and benefits, the therapist finally decided to use humor after concluding it was not a risk. This same participant later stated how he "felt confident and thought it [the use of humor] was the right thing even though it was a risk . . . . There wasn't much down side to the use of humor or a humorous style."

In addition to a strong emphasis on using humor for the benefit of the patient, there also were more specific descriptions of an appropriate use of humor. Participant 8, for instance, stated how in the use of humor the therapist has:

> to keep the humor sufficiently sharp that it makes it's point but not so sharp that it lacerates. So that what you try to do very carefully is bring the humor, as a tool, to bear on the pathology not on the person. On the irrational, self destructive behaviors; not on the fundamental person.

Participant 10 described how the therapist should respond to humor by the patient. Here, again, the therapist acted in the best interests of the patient. In her description of an incident in which a patient asked a very "funny question," the therapist made the following statements:

> But mainly I [the therapist] respond with the effort to sort of not let the humor carry us away from the point . . . Let's look at the humor rather than let it be an avoidance of something.

She further indicated how:

> if you [the therapist] laugh at a patient's joke then . . . I think that's probably alright, but I think the important thing is not to avoid understanding it.

6. Use with Difficult Patients: Some therapists described their use of humor with patients who are difficult to reach--that is "primitive" and/or "difficult." One such case, was related by Participant 7 and was discussed earlier in connection with the relation between therapist use of humor and patient characteristics. The patient involved was one who the therapist considered to not be "analyzable right now." The therapist noted how "more serious interpretations are warded off by her [the patient]. Which she finds more as assaults than not." The patient was further described as someone who was "extremely sensitive--hypersensitive to anything she might feel is rejecting or condemning of her." Hence the therapist found that humor was "less threatening" and sometimes had "a softer feel to it." She also noted that "humor is more readily, shall we say digested [by the patient]. It's easier for her to swallow that."

7. As a Last Resort: Therapists sometimes described their use of humor as a "last resort"; frequently after more traditional approaches had been tried and found wanting. Participant 8 illustrated this in the following statements he made regarding the treatment of a depressed patient who was obsessing over whether he should leave his wife. The humorous intervention took the form of a psychodrama, as part of a marathon group for mental health professionals:

> Well frankly I had said some serious things to the guy and all he did was obsess more. Humor is not my first resort. Ok. I would rather say something seriously, directly, respectfully. Ok. At the point they don't listen to me. That is at the point their resistance is too high, I have to make

> an assessment. Is the resistance a necessary defense against anxiety at that point which should be respected and left alone. Or [P. states with emphasis] is it a stale resistance that maybe can be moved past with a humorous intervention. In this case I decided to go for broke, particularly since this was a marathon, we were all professionals, there was plenty of support.

This participant continued on to say how he:

> might, in an individual therapy session, have let the guy go on for a few more weeks. But then at a point where I felt that we were in a rut then it's what salesman call "the end of the trail close." If you can't close the sale any other way do something outrageous to get the guy's attention.

It is interesting to note how in the first of these two statements, the close relationship between therapist use of humor and the diagnostic state of the patient is again illustrated.

The description of therapist use of humor as a last resort is illustrated in the following statement by Participant 4:

> I [the therapist] guess I used humor at that point, cause I figured it was a way of making contact with him [the patient]. There really was no other way. That the role of asking questions and getting him to think about things, trying to pursue him with the topics we'd discussed before. All this just really ran into a stone wall and didn't produce anything. So I guess I figured "Shit." You know. What not. I figured I wasn't enjoying these sessions. Certainly he must not be enjoying these sessions. And not that enjoyment is the goal. But without any pleasure or enjoyment--there also wasn't anything that was going on except we were sort of locked into a duel of silence. So I figured break the silence.

8. As a Diagnostic Tool: Though an infrequent occurrence, some participants described their use of humor as a diagnostic tool. In these instances a humorous intervention was made to obtain some diagnostic information regarding the patient. This is illustrated by

Participant 8 who, in discussing his used of a pun with a very depressed patient, stated how at the time he made it

> I was just thinking that [this pun] would be a cute playful thing to say and let's see where he goes with it. [That] the humor is partly interventive, it's partly diagnostic. Ok.

Participant 9, in his description of his use of a joke, also stated how:

> I made a decision I'm going to use this joke, and let's see where it takes us. Does he laugh? Can he talk about it? It's somewhat removed from him.

In both instances, humor was used to obtain some information regarding the patient. This use of humor should not be confused with the Diagnostic/Prognostic subtheme discussed earlier. In that subtheme, the therapist derived some diagnostic/prognostic information or attributed some meaning to something humorous or funny (from the perspective of the therapist) which the patient did.

9. Patient's Use of Humor: As noted at the very beginning of this section, therapists typically described their own use of humor and only infrequently described the use of humor by patients. The therapists in this study did occasionally describe humor by their patient's. Earlier in this section it was noted--by Participants 6 and 8--how a patient's use of humor can help in dealing with potentially painful and anxiety provoking issues. Another illustration of the use of humor by a patient was related by Participant 10. She described the use of humor by one patient as a means of coping with an aspect of therapy which she found very difficult. Participant 10 stated how her patient:

> handles . . . the separation at the end of the session; and the sort of, renewing our relationship at the beginning of the session, often with difficulty. [And] I think that she does cover it up sometimes with the questions. And sometimes with the humor. That it is hard for her.

Aspects Primarily Related to Change

This section concerns the perceived consequences of a humorous incident. These are changes or consequences as perceived by the therapist. Within this category the therapist focuses on what the humor does. In some instances the therapist focused on apparent positive changes in treatment. Terms and phrases such as "productive," "helpful," "useful," "pivotal" and resulting in "movement" convey, in the broadest sense, the apparent positive changes (or consequences) of humor in treatment. At other times, the therapist focused on apparent negative changes brought about by humor using terms such as: "pitfall," "risk" and "danger." Descriptions of positive changes as perceived by the therapist, were the ones most frequently noted and hence will be discussed first.

1. Positive Consequences: In discussing use, therapists primarily focused on their own use of humor. In discussing change, participants primarily focused on positive consequences for their patients and much less frequently on positive consequences for themselves. This would seem appropriate since being of assistance to the patient is the major focus of therapy. Although positive change was usually perceived by the therapist, in an almost causal fashion--as if the result of a humorous intervention by the therapist--this was not

always the case. At times positive consequences were seen as the result of an adventitious occurrence in therapy. One such incident was related by Participant 9 in which both the participant and his patient came in wearing identically mismatched shoes. This incident was already discussed in terms of its symbolic statement of the stalemate and mutual "resistance" in the therapeutic relationship. The therapist also saw this incident as having positive consequences. He described the session in which the humorous incident occurred as:

> a very productive [session]. We laughed like hell. But it lead to fantastically good transferential, countertransferential material.

Later, the participant described how this incident led to his sharing of negative countertransferential feelings with the patient. He reported how by

> sharing my [the therapist's] countertransference, in terms of what I was experiencing, and my thought of avoiding the session; I think it really freed the patient up to be able to talk about what was happening. Leading to a great deal of movement [P. states with emphasis] on his part. And I learned a great deal about myself as well.

Participant 5 also related an adventituous occurrence, which she saw as having a positive consequence for the patient and the therapy. The humorous incident was related as follows:

> Well I [the therapist] can remember a situation with one very anxious and frightened man [of] about the age of 20. Who was recounting a dream, and I was in the dream [P. states with emphasis]. And he was trying very hard to get to me in the dream. I don't remember all the details of the dream. But it was something to the effect that he had to get to me to show me something or explain something to me. And he was trying to open his door to his apartment and the lock broke. So he went to get a screwdriver, and tried to get the lock to work by using a screwdriver, and the handle came off the screwdriver. He went to get his scissors . . .

> and the scissors came apart in pieces. And we analyzed the dream. What it meant in terms of his resistance and his real unwillingness to talk about things that were very important to him. The session ended. And he got up to leave, and the handle came off my door [I. and P. laugh].

The therapist described the humor as being "enormously productive" and how this was "a very, very productive funny situation." In discussing the humorous incident, the therapist also reported how:

> We used this on an analytic basis for weeks afterward--exactly what the dream [and humorous incident] meant. And then why he felt that I was trying to hold him back from leaving. We talked about my countertransference, his transference; but the whole funny thing was [that] accidentally the actual event followed his dream [I. and P. laugh]. You can see how ridiculous that was! Can't you? [I. and P. laugh]. That was one very funny event.

Participant 10 described a patient initiated humorous incident which had positive consequences for the patient and for the therapy. The humorous incident was related by the participant in the following manner:

> Well something funny happened yesterday [P. begins to laugh] in the session . . . . One of my patients said something funny to me and I really just cracked up. It was a riot. But it was on a very serious topic. And I didn't use it, I don't think, in any therapeutically effective way; but I couldn't keep from laughing. It was when she was talking about her husband. And she's a very small woman. And she's dark and [is] sort of semitic extraction . . . . And she's married to a man who's very large. And he's extremely nonsemitic. He's pale. I guess he's blond. And she was complaining about having sex with him! And how she didn't like [P. starts to laugh] this big man on top of her! [P. and I. laugh] That was alright! I mean that was, sort of, very serious; when we were talking about that. Then she said she had this fantasy of maybe he would die and she would marry somebody else. And I said "Oh that's interesting! And who would you marry?" And she said without batting an eyelash: "a Japanese neurosurgeon who lives on the upper east side" [P. and I. laugh]. And I said "Oh really!" and that's when I started laughing. I just couldn't stop it!

The therapist indicated how the patient was able to eventually understand the meaning of her own humorous remark; How "it came out as we were talking, why a Japanese neurosurgeon? She figured that out." In addition, the therapist indicated how the humorous incident provided a sense of relief for both the patient and herself. The participant related how the patient

> was probably helped by the laughing to be a little bit more associative in her thinking . . . . And a little bit less tense. She often sits in the chair and sort of ponders. She doesn't know what to say. . . . It was a little bit more free. The session was a little bit more free, but a very rich session.

2. Insight: Some of the consequences, as perceived by the participants, can be clustered around "insight," improving "reality testing," developing "perspective" as well as an "observing attitude." This cluster appears to deal with increased awareness of self, increased reflectiveness regarding modes of relating to self and others as well as viewing the world in a more consensually validated way. Although psychotherapy is a dialogical enterprise, it is interesting to note that most of the terms and phrases involved the visual modality. Terms and phrases commonly utilized included: "insight," "perspective," "observing attitude," "observing ego," "see"/"seeing"/"able to see," "read"/"reading," "look into" and being "introspective." A sense of reflection was also conveyed by the use of words and phrases such as: "thoughtful," "perplexed" and "in deep thought."

Considering that most participants were psychoanalysts or psychoanalytically oriented, it is probably not surprising that "insight"

was the most frequently mentioned positive change or consequence. Insight as a positive change or consequence was well illustrated in Participant 9's description of his use of a joke as a "metaphor" or indirect form of communication. The patient in this incident was described by the therapist as "an exceedingly obsessive guy" who was constantly "doubting, weighing, mistrusting other people." The therapist indicated how

> with this word picture [the joke] . . . the particular patient with whom I used it could suddenly see himself.

The therapist indicated that he and the patient had already discussed some of the issues brought up in the joke, and how:

> the joke served the purpose of consolidating the picture for him. That it made it more vivid in terms of what he was doing! [P. states with emphasis]. Though he could acknowledge some of his doubting . . . I think he was able to see how foolish it is. Although we never used that term.

In addition to obtaining insight regarding interpersonal behavior, humorous interventions may also help a patient "see" pathological modes of relating. This was illustrated in the following statements by Participant 7, involving a depressed woman, who was distorting her children's behavior in order to attack herself. This therapist stated how after his humorous intervention:

> she [the patient] immediately starts smiling, laughing. And was able to see how she was . . . shall we say, distorting what was going on and using it as a means to attack herself.

Later the therapist added:

> Oh! She [the patient] laughed. . . . She had an immediate reaction. She laughed and thought it was funny. And then after that she began to use it. She began to see that she was distorting her children's behavior. And simply using it as a means to attack herself with.

Although only mentioned in one case, Participant 2 reported how a patient became aware of changes in her own use of humor. This case was already discussed in Subtheme B, in Participant 2's description of changes in a patient's use of key words during treatment. Noting changes in the meaning of the word "raspberry" Participant 2 stated how:

> She [the patient] saw it [as funny]. You know. Same word! [P. states loudly with emphasis]. You know, the same word pulling for fantastically different meanings!

It is also interesting to note that although "insight" typically occurred as a result of a therapeutic intervention, that this was not always the case. Participant 6 related a humorous incident in which this occurred. The humorous incident involved a woman, in her 40s, a nursing director of a "fairly large and prestigious hospital," who was seen on an outpatient basis. According to the therapist, the patient "had a reactive depression, of some sort," brought about by the death of her husband "who had been chronically ill." Even though the patient was extremely competent, within the depression "she'd tend to be very self derogating and kind of immobilized." The therapist described the patient as "very likeable, but this litany of helplessness kept emerging more and more and it was hard to deter her and have her address reality."

The therapist reported that he saw the patient "right after lunch which is a time that is not ideal for me, but that was the time she could manage. And I found myself in a calculated way, and maybe in a less calculated way, yawning after lunch with some regularity, to

give her the message that she ought to maybe move in other directions, instead of repeating her distress. Try to look at more positive things and socialize."

Participant 6 related the humorous incident as follows:

> One session she came in and kind of looked at me and sort of in the middle of session says "You know Dr. Jones [pseudonym] . . . I had a terrible night last night. I had a toothache and I was up the entire night and in this session I'm the one that's going to be doing the yawning!" [I. and P. laugh]. She laughed. I laughed.

The therapist indicated how at that time, he was thinking that:

> she [the patient] was perhaps reading my intent in a devastatingly perceptive way. [My intent] to sort of give her a message, though in all honesty it wasn't all that calculated a message. It may have been something . . . intrinsic in the way I may do therapy. It wasn't an explicit message, but I was trying to communicate something that she finally read. And read it in a . . . very direct way; which did not in any way, interfere with therapy moving on. As I said it did move on [P. states with emphasis] much more successfully. (Context: Therapist relates the message in his yawning regarded the patient's "being locked into a . . . given immutable model. "I'm not moving. . . . I'm just engaged in a litany of self pity. And that's it.")

The development of a sense of "perspective" was very well illustrated in Participant 5's description of her use of exaggeration with a pedophile. The therapist stated--prior to her discussion of the humorous incident proper--how this was a situation "where laughter came out, and it was able to get a man to proper sense of perspective about himself." Later the therapist explicitly stated how the patient:

> was able to see how ridiculous this was [the father's critical statement], with my example . . . and was able to laugh about it! And was able to deal with a sense of rejection and low self esteem that the father had raised in him all these years.

Closely related to "insight" and "perspective" are participant reports of improved "reality testing" on the part of their patients. Improvement in reality testing is well illustrated in the following humorous incident related by Participant 7. The humorous incident involved a female patient who worked "down in a very busy brokerage trading floor where all hell's breaking loose. And no one's really too aware of what anyone else is doing, cause they're making trades and screaming and yelling." Despite this, the patient "had this feeling that if she were down there and looked at this fellow who she was kind of interested in, that suddenly . . . it be so obvious, they all would know [that] she had these greedy feelings to possess this man." The therapist related the humorous incident as follows:

> Like one patient felt that if she looked at a man, that everyone in the room would know what she was up to. And of course this had roots in the oedipal situation, and for that matter even preoedipal issues. But just in terms of helping her with that . . . reality testing. That she could look at a man without being so transparent and no one would know. I would use humor to sort of underscore: "Yes everyone would stop! And everyone would stop what they're doing!"--this was in a very busy office where there was a lot of activity--"and just be fixated." And sort of underscored how preposterous it was . . . that everyone would know. And she was able to use that to see that not all eyes would turn to her in this knowing look.

The participant noted how the patient's reacted to his humorous remark by smiling and "was able to see that just in terms of the actual reality, it was really preposterous."

Participant 8, in describing the perceived consequences of humor, also emphasized the importance of reality testing. He stated how humor:

> makes the fundamental reality testing point, which is that thoughts, feelings, fantasies and wishes on the one hand, are different from . . . quote "realities, facts and objects" in the material world. And just cause you feel something, or just because you feel overwhelmed doesn't mean you are overwhelmed.

In describing the positive consequences for this very same patient, Participant 8 also noted how it seemed to help the patient develop a more "observing attitude" towards things. He stated how:

> It [the humor] also allowed him [the patient] to develop a more observing attitude. For him to split out into real split level functioning. Where he could both be in the situation and observe it, and get mastery through observing ego functions. I think that's another thing that humor does. Is that, it separates the "stuckness" from the healthy party of the ego.

3. Self Exploration by Patient: Closely related to this cluster of "insight," "perspective," etc., are participants' descriptions of self exploration by the patient after a humorous incident had occurred. This was already noted in Participant 10's description of the positive consequences which resulted from a patient's own humorous remark. The therapist described this patient as someone who "often sits in the chair and sort of ponders. She doesn't know what to say." The therapist related how as a result of the humorous incident the patient "was probably helped by the laughing to be a little bit more associative in her thinking . . . And a little bit less tense."

Participant 7 also illustrated patient self exploration when he stated how, after he (the therapist) made a humorous intervention, the patient:

> was laughing. He [the patient] said, "Yeah." And . . . sort of, used that as a springboard to get into his

> unconscious guilt about being successful and his inability to tolerate it. And coupled with other feelings that he won't be able to succeed and he'll fuck up.

4. Productive Dialogue: Participants also reported how humorous incidents seemed, at times, to result in a great deal of productive dialogue. This was already noted in Participant 5's description of the humorous incident in which the door knob came off in the patient's hand. The therapist stated how:

> We [patient and therapist] used this on an analytic basis for weeks afterwards--exactly what the dream [and humorous incident] meant. And then why he felt that I was trying to hold him back from leaving. We talked about my counter-transference, his transference, but the whole funny thing was [that] accidentally the actual event followed his dream [I. and P. laugh]. You can see how ridiculous that was! Can't you! [I. and P. laugh]. That was one very funny event.

Productive dialogue is also evident in the following statements made by Participant 9 regarding the humorous incident in which both therapist and patient came in wearing identically mismatched shoes. The therapist stated how:

> I therefore dealt with that in terms of what this "being out of sorts" was. And it was a very productive [session]. We laughed like hell. [I. laughs]. But it led to fantastically good transferential, countertransferential material.

The therapist later added how:

> by my sharing my countertransference, in terms of what I was experiencing, and my thought of avoiding the sessions, I think it really freed the patient up to be able to talk about what was happening with him. Leading to a great deal of movement [P. states with emphasis] on his part. And I learned a great deal about myself as well.

5. Freedom: Though not as frequent as the insight cluster, another important positive consequence of humor was discussed in terms of concepts such as "liberation," "freedom," and "choice to change." The positive consequences of liberation, freedom and choice are clearly illuminated in statements made by Participant 8. They were made during the description of an elegant and humorous psychodrama involving a mental health professional, who was "in a great deal of obsessional struggle over whether or not he should divorce his wife for another woman he was involved with." The therapist described how, during the group, this member "was going back and forth, very ponderously back and forth, and back and forth" over this issue. According to the therapist, group members "were all trying to work with him. And there was simply no way to get him out of his obsessional rut." It was at that juncture that the therapist decided to conduct a psychodrama scene, which involved a great deal of humor. The therapist stated how the psychodrama:

> was very liberating for him. In fact he did separate rather amicably from his wife . . . And married this lady and lived pretty unhappily ever after from what I heard. But that was his choice.

Later, in discussing the humorous episode, the therapist elaborated on how the humorous psychodrama:

> freed him [the patient] to make the choice based on current reality. It also freed him from the control of the domineering, guilt provoking mother of childhood. So he was able to make the choice as an adult. . . . He could decide I want this or I don't want it and I take the consequences. Versus I want it but mommy won't like it.

Choice is also illuminated by the following statement by Participant 1. In discussing the humorous incident, he indicated how it occurred "well along in the session," and how the:

> session ended. I'm guessing. . . . [indistinguishable] with him reasonably up. Not too down on himself. . . . Ready to go on trying to deal with . . . yeah. Right. The issues he faced. That he did have some choices. And it wasn't all as hopeless as it had looked a few weeks back when it all looked like Hobson's choice. Now he had maybe some choices [undistinguishable]. A or B. I think before . . . both of them looked very bleak. And now maybe . . . there were beginning to be some choices and possibilities. Changing A . . . Modifyng A, modifying B, in such ways that one would be more satisfying than the other and he'd have a choice. Or he'd decide which one he wanted to do and make changes in it, and make it work for himself. And that's what's going on.

Intimately related to choice is the "having" of possibilities. This was described in the statement above and is clearly indicated in the following statement by Participant 8. Here again this statement was made in the context of the humorous psychodrama described earlier. Participant 8 stated how:

> the reason for putting the humorous stuff in was to make it somewhat playful, so it wasn't all that deadly serious. So that it loosened him up to play with possibilities.

6. Responsibility: Closely related to freedom and choice is responsibility. Responsibility, as a positive consequence, is clearly illuminated in a vignette shared by Participant 1. This incident, though experienced as humorous, was also rather confrontational. It involved a young man seen on an outpatient basis at a municipal facility. The patient came from a very emeshed family, and as the therapist noted, had "some very cooperative parents in terms of

keeping him stuck." To illustrate this, the participant related how the patient as "a 21 year old man . . . didn't have the alarm clock in his room, [how] it was in his parents room . . . to get him up . . . in the morning to go to school." The actual humorous incident was related in the following manner:

> About two years later [after the initiation of treatment], at the age of 23, he [the patient] was about to go on his first date . . . It's scheduled for the next day. [And] he comes in telling me, that he's having a recurrence of all of his fantasies of choking a girl. Gonna choke this girl. And he keeps going on and on and on and on, and escalating this and escalating this and escalating. Until finally he says, "How will it look in the newspaper: Psychologist's patient kills girl". . . . And finally I said to him "I don't make house calls! He said "not even in jail." I said "no."

In addition to enumerating other positive consequences, the therapist indicated how through this humorous confrontation he conveyed to the patient that:

> He's a big boy. He's going to take responsibility for who he is and what he does. And that theme is there . . . in "I don't make house calls." [That] the work is here in the office and not outside.

Although the therapist did not mention freedom explicitly, he did indicate how he was "struggling" and thinking "what do I do with this monster" and that his humorous confrontation

> cut the Gondian knot. And was useful in getting through something that was so complicated that in terms of any kind of standard technique I don't know that we'd have settled anything in the forty-five minutes that we had, before he had to go on that date.

7. Tension Reduction: Another positive change described by participants was a reduction in "tension," or providing for a sense of "relief" and "relaxation." Participant 1 stated that he said something

humorous instead of being serious in order: "To break the tension . . . [And] I think it had that effect." He later noted how after he made his humorous remark how he suspected the session:

> became more like any other session we've had. The tension . . . dropped.

Participant 10 also discussed how a humorous remark made by a patient--while discussing content that was difficult for her to deal with--provided a sense of "relief" for both the patient and the therapist. This was clearly illuminated in the following statement made by the therapist:

> I [the therapist] suppose at that point it was a relief to her [the patient], as well as to me that she could laugh about the event. Cause she said this is hard to talk about. I don't talk this way with people.

In her discussion of her own use of humor with "a very atypical person," Participant 10 stated how as a result of humor the patient:

> got very funny. And she also got more relaxed. And she sat with more comfort in the chair. And looked more loose and comfortable when I [the therapist] saw her.

Although not explicitly mentioned, there is a sense of bodily freedom conveyed in this description. This seems to be the case, especially, when one notes that the therapist described the patient as someone who did not have much "physical nor mental flexibility."

8. Improved Relationship: Another positive "change" perceived by the participants as a result of humor was an increase in freedom in the way in which therapist and patient related to one another. Participant 4, in his description of his reversal of roles (where he assumed the patient role and the patient assumed his role) with an

oppositional adolescent boy, indicated how he thought the humorous exchange "warmed things up a little bit. Sort of freed things up a little bit." Participant 10, also noted this in her discussion of her use of humor with an extremely disturbed ("atypical") adolescent girl, who the therapist found "very trying" to work with. The therapist stated how after she began making use of humor with this patient, how "it was much, much easier to work with her. It really was free."

9. Increased Rapidity of Movement in Treatment: Some participants also noted how humorous episodes seemed, at times, to be followed by an increased rapidity of movement in the treatment. Participant 9 makes this point in his discussion of the humorous incident where both he and the patient came for the session wearing identically mismatched shoes. In his description of the incident, he stated how it "hastened something happening."

Participant 2, in his discussion of a humorous incident, in which laughter accompanied the achievement of "the key insight" of the therapy, related how:

> after that session, he [the patient] really took the lead. And systematically went into different areas in which this axis fit. It was like the missing piece. And so a better understanding both intellectually and affectively of issues that we had talked about before; but the key element was missing! So it was like again rapidly re-going over the entire course of treatment.

At another point this therapist stated how after achieving this key insight, the patient "could sort of fall back on his rather formidable intellectual powers and began to retrace and rather rapidly, went over almost everything we had done in treatment before. And began to put

it in place. Now that it was cognitively labeled and in full consciousness."

10. Idiosyncratic Consequences: A rather idiosyncratic positive consequence was described by Participant 4. The humorous incident itself was highly unusual. It involved a "very clingy, dependent [and] psychotic" psychiatric inpatient, who was also described as being "very obnoxious" and "hostile." The patient would come up to staff members, including the participant, and do very invasive and obnoxious things. The humorous incident involved the patient "sucking on the nipple" of the participant's chest, while the participant was in his supervisor's office. Both patient and therapist were male. The therapist noted how after this incident:

> the patient never bothered me again. He always maintained a certain boundary [P. begins to laugh]. . . . He never intruded upon my space. I guess he felt he'd met his match.

Participant 8 also related another idiosyncratic positive consequence in his description of the use of a pun with a man who "is painfully, painfully depressed, and painfully anxious." The therapist noted how his use of humor helped the patient "lighten his [own] humor which he uses sadistically against himself."

11. Positive Consequences for Therapist: Though not frequent, it is interesting to note that participants sometimes describe humorous occurrences as having positive consequences for themselves as well as for their patients. Usually the positive consequence involves some type of self knowledge or understanding on the part of the therapist.

Participant 8, for instance, related how his humorous psychodrama "kind of lightened and enlightened me [the therapist] too. So I got some benefit out of it as well."

Participant 9, in his description of the incident in which both he and his patient came to the session wearing identically mismatched shoes, related how he "learned a great deal about himself." The therapist later stated how after initially feeling "foolish":

> I suddenly began to feel elated about it. And the reason I think I felt elated about it was that I firmly believe that therapy has to be not only an awakening or growing awareness for the patient, but that it also has to be so for the therapist . . . After every session . . . I still ask myself "was there something you learned about yourself today?" And I think that was the sense of elation. That I was able to grasp something about myself [P. states with emphasis]. And that also related to the patient. That could be useful in the therapy.

12. Immediate and Longer Term Benefits: Participant 7 also distinguished between more immediate and longer term benefits apparently resulting from a humorous occurrence. He did this while describing a humorous intervention he made with a depressed woman, who had a strong tendency to denigrate herself. The therapist stated how:

> in that particular session she [the patient] began to feel better . . . The self denigrating attacks ceased . . . at least temporarily. And she sort of carried that [the therapist's humorous stance] with her! She sort of went out with it, and was able to use it in terms of some of the interactions between her and her kids. So that she wouldn't jump at any opportunity to attack herself or think less about herself as a mother.

Later the participant stated:

> So at first it was strictly humorous. Sort of a sense of relief. Laughter. And then it became more integrated (I. More integrated in?). In terms of her ability to alleviate these superego onslaughts.

13. Dangers and Risks in Using Humor: As noted earlier therapists did at times--though far less frequently--focus on the possible negative consequences of humor in psychotherapy. Here terms like "pitfall," "danger" and "risk" conveyed this in the broadest sense. Though these negative consequences could be considered "misuses" of humor, they were placed here because the therapist's focus or emphasis primarily appeared to be on the potential for "danger" or "risk."

Interestingly, the discussion of potential "dangers," "risks" and "pitfalls" associated with therapist interventions tended to be rather abstract and intellectual. They were not directly related to the humorous incidents described by participants. Participant 8, for instance, described how he and an extremely depressed patient would "sit there and tell jokes to each other in between these [the patient's] painful bouts of depression. And puns." He then went on to describe his use of a particular pun with this patient. In his description of this incident and all its ramifications, the therapist stated, almost as an aside, how:

> The pitfall in this [telling a pun] is that you can just sit there and crack jokes all day.

It was explicitly clear, however, that he was not saying that he had done this; only that it existed as a potential danger.

Participant 10 also stated during the course of her interview how she thought of a friend she knew who

> used to go to a psychiatrist. And this friend was a bright guy. And . . . I think they just told jokes. He [the friend] told him stories. And the psychiatrist told him

> stories back. I mean that's a travesty, a parody of what can happen.

In the area of therapist use Participant 8 added how humor is:

> also a risky intervention. Because your [the therapist's] own limits have to be very carefully held to. And one's own sadism or narcissism or "show-offism" can come out.

Participant 8 also indicated how the use of humor may be risky with a healthier appearing patient; the risk being the therapist may not be aware that he is overusing humor or that it is having an adverse impact on the patient. This is clearly illustrated in the following statement where the therapist contrasts his use of humor with a healthier patient and a much more disturbed individual:

> Well he's [the patient in the humorous incident] depressive-obsessive with a mild paranoid overlay. And the other person [a different patient used to contrast the patient in the humorous incident with] is flat out psychotic. Sometimes. Not all the time. Now there's a risk with people like this [the patient in the humorous incident] because they may have a psychotic core and three years later tell you, "I don't mind your jokes but your doing a little too much of them." [P. laughs] . . . The other patient will tell you in ten seconds when you're off base [I. and P. laugh].

Though infrequent, dangers associated with patient initiated humor were much more frequently and eloquently elaborated than those associated with therapist-initiated humor. Dangers associated with patient initiated humor include: (1) loss of control by the therapist in response to patient humor ("I could go off into gales of laughter and not be able to bring myself back); (2) therapist being surprised and/or thrown off guard or balance by patient humor; not being sure how to handle it; (3) therapist loosing "the limits of treatment," a sense of process, or the meaning of a patient's humorous remark;

(4) patient humor distracting or resulting in the seduction of the therapist; (5) patient attempting to "charm" the therapist into "taking care of" him or her; (6) patient humor resulting in the therapist simply gratifying the patient, or with the patient not changing in a meaningful way; and (7) patient using humor to avoid the patient role.

Some of the "dangers" and "risks" of patient initiated humor are illustrated in the following statements by Participant 10. These statements all refer to Participant 10's description of a "funny" and "eccentric" question made by one of her patients. The statements by the participant included:

> And also I [the therapist] think about her [the patient] because she's a woman who uses humor a great deal and is very, very charming; very witty; and if I were to allow myself I could be seduced by that humor; that wit, a lot of the time.

This participant also stated how:

> I [the therapist] don't want her [the patient's] humor to lead us both astray. And I think she would like to charm me completely with it. And charm me so that I would say, "You are the most lovable, charming, funny, intelligent; child/patient, child/woman that I know." [I. laughs] and I will take care of you. You know. [I. and P. laughing]. And she's being a beguiling child/woman for me, I think. And that's I think the danger of humor in any case.

Some Illustrations of Both Use and Change

The first illustration involved the use of humor as an indirect communication. This incident was related by Participant 9 and involved a patient who was described by the therapist as "an exceedingly obsessive guy," who was constantly "doubting, weighing, mistrusting other people." The therapist reported how the situation

depicted in the joke, where the main character was "in effect expressing anger, for not getting something that, in his head he hadn't even asked for, yet was really so typical" for this patient. According to the therapist, the patient "would have fights with his wife . . . almost kicking the dog as soon as he enters the house without even knowing what [the reason was]." During these situations "nothing had happened or that certainly nothing had happened with this person [with whom he was angry]. But [rather it] had something to do with some other incident or event."

In this particular instance the therapist referred to his joke as a metaphor. Prior to telling the joke he stated how even though his "sessions are . . . working sessions and there isn't a lot of humor in them" that he still "periodically . . . might use a metaphor in the form of a joke." He also alluded to its indirect communicative properties when he stated, once again prior to the actual humorous incident, how he has used jokes "as a way of opening areas in indirect ways rather than to [P. slaps hand] hit the patient head on." The therapist told his patient the following joke:

> You know, you [the patient] remind me of the guy who's riding on farmland with miles and miles and miles between houses and his car breaks down. He gets a flat. And he remembers that he passed a farmhouse about five miles back. So he gets out of the car and he doesn't have a jack; so he decides to walk to the farmhouse to ask if he could borrow the jack. Meantime it's about one or two o'clock in the morning. And as he's walking, he keeps thinking "gee will he give me the jack," "gee maybe he won't give me the jack." And he's ruminating, ruminating, ruminating. Finally he rings the bell. The place is all dark. He sees lights and the guy comes to the door. And he says "you can keep your fucking jack!" You know. [I. laughs.]

Immediately after telling this joke the participant stated how "with this word picture . . . the particular patient with whom I used it could suddenly see himself." Later in the interview the participant related how the patient saw the joke as being similar to his life:

> in the sense that--and we had talked about a good bit of this, namely what goes through his head whenever he has to have an interaction with somebody. And where he writes his own scripts. Wanting the specific end point. And generally views the end point as being terribly negative. So what he saw--that here's a guy [the man in the joke] who didn't say anything yet. There was no negotiation. And he was already, in effect, expressing anger for not getting something that in his head [P. states with emphasis] he hadn't even asked for yet. And that was so typical of this guy [the patient].

In this particular example we see the therapist perceived his joke as having a positive consequence for the patient. In this instance it specifically helped the patient to attain some understanding of his mode of relating to others.

Another illuminating description of therapist use of humor was provided by Participant 5. The "type" of humor illustrated here would generally be called exaggeration, although the therapist never actually called it that. The patient involved was described as a "very frightened man," who was a pedophile. According to the therapist the patient entered treatment after "he had been caught fondling his niece." Apparently the mother of the girl "threatened to take him [the patient] to the police about this, unless he went into therapy." The therapist reported that the patient "came into therapy right away . . . because he was becoming anxious about this." The therapist

also related how this patient was involved in treatment for approximately nine years.

To make sense of the humorous incident, it is important to understand that the patient "had a father who was 20 years older than he" and "was a very destructive man, in that he was hypercritical [of the patient]. And always put this fellow down by saying, no matter what he said or did, that it had no validity [or] value, because he [the patient] hadn't lived long enough." The father said to his son, "I'm 20 years older than you. I've lived 20 years longer than you. And I know what I'm talking about. [Whereas] you [the patient] don't know anything." After one such occasion the therapist said to her patient:

> Joe [a pseudonym] listen. Just consider if you would be 1,000 years old. And you tried something. And your father would come to you and say "you're all wrong. You don't know what you're doing. I've lived 20 years longer than you. I know that much more about life than you do. What would you think? [P. states laughing]. He got the point. That if he were 1,000 years old and his father was 1,020, that he still couldn't please his father! He still wouldn't know enough! And that he should give up this hypersensitivity to his father's opinion . . . He laughed about that! He was able to see how ridiculous that was!

In the actual description of the incident itself, the therapist noted its positive consequence for the patient. In introducing the case and humorous incident the therapist stated how she remembered "another situation where laughter came out, and it was able to get a man to a proper sense of perspective about himself." In discussing this incident, the therapist explicitly stated how as a result of the humorous incident the patient "was able to see how ridiculous this was

[the father's critical statement], with my example . . . and was able to laugh about it! And was able to deal with a sense of rejection and low self esteem that the father had raised in him all these years." Hence here we see the development of a sense of persepctive and the ability to cope with the painful criticisms of a significant other.

The final use of humor to be described here, involves the therapist's use of a word or a brief phrase in an interventive manner. The incident reported below was related by Participant 3. It involved a patient who's "issue is taking care of everybody." The therapist also reported how the patient had "tried like a bitch to take care of me [the therapist]. [A] son of a bitch." The therapist also indicated how sometimes the patient was even successful in doing this. During these times, the therapist stated how:

> sometimes I [the therapist] will quip about how she's trying to take care of me and mother me or whatever. And I'll say "Ok, mom. What have you got to say?"

The participant continued on to say how:

> that "Ok mom" cuts through it. Like "you're reversing the roles. What are you doing again? This is your issue. Why are we wasting time with that? Why is that stuff up again?" And she'll hear it and think "Ok! All of that stuff." And we'll have to talk about why she want to mother me instead of her being, in some sense, taken care of, in a session. And her talking about her own issues, as opposed to avoiding by nurturing me.

The therapist indicated how her humorous remark "gets to it. And she [the patient] will sometimes stop dead in her tracks."

Participant 7 also described an incident similar to the one described above. Here the therapist would say "Thank God" to a patient who was very conflicted about success whenever the patient

"was really tearing himself down or ripping himself apart." The therapist indicated how by saying "Thank God" he was:

> sort of saying . . . "Thank God you're not enjoying your success." . . . [I. laughs]. Sort of being ironic [I. laughing]. You know. "Sure. This is good! You don't enjoy your success! This is much better! Thank God!"

The therapist indicated how:

> In a way it's almost . . . a conditioning kind of thing by now. That he [the patient] knows if I were to say something like this, it's time to look into . . . this masochistic gratification actually! Cause that's what it is [P. states with emphasis], in a sense.

As a result of the therapist's humorous remark, the patient:

> tends to look into this need to tear himself apart, and his guilt over doing well and how it really doesn't coincide with this image of himself.

In both of these incidents a brief phrase ("Hi Mom" and "Thank God") was used to help the patient become aware of a pathological aspect of her/himself. Here again we see the close interconnection between use of a humorous intervention by the therapist, and positive change for the patient.

Theme II. Specific Qualities of Humor Occurring in Psychotherapy

A. Figure-Ground Reversals and Other Odd Figures

In discussing figure-ground aspects of humor in psychotherapy there are several different ways in which this subtheme manifested itself. One grouping clustered around terms such as: "incongruity," "irony," "role reversal," and "opposites." A second grouping clustered around participant descriptions of contrast in regard to particular humorous events. A third grouping appeared to cluster

around terms such as "absurd"/"absurdity," "ridiculous"/"ridiculousness," "ludicrous," "preposterous," "idiocy" and "silly." A fourth grouping appeared to cluster around terms such as: "strange," "bizarre," "eccentric" and "weird." The fifth and final grouping appeared to cluster around participant descriptions of the ground of particular humorous incidents.

1. Figure-Ground Shifts. The first cluster usually dealt with shifts in figure-ground. At times, these shifts could be rather rapid. Often they involved some violation of one's expectation of what should be figure and what should be ground. At times, this subtheme involved something incongruously becoming figural as oppossed to what one would expect.

A good example of role-reversal was already alluded to during the discussion of Theme I. It occurred in the case of the therapist who "switched roles" with an oppositional adolescent boy. The therapist noted during his recounting of the humorous incident how:

> And I [the therapist] mimicked, exactly, the whole scenario of what he'd [the patient] been dishing out to me for the last two months. And he smiled and started to laugh, and I was just being him. So I was him for the session. And it was very funny because then he became me. See. So we switched roles. He was the therapist and he asked [I. begins to laugh] me whether I had these problems. And he asked some of the stupid questions I would ask him that were stupid. And he got a feeling, I think, of how powerful he was and powerless I was, because the roles were reversed.

Here, we have a rather dramatic instance of role reversal and a humorous shift in figure-ground. The therapist played the role of the patient ("and I was just being him. So I was him for the session"),

and the patient the therapist ("And it was very funny because then he became me. See. So we switched roles. He was the therapist"). In this case there was a playful shift in what one would typically expect.

Participant 4 also related a humorous incident which is an excellent illustration of this cluster. The incident involved a patient who had "claustrophobia and a fear of elevators." This patient had come in for an intake interview, and the humorous incident occurred on an elevator going from the waiting room of the clinic (on the second floor) to the therapist's office on the third floor. To understand the humorous incident it is important to note that the therapist had a history of some phobic type reactions. Obviously the patient did not know this. During the research interview the participant related how:

> there was a time when I [the therapist] was personally having, I think they were kind of, almost like phobic reactions to being in closed places like driving under the Lincoln tunnel. And I've always had sort of a fear of like . . . the elevator, being closed and trapped in it. I guess there's sort of a general tendency, [of] not wanting to be confined.

The humorous incident was described by the participant in the following manner:

> And the woman [patient] greeted me [the therapist] on the floor. And was so thankful that I was there. And as the door closed to the elevator she started to tell me what her problem is. And she said she felt so pleased to have me there, and felt so safe to be able to go up with somebody on the elevator cause she had claustrophobia and fear of elevators. And I thought that was rather humorous because she really didn't know who she was dealing with. I thought that was pretty funny. That was one instance.

It seems as if the therapist found the event humorous because of the "disparity" between what one would expect and what was going on. As the participant put it: That "one isn't necessarily who one appears

to be." This sense was conveyed through the following statements by Participant 4:

> I [the therapist] guess the thing that was humorous . . . was sort of the disparity between what the woman would [expect], I guess any patient has a certain impression of safety and security . . . in the therapist.
>
> I [the therapist] don't have very much more to say other than . . . I wasn't the person she projected I was. She saw me as being the Rock of Gibraltar. Or this very safe, secure person; when in fact it was rather ironic that at one time I had the same kind of feeling [of being phobic] that she had. And I don't like this particular elevator either.

One should not fail to note how in the second of these statements, the therapist also pointed out that there was a "rather ironic" aspect to this incident ("that at one time I had the same kind of feeling [of being phobic] that she had").

This humorous incident is even more interesting considering the fantasy the therapist had while riding up in the elevator.

> in some ways it reminded me of a Woody Allen film. You know. The psychiatrist or psychologist has the same problem his patient has. I had the same issue as her [the patient]. You know. [I was] picturing. Actually it wasn't me. I was sort of picturing a Woody Allen type therapist with a patient. You know . . . . This is the mental imagery of what [I] was also into. The mental imagery is the patient that has the elevator phobia goes in with the therapist, by the time they get off at the floor, the patient looks fine but the therapist is standing there sweating, chewing his nails, completely and totally out of it.

The therapist's fantasy seemed to involve a shifting of figure-ground into a rather incongruous mental image. Here there is a reversal of roles and a violation of expectations. The therapist--in his "mental imagery"--assumed the role of the patient and vice versa. One might expect a therapist to be cool, calm, collected and "in charge"; instead this incident finds him "sweating, chewing his nails,

completely and totally out of it." In a similar fashion, one might expect the patient to exhibit the symptoms but instead discovers that he "looks fine." The fantasy involves a shift of figure-ground into an incongruous mental image, involving a reversal of roles, a violation of expectations as well as a touch of the ironic.

Another instance of the grouping under discussion was provided by Participant 3. The therapeutic situation was one in which the therapist saw a 16 year old girl, once a week, alternately with one of her parents. The girl's parents were separated. The participant also "on occasion" had individual sessions with this adolescent girl's mother. The humorous incident occurred on one such occassion.

In understanding the incident, it is important to note that the patient's presenting problems had been a history of poor school attendance. At the time of the incident the child essentially was not attending school. This area had traditionally been a "battleground" between daughter and both of her parents, especially her mother. Another important aspect of the case, in regard to the humorous incident, was that the daughter generally perceived her mother as being overintrusive, especially in the area of school.

The humorous incident revolved around the daughter complaining to her mother that no one had followed up on arranging some psychological testing required for her entrance into a private school for the "emotionally handicapped." Apparently the daughter had recently interviewed for this school and was very interested in attending. The mother called the therapist the night prior to her session stating how "the daughter was all upset because the daughter

felt no one was caring about her. No one was following the testing." According to the therapist, the humorous incident was particularly funny because the daughter "was berating mother for what she usually did." The participant related the actual humorous incident as follows:

> When the mother came in yesterday . . . It's low humor. But it was humorous and the two of us sort of chuckled about it. She said to me [the therapist], [that] her daughter was saying "look no one's taking care; no one's followed up. No one's done this--done that. . . . And you don't seem interested" kind of thing. And we both sort of laughed because the daughter was calling her for a change. And it was a complete role reversal in that respect.

After relating the incident the therapist immediately stated how:

> It was funny because of the complete change in position. And the mother thought it was funny, for a change the kid, was knocking on her door instead of visa versa.

Later the therapist reiterated this point by stating how: "the reversal sort of was, not uproariously [funny], [but] once again humorous!"

The therapist also related how the humorous incident was interesting because the therapist had called, awakening the daughter, the Saturday morning prior to the session of the humorous incident. At that time, the therapist gave the daughter the name and telephone number of the psychologist she was supposed to contact. Hence mother and therapist had done their respective parts; it was the daughter who "had not done her piece"; who hadn't followed through. According to the participant this added a sense of irony to the incident. The therapist stated how:

> it [the humorous incident] was really ironic because it had all been done and the kid had totally blanked out that I [the therapist] had called her and been taking care of her in a way. That she was supposed to take the next step and take care of herself.

> I [the therapist] guess the other thing that was funny about it was, we [the therapist and mother] had done our part, and had taken care of her. It just hadn't worked out that way. It was ironic . . . too.

In reviewing this incident, we can again see that there was a shift in figure-ground relationships. The participant suggests this in her use of phrases like: "a complete role reversal" and "complete change in position." This also was indicated by the therapist's statement that the daughter "was berating mother for what she usually did." It is significant to note that a sense of irony was also involved: it was the daughter berating mother for not doing something that, in actuality, had already been done for her [the daughter].

A more subtle instance of this cluster is illustrated by a humorous incident already discussed. The incident involved a female patient, who was complaining about having sex with her husband. During the session of the humorous incident the patient reported how she had a "fantasy of maybe he would die and she would marry somebody else." The therapist subsequently asked her who she would marry, to which the patient replied: "A Japanese neurosurgeon who lives on the upper east side."

In discussing this remark, the thearpist seemed to convey a sense of how, for her, there was something incongruous about it. She stated:

> it [the patient's humorous remark] was just so incredibly funny . . . She's a sort of little girl, [and has] sort of a very precise little girl quality to her. And she comes out with this crazy idea that she would marry a Japanese neurosurgeon. I just couldn't stop laughing.

In this incident the incongruous figure-ground appears to involve this "crazy idea" coming out of this woman who was described as being

"sort of little girl," and who had this "sort of precise little girl quality to her."

The idea of "opposites" and extremes was also conveyed by this participant. She stated how:

> The neurosurgeon part was the part I thought was especially funny because she's married to a man who's very creative. And so it's quite the opposite. (I. So she's married to someone who's sort of artsy?) Yes exactly! It would be just the opposite of him. But to take it to the point of neurosurgery.

2. Contrasts: Participants 7 and 8 both noted how humorous incidents stood out in contrast to some "negative" affect. In Participant 7's case, it was negative affect on the part of the patient, whereas with Participant 8 it was in relation to pain he, the therapist, was experiencing. Participant 7 stated how he said something humorous to a patient because he:

> thought it would strike her [P. states with emphasis] more strongly if there was a greater contrast; and humor would provide that contrast. You know since she was pretty gloomy and dour . . . "I'll never get out of this." "My kids hate me." [P. imitating patient]. That this would sort of startle her. And would help her look at it more forcefully. Rather than saying something very serious which I think would have had less impact on her, at that time.

Participant 8, also stated how one particular incident:

> stood out because of the intensity of the pain I [the therapist] was experiencing. Followed by the lightness. . . . the contrast was tremendous.

Participant 1 also spoke of contrast in his description of a humorous incident which involved his getting up and leaving the room during the course of a session. In talking about the incident, the therapist stated:

> Well I [the therapist] thought of doing it! And had that in contrast to my whole background . . . and experience as a therapist and supervisor . . . I don't think you're going to get that kind of story from anybody [P. states laughingly] . . . . It was very unique. (I. It was different.) Yeah. It appeals to me.

3. Absurdity: Another way in which figure/ground issues manifested themself involved the therapist's use of terms such as: "absurd"/"absurdity," "ridiculous"/"ridiculousness," "ludicrous," "preposterous," "idiocy," and "silly." Through the use of such terms the participant is placing emphasis on the figuralness, of some aspect of a humorous event, in contrast to an unarticulated ground. This nonanticulated ground includes the more mundane and commonplace experiences of everyday life.

At times, the therapist emphasized how an incident stood out because of one of these qualities. This is illustrated in an incident discussed earlier, that was related by Participant 5. In this case the father was very critical of his son and frequently told him that he knew nothing. The father also said how he knew everything because he was 20 years older then the son. The therapist stated how this incident stood out because of:

> the whole idiocy of the father's suppositions. That this 33 year old man. His value and judgement and knowledge was invalid because he was still a kid in the father's eyes. And of course the man felt this way. Where the father was concerned he was a child. And he asked his father for his opinions in buying property and buying suits.

This same participant, while discussing another incident involving a patient with an abusive boyfriend, stated how it's "ridiculousness" was what made the incident focal for her. She stated how it stood out for her because of:

> the ridiculousness of it . . . See this is funny. It's funny that she would feel so unacceptable because of someone else's judgment.

The therapist, in this very same statement, continued on to say:

> And if you [the therapist] could see how funny that is, and make her [the patient] understand that it [her position] was really . . . ludicrous. If she would laugh at it, then it would undo the prohibition that she should not dare to question him.

In this statement we see how by presenting something as "ludicrous" a therapist can help promote insight by making an aspect of the patient figural for the patient. It also suggests that this insight could in some way free the patient (that it would "undo the prohibition"). This use of the "absurd" to make focal for a patient, an aspect of the patient (and thereby promoting insight) is conveyed through the following statements by Participants 7 and 8

> Well I [the therapist] wanted to [by making my humorous remark] . . . clearly [P. states with emphasis] point out his conflict and anxiety over good things occurring to him. So that's basically why I said that . . . to really highlight it! You know! And make it absurd! . . . Present it in an absurd way. [So] it was something that could really strike him [Participant 7].

> First of all it [the therapist's humor] reflected the absurdity of the situation he [the patient] was putting himself in. This man's very intelligent and well trained [the patient was a mental health professional]; yet he was able to see me [P. states with emphasis referring to himself] essentially playing paradigmatically a part of him. Alright. That he was acting out the absurdity in an obsessive-depressive way and I was acting it out in a impulsive-buffoony kind of way. But nonetheless it was absurd. I think he was able to perceive the absurdity of the position and let it go. And say "Oh! I don't need that one." It seemed to sprout free energy or attention or whatever you want to call it. I'm not a cathexis fan. But . . . it somehow freed [him up] . . . made him more available to his own processes of thinking, evaluating and reasoning [Participant 8].

Both instances illustrate how the therapist through the use of the absurd facilitated insight in the patient, by making figural for the patient an aspect of him/herself.

4. Strange: In a closely related way, therapists also emphasized figural aspects of a humorous incident in their use of terms like "strange," "bizarre," "eccentric" and "weird." Here again the ground was unarticulated, and included that which was not "bizzare," "eccentric," "strange," or "weird"; i.e., the more mundane or usual aspects of everyday life.

This manifestation of this subtheme was well illustrated in a humorous vignette already discussed in which a psychiatric inpatient sucked on the "nipple" of Participant 4's chest. The incident occurred in the office of the therapist's supervisor, at the time the supervisor was present. The therapist saw this as a "bizarre experience." In describing the incident he stated how:

> It struck me [the therapist] funny at about the point where he started sucking on my tits. I felt like, "Well Jesus." You know. I felt like this is a very strange experience. Nobody had ever done this before. . . . And then afterwards, it struck me as very funny. And now that I think about it, it strikes me as being very funny.

The therapist also added how during the incident he:

> started to think this is bizarre as fucking [shit]; this guy's older than I am. And there was a certain, I guess bizarre aspect to it that made it sort of . . . just weird.

5. Ground: Although the last three examples of this subtheme have emphasized figurality, participants also discussed the ground of the particular humorous incidents. An instance of this was related by Participant 3. It was part of a humorous incident described earlier in

this subtheme, where the patient was being berated by her daughter for not doing what she (the mother) usually does. The therapist stated how:

> I guess [the humor] was situational, that was what made it funny. You know. If someone else had said something about, "Oh my daughter's calling"; it wouldn't have been a funny incident. It [the humorous incident] was just funny, in the background of this almost year we know one another her daughter basically saying: "don't call so often. Don't bug me." And then she called and said "Why didn't you call me? Why didn't you take care of this?"

Another instance of this aspect of the subtheme, involved Participant 5 and concerned a patient who had a dream of being unable to reach the therapist, specifically being unable to get through a door, and who then had the door knob of the therapist's office door come off in his hand, at the end of the session. The therapist emphasized how the patient's background contributed to the humorousness of the event. She stated how:

> This young man [the patient] came from a very superstitious and very religious Italian household. And his grandmother believed in the evil eye. And what makes it [the humorous occurrence] so enormously funny is that when he was growing up he wore a talisman on a chain--against the evil eye. And, of course, this magical occurrence, in my office with the handle coming off following his dream. And it was a long time before I could get him to understand that it was an accident. And it was not, something predicted by the dream. But it was very funny when it happened.

In both instances the participant was emphasizing the ground or context (background/situation) which contributed to the actual incident being so humorous or funny.

B. Spontaneity

In general participants spoke of their use of humor as being a very unreflected and spontaneous occurrence. Participant 5 illustrated

this in her discussion of a humorous incident with a female patient who "was involved in a very demanding love affair" with a man "who was very demanding and critical" of her. The humorous incident occurred during a session following "a big fight" the patient had with her boyfriend. Apparently the boyfriend struck the patient, which was something he had never done before. The therapist reported how during this session she knew the patient "wanted to cry. But somehow or other the tears wouldn't come." During the session the patient was lamenting how "she was not beautiful enough to satisfy his [the boyfriend's] needs to be married to a real beauty."

In this session the therapist said to the patient, "just think what would happen, if you were to make soup and leave the salt out?"; to which the patient replied "I did that last week." According to the therapist they both started to laugh and the remark apparently promoted a strong emotional reaction on the part of the patient. In the course of describing this incident, the therapist conveyed the spontaneous, unreflected, quality of her remark when she stated "And it just so happened that I just plucked this idea out of thin air! And it was what she had done!" She also noted how after this the patient "was able to laugh and cry as a result! Cry and let the rage out!"

Participant 1 described a humorous intervention illustrating spontaneity. This incident involved the therapist's getting up and leaving the treatment room, after the patient challenged the effectiveness of a cognitive technique the therapist had taught him (to deal with the patient's tendency to "belittle himself"). The patient said to the therapist that "it's [the cognitive intervention] only

working because you're [the therapist] here. When I'm [the patient] away from here and you're not with me it won't work." The participant emphasized the spontaneous aspects of the humorous incident in the following two sequential statements:

> The humor about it is--I guess is about my spontaneity. The willingness to deal with something very practically and concretely. Psychoanalytically this man [is] never going to understand what that's all about.

> Well what was funny was my technique (I. The technique overall or the leaving the room) The leaving the room! [P. states with emphasis] (I. The leaving the room). Yeah. That spontaneous bit of . . . creativity! [P. states with emphasis, laughing softly]. It had something joyous about it . . . It's the first time I've ever gotten up and walked out of the room with a patient, and then walked back in [P. laughs]. (I. So for you it was different) Yeah . . . I don't know of too many reports in the literature of such events.

The unreflected quality of humor is also illuminated through the following statements by Participants 3 and 1. Participant 3, for instance, stated how:

> It's [the use of humor] my manner . . . as you know. And it's the way I think. And it's not something I would want to give up using in therapy. But I don't always think about, as you forced me to today all of what it means. Cause we go in and it works the way it works. And the session takes a different bend. And then you're OK. And I don't always sit there analyzing why I made that particular quip or exactly what purpose it would serve.

The unreflected quality of a participant's humorous remark is also evident in a statement made by Participant 1. In this statement the participant was responding to the investigator's summarization and reflection of the meanings he (the participant) had earlier attributed to a humorous remark he made. The interchange went as follows:

> (I. So it sounds like in that statement you [the therapist] were saying a lot of things. You were sort of saying "it isn't a perfect world. You're not always going to get what

> you want." And then you're also talking about your relationship with him; that I'm not Santa Clause either. And) I'm [the therapist] not going to be perfect. You're [the patient] going to have to learn to live with that too. But if you [the investigator] think I thought this all out, you are . . . wrong [P. states with emphasis, laughing softly; I. joins in.] Afterwards I can think of lots of things.

Shortly after the interviewer said to the participant "so it just sort of happened," the therapist replied "Yeah. Very much so."

In addition to describing humor as occurring in an unreflected or spontaneous manner, participants, also spoke of the perceived "changes" or consequences of a humorous incident as being spontaneous. This did, however, tend to occur rather infrequently and is illustrated in a statement made by Participant 9 in his description of a humorous incident previously discussed, where both therapist and patient came to session wearing identically mismatched shoes. In particular the therapist stated how his sharing of his countertransference:

> tended to be a spontaneous thing that occurred and fortunately it worked out! I [the therapist] will not admit to the fact that I had thought it out. Planned that this is what I'm going to do. But as I say it came out of this quote, humorous event, the patient's comment.

Of all ten participants, only Participant 8 described the use of humor in a more planned, reflective way. At one point, this participant stated how humor "should only be used (a) appropriately. That is to say where it has a goal, an aim, a purpose." A more reflective use of humor is also evident in the following statement made by this participant.

> And then somehow this [the humorous psychodrama] did allow him to reach the feelings rather than just the dry

> obsession. So that was my goal in the matter and I think I reached it.

It is interesting to note that even though this participant discussed his use of humor in a very planned and reflected way, his humorous interventions still had some unanticipated consequences. In the same discussion of the psychodrama he also related how:

> the broader I got with the humor . . . the more introspective he got about himself. And it is almost as though he was taking an absurd position with his obsession. I took an absurd, but somewhat different position with the humor. And that somehow freed him [and] his observing ego up to be introspective about himself. Can't say that was a goal up front. But that is what happened. And that was kind of interesting [P. states with emphasis]. He didn't get either raucous or offended; he just got more thoughtful as time went on . . . . It was certainly not something I had expected. I was just hoping to somehow shake him up into a satori [I. and P. laugh].

Even this therapist who spoke of using humor in a planned and reflected way, still found that his humor appeared to have consequences he did not anticipate.

C. Playfulness

It is perhaps surprising, considering the phenomenon under investigation, that the humorous subtheme of play was so infrequently mentioned by the participants of this study. Therapist references to play in the interviews are relatively brief, and include phrases and statements such as: "a sense of play," "and sometimes it's [the use of a pun] just playing," "so you could see he [the patient] was having fun playing with me [P. states with emphasis; referring to himself], and "I [the therapist] just play with him a little."

An illustration of the subtheme of play was given by Participant 4. The statement was made during his description of a

humorous incident discussed earlier in which a psychiatric inpatient was sucking on his "nipple":

> It's almost like I [the therapist] felt there was an aspect of play that he [the patient] seldom experienced as a person. I mean I could play with him, and not at a cost or like hurting him.

Participant 8 also referred to play in his discussion of a humorous incident with a patient he described as being "painfully, painfully depressed and painfully anxious." The therapist related how at the moment he made his humorous remark the patient was in a great deal of pain. It was the therapist's belief that a more traditional intervention would have only driven the patient further into his depression. The therapist stated how he

> didn't want to interpret into that [the patient's depression and pain] or deprive the guy. I [the therapist] didn't want to take a depriving or abstinant position at that point. I wanted to play with him and let him come out a little bit. Let the real self come out and play a little bit. And once he did then he was able to buckle down and do the work again.

One of the therapists, Participant 8, also used the term play in a manner closely related to freedom. In the psychodrama discussed earlier where the patient was "stuck" obsessing over whether or not he should divorce his wife, the therapist described play in the following manner. In this instance, "the humor to my mind, served to bring some energy and playfulness into this otherwise stuck situation." Immediately thereafter, the participant stated how "the reason for putting the humorous stuff in was to make it somewhat playful, so it wasn't all that deadly serious. So that it loosened him up to kind of play with possibilities." Later in his description of the same incident, the participant added how "essentially the humor allows you [the

therapist] to take a playful position to things that seem like they were fundamentally concrete."

D. Bodily and Affective Experiences

In this subtheme participant's descriptions of the "affective" and "visceral" aspects of humor are figural. These aspects cluster together because they seem to deal with the less cognitive aspects of experience. Explicit mentions of the body and bodily reactions were relatively infrequent and appear to be more embedded than affect. The discussion of this subtheme will conclude with a brief discussion of "surprise." Though surprise is frequently thought of in a very cognitive/cerebral way, it is clustered here because it seemed frequently to involve affective and visceral components.

The close interrelatedness of affect and body was illuminated in terms of a humorous incident related by Participant 2. This incident involved tremendous laughter on the part of the patient at the achievement of "the key insight" of his therapy. The therapist described the event as being "primarily affective, visceral, muscular," and the insight as involving "an affective, total realization" on the part of the patient. In relating the humorous incident, the therapist described the patient as "a person who very rarely laughed or smiled," and who at the moment of insight "had this tremendous smile" and "for the first time his body became loose and relaxed." The therapist further added how the laughter, at the moment of insight, accompanied "the understanding, the posture of relaxation, everything. It was just like a ripple effect." Hence the humorous incident seemed to be a whole-person response in which both affective

and visceral aspects figured prominently. Though dramatic and unique, this incident does illustrate how closely related affect and body can be.

Considering the phenomenon under investigation, it is probably not surprising that positive affects were mentioned far more frequently then negative ones. Similar terms and phrases were used by participants to convey a sense of positive affect for both their patients and themselves. Some of the words and phrases included: "satisfaction," "gratification," "pleasure," "pleased"/"pleasing," "hallelujah!," "it felt good," "a happy moment," "a good feeling," "a lot of good feeling," "having fun," "a feeling of fun," "had/having a good time," "I thought great!," "enjoyed it," "felt rather elated," and "there was something joyous about it."

Some illustrative statements by the participants are listed below. Participant 1, discussing a humorous incident which involved his abruptly getting up and leaving the consultation room, stated how: "Well I [the therapist] felt good about my own spontaneity and creativeness." In describing a humorous psychodrama, Participant 8 stated how: "I [the therapist] was just having a lot of fun . . . I was having a good time and things were working."

A sense of positive affect on the part of the patient is conveyed in the following statements. Participant 7 in describing how a patient responded to one of his humorous remarks stated how: "He [the patient] laughs! He likes it!" Participant 10 in discussing her use of humor with a patient, reported how: "I [the therapist] think she [the patient] had a good time [I. and P. laugh]. I think she had a good

time." A sense of shared positive affect between the therapist and patient is conveyed by Participant 1's statement how: "We both enjoyed the fact that it [the therapist's humorous intervention] worked."

There were also some reports of affects which would typically be described as "negatively" tinged. These differed somewhat for therapist and patient. Terms and phrases used by the participant to describe the patient in this regard included: "hostility," "fear," being "anxious" and "afraid." In the case of the therapist these terms included: "guilt," "shame," "impatience," "hostility," feeling "foolish," "painful" and "hurting." Negative affect was also conveyed for the therapist through phrases like: having "a somewhat embarrassed laugh" or "not feeling all that kindly towards him [the patient]." A sense of frustrations was conveyed by Participant 4 in his statement "Jesus Christ! Another session of silence!" at the very beginning of a humorous episode with an adolescent boy who was very oppositional and at times even refused to speak with him.

Three of the four terms listed above for "negatively" tinged patient affects were contained in the following statement made by Participant 5. This statement was made by Participant 5 in her description of a humorous incident in which the patient began the session by reporting a dream in which he was unable to reach the therapist (specifically he was not able to get through a door). The humorous moment occurred at the end of the session, when the door knob of the therapist's office came off in the patient's hand. Despite the fact that both therapist and patient initially laughed at this ("We

both collapsed in laughter") the therapist reported how after she was able to unlock the door the patient:

> didn't want to leave at that point. He was afraid to leave . . . . He was anxious about leaving. (I. Because?) I remember that now . . . I think it was some fear that some magical process had occurred here, without his knowing. The dream predicted what would happen. That things would come undone. As a result of his trying to go through a door they really did [P. laughs]. They really did become undone.

"Negative" affect on the part of the therapist is illustrated in the following statement by Participant 4. This statement was made in the course of the description of the already discussed humorous incident where the patient and therapist switched roles. The therapist stated how when he began mimicking the patient:

> part of me thought "Jesus Christ! Another session of silence!," and this stuff. That feeling passed and I said, "Well let me try something new. It certainly can't be worse than what I've been doing, in the past week or so" . . . . I felt a certain degree of guilt or shame. "My God! I'm acting out something for him." Then I said, "Fuck that!" This is a kid who you've been knowing and working with for a long time. You're not going to do anything that's shocking or hurtful. So try it out.

Only the first of these two statements--illustrating negatively tinged affect on the part of the patient--followed the humorous incident. All other occurrences either slightly preceded or could be considered to have occurred at the very beginning of the humorous incident. All have a transitory quality to them. In all of the instances in which "negatively" tinged affects were reported, the perceived outcome of the humorous incident was positive. There were no instances of a humorous occurrence, where a "negatively" tinged affect was involved, which had a lasting detrimental effect on the patient or the therapy.

Obviously what one feels cannot be separated from other aspects of one's experience. Hence affect is frequently described in conjunction with some other aspect of the therapist's experience; i.e., positive affect at learning something about oneself or seeing positive change in a patient, etc. Though it is not necessary to articulate each and every aspect with which affect co-occurred, it is interesting to note that almost every therapist experienced positive affect regarding positive changes perceived in their patients as a result of a humorous incident. Some illustrative statements are provided below.

The first statements were provided by Participant 3. They come from a previously discussed humorous incident in which an overinvolved, overintrusive mother is berated by her daughter for not doing what she characteristically does. The therapist stated how when the mother reported this and began laughing about it, how she, the therapist, thought:

> hallelujah! . . . Meaning how wonderful for this kid to have some space, and for the mother to have to listen for a change, and back off enough . . . . It's the first time, in a long time, the mother has really not pursued [this kid]. I mean she really has kept her hands off of this school stuff, and she wants it so desperately, so badly.

Shortly after this the therapist added how she was feeling:

> pleased [P. stated laughingly] . . . . I really was. I thought it's a healthy kind of situation. It's rare that this child gets a sense of space and of being independent. The mother just doesn't really permit that. And that she could pursue her mother and say that kind of stuff. I thought it was great!

Another illustrative statement was provided by Participant 7, who stated how in making a humorous remark he:

> wanted to sort of jolt her [the patient] a little bit. Have more impact on her. And I [the therapist] guess I felt some

> gratification that I was able to do that in a therapeutic sense. So afterwards I felt a sense of satisfaction that she was able to use that . . . and it did help her.

Another manifestation of this subtheme was discussed earlier in Subtheme C of Theme I. Basically this involved humorous incidents which were perceived by participants as resulting in improved affect and increased affective reactivity on the part of their patients. These were considered to be positive consequences and hence were discussed in the "Change" section of the subtheme noted above. To avoid redundancy, this particular manifestation of affect will not be discussed here and is mentioned only in passing

Specific statements regarding the bodily aspects of humorous experiences were less frequent then those involving emotion. They appeared to be more embedded in the experience and, presumably less accessible to awareness. Perhaps the most dramatic mention of body was the incident described at the very beginning of this section. In this incident, patient laughter accompanied "the key insight" of the psychotherapy. In general, however, descriptions of body were much more implied. Terms used by the participants like: "strike," "startle," "jolt," "get an immediate visceral reaction," be "non-plussed," and "bolted" all seem to imply a sense of body. Only these terms when actually involving body directly are included in this subtheme.

Body was also strongly implied in the discussion of tension reduction, relief, and relaxation, as the perceived positive consequences of humorous events. This aspect of body was discussed earlier in connection with Theme I.

Though usually conceived of in cognitive terms surprise was clustered here because it seemed to relate to affect and the body. In addition to the actual word "surprise," a sense of surprise was conveyed through terms like: "startled," "caught off guard," and "caught with the goods." Surprise is clearly illustrated in the following statement by Participant 10:

> Anyway I [the therapist] suppose it was surprising of me that I laughed so. But I found it [a humorous remark made by the patient] so funny.

A statement by Participant 6 also conveyed a sense of surprise. In this instance the patient read a nonverbal, inexplicit, message of the therapist's "in a devestatingly perceptive way." This was conveyed through the patient's humorous remark. The participant stated how upon hearing this he:

> was kind of startled [P. starts laughing, I. joins in] and I sort of laughed. It may have been a somewhat embarrassed laugh. She caught me with the goods [P. states with emphasis] in a rather formidable way [P. states jokingly, I. joins in]. But . . . sure my reaction was one of "Yeah! You're right!" [P. states loudly.] I sort of laughed and she laughed [I. laughing].

This statement is interesting because it implies a connection between surprise and the affective and visceral aspects of humor. In the statement above, the word "startled" seems to have a real bodily sense to it. Likewise the phrase "a somewhat embarrassed laugh" is strongly indicative of affect. A sense of surprise and disbelief was also conveyed through therapist descriptions of patients asking themselves--in a puzzled manner--questions like: "How could I have said that?" or "How could it just happen."

E. Temporal Aspects: Brevity and Rate

Like the subtheme Play, the temporal aspects of humor also were not described with great frequency. One manifestation of this subtheme deals with the temporal quality of the humorous incident itself. In general, the focus here is on the momentariness or brevity of the actual humorous incident. This particular manifestation of time is illustrated in the following statement by Participant 2. The statement was made as part of this participant's description of a humorous incident where patient laughter accompanied the achievement of "the key insight" of the psychotherapy. The participant, describing the humorous incident, states how:

> We're talking about really a few seconds in a long [therapy]. A few seconds which stand out. Like I said session 297 [I. laughs] . . . which you can see a lot of things have been put in place for those 296 sessions until the 297th. Getting closer and closer in place, but not in place! And then everything [P. slaps hand] falling into place. And then that new gestalt.

Another illustration of the brevity of the humorous moment was related by Participant 3. This statement was made regarding an incident discussed earlier that involved a "complete role reversal" between mother and daughter, where an overinvolved overintrusive mother was berated by her daughter for not doing what she (the mother) usually does. The therapist stated how:

> for a minute [the mother] could see the humor in it, but then again got on her usual bandwagon and proceeded.

It is intersting to note that even though both incidents were described as being brief, they differed radically in their therapeutic import. In the first instance, the patient's laughter was indicative of

the achievement of "the key insight" in his psychotherapy. It signified the achievement of a "new gestalt" and was indicative of progress in many different ways. This humorous occurrence was also followed by a great deal of movement in treatment. In contrast, in the second instance the insight achieved--if it can be called that--was fleeting and not followed by any therapeutic progress. As noted, after the humorous incident, the patient "got on her usual bandwagon and proceeded." According to the therapist the patient could not appreciate or see as advantageous the "change in role," that now her daughter was coming after her. The mother did not understand where the therapist "was coming from" in being "pleased that this was a certain progress." Hence from these two instances, we can see that the brevity of a humorous event has no necessary connection with it's therapeutic import.

Participant 9, in his descriptions of humorous incidents, related how each may or may not have "hastened" a particular positive consequence coming into being. In the first instance he related, the participant indicated how it definately "hastened something happening." In contrast, for the third incident he really felt it had no effect on the rate with which positive change occurred.

Closely related to this particular example, are the statements of two participants who discussed the rate at which positive movement was perceived to occur after a humorous incident. Participant 2, discussing the humorous incident in which patient laughter accompanied the "the key insight" of his psychotherapy, stated how:

> after that session he [the patient] really took the lead. And systematically went into different areas in which this axis fit. It [the insight] was like the missing piece. And so a better understanding both intellectually and affectively of issues that we had talked about before, but the key element was missing! So it was like again rapidly re-going over the entire course of treatment [italics added].

In contrast to this statement was one made by Participant 6. The incident involved a humorous remark made by a patient. The therapist described the humorous incident as being "pivotal," and indicated that it was followed by a great deal of movement in treatment. He also indicated, however, that the movement was not rapid, but gradual. Specifically the participant stated how he thought the humor:

> was pivotal. The humor was very pivotal there. [Though] this didn't happen overnight [italics added]. I continued to see her . . . for probably around six more months, once a week. And there was kind of an unfolding process, coming outside of herself [italics added].

In addition to the ways noted above, Participant 2 also described the "gradual turning" of a patient's "sense of humor" from a negative to a positive stance. The incident involved a female patient and was described in detail earlier in Theme 1. The therapist felt that changes in the patient's humor, reflected positive movement in treatment. The therapist reported how the patient's change in her sense of humor:

> was more like seepage [P. laughs] . . . . With her [the patient] it was a gradual turning from a negative to a positive stance . . . . So it was a gradual like turning. It wasn't like a sharp thing with the other patient [referring to the incident where the patient's laughter accompanied the achievement of "the key insight" of the psychotherapy].

Therapists also spoke of the frequency of occurrence, of laughter and humorous incidents, on the part of the patient and therapist. At times it was described as being relatively infrequent. This was

conveyed by the use of terms like "unique," "unusual," "atypical" and "a rare event."

Sometimes these terms were used by the participants in relation to something funny or humorous done by a patient. Participant 6, in a case already discussed, described a humorous incident during which the patient whipped out his own tape recorder as soon as the participant began taping him. The participant stated how:

> That's the only time it ever happened. Had someone bring their own tape recorder [P. laughs]. That's kind of funny.

Although usually dealing with humorous or funny things done by the patient, on occasion something "unique" was done by the therapist. This was already mentioned in the discussion of "contrast," in the humorous incident where the participant left the room. In the statement quoted earlier, the therapist emphasized this aspect of the subtheme when he stated how:

> I [the therapist] don't think you're going to get that kind of story from anybody [P. states laughingly; I. joins in] . . . . It was very unique. (I. It was different.) Yeah. It appeals to me.

In contrast to mentions of infrequent occurrence, Participant 6 spoke of how pathological laughter or "nonhumorous" humor "occurs all the time." To illustrate this, the participant described a humorous incident involving a male veteran who was separated from his wife. The therapist indicated how the patient "still pursued her [his wife]. In other words checked out her movements. He'd watch her at all times." According to the therapist, the patient would report this "laughingly" and "was laughing all the time at 'why was he fool enough

to do this?'" In his description of the actual humorous incident, the therapist noted how this:

> was typical of him . . . . It was a very prototypical session. So he would always kind of laugh at himself in a . . . self disparaging way . . . . It was characterological.

In addition to the ways already discussed, Participant 7 reported that two humorous incidents "stood out" because they were temporally close. On the first occassion the therapist stated how the humorous incident stood out because of "its recency. This was just a couple of weeks ago." Similarly on the second and following occassion he stated how: "Well once again [P. states in exaggerated way, I. and P. laugh] it was recency . . . . This happened last week."

Evaluation of Reliability for Coding Categories

In the reliability task, two independent raters, as well as the investigator, scored 50 statements randomly selected from transcripts. These items were scored for both major themes and for eight subthemes. Agreement on a particular theme or subtheme was scored when both raters coded a theme or subtheme as being present in one of the statements. Disagreement on a particular theme or subtheme was considered to occur when one rater scored a significant statement as including a particular theme or subtheme when a second rater did not.

Since each significant statement could be assigned several scores, there was always the possibility of having more than one agreement or disagreement per item. For instance, if one rater scored a significant

statement TQ/IN,UC; and a second rater scored it TQ/IN this item would contain one agreement on the theme level; and one agreement and one disagreement on the subtheme level. In this fashion, levels of agreement were obtained between the investigator and the raters, as well as, between both outside raters. Reliability levels for the themes and subthemes, as well as between raters, are presented in Table 3.

Agreement with the investigator across the two major themes was .93 for Rater 1 and .90 for Rater 2. Agreement with the investigator across all 8 subthemes was .86 for both raters. Though somewhat lower, the agreement levels between raters were relatively consistent with those obtained with the investigator. This was more the case for the agreement level across themes which was .87; while the agreement level across all subthemes was lower at .78.

The agreement levels ranged from .83 to .97 for major themes, and from .64 to 1.00 for subthemes. The theme "Specific Qualities of Humor Occurring in Psychotherapy" (HQ) had the lowest average agreement level across raters at .86; the subtheme "Intimacy and the Therapeutic Relationship" (IN) had the lowest average agreement level across raters at .75. In contrast, the theme "Therapeutic Qualities of Humor in Psychotherapy" (TQ) had the highest average agreement level across raters at .93, while the subtheme "Playfulness" (PL) had the highest average agreement level across raters at 1.00. Overall the level of agreement for themes was .90, and for subthemes .83.

The results of this reliability task appear strongly to suggest that individuals other than the major investigator are able to code the

Table 3

Reliability Rating Agreement Levels

	Percent Agreement			
	Investigator/ Rater 1	Investigator/ Rater 2	Raters/ Rater 2	Average Reliability
Theme				
Therapeutic Qualities of Humor in Psychotherapy (TQ)	.97	.93	.90	.93
Specific Qualities of Humor Occurring in Psychotherapy (HQ)	.88	.87	.83	.86
Total	.93	.90	.87	.90
Subtheme				
Intimacy and the Therapeutic Relationship (IN)	.82	.80	.64	.75
Diagnostic and Prognostic Aspects of Patient Humor (DP)	.78	.78	.80	.79
Using Humor for Psychotherapeutic Change (UC)	.92	.76	.75	.81
Figure Ground Reversals and Other Odd Figures (FG)	1.00	.71	.71	.81
Spontaneity (SP)	.75	1.00	.75	.83
Playfulness (PL)	1.00	1.00	1.00	1.00
Bodily and Affective Experiences (BA)	.86	.85	.85	.86
Temporal Aspects: Brevity and Rate (BR)	.75	1.00	.75	.83
Total	.86	.86	.78	.83

various major and minor themes. In summary, consensual validation is provided for the thematic system as presented and described in the preceding pages.

In addition, kappa coefficients were calculated for each theme and subtheme across raters. Invariably it was found that the kappa coefficients were either equal to or greater than the reliability ratings cited above. This finding appeared to be related to the fact that the number of items per theme/subtheme was variable and at times could occur with relatively low frequency in the scoring task (i.e., occurring 3 out of a possible 50 times). It was believed that the increased correlation coefficients were due, to a large extent, to the fact that in the calculation of kappa, both raters perceiving a theme/subtheme as being absent, was considered an agreement. This markedly increased the number of agreements and subsequently increased reliability coefficients. After obtaining this finding, it was decided to utilize the measure of reliability initially reported in this section, since it appears to be a more stringent measure of reliability for the data obtained in this study.

CHAPTER IV

DISCUSSION

The purpose of this investigation was to develop a thematic category system which would describe the phenomenon of humor as experienced by psychotherapists. An empirical, phenomenological approach was used to analyze the interview data to develop such a category system.

In the last chapter, fundamental aspects of the thematic category system were described. In the present chapter several theoretical and empirical issues will be discussed. Initially there will be a discussion of some rather broad methodological issues. Following this, major themes and subthemes will be discussed in relation to the existing literature. Finally, clinical implications of major findings will be addressed.

Methodological Issues

Though the number of phenomenological studies appears to be increasing, the methodology utilized in this research is still not widely used. The primary emphasis in this approach is on description rather than hypothesis testing. In this particular study, the investigator was interested in participants' experiences of humor in the special setting of psychotherapy. It is significant that this methodology was successful in enabling participants to describe relevant aspects of their experience in this area; since it was always possible participants might

not have anything meaningful to say regarding humorous events that occurred during treatment.

To obtain the present descriptions, a semistructured interview was conducted. It was hoped that such an interview, would allow participants maximum latitude in describing their experiences while still providing some structure. The investigator attempted to listen attentively to the participant at all times, and to be sure to follow the participants' lead. The interviewer assumed a nondirective stance and generally refrained from introducing preconceived and/or theoretical notions into the interview. The investigator functioned almost as a nondirective therapist, helping each participant to more fully and clearly articulate his/her experience. The specific interview questions were developed to get at less reflected and more experiential material. It was for this reason that therapists were asked to discuss specific humorous occurrences. It was hoped that by having them focus on specifics, that this would minimize their tendency to talk in abstract and highly reflected terms.

All participants in this study were intelligent and well educated individuals. They all were extremely articulate and easily able to share experiences with the investigator. In addition, they were all practicing psychotherapists, and overall were quite experienced clinicians. Hence it is not surprising that all would have had experiences involving humor in psychotherapy.

The method of data reduction as outlined by Colaizzi (1978) and elaborated by Dapkus (1982) was found to work rather well. This is

significant considering the fact that the data obtained in this study--unlike other phenomenological investigations--was largely narrative in form, and yet still could be analyzed when certain adaptations were made.

Relationship to Existing Literature

Therapeutic Qualities of Humor in Psychotherapy

The existing clinical and empirical literature on humor in psychotherapy seems to map rather nicely on to the first major theme, and its three subthemes. This probably reflects the apparent emphasis of both clinicians and clinical researchers on the psychotherapeutic aspects of humor as it occurs in dyadic psychotherapy. In other words, the awareness of the clinician or researcher has been on humor in psychotherapy, rather than on humor in psychotherapy--or more simply on the phenomenon of humor itself.

Subtheme 1: Intimacy and the Therapeutic Relationship. This first subtheme relates to the views of O'Connell (1978) and Rosenheim (1974, 1976), and would seem to lend strong support to O'Connell's (1978) contention that humor "allows, encourages and establishes genuine human object relatedness" (p. 2). Though not directly addressing Rosenheim's views of humor as a "corrective, emotional experience," it does support his view that the intrinsic attributes of humor are, indeed, intimacy, directness, and naturalness. The results of this study do not, however, seem to bear upon O'Connell and Rosenheim's assertion that it is the special relational qualities of

humor which exert a powerful healing influence in treatment. The major aspect of this subtheme--that the occurrence of humor frequently involves increased intimacy between therapist and patient--certainly does not disprove the above contention; at the same time it does not prove it. It is interesting to note, however, that if one did adhere to this assertion, then this particular subtheme would be very important. It would be important since the subtheme suggests that humor promotes intimacy and relationship; which in turn--according to this belief--effectuates therapeutic progress or "cure."

The subtheme of intimacy also relates to the existing empirical literature on humor in psychotherapy. Martin (1983) in her observational study of a brief seven session individual therapy found that 53% of the time humorous occurrences decreased client defensiveness. In addition, she discovered that 45% of all humorous occurrences increased the level of intimacy in treatment. Buckman (1980, 1984) also describes a theme that maps very nicely on to this subtheme. This theme was defined as "Humor as a Shared Human Experience." This theme, as the name implies, dealt with the shared relational aspect of humor as it occurs between therapist and patient. Obviously this theme is quite similar to the one presently being discussed here.

Subtheme 2: Diagnostic and Prognostic Aspects of Patient Humor. This second subtheme appears to support the widely cited contention in the literature that patient humor may provide a great deal of information about a patient (Grossman, 1977; Harrelson & Stroud,

1967; Kline, 1977; Kohut, 1971; McKinnon & Michaels, 1971; Nussbaum & Michaux, 1963; O'Connell, 1978; Redlich, Levine & Sohler, 1951; Reik, 1948; Rosenheim, 1974, 1976; Spiegel, Keith-Spiegel & Abrahams, 1969; Strother, Barnett & Apostolakos, 1954; Zwerling, 1955).

This subtheme also relates to prior literature in a number of very specific ways. Participants in this study, for instance, noted the absence of "genuine" humor in seriously disturbed psychiatric patients. This finding is similar to observations made by McKinnon and Michaels (1971), O'Connell (1978) and Rosenheim (1974). Though the examination of the content of jokes for meaning--as discussed by Grossman (1977); Spiegel, Keith-Spiegel & Abrahams, 1954; and Zwerling (1955)--was an infrequent occurrence; different types of patient humor were reported as revealing of the patient's diagnostic state as well as level of health/pathology. Pathological patient laughter; a patient doing something odd or idiosyncratic; or patient laughter at "the key insight" of a psychotherapy; were all considered examples of the revealing quality of patient humor. In addition, participants sometimes saw a humorous incident as having a meaning representative of, or related to, the overall content of a session. Although the analysis of patient jokes was not widely reported by participants, the broader assertion that patient humor has meaning was strongly supported. It is also of interest to note, that on one of the infrequent occasions in which a patient told an actual joke, that the therapist did not see the joke as having a great deal of diagnostic/prognostic significance. Instead the therapist emphasized

the intimacy aspects of the joke. Specifically the therapist emphasized how the patient had shared a joke with her, and the shared laughter which ensued following the joke. This instance illustrated how joke interpretation may have limitations, as documented by both Zwirling (1955) and Grossman (1977).

One participant described how changes in patient laughter/humor reflected positive changes in treatment. This was unlike anything reported in the literature on humor in dyadic psychotherapy, athough it bore resemblance to Harrelson and Stroud's (1967) observation of changes in the humor of chronic schizophrenics involved in a "resocialization-remotivation group." In this group humor was reported to have changed from a negative to positive direction.

Results of the present study are also very congruent with Kohut (1971), O'Connell (1978) and Reik's (1948) view of the emergence of humor as indicative of progress in treatment. The most notable instance of this occurred where the emergence of patient laughter accompanied "the key insight" of a psychotherapy.

It is interesting that one therapist reported a case where the humorous incident was seen as being not merely reflective of the state/status of the patient; but where it served as a symbol or "metaphor" for "what was happening" between therapist and patient. This incident was an adventitious occurrence in which both patient and therapist came to session wearing identically mismatched shoes. The therapist saw this incident as a "metaphor" for the stalemated treatment situation. This meaning and use of a humorous incident

appeared to be a new finding unlike anything previously reported in the psychotherapy literature.

Buckman (1980, 1984) in both of her studies describes the following theme: "Humor is Indicative of Self Esteem and Observing Ego." According to Buckman's description it seems to bear some relation to the subtheme presently discussed. The relation lies in Buckman's allusion that the presence of self esteem and observing ego are related to patient humor. It should be noted, however, that this theme of Buckman's seemed to primarily deal with issues concerning the subtheme: Using Humor for Psychotherapeutic Change. Buckman (1980), for instance, in discussing this theme reported how her:

> respondents stated that to use humor with a client the therapist needs to assess the ego strength of the client [italics added]. This was characterized by recognizing the client's ability to demonstrate an objectivity about oneself; an ability to step outside of oneself and self-observe, yet retain one's self-esteem and self-respect. (p. 86)

In this statement, one can see that Buckman is discussing the therapist's use of humor and its apparent relation to a patient's ego strength, ability to self-observe, as well as to his or her level of self esteem and self respect.

Buckman (1980, 1984) also reported another theme, "Humor Can be Used as a Diagnostic and Assessment Tool for Levels of Wellness," which despite its superficial similarity in title, appears to deal with therapist use of humor and the state/status of the patient--both as a particular diagnostic entity and also on a more individual basis. Buckman also discussed therapist use of humor and the diagnostic yield it provides regarding each patient. For instance, Buckman

(1980) stated how "positive client responses to the therapist's appropriate uses of humor in the working phase of therapy was indicative of increasing levels of patient wellness" (p. 72). Obviously this latter variation lies more in the realm of "Use," as described in this thematic system, than it does with "Diagnosis/Prognosis."

Subtheme 3: Using Humor for Psychotherapeutic Change. This subtheme relates to a great deal of the clinical literature concerning humor in psychotherapy. Though participants did not typically name the humorous interventions utilized, numerous types were described. In the past literature, therapists of varying theoretical persuasions described therapeutic techniques utilizing humor (Boorstein, 1980; Ellis, 1977; Frankl, 1963, 1967, 1969; Greenwald, 1967, 1977; O'Connell, M. J., 1983; Roncoli, 1974; Salameh, 1983). Likewise participants in this study--through not using the word technique--did describe using humor in varying ways.

One major type of humor reported in the literature, for instance, was exaggeration. Numerous therapists described their use of this type of humor (Frankl, 1969; Greenwald, 1967; Salameh, 1983). In this study, participants similarly described uses of humor which would be considered to be and/or involve exaggeration. Participant 5, for instance, described her use of this technique with a pedophile she was treating. Via the use of exaggeration the patient was helped to develop a sense of perspective about himself, as well as concerning a recurrent critical comment made by his (the patient's) father.

The use of humor as a means of circumventing a patient's defenses was frequently discussed in relation to the making of a

humorous interpretation (Grossman, 1977; Grotjahn, 1971; Levine, 1977; Poland, 1971; Rose, 1969). Though participants in this study did not specifically use the phrase "circumventing a patient's defenses," they did cite a number of advantages to the use of humor which, cumulatively, appeared to have the same net effect. Grotjahn (1971), for example, asserted that jokes are an excellent means of making an interpretation because they frequently bypass resistance and thereby make an interpretation more acceptable to the patient. This assertion was supported by findings of the present study. The bypassing of resistance and increased probability of patient acceptance were both cited by participants as specific advantages to using humor in treatment. Grossman (1977) also contended that jokes and humor may be particularly helpful in providing a "light touch . . . [in] approaching a patient in a nonthreatening fashion when some of the more traditional means are not adequate or appropriate" (p. 151). This assertion was also provided support by the results of the study. The avoidance of pain, anxiety and lowered self esteem was clearly viewed by participants as an advantage of using humor. Participants in this study also, at times, described their use of humor as a "last resort" after more traditional or conventional approaches had been tried and found wanting.

Findings of this study also provided some support for Rose's (1969) contention that humorous interpretations may be particularly helpful with preoedipal patients in which the boundaries between self and object are frequently blurred. Participants in this study

described their use of humor with patients who would most likely be considered to have "preoedipal" difficulties. Such patients would often be described as being "primitive" and/or "difficult." One participant, for instance, related a case involving a patient whom he viewed as being not currently analyzable. The therapist indicated how "more serious [P. states with emphasis] interpretations" were "warded off" by this patient. According to the therapist the patient experienced these interpretations "more as assaults than not." The therapist reported how with this patient humor was "less threatening" and was more readily "digested" by the patient.

Another participant indicated that she successfully used humor with a young female patient described as being very "atypical" and "trying" to deal with. Essentially this therapist described how the introduction of humor into the therapy greatly improved this therapist's working relationship with her patient.

Results of this study also appear to relate rather well to the use of humor as a coping device. As noted in the literature review, a number of clinicians and theorists describe the use of humor as a way of asserting freedom and ego mastery and, in this manner, of coping with life's difficulties (Boorstein, 1980; Ellis, 1977; Frankl, 1963, 1965, 1969; Freud, 1928/1960; Greenwald, 1967, 1977; Levine, 1977; Mindess, 1976; O'Connell, M. J., 1978; Pollio, 1983; Wolfenstein, 1954). Though the term "coping" was not used with great frequency, the freedom producing qualities of humor were clearly evident in interviews with participants.

One important positive consequence was discussed in terms of concepts such as: "liberation," "freedom" and "choice to change." That these positive consequences can result in improved "coping" is illustrated in a case related by Participant 1. The participant described how humor helped a patient see that he had choices and possibilities; before this event, everything was "hopeless" and it "all looked like Hobson's choice." The therapist further noted how as a result of the humorous incident, the patient was "ready to go on trying to deal with . . . the issues he faced. That he did [indeed] have some choices."

Another illustration was provided by Participant 8. The therapist had conducted a humorous psychodrama with a patient who was "in a great deal of obsessional struggle." The patient was uncertain as to whether or not he should divorce his wife for another woman with whom he was involved. According to the therapist, the humor enabled the patient to get himself unstuck and to "separate amicably from his wife" and marry the other woman.

Participants in this study perceived the development of "insight," "perspective," improved "realty testing" and "observing ego" as perhaps the major positive consequence of humor in treatment. Insight was probably the positive consequence most frequently reported by participants. This might be due to the fact that most participants adhered to a psychoanalytic perspective, where the attainment of insight is considered the sine qua non of effective treatment. Interestingly, although frequently alluded to in the clinical literature

on humor in psychotherapy, only Kuhlman (1984) has discussed insight as a possible positive consequence of humor in treatment. It seems as if the theoreticians are more interested in writing about the technique of interpretation than the positive consequence of insight so typically associated with it.

In contrast to insight, the development of perspective is discussed by quite a number of theorists in the psychotherapy and humor literature (Boorstein, 1977; Kuhlman, 1984; Mindess, 1976; O'Connell, 1978; Rasch, 1976; Sullivan, 1954). Perhaps this positive consequence of humor is emphasized because of the apparent special capacity humor seems to have in helping individuals distance and detach themselves from difficult life circumstances (Frankl, 1963, 1965, 1967, 1969; Freud, 1928/1960; Kuhlman, 1984). In contrast, theorists may view insight as a positive consequence that can be attained by both humorous and more serious means with equal success.

Though mentioned nowhere as frequently, the perceived consequences of improved reality testing and the development of observing attitude/ego are also alluded to in the literature. Interestingly, however, at times they may be discussed under the more broadly used terms of insight and perspective.

The potential "risks," "pitfalls" and "dangers" of the use of humor in treatment--by both therapist and patient--most clearly relates to the clinical literature regarding the controversy over the use of humor in psychotherapy. Many of the potential dangers of the use of humor as outlined by Kubie (1971) were also cited by participants in

this study. Participant 8, for example, stated how the therapist's use of humor is a "risky intervention" because "one's own sadism or narcissism or 'show-offism' can come out." This perceived negative consequence is very close to one of the dangers outlined by Kubie. In particular, Kubie (1971) writes how "it is all too easy [for therapists] to shut our eyes to the fact that our manifestations of humor can be a form of self-display, exhibitionism, or wooing. They say to a patient 'See how bright and witty and charming and delightful I can be'" (p. 864).

Although this study concerns therapist descriptions of humor in psychotherapy and not a more reflected weighing of the pros and cons of using humor, the overall pattern of participant descriptions would seem to be more in line with theorists who, unlike Kubie, view humor in a more balanced way (Levine, 1977; Rose, 1969; Rosenheim, 1974, 1976; Salameh, 1983; Mindess, 1976). These theorists see humor as being like any other intervention in having both potential advantages and potential risks. Participant 8, for instance, generally has a positive view of humor in treatment even though he did outline several potential dangers of therapist use of humor in treatment. Even Participant 10, who may have had the most reservations regarding the use of humor in treatment, still perceived positive consequences in the use of humor in treatment.

As noted in the results section, most participants described the dangers of therapist use of humor in a very abstract and intellectual way. In general, most theorists in the literature also discussed the

dangers of therapist use of humor in a similar manner. One notable exception, however, was Kuhlman (1984) who described an instance in which "a first attempt at light sarcasm . . . had unfortunate and unremedied consequences" (p. 79) for the patient and the therapy. The negative consequence was the patient abruptly leaving treatment.

This particular subtheme also relates to the empirical literature on humor in psychotherapy. One perceived positive change reported by participants in this study, was humor being seen as resulting in a reduction of "tension," or in providing a sense of "relief" and "relaxation." This finding appears similar to Martin's (1983) finding that 63% of the time, humor was reported as reducing tension and anxiety. It also seems related to Buckman's (1980, 1984) theme of "Humor as a Reliever of Tension and Aggression." In her discussion of humor as a tension reliever, Buckman also asserted that humor can diffuse anxiety, thereby helping a patient tolerate a painful issue. Martin (1983) and Buckman's (1980) finding that humor can reduce anxiety, seems to relate to an advantage cited by participants in this study, of humor being a way to avoid pain and anxiety. In contrast, Buckman's description of humor as a "reliever" of aggression was not given any strong support by present results.

The various types of humor described by participants in this study would appear to be related to Buckman's (1980, 1984) theme of "Humor is the pun, wit, joke, banter, paradox, slips of the tongue, vignette." Humorous interpretation was also mentioned by participants in this study and seems related to Buckman's (1980, 1984) theme of

"Humor as Interpretive in Nature." Descriptions of humorous interpretations, however, were not a frequent occurrence in the present study. Participants seemed to focus on the perceived changes (i.e., facilitation of insight, observing ego, etc.) which are frequently associated with interpretation. This difference in focus between the present study and Buckman's prior study may be a reflection of the fact that Buckman (1980, 1984) was interested in therapists' "conceptualizations" regarding "their [the therapists'] use of humor as an intervention" (1984, p. 1), and not of therapist "descriptions" of the role humor plays in psychotherapy. Considering this, it does not seem surprising that therapists in Buckman's studies tended to focus more on their use of humor as an interpretation. Since participants in the current study described actual humorous events that had occurred, it is probably not surprising that these therapists focused more on what their humor did.

The various "dangers," "risks" and "pitfalls" of therapist initiated humor, as described in this study, seem to relate to Buckman's (1980, 1984) theme of "Humor When Used Has Some Attendant Cautions." Buckman, however, did not deal with the dangers of patient initiated humor, as this study did. Interestingly, this theme of Buckman's also seemed to relate to descriptions by participants regarding criteria for therapist use of humor with a patient. In particular, that the therapist's use of humor must be done with the best interests of the patient at heart.

In her original research, Buckman (1980) also described a theme entitled "Humor as a Defense Mechanism." This theme seems to relate to the finding of this study that humor can be used by both therapist and patient to avoid the elicitation of pain and anxiety. It should be emphasized, however, that Buckman primarily discussed this capacity in respect to the patient, and only secondarily in regard to the therapist.

The present subtheme also seems to relate to a theme of Buckman's (1980, 1984), entitled "Humor Can Be Used as a Diagnostic and Assessment Tool for Levels of Wellness." This theme seems to involve the relationship between a therapist's use of humor and the diagnostic state of the patient--that is, the patient's level of health/pathology. This theme also relates to the infrequent descriptions by participants of their use of a humorous intervention as a diagnostic tool. On such occasions, a humorous intervention was made in order to obtain some diagnostic information regarding the patient.

Buckman's (1980, 1984) theme entitled "Humor Is Indicative of Self Esteem and Observing Ego," also seems to bear some connection to the subtheme currently being discussed. It appears related in that it once again speaks to the relationship between therapist use of humor and certain diagnostic aspects of the patient--namely ego strength, observing ego and level of self esteem.

It does not seem to be an adventitious occurrence that the particular subtheme under discussion was found to relate to so many

different themes of Buckman's (1980, 1984). Essentially, Buckman was interested in therapists' "conceptualizations" regarding their own use of humor in dyadic psychotherapy. Taking this contextual consideration into account, it is not surprising that so many of Buckman's themes would map on to a subtheme entitled "Use of Humor and Psychotherapeutic Change." Fundamentally, this subtheme deals with aspects of humor discussed in detail by Buckman's interviewees. In fact, Buckman's work could be considered a detailed investigation of this one particular aspect of humor in therapy. This observation suggests that the present study deals with a greater range of experiences than did Buckman's since it includes adventitious and patient initiated humor in addition to humor perceived as emerging primarily from the therapist.

Specific Qualities of Humor Occurring in Psychotherapy

The second major theme concerns the specific qualities of humor as it occurs in psychotherapy. The focus here is on humor as the phenomenon of interest, and it is not surprising to find that both the major theme and its five minor subthemes do not map on to the clinical and empirical literature as well as the first theme and its subthemes did. This appears to be due--at least in part--to the observation made earlier that the major focus of both clinicians and researchers is on the therapeutic aspects of humor in psychotherapy, rather than on humor. In reviewing the clinical and empirical literature, it can be seen that aspects related to this second major theme (i.e., spontaneity, playfulness) usually had more of a ground like quality to

them. They generally were not the major focus of the studies reviewed.

Despite the relative paucity of literature in this area, an attempt will be made to explicate what the prior literature has said regarding humor in psychotherapy.

First, as noted above, aspects of this theme are generally not the focus of prior studies. Hence there is simply less of a literature to which this theme can be related. Second, participants in the present study spent much more time describing the therapeutic aspects of humor in psychotherapy rather than the humorous event itself. Although this particular theme was found to require many subthemes, there are far fewer variations to each subtheme than was true for subthemes falling under the first major theme. Hence this theme was discussed by participants, far less than the first theme, and there is far less of a literature to which it can be related. Both of these factors indicate why less will be said--and need be said--about how this particular theme (and its respective subthemes) relate to the prior literature.

In addition, more general theories of humor, when relevant, will be discussed in the following section. Since, the major thrust of this study was an investigation of therapists' experiences of humor and not the development of a theory of humor, discussion of various theoretical perspectives will be limited in scope. The focus here will be to include only theories which directly relate to the subtheme in question; not to account exhaustively for each and every theory of humor.

Subtheme 1: Figure Ground Reversals and Other Odd Figures. The clinical literature seems to concern this subtheme in relation to a grouping clustered around terms such as: "absurd"/"absurdity"; "ridiculous"/"ridiculousness," "ludicrous," "preposterous," "idiocy" and "silly." Some theorists propose that the development of a sense of the "absurd" in a patient can help him/her to develop a more adaptive perspective towards difficult life circumstances. Mindess (1976), for instance, relates how he has "seen people come to terms with themselves by perceiving their own absurdity" (p. 334). It is Mindess' (1976) contention "that many circumstances that we normally experience as depressing, annoying or painful can just as legitimately be experienced as amusing and ludicrous" (p. 335).

Mindess further asserts that the patient who is able to perceive "the irony, absurdity, or outright comedy of his or her predicaments has achieved a wider more flexible, more uplifting and therefore more desirable outlook on life" (1976, p. 335). Mindess also believes that therapists can assist patients in developing an appreciation of the absurdity of their own lives by acting as a model or "living example" for them. In particular Mindess--like Greenwald (1977)--believes that the therapist can accomplish this by recognizing and accepting the "absurd" and "ridiculous" aspects of his/her own profession (psychotherapy). It should be noted that in recommending this Mindess in no way sees himself as denigrating his profession; rather he views all human endeavors as having an "absurd" or "ludicrous" aspect to them.

In the humor in psychotherapy literature, absurdity is also viewed, at times, as being a type of intervention that can be utilized with patients. Salameh (1980), for instance, lists "Absurdity" as one of his "Therapeutic Humor Techniques." In contrast, this investigator tends to view the "ludicrous," "ridiculous," "absurd," etc., as being more of a direct attribute of humor that can be utilized as a special variant of exaggeration. This view relates to Killinger (1977, 1987) who lists absurdity under Exaggeration or Simplification--one of seven categories used by Killinger to classify therapist interventions in an observational study she conducted.

Another aspect or variation on this subtheme concerns a grouping clustered around terms such as: "incongruity," "irony," "role reversal" and "opposites." Illustrative examples included: a therapist and an oppositional patient switching roles; a therapist with a history of phobic type reactions being told by a claustrophobic patient how she felt safe and secure with him (the therapist) while both were on an elevator; and an overinvolved, overintrusive, mother being berated by her daughter for not being involved enough. These examples would seem to bear a marked resemblance to incongruity theory. Keith-Spiegel (1972), in a summary of theories of humor, describes incongruity theory as involving "humor arising from disjointed, ill suited, pairings of ideas or situations or presentations of ideas or situations that are divergent from habitual customs" (p. 7). It should be noted that results of this study lend some support to the assertion that the mere presentation of an incongrous percept is adequate for a

humorous reaction to occur. Resolution--at least in any sophisticated sense--seems not to have been reported by participants. Participant 4's description of the elevator incident, for instance, does not appear to involve any type of resolution. Instead, the therapist seems to focus on the incongrous mental image, the reversal of roles, the violation of expectations and the sense of irony involved. In regard to this topic, it is interesting to note that Killinger (1977, 1981) lists "Incongruity" as one of the seven categories by which she classified humorous interventions by therapists.

In addition, this subtheme relates to Configurational and Gestalt theories in that there is an apparent reversal of figure ground. Reports of participants, however, are not quite congruent with these theories, which seem to emphasize that "it is the 'falling into place' or sudden 'insight' that leads to amusement" (Keith-Spiegel, 1972, p. 11). In the present study, participants did not describe an experience of "sudden insight" or of "things falling into place," but rather emphasized reversals and shifts in figure ground.

Subtheme 2: Spontaneity. Though not a frequent occurrence, this subtheme was alluded to in the humor in psychotherapy literature (Killinger, 1987; Kuhlman, 1984; Mindess, 1976; Poland, 1971; Rasch, 1978). Rasch, for instance, emphasizes spontaneity in his attempt to distinguish what he calls humor from "pseudohumor." He relates how humor is "that spontaneous human eruption of mirth, wit, pun or the knowing laugh," and how "like lightning it flashes and disappears in an unpredictable moment" (p. 8).

It is interesting to note that other therapists also discuss the nature of therapist humor in terms of spontaneity. Poland (1971) writes that in his use of the word spontaneous, he does not "mean to suggest that the impulse expressed in wit is not digested by the ego prior to expression," but rather that "much of the processing done by the therapist's work ego is done unconsciously" (p. 637). Buckman (1980, 1984), in her more empirically based interview studies, describes therapist use of humor by the theme: "Humor is Thoughtfully Spontaneous." In the discussion of this theme, Buckman appears to be talking about a tension between the spontaneous tendency to be humorous and the therapist's capacity to monitor and moderate this in a more reflected way. Buckman (1980) quotes one of her interviewees--a psychiatric nurse--who was described as being "explicit in her thoughts about humor as being a thoughtfully spontaneous intervention." This interviewee stated how she uses:

> humor thoughtfully even though by definition it tends to be spontaneous. I can bite my tongue at the last minute if I feel that it's inappropriate. It's like giving an interpretation; the thought may come to you somewhat spontaneously but it is still thoughtful and it can be regulated. Humor in the therapeutic situation is not only interpretive in nature but it is thoughtfully spontaneous. Therein lies the risk for both the humor and the interpretation. (p. 92)

Obviously Buckman (1984) views this concept as being important, since it is her belief that "with the exception of slips of the tongue, all humor can be guided by the concept of thoughtful spontaneity" (p. 6).

Interestingly, Kuhlman (1984) asserts that "spontaneity is the essence of all effective humor" (p. 6). Even though Kuhlman concedes that some humorous interventions do seem more planned such as

"Viktor Frankl's use of humor in paradoxical intention," he still believes that "in the majority of cases it is clear that therapeutic humor arises from the therapist's spontaneous use of humor rather than from a prearranged plan to use humor" (p. 6).

Subtheme 3: Playfulness. The subtheme of play, like spontaneity, is not mentioned with great frequency in the humor in psychotherapy literature. A small number of theorists, however, do acknowledge it (Greenwald, 1967, 1977; Killinger, 1987; Kuhlman, 1984; O'Connell, 1978; Rasch, 1978). Although not a major focus of his paper, O'Connell (1978) does use the term play throughout. In his description of bantering, for instance, O'Connell's cumulative use of the word play suggests that he sees bantering as a form of play.

Rasch (1978), in distinguishing humor from "prehumor," notes how in addition to being spontaneous "it [humor] is associated with play, the capacity and freedom to play, and the enjoyment of that play. [That] it is almost always an accompaniment to play" (p. 8). Kuhlman (1984) also emphasizes the importance of play in relation to humor. According to Kuhlman, for effective humor to occur, the "receiver" must be in a "playful state of mind." Kuhlman (1984) asserts that this can only be accomplished through the issuance of a "play signal" which "serves as a cue, a prompt, a priming for the humor stimulus that is to come" (p. 17). According to Kuhlman "the play signal . . . functions as an invitation from sender to receiver to suspend the normal 'work' of adaptation and enjoy a brief play period"

(1984, p. 17). In short, Kuhlman sees play as being of fundamental importance in that it is absolutely necessary for humor to occur.

Greenwald (1967) also notes in an article aptly entitled, "Play Therapy for Children Over Twenty-One," that play can be beneficial for both therapist and patient, and may assist both in coping. Greenwald sees play as helping the therapist to not become overwhelmed by a patient's pain and suffering. Greenwald asserts that "it is not helpful to the sufferer [patient] to permit his difficulties to engulf the therapist" and that, indeed, "one of the reasons many patients cannot be helped is that they arouse such intense emotions in the therapist that he cannot cope with them" (1967, p. 46). A playful attitude, according to Greenwald, prevents this from happening and also "insulates" the therapist from retaliating by becoming "vengeful or punative" with his patients.

Greenwald (1967) also comments on the beneficial functions that humor may have for the patient. He relates how, in his capacity as a consultant to industry, he has often noted how "executives, who managed to maintain their humor and to treat work like play were more productive, more creative and generally more efficient than the grim, serious, hard-driven and hard-driving, ulcer-ridden types that one expects to be efficient" (Greenwald, 1957, p. 46). Though stopping short of describing play as a form of freedom, Greenwald does indicate that "it is through play that animals and primitive peoples train their young for their tasks of living"; and that "play is a way of being in

the world, a way of coping with the absurdities of the human condition" (p. 46).

Subtheme 4: Bodily and Affective Experiences. Perhaps the most dramatic illustration of the body and affect subtheme was provided by Participant 2 who described an incident in which tremendous laughter accompanied the achievement of "the key insight" of a psychotherapy. This event was described by the therapist-participant as being "primarily, affective, visceral, muscular." The insight was seen as involving "an affective, total, realization" on the part of the patient. In addition the therapist also noted how the laughter, at the moment of insight, accompanied "the understanding, the posture of relaxation, everything [italics added]."

Phrases such as those used above, together with the more detailed description provided, lend support to Pollio's (1983) assertion that laughter is a "total person event" involving every aspect of the individual. That is: in "the unreflected world of emotional experience" there is "no separation of movement and experience; only the laughing/smiling person in this or that situation, talking to this or that person, concerning this or that topic" (p. 223).

In addition, this rather dramatic event also seems to relate to Pollio's (1983) assertion that humor is a centrifugal, explosive, freedom producing phenomenon "in which the person experiences himself as free of the constraints imposed by society, time, others and even his own body" (p. 215). The patient's laughter accompanied the achievement of "the key insight" of his psychotherapy. This insight

involved a realization on the part of the patient, that all of the assumptions by which he had lived his life, had now "fallen apart and no longer had any hold on him." In short, that his world view had now been significantly and unalterably changed.

In the extant literature, humor has also been considered, at times, to be an outlet for hostility (Freud, 1905/1960; O'Connell, 1978; Wolfenstein, 1954). In the empirical literature concerning groups (Scogin & Pollio, 1980) and group psychotherapy (Peterson & Pollio, 1982), it was discovered, for instance, that most humor was targeted and negative in tone. Martin (1983), in her observational study of a brief individual therapy, likewise found a similar state of affairs. Killinger (1987), who also conducted observational research, found that her category of "Superiority and Ridicule" was the most frequently used technique. In contrast to these studies positively tinged affects were found, in this investigation, to exceed negatively tinged ones. In fact there is only one specific mention of "hostility" in all of the humorous incidents reported. The apparent lack of "negative," hostile and deprecatory humor in this study--as contrasted to those above--may be due to a difference in perspective. Specifically, this study was based on first person reports, whereas the remaining studies were observational--that is took a third person point of view. It is possible, therefore, that humor that would appear deprecatory to an outside observer would not appear to be so to one of the participants in the present investigation. Taking this into consideration, the investigator may not have viewed the humor in this study as hostile, since it came

from the perspective of the participant rather than an outside observer taking a third person point of view.

Interestingly, Scogin and Pollio (1980) suggest that the external/objective viewpoint may not be the best way of understanding the function and significance of humor, and that humor is perhaps best understood from the perspective of the group. These researchers speculate that from that perspective even deprecatory humor should be viewed as providing group support. Martin (1983), similarly reasoned, that apparently derogatory humor may not be viewed as such from the perspective of the patient.

In addition to varying perspectives, the difference between this study and those cited above may be due, in part, to some selective reporting on the part of the participants. Specifically, they may not have felt comfortable sharing humorous experiences which they do not perceive as being hostile or aggressive, but which might be considered as such by outsiders.

Surprise was also mentioned in the humor literature (Keith-Spiegel, 1972; Killinger, 1987; Rasch, 1978; Salameh). Keith Spiegel (1972) in her categorization of humor notes how "the elements of 'surprise,' 'shock,' 'suddenness,' or 'unexpectedness' have been regarded by many theorists as <u>necessary</u> (though not necessarily <u>sufficient</u>) conditions for the humor experience" (p. 9). Salameh (1980) has listed "Surprise" as a "therapeutic humor technique." Killinger (1987) similarly lists "Unexpectedness or Surprise" as being one of seven categories used to classify therapist interventions. Interestingly

Killinger at one point actually refers to this category--in a way similar to Salameh--as "the unexpectedness or surprise technique of humor." In contrast to both Salameh and Killinger, the present investigator views surprise more as an aspect of the humorous event itself, rather than as a particular therapeutic technique to be used by the therapist.

Subtheme 5: Temporal Aspects: Brevity and Rate. In terms of the temporal quality of an actual humorous event, there have been those, like Shakespeare and Freud, who noted the brevity with which most humorous events take place (though this seems to have not been explicitly discussed in the more limited context of psychotherapy). It seems evident that there are those who know--as did Shakespeare--that "brevity is the soul of wit." Pollio (1983) in an article entitled, "Notes Toward a Field Theory of Humor," also emphasizes how the freedom provided by laughter is momentary and fleeting. Essentially he asserts that "such liberation . . . can only be ephemeral for we, as individuals, continue to depend upon the support provided by the very constraints we occasionally manage to escape through humor" (1983, p. 216).

The psychotherapy and humor literature also contains some sparse references regarding the frequency with which humor/laughter occurs in treatment. Both Rasch (1978) and Martin (1983), for instance, note how humor in treatment occurs with a relatively high frequency. Rasch (1978) speaking from his own experience as a clinician, states how he has "always been concerned about humor in therapy. [Since] it occurs with such frequency [italics added] and at such unexpected

times." Martin (1983) approaching the subject from a more empirical standpoint, noted how humor occurred with great frequency in her observational study of a brief, seven session psychotherapy. Specifically she reports how a humorous event occurred approximately once every three minutes during the therapy. Though not actually emphasizing time, Killinger (1987) relates how in her observational study, she examined therapist interventions for their "uniqueness" or "originality" thereby looking for events that were temporally rare or infrequent during the course of a therapy.

Clinical Implications

The finding that therapists report the occurrence of humor as involving--and possibly even promoting--increased intimacy between therapist and patient would seem to have important implications for clinical work. If one adheres to the position of Object Relations theorists such as Guntrip and Fairbairn, or to a Humanistic psychologist like Rogers then humor would be seen as extremely important in that it promotes relationship which is absolutely essential for the patient to make significant progress in treatment.

Even for those clinicians who do not adhere to such an extreme position as Guntrip, Fairbairn and Rogers humor must still be considered to be relatively important. Even for those clinicians who do not perceive the patient-therapist relationship as being crucial for effective treatment, they still see a positive therapeutic relationship as being a necessary, if not sufficient, aspect of effective treatment.

Freud emphasized that a positive relationship or transference was needed in order for a patient to withstand the negative transference and pain involved in the process of an analysis. Most therapists--be they behavioral, psychoanalytic or phenomenological--would see a strong therapeutic relationship as being necessary for the patient to stay in treatment and withstand the pain, risks and surrendering of illusions frequently involved in treatment. In short, any treatment which placed value on the therapeutic relationship, would place some significance on the finding that therapists perceive the occurrence of humor as involving an aspect of increased intimacy. The importance attributed to this finding would probably be roughly related to the importance the clinician placed on the therapeutic relationship. Only a therapist who adhered to a philosophy of treatment totally devoid of emphasis on the therapeutic relationship could disregard the value of humor for treatment.

This study is significant in that therapist reports suggest that patient humor has a diagnostic and prognostic value. That is, humor is not merely a trivial occurrence but has meaning and significance; and can be helpful in understanding a patient. Humor has a revealing quality to it which may provide the clinician with a great deal of information regarding the state/status of a patient and/or of the therapeutic relationship. In discussing present results, for instance, it was noted how a patient doing something odd or idiosyncratic (i.e., pulling out a tape recorder during session, or lying down on the floor mid session) provides a clinician with certain psychodiagnostic

information about him/her (i.e., that the patient is paranoid, or has poor reality testing). Likewise, an adventitious humorous occurrence (i.e., both patient and therapist wearing identically mismatched shoes) can have meaning in terms of the state/status of the therapist-patient relationship, i.e., that the therapy is stalemated or blocked.

The diagnostic value of patient humor is also significant because diagnosis is so intimately related to treatment. This holds true regardless of whether it involves a more formal diagnosis (i.e., a traditional assessment battery) or an informal one (i.e., the therapist's moment to moment assessments of the patient). One must have some understanding or conceptualization of the patient--no matter how tentative--in order to treat him/her. Hence patient humor may provide the clinician with information that is valuable in formulating and carrying out a treatment plan.

The emergence of laughter and a sense of humor in a hospitalized patient, for example, may tell a clinician that the patient is beginning to mobilize. This can have implications for the management of the case, such as, increased privileges and responsibilities within an inpatient milieu. Likewise, if a patient engages in pathological or "nonhumorous" laughter/humor, the clinician may not only not laugh with him but move in, in a more serious way, to help the patient differentiate the incongruity between his/her laughter and the painful content of what is being discussed. In both of these illustrations, one can see a relationship between patient humor/laughter, and the formulation and conduct of treatment.

Reports provided by the therapists interviewed in the present study also suggest that the use of humor by the therapist may have certain advantages in treatment. Though already listed in the results section, they will be repeated here for emphasis: (1) humor may serve as an indirect communication, (2) humor may serve as a way of avoiding patient pain, anxiety and lowered self esteem, (3) humor may serve as a way of increasing the probability of the patient accepting the therapist's message and seeing aspects of themselves and what they do, (4) humor may serve as a way of avoiding patient resistance, (5) humor may serve as a way of avoiding a negative transferential reaction on the part of the patient, (6) humor may serve as a way of "cutting through" a patient's pathological mode of relating to self or other (i.e., the therapist), and (7) humor may serve as a way of increasing clarity on the patient's part in "seeing" pathological aspects of themselves and of their mode of interpersonally relating. As noted earlier, the most common and frequently mentioned advantage was as a means of avoiding pain and anxiety. This function most of the time involved the use of humor by the therapist to avoid eliciting pain and anxiety in the patient. Therapists also described their own use of humor as a way of dealing with their own conflicts and anxieties as they emerged during the course of treatment. Participants also noted how patients used humor in dealing with difficult, painful and anxiety provoking issues.

Therapists described their use of humor with patients who are difficult to reach--that is "primitive" and/or "difficult." In

psychoanalytic theory these patients would be considered to have difficulties in the preoedipal domain. One such case involved a patient considered by the therapist to not be "analyzable right now." The therapist indicated how a humorous remark he made resulted in improved reality testing on the part of the patient. He also noted how the patient--who experienced more serious interpretations as "assaults"--found the therapist's humorous remark to be "less threatening" and more easily "digested."

Another therapist discussed her use of humor with a very "atypical" young woman who was described as being "very trying" to work with. The therapist emphasized in her follow-up interview just how "atypical" she found this girl to be. The therapist noted how her use and encouragement of humor was "like a survival . . . for both of us [therapist and patient]" and that the humor made it "much, much easier to work with her [the patient]. It really was free."

Therapists indicate that humorous occurrences frequently result in positive changes for the patient and the therapy. These positive consequences are varied and include: (1) "insight," improved "reality testing," the development of "perspective" and "observing ego/attitude" on the part of the patient; (2) self exploration on the part of the patient; (3) productive dialogue between patient and therapist; (4) "liberation," "freedom," "choice to change" and an increased sense of "responsibility" on the part of the patient; (5) reduction in "tension" and the provision of a sense of "relief" or "relaxation" for both patient and therapist; (6) improvement in the

patient's affective state; (7) increased patient affectivity; (8) improvement in the therapeutic relationship; (9) increased rapidity of therapeutic movement after a humorous incident; (10) establishment of a boundary with a psychotic patient and (11) a patient's softening of his/her own sadistic sense of humor.

It is interesting to note that even those participants who were more reserved about the place of humor in psychotherapy related humorous incidents in which they experienced humor as resulting in positive consequences for the patient and the treatment. Though less frequent, therapists did describe the positive consequences humor had for themselves. Typically the positive consequence involved some type of increased self knowledge or understanding on the part of the participant.

In addition to describing positive consequences, therapists also outlined the potential "dangers," "risks" and "pitfalls" associated with therapist and patient use of humor. The potential dangers associated with therapist use of humor included: (1) overuse of humor, with the therapist "simply gratifying" him/herself or the patient, (2) the therapist's "sadism or narcissism or 'show-offism' coming out" and (3) the therapist <u>not</u> being aware that he's overusing humor or it's having an adverse impact on healthier appearing patients.

Participants also noted "dangers," "risks" and "pitfalls" associated with patient initiated humor. Specific dangers include: (1) loss of control by the therapist in response to patient humor ("I could go off into gales of laughter and not be able to bring myself back");

(2) therapist being surprised and/or thrown off guard or balance by patient humor, not being sure how to handle it; (3) therapist loosing "the limits of treatment," a sense of process, or the meaning of a patient's humorous remark; (4) patient humor distracting or resulting in the seduction of the therapist; (5) patient attempting to "charm" the therapist into "taking care of" him or her; (6) patient humor resulting in the therapist simply gratifying the patient, or with the patient not changing in a meaningful way, and (7) patient using humor to avoid the patient role.

The discussion of potential "dangers," "risks" and "pitfalls" associated with therapist interventions tended to be somewhat abstract and intellectual. They were not directly related to the humorous incidents shared by participants. Though risks associated with patient initiated humor were somewhat more clearly and directly addressed, they were still rather infrequent occurrences. It is not surprising that the perceived negative consequences of humor would be less frequently and more abstractly discussed than positive consequences were. First, it would seem that therapists, like most individuals, would prefer to focus more on successes than failures. Second, during the interview, participants were not asked to discuss specific instances in which humor was harmful or destructive; rather they were asked to discuss humorous incidents that occurred in therapy. Third, the investigator was both a junior colleague and former supervisee of most participants, which would probably have only contributed to their reluctance to discuss what might be viewed as a "failure."

Considering all of these factors it is probably not surprising that the perceived negative consequences of humor would be discussed so infrequently and/or so abstractly. This picture also suggests that perceived negative consequences may be under-represented in the data and may occur with more frequency than one might expect based on these reports. It further suggests that the therapist should be fully cognizant of potential risks and dangers in regard to humor as it occurs in the process of treatment.

Considering the history of the taboo against humor in therapy, it seems that this study is perhaps most significant because it suggests that the therapist should at least allow humor, when appropriate (that is, not denigrating or pathological), if not actively promote it. This would provide the therapist with the possibility of being more free and playful in therapy, rather than always having therapy be a joyless, deadly serious affair. Such a perspective would seem to provide the therapist with another option, or way of being with patients, that might be of value with certain types of individuals (i.e., such as someone raised in a household where the atmosphere was oppressively serious, and a playful or humorous perspective on problems was never taken or allowed).

REFERENCES

REFERENCES

Barrell, J. E. (in progress). A phenomenological investigation of feeling alone. Unpublished doctoral dissertation, The University of Tennessee, Knoxville.

Bloomfield, I. (1980). Humor in psychotherapy and analysis. International Journal of Social Psychiatry, 26, 135-141.

Boorstein, S. (1980). Lightheartedness in psychotherapy. The Journal of Transpersonal Psychology, 12, 105-115.

Brown, P. E. (1981). Effectiveness of humorous confrontation in facilitating positive self-exploration by clients in an analogue study of therapy. Dissertation Abstracts International, 42(1-B), 363.

Buddenhagen, K. W. (1984). The worlds of cancer patients. Unpublished doctoral dissertation, The University of Tennessee, Knoxville.

Buckman, E. S. (1980). The use of humor in psychotherapy. Unpublished doctoral dissertation, Boston University, Boston.

Buckman, E. S. (1984). Therapist's apperceptions of their use of humor: Humor and its relation to the psychotherapeutic process. Paper presented at the International Congress on Humor, Tel Aviv, Israel.

Buckman, E. S. (1986). Personal communication.

Burbridge, R. T. (1978). The nature and potential of therapeutic humor. Dissertation Abstracts International, 39(B), 2974.

Chapman, A. J., & Foot, H. C. (1983). Humor and laughter in social interaction and some implications for humor research. In P. E. McGhee & J. H. Goldstein (Eds.), Handbook of humor research: Vol. 1. Basic issues. New York: Springer Verlag.

Chapman, A. J., & Foot, H. C. (1976). Humor and laughter: Theory, research and applications. London: Wiley.

Chapman, A. J., & Foot, H. C. (1977). It's a funny thing, humor. Oxford: Pergamon Press.

Childs, A. W. (1976). A tale of two groups: an observational study of targeted humor. Dissertation Abstracts International, 36(B), 5860.

Cohen, D. (1977). Humour, irony and self-detachment. In A. J. Chapman & H. C. Foot (Eds.), It's a funny thing, humour. Oxford: Pergamon Press.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), Existential-phenomenological alternatives for psychology. New York: Oxford University Press.

Corsini, R. J. (Ed.). (1981). Handbook of innovative psychotherapies. New York: Wiley.

Daniels, E. B. (1974). Some notes on clowns, madness and psychotherapy. Psychotherapy and Psychosomatics, 24, 465-470.

Dapkus, M. A. (1982). A phenomenological analysis of the experience of time. Unpublished doctoral dissertation, The University of Tennessee, Knoxville.

Dapkus, M. A. (1983). A thematic analysis of the experience of time. Unpublished manuscript, The University of Tennessee, Knoxville.

Dapkus, M. A. (1986). Personal communication.

Dewane, C. M. (1978). Humor in therapy. Social Work, 23, 508-510.

Domash, L. (1975). The use of wit and the comic by a borderline psychotic child in psychotherapy. American Journal of Psychotherapy, 29, 261-270.

Doris, J., & Fierman, E. (1956). Humor and anxiety. Journal of Abnormal and Social Psychology, 53, 59-62.

Eisenbud, J. (1964). The oral side of humor. Psychoanalytic Review, 51, 57-71.

Ellis, A. (1977). Fun as psychotherapy. Rational Living, 12, 2-6.

Fairbairn, W. R. D. (1954). An object-relations theory of the personality. New York: Basic Books.

Farrelly, F., & Lynch, M. (1987). Humor in provocative therapy. In W. F. Fry & W. S. Salameh (Eds.), Handbook of humor and psychotherapy: Advances in the clinical use of humor. Sarasota: Professional Resource Exchange, Inc.

Farrelly, F., & Matthews, M. (1981). Provocative therapy. In R. J. Corsini (Ed.), Handbook of innovative psychotherapies. New York: Wiley.

Frankl, V. E. (1963). Man's search for meaning. New York: Washington Square Press.

Frankl, V. E. (1965). The doctor and the soul: From psychotherapy to logotherapy. New York: Bantam Books.

Frankl, V. E. (1967). Psychotherapy and existentialism: Selected papers on logotherapy. New York: Washington Square Press.

Frankl, V. E. (1969). The will to meaning. New York: Plume Books.

Freud, S. (1960). Jokes and their relation to the unconscious (1905). In J. Strachey (Ed.), Standard edition of the complete psychological works of Sigmund Freud. London: Hogarth Press Ltd.

Freud, S. (1960). Humor (1928). In J. Strachey (Ed.), Standard edition of the complete psychological works of Sigmund Freud. London: Hogarth Press Ltd.

Fry, W. F., & Salameh, W. S. (1987). Handbook of humor and psychotherapy: Advances in the clinical use of humor. Sarasota: Professional Resource Exchange, Inc.

Giorgi, A. (1970). Psychology as a human science: A phenomenologically based approach. New York: Harper & Row, Publishers.

Goldstein, J. H., & McGhee, P. E. (Eds.). (1972). The psychology of humor. New York: Academic Press.

Golub, R. R. (1979). An investigation of the effect of use of humor in counseling. Dissertation Abstracts International, 40(B), 2837.

Goodrich, A. J., Henry, J. H., & Goodrich, D. W. (1954). Laughter in psychiatric staff conferences: A sociopsychiatric analysis. American Journal of Orthopsychiatry, 24, 175-184.

Greenwald, H. (1967). Play therapy for children over twenty-one. Psychotherapy: Theory, Research and Practice, 1, 44-46.

Greenwald, H. (1977). Humour in psychotherapy. In A. J. Chapman & H. C. Foot (Eds.), It's a funny thing, humour. Oxford: Pergamon Press.

Greenwald, H. (1987). The humor decision. In W. F. Frye & W. S. Salameh (Eds.), Handbook of humor and psychotherapy: Advances in the clinical use of humor. Sarasota: Professional Resource Exchange, Inc.

Grossman, S. A. (1977). The use of jokes in psychotherapy. In A. J. Chapman & H. C. Foot (Eds.), It's a funny thing, humour. Oxford: Pergamon Press, 1977.

Grotjahn, M. (1971). Laughter in group psychotherapy. International Journal of Group Psychotherapy, 21, 234-38.

Guntrip, H. (1969). Schizoid phenomena, object relations and the self. New York: International Universities Press, Inc.

Guntrip, H. (1971). Psychoanalytic theory, therapy and the self. New York: Basic Books, Inc.

Harrelson, R. W., & Stroud, P. S. (1967). Observations of humor in chronic schizophrenics. Mental Hygiene, 51, 458-461.

Hershkowitz, A. (1977). The essential ambiguity of, and in, humour. In A. J. Chapman & H. C. Foot (Eds.), It's a funny thing, humour. Oxford: Pergamon Press.

Heuscher, J. E. (1980). The role of humor and folklore themes in psychotherapy. American Journal of Psychiatry, 137, 1546-1549.

Hickson, J. (1977). Humour as an element in the counseling relationship. Psychology, 14, 60-68.

Ihde, D. (1979). Experimental phenomenology. New York: G. P. Putnam's Sons.

Jacobsen, E. (1946). The child's laughter: Theoretical and clinical notes on the function of the comic. The Psychoanalytic Study of the Child, 2, 39-60.

Janus, S. S. (1981). Humor, sex, and power in American society. The American Journal of Psychoanalysis, 41, 161-167.

Jones, C. S. (1984). Training manual for thematizing interview protocols phenomenologically. Unpublished manuscript, The University of Tennessee, Knoxville.

Kaneko, S. Y. (1972). The role of humor in psychotherapy. Dissertation Abstracts International, 32(9-A), 5344.

Keen, E. (1975). A primer in phenomenological psychology. New York: Holt, Rinehart and Winston, Inc.

Killinger, B. (1977). The place of humour in adult psychotherapy. In A. J. Chapman & H. C. Foot (Eds.), It's a funny thing, humour. Oxford: Pergamon Press.

Killinger, B. (1987). Humor in psychotherapy: A shift to a new perspective. In W. F. Frye & W. S. Salameh (Eds.), Handbook of humor and psychotherapy: Advances in the clinical use of humor. Sarasota: Professional Resource Exchange, Inc.

Killinger, B. E. (1978). The place of humor in adult psychotherapy. Dissertation Abstracts International, 38(B), 3400.

Kline, P. (1977). The psychoanalytic theory of humour and laughter. In A. J. Chapman & H. C. Foot (Eds.), It's a funny thing, humour. Oxford: Pergamon Press.

Koestler, A. (1964). The act of creation. New York: The Macmillan Company.

Kohut, H. (1971). The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders. New York: International Universities Press, Inc.

Kubie, L. S. (1971). The destructive potential of humor in psychotherapy. The American Journal of Psychiatry, 127, 861-866.

Labrentz, H. L. (1974). The effects of humor on the initial client-counselor relationship. Dissertation Abstracts International, 34(A), 3875.

Levine, J. (1977). Humour as a form of therapy: Introduction to symposium. In A. J. Chapman & H. C. Foot (Eds.), It's a funny thing, humour. Oxford: Pergamon Press.

Loewald, E. (1976). The development and uses of humor in a four-year-old's treatment. International Review of Psycho-Analysis, 3, 209-221.

MacGillivrary, W. A. (1985). Embodiment and ambiguity: A phenomenological investigation of the lived-body. Unpublished doctoral dissertation, The University of Tennessee, Knoxville.

MacKinnon, R. A., & Michels, R. (1971). The psychiatric interview in clinical practice. Philadelphia, Pennsylvania: W. B. Saunders Company.

Martin, J. F. (1983). Humor in therapy: An observational study. Unpublished doctoral dissertation, The University of Tennessee, Knoxville.

McGhee, P. E. (1971). Development of the humor response: A review of the literature. Psychological Bulletin, 76, 328-348.

McGhee, P. (1979). Humor, its origin and development. San Francisco: W. H. Freeman.

McGhee, P. E., & Goldstein, J. H. (1983). Handbook of humor research: Vol. 1. Basic issues. New York: Springer-Verlag.

McGhee, P. E., & Goldstein, J. H. (1983). Handbook of humor research: Vol. 2. Applied studies. New York: Springer-Verlag.

Megdell, J. I. (1982). Relationship between counselor-initiated humor and client's self perceived attraction in the counseling interview. Dissertation Abstracts International, 42(B), 4584.

Mindess, H. (1976). The use and abuse of humor in psychotherapy. In A. J. Chapman & H. C. Foot (Eds.), Humor and laughter: Theory, research, and applications. London: Wiley.

Murphy, B., & Pollio, H. R. (1975). The many faces of humor. Psychological Record, 24, 545-558.

Nies, D. C. (1982). A role of humor in psychotherapy: Reduction of dating anxiety in males. Dissertation Abstracts International, 43(B), 1982.

Nussbaum, K., & Michaux, W. W. (1963). Response to humor in depression: A predictor and evaluator of patient change. Psychiatric Quarterly, 37, 537-539.

Obrdlik, A. J. (1942). "Gallows Humor"--a sociological phenomenon. American Journal of Sociology, 47, 709-716.

O'Connell, M. J. (1978). Humor as a therapeutic counterpoint to antilibidinal ego functioning. Unpublished manuscript, The University of Tennessee, Knoxville.

O'Connell, M. J. (Date Unknown). The turkey that ate Chicago. Unpublished manuscript, The University of Tennessee, Knoxville.

O'Connell, W. E. (1981). Natural high therapy. In R. J. Corsini (Ed.), Handbook of innovative psychotherapies. New York: Wiley.

O'Connell, W. E. (1960). The adaptive functions of wit and humor. Journal of Abnormal and Social Psychology, 61, 263-270.

O'Connell, W. E. (1964). Resignation, humor and wit. Psychoanalytic Review, 51, 49-56.

O'Connell, W. E. (1977). The sense of humor: Actualizer of persons and theories. In A. J. Chapman & H. C. Foot (Eds.), It's a funny thing, humour. Oxford: Pergamon Press.

O'Connell, W. E. (1987). Natural high theory and practice: The humorist's game of games. In W. F. Fry & W. S. Salameh (Eds.), Handbook of humor and psychotherapy: Advances in the clinical use of humor. Sarasota: Professional Resource Exchange, Inc.

Orfandis, M. M. (1972). Children's use of humor in psychotherapy. Social Casework, 53, 147-155.

Peterson, J. P. (1980). The communicative intent of laughter in group psychotherapy. Unpublished doctoral dissertation, The University of Tennessee, Knoxville.

Peterson, P., & Pollio, H. R. (1982). Therapeutic effectiveness of differentially targeted humorous remarks in group psychotherapy. Group, 39-50.

Plessner, H. (1970). Laughing and crying: A study of the limits of human behavior. Evanston: Northwestern University Press.

Poland, W. S. (1971). The place of humor in psychotherapy. American Journal of Psychiatry, 128, 635-637.

Pollio, H. R. (1982). Behavior and existence. Monteray: Brooks/ Cole Publishing Company.

Pollio, H. R. (1983). Notes toward a field theory of humor. In P. E. McGhee & J. H. Goldstein (Eds.), Handbook of humor research: Vol. 1. Basic issues. New York: Springer-Verlag.

Pollio, H. R., & Kubo Bainum, C. (1983). Are funny groups good at solving problems?: A methdological evaluation and some preliminary results. Small Group Behavior, 14, 379-404.

Rasch, N. L. (1978). The therapist as learner and teacher illuminated in a consideration of humor and laughter. Unpublished manuscript, The University of Tennessee, Knoxville.

Redlich, F. C., Levine, J., & Sohler, T. P. (1951). A mirth response test: Preliminary report on a psychodiagnostic technique utilizing dynamics of humor. American Journal of Orthopsychiatry, 21, 717-734.

Reik, T. (1948). Listening with the third ear. New York: Farrar, Straus and Company.

Robinson, V. M. (1983). Humor and health. In P. E. McGhee & J. H. Goldstein (Eds.), Handbook of humor research: Vol. 2. Applied studies. New York: Springer-Verlag.

Roncolli, M. B. (1974). Bantering a therapeutic strategy with obsessional patients. Perspectives in Psychiatric Care, 12, 171-175.

Rose, G. J. (1969). King Lear and the use of humor in treatment. Journal of the American Psychoanalytic Association, 17, 927-940.

Rosen, V. (1977). Style, character and language. New York: Jason Aronson Inc.

Rosenheim, E. (1974). Humor in psychotherapy: An interactive experience. American Journal of Psychotherapy, 28, 584-591.

Rosenheim, E. (1976). Humor in psychotherapy. Current Psychiatric Therapies, 16, 59-65.

Rule, W. R. (1977). Increasing self modeled humor. Rational Living, 12, 7-9.

Salameh, W. A. (1983). Humor in psychotherapy--past outlooks, present status, and future frontiers. In P. E. McGhee & J. H. Goldstein (Eds.), Handbook of humor research: Vol. 2. Applied studies. New York: Springer-Verlag.

Schienberg, P. (1980). Therapists' predictions of patients' responses to humor as a function of therapists' empathy and regression in the service of the ego. Dissertation Abstracts International, 40(A), 4501.

Schwartz, B. E. (1974-75). Telapathic humoresque. Psychoanalytic Review, 61, 591-606.

Scogin, F. R., & Pollio, H. R. (1980). Targeting and the humorous episode in group process. Human Relations, 33, 831-852.

Seidner, B. G. (1987). A phenomenological analysis of the experience of "falling apart." Unpublished doctoral dissertation, The University of Tennessee, Knoxville.

Simon, R. K. (1977). Freud's concepts of comedy and suffering. The Psychoanalytic Review, 64, 391-407.

Spiegel, D., Keith-Spegel, P., & Abrahams, J. (1969). Humor and suicide: Favorite jokes of suicidal patients. Journal of Consulting and Clinical Psychology, 33, 504-505.

Sproule, J. B. (1984). The therapist's experience of significant events and the occurrence of insight in psychotherapy. Unpublished doctoral dissertation proposal, The University of Tennessee, Knoxville.

Starer, E. (1961). Reactions of psychiatric patients to cartoons and verbal jokes. The Journal of General Psychology, 65, 301-304.

Strother, G. B., Barnett, M., & Apostolakos, P. C. (1954). The use of cartoons as a projective device. Journal of Clinical Psychology, 10, 38-42.

Sullivan, H. S. (1956). Clinical studies in psychiatry. New York: W. W. Norton and Company, Inc.

van den Berg, J. H. (1972). A different existence. Pittsburgh: Duquesne University Press.

Wolfenstein, M. (1954). Children's humor. Bloomington: Indiana University Press.

Zillman, D. (1983). Disparagement humor. In P. E. McGhee & J. H. Goldstein (Eds.), Handbook of humor research: Vol. 1. Basic issues. New York: Springer-Verlag.

Zuk, G. H. (1964). A further study of laughter in family therapy. Family Process, 3, 77-89.

Zuk, G. H., Boszormenyi-Nagy, I., & Heiman, E. (1963). Some dynamics of laughter during family therapy. Family Process, 2, 302-314.

Zuk, G. H. (1966). On the theory and pathology of laughter in psychotherapy. Psychotherapy: Theory, Research and Practice, 3, 97-101.

Zwerling, I. (1955). The favorite joke in diagnostic and therapeutic interviewing. Psychoanalytic Quarterly, 24, 104-114.

APPENDIXES

APPENDIX A

SALAMEH'S HUMOR TABLES

Table A-1

Therapeutic Humor Techniques (from Salameh, 1983)

Therapeutic Humor Techniques	Definition	Clinical Vignette
Surprise	Using unexpected occurrences to transmit therapeutic messages	Drilling noise outside office. Patient is talking about his domineering wife. Therapist: "Your wife is talking to you now!"
Exaggeration	Obvious overstatement or understatements regarding size, proportions, numbers, feelings, facts, actions.	To patient who romanticizes his depression while refusing to consider alternatives: "I could help you, but I guess that wouldn't do any good anyway. You know we all die eventually."
Absurdity	That which is foolish, nonsensical, inane, irrationally disordered. That which is without having any logical reason to be.	A young businessman is spending inordinately long hours at the office and on business trips. He reports that his wife has complained about his increasing lack of interest in their sexual relationship. Therapist responds: "It sounds like the best way for you to get more invested in your sex life is to make it tax deductible!"
The Human Condition	Refers to problems of living that most human beings encounter, viewed from a humorous perspective to stress their commonality.	Therapist to perfectionistic patient who worries that he is not being "totally honest" in communicating all his feelings to others: "As the holy books have indicated, it is difficult for mankind to be honest at all times. But if you want to be a phony you should be honest about it.

Table A-1 (continued)

Therapeutic Humor Techniques	Definition	Clinical Vignette
Incongruity	Linking two or more usually incompatible ideas, feelings, situations, objects, etc.	Oppositional female patient reacts to therapist interpretation by stating that she "has already entertained that possibility." Therapist response: "You've entertained it, but you didn't go to bed with it."
Confrontation/ Affirmation Humor	Confronts patients' maladaptive and self-defeating behaviors while simultaneously affirming their personal worth as individuals. Assumes that patient confrontation is best digested by patients when coupled with affirmation.	A patient in group therapy is confronted by other group members regarding his compulsive nose-blowing behavior. He passionately defends his need to "Breathe clearly." Therapist responds: "You know we can see that you've got a lot of intensity, but you don't have to blow it out your nose!"
Word Play	Using puns, double entendres, bon mots, song lines, and well-known quotes or sayings from popular culture to convey therapeutic messages.	Therapist to patient who keeps depriving himself of what he really wants: "You know what Oscar (Wilde) said, 'I can resist anything but temptation.'" To another man who prevents himself from enjoying life or other people because he refuses to take small acceptable risks. "Mae West did say 'When I choose between two evils, I always like to take the one I've never tried before.'"
Metaphorical Mirth	The use of metaphorical constructions, analogies, fairy tales and allegories for thera-	Patient is talking about how his interpersonal communication is becoming less confused as he really lis-

Table A-1 (continued)

Therapeutic Humor Techniques	Definition	Clinical Vignette
Metaphorical Mirth (cont.)	peutic storytelling to help patients assimilate new insights or understand old patterns.	tens to others and gives relevant feedback. Therapist: "It's like that lion you see at the zoo who always growls at you but you don't know what he means. And one day you go to the zoo and he smiles and says, 'Hi there I've been fixin' to talk to you.' And then you talk to each other and become penpals."
Impersonation	Humorously imitating the typical verbal response or maladaptive style of patients and of significant others they may bring up in therapy.	Patient repeats a characteristic "Fssss" sound with his tongue whenever he experiences sadness or other "vulnerable" emotions, so as to block the expression of such feelings. Therapist imitates this "Fssss" sound when patient displays it. Patient gradually shifts from suppression to acknowledgment of his feelings.
Relativizing	Contextualizing events within a larger perspective such that they lose their halo of absoluteness. Relativizing gives the message that: "Nothing is as serious as we fear it to be, nor as futile as we hope it to be" (Jankelevitch, 1964).	Patient recounts his painful struggle with his "weight problem," even though his physician informed him he is only 3-5 pounds overweight. Therapist, "Well, I notice you've lost some weight behind the ears since last week."
The Tragi-Comic Twist	A delicate humor technique requiring almost surgical precision that consists of a transfor-	Patient who has chosen depression and crying as a behavioral mode of response to any environmental stres-

Table A-1 (continued)

Therapeutic Humor Techniques	Definition	Clinical Vignette
The Tragi-Comic Twist	mation of patients' detrimental tragic energies into constructive comical energies. It begins with a well-timed implicit or explicit juxtaposition of the tragic and comic poles of a given phenomenon followed by a reconciliation of the two poles in a humoristic synthesis that triggers laughter.	sor is crying during session about feeling rejected and tense. Therapist responds: "I guess you're trying to relax now." Patient's crying turns into frantic laughter as he replies: "That's one thing I do really well, I know how to cry." Therapist: "Maybe you can relax about crying." More laughter. Therapist asks patient why he is laughing. Patient: "I suppose there are other ways of releasing tension besides crying." The entire session then focuses on the above issue.
Bodily Humor	Using the entire body or specific muscle groups in physical activity aimed at imitating or creating nonverbal reflections of typical maladaptive mannerisms in order to encourage their extinction.	Patient exhibits a typical rotational hand movement to express disillusionment with others' behavior when it does not meet his "requirements." Therapist uses this same hand movement in therapy whenever patient is expressing disillusionment with therapist's behavior not meeting his expectations.

Table A-2

Humor Rating Scale (from Salameh, 1983)

Level of Therapist Humor	Clinical Vignette
Level 1 Destructive Humor	
Therapist humor is sarcastic and vindictive, eliciting client feelings of hurt and distrust. Therapist abuses humor to callously vent his/her own anger towards clients or the world and is consequently insensitive to and unconcerned with the impact of his/her humor on clients. Therapist humor may judge or stereotype clients; its caustic quality denigrates clients' sense of personal worth, leaving them with a typical "bitter after-taste" reaction. Since the therapist's use of humor is destructive and retaliatory in nature, it tends to significantly impede client self-exploration and divert the therapeutic process.	Therapist to client who reports feelings of inadequacy related to a negative self-image: "Well, you obviously have much to be modest about: your face could sink a fleet, and on top of it you have the I.Q. of a tree. On the other hand, being stupid could help you qualify for disability payments."
Level 2 Harmful Humor	
Therapist humor does not manifest the blatant client disrespect found at level 1, but is still not attuned to clients' needs. Therapist mixes the irrelevant use of humor with its abuse, at times introducing humor when it is unapplicable to the issues at hand. The therapist may follow up his/her abuse of humor with a "redemptive communication" that essentially acknowledges the inappropriateness of the	Client states that he is confused about his goals in life and unable to understand himself. Therapist replies "Here you go off on a fishing pole again! It's almost like your mind is full of wallpaper." Client with a nervous titter: "So I guess I should be perfect! Asking confusing questions can led me astray, right?" Therapist now self-conscious: "Well, uh, I'm like that too sometimes. Sometimes I can't

Table A-2 (continued)

Level of Therapist Humor	Clinical Vignette
Level 2 Harmful Humor (continued)	
previous abusive comment and attempts to make verbal or nonverbal amends for it. Overall, therapist humor is harmful and incapable of facilitating therapeutic process since it is indiscriminate and invalidated either by missed timing or by the attempt to redeem derisive comments.	think straight." Therapist goes on to explain about this own periods of confusion, indirectly apologizing. Attention is gradually shifted away from the client's experiencing.
Level 3 Minimally Helpful Humor Response	
Therapist does not question the essential worth of individuals and is adequately attuned to clients' needs. Therapist uses humor for and not against clients as a means of reflecting their dilemmas in a concerned yet humorous manner. Therapist humor promotes a positive therapist-client interaction, yet remains mostly a reaction to clients' communication rather than an active or preferred therapist-initiated mode of communication.	A married couple is reporting to the therapist that their sexual contacts have gradually decreased in frequency and are presently relegated to rare "special occasions" instead of being a continuous element of their relationship. Therapist: "So I guess it's (sexuality) now like the good old Christmas tree. It's a hassle to get it from the attic and set it up. It's nice while it lasts, but it only gets turned on once a year!"
Level 4 Very Helpful Humor Response	
Therapist humor is substantially attuned to clients' needs and to helping them identify new options. Therapist humor may expose or amplify specific maladaptive behaviors yet simultaneously conveys a respect for clients' personhood. It facilitates clients'	Client complains that she and her husband are always arguing yet it becomes increasingly clear to the therapist that the client and her husband use arguing as an "exciting" (albeit offensive) conduit for expressing both their intellectual inquisitive-

Table A-2 (continued)

Level of Therapist Humor	Clinical Vignette
Level 4 Very Helpful Homor Response (continued)	
self-exploration while inciting them to recognize and alter dysfunctional patterns. The educational, comfortable, and enjoyable nature of therapist humor stimulates a positive and candid client-therapist relationship. Nevertheless, therapist humor still lacks some of the intensity, timing, and graphic language characteristic of level 5 humor responses.	ness and their emotional affinities towards each other. Client ends her story with: "It's funny, but after we argue I end up feeling both frustrated and aroused." Therapist replies: "You mean the rocks he throws fit the holes in your head?"
Level 5 Outstandingly Helpful Humor Response	
Therapist humor conveys a profound understanding of clients, is characterized by spontaneity and excellent timing, and challenges clients to live to their fullest potential. Therapist humor reflects his or her emotional and cognitive freedom used to facilitate clients' emotional arousal and cognitive restructuring. It generates significant self-exploration and accelerates the process of client changes by defining problems, condensing and symbolizing therapeutic process material, identifying new goals and promoting constructive alternatives. The creative nature of therapist humor can elicit decisive existential insights and encourages clients to develop their own humor along with other attitudinal changes.	During a group therapy session, a manipulative client is recounting to the group his repeated failings at achieving honest nonmanipulative communication with others. Although he tries, others don't seem to believe or respond to his "authentic" self-revelations. Therapist: "You know your situation reminds me of a corrida scene with a bull and toreador. We don't know whether you're the bull for whose slaughter we should feel sorry or the toreador whose courage we ought to admire." Another group member: "But he's really not the bull, he sets other people up as being bulls." Client, laughing: "So I end up being the toreador. I give my coup de grace and demand my Ole!" Group members, in unison: "Ole!"

APPENDIX B

BUCKMAN'S OPENING STATEMENT

I have been a practicing psychotherapist for fifteen years. During the past six years I've become acutely aware of the presence of humor during the therapy sessions--most pointedly of my use of humor at times as the therapist. Since my awakening to this I began wondering and asking myself: "Do other therapists use humor? Am I the only one? Oy way, what will my colleagues say if they know--this therapy is serious business. Maybe there's something theoretically kosher to this being funny!" So, I began asking--a few therapists admitted using it, many wouldn't talk about it, many hedged. I became curious, wanting to seriously study this phenomenon of humor and therapist's use and reactions.

I have read the literature and am now at the point in my doctoral work of researching my interest through interviews. The purpose of my research is to look at how therapists conceptualize the use of humor in the therapy session; if they use it; how and why they use it; what they think it accomplishes. I am very interested in hearing what you have to say about this and would be pleased if you would share your thoughts as a therapist, on your use of humor with me.

APPENDIX C

ORIGINAL INTERVIEW QUESTIONS

1. Tell me about a time when something funny or humorous happened in therapy. Can you think of 1 or 2 other funny incidents that stood out for you? What made them stand out?

2. Tell me about a time when a patient said or did something funny or humorous in therapy. What was the context in which this incident occurred? Do you remember what you were thinking at that time? (If so) Tell me about it. Do you remember how the patient reacted? (If so) How did she/he react?

3. Tell me about a time when you said something funny or humorous to a patient. What was the context in which this incident occurred? Do you remember what you were thinking at that time? (If so) Tell me about it. Do you remember how the patient reacted? (If so) How did he/she react? What made you use humor instead of saying something serious?

4. Has there ever been a time when you experienced humor in a session as something harmful or destructive? (If so) Tell me about it. Do you remember a time when you thought it was particularly helpful? (If so) Tell me about it.

5. Is there anything else you'd like to say about what we've been discussing?

APPENDIX D

INFORMATION AND CONSENT FORM

At this time I am conducting research for my doctoral dissertation in Clinical Psychology. I am interested in the place of humor in psychotherapy, as experienced by the psychotherapist.

In this research study each of you, as a subject, will be interviewed regarding humorous incidents that occurred in therapy. These can be incidents initiated either by yourself as therapist; by your patient; or by both your patient and yourself. This initial interview will last approximately an hour to an hour and a half. All interviews will be audiotaped.

After the initial interview, you will subsequently be recontacted to participate in a brief follow-up interview. Prior to the follow-up interview, you will be given written feedback regarding our first interview. At this follow up interview you will be asked for your reaction to the feedback previously given. Each of you will be asked if there is anything you would like to add or change. The follow-up interview will last approximately fifteen minutes to a half hour. This interview will also be audiotaped. If it is impossible to conduct a personal interview, this aspect of the research will be conducted via telephone. If a telephone interview becomes necessary, I will at the time, of the interview; once again remind you that I would like to tape our conversation. If you feel uncomfortable being audiotaped, at that time; but would still like to continue in the study, I will utilize written notes in lieu of audiotaping.

All information will be kept strictly confidential. At no point in the research will the actual names of the participants be utilized. All audiotapes and other data will be coded by number, and will only be able to be identified through a master list. The master list will be kept in a secure place to which only the researcher will have access. No permanent record of subject participation will be kept. The master list and all of the audiotapes will be destroyed after the research project has been completed.

It should be noted that your participation in this research project is completely voluntary. As a subject, you are free to withdraw at any point, with no questions asked.

As a researcher I am fully aware of the importance of therapist-client confidentiality. Hence I would simply like to remind you, prior to actually beginning the study, to not identify any of your clients by name and that you keep all identifying information to an absolute minimum. If, in the highly unlikely instance, that I suspect I know

the identity of the client involved in the humorous incident; I will immediately terminate the interview.

If you have any questions now or at any point in the study, please do not hesitate to question me. A copy of this Information and Consent Form will be given to you to keep, in the event you wish to contact me at any point regarding the research project.

Researcher: James M. Koelln
Apt. 712
2521 Kingston Pike
Knoxville, Tennessee 37919
(615) 523-9305

or

Office 401 H
Psychology Department
Austin Peay Building
Knoxville, Tennessee 37996-1000
(615) 974-6060

Faculty Advisor: Howard R. Pollio, Ph.D.
Psychology Department
Austin Peay Building
Knoxville, Tennessee 37996-1000

I have read and understand the information provided above, and hereby consent to participate in this investigation.

Participant: _____ Witness: _____

Date: _____ Date: _____

APPENDIX E

FOLLOW-UP LETTER

James M. Koelln
Apartment 712
2521 Kingston Pike
Knoxville, TN 37919

March 5, 1987

Dear

As I indicated during our initial interview regarding humorous incidents that occurred in psychotherapy; one aspect of this study was to provide written feedback regarding the experiences you shared with me during our interview, and to ascertain your reaction to this feedback. Ideally I would have preferred to have met with you personally in order to conduct a follow-up interview; however geographic and financial considerations have made this highly impractical. I am, however, interested in your reactions to the feedback provided, and would appreciate it if you could provide me with this information via a follow-up telephone interview.

Enclosed you will find a summary of your interview (or a reduced text), which I would appreciate if you would review. However, prior to your doing this, I would like to discuss the general format utilized in the interview summary, in order to make it more intelligible for you to read. Each interview consisted of the participant telling me about several cases in which something humorous or funny occurred. Essentially to reduce the voluminous raw interview data into more manageable form, I decided to divide each of these cases or vignettes into the following three parts: (1) context, (2) humorous incident and (3) significant statements.

In the context section I attempted to concisely present all of the relevant context (i.e., major themes in therapy; patient diagnosis and other information; session context, etc.) provided by you; which I felt was necessary and/or helpful in understanding the humorous incident and significant statements. In this section, quotations by yourself were clearly indicated as such by the use of quotation marks.

In each case the context section was followed by the humorous incident. As the name implies, this refers to the actual humorous or

funny event which you related. The significant statements which follow the humorous incident, are relevant commentary or statements made by yourself, which directly pertain to the phenomena under investigation. In contrast to the context section; the humorous incident and significant statements utilized, to the fullest extent possible, the exact language of the participant. I did attempt, however, to write these statements in a more abbreviated form (i.e., eliminating nonrelevant commentary; casual asides; "uhms", "ohs", "you knows", etc.).

In some interviews there is a heading, "Question No. 2", which refers to the final question of the interview ("Is there anything else you'd like to say about what we've been discussing?"). The significant statements listed under this heading consist of relevant statements made by you in response to this question. Also significant statements beginning with the term "Additional" were statements you made, after that particular case had been discussed.

Essentially I would appreciate it if you would read over the enclosed summary (reduced transcript) and participate in a follow-up telephone interview. At this follow-up interview you will be asked: (a) for your reaction to the written feedback provided and (b) if there is anything you would like to add or change. The follow-up interview should be relatively brief and will, with your permission, be audiotaped. At the time of the interview I will remind you that I would like to tape our conversation. If you feel uncomfortable being audiotaped, at that time; but would still like to continue in the study, I will utilize written notes in lieu of audiotaping. Of course, if you do not wish to participate in the follow-up interview, you are free to decline, with no questions asked.

I would like to thank you once again for participating in my study. I will be in contact with you soon to set up a mutually convenient time for a follow-up interview. If you have any questions or concerns, please feel free to contact me. I can be reached at the above address or the following telephone numbers: Home 1-(615) 523-9305 or School 1-(615) 974-6060.

Thanks again for your time and consideration.

Sincerely Yours,

James M. Koelln

APPENDIX F

SCORING MANUAL

Introduction

The purpose of this scoring manual is to describe and illustrate the thematic category system which I have developed regarding therapists' experiences of humor in psychotherapy. The themes were formulated through a process of analyzing individual taped interviews for thematic content, and then clustering similar thematic content until two major themes emerged. Two reliability raters will utilize the scoring manual in order to determine whether other people can reliably score statements from the interviews using the thematic category system described in this manual.

Directions

The reliability task consists of each rater scoring 50 statements randomly selected from the interview transcripts. As a rater, your task is to read over each statement and score it, according to the scoring system outlined below. Each statement has been typed on a separate page, and a space provided under each statement for you to write the score. You may take as much time as you need to complete the scoring task. Also you may go back over your choices to review or change scores as you wish. In addition, please feel free to refer to the Scoring Manual and the scored examples as often as you like.

There are two major scores or themes which describe therapists' experience of humor in psychotherapy. These two major scores or themes are:

1. TQ--for the theme "Therapeutic Qualities of Humor in Psychotherapy"
2. HQ--for the theme "Specific Qualities of Humor Occurring in Psychotherapy"

These two major scores or themes are divided into eight minor scores or subthemes. The first major theme, "Therapeutic Qualities of Humor in Psychotherapy" (Scored TQ) can be further differentiated into three minor scores or subthemes. These include:

1. IN--for the subtheme "Intimacy and the Therapeutic Relationship"
2. DP--for the subtheme "Diagnostic and Prognostic Aspects of Patient Humor"
3. UC--for the subtheme "Using Humor for Psychotherapeutic Change"

The second major theme, "Specific Qualities of Humor Occurring in Psychotherapy" (Scored HQ) can be further differentiated into five minor scores or subthemes. These include:

1. FG--for the subtheme "Figure Ground Reversals and Other Odd Figures"
2. SP--for the subtheme "Spontaneity"
3. PL--for the subtheme "Playfulness"
4. BA--for the subtheme "Bodily and Affective Experiences"

5. BR--for the subtheme "Temporal Aspects: Brevity and Rate"

In scoring a statement, please include both the major score for the theme present, and the minor score for the subtheme of the major theme. The major and minor scores should be listed together in the following manner: major score/minor score. For example, a statement containing the major theme "Therapeutic Qualities of Humor in Psychotherapy" (Scored TQ) and its subtheme "Intimacy and the Therapeutic Relationship" (Scored IN) would be scored:

TQ/IN

It is important to remember in scoring a particular statement that more than one subtheme may be present for any particular major theme. In such instances, please list the minor scores along with the major score in the following manner: major score/minor score, minor score, etc. For example, a statement containing the major theme "Specific Qualities of Humor Occurring in Psychotherapy" (Scored HQ) and its subthemes "Spontaneity" (Scored SP) and "Bodily and Affective Experiences" (Scored BA) would be scored:

HQ/SP,BA

On each occasion, an attempt should be made to provide the minor score(s) for a given major score. If, however, you are unable to

determine the minor score(s), the major score should be followed by an "?". For example, if you believe the theme "Therapeutic Qualities of Humor in Psychotherapy" (Scored TQ) is present in a statement, but are unable to determine which of its subthemes are present, then the statement should be scored as follows:

TQ/?

A particular statement may also contain both major themes. In such instances, each theme must be scored along with its respective subtheme(s). The scores should be listed in the following manner: major score/minor score(s); major score/minor score(s). For example, if the theme/subtheme combination "Therapeutic Qualities of Humor in Psychotherapy" (Scored TQ)/"Intimacy and the Therapeutic Relationship" (Scored IN) is found in a particular statement along with the theme/subtheme combination "Specific Qualities of Humor Occurring in Psychotherapy" (Scored HQ)/"Spontaneity" (Scored SP), the statement would be scored:

TQ/IN; HQ/SP

If you are unable to assign any of the above themes or subthemes to a particular statement, please score it as a "?". If you have any difficulty in scoring a statement, please try to explain the nature of the difficulty in the space provided beneath it (labelled "Comments").

This will be of assistance in making final revisions of the thematic category system.

The next section of the manual is a description of the two major themes and eight subthemes of the thematic category system. Please be sure to read the following descriptions at least once before beginning to score the reliability items.

DESCRIPTION OF THEMES AND SUBTHEMES

I. Therapeutic Aspects of Humor in Psychotherapy--Score as TQ

The first major theme deals with humor as it relates, or "maps onto," the therapeutic process. This theme is comprised of three subthemes, each of which will be discussed below.

A. Intimacy and the Therapeutic Relationship--Score as TQ/IN

The subtheme of intimacy essentially deals with the relationship between therapist and patient. This sense of relatedness is conveyed by the use of terms such as: "sharing," "feeling intimate"; "comradery"; "contact," "closeness"; "a bond"; interpersonal chemistry"; "connected" and "involved." It is also conveyed through such phrases as: "enjoying something together"/"sharing a joke together."

One participant in describing what made a particular humorous incident "stand out," responded in a way which clearly conveyed a strong sense of relationship:

> The feeling of being in synch with him [the patient]. Enjoying something together. And that was what was special about that. It was that we were sharing a joke together and both of us were happy about it.

Another aspect of intimacy involves the shared laughter and smiling between therapist and patient. This aspect of "intimacy" was usually conveyed by statements such as: "she laughed and I laughed," "we both laughed and giggled about it," and "we both smiled."

There were also instances in which the therapist saw some aspect of the therapeutic situation as being humorous or funny, and yet chose not to share this with the patient. Typically these were instances in which the patient did something odd or idiosyncratic, which the patient did not view as humorous or funny. The incident was only humorous from the perspective of the therapist. The quality of unshared laughter is illustrated in the following participant statement: "I [the therapist] didn't laugh . . . . No there was no laughter. He [the patient] was dead serious. And I was dead serious." Instances of unshared humor were considered to still be within the realm of intimacy, because the intent of the therapist was to preserve the possibility of intimacy or relationship, both in the present and the future.

Another aspect of the subtheme of intimacy involves a sense of "knowing" that exists between therapist and patient. "Knowing" as discussed here is warm and intimate. It often involves a shared history of being together.

This type of knowing is illustrated in the following humorous incident. The therapist was working with a patient who was living with an ex-addict "who has not been very responsible." The patient was also described as someone who "has a sense of being psychic and [that] sometimes it's true." During the session of the humorous incident the patient came in stating how she had an irresistible urge to contact someone she had had an affair with many years earlier. The

therapist quipped about this, and believed that through her "quip" was saying:

> we'll have to talk about both [her urge to contact her ex-lover "in light of . . . her relationship with the man she's currently living with and this psychic 'stuff'"]. Cause I know you, we'll have to talk about both. Though my bent would be, with anyone else, not to talk about this other stuff. But knowing you we're going to have to do that. And it was somehow . . . acknowledging both.

The warmth and intimacy involved in this kind of "knowing" is revealed by the participant's subsequent statement that frequently humor "is an intimate moment. It's a way of both of us laughing at something, cause we know each other well."

Another aspect of intimacy deals with "acceptance," "acknowledgement" and "validation" of the patient by the therapist. This is illustrated in a statement involving the humorous "quip" described above. The therapist reported how in reaction to her "quip":

> She [the patient] laughed! And sort of agreed with it. That for her, that was true and it was an acknowledgement of a piece of her that she considers important. That some places [and] people don't give credence to. And [it] was a shorthand for two of us who knew each other.

Intimacy also manifests itself in participant descriptions of "caring" "compassion" "love" as well as maternal feelings towards the patient. Though obviously belonging to this subtheme, this aspect is explicitly mentioned less than most of the others discussed.

Another aspect of this subtheme deals with the creation of a more genuine relationship between patient and therapist. A sense of this was conveyed by the use of phrases such as: "being genuine," "more

real," and "more human." One participant discussed an adventitious humorous incident, after which he really shared some of his countertransferential issues with his patient. The therapist indicated how in doing this:

> I [the therapist] shared an inner experience of my own. That apparently hit him [the patient] as being very real. That I became more real [P. states with emphasis] as a person. But suddenly he saw that I too could have clay feet.

At times a patient may also use humor in order to determine if the therapist is open to having a more intimate, close, and authentic relationship with him. One participant described an incident where a patient began a session with a joke which is something he usually did not do. The therapist stated how:

> If you think about it now. I would say it was more an effort to test my waters. [To] see where I was . . . . To see how involved he could get with me . . . . Cause he does see me as different! As someone he can be free with, although . . . not always! There's still a great hesitancy.

B. Diagnostic and Prognostic Aspects of Patient Humor--Score as TQ/DP

This subtheme deals with humor as it reveals the state/status of the patient and/or of the therapeutic relationship. Incidents within this subtheme usually tend to be "funny" things done by the patient. One of the major aspects of this category is the relationship between the presence/absence of patient humor, and the diagnostic category or level of health/pathology of the patient. Participants, for instance, noted the absence of any "genuine" humor in very disturbed psychiatric inpatients. One participant related how he:

> found very little humor in these very decompensated, hospitalized patients. I [the therapist] found humorous things . . . . You know. Funny sounding things . . . I worked with a couple of hebephrenic schizophrenics who were fantastically regressed. Baby talk . . . . And yeah, in quotes, there's a funny thing about that, but not really funny.

In addition to seeing the absence of "genuine humor" being seen as related to severe psychopathology, different types of patient humor were considered to be revealing of the patient's diagnostic state as well as level of health/pathology.

One participant, for instance, discussed how "funny" or "humorous" incidents--where the patient does something odd or idiosyncratic--can provide a clinician with a great deal of psychodiagnostic information. It should be noted that this type of humorous incident was only funny from the perspective of the therapist, and that the humor in such instances was not shared.

The humorous incident occurred during an intake interview and involved a patient described as being rather paranoid. Apparently the therapist began recording the session and the patient subsequently "whipped out his own tape recorder" in order to tape the therapist. The therapist stated how at that moment:

> it was a diagnostic thought that went through my [the therapist's] mind that I thought was very funny. [P. states laughingly]. I didn't laugh . . . . No there was no laughter. He was dead serious. And I was dead serious. But . . . I thought it was kind of funny, that he would have better equipment than I did.

In addition to the types of humor described above, one participant also talked about patient humor when "it's very self derogating" and the patient "is the object of his own self ridicule."

This therapist described an incident where the patient would report on his own inappropriate behavior laughingly. The therapist noted how the humor on this occasion:

> wasn't so much humor, obviously, [rather] it was being caught up in this compulsive webb, and trying to laugh off the seriousness of his behavior which is not working.

Here again, the type of patient humor--this time pathological laughter--revealed a great deal of diagnostic information regarding the patient.

The emergence of humor/laughter can also be a "positive prognostic sign" and indicative of progress in treatment. This development is clearly illustrated in a rather dramatic case in which the emergence of laughter by a patient accompanied "the key insight" of his psychotherapy. This incident was described by the participant as being indicative or a "marker," of progress in a number of different ways. Some of these ways are conveyed by the use of the following phrases such as: "therapy's over," "like a tremendous hurdle had been bridged," and the achievement of "a new gestalt."

Considering the cases described above, it should come as no surprise that therapists reported that changes in patient laughter/humor can also reflect positive changes occurring in treatment. This was illustrated in a case involving a woman seen privately on an outpatient basis. The therapist noted how the patient's use of key words changed in meaning, and reflected progress made during the course of treatment. Apparently it was the patient who found this development funny.

One of these terms--"the Raspberry"--referred to one of the patient's previous therapists, and this therapist's "somewhat ruddy complexion." Changes in the patient's use of this term are summarized in the following statement:

> But a very acid description of him as the raspberry [in the early parts of the treatment] . . . . It was apparent to me throughout the treatment, but not apparent to her--her resistance against that therapist. I think [this] therapist did most of the work that helped her. Towards the end of the treatment she was able to talk affectionately about "the Raspberry." And when she said that; recalling--using that same word, but in a very different way earlier in the treatment. And how now "the Raspberry" was a good person, a helpful person, a person who kept her alive, that type of thing. And again the contrast between "Raspberry" meaning almost the shit [P. states with emphasis] and the Raspberry who really helped her.

The participant clearly perceived a relationship between positive movement in treatment and changes in the meaning of this key word.

Another aspect of this subtheme occurs when the therapist sees the humorous incident as having a meaning representative of, or related to, the overall content or context of the session. This theme is illustrated in an incident involving a patient described as a "health professional," who is "very competent" and not a person "who gets turned around." The humorous event occurred after the patient's session had ended. During the incident the patient, who is very familiar with the office set-up of the therapist, rushed out of the bathroom and up the stairs to the second level of the therapist's home. The therapist described the patient as being "tremendously embarrassed" about this. The therapist also noted how the patient's wife "has a chronic illness [which] could be terminal but isn't," and

how during that session the patient was fumbling about "what to do with his wife" and "wanting me [the therapist] to do something about it."

Now the therapist saw this incident as being related to the patient and his wife's "fumbling" regarding the wife's illness, and the discussion he and the patient had regarding this during the session just prior to the incident. The therapist reported:

> And part of the thing is they're fumbling [P. states with emphasis!] He's fumbling and they're fumbling [P. states with emphasis!] So they're fumbling individually and together about what to do with his wife's illness. . . . And part of that is what we're talking about prior to the end of the session. So that's why I [the therapist] don't have to do much thinking about it. I just said, "Well yeah. Go ahead. We've got a physical confirmation of what we've been talking about verbally? And just store it away and we'll get back to it next time.

This subtheme also manifests itself when the therapist is focused on his own questioning of the meaningfulness or "diagnostic-prognostic" significance of a humorous event. This aspect was illustrated in a humorous incident where a patient started a session with a joke. When the patient made his joke, the therapist thought:

> I wonder what it's got to do with what he's going to be talking about . . . Generally with these things I don't just listen to the joke and say "Ha, ha--now, what's on your mind?" The joke is part of the process of treatment. It's not separate . . . we're not being entertained [P. states with emphasis] (I. So it sounds like you were curious about its significance) Yeah. Yeah.

C. Using Humor for Psychotherapeutic Change--Score as TQ/UC

This subtheme primarily deals with the process aspects of psychotherapy, in which the participant is particularly focused on

"doing." In their descriptions of use, the participants' discussion primarily focused on what they and their patients "do." In their discussion of change, the participants' descriptions primarily deal with and revolve around what the humor "does"--that is its perceived consequences or results. In short use and change are both aspects of a single process: transformation in psychotherapy.

Aspects Primarily Related to Use

In describing the use of humor in psychotherapy, therapists focused primarily on themselves as the "user" of humor and much less frequently on the patient's use of humor. The terms "use," "intervention" and "tool" will be used interchangeably in this section.

Numerous types of humor were described. Some of these were: exaggeration, mimicry, role reversal, metaphor, indirect communication, humorous interpretation, humorous confrontation, puns as well as the use of a single word or brief phrase (almost like a "shorthand") in an interventive manner. Typically participants did not give a name to the humorous intervention utilized. The above listing is intended to be heuristic and is in no sense to be considered exhaustive. The participants described humorous incidents which were clearly interventive and yet could not easily be placed into one of the above categories.

Another instance of use occurred when the participant spoke of his/her use of humor as if it had an "intent," "goal" or "purpose." Here the therapist essentially described the anticipated impact his or her intervention would have upon the patient. At times the therapist

spoke of intent in terms of having a strong impact upon the patient. This was conveyed through the use of such terms as: "strike," "startle," "jolt" and "get an immediate visceral reaction." The therapists also spoke of intent in terms of helping to make core conflicts and issues salient for the patient.

On other occasions, a participant might speak of "intent" in a more narrow or focused sense as illustrated in the following statement:

> I [the therapist] tend to use humor both as a release of tension and sometimes as a way of focusing and getting something in there fast.

Closely related to the prior discussion of "intent" were the participants' descriptions of the various "advantages" the use of humor had. As with "intent," therapists did not themselves usually use the word advantage in describing the possible pluses to using humor in treatment. Specific advantages cited include the use of humor: (1) as an indirect communication; (2) as a way of avoiding patient pain, anxiety, and lowered self esteem; (3) as a way of increasing the probability of the patient accepting the therapist's message and seeing aspects of themselves and what they do; (4) as a way of avoiding patient resistance; (5) as a way of avoiding a negative transferential reaction on the part of the patient; (6) as a way of "cutting through" a patient's pathological mode of relating to self or other (i.e., the therapist), and (7) as a way of increasing clarity on the patient's part in "seeing" pathological aspects of themselves and of their mode of interpersonally relating.

Perhaps the most common and frequently mentioned advantage was as a means of avoiding pain and anxiety. This use of humor was illustrated in the following statement:

> And also it [the use of humor] allowed me [the therapist] to make interpretations in a way that were not painful to him [the patient].

Humor can also be used to deal with therapist conflicts and anxiety as they emerge during the course of treatment. This was illustrated in the following statement in which a participant discussed her reasons for making a humorous "quip," as opposed to a more serious intervention. The therapist reported how:

> in this particular situation when I look at it more carefully, it [the therapist's use of humor] had to do with my own discomfort about this [the patient's belief that she's psychic] and how it's not totally resolved for me. And so that's why I've quipped with it. You know.

Though not a frequent occurrence participants noted how patient's use of humor helped in dealing with potentially painful and anxiety provoking issues and situations.

> if you [the therapist] can work with the humor in therapy generally, and the patient has a sense of humor of his own behavior . . . to some degree and can lighten some of his own more serious concerns with a little humor, in being self analytic, to some degree. I [the therapist] think being able to use humor is helpful.

Participants also described the relationship between the use of humor and therapist and patient characteristics. The relationship between use of humor and therapist character style was suggested in the following statement:

> It's [the use of humor] my [the therapist's] manner . . . as you know. And it's the way I think. And it's not something that I would want to give up using in therapy.

The use of humor by the therapist was also viewed by the participants as being related to various characteristics or aspects of the patient (i.e., certain patients more readily hearing a humorous remark or interpretation by the therapist, patient's possession of a sense of humor as well as the diagnostic state of the patient, etc.). One important patient characteristic was that certain patients appear to be "more receptive" and "amenable" and less "defensive" to a therapeutic intervention when the therapist takes a humorous approach. One participant described his use of humor with a patient who he does not consider "to be analyzable right now" and who experiences "more serious interpretations" more as "assaults." The therapist discovered that with this patient humor is "less threatening" and "more readily . . . digested" by her.

Another important patient characteristic related to therapist use of humor is the perception that the patient has a "good sense of humor." This is illustrated in the following statement involving a female patient described as being depressed and self deprecating:

> This was a woman who was able to, use humor--I mean prior to this--to some extent. So it wasn't as though it [the therapist's use of humor] came out of the blue. I mean she had a certain humorous, self deprecating, quality. So I mean she would use it in a sadistic way. But there was humor there. And so . . . I felt she would be open to it. (I. Because she had used it before?) She had used it. And she had a good sense of humor, whenever it did show itself.

Statements such as the one above indicate how patients with a sense of humor "would be open," "more receptive" and "more amenable" to the use of humor by the therapist. Hence it may be that a

patient's "sense of humor" is perhaps just a special instance of certain patients being more open and receptive to therapist humor.

Another important relationship between therapist use of humor and patient characteristics involved the use of humor and the diagnostic state of the patient; that is, the patient's level of health or pathology. One participant stated--in his description of a humorous psychodrama with a depressed patient--how;

> this guy's [the patient's] pretty sound psychologically. He was a depressive, but . . . really no major psychopathology, just somewhat depressed. And otherwise [a] generally functional guy. So that he was able to take the humor and not feel it as a denigration or an attack. With somebody with somewhat more severe pathology you have to be much more careful with the humor.

Closely related to patient diagnosis, was the therapist's description of criteria for his/her use of humor with the patient. Perhaps the broadest criteria for therapist use of humor was that it must be done with the best interests of the patient at heart. This is illustrated in one participant's statement:

> That it's really important to recognize that the humor is an intervention. That it's not just because one has a humorous stance or one likes humor. I mean it helps to like humor. But it is an intervention and it must be done for the benefit of the patient, even if you happen to have fun with it. But it's got to be first for the benefit of the patient.

Another participant described how the therapist should respond or make use of patient humor with the best interests of the patient at heart. In her description of an incident in which a patient asked a very "funny question," the therapist made the following statement:

> But mainly I [the therapist] respond with the effort to sort of not let the humor carry us away from the point . . .

> Let's look at the humor rather than let it be an avoidance of something.

Aspects Primarily Related to Change

This section concerns the perceived changes or consequences of a humorous incident. These are changes or consequences as perceived by the therapist. Within this category the therapist is focusing on what the humor does. In some instances the therapist focused on apparent positive changes in treatment. Terms and phrases such as "productive," "helpful," "useful," "pivotal" and resulting in "movement" convey, in the broadest sense, the apparent positive changes (or consequences) of humor in treatment. At other times, the therapist focused on apparent negative changes of humor in therapy. Here terms like: "pitfall," "risk" and "danger" convey the possible negative consequences. Descriptions of positive changes as perceived by the therapist, were the ones most frequently noted by the participants and hence will be discussed first.

In discussing change, the participants primarily focused on positive consequences for their patients and much less frequently on positive consequences for themselves. Although positive change or consequence was usually perceived by the therapist, in an almost causal fashion--as if the result of a humorous intervention by the therapist--this was not always the case. At times positive consequences for the patient and therapy were seen to be the result of adventitious occurrences or patient initiated humor.

Some of the positive consequences can be clustered around "insight," improving "reality testing," developing "perspective" as well as an "observing attitude." This cluster appears to deal with increased awareness of self, increased reflectiveness regarding characterological modes of relating to self and others, as well as viewing the world in a more consensually validated way. It is interesting to note that most of the terms and phrases used involved the visual modality. Terms and phrases commonly utilized included: "insight," "perspective," "observing attitude," "observing ego," "see"/"seeing"/"able to see," "read"/"reading," "look into" and being "introspective." In addition, a sense of reflection was also conveyed by the use of words and phrases such as: "thoughtful," "perplexed" and "in deep thought." Occasionally the auditory modality was utilized as in the phrase "and she'll hear it."

"Insight" was the most frequently mentioned positive change or consequence. Insight as a positive change or consequence was well illustrated in one participant's description of his use of a joke as a "metaphor" or indirect form of communication. The therapist indicated how

> with this word picture [the joke] . . . the particular patient with whom I used it could suddenly see himself.

The therapist indicated that he and the patient had already discussed some of the issues brought up in the joke, and how:

> the joke served the purpose of consolidating the picture for him. That it made it more vivid in terms of what he was doing! [P. states with emphasis]. Though he could acknowledge some of his doubting . . . I think he was able to see how foolish it is. Although we never used that term.

The development of a sense of "perspective" was very well illustrated in another participant's description of a situation "where laughter came out, and it was able to get a man to proper sense of perspective about himself." The therapist explicitly stated how, in this instance, the patient:

> was able to see how ridiculous this was [his father's criticality towards him], with my example . . . and was able to laugh about it! And was able to deal with a sense of rejection and low self esteem that the father had raised in him all these years.

Closely related to "insight" and "perspective" are participant reports of improved "reality testing" on the part of their patients. Improvement in reality testing is well illustrated in a humorous incident involving a female patient who worked "down in a very busy brokerage trading floor where all hell's breaking loose. Apparently the patient felt that if she looked at a man she was interested in, that everyone "would know [that] she had these greedy feelings to possess this man."

The participant noted how his use of humor was able to help the patient "see that just in terms of the actual reality, it was really preposterous." Later the therapist reported how:

> She [the patient] smiled. She was able to see that it was very unlikely, that anyone would really know, what was really on her agenda. And she began to consider that perhaps if she could say hello to this man or look at him a little more directly, without everyone knowing what was behind the look.

Other participants noted how their use of humor seemed to help patients develop more "observing ego", or a more "observing attitude" towards things.

Participants also reported how humorous incidents seemed at times, to result in self exploration by the patient, as well as, productive dialogue between patient and therapist.

Though not as frequent as the first cluster discussed ("insight," etc.), another important positive consequence of humor was discussed in terms of concepts such as: "liberation," "freedom," "responsibility," and "choice to change." "Freedom" and "choice" are clearly illuminated in the following statement, which was taken from the description of a humorous psychodrama involving a mental health professional, who was obsessing "over whether or not he should divorce his wife for another woman he was involved with." The therapist stated how the psychodrama:

> freed him [the patient] to make the choice based on current reality. It also freed him from the control of the domineering, guilt provoking mother of childhood. So he was able to make the choice as an adult. . . . He could decide I want this or I don't want it and I take the consequences. Versus I want it but mommy won't like it.

Another positive change described by the participants was a reduction in "tension," or the provision of a sense of "relief" and "relaxation." One participant noted how after he made his humorous remark how he suspected the session:

> became more like any other session we've had. The tension . . . dropped [P. states with emphasis].

Therapists also described improvement in their patient's affective state after a particular humorous remark. One therapist noted how as a result of a humorous intervention he made how "in that particular

session she [the patient] began to feel better" and how her "self denigrating attacks ceased . . . at least temporarily."

Participants also noted how humorous remarks and interventions, at times, allowed patients to become more affectively reactive. One participant after relating a particular humorous incident indicated how:

> we laughed about that. I said see "not even soup, you can make." And she [the patient] started to laugh, and on the other side of the laughter came on the tears. It [the humorous incident] was a situation in which, the laughter uncorked the plug on the feelings . . . the tears came and the rage was expressed.

Another positive "change" perceived by the participants as a result of humor was an improvement in the relationship between therapist and patient. One participant stated how he thought a humorous exchange "warmed things up a little bit. Sort of freed things up a little bit."

Some participants also noted how humorous episodes seemed, at times, to be followed by an increased rapidity of movement in the treatment. One participant made this point in his discussion of a humorous incident where he felt it quickened a particular positive consequence coming into being.

Though not frequent, participants sometimes describe humorous occurrences as having positive consequences for themselves as well as their patients. Usually the positive consequence involves some type of self knowledge or understanding on the part of the therapist. One participant, for instance, related how his humorous psychodrama "kind of lightened and enlightened me [the therapist] too. So I got some benefit out of it as well."

As noted earlier therapists did at times--though far less frequently--focus on the possible negative consequences of humor in psychotherapy. Here terms like "pitfall," "danger" and "risk" conveyed this in the broadest sense. Though these negative consequences could be considered "misuses" of humor, they were placed here because the therapist's focus or emphasis primarily appeared to be on the potential for "danger" or "risk."

Interestingly, the discussion of potential "dangers," "risks" and "pitfalls" associated with therapist interventions tended to be rather abstract and intellectual. They are not directly related to the humorous incidents described by the participants.

One participant, for instance, stated how she thought of a friend she knew who

> used to go to a psychiatrist. And this friend was a bright guy. And . . . I think they just told jokes. He [the friend] told him stories. And the psychiatrist told him stories back. I mean that's a travesty, a parody of what can happen.

Though still infrequent, the dangers associated with patient initiated humor are much more clearly, frequently and eloquently elaborated than those associated with therapist-initiated humor. Dangers associated with patient initiated humor include: (1) loss of control by the therapist in response to patient humor, (2) therapist being surprised and/or thrown off guard or balance by patient humor; not being sure how to handle it, (3) therapist loosing "the limits of treatment," a sense of process, or the meaning of a patient's humorous remark, (4) patient humor distracting or resulting in the seduction of

the therapist, (5) patient attempting to "charm" the therapist into "taking care of" him/her, (6) patient humor resulting in the therapist simply gratifying the patient, or with the patient not changing in a meaningful way, and (7) patient using humor to avoid the patient role.

An illustration of the "dangers" and "risks" of patient initiated humor is conveyed through in the following statement which refers to a participant's description of a "funny" and "eccentric" question made by one of her patients. The therapist stated how she:

> think[s] about her [the patient] because she's a woman who uses humor a great deal and is very, very charming; very witty; and if I were to allow myself I could be seduced by that humor; that wit, a lot of the time.

II. Specific Qualities of Humor Occurring in Psychotherapy--Score as HQ

The second major theme deals principally with the specifically humorous aspects of the humorous events reported by the therapists. This theme deals, in part, with the question "What made it funny?" for these participants. It also includes aspects of the participant's experience, that deal with humor, per se, rather than how the humorous incidents relate to the process of treatment. The second major theme is comprised of five subthemes, each of which will be discussed below.

A. Figure-Ground Reversals and Other Odd Figures--Score as HQ/FG

There are several different ways in which this subtheme manifested itself. One grouping appeared to cluster around terms such as: "incongruity," "irony," "role reversal," and "opposites."

This cluster usually dealt with shifts in figure-ground. At times, these shifts could be rather rapid. Often they involved some violation of one's expectation of what should be figure and what should be ground. At times, this subtheme involved something incongruously becoming figural as oppossed to what one would expect.

One of the participant's related a humorous incident which is an excellent illustration of this cluster. The incident involved a patient who had "claustrophobia and a fear of elevators." The humorous incident occurred on an elevator going from the waiting room of the clinic to the therapist's office. It is important to note that the therapist had a history of some phobic type reactions, of which the patient was unaware. On the elevator the patient stated how she felt "pleased" and "safe" having the therapist there, because of her phobic reactions.

The therapist found the event humorous because of the "disparity" between what one would expect and the actuality; that is, that "one isn't necessarily who one appears to be." The therapist also pointed out that there was a "rather ironic" aspect to this incident in that "at one time I [the therapist] had the same kind of feeling [of being phobic] that she [the patient] had".

This humorous incident is even more interesting considering the fantasy the therapist had while riding up in the elevator. How:

> in some ways it reminded me of a Woody Allen film. You know. The psychiatrist or psychologist has the same problem his patient has. I had the same issue as her [the patient]. You know. [I was] picturing. Actually it wasn't me. I was sort of picturing a Woody Allen type therapist with a patient. You know . . . . This is the mental

> imagery of what [I] was also into. The mental imagery is the patient that has the elevator phobia goes in with the therapist, by the time they get off at the floor, the patient looks fine but the therapist is standing there sweating, chewing his nails, completely and totally out of it.

The therapist's fantasy seemed to involve a shifting of figure-ground into a rather incongruous mental image. Here there is a reversal of roles and a violation of expectations. The therapist--in his "mental imagery"--assumed the role of the patient and vice versa. One might usually expect a therapist to be cool, calm, collected and "in charge," but instead here finds him "sweating, chewing his nails, completely and totally out of it." In a similar fashion, one might expect the patient to be the one exhibiting the symptoms noted above, but instead discovers that he "looks fine." The fantasy presented above involves a shift of figure-ground into an incongruous mental image, involving a reversal of roles, a violation of expectations as well as a touch of the ironic.

Another manifestation of figure-ground alteration occurred when participants focused on contrast in their descriptions of humorous events. In these instances, participants focused on how some aspect of the event stood out as figural, in contrast to something that served as ground.

Some participants noted how humorous incidents stood out in contrast to some "negative" affect. In the following case, it involved negative affect on the part of the patient. The participant stated how he said something humorous to a patient because he:

> thought it would strike her [P. states with emphasis] more strongly if there was a greater contrast; and humor would

> provide that contrast. You know since she was pretty gloomy and dour . . . "I'll never get out of this." "My kids hate me." [P. imitating patient]. That this would sort of startle her. And would help her look at it more forcefully. Rather than saying something very serious which I think would have had less impact on her, at that time.

Another way in which this subtheme manifested itself involved the therapist's use of descriptive terms such as: "absurd"/"absurdity," "ridiculous"/"ridiculousness," "ludicrous," "preposterous," "idiocy," and "silly." Through the use of such terms the participant is placing emphasis on the figuralness, of some aspect of a humorous event, in contrast to an unarticulated ground.

At times a therapist emphasized how an incident stood out for them because of one of these qualities. Therapists also made use of the "absurd," "ridiculous," etc., in order to make an aspect of the patient figural for the patient (thereby promoting insight). This use of the absurd is conveyed through the following statement:

> Well I [the therapist] wanted to [by making my humorous remark] . . . clearly [P. states with emphasis] point out his conflict and anxiety over good things occurring to him. So that's basically why I said that . . . to really highlight it! You know! And make it absurd! . . . Present it in an absurd way. [So] it was something that could really strike him.

In a closely related way, these therapists also emphasized the figural aspects of a humorous incident in their use of terms like "strange," "bizarre," "eccentric" and "weird." Here again the ground was unarticulated.

This manifestation of this subtheme was well illustrated in another humorous incident involving a psychiatric inpatient sucking on the

"nipple" of a participant's chest. The therapist saw this as a "bizarre experience" and in describing the incident stated how:

> It struck me [the therapist] funny at about the point where he started sucking on my tits. I felt like, "Well Jesus." You know. I felt like this is a very strange experience. Nobody had ever done this before. . . . And then afterwards, it struck me as very funny. And now that I think about it, it strikes me as being very funny.

Participants also discussed the ground of particular humorous incidents. An instance of this aspect of the subtheme, concerned a patient who had a dream of being unable to reach the therapist, specifically being unable to get through a door. The patient then had the door knob of the therapist's office door come off in his hand at the end of the session. The therapist emphasized how the patient's background contributed to the humorousness of the event. She stated how:

> This young man [the patient] came from a very superstitious and very religious Italian household. And his grandmother believed in the evil eye. And what makes it [the humorous occurrence] so enormously funny is that when he was growing up he wore a talisman on a chain--against the evil eye. And, of course, this magical occurrence, in my office with the handle coming off following his dream. And it was a long time before I could get him to understand that it was an accident. And it was not, something predicted by the dream. But it was very funny when it happened.

In this instance the participant was emphasizing the ground or context (background/situation) which contributed to the actual incident being so humorous or funny.

B. Spontaneity--Score as HQ/SP

In general participants spoke of their use of humor as being a very unreflected and spontaneous occurrence. One participant

illustrated this in his discussion of a humorous incident involving the therapist's getting up and leaving the treatment room, after the patient challenged the effectiveness of a cognitive technique the therapist had taught him. The participant emphasized the spontaneous aspects of the humorous incident in the following statement:

> The humor about it is--I guess is about my spontaneity. The willingness to deal with something very practically and concretely. Psychoanalytically this man [is] never going to understand what that's all about.

The unreflected quality of humor is also illuminated through the following statement by a participant who stated how:

> It's [the use of humor] my manner . . . as you know. And it's the way I think. And it's not something I would want to give up using in therapy. But I don't always think about, as you forced me to today all of what it means. Cause we go in and it works the way it works. And the session takes a different bend. And then you're OK. And I don't always sit there analyzing why I made that particular quip or exactly what purpose it would serve.

In addition to describing humor as occurring in an unreflected or spontaneous manner, participants infrequently spoke of the perceived "changes" or consequences of a humorous incident as being spontaneous. This is illustrated in a statement from a humorous incident where both therapist and patient came to session wearing identically mismatched shoes. In particular the therapist stated how his sharing of his countertransference:

> tended to be a spontaneous thing that occurred and fortunately it worked out! I [the therapist] will not admit to the fact that I had thought it out. Planned that this is what I'm going to do. But as I say it came out of this quote, humorous event, the patient's comment.

C. Playfulness--Score as HQ/PL

It is perhaps surprising, considering the phenomenon under investigation, that the humorous subtheme of play was so infrequently mentioned by the participants of this study. One aspect of play involves a sense of relatedness between therapist and patient. Therapist references to play in the interviews are relatively brief, and include phrases and statements such as: "a sense of play," "an aspect of play," "just playing," "I was having fun playing with the patient," and "the patient was just playing with me."

An illustration of the subtheme of play was made during the description of a humorous incident where a psychiatric inpatient sucked on the "nipple" of a male participant's chest:

> It's almost like I [the therapist] felt there was an aspect of play that he [the patient] seldom experienced as a person. I mean I could play with him, and not at a cost or like hurting him.

One of the therapists also used the term play in a manner closely related to freedom. This participant, in describing a humorous psychodrama, stated how:

> the reason for putting the humorous stuff in was to make it somewhat playful, so it wasn't all that deadly serious. So that it loosened him up to play with possibilities.

D. Bodily and Affective Experiences--Score as HQ/BA

It is probably not surprising that positive affects were mentioned far more frequently then negative ones. Similar terms and phrases were used by participants to convey a sense of positive affect for both their patients and themselves. Some of the words and phrases

included: "satisfaction," "gratification," "pleasure," "pleased"/"pleasing," "hallelujah!," "it felt good," "a happy moment," "a good feeling," "a lot of good feeling," "having fun," "a feeling of fun," "had/having a good time," "I thought great!," "enjoyed it," "felt rather elated," and "there was something joyous about it."

Some illustrative statements by the participants are listed below. One participant discussing a humorous incident which involved his abruptly getting up and leaving the consultation room, stated how: "Well I [the therapist] felt good about my own spontaneity and creativeness." Another participant stated how: "I [the therapist] was just having a lot of fun . . . I was having a good time and things were working."

A sense of positive affect on the part of the patient, is conveyed through the following participant statements. One participant in describing how a patient responded to one of his humorous remarks stated how: "He [the patient] laughs! He likes it!" A sense of shared positive affect between the therapist and patient is conveyed in the following statement: "We both enjoyed the fact that it [the therapist's humorous intervention] worked."

There were also some reports of affects which would typically be considered to be more "negatively" tinged. These differed somewhat for therapist and patient. Terms and phrases used by the participant to describe the patient in this regard included: "hostility," "fear," being "anxious" and "afraid." In the case of the therapist these terms included: "guilt," "shame," "impatience," "hostility," feeling

"foolish," "painful" and "hurting." Negative affect was also conveyed for the therapist through phrases like: having "a somewhat embarrassed laugh" or "not feeling all that kindly towards him [the patient]."

Obviously what one feels cannot be separated from other aspects of one's experience. Hence, at times, affect is described in conjunction with some other aspect of the therapist's experience (i.e., positive affect at learning something about oneself or seeing positive change in a patient, etc.). It is interesting to note that almost every therapist experienced positive affect regarding positive changes perceived in their patients as a result of a humorous incident. The following illustrative statement comes from a humorous incident in which an overinvolved, overintrusive mother is berated by her daughter for not doing what she characteristically does. The therapist stated how when the mother reported this and began laughing about it, how she, the therapist, thought:

> hallelujah! . . . Meaning how wonderful for this kid to have some space, and for the mother to have to listen for a change, and back off enough . . . . It's the first time, in a long time, the mother has really not pursued [this kid]. I mean she really has kept her hands off of this school stuff, and she wants it so desperately, so badly.

Specific statements regarding the bodily aspects of humorous experiences were less frequent then those involving emotion. They appeared to be more embedded in the experience and, presumably less accessible to awareness. Perhaps the most dramatic mention of body was an incident in which patient laughter accompanied "the key insight" of the psychotherapy. The therapist described the event as

being "primarily affective, visceral, muscular," and the patient's insight as involving "an affective, total realization." In general, however, descriptions of body were much more implied. Terms used by the participants like: "strike," "startle," "jolt," "get an immediate visceral reaction," be "nonplussed," and "bolted" all seem to imply a sense of body. Only these terms when actually involving body directly are included in this subtheme.

Surprise was clustered here because it seemed to relate to affect and the body. In addition to the actual word "surprise," a sense of surprise was conveyed through terms like: "startled," "caught off guard," and "caught with the goods." Surprise is clearly illustrated in the following statement:

> Anyway I [the therapist] suppose it was surprising of me that I laughed so. But I found it [a humorous remark made by the patient] so funny.

A sense of surprise and disbelief was also conveyed through therapist descriptions of patients asking themselves--in a puzzled manner--questions like: "How could I have said that?" or "How could it just happen."

E. Temporal Aspects: Brevity and Rate--Score as HQ/BR

The temporal aspects of humor are not described with great frequency. Obviously time is always present, but here only direct mentions of time will be discussed. One manifestation of time deals with the temporal quality of the humorous incident itself. In general, the focus here is on the momentariness or brevity of the actual humorous incident.

An illustration of the brevity of the humorous moment was made describing an incident involving a "complete role reversal" between mother and daughter, where an overinvolved overintrusive mother was berated by her daughter for not doing what she (the mother) usually does. The therapist stated how:

> for a minute [the mother] could see the humor in it [the "complete role reversal"], but then again got on her usual bandwagon and proceeded.

One participant, in his descriptions of humorous incidents, related how each may or may not have quickened a particular positive consequence coming into being.

Other participants who discussed the rate at which positive movement was perceived to occur after a humorous incident. One participant, discussing a humorous incident in which patient laughter accompanied the achievement of "the key insight" of his psychotherapy, stated how:

> after that session he [the patient] really took the lead. And systematically went into different areas in which this axis fit. It [the insight] was like the missing piece. And so a better understanding both intellectually and affectively of issues that we had talked about before, but the key element was missing! So it was like again rapidly re-going over the entire course of treatment [italics added].

In contrast to this statement was one made by a participant who described the humorous incident as being "pivotal," yet indicated that the movement following it was not rapid, but rather gradual.

In addition to the ways noted above, another participant described the rate at which a patient's "sense of humor" changed from a negative to a positive direction.

Therapists also spoke of the frequency of occurrence, of laughter and humorous incidents, on the part of the patient and therapist. At times it was described as being relatively infrequent. This was conveyed by the use of terms like "unique," "unusual," "atypical" and "a rare event." One participant described a humorous incident during which the patient whipped out his own tape recorder as soon as the therapist began taping him. The participant stated how:

> That's the only time it ever happened. Had someone bring their own tape recorder [P. laughs]. That's kind of funny.

Although usually dealing with humorous or funny things done by the patient, on occasion something "unique" by the therapist was also described by the participants.

In contrast to mentions of infrequent occurrence, one participant noted how pathological laughter or "nonhumorous" humor "occurs all the time." This participant described how the patient would report "laughingly" on his inappropriate behavior and "was laughing all the time at 'why was he fool enough to do this?'" In his description of the actual humorous incident, the therapist noted how this:

> was typical of him . . . . It was a very prototypical session. So he would always kind of laugh at himself in a . . . self disparaging way . . . . It was characterological.

In addition to the ways already discussed, one participant reported on humorous incidents "stood out" because they were temporally close--that is occurred in the near past.

APPENDIX G

RELIABILITY ITEMS

1. (I. So it sounds like in that statement you [the therapist] were saying a lot of things. You were sort of saying "it isn't a perfect world. You're not always going to get what you want." And then you're also talking about your relationship with him [the patient]; that I'm not Santa Claus either. And) I'm [the therapist] not going to be perfect. You're [the patient] going to have to learn to live with that too. But if you [the investigator] think I thought this all out, you are . . . wrong (P. states with emphasis, laughing softly; I. joins in). Afterwards I can think of lots of things.
(Context: Shortly after this the investigator said to the participant, "So it just sort of happened." To which the participant replied "Yeah. Very much so.")

2. And again the meaning of laughter had changed for this patient also [during the course of treatment]. The laughter before was a defense against crying. And laughter was a way to attract people. A way to be like flypaper, in a social setting. While towards the end [of treatment], she [the patient] could be "clownish and laugh" [P. states with emphasis] and not feel that that was needed necessarily to be a ploy to get something. But she could laugh because she wanted to laugh . . . just enjoying life. Yeah.

3. She [the patient] immediately starts smiling, laughing [after the therapist's humorous remark]. And was able to see how she was . . . shall we say, distorting what was going on and using it as a means to attack herself.

4. It's [the humor is] a hypnotic communication . . . [A] multilevel, indirect form of suggestion. And . . . you [the therapist] get the good unconscious, if you will, the Eriksonian hypnotic unconscious as opposed to the Freudian unconscious [I. and P. laugh]. You get the below the surface wisdom to listen. You talk to that part while you're juggling some pretty balls to keep the dumb part, or intellectual part [occupied]. (P. laughs).
(Context: The therapist states that this "below the surface wisdom" is "really one aspect of the preconscious ego that's spoken to . . . it's really, in other terms the real self." The therapist continues that "the intellect is a false self," and that while "you're distracting the other guy [the false self] with trinkets, you talk to the real self.")

5. As I [the therapist] said it [a humorous remark] I felt confident and thought it was the right thing even though it was a risk . . . There wasn't very much down side to the use of humor or a humorous style.

6. (I. So he [the patient] was healthy enough that you [the participant] could use it [humor] in that way.) And to that extent--that essentially forcefully. This is a very forceful intervention. This wasn't light handed. This was done with a very wide paintbrush. And somebody else might have felt ridiculed. He [the patient] was able to join in the spirit of the thing.

7. There's another consideration. As you [the therapist] go in with the humorous intervention--assuming it's not simply a one liner--if you see too much anxiety building up, where the person's [the patient's] disassociating or getting upset, well obviously you don't forge on with the intervention. You try something else or moderate it . . . you know, start talking about the weather or whatever. So that it always has to be done with a healthy respect for the state of the patient's defenses--whatever their overall state is--but the state of their defenses at that moment [P. states with emphasis]! And how they're reacting to you at that moment [P. states with emphasis]! Cause the sanest people can get flaky at times. I've had that happen too [P. laughs, I. joins in].

8. (I. [the investigator] had one question that I wanted to ask you [the participant] about the . . . incident. I just wanted to ask you in a very explicit way. You said that you felt like the incident where you were both wearing a different type of shoe was a metaphor) Yes. (I. And I just wanted to make sure I understand what you were thinking it was a metaphor for. And was it sort of the stalemate) Yes (I. the mutual resistance.) Yes. Right. (I. That's what you saw it as a methaphor for?) Exactly . . . And the nonintegration . . . In terms of what was happening. (I. You mean in terms of your [the patient-therapist] relationship?) Yes (I. That it wasn't clicking?) Right. (I. It wasn't going?) That's right.

9. I [the therapist] think life is wonderful. It's a great joy to be alive. And . . . with all the tragedy, still if you can laugh you can get through the tragedies . . . It makes it a lot easier.

10. I [the therapist] was thinking that this is kind of a . . . a guy [referring to the patient] who . . . probably [is] hypervigilant and [has] paranoid like behavior. Guarding against self disclosure that might be used against him.

11. (Context: "Clown" was a term used by the patient throughout the course of treatment)

Now earlier in treatment clown meant someone who was a fool. Pejoratively funny. But to cover for the sad person. So the clown was really the envelope of the sad sack . . . And then later clown was someone who really had a good sense of humor. Has a very good wit. Can see apparent incongruities between things. Who doesn't lose touch with the cognitive reality . . . You can talk about regression in the service of the ego. That type of thing. She [the patient] wouldn't use those words. But that kind of thing where she can just kind of daydream and utilize that creatively, productively.

12. (I. Could you [the therapist] tell me [the investigator] a little bit more about that! And how it [the humorous occurrence] came about!) Well I [the therapist] thought of doing it! And had that in contrast to my whole background . . . and experience as a therapist and supervisor . . . I don't think you're [the investigator] going to get that kind of story from anybody [P. states laughingly; I. joins in] . . . It was very unique (I. It was different.) Yeah. It appeals to me.

13. I [the therapist] was sort of therapeutically oriented. And just assessing this bit of behavior [something the patient did which the therapist found humorous] . . . What does it mean? What does it mean in terms of treatment planning? In other words what is the diagnostic formulation, then [how does] it lock into the sort of treatment, you know, [you] work on.

14. And thus it [humor] makes the fundamental reality testing point, which is that thoughts, feelings, fantasies and wishes on the one hand; are different from . . . quote realities, facts and objects in the material world. And just cause you feel something; or just because you feel overwhelmed doesn't mean you are overwhelmed.

15. And I [the therapist] sort of knew him [the patient]. I knew what it was like to be that way and so I felt like it was not artificial. I felt that I was sort of being genuine with him, and also in a satirical way that wouldn't be hurtful.

16. And it [humor] should only be used (a) appropriately. That is to say where it has a goal, an aim, a purpose. And it should only, frankly, ethically be used by those who know how to use it. Cause some people's attempt at humor will end up being sadism. A lot of what passes for humor is sadism. Alright. So the important thing is to be playfully humorous rather than sadistically humorous. And to use the humor as an appropriate intervention only with those patients where it is indicated, based on your own experience and training and ability to manage the tool. And if you can't manage the tool don't pick it up.

17. I [the therapist] think the humor was I was laughing at myself . . . It wasn't shared.

18. (Context: The humorous incident involved a psychotic patient) And the patient walked away [from the humorous episode] a little bit perplexed. And he looked as if in deep thought. And then afterwards [P. states with emphasis] he was very friendly, but he maintained a certain boundary with me [the therapist]. And we seemed to have a pretty good relationship in group therapy. But he always maintained a certain boundary with me, which he didn't with other people.

19. Well I [the therapist] was thinking that she [the patient] was perhaps reading my intent in a devastatingly perceptive way. [My intent] to sort of give her a message--though in all honesty it wasn't all that calculated a message. It may have been something . . . intrinsic in the way I may do therapy. It wasn't an explicit message, but I was trying to communicate something that she finally read. And read it in a . . . very direct way; which did not in any way, interfere with therapy moving on. As I said it did move on [P. states with emphasis] much more successfully.

20. And then when she [the patient] repeated it [a cute story involving the patient's son] here she laughed. [She] was rather surprised I think. See I [the therapist] laughed with her because I did think it was rather humorous for a little kid like that to a.) be so articulate. To really confront her in that way. But then I opened it up for discussion. What was her need to be so punishing [in regard to her--the patient's--son]? And I think she began to really feel very uncomfortable, but stuck with it [P. states with emphasis]. Because it again related or touched on things that we had talked about. And it was again productive for her.

21. I [the therapist] think it [the patient's humorous remark] must have been a relief for me [the participant] too, although I don't think I was finding the topic very hard. But I just thought it was so much fun. I mean I enjoyed it. You know. [I. and P. laugh]. It was so much fun.

22. That was my [the therapist's] hypothesis. That it [behavior by the patient which the therapist defined as humorous] was the inner person. That he's [the patient's] not the supremely confident and competent health professional. Part of him is a bumbler. And part of him is a guy who get's lost and confused. And so far I've been right. I don't know. I'm still exploring that. Yeah.

23. In a way it's [a brief phrase used repetitively by the therapist] almost . . . a conditioning kind of thing by now. That he [the

patient] knows if I [the therapist] were to say something like this, it's time to look into . . . this masochistic gratification actually! Cause that's what it is (P. states with emphasis), in a sense.

24. I [the therapist] started to think this is bizarre as fucking [shit]; this guys [the patient's] older than I am. And there was a certain, I guess bizarre aspect to it that made it sort of . . . just weird.

25. A lot of the inpatients that I [the therapist] worked with . . . Genuine humor was one of the signs that I used, about this person [the patient] being able to get ready to mobilize. Not necessarily go home, but at least the patient is beginning to recompensate. Yeah.

26. Well what was funny was my [the therapist's] technique (T. The technique overall or the leaving the room.) The leaving the room! [P. states with emphasis] (I. The leaving the room). Yeah. That spontaneous bit of . . . creativity! (P. states with emphasis, laughing softly). It had something joyous about it . . . It's the first time I've ever gotten up and walked out of the room with a patient, and then walked back in [P. laughs]. (I. so for you it was different) Yeah . . . I don't know of too many reports in the literature of such events (I. laughs).

27. When it was happening, I [the therapist] guess I was laughing to myself, but not out loud . . . A little bit maybe. Maybe I laughed mostly afterwards. I think I was preoccupied with what was happening. And as it sort of hit me, this was a bizarre experience. You know.

28. I [the therapist] think she [the patient] had a good time [I. and P. laugh]. I think she had a good time.

29. I've [the therapist] used it [humor] in the treatment. I've also used it with certain patients both inpatient and outpatient, to deal with very anxiety provoking issues in which you can dampen the anxiety by reframing the item, in a humorous vein. Yeah. (I. Making it less serious?) Yes! No! Still serious! It's still serious, but for the moment we're almost talking about it as a tertiary equivalent, as something else. Not directly connected with the person.

30. A "hot bath" remark would make us both feel we knew each other, and would be a way of touching.

31. I [the therapist] guess what I thought was just so wonderfully funny though was that . . . it wasn't like she [the patient] said "Well let me think" . . . It just came right out. I mean [P.

begins to laugh] she had already thought of it. She had already been thinking about her Japanese neurosurgeon [P. states laughingly]! And that was very funny and surprising to me. So I was very surprised by her quick response to my question.

32. (I. . . . What made you [the therapist] say something humorous instead of being serious?) To break the tension . . . [And] I [the therapist] think it had that effect.

33. And I [the therapist] validate the survival defenses. His [the patient's] survival defenses were self denigrating humor. Now at a certain point he will outgrow those defenses and not need them. But for the time being . . . they did save his life once upon a time. (I. And so you're respectful of them.) Not only respectful but . . . celebrate. Celebrate. This is what kept you alive. After a while he's going to say "alright already! That's what kept me alive."

34. So his [the patient's] reaction [to the therapist's humorous remark] was to kind of smile. Lighten up a bit on the attacks, on himself. And from these he was more able to get into this whole issue about his discomfort and conflict over success and doing better.

35. I'm [the therapist] not sure what else I could say about it [a humorous remark by the patient regarding the therapist's repeatedly yawning during sessions] except that it came up . . . in the middle of the session. She [the patient] was going over the same ground that she always had, that: "I'm devastated. I can't relate to other people. I'm . . . locked in. I'm depressed. I'm discouraged. I can barely do my job." I [the therapist] guess the yawning triggered the association--with a smile though! She saw the humor in it too! (I. So it was sort of something between the both of you?) Yeah . . . It was an interpersonal chemistry if you will.

36. At that time I [the therapist] was feeling an enormous sense of fun. I have a very good sense of humor. I'm able to laugh at myself. I've never been overwhelmed with my own importance. And I have enough sense of the ludicrous.

37. At that time I [the therapist] was feeling pleased (P. states laughingly) . . . I really was. I thought it's a healthier kind of situation. It's rare that this child gets a sense of space and of being independent. The mother just doesn't really permit that. And that she could pursue her mother and say that kind of stuff. I thought it was great!
(Context: The humorous incident involved the patient, who was an overinvolved mother, laughingly reporting how her daughter berated her for not being involved enough.)

38. It was saying to him "Look I [the therapist] know that you [the patient] act like an asshole, but that doesn't mean you're an asshole. Because I can act like an asshole; and that doesn't mean I'm an asshole. So look you're still acceptable to me even though you look and act like an asshole. And I think he knew that.

39. And it [the therapist's humor] was very liberating for him [the patient]. In fact he did separate rather amicably from his wife . . . And married this lady and lived pretty unhappily ever after from what I [the therapist] heard. But that was his choice [Both P. and I. laugh].

40. Both of these people . . . the last two [patients] I [the therapist] talked about were locked in by hypercritical parents. Which is ridiculous! An adult shouldn't have to be afraid of what a hypercritical parent says! If you think about it, it's kind of silly.

41. And that "OK mon" [a brief phrase used by the therapist] cuts through it [the patient's tendency to "mother" the therapist]. Like you're [the patient] reversing the roles. What are you doing again? This is your issue. Why are we wasting time with that? Why is that stuff up again? And she'll hear it and think "OK!" All of that stuff. And we'll have to talk about why she wants to mother me instead of her being, in some sense, taken care of, in a session. And her talking about her own issues, as opposed to avoiding by <u>nurturing</u> (P. says slowly with emphasis) me.

42. So as I [the therapist] said it, I said it was a certain degree of love for him [the patient]. And . . . a sense of play. And freedom to be uninhibited as opposed to being some stereotypic frozen role that I was before. Creeping up to be more human with him.

43. As I [the therapist] told you [the investigator], I use humor a lot. I find humor is very, very helpful. Not only to unlock feelings that are under the surface and difficult to reach; but because I think they reflect a great deal of the unconscious motivations that are there. The unconscious blocks . . . are things that people laugh at . . . You can analyze "why is that funny to you?"

44. But it [the humorous occurrence] was funny because of the complete change in position. And the mother [the patient] thought it was funny, for a change the kid [the patient's daughter], was knocking on her door instead of visa versa.

45. If I [the therapist] recall, I think I felt rather elated. I felt foolish . . . I think that was the initial response. But then I suddenly began to feel elated about it [the humorous incident]. And the reason I think I felt elated about it was that I firmly believe that therapy has to be not only an awakening or growing awareness for the patient; but that it also has to be so for the therapist . . . After every session . . . I still ask myself "was there something you learned about yourself today?" And I think that was the sense of elation. That I was able to grasp something about myself [P. states with emphasis]. And that also related to the patient. That could be useful in the therapy.

46. So I [the therapist] think the reason it [the humorous incident] was sort of funny was cause it was a way of really making contact with him [the patient]. He was important enough for me to pursue. I wasn't going to abandon him, even though he was trying to abandon me. You know sort of a mutual abandonment thing . . . I wasn't going to be the mother that was gonna move to a different state, and not try to contact him. Contacting him was important.

47. But I [the therapist] think it was the laughter that enabled her [the patient] to free the feelings about the rage. They would have come out in some other context; but they came out in this session as a result of the laughter.

48. The man's [the patient's] extremely depressed . . . I [the therapist] use the humor as an anesthetic. OK. When he gets into situations that are so painful that he can't really tolerate it. I lighten it up a little bit! And that gives him a little bit of energy . . . relief, and he can go back into the fray. So that it's not all dredgy, drudgy work.

49. He [the patient] laughed [at the therapist's humorous remark], and was able to see how stupid that was. It was really a very unfair judgment to put on this man, by his father . . . Making him doubt his reasoning powers, his judgment.

50. But this gift came with a lot of laughter and a lot of good feeling.

APPENDIX H

PRACTICE ITEMS

1. I [the therapist] smiled to myself. She [the patient] was preoccupied during the flight up [patient and therapist were going up on an elevator], after initially stating that she felt safe and secure with me.

2. Well it [the humorous occurrence] has started while we were still sitting . . . with my [the therapist] in a way [P. states with emphasis] suggesting rather . . . covertly, that I ain't Santa Claus either and I ain't got all the answers either. And he's [the patient's] going to have to fight for himself . . . I wasn't being explicit . . . Somewhere along the line it's going to hit him that he's a grown up. And he can live his own life.

3. And again and this was towards, I [the therapist] guess, the end of treatment . . . She [the patient] began to realize that part of her is a clown . . . And that the kind of clown face that she always drew with the make up was like a sad clown. A tearful clown. With almost like teardrops that she would put with some kind of make-up on her face . . . Towards the end [of treatment], that now she can be a happy clown. And would sort of even describe herself as a happy clown. No longer would wear any kind of weird make-up or anything.

4. And so this event . . . was like the Rorschach ink blot . . . The metaphor! [P. states loudly] for what was happening between us [the therapist and patient].
(Context: The humorous event was an adventitious occurrence in which both therapist and patient came to session wearing mismatched shoes.)

5. But yeah I [the therapist] think it [the patient's humorous remark] probably was a relief to her [the patient].

6. Well my [the therapist's] thought was fundamentally that . . . he [the patient] was at an impasse of obsession in that he thought that he was debating with his own psyche. He did not recognize the external objects, or the introjections of the external objects that were operating. He didn't recognize the parental attitudes. He didn't recognize the fear of shame and embarrassment. He was just frozen. And . . . the humor to my mind, served to bring some energy and playfulness into this otherwise stuck situation.

7. (I. What made that incident stand out for you [the therapist]? . . . Once again I think the ridiculousness of it . . . See this is funny. It's funny . . . that she [the patient] would feel so unacceptable because of someone else's judgment. And if you could see how funny that is, and make her understand that it was really . . . ludicrous. If she would laugh at it, then it would undo the prohibition that she should not dare to question him [the patient's boyfriend].

8. He [the patient] doesn't usually start with a joke.

9. And he [the patient] could connect to that [the therapist's humorous intervention]. He was laughing. He said, "Yeah." And, sort of, used that as a springboard to get into his unconscious guilt about being successful and his inability to tolerate it. And coupled with other feelings that he won't be able to succeed and he'll fuck up.

10. And of course when she [the patient] forgot to put the salt in the soup; this even proved that she wasn't even a good cook . . . [I. starts laughing] It was further proof that she was an inadequate human being! And it's ridiculous! And it just so happened that I [the therapist] just plucked this idea out of thin air! And it was what she had done! [referring to the patient's forgetting to put the salt in the soup]. And [she] was able to laugh and cry as a result! Cry and let the rage out!

VITA

James M. Koelln was born in Queens, New York, on February 25, 1954. He attended elementary school in that borough of New York City, and graduated from Monsignor McClancy Memorial High School in June 1972. The following September he entered Foraham University in the Bronx, New York, and in June 1976 graduated with a Bachelor of Science degree in Psychology. In September of that year Mr. Koelln began a Master of Arts program in general psychology at the City College of New York (C.U.N.Y.). He attended this institution of higher learning through June 1978.

In September 1978 Mr. Koelln began the doctoral program in clinical psychology at the University of Tennessee, Knoxville, and was awarded the Doctor of Philosophy degree in December 1987. During his doctoral training, he completed an internship in clinical psychology at Kings County Hospital/Downstate Medical Center in Brooklyn, New York, from July 1982 through June 1983. Subsequent to his internship Mr. Koelln was employed as the Clinical Director of Geel Community Services, Inc., a supportive apartment program for former psychiatric patients, locted in the Bronx, New York. He was also employed as a staff psychologist for the New York City Police Department. Mr. Koelln left the latter position in January 1986, in order to return to work full time on his doctoral dissertation.