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Humor in Psychotherapy: Is It Good or Bad for the Client?

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Although little systematic empirical research conclusively supports the contention that humor in, as, or with psychotherapy is beneficial, the past 15 years or so have witnessed a burgeoning advocacy of its use. Most of the literature advocating the use of humor as well as some of the research studies are briefly reviewed in this article. The latter are found wanting in terms of design, methodology, and definitive results. Employing a cognitive–behavioral or social learning model, we suggest a functional analysis to explore the complex nature of the interlacing components of the humor concept and experience as well as to expose the complicated mechanisms by which mirth may effect the significant ingredients of the psychotherapeutic process to produce positive change. Finally, specific humor strategies and techniques and their effects are briefly discussed. We conclude that deliberately bringing together humor and psychotherapy is not without its risks. As in the case of copulating porcupines, such a union, although potentially productive, should be consummated very carefully.

In recent years, more and more psychotherapists have been issuing reasons and seeking both theoretical and empirical evidence to support incorporating humor into the psychotherapeutic transaction (Bloch, Browning, & McGrath, 1983; Domash, 1975; Goldstein, 1982; Heuser, 1980; Hickson, 1977; Levine, 1977; Olson, 1976; Peter & Dana, 1982; Rosenheim, 1976; Schimel, 1978). Psychotherapists of different schools, from the self-consciously serious psychoanalysts, such as Sigmund Freud (1960) and Maurice Grotjahn (1970, 1971), to the more contemporary and flamboyant practitioners, such as Albert Ellis (1977) and Harold Greenwald (1975), have advocated the use of humor to promote therapeutic change. How justified are they in their advocacy?

This article addresses the state of the art as it has evolved into the mid-1980s. More specifically, it (a) briefly examines the more recent advocacy literature, (b) describes some of the systematic research on humor in psychotherapy, (c) presents a few dissenting opinions, (d) offers a cognitive–behavioral formulation and functional analysis of humorous behavior and how it influences the salient components of the therapeutic process, (e) indicates some humor techniques that therapists claim to have incorporated effectively into their therapeutic practice, and (f) suggests ways to enhance their proper use.

The terms *psychotherapy* and *counseling*, as well as *patient* and *client*, are used interchangeably throughout this article.

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The Advocates

Provocative therapy, identified as a variant of the client-centered approach, was developed by Farrelly and his associates (Farrelly & Matthews, 1981). As the name implies, the therapists try to be provocative and self-disclosing. They favor a full-fledged and intensely interactive relationship with the client. They humorously verbalize their emotional reactions to the client's behavior in order to provoke therapeutic change. Provocative therapy assumes that clients are not as psychologically fragile as is usually considered and that challenging the pathology that clients exhibit can be a catalyst for their growth. The focus is on here-and-now experiences and on client–therapist interactions. Childhood experiences are not ignored or dismissed if deemed desirable. Another assumption holds that people can achieve significant change if they wish, regardless of the degree of severity or duration of their disorder, and that both they and their therapists too often underrate the possible positive growth that can be achieved. Provocative therapy also hypothesizes that when facetiously provoked by the therapist and cajoled to continue their self-defeating behaviors, clients will tend to move in the opposite direction from the therapist's verbal definition of them; that is, clients will move in the direction of positive self-concept and self- and other-affirming behaviors.

Humor plays a central role in provocative therapy. Among the techniques used by the therapist are exaggeration, mimicry, ridicule, distortion, sarcasm, irony, and jokes. These techniques presumably help to highlight clients' maladaptive behaviors while revealing their worst thoughts and fears about themselves. These tactics deprive clients of their usual defensive ploys. "The therapist will express the unutterable, feel the unfeelable, and think the unthinkable . . . often the therapist will overemphasize the negative, thus forcing the client to emphasize the positive aspects of his or her life" (Farrelly & Matthews, 1981, p. 686).

Because this is a client-centered approach, what about support, warmth, and acceptance (unconditional positive regard) of clients? Farrelly addressed this question with three

explanations: First, the provocative therapist is not ridiculing patients as human beings but is rather ridiculing their maladaptive behaviors in an effort to extinguish or countercondition their behaviors. Thus irony and ridicule are usually not perceived by patients as destructive when used judiciously, specifically, and constructively by the mature therapist. Second, Farrelly did not deny that his techniques might initially provoke anxiety in clients as they discover that their defenses will be constantly challenged. However, the positive aspects and results of such confrontation are quickly visible: "Often in therapy, distinction must be made between short-term cruelty with long-term kindness versus short-term kindness and long-term detriment" (Farrelly & Matthews, 1981, pp. 683–684). Third, he argued that there is an equilibrium between ironic verbal feedback and supportive nonverbal feedback. These two levels of therapist communication are postulated to provoke anxiety as well as to heighten the client awareness needed to initiate change.

Another humor-based therapeutic approach is O'Connell's (1981) natural high therapy. He postulated the existence of three equally important and progressively related dimensions of self-actualization. Level 1 refers to the struggle to move from the external ego attachments of roles, goals, and controls toward a healthy sense of self-esteem that is generated from within the person. Level 2 refers to the development of positive social interest in terms of fruitful relationships with others and the ability to encourage and be encouraged in dyadic interactions. Finally, Level 3 corresponds to the maturation of transpersonal dimensions and the experience of spiritual communion, with the expansion of both self-esteem and social interest as the person transcends "ego-addictions" and gives up "demandments" to pursue the process (not the goal) of self-actualization.

Natural high therapy also holds that the symptoms that clients present to therapists are behavioral manifestations of displaced creative energies, indicating high motivation to "search for power on the useless side of life" (O'Connell, 1981, p. 560). Therefore, symptoms are initially encouraged so as to tap their psychic energy. Eventually, at the conclusion of therapy, the client comes to view symptoms as "an interesting side-show" (p. 562).

This approach uses psychodramatic and empty-chair techniques, role playing by both client and therapist, dialogue with significant others, guided imagery, exercises to develop encouragement of self and others, and meditation techniques using breath focusing and contemplation. Throughout these exercises (which are derived from those of Moreno, combined with some derivatives of the methods of Jung and Adler), patients are encouraged "to stroke the self for effort, never for perfection" (O'Connell, 1981, p. 563). Blaming behaviors are discouraged. Humor may be incorporated into any of these procedures because O'Connell considered it "the royal road toward actualization" (p. 563).

O'Connell has conducted workshops and has developed a therapeutic technique, "humordrama." This is a group approach to teach and learn the sense of humor within a psychodramatic format. Participants are asked to soliloquize their thoughts and feelings while playing out their stressful situations. "Doubles are employed . . . to stimulate alternative humorous responses . . ." (1981, p. 563). These doubles are encouraged to use such techniques as brief sudden switches, verbal condensations, understatements, and overstatements to elicit the humorous attitude.

A growing number of therapists have reported using humor in their practice when they deem it appropriate. Among the better known is Albert Ellis, who in his rational–emotive therapy employs absurdity and humor as one of his "disputing interventions" to challenge clients' false and irrational belief systems. He has said "human disturbance largely consists of exaggerating the significance or the seriousness of things and the ripping up of such exaggerations by humorous counterexaggeration may well prove one of the main methods of therapeutic attack" (Ellis, 1977, p. 4).

Ellis believed that people disturb themselves cognitively, emotively, and behaviorally. Humor, because of its very nature, works in all three of these basic ways. Cognitively, it presents new ideas to the absolutistic, rigid client in an insightful, hard-hitting way. Emotively, it brings enjoyment and mirth, makes life seem more worthwhile, and dramatically intrudes on gloom and inertia. Behaviorally, it encourages radically different actions, it constitutes an antianxiety activity in its own right, and it serves as a diverting relaxant. If clients can even briefly experience amusement, it can serve as an antidote to their sadness.

Mindess (1971, 1976) is probably the chief exponent and most efficient practitioner of the careful and judicious use of humor in psychotherapy. An anecdotal example comes from his book *Laughter and Liberation* (1971). A young woman suffering from severe anxiety consulted him. It was the first time she had ever visited a psychotherapist. She had heard that therapists not only failed to help many patients but that they frequently harmed them. The word she used was "destroy." "I have heard about people," she said, "who have gone into therapy and been destroyed." Now, Mindess could have responded in several ways. He decided to react in a mildly facetious manner. What he said was "Well, you're in luck. I've already destroyed my quota for this week!" Her response, says Mindess, was rich laughter, which he believed expressed both relief and expanded awareness: relief that she had found a therapist who understood her anxiety not in professional terms but as a fellow human being, and awareness that her fear that he would destroy her was absurd (Mindess, 1971).

A number of therapists have reported the successful use of humor in behavior therapy (Ventis, 1973, 1980), in counterconditioning (Smith, 1973), and in self-management (Lamb, 1980). Corey (1986) has stated that Adlerian therapists often use humor in their therapy. He subscribed to this position himself:

> Although therapy is a responsible matter, it need not be deadly serious. Both clients and counselors can enrich a relationship by laughing. I have found that humor and tragedy are closely linked and that, after allowing ourselves to feel some experiences that are painfully tragic, we can also genuinely laugh at how seriously we have taken our situation. We secretly delude ourselves into believing that we are unique in that we are alone in our pain and that we alone have experienced the tragic. What a welcome relief when we can admit that pain is not our exclusive domain. The important point is that therapists recognize that laughter or humor does not mean that work is not being accomplished.

> There are times, of course, when laughter is used to cover up anxiety or to escape from the experience of facing threatening material. The therapist needs to distinguish between humor that distracts and humor that enhances the situation. (Corey, 1986, p. 380)

A balanced discussion of humor and psychotherapy is provided by Kuhlman (1984), who does not appear to be as enthusiastic as Farrelly, O'Connell, Ellis, Mindess, Greenwald, and the others. Kuhlman's book is based on the premise that humor in psychotherapy has short-term and long-term effects that can be distinguished. The short-term effects are signaled by the tension-reduction, mirth, and other emotional responses that are the immediate consequences of any effective humor. These, said Kuhlman, have been studied and articulated by philosophers and scientists who have analyzed humor outside of the psychotherapy situation. He went on to develop the thesis that with some exceptions, humor has been conceived as having moment-to-moment tactical benefits in therapy rather than as an overall strategy or goal. On the one hand, it can facilitate a client's movement into a problem upon which the humor is built. On the other hand, it can promote the client's psychological distance away from the problem at hand. Which of these two opposing ends is achieved depends on the therapist–client interaction prior and subsequent to the occurrence of the humorous interlude.

The long-term effects of humor (whether considered as isolated instances or collectively) are to shape, define, and change the relationship of the participants. Hostile, sarcastic, and put-down humor are described as promoting insight into a problem or detachment away from a problem in many different psychotherapy systems. He goes on to state that the fact that such aggressive humor can achieve therapeutic ends without resulting in the client's unilateral termination attests to relationship factors that mitigate the expected negative consequences of the therapist's attack. On the other hand, Freud's concept of veiled aggression may apply in circumstances in which these relationship factors do not exist. The therapist then may blindly (or otherwise) tyrannize a client under the guise of helpful humor. In these and other circumstances humor in psychotherapy has clear destructive potential. Group and family settings alter the meaning and implications of humor dramatically.

Kuhlman correctly concluded that humor serves different functions within different therapeutic modalities. As will be stressed later in this article, different forms of humor serve different functions depending on the different components of the therapeutic process into which it is introduced.

Some Empirical Research

In the past 15 years an estimated two dozen doctoral dissertations have been promulgated that more or less systematically address humor and psychotherapy (Buckman, 1980; Burbridge, 1978; Golub, 1979; Kaneko, 1971; Labrentz, 1973; Peterson, 1980; Schienberg, 1979). Some of these are briefly described because they reflect the kinds of empirical studies that have been undertaken to explicate this relationship, they indicate the variety of methodological approaches that have been used, and they emphasize the inadequacy of the research evidence currently available to demonstrate that humor is beneficial in psychotherapy. This section is not meant to be exhaustive or incisive.

Labrentz (1973) completed a study to determine (a) whether humor presented prior to an initial counseling interview has an impact on the client–counselor relationship and (b) whether the combined effects of humor and sex of client have an impact on the initial client–counselor relationship. The results revealed that the presentation of "cartoon" humor prior to an initial counseling session resulted in significantly higher Relationship Questionnaire scores when compared with a group that merely examined geometric designs, a group placed in a waiting period prior to counseling, or a group receiving counseling only (control). In other words, there was a significant difference between the means for the main treatment effect (i.e., humor vs. designs, vs. waiting period, vs. control). This was barely confirmed at the .05 level of significance.

Huber (1974) conducted a study to investigate the effect of counselor-introduced humor on client discomfort and client perception of the relationship. The subject's discomfort or tension was measured by the discomfort relief quotient. It was used to test the main hypothesis, which predicted a decrease in discomfort expressions following the introduction of humor.

A three-way analysis of variance for the change scores for humor, level of discomfort, and counselor relationship in two instances of humor used in the first interview indicated no significant difference between the scores of the humor and control groups in expressions of discomfort. An analysis of the two instances of humor in the second interview similarly demonstrated no significant difference in the change scores between the humorous and nonhumorous treatments. The findings based on the discomfort relief quotient failed to support the main expectation of the study: that humor would decrease tension.

Burbridge (1978) wrote a dissertation entitled "The Nature and Potential of Therapeutic Humor." It presents an extended discussion—with virtually no original empirical data—of the pros and cons of using humor in therapy, coming down heavily on the pro side.

Golub (1979) attempted to determine whether counselors' use of humor increased subjects' positive ratings of the counselor and counseling session in which it was used. Videotapes were used, based on a detailed script that employed three hired actresses, two of whom played the role of counselor and one of whom played the role of client. The humor used took the form of gentle confrontation that highlighted what the client was saying and called attention to the process between counselor and client. One $3 \times 2 \times 2$ analysis of covariance was conducted with three dependent variables (Counselor Evaluation Inventory of comfort, satisfaction, and climate), three independent variables (counselors [1 and 2], conditions [humor and nonhumor], and subject groups [counselor, client, noncounselor/nonclient]), and one covariate (anxiety as measured by the Institute for Personality and Ability Testing [IPAT] Self Analysis Form). Analysis of the data indicated no significant difference between subjects' evaluations of counselors when counselors did and did not use humor.

Finally, studies by Peterson (1980) and Peterson and Pollio (1982) addressed empirically the question of whether laughter was constructive specifically within the context of group psychotherapy as recorded on video. Humorous remarks (including laughing and smiling) were categorized according to humor target: self, other in group, and generalized other. Results indicated that the vast majority of humorous remarks were directed at some specific target and that more than 50% of these remarks were negative in tone. Results also revealed that remarks targeted at others in the group tended to decrease therapeutic effectiveness, whereas remarks targeted at individuals or institutions not currently in the group were found to increase therapeutic effectiveness. Self-targeted remarks were found to produce inconsistent effects.

Clearly, the more careful and systematic empirical research does not yet conclusively support the positive claims made on the basis of anecdotal data and therapist experience that humor is productive in psychotherapy. On the contrary, this research seems to point in the opposite direction. Moreover, there appears to be a mounting wave of dissenting opinion that holds that under certain conditions humor may be counterproductive, even dangerous.

Dissenting Positions

Kubie (1971) has been vehement in emphasizing humor's destructive potential. He has insisted, not without good reason, that humor can mask hostility. The patient may perceive it as heartless and cruel. If in psychoanalytic treatment, the patient may be diverted from free associating productively. He or she may begin to wonder whether the therapist is serious or merely joking. If the patient uses humor as a defense, the therapist who uses humor will reinforce the defense. The patient is essentially a captive audience, and the therapist may be self-aggrandizingly "parading his wit." If the patient was a victim of cruel joking in early life, the use of humor may serve to hinder progress in therapy. Patients may resent the therapist's lightheartedness in the face of their suffering. Humor could undermine the therapist's leverage of objectivity. Kubie believed that inexperienced therapists really do not know how to handle humor properly. According to Kubie, it is never justifiable to make fun of patients or their symptoms, no matter how strange or grotesque these may seem, or of neurotogenic patterns of general behavior that are the symptomatic expressions of the underlying neurotic process. Humor has its place in life; we should keep it there by acknowledging that one instance in which it has a very limited role, if any, is in psychotherapy.

Parry (1975) gave a similar dissenting opinion. He warned that joking may be appropriate in education, when it can be used to emphasize a point. But jokes are not appropriate in psychotherapy. He advised therapists not to joke with clients or to respond to jokes made to them. The client may accuse the therapist of being cold and humorless, but such a statement doubtlessly expresses some negative transference feelings. If a client presents a serious problem in the form of a joke, the therapist should always examine such a communication in the light of "true words are often spoken in jest." Parry believed it would be fatal to the relationship if the therapist were to fall into the trap, treating as a jest something that is deeply felt by the client.

Mindess and Turek (1984) have suggested a ranking procedure to maximize the benefits and minimize the abuses of humor. They believed that the worst approach is to *plant* a joke that is contrived, forced, and inappropriately pulled into therapy from nowhere without adequately preparing the client. A somewhat better technique is teasing or kidding the client naturally in a context of sufficient rapport and trust. This method may initially provoke a double take followed by laughter or (if done improperly in an atmosphere of mistrust) by anger. The best technique is for the therapist to provide a role model for the client to imitate, letting the good humor spill over, as it were, into the therapeutic transaction.

Salameh (1983), in an excellent even-handed summary of the status of the "alliance" between humor and therapy as reflected in the current theories and existing research, has presented a promising system for rating the levels of therapist humor. This 5-point Humor Rating Scale, which appears to have methodological significance and research potential, rates the therapists' input in the following terms: destructive humor, harmful humor, minimally helpful humor, very helpful humor, and outstandingly helpful humor.

Practitioners rushing to use humor in psychotherapy and the dissenting reactions of skeptics have moved us inexorably to address the issue of ethics. Obviously what is considered ethical by skeptics like Kubie and Parry is far different from what is considered ethical by adventurous practitioners like Ellis, Farrelly, Mindess, and O'Connell. Salameh attempted to accommodate these two opposing camps by listing what he believed they might all agree distinguishes "therapeutic" from "harmful" humor (1983, p. 51). Therapeutic humor has an educative, corrective message, promotes cognitive–emotional equilibrium, attacks behaviors while affirming the essential worth of the client, acts as an "interpersonal lubricant," and so forth. On the other hand, harmful humor exacerbates client's problems, thwarts cognitive–emotional equilibrium, undermines personal worth, leaves a deleterious "bitter aftertaste," and so forth.

Psychotherapeutic Process

A succinct and relatively neutral and nonpartisan formulation of the essential ingredients of the therapeutic process is as follows:

$$C \text{ is a function of } (T_{123}\ r\ Cl_{123}\ x)E.$$

The parentheses encompass what goes on within the sanctum sanctorum of the therapeutic session. The letter C denotes change, cure, or outcome—desirable or undesirable. The letter T identifies the therapist. The client or patient is indicated by Cl. The letter r denotes the nature of the *relationship* between therapist and client. The letter x suggests that there are numerous happenings, variations in settings and paraphernalia within the sessions that importantly influence the course of therapy, but about which therapists have very little, if any, dependable research or experiential knowledge. The letter E identifies those environmental factors *outside* of therapy that

influence change but which are not usually taken into consideration when evaluating the factors that may produce the outcome.

Subscript 1 denotes the personality traits and demographic attributes of the participants. Subscript 2 denotes the experiential overlays on the personality. The Cl_2 depicts the problem or complaint experienced by the client, which defines the diagnosis and indicates the purposes for which treatment is undertaken. The T_2 emphasizes the education and training, formal or informal, that is superimposed on the therapist's personality. Subscript 3 denotes what is said and done by the client and the therapist during the sessions.

It is possible to introduce humor into any one or all of these process components. For example, the therapist may be a basically funny person, prone to wit, flippancy, joking, and clowning (T_1). Via this demeanor, the therapist serves as a model of such deportment for the client. It has been said that a sense of humor can save a therapist from appearing pompous.

The client (Cl_1) may or may not have a sense of humor, may possess personality traits that permit greater appreciation of some types of humor rather than other types (Mindess, Miller, Turek, Bender, & Corbin, 1985; Ziv, 1984), and may be too depressed, anxious, tense, or aberrant to "get" the joke.

A great deal has been asserted about the importance of relationship in therapy. Some schools, like those in the humanistic or third-force camp, have insisted that the ideal therapist should be warm, empathic, and genuine. The therapist should relate to the client as a friend, a nonauthoritarian or nondirective helper. How would the therapist's attempt to introduce humor fit into such a relationship? The psychoanalytic schools—both the Freudian and neo-Freudian—are earnestly concerned about transference. How does the injection of frivolity or whimsicality alter the therapist's efforts to render the unconscious conscious, or to reduce client resistance, or to hit home a particular interpretation? Would the healing power of a directive and authoritarian psychiatrist diminish or increase in the event that joking and kidding were brought into therapy?

Humor Defined

Humor is a broad-gauged, complex, and multifaceted phenomenon. There are numerous theories and opinions—often simplistic—about what it is. They date back to the Greek philosophers Aristotle and Plato, who equated it with a general response to, respectively, the harmless ugliness and the incongruity of a stimulus. Subsequent philosophers saw it as a process that had the effect of making one person feel superior to another by deriding or attacking the pretentions of the latter. Others, ranging from the psychoanalysts to Norman Cousins (1979), viewed it as a process that produces release, catharsis, amelioration of stress, reduction of stultifying inhibitions, and relief from tension, whether physical or psychological. It is this feature that is most often invoked to explain humor's utility in treatment.

In the present context *humor* is defined comprehensively as an affective, cognitive, or aesthetic aspect of a person, stimulus, or event that evokes such indications of amusement, joy, or mirth as the laughing, smiling, or giggling response. The personality trait *sense of humor* embraces at least two human capacities: *appreciation*, or the set to perceive things as being funny, and *creativity*, or the ability to say and do funny things, to be witty. It implies a readiness to find something to laugh about even in one's own adversity.

A functional analysis of humorous behavior conducted within a cognitive–behavioral or social learning framework devolves on some interlacing sets of factors identified as the stimulus (S), the intervening organismic variables (O), the response (R), and the consequence (C). The acronym is SORC. In addition, the contexts or conditions that surround the event play a significant role. A brief description of each of these factors follows.

The essential features of the stimulus (S) are complexity, structure, content, and type. *Complexity*: Humorous stimuli that are too intellectually simple or too complex tend to be less funny. *Structure*: Incongruity is the sine qua non of structure. A sudden and unexpected juxtaposition of the stimulus elements, an exaggeration, or a sudden twist tend to elicit surprise and joy. *Content*: In the order of their likelihood of inducing laughter, the following topics tend to be most prepotent: sex, hostility or aggression, taboo subjects, personal concerns (e.g., about one's propensity to cheat, chisel, or be fat; or about sickness, death, or dying), ethnic relations, and the more distant and general events in the news, like politics, economics, and so forth. The content component of the stimulus holds up a mirror—a distorting, sideshow mirror—to the absurdity of grim reality and experience. *Type*: There is a wide variety of humorous forms. Visual ones include mime, farce, comedy, sight gags, clowning, and making funny faces. There are also verbal ones like jokes, gags, limericks, puns, and oxymorons, as well as parodies, spoofs, irony, hyperbole, and satire.

The organismic component (O) comprises the psychological and physiological states of the responder. It includes an immensely variegated class of intervening or mediating variables that tend to qualify the influence of both the stimulus and consequence on the response.

Among the psychological factors in this class, the personality traits appear to be one of the most important. A number of psychologists, including Eysenck and Eysenck (1969) and Ziv (1984), have extended the four character types classified by Hippocrates according to the bodily humors—melancholic, choleric, phlegmatic, and sanguine. They have generated a panorama of personality traits, defined by two axes: a social axis of introversion–extraversion and an emotional axis of instability–stability. Ziv (1984) has hypothesized that there are four general personality types (each with its distinguishing cluster of traits) and that they tend to prefer and enjoy different categories of humor.

The *emotional extraverts* appear touchy, restless, angry, aggressive, and excitable (recognize Type A behaviors?), as well as impulsive, active, and changeable (recognize Type T—thrill-seeking—behaviors?). These choleric people are more apt to be seen as emergency patients in the cardiologist's or surgeon's office than on the psychotherapist's couch. The *stable extraverts* display sanguine behaviors that might describe a role model for either the client or the therapist:

sociable, outgoing, responsive, easygoing, lively, and carefree. The *stable introverts* are rather phlegmatic: passive, careful, inhibited, reflective, and controlled. These people would probably seek psychotherapy for self-realization or self-actualization. They could have the feeling that life is one grand party to which they have not been invited. The *emotional introverts* are the most typical of the kind of people who come for psychotherapy. They are moody, pessimistic, unsociable, anxious, rigid, and cheerless. These melancholic people derive less enjoyment from humor than do any of the other types of personality in Ziv's scheme.

According to Ziv, emotional extraverts seem to enjoy aggressive humor most; stable extroverts, interpersonal types of humor; and stable introverts, intellectual types of humor. The emotional introverts have no strong preferences but are mildly affected by aggressive, defensive, intellectual, and general social types of humor.

Mindess et al. (1985) have similarly emphasized the apparent relation between different personality traits and certain humor preferences. On the basis of findings from their recently constructed Antioch Humor Test, they proposed that these clusters of humor preferences permit inferences, albeit imperfect ones, about traits of personality. For example, high preference for nonsense jokes (defined as silly, lighthearted or playful stimuli that do not attack, shock, or denigrate) suggests a person who "tends to be naive, uncritical and childlike [with] a strong playful [and somewhat impractical] streak" (Mindess et al., 1985, p. 41).

In their discussions, both Ziv and Mindess pointed out that when a particular therapist (T_1) elects to use a particular form of humor with a particular client (Cl_1), it becomes necessary to consider these individual differences in both the client and therapist.

Moreover, in addition to personality traits, such factors as disposition, mind-set or readiness to be aroused to laughter, motivational state, and cognitive capability are immensely significant. Cognitive ability—defined by intelligence, individual experience and knowledge—has been considered the single most important ingredient of sense of humor (McGhee, 1979). *Demographics—the ethnic group to which the client* belongs, age, class affiliation, level of education—have also been found to influence a person's sense of humor.

The *physiological* condition is composed of aspects such as health (healthy people are more prone to laughter), fatigue (tired and exhausted people are less apt to find things funny), and the status of the hormonal and autonomic nervous systems. The direction of an imbalance of the sympathetic nervous system over the parasympathetic nervous system, as in anger, despair, stress, or anxiety, will doubtlessly reduce the impact of a funny stimulus.

The response (R) may be expressive or reactive. The expressive response is creative; it includes kidding, clowning, and initiating funny remarks and actions. The reactive response is appreciative; it includes being amused, laughing, smiling, enjoying, and so forth.

The contingent consequences or effects (C) of the response will, according to the cognitive-behavioral model, determine whether it is repeated, maintained, or dropped from the response repertoire. Behavior is controlled by its immediate antecedents and consequences. So, if they are positively reinforcing, the laughter will intensify, continue, and increase in frequency. Laughter makes the person feel good, free, and happy. It also promotes better interpersonal relations. These consequences have been invoked to justify the use of humor in psychotherapy.

Finally, the context provides a potent cluster of situational variables. Ludicrous situations, funny settings, places like burlesque houses, comedy stores, and circuses contribute to the funniness of the stimulus and the readiness of the person to respond with laughter. Similarly, certain surrounding circumstances of an event, including zeitgeist, timing, and pacing, tend to add or detract from the humorous impact of a stimulus. A tragic happening too temporally or topographically close to the client's experience could never be appreciated as funny; joking about it would be in poor taste, to say the least. The condition or situation in which psychotherapy is performed usually precludes such humor-enhancing contextual variables. Therein lies a major problem of attempting to inject levity into a grave and solemn enterprise such as therapy. Moreover, as in all treatment modalities, a number of relationship conditions would have to be met before humor could have the desired effects. These would have to include mutual respect and caring, rapport, and similar indications that the client accepts the therapist in this particular humorous role and agrees that mirth and frivolity have a legitimate place in the therapy.

Previously Used Techniques

Numerous humorous techniques (T_3) have been used by therapists. Frankl (1960) employed a technique called "paradoxical intention" in which clients are encouraged to exaggerate their symptoms to the point of absurdity. He claimed that this develops their ability to laugh at their neurotic maneuvers, which in turn permits divestment and extinction of symptoms (see also Lamb, 1980). Greenwald (1975) focused on clients' ridiculous life decisions and, by mirroring or exaggerating their maladaptive behavior, provided them with a chance to explore new and perhaps better choices. Ellis (1977) had an extensive humorous armamentarium: puns, witty remarks, shocking language, sarcasm, and so forth. These presumably facilitate cognitive restructuring and undermine the tendency of clients to absolutize, "awfullize," and falsify the extent of their difficulties. Grotjahn (1970) made jokes, thereby signaling that clients in psychoanalysis may adopt a similar emotional freedom. He believed this fosters a wholesome identification with the therapist and, as a form of interpretation, enables the bypassing of client resistance.

Mindess (1971, 1976) used apt jokes, situationally generated wit and mirth, teasing and kidding naturally introduced, and himself (T_1) as a model of humorous demeanor. Such "fun" presumably frees the client (Cl_1) to emulate the therapist and adopt a similar way of approaching the goal of effectively getting along and getting ahead in life.

Salameh (1983) has pulled together the more useful techniques into a list, including definitions and examples, as follows: "surprise, exaggeration, absurdity, the human condi-

tion, incongruity, confrontation/affirmation humor, word play, metaphorical mirth, impersonation, relativizing, the tragicomic twist, and bodily humor" (pp. 78–79). When the definitions and examples of Salameh's techniques were presented informally to clinical psychology students, psychotherapists, and other mental health workers who attended my classes, seminars, and workshops, they generated considerable debate regarding the suitability of his definitions or the funniness of his examples. Salameh admitted to this problem of lack of agreement about what is funny and therapeutic.

Although the misuse of a technique is no argument against it, therapists should nonetheless exercise great care before adopting it. Needless to say, they would be on firmer ground if they could adduce more systematic and controlled empirical proof that the techniques they use are appropriate and effective. The multiplicity of factors in humorous behavior (SORC) and in the therapeutic process (T, r, Cl), and the complex interactions within and between these two sets of factors tend to render the research and intervention tasks formidable, if not impossible.

Suggestions for Proper Use

As already mentioned, different types of personality may prefer different types of humor. For this reason, therapists who set out to use humor in therapy (T_3) would be well advised to know themselves (T_1) as well as their clients ($Cl_{1,2,3}$) as thoroughly as possible. In cognitive–behavioral terms, the personality types in the organismic component (O) may be viewed as clusters of mediating responses, response tendencies, coping styles, or simply traits. A careful assessment of the clients' personality and the specific types of humor that they prefer may provide an effective basis for the decision to inject humor into the therapy.

Moreover, the therapist should be aware that some forms of humor are harmful to the therapeutic relationship and process. As Kubie (1971), Parry (1975), Salameh (1983), and most of the other humor-using therapists discussed in this article have been at pains to warn us, humor that humiliates, deprecates, or undermines the self-esteem, intelligence, or well-being of a client is never proper. Unfortunately, therapists can be adept at rationalizing their (T_3) inputs as potentially beneficial to the client.

Goodman (1983) distinguished between *laughing with* and *laughing at*. The former, which can be used for constructive purposes, includes "going for the jocular rather than the jugular vein ... based on caring and empathy ... builds confidence ... is supportive" (p. 11).

Appropriate humor makes a point. Whether to expose folly in the attitudes and actions of the client or to suggest better ways of getting along and getting ahead, the introduction of mirth and frivolity should fit the client, the therapist, and the goals and objectives of the psychotherapy. It is patently inadvisable to bring it in, procrusteanlike, for no purpose other than comic relief.

The question should be asked (with Kubie, 1971) whether psychotherapy is ever the proper place to provide humor, or is humor better provided outside of therapy in perhaps more popular, efficient, and immensely cheaper places and forms? How much better, if at all, is natural high therapy or provocative therapy than, say, the regular viewing of some situation comedy on television, or partaking of a dial-a-joke, or attending a 3-day workshop conducted by Joel Goodman on putting "smileage" into our lives? Should psychotherapists be required to have a comic vision of life or to train in the comic arts before they try to apply humor?

It would appear that some kind of formal exposure to the ways in which humor is constructed and in which it can be best presented is de rigueur. Moreover, to determine the underlying dispositions (O) and consequences (C) that do or do not dispose the client to benefiting from humor, a thorough behavior analysis would have to be routinely made. The premature adoption of humor in psychotherapy may be unilaterally and partially gratifying, but it could in the long run surely prove disastrous for the total enterprise.

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