

This article was downloaded by: [Steven Sultanoff]

On: 05 December 2013, At: 16:26

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



The Humanistic Psychologist

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/hthp20>

Integrating Humor Into Psychotherapy: Research, Theory, and the Necessary Conditions for the Presence of Therapeutic Humor in Helping Relationships

Steven M. Sultanoff ^a

^a Pepperdine University

Published online: 04 Dec 2013.

To cite this article: Steven M. Sultanoff (2013) Integrating Humor Into Psychotherapy: Research, Theory, and the Necessary Conditions for the Presence of Therapeutic Humor in Helping Relationships, *The Humanistic Psychologist*, 41:4, 388-399, DOI: [10.1080/08873267.2013.796953](https://doi.org/10.1080/08873267.2013.796953)

To link to this article: <http://dx.doi.org/10.1080/08873267.2013.796953>

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the "Content") contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms & Conditions of access and use can be found at <http://www.tandfonline.com/page/terms-and-conditions>

COMMENTARY

Integrating Humor Into Psychotherapy: Research, Theory, and the Necessary Conditions for the Presence of Therapeutic Humor in Helping Relationships

Steven M. Sultanoff

Pepperdine University

Although humor is a key element of all social interactions and is frequently present in the psychotherapy process, rarely do therapists consciously and purposely use humor with therapeutic intent. Each theoretical orientation helps clients change emotions, behaviors, and/or cognitions. Humorous interventions can activate change in each of these central areas of human experience.

A key unanswered question is how therapeutic humor is generated. This question has been virtually ignored. Unless people specify the elements that facilitate the creation of therapeutic humor, they cannot train practitioners to be therapeutic in their use of humor. Using Carl Rogers' (1957) "necessary and sufficient conditions" as a central theme, this article addresses the nature of the practitioner that is necessary for therapeutic humor to be communicated to the client. It further describes the qualities of the client/receiver of the humor that are necessary for therapeutic humor to be experienced, and, finally, it specifies the nature of the interactive relationship that influences the potential for humor to be therapeutic. It is the interaction of the skills and qualities of the therapist, the qualities of the client, and the nature of the bond of the relationship between them that accounts for the client's experience of therapeutic humor.

THERAPEUTIC HUMOR: IMPLICATIONS FOR PSYCHOTHERAPY

Although humor is recognized as a therapeutic component within psychotherapy (Corey, 2013; Ellis, 1977; Franzini, 2001; Fry & Saleme, 1987; Goldin et al., 2006; Saper, 1987; Sultanoff, 2002;), there is very little empirical research supporting its use (Franzini 2001; Saper, 1987):

Although little systematic empirical research conclusively supports the contention that humor is, as, or with psychotherapy is beneficial, the past 15 years or so have witnessed a burgeoning advocacy of its use. (Saper, 1987, p. 360)

Correspondence should be addressed to Steven Sultanoff, 3972 Barranca Pkwy., Suite J-221, Irvine, CA 92606.
E-mail: steven.sultanoff@pepperdine.edu

Little has changed since Saper's (1987) review of humor in psychotherapy in which he called for more controlled empirical proof of the effectiveness and value of humor. (Franzini, 2001, p.171)

Even the journal *Humor* (published by the multidisciplinary International Society for Humor Studies) has published very little research that addresses the direct impact of humor in psychotherapy (Franzini, 2001).

The multitude of articles and books on humor in psychotherapy are primarily anecdotal consisting of statements of support for humor and clinical examples of its use. Saper (1987, p. 363) described most publications on humor as "advocacy literature." These articles and books support the use of humor by sharing clinical stories, personal perspectives, suggested interventions, and some minor theoretical discussions.

The Handbook of Humor in Psychotherapy (Fry & Salameh, 1987) offers a series of chapters where therapists discuss using humor in therapy. Although these authors offer clinical examples, they provide little empirical or theoretical basis to support their use of humor. Goldin et al. (2006) is a classic illustration of a journal article on humor in psychotherapy where each master therapist shares observations, insights, anecdotes, and clinical interventions but fails to support his perspective with research evidence.

Although the research is limited, there is both theoretical and clinical support for the use of humor in psychotherapy. Sultanoff (2002) presented a comprehensive model including a clinical rationale and theoretical base for using humor in psychotherapy. The model suggests that humorous interventions help clients change feelings, behaviors, thoughts, and biochemistry. This model supports Ellis's (1977) contention that humor can be used to shift negative, self-defeating thinking, thus supporting its use in Rational Emotive Therapy. However, only a few studies have directly linked the use of humor with clients to change in emotion, behavior, or cognition.

Humor Changes Emotion, Behavior, Cognition, and Biochemistry

Psychotherapy is a process where therapists create interventions designed to promote change in clients' emotions, behaviors, cognitions, and/or biochemistry (Greenberger & Padesky, 1995). This is an interactive process where a change in one aspect (e.g., emotion) is likely to stimulate a change in another (e.g., behavior). Humorous interventions can activate change in all four areas, and therefore, can serve as a powerful intervention tool.

While empirical research directly linking therapist humor to outcome is sparse, a few studies have linked therapeutic humor to changes in client's emotions, behaviors, and cognitions (Bizi, Keinan, & Beit-Hallahmi, 1988; Gelkopf & Kreitler, 1996; Martin & Dobbin, 1988; Martin & Lefcourt, 1983; Porterfield, 1987; Thorson, Powell, Sarmany-Schuller, & Hampses 1997). Other nonpsychotherapeutic studies have found positive changes in biochemistry when subjects engage in deep heartfelt laughter (Berk et al., 1989; Dillon, Minchoff, & Baker, 1985; Martin & Dobbin, 1988).

Humor Influences Emotion

Humor is the great thing, the saving thing after all. The minute it crops up, all our hardnesses yield, all our irritations and resentments slip away, and a sunny spirit takes their place. (Mark Twain, 1998, p. 86)

The experience of humor changes distressing emotional states. Research on the impact of humor has indicated that humor relieves depression (Gelkopf & Kreitler, 1996; Porterfield, 1987)

and reduces the impact of stressful events (Bizi et al., 1988; Martin & Dobbin, 1988; Martin & Lefcourt, 1983). The experience of humor also serves as a vehicle to discharge and relieve pentup emotional conflict (Rosenheim & Golan, 1986). Humor has also been shown to reduce anxiety and negative mood (Strick, Holland, Van Baaren, & Van Knippenberg, 2009). As individuals experience humor, they feel emotionally uplifted and connect well with others (Richman, 1996).

It has been suggested that a humorous experience and distressing emotions (depression, anxiety, and anger) cannot simultaneously occupy the same psychological space (Sultanoff, 1997). In those moments of experiencing humor, emotional distress dissolves. Although feelings of distress may return, the experience of humor, at a minimum, provides momentary relief. Many clients recount stories where they have been angry, and the person with whom they are angry does something funny. A common reaction to such a situation is for the client to respond to the humor by saying, "Don't make me laugh, I want to be angry with you." We know intuitively that in a moment of experiencing humor we cannot sustain being angry.

One of my clients, who was dedicated to maintaining her depression, insisted that she wanted to feel less depressed. As part of her treatment, I integrated humorous interventions. After each of the first few humorous interventions (presented over several sessions), she responded fervently, "I hate when you do that (say something humorous)." She became increasingly annoyed with my use of humor until finally I inquired, "What is it about my use of humor that bothers you?" Instantly and emphatically she replied, "When you make me laugh, I don't feel depressed!"

In a moment of insight she perceived the incongruity that, even though she wanted to "feel better," she was upset when her depression was "taken away" or dissolved. The humorous interventions helped to "lighten" her depression while, unconsciously, she continued to be dedicated to maintaining her emotional distress.

A depressed client who experiences and is receptive to humor in therapy can learn *experientially* that, for at least a moment in time, the intensity of the depression fades. Clients can be taught to consciously seek humorous experiences outside of therapy sessions as ways of managing their emotional distress.

Humor Influences Behavior

When people are laughing they are generally not killing one another. (Alan Alda, 2013)

The experience of humor affects how one behaves. Levinson, Roter, Mullooly, Dull, and Frankel (1997) found that patients who experienced humor from their family physicians filed fewer lawsuits against those doctors. Bizi et al. (1988) noted that soldiers who activated their sense of humor when experiencing a stressful event performed better in those stress producing situations.

Thorson et al. (1997) found a positive correlation between sense of humor and exhibition, gregariousness, assertiveness, and creativity. Individuals experiencing distress tended to withdraw and disengage from relationships and opportunities, while individuals experiencing humor became more energized, attentive, and pursued connections with others. The results suggest that people who experience humor change the way they act in a wide range of situations.

Humor Influences Cognition

Humor is a healthy way of feeling a 'distance' between one's self and the problem; a way of standing off and looking at one's problem with perspective. (Rollo May, 1953, p. 54)

Although it is common for an individual to attribute fluctuations in mood to external stimuli, it is the client's interpretation of life's events that is the major determinant of emotional reactions (Beck, 1976; Ellis & Harper, 1979). It is the meaning that the client assigns to an event that is the primary influence on that client's emotional reactions.

The relationship between belief systems and both physical and emotional health is well documented. Optimism, personal control, and sense of meaning are associated with mental health (Seligman, 1998), and positive beliefs are related to physical well-being (Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000).

The experience of humor offers a client alternative ways to perceive daily events. Humor provides perspective (Gelkopf & Kreidler, 1996; Richman, 1996; Rosenheim & Golan, 1986) and increases problem-solving abilities (Rosenheim & Golan, 1986; Thorson et al., 1997). By enabling a client to gain perspective, humor invites the client to examine and change distorted thinking patterns. Corrections of unhealthy, distorted beliefs translate directly into emotional and behavioral changes (Beck, 1976; Ellis & Harper, 1979). Strick et al. (2009) found that humor served as a complex distraction that exhausted cognitive resources leading to a reduction in negative mood. Strick et al. (2009) results support Saper's (1987) position that one of the benefits of humor is its ability to shift emotional distress and adjust negative thinking.

A client's capacity to experience a stimulus as humorous requires that the client cognitively process the context in which the stimulus is presented and perceive the twist (incongruity, absurdity, surprise, etc.) that places the stimulus out of context. If a client is unable to perceive the twist, it is possible that the client's cognitive process is rigid and, therefore, the client is less able to generate perspective in relation to personal environmental stressors. A humorous intervention can uncover the rigidity of a client's thinking pattern. In cognitive therapy, humor can assist the therapist to assess the strength of irrational belief systems and faulty underlying assumptions.

Using humorous interventions to identify changes in a client's underlying distorted thought patterns (such as irrational beliefs or faulty assumptions) can help evaluate the success of cognitive restructuring. For example, a client, during her first therapy session, explained that "bad things" happened to her because she was "stupid." On subsequent visits, she was treated with a traditional cognitive therapy approach, helping her to restructure that belief system. On her tenth visit, she reported that another "bad thing" had happened, but she could not explain why it had occurred. I insisted that she knew why, but she insisted that she did not. Finally, I looked directly into her eyes and exclaimed, "It happened because you are stupid!" After a brief moment of shock (startle, the unexpected), she burst out laughing.

Her ability to perceive the absurdity of the "bad event" being associated with her "being stupid" triggered her laughter. She perceived that her belief that bad things happened because she was "stupid" was, indeed, ludicrous, indicating a shift in thinking from the first session (when she would not have made the connection and would have agreed with the statement) to the tenth session (where it seemed ridiculous to her).

Humor Influences Biochemistry

Laughter is the best medicine. (Source Unknown)

Multiple studies have reported that laughing, as a result of experiencing a humorous stimulus, leads to positive biochemical changes. When individuals laugh, they have decreased levels of stress hormones (Berk et al., 1989) and increased levels of antibodies (Berk et al., 1989; Dillon

et al., 1985; Martin & Dobbin, 1988). During laughter, many body systems (such as cardiovascular, muscular, and skeletal) are activated or exercised (Fry, 1992).

Although the empirical research is limited, it appears that (as clinicians and theorists have suggested) humor positively influences emotions, behaviors, cognitions, and biochemistry. Therapists who learn to effectively integrate humorous interventions into their therapeutic framework, increase their ability to help clients relieve emotional distress, activate positive thinking, and generate new, healthier behavior (Gelkopf & Kreitler, 1996).

It is evident that the emotional and cognitive aspects of humor are closely interwoven and interact with each other. Thus, optimism, for example, may be considered as a direct effect of the cognitive aspect of humor or as a mediated effect of the change of mood characterizing humor. Similarly, the decrease in hostility may reflect a direct emotional change or a mediated cognitive effect due to the increase in positive attitudes toward people or of a light-hearted, easy going view of the world. (Gelkopf & Kreitler, 1996, p. 247)

A humorous intervention, therefore, stimulates change in a client's feelings, behaviors, cognitions, and/or physiology, and, as suggested by Greenberger and Padesky (1995), each of these aspects of human experience influences the others. Therefore, a humorous intervention has the potential of activating a dynamic, interactive process between and among a client's feelings, behaviors, thoughts, and physiology making it a potentially powerful tool in the psychotherapeutic process (see Figure 1).

Humor Builds and Strengthens the Therapeutic Alliance

For over 50 years, research has supported the strength of the therapeutic alliance as the primary factor for client change in psychotherapy (Carkhuff & Berenson, 1967; Lambert & Barley, 2001; Rogers, Gendlin, Kiesler, & Truax, 1967; Strupp, 1960; Truax & Carkhuff, 1967; Watson, 2007).

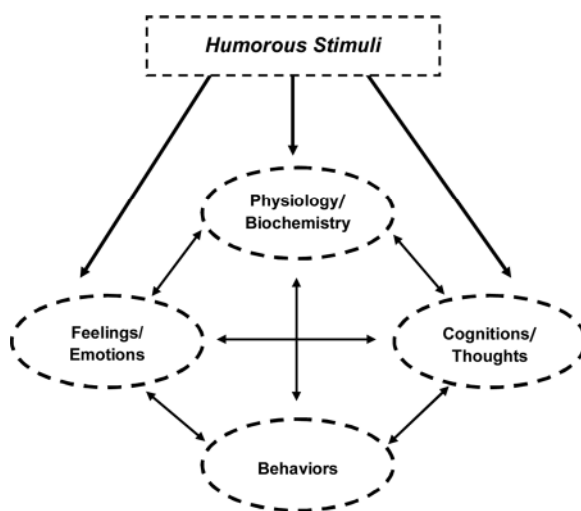


FIGURE 1 The interactive model of human experience as influenced by humorous stimuli.

Psychotherapy as a relationship is unique, and the methods by which therapists build intimacy in the therapeutic alliance are generally different from the methods by which they build intimacy in other types of relationships. Although humor is present in both personal and clinical relationships, its use in therapy is selective and for the benefit of the client.

Humorous interventions help build the therapeutic alliance (Gelkopf & Kreidler, 1996; Richman, 1996) and have great potential to deepen the relationship because they can result in positive accepting, empathy, cohesion, and belonging (Richman, 1996). Therapists who are able to create humorous interventions from a genuinely warm and caring perspective can increase their connection with clients. Just as empathy demonstrates a level of caring and understanding and builds the therapeutic alliance, the use of humor can enhance the bond between therapist and client.

A new client entering treatment indicated on the intake form that, over the past year, she had sought therapy three times with three different therapists, and each time she terminated after the second visit. During the intake I explored this pattern. The client explained that in each case, when she began to feel close to the therapist and reveal her hidden emotions and deeper issues, she abandoned the therapeutic process. I asked her what she wanted in therapy, to which she replied, "I want to minimize emotional distress and feel comfortable and safe." To that I responded, "It seems as though you want an uninvolved and somewhat distant therapist who will help you remain unemotional so that you can feel comfortable and safe." She looked at me with a momentary quizzical look and then laughed.

In that moment, the client's experience of humor was based on her capacity to perceive the incongruity between the process of therapy (to establish a close relationship between therapist and client and to explore distressing emotional issues) and her goal of maintaining emotional comfort and safety. She perceived the absurdity of how her own behavior of abandoning the therapeutic process had prevented her from receiving the help she desired. Her capacity to perceive that what she "wanted" was ludicrous triggered her humorous response.

When this client arrived for her second session, I began the session by stating, "Since this will be our last session, I wonder if there is anything in particular you would like to discuss?" Again the client looked quizzical for a moment and then laughed. In this statement, I had presented two points of incongruity. First, by presenting the second appointment as termination, I addressed her history of dropping out after two sessions. Second, by establishing the incongruity of seeking treatment while preventing it from becoming effective, I again validated her fear about getting into her issues.

The client remained in therapy for about a year and terminated only because she moved out of the area. Her ability to connect with me and remain in therapy may have partially been a result of the initial use of humor to establish the relationship (which she had not been able to do on the three prior attempts with other therapists).

Although the use of humor may enhance the therapeutic relationship, Kubie (1971) cautioned that humor may also be harmful to the therapeutic alliance. Kubie stated, "The author believes that the use of humor by the psychiatrist is potentially destructive to the psychotherapeutic relationship. Humor has its place in life. Let us keep it there" (p. 42). Kubie may be accurate in his observation that "humor is *potentially* destructive," but he fails to trust the skill of the therapist to either select humor appropriate to the client or be capable of responding effectively to a client's negative reaction to the humor.

In a broader sense, Kubie assumed that clinicians are not capable of addressing the impact of interventions that clients experience as negative. Many interventions in therapy have the potential

to be destructive. Interpretations or confrontations could be detrimental to the therapeutic alliance, yet it is unlikely that Kubie would suggest that clinicians abandon these types of responses.

Because the client places trust in the therapist and is, therefore, more vulnerable to emotional harm, the risk of using humor in psychotherapy is greater than the risk of using humor in other relationships. The purposeful intention of using humor in psychotherapy must clearly be for the benefit of the client and not for the therapist's personal gratification or pleasure. By using humor, the therapist may risk alienating the client. The therapist may be perceived as not taking the client's issues seriously, and/or may be perceived as less competent and, therefore, less capable of helping. The effective use of humor as a therapeutic tool requires that the therapist maximize the potential for clients to experience humor in a positive way.

ON BECOMING THERAPEUTIC WITH HUMOR

In the literature discussing therapeutic humor, one critical missing piece is the answer to the question, "What makes therapeutic humor therapeutic and how do practitioners create therapeutic humor interventions?" While many therapists report using humor and even support its usefulness few consider how to purposely create humor and make humorous intent therapeutic.

Therapeutic humor can be defined as the conscious and purposeful use of humor by a professional health practitioner for the purpose of activating a positive therapeutic change in an individual's feelings, behaviors, thoughts, or even physiology. It is the purposeful intention of using humor for the client's benefit that distinguishes health practitioners (therapists) from those who are not health practitioners. When therapists offer questions, confrontations, or interpretations, they are doing so with the intent of being helpful, and generally, the intervention has some basis in theory, research, or clinical experience. When a friend responds to a friend with questions, confrontations, advice, or interpretations, those responses may be helpful, but they are not generally with the purposeful intention of being healthful, and they lack the theoretical rationale or research base that supports their potential helpfulness.

The Association for Applied and Therapeutic Humor (2005) developed an outcome oriented definition that describes therapeutic humor as:

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

In this definition, therapeutic humor is therapeutic, based on the outcome of the humor. If it promotes health and wellness, then it is therapeutic. As an outcome-oriented definition, it does not provide guidance on how a practitioner can create a humorous intervention for the purpose of promoting health and wellness. How a practitioner generates therapeutic humor is a central question that remains unanswered. Without conscious and purposeful creation, and some guidance as to what makes therapeutic humor therapeutic, the humor remains random, and the therapist has no basis from which to create a humorous, therapeutic intervention.

For most clinical interventions (confrontation, interpretation, solicitation, reflective listening, and even questioning), it is assumed (based on theory or research) that there is a therapeutic or clinical benefit of the response for the client. Based on the clinical knowledge of the

therapist, responses are purposely selected so that they have potential to be helpful to the client. Clinicians use their clinical knowledge, sense of themselves, and sense of the client to create interventions.

Rogers (1957) proposed that not only are specific skills/behaviors significant in the creation of beneficial interventions for clients, but the nature of the therapist (the way in which these skills are communicated) is also essential for any of these interventions to be of therapeutic value. Rogers suggested that clinical interventions must be offered in conjunction with specific therapist “ways of being” (p. 97).

Rogers (1957) proposed that there are specific, necessary conditions for positive outcome in psychotherapy. These are: (a) the skill/behaviors of the therapist (e.g. empathic responding); (b) the nature of the therapist’s being (embracing empathy/compassion, genuineness, and positive regard/acceptance); (c) the receptivity of the client (being able to experience the presence of the therapist); and (d) the relationship bond that develops.

These same four conditions can be applied to the presence of therapeutic humor. For humor to be therapeutic, (a) the sender (therapist) of the humor must be skilled in the creation of humorous interventions and act in a conscious and purposeful way; (b) the sender must embody Rogers’ “ways of being” (core conditions) that are central to all therapeutic interpersonal interactions; (c) the receiver (client) of the humor must receive and perceive (get) the humor; and (d) the bond between the two must modulate the “tone” for the humor. When a skilled practitioner chooses to use humor with intention, when the ways of being are an integral part of the health practitioner’s being, when the receiver “gets” the humorous experience, and when the relationship is connected and a bond exists between the practitioner and the client, then the humor has the greatest potential for being therapeutic.

Skills of the Sender

Humor skills like any other skills in therapy must be learned and incorporated into the therapeutic “set” of the therapist. Just as a therapist practices new skills for them to become integrated into a therapeutic style, a therapist must find ways to practice creating humorous interventions so that those skills are added into the traditional intervention skills. Because the experience of humor requires perception of what is funny, the therapist must learn to expand his view of the world to increase his comic vision and learn to generate interventions that have the capacity to tickle the funny bones of clients.

Nature of the Sender: Core Qualities

In addition to being skilled in the use of humor, the sender of the humor must have conscious intent and embody three central core conditions or “ways of being” as suggested by Rogers (1957, p. 97). These ways of being are (a) empathy/compassion; (b) genuineness/congruence; and (c) positive regard/acceptance. Rogers suggested that if these central conditions are present in any relationship, then by its very nature, it will be therapeutic. We can apply these therapist conditions originally proposed by Rogers to the use of humor in the helping relationship.

Core Conditions: The Therapeutic Ways of Being

Empathy. The sender of the humor must experience compassion and caring (empathy) for the receiver. Empathy embodies a “feeling” of understanding, caring, and compassionate sensitivity for the other person and for his situation in life. The therapist who experiences empathy for the client will create humor that demonstrates understanding of the client and the client’s world. This understanding communicates caring and, therefore, increases the likelihood that the client will experience the humor as therapeutic.

Genuineness. The sender of humor must experience genuineness or congruence within himself. Genuineness/congruence is the sense of internal consistency that will naturally result in presenting oneself as “real.” There is no façade or phoniness in one’s being and, therefore, no phoniness in one’s presence. The sender of the humor is “real” and uses humor that is congruent with his way of being in the world. The effective use of humor requires that the humor offered be genuine for the health practitioner/therapist. If the humor being used is incongruent, it will likely be experienced by the client/receiver as fake, insincere, clumsy, or out of context.

Positive regard (acceptance). The sender of the humor must embrace acceptance (positive regard) for the receiver. The humor is offered out of respect for the receiver and is specifically for the benefit of the receiver (client). The sender does not judge the receiver and, therefore, acceptance is experienced by the receiver. The humor is not for the gratification of the sender by, for example, teaching the client a lesson, or sending a corrective message as in a hostile tease, but is for the purpose (without bias or with minimal bias) of activating the therapeutic process within the receiver. The humor is intended to benefit the receiver.

If these three conditions are present as an integral part of the therapist/sender, then the therapist’s humor has the greatest potential to be experienced as therapeutic. Therapeutic humor is nested in the being of the therapist as an empathic, genuine, and accepting individual. If these conditions are not present then the humor is likely to be experienced as non-therapeutic and may be experienced as hostile or negative.

Nature of the Receiver

As suggested by Rogers (1957) the client must also, at least minimally, perceive/experience the core ways of being embodied within the therapist. The client’s capacity to experience the core qualities (compassion, genuineness and acceptance) of the therapist maximizes the potential for any humorous intervention to be received as therapeutic. In addition to being able to receive therapeutic humor, the client must also be able to perceive the intervention as humorous. To perceive humor, the client must experience one or more of the universal stimuli that activate a humorous response. These stimuli include the experience of incongruity, ludicrousness, or ridiculousness (Sultanoff, 2002). The client’s sense of humor must be activated. If the client does not perceive a humorously intended intervention then, of course, it cannot have a humor based therapeutic impact. As Rogers suggested, the receiver must “experience” the empathy,

genuineness, and acceptance of the sender and in therapeutic humor must also “perceive” the humor (p. 99).

Blocks to Client Receptivity

The presentation of an intervention intended to be humorous does not guarantee that the client will receive the humor. Occasionally, receivers of humorous interventions are locked in to their present moments of thought or distress, and when locked in, they are unable to think outside the box, which is essential in the perception of humor. The narrow cognitive focus created by emotional distress may inhibit a receiver’s ability to perceive an intervention as amusing. Unless the receiver can perceive the incongruity, ludicrousness, or ridiculousness of a humorous intervention, it is not going to be experienced as funny.

The Nature of the Relationship: Bond Between Therapist and Client

As proposed by Rogers (1957), the empathy, genuineness, and positive regard of the therapist must be at least minimally achieved by the therapist and received by the client. The experience by the client of these conditions in the therapist maximize the potential for the client to perceive the humor as emanating from the therapist’s caring and compassionate self. The experience of these positive core conditions can reduce or even eliminate the negative filters that might impede the client from experiencing the intervention as funny. If the client does not perceive the therapist’s empathy, genuineness, and accepting/nonjudgmental presence, then the client may misinterpret the humor as uncaring, insensitive, or even hostile, based on his automatic (unconscious) perception of the world. The strength of the relationship bond between the therapist and client may enhance the experience of humor and may serve as a psychological buffer against a humorous intervention that is experienced by the client as unpleasant, uncaring or even hostile. Clients who feel bonded to their therapists will “forgive” humor that they experience as insensitive or unpleasant.

CONCLUSION

Humor can be a powerful tool to help clients shift their emotional distress, undesired behavior, and negative thinking. The experience of therapeutic humor is created when a health practitioner consciously and purposefully chooses humor based on specific behavioral skills (including the ability to create funny interventions), and when that practitioner embodies compassion, genuineness, and acceptance. The practitioner’s skills and being then interact with a client who processes and perceives the intervention through one of the universal triggers of humor and who, at least minimally, experiences the positive/therapeutic intent of the therapist. When these conditions are present, the likelihood of the therapeutic humor being perceived and received by the client is maximized. Therapeutic humor can be added to a skilled clinician’s repertoire of clinical interventions and, like all other skill interventions used in the helping relationship, offered by the therapist based on his clinical judgment, theoretical orientation, research, and past experience.

REFERENCES

- Alda, A. (2013). *BrainyQuote*. Retrieved October 10, 2013 from http://www.brainyquote.com/quotes/authors/a/alan_ald.html
- Association for Applied and Therapeutic Humor. (2005). *AATH - Association for Applied and Therapeutic Humor*. Retrieved from <http://www.aath.org/general-information>
- Beck, A. T. (1976). *Cognitive therapy of emotional disorders*. New York, NY: New American Library.
- Berk, L. S., Tan, S. A., Fry, W. F., Napier, B. J., Lee, J. W., Hubbard, R. W., ... Eby, W. C. (1989). Neuroendocrine and stress hormone changes during mirthful laughter. *American Journal of the Medical Sciences*, 298(6), 390–396.
- Bizi, S., Keinan, G., & Beit-Hallahmi, B. (1988). Humor and coping with stress: A test under real-life conditions. *Personality and Individual Differences*, 9(6), 951–956.
- Carkhuff, R., & Berenson, B. (1967). *Beyond counseling and therapy*. New York, NY: Holt, Rinehart and Winston.
- Corey, G. (2013). *Theory and practice of counseling and psychotherapy*. Belmont, CA: Brooks/Cole.
- Dillon, K. M., Minchoff, B., & Baker, K. H. (1985). Positive emotional states and enhancement of the immune system. *International Journal of Psychiatry*, 15(1), 13–18.
- Ellis, A. (1977). Fun as psychotherapy. *Rational Living*, 12, 2–6.
- Ellis, A., & Harper, R. (1979). *A new guide to rational living*. North Hollywood, CA: Wilshire.
- Franzini, L. R. (2001). Humor in therapy: The case for training therapists in its uses and risks. *Journal of General Psychology*, 128(2), 170–193.
- Fry, W. F. (1992). The physiologic effects of humor, mirth, and laughter. *Journal of the American Medical Association*, 267(13), 1857–1858.
- Fry, W., & Salameh, W. (1987). *Handbook of humor and psychotherapy: Advances in the clinical use of humor*. Sarasota, FL: Professional Resource Exchange.
- Gelkopf, M., & Kreitler, S. (1996). Is humor only fun, an alternative cure or magic? The cognitive therapeutic potential of humor. *Journal of Cognitive Psychotherapy: An International Quarterly*, 10(4), 235–254.
- Goldin, E., Bordan, T., Arazo, D., Gladding, S., Kaplan, D., Krumboltz, J., & Lazarus, A., (2006). Humor in counseling: Leader perspectives. *Journal of Counseling and Development*, 84, 397–404.
- Greenberger, D., & Padesky, C. A. (1995). *Mind over mood*. New York, NY: Guilford.
- Kubie, L. (1971). The destructive potential of humor in psychotherapy. *American Journal of Psychiatry*, 127, 861–866.
- Lambert, M., & Barley, D. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy*, 38, 357–361.
- Levinson, W., Roter, D., Mullooly, J., Dull, V., & Frankel, R. (1997). Physician–patient communication: The relationship with malpractice claims among primary care physicians and surgeons. *Journal of the American Medical Association*, 277(7), 553–559.
- Martin, R. A., & Dobbin, J. P. (1988). Sense of humor, hassles, and immunoglobulin A: evidence for a stress-moderating effect of humor. *International Journal of Psychiatry in Medicine*, 18(2), 93–105.
- Martin, R. A., & Lefcourt, H. M. (1983). Sense of humor as a moderator of the relation between stressors and moods. *Journal of Personality and Social Psychology*, 54, 520–525.
- May, R. (1953). *Man's search for himself*. New York, NY: Norton.
- Porterfield, A. L. (1987). Does sense of humor moderate the impact of life stress on psychological and physiological well-being? *Journal of Research in Personality*, 21, 306–317.
- Richman, J. (1996). Points of correspondence between humor and psychotherapy. *Psychotherapy*, 33(4), 560–566.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95–103.
- Rogers, C., Gendlin, E., Kiesler, D., & Truax, C. (1967). *The therapeutic relationship and its impact*. Madison, WI: University of Wisconsin Press.
- Rosenheim, E., & Golan, G. (1986). Patients' reactions to humorous interventions in psychotherapy. *American Journal of Psychotherapy*, 40(1), 110–124.
- Saper, B. (1987). Humor in psychotherapy: Is it good or bad for the client? *Professional Psychology: Research and Practice*, 18(4), 360–367.
- Seligman, M. (1998). *Learned optimism: How to change your mind and your life* (2nd ed.). New York, NY: Pocket Books.
- Strick, M., Holland, R. W., Van Baaren, R. B., & Van Knippenberg, A. (2009). Finding comfort in a joke: Consolatory effects of humor through cognitive distraction. *Emotion*, 9, 574–578.

- Strupp, H. (1960). Nature of the psychotherapist's contribution to treatment process. *Archives of General Psychiatry*, 3, 219–231.
- Sultanoff, S. (2002). Integrating humor into psychotherapy. In C. Schaefer (Ed.), *Play therapy with adults* (pp. 107–143). New York, NY: Wiley.
- Sultanoff, S. (1997). Survival of the witty-est; Creating resilience through humor. *Therapeutic Humor*, 11(5), 1–2. Retrieved from <http://www.humormatters.com/articles/resilience.htm>
- Taylor, S. E., Kemeny, M. E., Reed, G. M., Bower, J. E., & Gruenewald, T. L. (2000). Psychological resources, positive illusions, and health. *American Psychologist*, 55(1), 99–109.
- Thorson, J. A., Powell, F. C., Sarmany-Schuller, I., & Hampes, W. P. (1997). Psychological health and sense of humor. *Journal of Clinical Psychology*, 53(6), 605–619.
- Truax, C., & Carkhuff, R. (1967). *Toward effective counseling and psychotherapy*. Chicago, IL: Aldine.
- Twain, M. (1998). *The wit and wisdom of Mark Twain: A book of quotations*. New York, NY: Dover Publications.
- Watson, J. (2007). Reassessing Rogers' necessary and sufficient conditions of change. *Psychotherapy: Theory, Research, Practice, Training*, 44(3), 268–273.

AUTHOR NOTE

Steven M. Sultanoff, PhD, is a clinical psychologist, adjunct professor (Pepperdine University), professional speaker, and internationally recognized expert on therapeutic humor. In 2012 he received the Lifetime Achievement Award presented by the Association for Applied and Therapeutic Humor. Dr. Sultanoff has authored many innovative articles on humor, and his chapter, "Integrating Humor Into Psychotherapy," is published in the psychology textbook *Play Therapy With Adults*. Dr. Sultanoff has appeared on STARZ, *The Morning Show* (FOX), Lifetime, and PBS and is frequently quoted in national publications such as *Forbes*, *Prevention*, *USA Today*, *Men's Health*, *Women's Health*, *Redbook*, and others. His website (humormatters.com) provides a wealth of information on therapeutic humor as well as a wide range of topical humor.