How Humor Heals;
The Therapeutic Nature of Humor In Psychotherapy

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They Never Taught This in Graduate School:
Taking Humor Seriously in Psychotherapy

Whether generated by the therapist or the client, humor can play a significant and powerful, healing role in psychotherapy. When asked, most therapists reveal that they share humor with clients, however, almost none indicate that they express it intentionally and with a clinical purpose. Like all therapeutic interventions, humor, when used with intent and clinical purpose, can be a powerful intervention to assist clients to grow emotionally, cognitively, behaviorally, and socially, and humor can also have physiological benefits. After all, we have heard that "laughter is the best medicine," and while laughter is good medicine, the experience of ***humor*** is even better and more powerful "medicine."

Hee Hee Healing;
The Model of Humor In Psychotherapy

As therapists, we create interventions that target how clients feel, act, and think. For example, theoretical orientations such as person centered targets emotion, behavioral therapy targets behaviors, and cognitive therapy targets thinking process as central targets for client change. Therapeutic interventions may also be intended to affect client physiology (e.g., referring for medication or supplements). In addition, we help clients with interpersonal bonding, and, of course, we help clients connect with us. As therapists, we offer a depth of understanding, connection, and bonding that is rarely experienced outside of therapy.

By employing humor intentionally and with clinical purpose, a therapist can create shifts in emotions, cognitions, behaviors, and physiology. In addition, the experience of humor is a key element in social bonding and thus, can enhance the therapeutic alliance.

In the late 1980's, I created and published a model of humor in psychotherapy that illustrates how, when experiencing humor, the client creates positive shifts in four areas of human experience: emotions, behaviors, thoughts, and physiology. Recently, I added a fifth component to the model. While this component has always been present, I failed to identify it and incorporate it into the model until recently. This most recent component is "social bonding" which the client experiences as "Relational Fusion."

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Relational fusion is primarily the bonding that occurs when one (the receiver) experiences humor shared by another (the sender). When the client experiences the empathic humor of the therapist, the clinical bond is strengthened, and the client experiences relational fusion with the therapist.

While the greatest clinical impact of humor occurs as the client experiences the humor of the therapist, the act of sharing humor by the therapist (the sender) is also bonding and part of relational fusion. While I am suggesting that "receiving" humor (the client's experience) is more therapeutically impactful than "sharing" humor (the therapist's experience), both add to the potency of relational fusion.

Humor, by stimulating relational fusion enriches the therapeutic alliance. Relational fusion is particularly important given the extensive research that suggests that, by far, the most important factor for positive client outcome is the therapeutic alliance or bond established between the therapist and the client.

Scott Miller's research on outcome in psychotherapy suggests that of the 13% of outcome attributed to the therapist, 8% is attributed to the therapeutic alliance. While there are many ways to enhance the therapeutic alliance (e.g., accurate reflective listening), humor is a potent and underutilized modality. This is likely because rarely, if ever, is humor taught, recommended, or understood as a therapeutic tool. Therapists are simply not prepared (trained) to offer humor as an intentional and purposeful intervention.

In addition, unlike reflective listening, which is rarely experienced as "negative" by the client, humor has greater potential to be experienced as negative, even though a skilled therapist can effectively navigate negative client reactions. With the lack of skill and training and to avoid potential issues, therapists tend to avoid intervening with humor or when they offer humor, it is without therapeutic purpose.

Today, the revised model of humor in psychotherapy illustrates how humor targets five components of clinical intervention (emotions, behaviors, thoughts, social bonding, and physiology). [see diagram] By targeting these components, humor has the potential to activate positive change in clients. While humor shared by the therapist targets emotions, behaviors, thoughts, social bonding, and physiology, the client's experience of humor activates mirth (the emotional experience of humor), laughter (the physical experience of humor), wit (the cognitive experience of humor), and/or relational fusion (the social bonding experience of humor).

Tickling The Client's Funny Bone;
Using Humor To Build the Alliance

In pop psychology, humor is a well-known bonding agent in relationships. In most surveys asking participants to list the top qualities of a desired and healthy relationship, humor is almost always in the mix. In fact, humor, is typically listed in the top five

qualities and is generally ranked as more important than a good sexual relationship. While survey results invariably list “communication” as the number one quality of a healthy relationship, humor generally ranks two or three.

We know that humor is desired in relationships. Of course, the assumption is that desired humor is “empathic” (supportive and understanding) rather than “hostile” (divisive and judgmental). Note that “empathic” humor can sometimes appear caustic to observers even when it is empathic to the receiver. Teasing often fits this style of empathic humor. Teasing, by its very nature, demonstrates a deeper level of understanding in the relationship, and therefore, can be experienced as caring and bonding. However, sometimes playful and empathic teasing, observed from the outside, appears to be hostile even though it is not experienced as hostile by the receiver. If the sender is perceived as empathic and caring, then teasing humor that appears hostile to observers is generally experienced as empathic and caring by the receiver.

Understanding is one of the most important qualities of effective therapists, and empathic humor can demonstrate a deeper level of understanding. Empathic humor is a path for the client to experience the therapist’s humor as “you get me.” Hostile humor, on the other hand, can easily rupture the relationship. Hostile humor includes humor that puts someone down, corrects behavior, implies superiority, can be cruel, etc.

One of my favorite examples of the masterful use of empathic humor to demonstrate “I get you” comes from Dr. Miriam Polster (the renowned Gestalt therapist) during a live demonstration of Gestalt supervision at a psychotherapy conference. The supervisee (Wendy) was sharing that her dependent client would obsessively call her between sessions. Wendy indicated that the client even addressed her as “Wen” and explained that only her closest friends called her by her familiar, pet name “Wen.” Dr. Polster, without missing a beat, responded, “It sounds like she calls you ‘When-ever.’” Reflecting “When (Wen) Ever” to demonstrate understanding of both the client’s frequent calls and the client’s use of the supervisee’s pet name demonstrated a personalized understanding of the supervisee’s experience. By pairing the client’s frequent calls and being overly familiar (by using Wendy’s pet name “Wen”), Dr. Polster conveyed, “I understand your experience. I get you.” The depth of understanding, illustrated by the use of humor, likely created a deeper and more personal bond between Dr. Polster and Wendy. While most therapists are not sufficiently skilled as to create such a simple and yet powerful intervention, there are many easy ways therapists can learn to integrate humor into their work.

Guaranteed to Shrink;
Using Humor as a Diagnostic Tool

Humor can be used to “diagnose” client emotional, cognitive, and behavioral growth. Here is an example, from my clinical practice, of humor as a “cognitive” diagnostic tool. I was working with a client who, on her first visit, stated, “bad things happen to me

because I am stupid." During the first visit, it was apparent that this was a false belief. For those of you who are familiar with cognitive therapy, you likely immediately recognized the faulty assumption (irrational belief) "bad things happen because I am stupid," as well as the negative core belief (schema), "I am stupid."

For the next 10 sessions, using cognitive restructuring, we worked on both the belief and the schema. She arrived for the 11th session and promptly shared that something bad had happened to her, and she was mystified as to why it happened. I insisted she knew why it happened. She indicated she did not, and I continued to insist that she knew. After a few back-and-forth responses, I finally looked her in the eye and totally out of character firmly said, "This bad thing happened because you are stupid." She was stunned and looked back at me for a moment and then, burst out laughing. The laughter was the indicator that she "got it." What did she get?? She got that it was ludicrous, absurd, and ridiculous to think that this bad thing happened because she was stupid. Of course, this had been her firm belief during the first session. How is that diagnostic?? The shift from the belief being true in the first session to being absurd in the eleventh illustrated the transformation of her thinking as a result of the cognitive restructuring process. The progress of treatment was "diagnosed" as the client perceived the original faulty assumption (negative belief) that "bad things happen to me because I am stupid" as now being absurd. You may be wondering what would have happened if she had said, "Oh, yes. You are correct." It would have been equally diagnostic indicating that the therapeutic process of cognitive restructuring had not been effective since she continued to maintain the faulty assumption.

Choosing to be Amusing; Humor as a Treatment Tool

Humor can be used to directly help clients change feelings, thoughts, behaviors, and to build the therapeutic alliance. For example, a simple way to offer a humor intervention that directly targets *emotion* is to have the client engage in a "humor visualization." The process is quite simple. When the client is emotionally distressed, ask them to rate that distress on a scale of 1-10. Then invite them to participate in an experiment with you. Ask the client to visualize and describe a time when they laughed so hard, they fell down. If they cannot recall such an event, then ask them to share something that they found particularly funny. After they share the humorous experience, ask them to again rate their emotional distress on that same scale of 1-10 as they had done moments before.

Invariably, the emotional distress will be reduced or even eliminated. Then, invite the client to repeat this process in times when they want to directly relieve their emotional distress.

As the client learns to manage emotional distress with humor visualization, the client also becomes increasingly confident (change in thinking) in having the power to

manage emotion. This confidence results in a cognitive shift making the emotional distress less concerning and therefore, less potent. While any "visualization" will serve as a "distraction" (from the negative thinking) and reduce emotional distress, a humor visualization is particularly powerful in reducing emotional distress. It is well established that, "humor and distressing emotions cannot occupy the same psychological space." The experience of humor directly dissolves distressing emotions.

Expanding Your "Comic" Vision; Increasing your Sense of Humor

Some therapists shy away from sharing humor with clients because they see themselves as not particularly funny and not skilled at generating humor. While the ability to generate humor does generally require training, there are simple ways to integrate humor without having to create it. In my early days of intervening with humor, I collected cartoons that illustrated psychological issues. Many of these cartoons offered perspective on specific mental health issues, and if a client presented one of those issues, I would share and discuss the cartoon. It was not necessary to learn humor. All I had to do was be prepared with cartoons, remember them in potentially therapeutic moments, and then to rely on my clinical skills to process the impact of the cartoon on the client.

Here is one example of using such a cartoon. We know that negative thinking leads to distressing emotions and/or problematic behaviors, and humor can target negative and distorted *thinking* directly by providing perspective. The "Ziggy" cartoon where Ziggy is lying on the psychiatrist's couch, and the psychiatrist says, "The whole world isn't against you. There are *billions* of people who don't care one way or the other" is an excellent example of a cognitive shift based on an alternate perspective. Ziggy's exaggerated belief that the whole world is against him is challenged by the alternate perspective that billions don't care. Presentation of this cartoon to a client who exaggerates creates perspective and helps shift negative thinking.

The best way to increase your sense of humor is to practice, practice, practice. In the beginning this practice should occur outside the therapeutic relationship; just like you initially learned traditional therapeutic interventions outside of the therapy room. You practiced therapy with peers, pseudo-clients, teachers, supervisors, trainers, etc. Practice humor with your friends, family, colleagues, and even strangers. Immerse yourself in humor by joining online joke lists or listening to, reading, or watching "funny stuff." Learn a few simple jokes, save cartoons, collect anecdotes, etc. These can be shared at clinical moments in therapy. This is called, "Planned Spontaneity." You planned by collecting humorous items, but your humor is shared spontaneously when the therapeutic moments arise.

My favorite example of planned spontaneity from my clinical practice was implanted and therefore, "planned" many years before I used the intervention. I was attending a

conference, and a colleague was presenting. During her presentation she told a personal story about her fifth-grade daughter who had been chosen by her teacher to be the chairperson for the class. When her daughter returned home from school and informed her mother of this honor, her mother was so proud. Later that day her father returned home from work, and excitedly, her mother rushed to him to share the wonderful news that their 11-year-old daughter had been chosen to be the class chairperson. Her father, with his engineering curiosity, approached his daughter and inquired, “What exactly does a class chairperson do?” With excitement and pride in her voice, his daughter replied, “At the end of each day, I collect all of the chairs and stack them on the side of the room.” I loved the story, and it became embedded in my mind. Little did I realize that perhaps 10 years later, it would become part of my clinical work.

It was indeed about 10 years later when the clinical moment presented itself. I was working with a couple who I had seen for many years. The issue of the day was that during their shopping expedition for a lounge chair for his new man cave, they could not agree. Following the female/male stereotypes, she wanted a chair that looked good, and he wanted one that was comfortable. They shared that they had been to numerous stores. She had seen ones that looked great (but were not comfortable for him), and he had seen some that were comfortable (but did not look good to her). This process had been going back and forth in therapy until I finally intervened, and yes, I imagine you have guessed where this is going. I activated my Planned Spontaneity moment and retrieved the memory of my colleague’s story and said, “I understand the problem completely. You both want to be the ‘Chairperson.’” This, of course, acknowledged that not only did each want to offer input on the selection of the chair, but each wanted to be in charge of the selection. Once identifying the power struggle to be the “chairperson” in a playful way, they successfully resolved the issue.

The intervention of “Chairperson” was “planned” in that it existed embedded in my memory from years prior, and I activated it in a moment where it had therapeutic potential. While I never could have anticipated using the “Chairperson” intervention with clients, it was certainly tailored to the therapeutic moment.

Finally, expand your “comic vision” by looking for the humor around you. In addition to looking for everyday events that may be meant to be humorous, “look” for those that are not intended to be humorous but are. Coming to the end of a street and seeing a cemetery before you with a street sign that reads “Dead End” is one example of a humorous moment that was not intended to be humorous.

The Punchline; Did You Get It?

I hope from the tone of this article that you understand that I am not promoting “humor therapy” or “laughter therapy.” In fact, I do not see these as therapies. Instead, I see the use of humor as a powerful tool within a traditional therapeutic relationship. Humor can

be integrated as an additional intervention added to those already employed by therapists. My use of humor in my practice was limited, and for most clients, that meant that I would occasionally add a humor intervention into my work. While my clients were certainly aware of my periodic use of humor, very few actually were aware of how or why I was using it as a clinical intervention. There were, however, some situations where I identified humor as a tool and taught clients to use humor in therapeutic ways (e.g., the humor visualization process discussed above).

If you choose to use humor as a therapeutic intervention, then trust your clinical skills to be able to address the client reaction (positive or negative) to that humor. As a skilled clinician you know how to respond to and manage client reactions to your interventions.

Humor can be a sophisticated and potent psychotherapeutic intervention when used skillfully, intentionally, and purposefully. If you want to increase your use of humor with clients, then seek training opportunities that can provide you with the theory, rationale, and application of humor, and then practice, practice, practice. While psychotherapy, for the most part, is a serious interaction, adding a bit of humor and playfulness can be fun and powerfully therapeutic.