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THE HUMOR IN THERAPY: THE HEALING POWER OF LAUGHTER

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SUMMARY

Although humour is a key element of human communication, and, for this reason, it is also present in therapeutic contexts, its use in this sense still remains largely untapped. The purpose of this article is to increase curiosity and broaden the reflection on the use of humour in the psychotherapeutic relationship. The first part is dedicated to a short review of the main theories on the origins of laughter. The second part will examine those studies reporting a beneficial effect of humour on physical well-being, while the third part will review those studies describing how humour can help improve psychological well-being. The fourth part will further explore the clinical effects of humour in the therapeutic relationship. Both the positive and negative effects of humour in the therapeutic relationship will be discussed. In addition, some brief examples are included.

Key words: *humour – psychotherapy - therapeutic alliance*

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What Causes an Entertained Reaction?

The explanatory models that attempted to tackle this issue were the following: the Incongruity-Resolution Theory, the Superiority Theory, and the Relief Theory.

The Incongruity-Resolution Theory

The act of laughing is part of a "mental game set-up" where what occurs is real and unreal at the same time. Humour is a game with a climax, an unexpected and illogical element (Fry 2001) that occurs when the stimulus is congruous and incongruous at the same time, deviating from the recipient's perspective. There are two stages: the initial portion, the central "object stage", and an implicit element that does not make sense, which is revealed in its paradoxical nature at the climax of the joke. Freud (1905) defined this element "unreasonable" or "meaningless", and identified its characteristics: contraposition between proper meaning and absurd, union of two contrasting representations and joyous judgement. Bateson (2006) in The Position of Humour in Human Communication refers to the reversal of the figure-ground and to paradox, as paradigm of the humorous act. Something becomes comedic when the meaning of an expression is interpreted as "proper", even though it was meant to be construed "figuratively", or when there is contradiction between words and body language. These meta-communicative passages discriminate and qualify reality: "what occurs makes us laugh." Incongruity is determined subjectively, that is, it must not go beyond what the recipient is comfortable dealing with, or be felt as threatening (Provine 2003). Koestler's "bisociation" theory has had a strong impact on clinical psychology (Koestler, cit. Forabosco 1987). Bisociation is a creative act: two elements belonging to two different registers are perceived as connected and incompatible at the same time. The cognitive field broadens (Arieti 1976) with problem solving or cognitive resolution functions, subverting the rules, motives, values and ideas: "the temporary abandonment of conscious control frees the mind from certain constraints required to regulate common reasoning, but which may hinder creative impulses; at the same time, different, more primitive mental organization processes are established" (Forabosco 1987).

Psychoanalytical theories

Psychoanalytical theories stress the essential role of humour as a tension reliever. Ever since the famous essay by Freud of 1905, Jokes and Their Relations to the Unconscious, jokes have been identified as part of the unconscious language. Freud identifies the contraposition between proper meaning and absurd, union of contrasting representations and the presence of joyous astonishment in the origin of laughter. Libidinal and aggressive impulses - which are sent back to the unconscious due to their unacceptability - are recovered through jokes, which would allow our mind to express what is inexpressible through linguistic, semantic and conceptual artifices. The enjoyment depends upon "psychic economy", by overcoming the internal or external obstacle and expressing our libidinal or aggressive impulses in a socially acceptable way. Even more, jokes are a moment of personal and narcissistic elevation, associated with the enjoyment resulting from intellectual activities and from self-affirmation. Freud reveals its relational nature: it takes two people to tell a joke, and three for it to be appreciated (Lothane 2007).

The Superiority Theory

The Superiority Theory identify jokes as the psychological need to laugh about the misfortunes of others to assert our superiority (Chaloult & Blondeau 2017, Martin 2007), obtaining a narcissistic gratification and a triumph of ego.

Humour, Pain and Physical Disorders

In popular language, "Cheer up, you'll get over it" highlights the healing power of laughter. Research

shows a reduction of pain and discomfort after listening and/or watching funny or relaxing comedy videotapes rather than neutral materials, especially in people with a high sense of humour (Cogan et al. 1987, Hudak et al. 1991). Humour decreases discomfort due to overcrowding (Aiello et al. 1983). For people that undergo surgery, watching comedy films after surgery reduces the quantity and intensity of lamentations and drugs request (Rotton et al. 1996), provided that the patient picks out the film. Laughing decreases pain in residential children and seniors, stress perceived during dental surgery, cardiovascular risk, and anxiety before a negative event (Schneider et al. 2018, Gelkopf & Kreitler 1996, Trice & Price Greathouse 1986). The mechanism concerns the production of catecholamines - responsible for the cerebral production of endorphins - an increased level of adrenaline and noradrenaline, slower breathing, and a reduction of blood pressure and muscular tension (Fry & Salameh 1987, Berk 1983 in Provine 2013). Echoing the research that indicated a decrease of Immunoglobins A in stressful situations, Marting & Dobbin (1988) indicate a significantly higher level of Immunoglobins A in the saliva (S-igA) of persons with high humour scores (Gelkopf & Kreither 1996, Fry & Salameh 1987, Martin & Dobbin 1988). Lefcourt (1990) describes a strengthening of the immune system. Berk (1989) finds a reduction of the stress hormone. However, due to some methodological flaws, the results of these studies cannot be deemed as entirely valid (Provine 2013).

Humour and Emotions: What Are the Effects?

Many studies attest the beneficial effect of humour in managing stress and reducing negative emotions. In stressful situations, it regulates the emotional response, mitigates the effects caused by stressful materials, and reduces occupational stress (Martin & Lefcourt 1983, Martin et al. 1993). Positive humour (affiliative humour and self-enhancing humour) is negatively related to burnout levels (Tümkaia 2007). In depressed senior patients, it increases personal satisfaction and resilience to negative events (Konradt et al.. 2013), and it has a protective effect on parents of hospitalized children (Schneider et al. 2018, Lamas 2015). Laughing reduces aggressive behaviour (Prerost 1987), and yet it improves performance in soldiers with a sense of humour in stressful situations (Bizi et al. 1988). Humour produces a cognitive-affective shift, with consequent decrease of arousal (Abel 2002, Martin et al. 1983). People with a high sense of humour experience less anxiety and sadness, employ issue-related and emotion-focused coping strategies, and receive more social support (Fry 1995, Martin & Lefcourt 1983, Yovetich et al. 1990). Humour is negatively related to neuroticism (Deaner & McConatha 1983). Not all studies support these assumptions. According to Porterfield (1987), humour does not mitigate negative life experiences, and, on the contrary, it can help develop prejudice and distorted behaviour, or it can be used against other people, even though it can directly mitigate depression. Both the appreciation and the production of humour reduce depression, as measured by the Beck Depression Inventory (Deaner et al. 1993). In agreement with the constructs of low self-esteem, impairment and personal vulnerability, people with high depression levels, as measured by the Beck Depression Inventory, enjoy cartoons with other people in them the most, although the differences between the experimental group and the control group are not significant. In case of Obsessive-Compulsive Disorder, it is counter-productive. There is a correlation between humour and perceived social cohesion, reduction of social fear and fostering of healthy work relationships (Sultanoff 2013, Fry 2001).

Humour and Therapy: Preliminary Considerations

Freud defined humour as “a refined and special skill”. Whether or not this skill should be used in psychological therapy, is a controversial subject. Men are born with an innate ability to laugh, but humour in psychotherapy requires a careful analysis. Although there are many articles on this subject, they are mainly anecdotal, and even Humour - the magazine published by the Multidisciplinary International Society for Humour - has published very few research plans. The AATH (American Association for Therapeutic Humour) defines it as: “any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life’s situation. 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” (Sultanoff 2000, cit. by Franzini 2001).

People with a sense of humour are perceived as socially appropriate, intelligent and capable of solving problems (Francescato 2002). If we combine these characteristics with empathy, acceptance and commitment, aren’t we describing a therapist? Maturity and flexibility, naturalness, emotional connection, good professional experience, empathy and positive regard, as well as moral and ethical sense are what describes a “good therapist”, whether s/he uses this tool or not (Scarinci et al. 2018, Leus et al. 2017, Sultanoff 2013, Salameh 1987).

Kubie (1971), one of the most prominent opponents to the use of humour, states: “Humour has its essential place in life. Let us leave it where it is, and take note that there is an area of life where it can have a marginal role, or maybe no role at all: psychotherapy.” The author paved the way to a reflection: how consciously and “therapeutically” employed is humour? Therapists consider themselves as humour appreciative, rather than active humourists (Lefcourt & Martin 1986), and have little awareness of a communication method they widely use (Gibson & Tantam 2018). International literature (Scarinci 2018, Chaloult & Blondeau 2017, Franzini

2001) reports the lack of specific training, despite humour being used in therapy. Franzini (2001) suggests adding it to specialist training, and recommends its use in supervision, as element to strengthen the supervisor-supervisee relationship. Salameh (1987), created a Humour Immersion Training with numerous exercises and role-plays.

In therapeutic practice, it has been considered: expression of nearness, positive feedback, coping ability to mitigate the effects of stressful events, cognitive skill to shift away and distance oneself from negative events, and ability to grasp paradox (and therefore change). Laughing is considered essential to recover the healthy and constructive parts of oneself, by accessing a meta-position that allows distancing negative emotions. In all these forms, it is construed as a useful tool (Gibson & Tantam 2018, Scarinci et al. 2018, Cann et al. 2008; Querini & Lubrani 2009, Abel 2002, Martin & Lefcourt 1983, Arieti 1976).

Ventis (2001) suggests its use as stand-alone technique to desensitize when treating phobias; Prerost suggests the Humorous Imagery Situation Technique (HIST; Prerost 1994), useful to reduce anxious symptoms in averagely depressed patients (Ciera et al. 2015). Although these studies are promising, it is hard to employ humour as a stand-alone technique. Research on its efficacy highlight a positive correlation between humour and effectiveness, both in the therapist and in patients, although severe patients report a lower level of subjective perception (Ponchielli 2018). In conclusion, it is essential to analyse in depth the use of humour in therapeutic relations, the only feasible path in a psychotherapeutic context.

The Five Uses of Positive Humour

Humour in clinical use (metaphor, narrations, film production, therapist's self-derision, jokes or gags and imaginative techniques), (Scarinci 2018, Taber et al. 2011, Fry 2001, Prerost 1994) is precious: during the assessment phase; to build/monitor the therapeutic alliance; for cognitive development, emotional adjustment and as a model.

During the assessment phase, it is important to observe if and how the patient adds light elements to the narration, showing his level of insight and the use of more mature defence mechanisms (Chaloult & Blondeau 2017). During the second session, a patient expresses her insight through this gag: "I am constantly unhappy. I should have been a poet... The Leopardi of the South." It is essential to understand the personal, ethnic and religious characteristics, as well as the attachment quality. An insecure attachment leads the patient to appreciate humour less, and to use it less as a stress management and interpersonal distance adjustment strategy. A negative vision of oneself and of the other person, perceived as distant, unpredictable or hostile requires particular caution. People with an insecure attachment are least likely to resort to an affiliative style, favouring maladaptive behaviours (Cann et al. 2008). Kelly (1955) suggested the use of a dedicated assessment tool: a type of self-characterization where the patient has to write a "humorous sketch", as if they were the character of a comedy. Self-characterization is a tool to assess the patient's personality, affective and relational aspects, and central topics, whose analysis can be performed "along three structural dimensions: focused contexts, storytelling and content" (Scarinci 2018), causing the topics the patient is willing to joke about to emerge. It is essential to preserve the primary topic of personal suffering and anything related to it (Chaloult & Blondeau 2017).

To build and preserve the therapeutic alliance, it helps the patient perceive a greater emphatic connection, it fosters a shared construction of the issue, and it may highlight ambivalent requests. "Psychotherapy as a relationship is unique, and the methods by which they build intimacy in the therapeutic alliance are generally different from the methods by which they build intimacy in other types of relationships. Although humour is present in both personal and clinical relationships, its use in therapy is selective and for the benefit to the client" (Sultanoff 2013).

Let us analyse the following case

During the first session with A., the therapist finds out he has already had a first session with five other therapists. Believing that A.'s behaviour needs to be furthered explored, the therapist tries to probe around, asking what did not go well with the previous first sessions. A. tells her he did not like the other therapists, and that, in any case, he "has trust issues". The therapist notices how painful A.'s emotional position is: his need to get help and the impossibility to get it; she decides to use a joke, and, pretending to stroke an imaginary beard, she says: "You and I, Mr. A, are in serious trouble!" The joke, accompanied by a big smile, throws him off for a few seconds; then his face lights up, and he smiles back heartily, asking the therapist, "What can we do?". The use of plural is the first hint of cooperation and parity in building a human and therapeutic alliance to define a shared goal and reach pain resolution.

In this context, humour created nearness, made the therapist accessible and authentic, and made the patient relax before the daunting task of opening up before a stranger (Chaloult & Blondeau 2017, Taber et al. 2011, Trenkle 2009, Martin 2007). The playful mode highlighted a nodal point of its use, returning it in a way that allowed content to overcome the patient's defence, creating a first hint of balanced therapeutic alliance, and conveying amiability. This movement regulates distance, transference and balance between the primary and the secondary process (Fabian 2017).

The third contribution is the development of new perspectives and standpoints, and the improvement of the problem solving ability and of creativity. Humour is useful to explain both some therapeutic passages and the

way things work to the patient, preventing the boredom of "persistent repetition of concepts and explanations", and to foster recollection (Ellis 1976).

To this end, let us see G.'s case

G is a young woman with anxiety issues that cause her to vomit before going to work. With this patient, it was hard to share a working assumption, because she simply wants to be freed from her anxiety, without having to give up the idea of "I have to do everything right, or other people will judge me for it", so she thinks she can't ever fail. Her attitude toward others is absolutely not judgemental. G. struggles to accept that this dysfunctional idea may be the source of her malaise, and does not understand the negative implications of her way of thinking. Then, the therapist tells a funny story to explain her patient's standpoint: the Mother Superior of a convent meets the nun in charge of cooking, and praises a dish, calling it a "great dish", but when the nun tells her the plate is for her, the Mother Superior says, "What? This little thing?" If told with the right gestures, the story is light and funny. G. laughs: "You are right, it is me, the other way around. I'm just like that!"

The fourth use involves affect regulation (Chaloult & Blondeau 2017, Scarinci et al. 2018, Gelkopf & Kreitler 1996). In the REBT (Rational Emotional Behaviour Therapy), humour helps restructuring dysfunctional and catastrophic contents, and the negative implications on the personal value - REBT's goal (Ellis 1976) - to show new ways to react to activating situations. The last aspect involves the positive reinforcement value that the therapist can portray by acting as a model and reinforcing an attitude with a light vision of life.

Ventis (1987) warns us to "remember that the use of humour and laughter in therapy is not a goal in itself, but one option for facilitating therapy", making it clear that it must be applied according to the same principles that guide all therapeutic interventions (Gibson & Tantam 2018, Richman 2001, Dimmer et al. 1990), based on the therapeutic stage, the type of topic discussed, the needs and the level of emotional understanding of the patient.

Negative Humour

Just like many other therapeutic interventions, humour can have negative effects and pose some risks (Haig 1986), when it is used to humiliate or diminish self-esteem, and attack the patient's intelligence and well-being (Chaloult & Blondeau 2017, Franzini 2001, Kubie 1971). It is contraindicated: in those patients that have suffered humiliation, intimidation or who can feel diminished; those patients with paranoid or narcissistic traits (Salameh 1987); in those cases when it is ill-suffered by the patient or the therapist (Martin et al. 2003); if it prevents awareness (Kubie 1971) or if it is premature with respect to the therapeutic progress, alliance and patient's insight capacity. In therapists, it affects the "required confidentiality" (Kubie 1971) and it can hide conscious or unconscious negative counter-transference emotions, breaking the therapeutic alliance and triggering a paranoid or distancing reaction (Chaloult & Blondeau 2017, Fabian 2017, Salameh 1987).

Let us review R.'s case

R, 65 years old, is in therapy for anxiety and depression. His obsessive, narcissistic and controlling behaviour make him a very complicated patient, who struggles to emotionally connect to other people, who only receive his reprimands or complaints. One day, the therapist breaks her foot, and shows up at the office in a cast. R., who usually waits for her in the parking lot to start the session right away, looks unhappy not to find her in her usual place, and loquaciously tells her how impolite this is. Without giving importance to his interlocutor's conditions, he starts complaining. While the therapist struggles between the crutches, her purse, her keys, one of her crutches falls. The sound interrupts R., who, angered, brings his hand to his sides, "Can you reach it yourself... You know..." The therapist, visibly annoyed, stops him, sarcastic: "Sure! Don't worry... I wouldn't want you to hurt your back." This sarcastic and aggressive comment breaks the therapeutic alliance, which must be re-discussed in session (Martin et all. 2003).

A joke is negative when it is not relevant to the therapeutic goal (Pierce 1994), when it is excessive (Ellis 1976), when it only rewards the therapist in a narcissistic way (Chaloult & Blondeau 2017, Schneider et al. 2018) or when it is a mutual form of captatio benevolantie. It must not be used to shift the focus from unpleasant topics and emotions, to prove that the therapist or the therapy is "not dangerous" (Pierce 1994). The illusion created by humour hides the lack of therapy.

Let us review M.'s case

M. is a patient with Binge Eating Disorder, Class 2 obesity, sent to therapy by the dietician, because he does not comply with the diet; he proves to be friendly and cooperating, right from the start. Once therapy starts, the therapist realizes the she often feels gratified, but the patient does not make any progress. In supervision, she realizes M. and her are "indulging" each other in an illusion, maintained by the use of humour as shield to avoid tackling any emotional topic. When she understands this mechanism, the therapist takes the lead again. Laughing can be a way to flee from pain, to mask the issues, a seductive mode that bridges the gap with the therapist.

Let us review G.'s case

G. is an intelligent and experienced man, proud of his career, in therapy for Pathological Gambling. He has two sides: on one side, he is a valid and skilled man, and on the other side, he is an out-of-control person, who gambles in the most run-down places, Dr. Jekyll and Mr. Hyde. His fabling skills are disruptive and make the sessions lighter. Often, when they reach a topic that is

too emotionally daunting, G. finds a way to add a joke or a story, something that slows progress down to avoid tackling the difficult core. This aspect has been discussed during therapy. Turning the emotional axis upside down places back the patient in a safe area, and "neutralizes" the therapist, seducing him with positive emotional aspects to maintain G.'s false split ego, and, at the same time, portraying his impossibility to change.

It is the opinion of this author that keeping personal traits out of therapy is like tending for a bee (something notoriously impossible!). And so, laughter, jokes and gags have become part of the way I do therapy. Out of this came the decision and the obligation to further analyse its use, because, if the idea of doing therapy while having fun is fascinating, the need to explore and improve the use of this technique in the therapeutic style is absolutely essential.

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