Psychotherapy and Humor: A Theoretical Study

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PSYCHOTHERAPY AND HUMOR:
A THEORETICAL STUDY

by

Robert B. Koach

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Degree of Master of Arts

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I wish to convey my sincere appreciation to all those graduate and undergraduate professors who have contributed to both the preparation of this thesis and my professional education in psychology. Some of these at Western Michigan University include Professors Malcolm Robertson, James Lowe, and Christopher Koronakos. At Baldwin Wallace College, Professor S. Lee Whiteman and the entire Department of Psychology deserve many thanks. To these names I wish to add that of my fiancee, Ms. Della DiPietro, without whom this accomplishment would not have come to pass. The financial support of the University which I received in the form of Assistantships and paid Internships has also been greatly appreciated.

Robert B. Koach
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Introduction

This is a report of a theoretical investigation into the interrelationship between humor and psychotherapy. The question, "To what extent do theories of cure, i.e., theories that attempt to explain and predict change for the better, allow for humor?", was stimulated by a personal investment on the part of the author. It had become unavoidably obvious that most approaches to psychotherapy were humorous at one time or another. What's more, it seemed that funny experiences were generally beneficial for clients, without respect to the particular brand of therapy being employed.

To illustrate these observations, consider this narrative from the history of a client called "Mr. Elephant," as reported by Haley (1963):

A patient suffered from an involuntary squint which occurred whenever anyone behaved hostily toward him . . . . He was a young executive in a selling situation where he needed to appear self-confident . . . and so the squint was a handicap . . . . The patient wanted to get over this symptom quickly, and it was clear that an approach in terms of self-understanding . . . would not be quickly productive . . . he had been through 3 years of psychoanalysis with that emphasis.

The fact that the patient felt condescending about a relationship with a hypnotist made it possible to arrange his situation . . . . He did not prove to be a good hypnotic subject; . . . so another tactic was used. First, a question was raised whether or not he had ever dealt with his name in his psychoanalysis, since it was such an odd name. We will call him Mr. Elephant. He replied that he had not. He became somewhat defensive about this, pointing out that he had probably not dealt with many things in his analysis. He was
then told that for this particular treatment it was extremely important that he know he squinted each time it happened. When asked how often he had squinted during the interview up to that point, he was uncertain. He was advised that it was important . . . so important that it was necessary to point the squint out to him each time in such a way that he would be increasingly aware of it . . . . Each time he squinted, the therapist would squint back at him, thereby calling the squint forcefully to his attention. It was pointed out that this procedure might be painful to him, but it was for a good cause. He readily agreed to this procedure . . . . However, the question was then raised: How could the therapist know if the patient had noticed him squinting back at him? It was then decided . . . that the patient would acknowledge that he noticed the therapist squinting back at him by stating his name each time it happened.

In a few moments the patient squinted, the therapist squinted back, and the patient said "Elephant." He asked politely if that was what was wanted . . . . Once again he squinted, the therapist squinted back, and the patient said "Elephant." Since the patient habitually squinted every few moments, this procedure was repeated every few moments . . . . The patient began to get angry . . . . As the interview continued, the patient began to react to the squinting back as if it was an aggressive or hostile act . . . . Naturally his squinting increased. Yet, the more it increased, the more he was forced to go through this unpleasant procedure. Toward the end of the interview the patient began to squint less and less. At the beginning of the next session, he was asked to go through the same procedure once again. He did not squint during an entire hour and a half session. (pp. 56-58)

Other examples might be supplied here, such as the often hilarious elements in the therapy of Ellis, including such coined labels as "musterbating," "wormhood," and "nuttiness" (e.g., Ellis, 1973). The reality strongly appeared to be that humor, at the very least, existed in psychotherapy.

The author's hypothesis that a relationship could be delineated between humor and psychotherapy was for the most part based on the fact of their coexistence. Further support for the hypothesis was based upon the author's experience as a beginning
therapist, at which time he found it nearly impossible to implement any intervention in a stern or humorless way. The hunch was that while a humorous approach to therapy certainly said something about the therapist's mental status, it might also be saying something about mental health in general!

Adler, Sullivan, and May had strongly hinted at a relationship between humor and psychotherapy. Adler (Ansbacher, 1977) would frequently tell a patient that "there are jokes altogether like the structure of his peculiar neurosis, and that therefore, the latter could also be taken more lightly than he does" (p. 29). Sullivan (1954) defined humor as "the capacity for maintaining a sense of proportion as to one's importance in the life situations in which one finds oneself" (p. 182). He would regularly assess a patient's sense of humor in the first interview. May's (1967) definition closely resembled that of Sullivan:

> It is not generally realized how closely one's sense of humor is connected with one's sense of selfhood... it is the expression of our uniquely human capacity to experience ourselves as subjects who are not swallowed up in the objective situation. It is the healthy way of feeling "distance" between one's self and the problem... looking at one's problem with perspective. (pp. 53-54)

Supported by these statements, the author drew some generalizations that seemed to be undergirded by both common sense and personal observation.

Proportion seemed to be a common theme in attempts to relate humor to mental health. For instance, the observation has been made of the lack of proportion in those labeled...
mentally ill. To illustrate further, it is safe to predict that at this moment, somewhere, all of us are being talked or thought about (i.e., by friends, family, people at the office) to some degree. "So what!" is the response the autistic, referential-thinking paranoid can not (or will not) make. Such a person is said to have an over-blown sense of his own importance in proportion to the world. He probably has little sense of humor.

In the author's judgement, there does seem to be a relationship between happenings that are funny (or not) and events that accompany improved mental health. In the present investigation, it is reasoned that one of these events, psychotherapy, should contain within its theories of cure, an implicit validation of the use of humorous interventions.

The goal of the investigation was to select several theories of cure and to examine them for such validation. A more specific objective within that general goal was the formulation of hypotheses that would describe the relationship between that which is funny and the outcome of psychotherapy. Because of the large scope of the subject area of humor and therapy, the investigation was limited to three approaches: (1) psychoanalysis, (2) client-centered therapy, and (3) elements of behavior therapy. These theories in particular were thought to encompass the cognitive, affective and behavioral modalities within which psychotherapies are usually grouped. They were also considered to be germane to a variety of other
theories of cure, to which the resulting conclusions might be
generalized.

The methodology was mainly a review of the literatures of
the three selected cure theories, together with a less detail-
ed review of the literature of humor. For each theory of cure,
two questions served as a guide. The first was, "Within that
school of thought only, what constructs, intervening variables,
or other elements of the cure theory would provide a rationale
for the use of humor?" The second question was, "Are there
certain theories or notions on humor that are more compatible
than others with that particular cure theory?" The assumption
was made that there is a relationship between humor and therapy.
No hypotheses was made as to the comparative effectiveness of
the three cure theories; nor was any made as to the correct-
ness of various explanations of humor.

The present investigation made no attempt to synthesize
one universal definition of humor from the large number avail-
able in numerous disciplines. The difficulties involved in
4) called "this little problem" are notorious. Chapman and
Foot (1976) point out one of the difficulties, namely, that
humor can be viewed as a stimulus, a response, or a disposition.
Virtually all definitions of humor are tightly bound to a par-
ticular theory of humor. Therefore, the investigation report-
ed here relied upon an everyday understanding of the word,
represented by two definitions found in the Dictionary of
Behavioral Science (Wolman, 1973). They are (1) "a positive, pleasant emotional attitude," and (2) "a comical attitude or expression" (p. 179). Taken together, these definitions are broad enough to subsume all others encountered during the research.

Within the present study, the author defends the position that humor is allowable within the three selected psychotherapeutic theories. Where possible, care is taken to present both pro and con points of view, because the quality of the debate by professionals over the use of humor contributed greatly to the author's conclusions. Three hypotheses are presented in the summary section, which reflect the author's understanding of the relationship between humor and psychotherapy.
Three Cure Theories and Humor

In this chapter the author outlines those aspects of psychoanalytic, client-centered, and behavioral psychotherapy that lend themselves to the use of humorous interventions. Humor is acknowledged as a helpful therapeutic strategy by relatively few clinicians, though in the author's judgement it would be hard to imagine an approach to therapy that does not from time to time include a funny happening. Both proponents and opponents of the use of humor have generally failed to examine their theories of cure to validate their stands. While most other elements (i.e., the role of the therapist, techniques, therapeutic objectives) in psychotherapies are justified by their relationships to individual cure theories, clinicians fail to consult their cure theories with respect to humor. Typically, therapists make one of two assumptions: (1) Humor is justified only as a coincidental byproduct of psychotherapy, or (2) Humor is ruled out on a priori basis.

On the other hand, some clinicians who have taken positions on the planned use of humor have consulted their theories of cure for support. Many aspects of humor which are labeled as inimical by opponents, can also be viewed as rationales in favor of its utilization by those of a different theoretical persuasion. The primary factor in taking a pro or con position appears to be the individual clinician's interpretation of a cure theory, rather than the theory itself. The following
overview of the three selected cure theories is intended to encourage the acceptance of therapeutic humor on legitimate theoretical and pragmatic grounds. Examples of the use of that which is funny are also provided for each theory of cure.

**Psychoanalysis**

Psychoanalysts have devoted a significant amount of energy to the debate on humor. This is almost certainly due to Freud's (1905/1938) publication, which represents psychology's most comprehensive theory of humor. Something of an enigma has resulted from the fact that Freud's interest in humor was never directly applied to his theory of psychotherapeutic cure. It appears to the author that Freud's interest in the everyday roles of the ludicrous was mainly heuristic (i.e., an attempt to expand the explanatory value of psychoanalysis), as was originally the case with respect to dreams and commonplace slips of the tongue. It is therefore unclear as to whether or not Freud did or would have incorporated the intentional use of humor into psychoanalysis, in spite of the great separate contributions he made in each area, i.e., humor and psychotherapy. Several authors have commented that Freud was known to tell his patients an occasional joke, but any conclusions drawn as to his views on the purposeful use of therapeutic humor are difficult to substantiate.

A case made against humor: Kubie's "dangers." As a psychoanalyst and commentator on professional issues, Kubie (1971)
opposes the use of humor in psychotherapy on numerous grounds. Among them is that it almost always represents the therapist's attempt to enjoy himself at the patient's expense. He strongly implies that because humor in everyday life can be used as a weapon, only the most experienced therapists can use it for the benefit of their patients. Kubie's objections are paraphrased as follows:

1. There is no reason to believe that what will be enjoyable to the therapist will be therapeutic for the patient.

2. Although humor can reduce interpersonal distance, it can also cause some people to feel sealed-off and frightened.

3. Humor, because it can mask hostility in addition to expressing true warmth, is a potentially unkind weapon.

4. A patient's stream of thought can be interrupted by therapist humor.

5. Patients will be unable to determine if the therapist is serious or kidding after humor is used.

6. Patients will feel pressured to treat lightly whatever the therapist treats lightly.

7. In using humor to defend against his own anxiety, the therapist teaches the patient likewise.

8. Anger and other negative feelings are less apt to be expressed when humor is used.

9. When a therapist stumbles upon a patient's buried reactions to earlier humor, he can unknowingly mock or tease symptoms and fantasies of childhood that are associated with cruel humor.
10. Humor reduces the necessary distance or "incognito" of the therapist, thus removing the patient's protection from the therapist's frailties.

11. A strong emotional involvement is fostered by sharing humor with a patient. This amounts to the therapist putting himself on display or "wooing" the patient.

12. Therapists who do use humor must feel guilty about it, since they rarely include accounts of humor use in the reports of their therapy.

A case made for humor: Rosenheim's response. Rosenheim (1974) has responded to Kubie's warnings about humor. From what evidently is a different interpretation of psychoanalytic cure theory, he argues that humor enhances therapy. According to Rosenheim, the important question regarding therapeutic humor is: "Who does what with whom, why, when, and how?" He goes on to make a point by point rebuttal of Kubie's (1971) warnings. His position is summarized below:

1. As an interpersonal experience, humor can be uniquely corrective in that it broadens a patient's ability to view himself and others objectively.

2. A therapist using the argument that humor disrupts therapeutic distance (i.e., "blank screen" or "incognito") may fear the closeness made possible by humor because of his own low ego strength.

3. While humor sometimes has a critical or aggressive message at the verbal level, its nonverbal message frequently
conveys support and encouragement.

4. Introduction of humor by the therapist is a valuable assessment tool. If the patient views humor as a threat or mock, therapy progress may indeed be temporarily halted. However, if he accepts it, he has demonstrated the capacity for self-exploration.

5. Humor does produce associations with the patient's transferential background, but usually these are productive associations.

6. Emotional expression, so lacking in the repertoires of many patients, can be facilitated with humor. While it is not the main duty of therapists to amuse, patients who are overly stern or gloomy need to be shown the lighter side of life.

7. Especially with adolescents, humor can counteract a tendency to resist talking to a therapist. Rosenheim provides an example in which he responds to a teenage male who has just called him stupid: "You have discovered my secret so quickly? You must be very bright." This produced a moment of startled hesitation, followed by, "O.K., let me give you a chance.", from the teenager (p. 589).

8. Two possible errors in the application of humor are mentioned, both resulting from countertransference. On the one hand, a therapist may fail to respond to a patient's self-humor. This is often due to a beginning therapist's attempts to protect an already excessive therapeutic distance. On the other, a
therapist who used too much humor may be intending to degrade or attack the patient. This is a potential pitfall in all aspects of therapist behavior, including but not limited to humor.

As will be demonstrated, Freud's final theory of cure depends heavily on the construct, libido. The free expression of repressed libido is clearly the main thrust of psychoanalytic cure. The different stances of Kubie (1971) and Rosenheim (1974) presented above, can be collapsed into opposite positions as to whether humor enhances or detracts from the free expression of repressed libido. In the present author's judgement, Rosenheim's propositions effectively counter Kubie's list of contraindications for a funny Freudian cure. Furthermore, the following overview of Freud's "final theory of cure" (Rychlak, 1973) supports the author's contention that humorous experiences facilitate the free expression of repressed libido and its associated material.

Theory of cure. Psychoanalysis is the only major system addressing itself to both humor and psychotherapy. Although the two separate phenomena have not been conclusively linked together, the fact that there exists both a psychoanalytic theory of cure and a psychoanalytic theory of the ludicrous permits an uniquely direct attack on the question of their interrelationship. Freud's final theory and technique of cure have been rigorously abstracted and explained by countless authors. Among them are Rychlak (1973) and Fine (1973). The present author
relied upon them, and the reader is directed to these sources for details beyond the scope of this report.

Psychoanalytic cure results from the analyst's encouragement of the free expression of libido. Illness has previously been manifested because libidinal energy is trapped or fixated during the patient's development. The material associated with this libido is repressed, and is therefore not available to the patient's ego. The analyst's molar goal is the achievement of insight, and the concommitant elimination of pathological repression and regression. This can be stated in terms of the psychoanalytic levels of consciousness: making the unconscious material, generally associated with the id and superego, available to the consciousness of the patient's ego, by working through the resistance. More specific objectives defining psychoanalytic cure include (1) the facilitation of transference; (2) the development of a transformed neurosis; (3) enhancing cathexis to the analyst; (4) the elimination of pathological censorship by the superego; (5) supporting the ego, and (6) establishing a variety of available conscious and unconscious ego defense mechanisms, which then replace the patient's overreliance upon repression and regression.

In the next section the author summarizes a continuum of cure, characterized by six stages through which the patient passes during psychoanalytic therapy. Libido will be established as the common thread in the cure process, as it is redirected by the analyst to the patient's ego.
**Libido: Common construct in psychoanalysis and cure.**

The following stages of psychoanalytic cure reflect the dynamics of libidinal energy cathexis as they manifest themselves during treatment:

1. Libidinal energy that is fixated at a primal psychosexual stage (most often the oedipal) causes the neurotic individual difficulties in relating to people in the present. The patient frequently regresses to defend against anxiety produced when people encountered in the present frustrate (i.e., do not provide resolution to) the need to feel loved. In doing so, the patient is reenacting his unresolved oedipal conflict, transferring to others the frustrated feelings associated with idealized parental people (love objects) from his past.

2. Transference is also an important aspect of cure. In therapy the patient transfers feelings to the therapist in three ways: (a) positive transference to the therapist as the therapist; (b) positive transference to the therapist as an idealized loved one from the past; and (c) negative transference to the therapist as an idealized loved one from the past. It is through positive transference to the therapist as the therapist that the patient is influenced to change in the direction of cure.

3. Cure begins when the patient starts to gain insight into his early childhood. Due to the type (a) transference relationship with the analyst, resistance, which is due to types (b) and (c) transference, is overcome.

4. As the cure process continues, the patient develops an
artificial or transformed neurosis, that is, a miniature of the patient's past and current life outside of the consulting room.

5. The patient must be able to cathect (i.e., by means of positive and negative transference) libido to the analyst. By means of this transference neurosis, the patient's ego gleans insight from the overt interpretations of the analyst's ego. As id-related libido is given free expression, the censorship functions of the patient's superego are thus lessened. Patients who cannot cathect, those suffering from the narcissistic neuroses (e.g., the schizophrenias), have no libido to invest in the outside world. They can not be helped by psychoanalytic therapy.

6. The patient slowly comes to direct libido to the analyst, who refuses to allow further repressions. This strengthens the patient's ego, releases formerly unconscious material from the id, and subverts the repressive forces of the superego. The analyst helps the conscious to gain control over the unconscious by directing the libidinal energy, which is set free in transference, back to the patient's ego.

In the author's judgement, nothing in the above summary of psychoanalytic cure theory contraindicates the use of humor. In fact, the author contends that laugh-provoking events, jokes, and other humor that might be shared between therapist and patient, would enhance the cure process to the extent that the free expression of repressed libido and its associated material
is enhanced. This assertion is based upon the fact that the free expression of repressed libido is also the main thrust in the psychoanalytic theory of the ludicrous. In the following section the author continues to trace libido dynamics as the common thread that links psychoanalytic cure and the use of humor.

**Libido: Common construct in psychoanalysis and humor.**

Freud's (1905/1938) treatise on the ludicrous is divided into interdependent sections on "wit," "the comic," and "humor." Together, these three theories make up what is properly called Freud's theory of the ludicrous. The reader is referred to Koestler (1949) for a summary and critique of Freud's theory of the ludicrous that is not possible within the scope of the present investigation.

The author's analysis of these "ludicrous theories" (no pun intended) finds them falling into a group of "release" or "relief" theories of humor (Keith-Spiegel, 1972; Monro, 1968). These theories generally hold that humor functions to liberate or unblock the tensions of everyday life.

Freud (1905/1938) posited that the ludicrous always permits a savings in the expenditure of libido. The function of all three forms of the ludicrous is determined by the principle of economy and its associated mechanisms. This economy results in a libidinal net gain. The redundant libido is pleasurably discharged in laughter. Just as the mechanisms of economy in dream work (e.g., symbolization, condensation, etc.) explain
the manifest content of dreams, they also explain jokes, sarcasm, and all other forms of the ludicrous. Here is Freud's summary of these libido economics: "It has seemed to us that the pleasure of wit originates from an economy of expenditure of inhibition, of the comic from an economy of expenditure in thought, and of humor from an economy of expenditure in feeling" (p. 803).

Libido is economized because normal rational controls, generally labeled as superego censorship functions, are relaxed while something ludicrous is taking place. Temporary regression to a childish, more unconscious way of thinking takes place, and the id experiences this as pleasurable. The libido savings results both from reduced consumption associated with reduced censorship, and from the economy of mechanisms like symbolization and condensation. An analogy can be drawn here with heating a home: One can save energy by: (1) closing-off rooms, and (2) relying upon the heat generated in cooking to warm the kitchen; superego is to closed-off rooms, as symbolization is to cooking heat.

Freud (1905/1938) draws attention to two basic differences between wit work and dream work. First, the ludicrous is often a much less distorted form of regression to protect the ego than are dreams; second, the ludicrous is a much more social way of managing one's psyche. More specifically Freud noted that:

Not only does the dream find it unnecessary to place
any value on intelligibleness, but it must even guard against being understood. . . it can exist only in disguised form . . . producing undedipherable distortions . . . through a regressive detour of hallucinations. Wit on the other hand, is the most social of all those psychic functions whose aim is to gain pleasure. . . . The dream serves preponderantly to guard against pain, while wit serves to acquire pleasure; in these two aims all our psychic activities meet. (pp. 760-761)

Rationales for using the ludicrous in psychoanalytic therapy abound here. Elements of cure such as improving cathexis to the analyst, supporting the ego, and subverting the superego, can all be enhanced based on a coalition with Freudian explanations of the dynamics of the ludicrous. As a less distorted, more social mode of expressing libido, humor must be considered at least as important to the patient and the analyst as dreams are! Also, if the elimination of repression is a salient goal of psychoanalysis, it is safe to conclude that the ludicrous facilitates the opposite of repression, i.e., expression. Before drawing more detailed conclusions about the relationship between humor and psychoanalytic therapy, some attention to technique is in order. Application of psychoanalytic cure theory, with or without the use of humor, depends upon technical considerations.

**Technical considerations.** Psychoanalytic technique must be differentiated from the theory of cure as a whole. The addition of humor into the repertoires of analysts is compatible with the accepted strategies of cure. The four main psychoanalytic techniques are described here:

1. Free-association, whereby the patient says whatever
comes to mind (sometimes in response to stimuli from the analyst), is the main vehicle by which the analyst makes available to the conscious, material released by the unconscious. The past, especially early childhood, forms the background against which present events are interpreted.

2. Dream interpretation ties the manifest content (the surface elements of the dream, partially constructed of the preceding day's residue) to the latent, or unconscious content of the dream. The dream conforms to the principle of economy. It utilizes the mechanisms of symbolization, condensation, and displacement. Dreams are usually analyzed on the day following the dream.

3. Resistance analysis is the analyst's interpretation to the patient of events he perceives as significant. Resistance can take the form of the patient refusing to discuss particular topics, or coming late to an appointment, or a variety of other avoidances. In interpreting these events to the patient, the analyst labels the painful or threatening material which the resistance serves to block from awareness.

4. Transference analysis permits the distressing relationships from the patient's childhood to be interpreted in terms of the therapeutic relationship. The analyst labels instances in which the patient is relating to him as though he was an idealized loved one from the past.

Much innovation to this basic cure strategy has evolved within a diverse neo-Freudian approach. For example, one
school of psychoanalytic thought calls itself psychodynamic. Its technical innovations reflect its theoretical stress upon the psychosexual stages (i.e., Freud's dynamic theory). Another school of thought is ego psychology. In turn, its techniques reflect the emphasis upon the ego defense mechanisms. However, all are best viewed as extensions of the common theory of cure and its goals, which again are: (1) the facilitation of transference; (2) the development of a transformed neurosis; (3) enhancing cathexis to the analyst; (4) the elimination of pathological censorship by the superego; (5) supporting the ego; and (6) establishing a variety of available conscious and unconscious ego defense mechanisms, which thus replace the patient's over-reliance upon repression and regression. With further innovation, involving minor modifications and additions, humor is well within the grasp of psychoanalytic therapists.

**A funny Freudian cure.** A general rationale for the use of the ludicrous in psychoanalysis is clear. To the extent that humor enhances the free expression of repressed libido and its associated material, the above theory and technique of cure is also enhanced. Freud's theories of the ludicrous have provided the foundation for the following conclusions:

1. The formation of transference and the transformed neurosis can be enhanced by the use of that which is funny. Specifically, because humor encourages the free expression of repressed libido it encourages types a, b, and c transference.
2. Cathexis to the analyst is improved, which enhances the quantity and quality of the analyst's interpretations, and leads to improved insight.

3. When humor is utilized, the libido released through analysis of transference is less available for possible further repression, more available for redirection to the patient's ego.

4. The well developed superego, typical of many patients, tends to be incapacitated through the use of humor. Repressed emotions are more apt to be expressed.

5. Resistance can be circumvented entirely, or more effectively analyzed by using humor.

6. Humor, as a disguised rather than a distorted representation of the patient's conflicts, is much more available for interpretation than are many other forms of expression. Humor can communicate resistance: it can symbolically represent what the patient is working through.

7. Because humor is social rather than asocial in nature, it encourages cathexis, leading to more and better relationships between the patient and other people.

8. All of the techniques of psychoanalysis can benefit from the application of humor. For example, free-association can lead to humorous responses and humorous interpretations. Dream interpretation can be supplemented by the analysis of humor. Resistance can take humorous forms, or it can be analyzed using humorous interpretations. And, transference is encouraged, with improved potential for interpretation when humor is used.
Applications might include the analyst's interpretations of the patient's freely-associated humor, or humor induced by the analyst. This could either replace or pave the way for a more direct interpretation. For example, using a joke that represents important material might facilitate this. If the patient is able to experience the joke as funny, the analyst is free to interpret the associated material with less chance of additional repression.

Legman (1975) has compiled thousands of jokes blatantly labeled "dirty." The fact that he has patterned his analysis and rationale of the dirty joke after Freud is evident in the following:

It may be stated as axiomatic that: A person's favorite joke is the key to that person's character, a rule of thumb all the more invariable in highly neurotic people . . . . I would go so far as to paraphrase the proverb about eating, and say, "Tell me what you laugh at and I will tell you what you are." (Legman, 1975, pp. 16-17)

Legman has grouped jokes according to theme, e.g., homosexuality, prostitution, disease and disgust, and castration. An illustrative joke dealing with what he calls the sadomasochism in homosexuality is presented here:

One homosexual is telling the other how he was beaten-up by a great big truck driver, and thrown out of the second story window, "Right up there," he says, pointing with his bandaged arm - "Oh, there he is now! "Hel-lo" he calls, waving frantically; "I'm not ma-ad!" (p. 91)

Telling this sort of joke, when the analyst perceives a homosexual patient's ego is strong enough to grasp its implications might be a potent intervention. The pitfall of inadvertently mocking the patient does not need to be an issue for at least
two reasons. First, it is important to keep in mind that because the analyst is choosing to include the joke as an intervention, he is not necessarily directing his own latent homosexual feelings at the patient. This might be the case if the analyst spontaneously shared the joke as one he especially liked, or if he told jokes based upon homosexuality to most or all of his patients. Second, if the analyst later interprets the meaning of the joke, analogous to dream work, he can further the cure process while protecting the patient's ego. Rosenheim (1974) cited earlier, commented that if a patient feels mocked or attacked, therapy progress may be slowed, but implies that this is a risk worth taking. This is due to the positive prognostic message the patient communicates when he is able to appreciate the humor directed to him by the analyst. The present author agrees, and adds that nothing would prevent the interpretation of such an experience (i.e., the patient feeling mocked by the analyst) as a part of the patient's analysis.

The use of humor in psychoanalytic therapy, from the ribald to the sublime, is an asset or a liability depending upon the skill of the analyst. The skill results from the combined effects of personality, experience, and training. Freud's theories of the ludicrous and theory of cure clearly permit the use of humor. On the other hand, no theory of cure can prevent the abuse of any class of interventions.

Client-centered Therapy

Unlike psychoanalysts, client-centered therapists have
devoted little energy to the debate on humor. Neither is there 
a basic treatise by Rogers, the founder of client-centered the­
rapy, that presents a philosophy toward humor in general. There 
is one small piece of anecdotal evidence as to Rogers' opinion 
of humor in psychotherapy, and the temptation to include it here 
is irresistible.

Greenwald, a directive psychotherapist who strongly sup­
ports the use of therapeutic humor, and Rogers, were both par­
ticipating in a conference and therapy demonstration. Here is 
Greenwald's (1975) account of a public dispute with Rogers. 
The argument was over whether or not therapy should be fun for 
the therapist; the quote picks up after Greenwald has implied 
that it should:

I saw the red start at his collar and spread up and 
over his face, and finally he burst out, "I think 
it's hard work, and if you think it's fun, then to 
hell with you." Nobody had ever heard him speak 
that way. Obviously, since that time, Carl Rogers 
has been improved as a therapist. He talks about 
feeling and things like that. (p. 114)

It is safe to conclude that Rogers believes that psycho­
therapy should not be intentionally designed to offer fun for the 
therapist! On the other hand, it would be stretching a point 
to infer that this personal discount of self-serving therapist 
fun rules out humor from client-centered therapy (CCT). In fact, 
the following analysis will focus on the importance of being 
genuine in CCT. So, when Rogers does not find therapy fun, 
he is appropriately genuine in being aware of it.

As was done with psychoanalysis, the author will present
CCT cure theory. Again, the goal is to justify to the reader the conclusion that humor enhances cure. Considering the vast gulf between the philosophies associated with psychoanalysis and CCT, the author is moved to quip that "humor makes strange bedfellows."

**Theory of cure.** In addition to basic CCT literature (Rogers, 1951; 1961) the reader is referred to other references available on CCT theory and technique. Rychlak (1973) along with Meador and Rogers (1973) have prepared overviews that are beyond the scope of this report.

Within a phenomenological framework that stresses free will and self-responsibility, cure is brought about when three necessary and sufficient conditions are met by the therapist (Meador and Rogers, 1973). Empathy, positive regard, and genuineness are summarized below:

1. Empathy is operationally defined as the therapist's verbal reflections to the client, which demonstrate understanding of the client's world from the client's phenomenological perspective. In practice, empathic responses capture both the thought and feelings associated with what the client is attempting to communicate.

2. Positive regard is an unconditional accepting attitude on the part of the therapist. A non-judgemental atmosphere combines with empathy to give the client permission to express himself as he truly is.

3. Genuineness is the therapist's communicated awareness
of what he is experiencing during the interview. The therapist is congruent by demonstrating the process he is asking the client to engage in.

When these conditions are established by the therapist, the client begins to move in the direction of becoming a "fully functioning person" (Rogers, 1961). This process is made up of seven subjective stages of movement as follows. At stage one, the point at which the client enters treatment, psychological maladjustment is observed. At this stage, the client "denies to awareness or distorts in awareness, significant experiences, which consequently are not accurately symbolized and organized into the gestalt of the self-structure, thus creating an incongruence between the self and experience" (Rychlak, 1973, p. 427). In stages two and three the client becomes aware of the feelings. However, the feelings relate to objects external to self, usually past objects. By the beginning of stage four, the client accepts that a difference exists between feelings and experience, and perceives this conflict as within self, rather than in the external world. By the fifth stage, the client is sometimes greatly surprised by feelings experienced in the here and now. Responsibility for problems and solutions is now accepted as within the client, who no longer experiences self as an object.

At stage six, feelings may surge into the client's awareness. Fear of change diminishes as the client organizes feelings and perceptions into a new gestalt that is congruent with...
the self. "Locus of control" (Meador and Rogers, 1973) is perceived as within self. At the conclusion of treatment, stage seven, the client, "lives comfortably in the flowing process of his experiencing. New feelings are experienced with richness and immediacy . . . . Incongruence is minimal and temporary . . . . The meaning of experience is held loosely and constantly checked and rechecked against further experiencing" (pp. 148-149).

To summarize, at stage one the client is out of touch with feelings and the sources of those feelings. These sources are perceived as being in the outside world, e.g., "So-and-so or something is going wrong in my life, but I'm not hurt or angry, or anything like that!" During the cure process the client comes to recognize and accept the feelings, and the source as an internal one e.g., "Depending on other people so much really leaves me feeling hurt and abandoned." Eventually, change becomes a confusing, frightening, but exciting possibility, experienced in the here and now, e.g., "Right now the thought of being on my own is really scary, but I'll feel relieved to get out of the rut." The key process variable is incongruence, which is the internally experienced counterpart of perceived incongruity in the world. Sometimes these perceptions of incongruity make people laugh, but only if the incongruity is recognized as such. On the other hand, in CCT incongruity is no laughing matter.

Genuineness and humor: Concomitants of perceived incongruity. The experience of being genuine is basic to both
humor and the CCT theory of cure. Genuineness or congruence is the central construct that provides a rationale for the use of humor in CCT. CCT repeatedly stresses the importance of being real or genuine, as a basic condition in all helping relationships. This stems from the related variable of congruence. A basic assumption is that for therapy to be successful, the therapist must be more congruent than the client. By definition, clients are relatively incongruent (Rychlak, 1973).

Incongruence results from a lack of unconditional positive regard during the development of an individual. Instead, conditions of worth, once internalized, define some experiences as good and some as bad. Good and bad experiences, as defined by other people, enhance the actualization process when they are congruent with the organism. They distort the actualization process when they are incongruent with the organism. In other words, the definition of experience as "good or bad" either fits or it doesn't. When it doesn't, incongruence is the result. Psychological maladjustment is the clinical equivalent of incongruence.

In the therapy relationship it is critical for the client's movement that incongruence be reduced. Whatever goes on during CCT must be presented as congruently as possible. It follows that a genuine relationship must be established between the client and the therapist during the session. The therapist must demonstrate that he defines experience as "good or bad" based
upon an unconditional or organismic criterion. Rogers (1961) has asked himself a question in this regard:

Can I be in some way which will be perceived by the other person as trustworthy, as dependable, or consistent in some deep sense?

He has responded:

I used to feel that if I fulfilled all the outer conditions of trustworthiness—keeping appointments, respecting the confidential nature of the interviews, then this condition would be fulfilled. But experience drove home the fact that to act consistently acceptant, for example, if in fact I was feeling annoyed or skeptical or some other non-acceptant feeling, was certain in the long run to be perceived as inconsistent or untrustworthy. I have come to recognize that being trustworthy does not demand that I be rigidly consistent, but that I be dependably real. The term "congruent" is one I have used to describe the way I would like to be. By this I mean that whatever feeling or attitude I am experiencing would be matched by my awareness of that attitude. When this is true . . . I can be whatever I deeply am. (pp. 50-51)

Awareness of one's feelings or attitudes normally requires attending to them as a precondition of perception. In turn, this leads to a potential reduction of incongruence, the benchmark of change in CCT. When incongruence within one's self (or incongruity within the world external to the self) is perceived as such, the experience that results is more genuine than it might otherwise have been. At times, it can also be funny:

There are a number of ways in which the perception of incongruity and incongruence is facilitated; humor is one of them. To the extent genuineness is fostered by a humorous outlook on experience, therapeutic change is enhanced.

In addition to their key roles in CCT cure theory, incongruity and incongruence are central to some theories of humor.
Keith-Spiegel (1972, p. 7) reports these as holding that humor arises from "disjointed pairings of ideas or situations . . . that are divergent from habitual customs." Situations are experienced as funny when they are perceived as incongruous, i.e., when they seem to deviate from expectations. The greater the perception of incongruity, the greater the humor value. The author contends that experienced humor (e.g., "getting a joke") and change for the better in CCT can both result from the same perception and resolution of incongruity.

The following joke (author unknown) can be used as an illustration:

An elderly Jewish man is run over on a busy downtown street. A witness runs out to help the man. Taking off his coat and putting it under the victim's head as a pillow he asks, "are you comfortable?" The Jewish man, barely alive, responds, "Yes, I make a few dollars."

The incongruity is established here between the two connotations of the word, "comfortable." It represents the stereotypical meaning attached by the overly money conscious Jew. It is funny when the punch line allows for both the perception and resolution of this incongruity.

The undistorted experience is a sad, frightening, and repulsive one in the above example of incongruity humor. If either element in the joke is not perceived as incongruous with respect to the other, the joke will not be experienced as funny. A psychotic individual, for example, might not perceive the experience as repulsive. Archie Bunker, famous bigot of television's "All in the Family," might also miss the humor if he perceives
nothing odd about a dying Jew still being more concerned about his money than his life! The salient element here is that the incongruity will only be perceived, i.e., the joke will only be funny, to an individual who is congruent enough to experience both the distorted and undistorted aspects of the situation.

CCT practitioners can take advantage of this shared concept of incongruity. For example, it can bring about a more genuine relationship between themselves and their clients. By accepting and using humor, shared recognition of incongruity that emerges in the consulting room can be made easier, or more meaningful, than if humor is ruled out. On many levels, it contributes to the growth of client and therapist alike. This is because jokes and other potentially funny material can lead to the reduction of incongruence, which is a necessary condition of cure in CCT. Again, before attempting to formulate more specific conclusions as to the uses of humor in CCT, a look at the techniques associated with Rogerian therapy is in order. This will establish humor's feasibility on pragmatic grounds.

**Technical considerations.** CCT technique has been analyzed and operationalized into six clusters of therapist behavior and five levels of therapist proficiency (Jacobs, 1973).

Empathy, respect, concreteness, genuineness, confrontation, and immediacy can be displayed by the therapist at levels of proficiency varying from level one to level five. A higher level reflects higher proficiency. Expanding upon the three
"necessary and sufficient conditions" cited earlier (Meador and Rogers, 1973), these factors should be taken as descriptive rather than prescriptive with respect to therapist behavior. Although Rogers' earlier formulations placed considerable stress upon the technical aspects of cure, by 1970 he had concluded that, "personality change is initiated by attitudes which exist in the therapist, rather than primarily by his knowledge, his theories, or his techniques" (Rogers, 1970, p. 202). With very few exceptions, the following techniques, applied with sensitivity, capture both the essential CCT attitudes and the essence of humor:

1. Empathy, the most overt CCT technique, is demonstrated by the therapist's verbal and non-verbal responses to what the client is saying and how he is saying it. A verbal response attempts to capture the cognitive and affective aspects of the client's previous response.

2. Respect refers to the therapist's unconditional positive regard for the client. It is the opposite of the "doctor to patient" characterization of other approaches to psychotherapy. Client and therapist are equal in all respects other than congruency in CCT.

3. Concreteness is demonstrated by the therapist's specificity in responding to the client. Vagueness and generalizations are not descriptive of the proficient CCT Therapist.

4. Genuineness, or being real, is the therapist's awareness of his own feelings and attitudes during the session. He
may or may not communicate these awarenesses to the client.

5. Confrontation consists of the therapist's actively pointing out discrepancies he perceives in the client's communications. An example would be a discrepancy between the client's verbal and non-verbal behavior.

6. Immediacy in CCT refers to the therapist's inclusion of the "here-and-now" aspects of the interview in his empathic responses to the client. This is the mechanism by which the therapist confronts a client discrepancy, or shares with the client a feeling he is experiencing during the session.

A funny Rogerian cure. Humor is allowable in CCT based on the theory of cure as a whole and its associated strategies. The concepts of congruence, congruity, and genuinenessness can be viewed as common goals of at least one form of humor and CCT. A funny happening demonstrates what can be thought of as a miniature of the global CCT objective of psychological adjustment. Incongruity, called attention to through humor, nurtures the client's ability to organize himself more congruently. Using a simple figure-ground explanation, a good joke can establish the conditions within which personal incongruence is brought into awareness. This occurs because the recognition of incongruity in a potentially funny situation (ground) requires a fairly congruent self (figure) to experience the humor. Recall the difficulty a psychotic individual or an "Archie Bunker" might have in seeing something funny in the joke presented earlier.

Funny material can move the client in the direction of
becoming a fully functioning person in at least the following ways:

1. Humor facilitates the awareness of incongruity in the world external to the self. This is a precondition of the resolution of internal incongruence.

2. The resolution of incongruity, typical in the punch line of a joke, is a precondition for establishing personal congruence. This in turn is the salient goal of CCT.

3. Funny events shared between client and therapist help to establish a more genuine, accepting atmosphere in the consulting room. They can gently call attention to the equality of both parties as human being.

4. The use of humorous experiences in the session can enhance the therapist's ability to present a model of the genuineness he is attempting to pass along to the client.

5. All the techniques of CCT strategy can be improved or maximized through the use of humor. The recognition and acceptance of the humor in something that emerges for the client or therapist can be a form of empathic reflection. Respect is implied by the equality of those sharing humor and the unconditional nature of finding something funny, i.e., it is generally accepted as OK not to "get a joke." Humor can be a more concrete form of communication than many others. A funny perspective can assist in the confrontation of discrepancies within the client's communications. Last, by its spontaneous nature, humor can contribute an immediacy to therapeutic
interaction that is not replicated in any other form of human communication.

Given that humor is allowable and desirable in CCT, the following are some of its applications. It has implications for both client and therapist behavior, and the interaction of the two. For example, if the therapist becomes aware of personal incongruence within himself, he might say something funny to eliminate this roadblock to the process. If the roadblock stems from an annoyance with something the client is saying or doing, humor can remove it. If the client is blaming or complaining, the therapist might say (in a humorous tone of voice), "I'm hearing that you're really scared that you won't be able to get other people to meet your needs for you, and that you won't be able to meet them for yourself." And, with a short pause, followed by, "Excuse me, could you get a cigarette out of my pocket and light it for me?" By doing so, the therapist is letting the client know that he is mildly annoyed, an example of genuineness. He is also gently confronting what he sees as an incongruity between the client's expressed feelings and experience. He is saying in effect, "I don't see you as helpless," without discounting the fact that the client does in fact see himself as helpless.

Another possible use of humor would be for the therapist to choose to respond humorously where he experiences incongruence within the client. If a severely obese client is relating how he feels about his inability to lose weight, the therapist
might respond, "I'm hearing your frustration and disgust at being so fat, like you're about ready to eat yourself into oblivion." Or, "Being unable to find trousers in size 48 must really be frustrating; seems like you're about ready to give up and try the tent department." In this way the therapist is empathically labeling the client's feelings about being fat, which the client incongruently thinks of as "bad." Acceptance of the client as a fat person is also demonstrated.

In either of these two applications, the recognition of incongruous elements is made easier through humor. The client is free to react to these attempts at being funny in any way he chooses (i.e., with more, less, or an equal degree of incongruence). There need not be an immediate recognition on the client's part of what the therapist is attempting to accomplish. Rather, any client reaction (anger, sadness, humiliation) can represent a move in the direction of congruence, provided the therapist uses it as such. For example, if the client reacts defensively to the therapist's humorous comment about the tent department, the therapist is most helpful if he can continue to respond congruently along these lines: "My joking about your weight seems to have left you feeling attacked," or, "I get the feeling that you're really hurt because I told a joke about the tent department." Here too, the therapist is using immediacy by selecting material within the session to respond to. Eventually, the subject matter can re-emerge as how the client handles jokes other people make about him outside the consult-
A third application concerns the therapist's readiness to respond to something the client sees as funny. The therapist can be attentive to any movement made by the client toward a humorous awareness of incongruence. If the client makes a humorous observation along the lines of the tent department joke, he is thus signaling that the incongruence he once experienced is being reduced. This process of self-acceptance can be further enhanced when the therapist responds, "I'm getting a humorous picture, one in which you see yourself as much too fat to be able to meet your basic needs easily... sort of odd and silly, but not inferior."

These do not represent anything like a complete listing of the ways in which funny-ness can be made a part of CCT. The most important guide for the use of humor would appear to be that it must be honestly experienced by the therapist as funny. Therapists with less than an average comedic talent should probably not attempt to use what they do not possess. Nothing in the preceding discussion indicates that CCT has to be funny to work, or that humor is all that is necessary. Indeed, what is indicated is that to exclude humor in CCT is equally as unhelpful as ruling out any other mode of human experience. Also, ruling out humor is not justifiable on theoretical grounds.

Behavior Therapy Modalities
To a degree, behavior therapists have accepted the use of humor in therapy. Therefore, the author does not intend to belabor the basic issue of humor's usefulness as was done with respect to psychoanalytic and client-centered therapy. In this section, a group of similar interventions that are generally associated with behavior therapy are presented and analyzed for their humor contents.

This collection of interventions is called, "prescribing the symptom." In one way or another, they are based upon the practice of suggesting, telling, or encouraging the client to engage in symptomatic behavior. The case of "Mr. Elephant," cited earlier to illustrate the fact that humor exists in psychotherapy, is an instance of prescribing the symptom.

Lazarus' technique, called "blow-up" (1971), Haley's "directive therapy" (1963), and Frankl's "paradoxical intention" (1960) are the main examples of interventions that prescribe the symptom. The "flooding" technique of Wolpe (1973) is also presented in order to link this and other forms of prescribing the symptom (PTS) to Wolpean therapeutic principles.

Reciprocal inhibition (Wolpe, 1973) contains within it the notion of the incompatible response. The above practitioners generally hold that humor serves as an incompatible response to anxiety. However, a precise explanation of how humor fits into PTS does not exist. In fact, Wolpe does not delineate a role for humor in psychotherapy, and only alludes to a reciprocal inhibition explanation in discussing the flooding technique.
Below, the author presents the various views of the role of humor in forms of PTS. The notion of humor as a response incompatible with anxiety is offered as the most likely common explanation.

Some views on prescribing the symptom. According to Lazarus, his blow-up technique, "has a good deal in common with Stampfl's implosive procedure, but it is probably more similar to the method of paradoxical intention. Many phobic and obsessive-compulsive problems seem to disappear when the therapist prescribes the troublesome symptom" (1971, p. 232).

The intervention consists of exaggerating the client's imagery of anxiety evoking scenes until they no longer evoke anxiety. Through verbal rehearsal, the client blows out of proportion the obsessive fears that intrude upon his life. They become a burlesque, a ridiculous distortion of the client's real concerns. Lazarus (1971) describes the technique as applied to a client's fear that a theater will burn down. By verbally induced imagery, the anxiety evoking scene is burlesqued and distorted to include the conflagration of a city block, a city, and a state. Eventually, Lazarus has the client imagining the entire world turning into a ball of flame, all due to the client's carelessly unextinguished cigarette in the men's room of the theater! The client's in vivo compulsion to actually run back and forth to theater men's rooms (to make sure his cigarettes were out) was thus eliminated (p. 232).

In delineating a role for humor, Lazarus also sees his
approach as essentially the same as Haley's (1963) directive therapy, and Frankl's (1960) paradoxical intention intervention. Lazarus (1971) writes:

An integral part of Frankl's paradoxical intention procedure is the deliberate evocation of humor. A patient who fears that he may perspire is enjoined to show his audience what perspiration is really like, to perspire in gushes of drenching torrents of sweat which will moisturize everything within touching distance. The therapeutic impact lies in the fact that when people encourage their anticipatory anxieties to erupt, they nearly always find the opposite reaction coming to the fore. (p. 232)

Shelton and Ackerman (1974) also list the approaches of Lazarus, Haley, and Frankl as forms of PTS. With respect to the deliberate use of humor, they write:

An important part of paradoxical intention is the evocation of humor - a state incompatible with anxiety. The client is asked to magnify the symptom to ludicrous proportions . . . . Clients tend to resist doing this, but the therapist models, prompts and reinforces approximations to symptom exaggeration until the client and therapist are laughing together. (p. 149)

Note the preceding reference to the incompatibility of anxiety and humor as an explanation of the impact of the ludicrous. In addition, Frankl (1960) contends that humor interferes with a client's anticipatory anxieties. Here is yet another explanation in terms of the increased power and control a client gains from his symptoms.

Haley's (1963) explanation of the therapeutic results of encouraging symptomatic behavior (and the use of humor) relate to the effects a client's symptoms have in human interactions. Essentially, they give him an advantage. For example, a man
who walks with a limp (regardless of whether he sustained a war injury or is a conversion hysterical) must and normally will be treated by other people as a man who walks with a limp is treated. To this extent, the limp provides a degree of predictability and control. The symptom itself may be bothersome to the client, just as the limp is certainly bothersome.

The therapist's task is to gain control of the controlling symptom. This is accomplished by placing the client in a paradoxical situation, one which he cannot resolve as long as the symptom persists. His symptom is so arranged as to place him at a disadvantage, rather than at an advantage in controlling the relationship with the therapist. This impossible situation, a "therapeutic paradox" (Haley, 1963, p. 67), consists of a message to continue with the symptom, despite therapy's goal of symptom removal.

Due to Haley's insistence that the patient continue with his symptom, the patient must give it up if he is to maintain a modicum of control in the therapeutic relationship. In reality of course, the therapist gains the control. Once this has been accomplished in the consulting room, it is a fairly simple matter to define when, where, and how the symptom will show itself in vivo.

The following example of what Haley means comes from the author's own experience as a crisis center therapist:

Client: So, what am I going to do? I have a big day coming-up tomorrow, and after being rejected by my girl I'll never be able to get to sleep. I know
myself in these situations! I'll never, never, never be able to get to sleep!

The client's feared insomnia gives him some notion of how the therapist will respond. Or does it?

Therapist: From what you've just told me, I agree. I really don't think you'll have any success trying to get to sleep tonight. Suppose instead of forcing yourself to try to sleep, that you make a list of all the other crises in your life that have caused you trouble sleeping in the past. Then, call me in say, two hours and we'll go over the list together. That way we might be able to prevent this kind of thing in the future. O.K.?

Usually the two hours pass without a return call. In order to maintain some degree of control, the client (presumably) has disregarded the therapist's suggestion to continue having his symptom, and has gone to sleep.

In calling attention to the importance of humor in his and similar approaches, Haley (1963) quotes from another therapist, Gerz:

To evoke humor in the patient, I always exaggerate by saying, for example, "Come on; let's have it; let's pass out all over the place. Show me what a wonderful 'passer-out' you are." And, when the patient tries to pass out and finds he cannot, he starts to laugh. (pp. 65-66)

These views on the roles of humor in PTS by no means represent all the potentially valid explanations in existence. For example, a basic operant explanation might define the symptom as being under stimulus control. The therapist would then be changing the stimulus conditions by humorously coaching the client to continue with his symptom. Or, another operant explanation might define the therapist as withdrawing the particular
kind of reinforcement maintaining the symptom when he responds differently than the client expects, or perhaps the therapist is covertly punishing the client.

Implications for humor as an incompatible response. Explanations which stem from work on experimental neuroses provide the main foundations for Wolpean interventions like systematic desensitization and assertive training. They rely mainly on the concepts of reciprocal inhibition and the incompatible response. The principle of reciprocal inhibition is that: "If a response inhibiting anxiety can be made to occur in the presence of anxiety evoking stimuli, it will weaken the bond between these stimuli and anxiety" (Wolpe, 1973, p. 17). Relaxing and eating are two examples of responses that inhibit (are incompatible with) anxiety. When paired with an anxiety evoking event, or when the client is asked to imagine one, anxiety is reduced or eliminated by reciprocal inhibition.

The early prototypes of this paradigm were the famous cases of "Little Albert" (Watson and Rayner, 1920) and "Little Peter" (Jones, 1924). Both children were conditioned to fear white furry animals, and the latter's phobia was extinguished by what Wolpe came to call systematic desensitization.

Flooding is the deliberate evocation of strong anxiety all at once. Again, this is done either in vivo or with imagery, but Wolpe does not directly explain its therapeutic impact in terms of reciprocal inhibition. He is generally uncertain as to the exact mechanisms of flooding, but is convinced that
simple experimental extinction is not the explanation. The best explanation, and the one upon which Wolpe bases his cautious approval of flooding, relies upon the slightly different but related phenomenon of abreaction.

When an event from the patient's past (a highly emotional event) is re-evoked, abreaction has taken place. This happens spontaneously (unlike flooding, systematic desensitization, or other planned evocations of anxiety). According to Wolpe (1973) the reason why some clients are relieved of symptoms after an instance of abreaction is that "anxiety is inhibited by other emotional responses that the therapeutic situation induces in the patient" (p. 201). His best explanation of the positive effects of flooding is that it operates in the same way as abreaction, by what could be called an accidental reciprocal inhibition between anxiety and "some other emotion" being experienced in the consulting room. That "some other" emotion could well be humor.

The following example of the use of flooding demonstrate that humor could well be acting as a covert or spontaneous emotional response inhibiting anxiety. Wolpe (1973) is reporting his work with a dentist who has a phobia that a patient will die in his chair and that he will be subsequently made fun of:

I decided to try flooding. Under light hypnosis he was asked to imagine . . . seeing a patient slump forward, dead. Dr. K. became profoundly disturbed . . . . After a minute or so, noticing that the reaction was growing weaker, I terminated the scene and told him to relax . . . . The sequence was given three more times . . . no further reaction was observed . . . . At the next ses-
tion, the fear of ridicule was introduced. Dr. E. imagined that he was walking down the middle of a brilliantly lighted ballroom with people on both sides pointing their fingers at him and laughing derisively. At the fifth session it was clear that nothing remained to be treated. (p. 198)

Although experienced humor is not reported here, there are clues to that effect. Dr. E. was not merely exposed to a strong source of anxiety, he was at the same time exposed to laughter stemming from a burlesque of an anxiety evoking scene. The scene was not only exaggerated, it was distorted in such a way as to appear ludicrous.

By splitting hairs between the mechanisms of flooding and the explanation of the therapeutic effects of abreaction, the author is inclined to believe that humor acts as an incompatible response in some instances of flooding. Furthermore, except for the lack of an overt attempt to evoke humor, little difference seems to exist between flooding and other forms of PTS. It should also be said that when an exaggerated scene (nearly any exaggerated scene) is imagined by anyone, the result is frequently funny. Exaggeration seems to be the basis for burlesque, slap-stick, and other time honored forms of humor. (Just try imagining a 500 pound canary and see what that does to your fear of yellow fluffy objects).

Humor can (and very often does) naturally pair an anxiety related event with a response incompatible with anxiety. Jokes and more elaborate forms of humorous experiences commonly deal with sad, fearful, or repulsive themes. The jokes compiled by Legman (1975), on topics such as disease bear this fact out.
Nietzsche (cited in Keith-Spiegel, 1972) said, "Man alone suffers so excruciatingly in the world that he was compelled to invent laughter" (p. 20). A natural desensitization through reciprocal inhibition goes a long way toward explaining both everyday and therapeutic humor. Laughter, and other less overt aspects of experienced humor, appears to be incompatible with anxiety. Helping a client to learn to laugh, while entering an anxiety filled situation, seems equally as therapeutic as helping him learn to relax, be assertive, or a number of other anxiety inhibiting states.

Reciprocal inhibition may explain forms of PTS, such as Haley's paradoxical methods of gaining control of the controlling symptom. On the other hand, Haley's approach can be used to explain Wolpe's methods. In fact, Haley (1963) has put Wolpean methodology this way:

Wolpe, as well as Freud and many other therapists, provides a rationalization for the patient to proceed into the phobic area. . . . He "advises" him to voluntarily seek out the phobic situation . . . . The patient is faced with a typical therapeutic paradox.

The relief of irrational fear and anxiety occurs in an interpersonal context where the therapist is influencing and controlling the behavior of the patient. This influence and control occurs when the therapist accepts the patient's behavior and defines it as cooperation rather than opposition. (pp. 62-63)

And Haley completes a theoretical circle, by returning to a definition of his own work that strongly resembles Wolpe's principle of reciprocal inhibition: He (a) encourages the client to go through the fearful situation, while (b) behaving differently. It seems likely that b also reciprocally inhibits
A funny cure via prescribing the symptom. The use of humor in PTS is justified to the extent that it reciprocally inhibits anxiety. All forms of PTS can be explicated in terms of the incompatible response, as summarized below:

1. Other theoretical rationales for the use of humor in PTS are all collapsable into the explanation casting humor into the role of the incompatible response.

2. The deliberate evocation of humor, a response incompatible with anxiety, would appear to be advantageous to the reliance upon a spontaneous pairing of the anxiety stimulus with some other emotional stimulus in the therapy setting. The effects of flooding might be enhanced through this modification.

3. The deliberate evocation of humor that exaggerates phobic or obsessive symptoms would seem preferable to more subtle forms of humor. This is apparently true because exaggeration is a strategy common to all forms of PTS.

4. Humor in everyday life seems to have a naturally desensitizing impact, as judged by the combination of unpleasant subject matter (i.e., anxiety stimuli) and experienced pleasure (i.e., incompatible responses), typical in many forms of that which is funny. Thus, using humor in PTS would appear to take advantage of this natural characteristic.

To demonstrate how humor might be exploited to reciprocally inhibit anxiety outside its strict technical application...
in PTS, the trusty joke will be utilized. If an individual with an irrational fear of death were exposed to the following joke, his anxiety might diminish to the extent that he "got" the humor:

A man returns home after a day of golfing with a tragic story to tell his wife. "It was awful honey," he begins, with a look of acute suffering on his face, "Our threesome got up to the first tee and Harry dropped dead of a heart attack!" His wife responds, "Now I understand why you’re so upset. It must have been terrible for you!" The husband angrily replies, "Of course it was terrible! Do you realize what it was like the rest of the day? It was tee-off, drag Harry; tee-off, drag Harry, all day long!" (author unknown)

In this joke, death of course is the anxiety stimulus. It is exaggerated to a ridiculous degree when the punch line has the listener imagining a corpse being dragged around a golf course. It is certainly consistent with PTS and general behavior therapy practice to use such a joke. A client with thanatophobia might be given a homework assignment to record as many jokes as possible concerning death, and then tell them to his therapist or therapy group!

As an adjunct to assertive training, which Wolpe (1973) defines as the therapist’s constant efforts to encourage "the proper expression of any emotion other than anxiety toward another person" (p. 31), the following joke is a possibility:

A young athlete is playing his first game as a member of a major league baseball team. As fortune (or misfortune) would have it, the game was being played in his home town. He was out in the stands signing autographs for friends and family when his manager approached him and asked, "Well kid, are you nervous?" The player answered, "No coach, I've trained many years in preparation for this day; I have it coming to me; and I'm not
the least bit nervous." Again the coach inquires, "Are you sure you're not even a little scared? I mean, being in your home town and everything?"

Again the player denied having any misgivings or fears about his performance. The manager explained his concern by saying, "Well, it just looked like you might be a little nervous. You see, most of the other players wear their athletic supporters inside their trousers!" (author unknown)

Here the outcome of assertive behavior is exaggerated to nearly impossible proportions as the listener visualizes a man dressed inside out! (This particular joke has generalization potential for the client with performance anxiety, not uncommon in unassertive people). Over 400 contributions to the literature on the psychology of humor were added between the turn of the century and 1972, and the trend is in the direction of experimental rather than theoretical contributions. (Goldstein and McGhee, 1972). Behavior therapy, because of its close ties with experimental psychology, has the unique potential for the development of an unlimited number of empirically valid humorous interventions. Therefore, the present discussion of one small group of interventions does not exhaust the possible applications of humor to behavior therapy.
Summary and Discussion

This report has argued for the proposition that humor is a theoretically and pragmatically sound tool in the armamentaria of psychotherapists as they endeavor to achieve the closest possible match between the needs of their clients and their selected interventions. Three theories of cure were examined to determine the degree to which humor was allowable. It was found that at least one central construct or process variable in each cure theory provided a rationale for the inclusion of humorous interventions. Cure theories were not compared to one another. It was assumed that they all have their appropriate applications.

The author's discussion first summarizes the main conclusions reached about the use of humor in psychoanalytic, client centered, and behavioral therapy. Several new applications of humor to psychotherapy are presented. Next, three hypotheses are presented with their implications for the basic relationship between humor and mental health. Last, an example of an approach to psychotherapy that is explicitly based on humor is presented, along with suggestions on the preparation of psychotherapists to accept and use humor.

Results for the Three Cure Theories

Psychoanalysis. The salient construct that links psycho-
analytic cure theory to theories of the ludicrous is libido. Humor is allowable in psychoanalysis to the extent that it facilitates the free expression of repressed libido and its associated material. The ludicrous, as is true with dreams, results in a net savings of libido. This in turn can be directed by the analyst back to the patient's ego. Humor is also a disguised (rather than severely distorted) expression of the material it symbolizes. It is much more available for interpretation than the hallucinatory content of the dream. Because the ludicrous is typically a social rather than asocial experience, it paves the way for improved cathexis to the analyst and other people in general. All the basic techniques of psychoanalysis (e.g., resistance analysis, free-association) can be enhanced by using humor which is initiated by either the patient or the analyst. The jokes presented by the author represent only one vehicle by which humor can be made a part of psychoanalytic therapy.

Two new and interesting applications of humor have been made in psychoanalytic treatment. One deals with the suicidal patient, the other with homosexuality. Goldsmith (1973) adopted the view that the suicidal patient's ego lacks the strength and flexibility to permit adaptive regression. Kris (1952) has coined this adaptive mechanism, "Regression in the Service of the Ego." Humor may be one way in which a dialogue between the superego and the ego prevents pathological regression and suicide. In studying seriously lethal female patients,
Goldsmith found a significant relationship between ego strength and sense of humor, both of which were negatively correlated with lethality. These findings, which are consistent with the author's position, have obvious implications for assessment and treatment.

Homosexual male patients have been successfully treated using the value of humor in eliminating infantile self-pity. Van Den Aardweg (1972) made the assumption that homosexuals have repressed their childhood feelings of being inferior and weak, and used humor to confront the patient's inner child. The inner child's complaints are exaggerated until the patient is able to see how ridiculous they are. Childish emotionality (characterized by a longing for an idealized loved one) was eliminated in approximately half of those patients completing treatment. There is every reason to believe that this procedure might be applicable to a wide variety of other problems. It seems to the author that Van Den Aardweg is operating well within the boundaries of psychoanalytic cure theory. Freudian therapists who exclude the use of humorous interventions must be doing so on personal rather than on theoretical grounds!

Client-centered Therapy. The interrelationships of congruence, genuineness, and incongruity establish humor as an acceptable CCT strategy. As the change process unfolds, incongruence within the client's perceptions of himself is reduced as a function of the degree of congruity within the therapy relationship. Genuineness, the subjective equivalent
of congruence, is enhanced by the acceptance and recognition of incongruity in the therapy session. Humor can be used to precipitate this acceptance. It can also be utilized in a variety of ways to facilitate the resolution of discrepancies between the client's feelings and his experiences. As the client moves in this direction, he becomes a more fully functioning person (Rogers, 1961, pp. 191-192), which includes acceptance of an internal locus of control.

In CCT cure theory, the psychologically adjusted individual has an internal locus of control. This is essentially an attitude or belief that one has control over one's life, and that happiness depends on the self rather than other people. Independent thought and action result from this belief. Lefcourt (1974) has studied the relationship between appreciation of sexual humor and locus of control. A word association test filled with sexual humor was used to differentiate persons previously grouped as having internal or external loci. Internals generally laughed more than externals, and accepted the discovery that they had been covertly observed better than externals. Lefcourt concludes from the specific kind of sexual humor the subjects laughed most at, that internals accept feedback about themselves more easily. This suggests that individuals with an internal locus of control are less apt to experience anxiety or depression as a result of being criticized or evaluated. These results seem to support the present author's views on an interrelationship between humor and personal
congruence. Both appear to be involved in a potentially therapeu­
tic way with psychological adjustment.

Behavior therapy. Several behavioral interventions that
basically have the same objective were grouped under the cate­
gory of prescribing the symptom (PTS). Encouraging the client
to engage in symptomatic behavior was explained in a variety
of ways. It was found that some authors directly attributed
change to the role of humor as a response incompatible with
anxiety, while others did not. Wolpe (1973) cautiously explains
his flooding technique as a form of abreaction, in which non­
specific stimuli occurring in the consulting room accidentally
pair themselves with anxiety evoking stimuli, thus recipro­
cally inhibiting the anxiety. He does not propose that humor
is likely to result from the therapist's exaggeration of
anxiety evoking imagery. However, the present author has
taken precisely this position, that flooding and other forms
of PTS can best be explained with the concept of reciprocal
inhibition. Exaggeration is common to all forms of PTS, as
well as to many forms of humor. Humor commonly deals with
anxiety evoking themes. The listener appears to experience
relief from anxiety by a natural desensitization in which humor
reciprocally inhibits anxiety. Haley (1963) reduces his method
of PTS to a definition that is much the same as Wolpe's (1973)
definition of reciprocal inhibition. He strongly advocates the
use of humor in establishing a therapeutic paradox. With the
added support of Lazarus (1971), the present author contends
that the pragmatic rationale for the use of humor in PTS is as follows: The impact of humor stems both from its exaggerating qualities and the fact that exaggeration not uncommonly leads to a humorous result. This can be maximized if the therapist chooses to do so.

Three Hypotheses

This report began by asking the question: "To what extent do theories of cure allow for humor?" The author noted from his personal observations that humorous experiences seemed to be adaptive for clients, without respect to the therapy modality. It also seemed that in general, there was an interrelationship between humor and mental health. The following three hypotheses are offered in order to address the above questions:

1. A significant improvement in therapeutic results can be achieved by the addition of humorous techniques to the three selected modalities. This improvement should be observable, measureable, predictable, and controllable.

2. The major theories of cure share important premises with theories of humor. For example, theories of humor that stress the concepts of release and incongruity share premises with the psychoanalytic and client-centered theories of cure respectively.

3. Analyses of other cure theories will disclose theoretical rationales for the use of humor, comparable to those
reported here for psychoanalytic, client-centered, and behavioral psychotherapy. Enough collective substantiation would lead to the conclusion that humor is therapeutic, in and of itself.

Mindess (1976) believes that humor has curative power on its own merits, and is a strong advocate of the humorous path to mental health. He has eloquently summarized his opposition to therapists who fear humor, or see it as the sole arena of the comedian:

Well! An inhibiting, confusing type of communication, a defense against anxiety, a form of masked hostility, an obstacle in the path of taking illness seriously, an exhibitionistic display, a seductive ploy, and a dangerous weapon - if it does nothing else, humor certainly seems able to pack a wallop! (pp. 333-334)

He also believes that the true significance of humor does not lie in superficial levity or the comedian's bid for applause, rather it is found in the deep truths it can help to expose. To grasp only the verbal parrying of humor is to discount the humorous and profound assessments of life provided by Mark Twain, Moliere, and Jules Feiffer. While therapists are rarely the equals of these satirists, they are able to see the humorous and the ironic aspects in their own lives, and the lives of their clients (pp. 333-334).

Mindess accepts that life is an absurd combination of the tragic and the humorous. He therefore feels that using humor in psychotherapy helps clients to see and accept this, and thus gain a new outlook on their lives. He tells of a woman client who attempted suicide after discovering that her husband of 15
years had been unfaithful many times. This apparent attempt
to gain her husband's attention backfired. The husband, after
discovering that she had taken an overdose of tranquilizers,
was advised to have her drink egg whites to induce vomiting.
He was so inept at the task of separating the whites from the
yolks, that the wife, by now nearly unconscious, had to show
him how. She thus wound-up saving her own life! (pp. 334-335)

There appears to be an ever widening group of helping
professionals who hold that humor has curative power in its own
right. A recent newspaper article (Ratliff, 1978) reported the
opinions of psychologists, educators, and physicians. Not sur­
prisingly, Ellis is quoted as saying, "People's emotional prob­
lems are mainly caused by their nutty ideas. We reduce nutty
ideas to absurdities. If somebody says, 'I'm a worm, I'm
excrement,' I say, 'Yes, I can smell you from across the room.'"
Psychologist and humor advocate, O'Connell, says humor is, "the
ability to tolerate stress and not get paranoid . . . to under­
stand the fact that you are absurd and falling apart, but also
god-like." Physicians as well find that laughter is good for
the body. Fry, professor of medicine at Stanford University,
lists four reasons why prescribed laughter may replace jogging:
(a) Muscular activity is increased during laughter, but after
a good laugh muscles tend to relax to a greater degree than
would otherwise be the case; (b) the heart pumps slower after
a good laugh; (c) old, trapped air in the lungs is flushed out
after a hard laugh; and (d) laughter leads to an increase in
the manufacture of adrenaline and a general increase in available energy.

**Provocative Therapy: A Strategy Built Around Humor**

At this point an illustrative example of an approach to therapy that clearly labels humor as the main aspect of cure will be shared. Farrelly and Brandsma (1974) state that: "if the client is not laughing during at least part of the therapeutic encounter, the therapist is not doing provocative therapy . . . . Humor plays a central, crucial, key role in provocative therapy; it is encouraged and necessary, not just a tangential adjunct to the 'real work'" (p. 95). This highly directive, yet humanistic strategy lists seven forms of humor. They are designed to muster the client's resistance, to get him to argue with the therapist about his own pathology. Exaggeration, mimicry, ridicule, distortion, sarcasm, irony, and jokes are all used with clients over the whole range of pathology.

Here is an example of provocative therapy:

T. (Continuing to grimace): It's just, you're such a . . . stumble-bum and inept and . . . ugh! (T. finishes by gesturing helplessly and sighing as though saying "words fail me -- I can't express how ugh you are!"")

C. (Evenly): All right, I think . . . I think the thing that has been missing the most in my life . . . and the reason I'm such a stumble-bum and so . . . ineffective . . .

T. (Flatly interjecting): Yea.

C. : is that I don't, I don't care for myself,

T. ('Supportively'): Well I don't blame ya! . . . That's some -- I'm happy to hear you've got some judgement.

C. (Pause; nonplused): Wellll, I . . . as I look back on my childhood . . .

T. (Wearily): Oh must we? Oh, go ahead if you must . . .
C. (Gingerly proceeding) . . . there wasn't anything I did . . . that . . . that gave me any reason for . . . for disliking myself intensely.

T. (Flatly): Well, you got it somewhere . . . You've had plenty of reasons since then.

C. (Pause; persuadingly): But it's because I don't like myself that I do these things.

T. (Remonstrating): No, no, no! It's because you do these things, that's why you

C. (Interjecting): No

T. (Finishing): don't like yourself.

C. (Louder): No!

T. (Overriding her): Oh, you got it all back-asswards.

C. (Even more loudly and firmly): You're wrong!

T. (Matching her tone): What do you mean, I'm wrong?

C. (Attempting to explain): It's 'cause --

T. (Pompously; not waiting for her reply): Hell, you're just a patient and I'm a therapist. Now how the hell do you know . . . where do you get off telling me I'm wrong?

C. (Evenly; with assurance): Well you're not infallible, Mr. Frank Farrelly.

T. (Laughs): Oh, I'm not? And I could be wrong, is that what you mean?

C. (With assured firmness): Yes, you're wrong. You're wrong about me. I'm not as . . . as evil, and not as wicked, and not as . . . damned, and not as . . . as hopeless . . . (Phone rings; C. ignoring it; finishing) and not as . . . (Phone rings again; T. puts hand on receiver but doesn't lift it, waits for C. to finish) . . . inadequate as you . . . contend! (C. Laughs, nods head abruptly) There! (pp. 103-104)

Through the use of ridicule, one of the seven forms of humor making up provocative therapy, Farrelly has enlisted the client's anger. She has been bantered into defending herself! The basic notion of mustering the client's own defenses to bantering by a benevolent and ridiculing authority has been suggested by others (e.g., Roncoii, 1974).

Psychotherapists like Farrelly go out on a limb when they use humor to help the client accept his fallibility. This is because they also present a fallible and imperfect image to the client. In order to give the client permission to be imperfect,
the therapist must accept a degree of imperfection, even
absurdity within himself.

**Preparation for Using Humor in Psychotherapy**

Many of the questions yet to be answered concerning the
humorous route to mental health must wait until psychotherapists
accept that they too are human and therefore sometimes absurd.
The author suggests that psychotherapists can prepare themselves
for humorously helping their clients if they take steps in this
direction.

The interchange cited earlier between Greenwald and Rogers
(Greenwald, 1975) implies that Greenwald has accepted some of
his own fallibility. Mindess (1976) as well, asserts that
psychotherapy can be viewed as a basically ridiculous activity.
Consider the following:

I am a psychotherapist. Since I still have certain
hang-ups however, I go to another therapist for help.
I don't feel badly about it, because my therapist also
goes to another therapist. And his therapist goes to
a therapist. And his therapist comes to me. (p. 331)

Or this irreverent mock of Freudian therapy:

Space does not permit a review of the history of psy­
choanalysis here, but it should be noted that early in
its development it became obvious that the analyst need­
ed reinforcement of the setting if he was to remain one­
up on patients more clever than he . . . . The use of a
couch to lie upon, (This is often called "Freud's ploy," as are most other ploys in psychoanalysis) . . . gives
the patient the feeling of having his feet up in the air
and the knowledge that the analyst has both feet on the
ground . . . . He finds himself literally below the
analyist, and so his one-down position is geographically
emphasized. In addition, the analyst seats himself be­
hind the couch . . . . This gives the patient the kind
of disconcerted feeling a person has when sparring with
an opponent while blindfolded . . . Some patients try to solve this problem by saying something like, "I slept with my sister last night," and then whirling around to see how the analyst is responding . . . Most analysts have developed ways of handling the whirling patient. (Haley, 1963, pp. 193-194)

Even psychoanalysts are beginning to believe that "the ability to laugh at yourself is correlated to . . . the courage to be imperfect" (Ratliff, 1978, p. 7c). While the author was preparing the present report, he explained to a psychologist acquaintance that Freud's (1905/1938) volume on the ludicrous would be a significant part of it. The psychologist quipped back, "Too bad Freud never had a sense of humor." Somewhere, there is an illusive quote in which Freud is said to have responded to a jibe about phallic symbols, "Well, sometimes a cigar is just a cigar." If valid, this contradicts the above. Perhaps it was "pure projection" on the psychologist's part!

In addition to learning to laugh at themselves, psychologists can prepare themselves for using humor by learning about it. Humor is typically not included in either graduate or undergraduate psychology courses. Browning (1977) asks the question, "Why not humor?" in an article by the same name. He calls for the inclusion of humor as a topic for study in general psychology. In an opinion survey, Browning found the views of psychologists to split along three lines. Authors of undergraduate textbooks reported that while frequent use of humor as a mode of presenting material is made, there is not enough space available to justify including humor itself as a topic.
Instructors of psychology said they felt the study of humor was germane, but also felt the lack of time and space as prohibitive to making humor a regular part of the curriculum. Lastly, specialists in the psychology of humor unanimously reported that a sufficient body of basic information now exists to warrant its inclusion as an area of study.

The well-rounded clinician makes constant use of all the elements that went into his training. This includes undergraduate exposure to psychology's sub-disciplines, as well as graduate training as a practitioner and scientist. The author therefore suggests that the inclusion of humor as a topic for study in graduate and undergraduate psychology will facilitate the use of humor by future clinicians.
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