

Positive and negative aspects of employing humour in psychotherapy

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Abstract

The purpose of this article is to analyse the phenomenon of humour in therapy. Rod Martin [1] defines humour as a fundamentally positive emotion referred to as amusement, triggered by cognitive processes of appreciation of perceived amusing stimuli and non-threatening, funny incongruence, accompanied by specific facial and vocal expressions of laughter.

Humour in therapy can play a significant role. It might be a form of therapy, one of the therapist's competences, as well as a therapy technique.

Notwithstanding the multiple qualities of humour, we need to recognise the risks involved in utilising it in the therapeutic process. In fact, the lack of ambiguity in the humorous message is likely to lead to misunderstandings between the patient and therapist. The patient may not have a clear comprehension of the humorous message and may not perceive the message to be humorous. They may also consider the humorous message inappropriate.

Furthermore, humour is not a homogeneous phenomenon. There are styles of humour that are adaptive in nature, such as: affiliative humour and self-enhancing humour, and styles of humour that are non-adaptive, such as aggressive humour and self-defeating humour. The variability of humour styles in therapists and patients also needs to be addressed, as not all styles are suitable for therapy – they can disrupt relationships or impair patients' self-esteem.

humour in psychotherapy; relationship with the patient; humour styles; psychotherapy techniques

POSITIVE AND NEGATIVE ASPECTS OF EMPLOYING HUMOUR IN PSYCHOTHERAPY

Humour and humour styles

Humour is an umbrella term covering all phenomena related to humour [2]. Rod Martin et al. [3] systematised the phenomena covered by the term humour. They observed that the term can refer to the stimulus characteristics (verbal

and cartoon humour, comedy); to the mental processes involved in creating, perceiving, understanding and appreciating humour; and to a person's reactions (smiling, laughing, amusing, arousing). They note that it has both cognitive and emotional components. Further, while it occurs mostly in an interpersonal context, it can also be an intrapsychic phenomenon (it can represent an attitude towards life, or express that someone does not take themselves too seriously). It can also be a state of amusement, well-being, cheerfulness, joy.

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Rod Martin [1] defines humour as a fundamentally positive emotion referred to as amusement, triggered by cognitive processes of appreciation of perceived amusing stimuli and non-threatening, funny incongruence, accompanied by specific facial and vocal expressions of laughter.

Humour is basically a social phenomenon. We laugh and tell jokes far more often when we are with other people than when we are alone [4] [5]. Various forms of humour are most fully accomplished when shared with other people in a particular place and time, and are not always understood by others as they fail to understand the context. According to current research, people who smile and have a sense of humour are more socially desirable and are perceived as having more positive qualities. In addition, humour is also a tool for communication and persuasion and assists in influencing group processes and establishing interpersonal relationships [4][6].

One thing that differentiates people from each other is their sense of humour. Kirsch and Kuiper [7] attempted to define humour as a multidimensional construct that includes both positive and negative elements, and then to relate them to the broader categories described by psychologists: individualism and relationship orientation.

Martin et al. [3] referred to the aforementioned discussions and distinguished two basic components of using humour: an interpersonal one oriented towards defining relationships with others and an intrapersonal one, focused on the self.

Humour can thus be used to boost one's self in a way that is acceptable and harmless to others ('self-enhancing' humour). Humour can also be self-enhancing, but at the expense of other people by gossiping, discrediting, excessively teasing and mocking (aggressive humour). Humour can be used to strengthen relationships with others at no personal cost (affiliative humour). It can also be used to strengthen relationships with others at one's own expense (self-defeating humour).

Therapeutic humour

Therapeutic humour has been defined as the intentional and spontaneous use of humour techniques by therapists and other health profes-

sionals, leading to a change in the egocentric mindset and behaviour of both clients and patients [9]. According to the official website of The Association for Applied and Therapeutic Humor, therapeutic humour is defined as an intervention that promotes health and well-being through the playful creation, expression and utilisation of absurdity or incongruity in everyday situations. This intervention can improve health, and can support the healing process or coping with an illness, whether physically, emotionally, cognitively or spiritually [9]. A convincing and comprehensive definition of psychotherapeutic humour was given by Mindess [8][9], who believes that humour can be considered therapeutic when it serves as a tool in our lives and not just as a joke and laughter. It is a certain state of mind, an inner conditioning, a way of perceiving and, in the fullest sense, an attitude towards life.

Humour as a form of therapy

According to Albert Ellis, humour can be a form of therapy, as it compensates for an overly serious approach to life [1][10]. He believes (cited in [1]) that one of the basic human problems is an exaggerated and overly serious interpretation of real-life situations. The patient should relax and see that some problems are exaggerated and even funny [11].

Another example of humour-based therapy is the provocative therapy developed by Frank Farrelly and Jeff Brandsma [12]. Humour plays a central role in provocative therapy. It is not merely an add-on and a tool for therapeutic work. Humour provides a balance between the way we feel and the way we think. They believe that over-intellectualising the patient is not advisable.

A less confrontational form of humour therapy was proposed by Walter O'Connell (Natural High Therapy) [1]. The purpose of the therapy is to self-actualise the patient and help them to break free from being dependent and controlled by the environment and internal impulses and to develop a healthy sense of autonomy based on high self-esteem. A healthy sense of humour is seen as defining a state of self actualisation.

Humour as a therapy technique

Many researchers believe that the primary quality of humour is incongruence and that it provides amusement [13][14]. This feature of humour forms the basis of the techniques used in therapy. There are various forms of humour that can be used in therapy. These can include jokes or formally structured riddles [8]. In addition, Franzini [9] names pointing out absurdities, unintentional wordplay, behavioural and verbal parapraxes: illogical reasoning, extreme exaggeration, amusing retorts, illustrations of universal human weaknesses or comical observations of current social and environmental events.

Paradoxical intention, as another therapeutic technique, was proposed and described by Viktor Frankl in 1939 [15]. According to Viktor Frankl [15] it involves encouraging the patient to engage in behaviours that they tend to avoid. The therapist then helps them see the humorous context, enabling the patient gain some perspective on their own condition. Often, patients laugh when they hear an instruction forcing them to escalate a symptom. This technique has mainly been applied to neurotic and psychotic patients, regardless of the aetiology of the illness.

Albert Ellis [10] used many other humour-based techniques: charades, witty remarks, shocking language, sarcasm and so on. As noted by Saper [16], these presumably facilitate cognitive restructuring and attenuate clients' tendency to absolutise, 'scare' and falsify the extent of their difficulties.

Humour is often used to point out the client's illogical thinking. To do this, the therapist employs exaggeration, which, similarly to paradoxical intention, shows the irrationality of their way of thinking [1]. This method is often effective with people who struggle with perfectionism [17].

Borcherdt [17] states that when a patient succeeds in laughing at a problem, it means that they are overcoming it. An important benefit of humour in everyday life, as well as in therapy, is the transition from seemingly unrealistic and absurd thoughts to realistic ideas [1]. These thoughts can be shared in a humorous dialogue. These ideas open up possible ways to achieve therapeutic goals.

Dziegielewski et al. [18] note that the use of humour creates a more natural therapeutic conversation and succeeds in calming the patient down. Humour can bring a more positive mood to the therapy session. This can be achieved by therapists modelling a different perspective and encouraging clients to have a humorous, distanced perception of reality and behaviour in certain situations.

Humour influences the perception and understanding of reality because it generates surprise, like the punch line in a joke, when suddenly our expectations are not met and the recipient is forced to reinterpret the content of the joke in order to reconcile the narrative scheme with the punch line. According to Frank Farrelly and Jeff Brandsma [12], this increases awareness and allows us to experience uncertainty, at least for a while. The experience of uncertainty is of great importance in the therapeutic process, as the person tests their behaviour and attitudes or constructs reality more carefully or even changes their own point of view. It is a confrontation in which the patient is a listener on the one hand and the subject of the joke on the other. This is, as the authors point out, similar to a figure-ground reversal. The smuggled, suggested meanings in the joke used by the therapist relate to the patient's personal experience. In addition, there is an immediate triggering of emotions and the release of creativity to solve the problem.

The hallmark of provocative therapy is that it accepts the use of any type of humour if it serves a therapeutic purpose. Besides, constantly maintaining a serious attitude is, according to the authors, disingenuous, as there are many funny moments during therapy so it is difficult not to laugh.

Walter O'Connell [1] considers humour as a technique aimed at achieving self actualisation. But it also allows the therapist to model a playful perspective and to encourage the client's expression of spontaneous humour. Walter O'Connell [16] led and used the therapeutic technique of 'humour drama'. The participants were asked to monologue their thoughts and feelings while acting out stressful situations. Then, in pairs, their partners were asked to stimulate alternative humorous responses, in the form of verbal condescension, understatement, exaggeration, sudden unexpected punchline.

Salameh [19] lists the following examples of humour techniques: surprise, exaggeration, absurdity, incongruity, confrontational/affirmative humour, word games, metaphorical hilarity, personification, relativisation, tragicomic twists and physical comedy.

Chapman and Chapman-Santana [20] point out that the use of humour in therapeutic work can happen when interviewing parents who have problems with their children, to let them know that their problems are of a common nature. Conversely, when interviewing adolescents about their parents or other adults, the therapist may occasionally smile or laugh to reflect the adolescent's dislike of restrictive parents or other adult authority figures. Humour can also be used to discuss social situations to demonstrate the absurdity of some of the patient's beliefs about themselves and the reality around them and make them more realistic. As one technique, the authors mention the use of black comedy, which they recommend using in rare cases to put an event in a different light and reduce it to its proper proportions.

Humour as a therapist's competence

Increasingly, a new type of disorder is being demanded for incorporation into DSM VI: laugh deficiency disorder [21] or humour deficit disorder [22]. For this reason, it is important to develop the competence to use humour in therapy. The therapist's competence to use humour in therapy can be defined as the knowledge of and ability to use humour.

Many researchers highlight the importance of humour in therapeutic work. Good rational behavioural therapists actively use humour in therapy to help their clients identify their silly and irrational beliefs [23]. One of those who favoured the use of humour in therapy was Albert Ellis [10]. As a result, his REBT (Rational emotive behavior therapy) sessions became lively and memorable, especially when he would coach his clients in a group singing familiar tunes whose lyrics were foolishly modified to conform to REBT principles [9, 23]. According to Franzini [9], humour should not be used just because it is enjoyable, but must have a specific function, of which the therapist should be aware.

Franzini [9] advocates providing training for psychotherapists on humour. He remarks that, irrespective of the theoretical approach, most therapy trends have several elements in common regarding the use of humour in therapy:

- (1) imply a positive understanding with the patient,
- (2) contribute to a thorough understanding of the patient's thoughts, feelings and behavioural patterns,
- (3) help clients gain insight into their difficulties, recognise unrealistic aspects of their thinking and develop alternative perspectives and new ways of thinking,
- (4) reduce the level of emotional distress and increase feelings of well-being,
- (5) modify pathological behavioural patterns.

Therapists should therefore have the ability to establish an understanding with the patient. Salameh [19] pointed out that humour allows the therapist to reveal themselves constructively and show their human side to patients. In his opinion, humorous behaviour cannot be expected from patients if we do not accept it in ourselves. Streaun [25] added that the successful use of humour also depends on the personal qualities of the therapist, such as maturity and flexibility. Killinger [26] also found that the therapist's level of maturity was the key variable in the use of humour, rather than the length of their professional experience. After reviewing the research, Rod Martin [1] concluded that humour in itself has no value if the therapist does not convey empathy, caring and authenticity. These are personal characteristics of all effective therapists [9].

Humour vs. the therapeutic relationship

When using humour in therapy, there are two aspects that need to be considered: relational and technical. As Charles J. Gelso and Jeffrey A. Hayes point out, the technical dimension in psychotherapy consists of the techniques used by the therapist and the roles adopted by the participants in therapy. The relational dimension, on the other hand, consists of emotions, attitudes and the psychological bond between therapist and client based on emotions and attitudes. The

relationship is conceptualised differently by representatives of the various trends.

When considering the phenomenon of humour, the conclusion is that it is most fully accomplished in social relationships. One of the primary functions of humour is the social function. Humour is basically a social phenomenon; we laugh and tell jokes far more often when we are with other people than when we are alone [4, 5]. According to Michelle 'a Shiota et al. [28], humour plays an important role in:

1. making contact with others,
2. maintaining those contacts,
3. increases the sense of attraction and involvement in interpersonal relationships,
4. coordinates group interactions by triggering emotions.

It is emphasised that the use of humour in therapy only makes sense if the therapist consciously uses it [20], which does not mean that it always has to address the issues raised by the patient. It can serve only to create a friendly atmosphere [19]. Besides, the humour used by the therapist is part and parcel of their way of being if it is not forced [20]. It is also important that the recipient has a nice experience. This author notes that when using humour, it is important to be respectful of the patient, observing their reactions carefully so that the patient does not feel misunderstood. The problem occurs when the patient feels depressed and this prevents them from finding the humorous message amusing, but it is perceived as aversive. Studies with antecedents generating negative emotions indicate that humour stimuli occurring later are not perceived positively [29]. In such situations, the therapist may be perceived as lacking empathy. Franzini [9] sees many benefits from the use of humour by therapists. In addition to the benefits mentioned above, he mentions building trust and consolidating understanding.

Other benefits of using humour in therapy that affect the patient-therapist relationship include boosting mood and providing joy; reducing guilt, shame and anxiety; and lowering the therapist's fear of the patient. The common stereotypes that patients have about psychotherapists can hinder and delay the therapy process. The therapist's use of humour allows the ther-

apist to be perceived as human [9] and to overcome shyness, enabling relationships to be established [30]. L. Kubie [30] points out that humour in therapy can be implemented when the relationship between patient and therapist is fairly established and the patient feels a bond with the therapist, and the rules and style of working in therapy have been set. Similar observations were made by Haig [31], according to whom humour helps to overcome passivity and resistance through rigid defences and contact with unconscious processes. He believes that it releases emotions and allows people to experience catharsis.

Apart from the positive aspects of humour in the therapeutic process, many authors also emphasise its negative influences. For example, R. Haig [31] mentions:

1. Denial, repression and suppression: The patient (or therapist) may consistently avoid problem areas and deny suffering through the use of humour and thus hinder progress in therapy.
2. Ingratiation: The patient may try to reward or please the therapist by using humour to gain acceptance or to hide hostility. A therapist who prefers and accepts these humour conventions may interpret this as a sign of positive change in the patient and fail to see that the patient's aggression and hostility have been veiled by a socially acceptable form of humour.
3. Therapist hostility: The therapist may use humour, especially sarcasm, as a way of attacking their patient.
4. Narcissistic therapist: The therapist may wish to demonstrate their skills and brilliance by using humour as a form of self-expression.
5. Questioning confidence in therapy as a professional approach: Humour used excessively by the therapist can result in the patient doubting whether their problem is being taken seriously.

The efficacy of humour in clinical practice

Despite the many reports of the positive role of humour, empirically documented evidence of its effectiveness in the therapeutic process is

sought. The use of humour as a tool for coping with stress has received the most attention. It is pointed out that humour can allow a stressful situation to be reinterpreted [32] and is then perceived not as a threat but as a challenge [33].

Paul N. Bennett et al. [34] indicate that therapeutic interventions in dialysis can range from presentations from humorous films, stories, clown laughter to simulated laughter. Clown laughter is very popular in paediatric communities and the context of dialysis may play a similar role [35]. However, it is still unclear to the authors whether these interventions have a long-term therapeutic effect. In particular, there are suggestions that excessive laughter may actually cause some harm in chronic obstructive pulmonary disease [36]. The usefulness of laughter may be limited to relieving distress, and reducing pain and anxiety [37].

Studies show a reduction in pain and discomfort after listening to or watching funny or relaxing comedy films instead of neutral material, especially in people with a strong sense of humour [38][39]. For people undergoing surgery, watching comedy films after surgery reduces the amount and intensity of lamenting and drug demands [40].

Studies reveal that the onset of humour behaviour in patients during therapy is sometimes a better prognostic factor for their treatment than the remission of depressive symptoms [41]. It has also been noted that depressed patients show a decrease in humour [42-43]. It has also been observed that depressed patients appreciate humour during the therapeutic process [44]. Christophe Panichelli et al. [45] found that not all humour interventions are associated with therapeutic efficacy. Only those tailored to the clinical context and aimed at presenting the problem. They also concluded that when humour interventions were perceived as less funny, hope and enjoyment were also decreased. It is not entirely clear what the direction of the impact was. Perhaps a lack of hope and pleasure lowered ratings of the playfulness of the humour intervention.

It is suggested that a humour experience and distressing emotions (depression, anxiety and anger) cannot simultaneously occupy the same psychological space [46]. Ventis et al. [47] investigated the effectiveness of systematic desensitisation to reduce the fear of spiders using humorous scenes without relaxation. Participants were matched for fear level and randomly assigned to 1 of 3 treatment groups: (a) systematic desensitisation, (b) humour desensitisation and (c) untreated. Humour in systematic desensitisation reduced fear as effectively as more traditional desensitisation.

STYLES OF HUMOUR VS. THERAPY

Interest in the positive effects of humour on physical and psychosocial health and well-being has steadily increased in recent times [3] [48]. Rod Martin and colleagues [3] distinguish between adaptive and non-adaptive humour styles. Among the adaptive ones, they include affiliative and self-enhancing humour. On the other hand, non-adaptive ones include aggressive and self-defeating humour. Affiliative and aggressive humour are other-oriented styles, while self-enhancing and self-defeating humour are self-oriented.

Ongoing research on the relationship between humour styles and indicators of physical health and mental well-being does not provide conclusive results [3, 48, 49, 50, 51]. Positive relationships have been observed between adaptive humour styles: affiliative and self-enhancing humour and self-esteem [52] and a sense of efficacy in contrasting self-defeating humour [53-54].

Kfrerer's [54] research deepens the understanding of the relationship between humour and depression. Self-defeating humour is particularly damaging and has shown associations with depression. The self-defeating humour style reinforces the link between social anxiety and the effects of depression [55-56]. A study by Kfrerer [55] found that people with diagnosed depression do not use positive humour styles as often as people without depression. In contrast, the use of aggressive humour styles was not different between people with depression and those without depression. This is explained by the fact that this type of humour has more to do with hurting other people than hurting oneself [3][55].

Aggressive humour has been positively associated with neuroticism and negatively correlated with conscientiousness [57]. Therefore, this type

of humour may have less to do with depression and interpersonal interactions and more to do with general aggression, as it is a style that does not take into account other people's emotions and needs [55].

A study by Rnic et al. [58] attempted to identify the roles of humour styles as mediators of the relationship between cognitive distortions and depression. Their results show that rarely does self-enhancing humour mediate the relationship between cognitive distortions and depression. It can be hypothesised that self-enhancing humour does not show an association between the cognitive distortions that have been associated with depression and thus promotes their modification.

The findings revealed that adaptive humour styles were significantly positively related to adaptive emotion regulation and positive subjective well-being, while non-adaptive humour styles were positively related to non-adaptive emotion regulation and negatively related to subjective well-being [59].

A study by Quazi [60] found that the use of adaptive humour styles (affiliative and self-enhancing) reduced social anxiety and resulted in improved mental health, whereas the use of non-adaptive humour styles (aggressive and self-defeating) exacerbated social anxiety and resulted in poorer mental health.

It has also been observed that affiliative and self-enhancing humour styles are negatively correlated with levels of burnout syndrome [61].

CONCLUSIONS

The researchers' observations indicate that humour can be successfully used in psychotherapy. However, it is not a uniform phenomenon and hence many researchers emphasise the negative impact of humour on the therapeutic process. This is related to the fact that humour can be adaptive and non-adaptive, as different styles of humour are distinguished, both those that are other-oriented: affiliative and aggressive, as well as self-oriented: self-enhancing and self-defeating.

Another problem that arises with the use of humour in therapy is related to its ambiguous nature. Humour researchers point out, howev-

er, that it is not always made clear by the sender which mode of communication will be used. Is it a humour mode – non-bona-fide – or an informative mode – bona fide? While in social life this has its positive side, as it avoids confrontation between sender and receiver in many situations, in a therapy session it can lead to misunderstandings.

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