Counselor Humor and the Working Relationship

by

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ABSTRACT

While there is an extensive literature on the theoretical and anecdotal basis of humor being a key aspect of psychotherapy, there is relatively little research. In this study, I addressed whether the frequency of therapist humor is related to subsequent therapeutic alliance ratings by the client. I also examined if therapist humor use is related to improvement in client symptomology. I hypothesized that there will be a positive correlation between humor use and the working alliance while there will be a negative correlation between humor use and client symptomology. Video recordings of therapy sessions were coded for humor (defined by laughter present in response to the therapist) or no humor (laughter not present). These ratings were correlated to client perceptions of the working alliance (using the WAI-S) and client symptomology. I found no correlations between humor and changes in working alliance or client symptomology. The results suggest that humor use in counseling does not seem to matter, however possible limitations of the study mitigate such conclusions.

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CHAPTER 1

INTRODUCTION

Counselor Humor and the Working Relationship

Humor is an important part of life because it typically provides positive affect (via dopamine) and enhances an individual's subjective well-being. An fMRI study found evidence for the involvement of the well-known mesolimbic reward centers (that use dopamine as the major neurotransmitter) when being exposed to humorous cartoons (Mobbs et al., 2005). Further, an experiment has shown that by inducing positive emotions (including mirth which can be a result of humor), people experience a reduction in physiological arousal caused by negative emotions (Fredrickson & Levenson, 1998). Thus, by aiding in emotional regulation, humor may be seen as something that contributes to mental health (Gross & Muñoz, 1995). Humor plays a significant role in our daily lives and is found in all cultures and individuals (Martin, 2007). It is associated with many benefits in areas such as education (Hill, 1988), psychotherapy (Killinger, 1987), medicine (Francis, Monahan, & Berger, 1999), and work (Mesmer-Magnus, Glew, & Viswesvaran, 2012).

Having a sense of humor is viewed as a socially desirable personality trait (Lippa, 2007) and an important component of mental health because it is thought to help people cope with stressful life events and serves as an important social skill for initiating, maintaining, and enhancing satisfying interpersonal relationships (Galloway & Cropley, 1999; Kuiper & Olinger, 1998; Lefcourt, 2001). Humor can de-escalate conflict, soften the impact of a message, and enhance group identity and cohesion (Martin, 2007). According to trainers that conducted a HIV/AIDS counseling course, humor can be utilized as a bonding tool and relieve the tension

from the serious situation the client faces (as cited in Dziegielewski, Jacinto, Laudadio, & Legg-Rodriguezi, 2003). Hence, humor can lower people's guard and have them learn to relax.

Humor is reported to have a therapeutic component within psychotherapy (Corey, 2013; Ellis, 1977; Franzini, 2001; Fry & Salemeh, 1987; Goldin et al., 2006; Saper, 1987; Sultanoff, 2002). According to Kuhlman (1984), humor enhances all human relationships, including the therapeutic relationship. It has been argued that the client-counselor relationship can be nurtured by humor (Fry, 2001). Despite this, it appears that the literature shows little efficacy of humor and its potential impact on the therapeutic alliance. A majority of the evidence indicating the benefits of humor in therapy is from clinical anecdotes and there is little empirical research supporting its use (Franzini, 2001; Saper, 1987). The number of articles in this area is increasing however; they are anecdotal and lacking either in methodological systematization or theoretical conceptualization (Salameh, 1983). Many of the articles and books on humor in psychotherapy only give statements of support for humor and clinical examples of its use (Sultanoff, 2013). A classic example of this is a journal article from Goldin and colleagues (2006) who discuss humor in psychotherapy with master therapists sharing their insight without research evidence. Another example of support for humor through clinical examples is from Buckman's (1994) book, which states "what has worked and what has not worked in their experience. Humor is funny in large part because of the element of risk and surprise" (p. x).

The focus of the current study was to examine some of these assumptions and anecdotes regarding humor in therapy. However prior to explaining how this was done, it is essential to review the definitions of humor.

What is Humor?

A persistent issue is what actually *is* humor. In other words, how is it defined? This is important because as Nelson (2012) states, client laughter in psychotherapy can mean many things. For example, is the client laughing because they are nervous or because they are having a good time? The Oxford English Dictionary (OED) defines humor as "With reference to action, speech, writing, etc.: the quality of being amusing, the capacity to elicit laughter or amusement. Also: comical or amusing writing, performance, etc." Another definition from the OED is "The ability of a person to appreciate or express what is funny or comical; a sense of what is amusing or ludicrous" (Oxford University Press, 2018). As one can see, "humor is a broad term that refers to anything that people say or do that is perceived as funny and tends to make others laugh" (Martin, 2007, p. 5).

Humor appears to stem from two key characteristics. The first is that something is incongruous, unusual, unexpected, or surprising. The second is that the humor is playful, nonserious, or nonliteral (as cited in Martin & Ford, 2018). Jokes that have a punch line fall under this and examples are: "To be frank, I'd have to change my name." and "What's the dumbest animal in the jungle? A polar bear." Although there are basic elements common to all instances of humor (i.e., a perception of playful incongruity expressed through smiling and laughter), there are many different social situations and events that can elicit the humor response. However, humor is generally a difficult topic because it is inextricable from context.

Martin (2007) argues that humor could be thought of as an essentially neutral with regard to mental health. How it impacts others depends on how it is used. "Humor, by itself, then is not inherently therapeutic. To be effective, the therapist

must be skilled in using it in a positive manner" (Martin & Ford, 2018, p. 311). This led Martin and his colleagues to develop the widely used Humor Styles Questionnaire (HSQ), a measure designed to distinguish between helpful and destructive humor (Martin, Puhlik-Doris, Larsen, Gray, & Weir, 2003). Given that humor "should be descriptive of all forms of humor behavior (not only the prosocial ones), the sense of humor should also represent the disposition for less valued humor phenomena, such as sarcasm, mocking, ridicule, satire, or irony" (Ruch, 1996, p. 243) It bears repeating that this is important because humor can have a positive or negative impact on both the producer and recipient. By distinguishing the different forms, a greater focus can be placed on using humor that benefits others instead of harming them. This was important for my study as I intended to look at humor use within counseling sessions and how it is related to the client. As I found that therapists only used positive forms of humor, I did not analyze the valence (positive and negative) of humor used within counseling sessions for this study.

Another issue to consider for studies besides definitions and measures is outcomes. The primary goal of therapy is to help the clients. This can be done in different ways, one being the reduction of symptoms. Therefore, I focused on how humor is related to the reduction of symptoms. I expected this to occur because it has been shown that a humor therapy group on older patients suffering from depression led to higher satisfaction with life scores (Konradt, Hirsch, Jonitz, & Junglas, 2012). Humor used by undergraduate students to cope successfully with stressful life events has been linked with significantly lower levels of depression, anxiety and negative affect as well as significantly higher levels of self-esteem and positive affect (Kuiper, Grimshaw, Leite, & Kirsh, 2004). Furthermore, the research has demonstrated that a

key process variable in therapy is the working alliance established between the therapist and client. It makes sense that humor may be related to the working alliance because an exploratory analysis of the use of humor as an essential communication tool showed that humor helps to build and enhance communication (Dziegielewski et al., 2003), which in turn could foster the working alliance.

The goal of this research was to examine the relation of humor use and key therapeutic variables of depression, anxiety, and the working alliance. I expected that greater use of humor by the therapist would be associated with a higher working alliance and lower client symptomology. In this study, I looked at the counselor-client dyad. Additionally, I looked at the therapeutic alliance of a randomly picked session and how the ratings of counselor humor in it were correlated to the client working alliance and changes in symptomology (anxiety and depression) in the subsequent session. The study was important to carry out because it contributes to the understanding of working alliance and changes in client symptomology.

In the following chapter, the relationship (both theoretical and empirical) between humor and the domains of physical health, social connection, psychological health, depression, and anxiety are summarized. After this, the relationship (again theoretical and empirical) between humor and the counseling areas of: theory, therapist, client, and the relationship are reviewed. Hypotheses are stated, measures defined, and the methodology is discussed. The results and a discussion are provided in addition to limitations and implications of my study.

CHAPTER 2

REVIEW OF THE LITERATURE

Definitions of Humor

A key issue in any research on humor is its definition. Although humor is universally present, it is "interpreted, defined, and valued differently by various cultures" (Maples et al. 2001, p. 59). Even though we may recognize it, the definition of humor could account for the findings in any study. In his book, Martin (2007) broke down *the personality approaches to the sense of humor* (see Chapter 7) into humor as trait (*self-report measures of sense of humor dimensions i.e., self-ratings of a person's tendency to produce humor*), behavior (*sense of humor as styles of humorous conduct i.e., observing a person engage in a variety of humor-related behaviors in a range of situations)*, perception (*individual differences in humor appreciation i.e., a person rating a series of jokes on a dimension such as funniness*), and rating (*sense of humor as an ability i.e., humor production tests rated by experimenters*). This outline was used to explore how humor is conceptualized and how I came to the definition and measurement of humor for this study.

The VIA (formerly known as Values in Action) character strengths (Peterson & Seligman, 2004), a classification of positive traits in human beings, defines humor as "liking to laugh and tease; bringing smiles to other people; seeing the light side; making (not necessarily telling) jokes" (Park, Peterson, & Seligman, 2004, p. 606). A humorous person can inject humor into a situation by choosing the right moment to raise an eyebrow or make a witty comment instead of telling a joke. Self-report scales for humor have been developed and measure different components or aspects of humor (For a more complete listing, see Ruch, 1998). An example is The Coping

Humor Scale (Martin & Lefcourt, 1983). It focuses on one particular function of humor and contains seven items that are self-descriptive statements such as “I have often found that my problems have been greatly reduced when I tried to find something funny in them”.

When humor is viewed as a behavior, early psychological humor research (i.e., Freud, 1905) took the psychoanalytic perspective and defined humor as a defense mechanism, an indirect expression of forbidden aggressive or sexual impulses. Laughter was a way to release excess nervous energy. In a recent publication, Gupta, Hill, and Kivlighan (2018) examined clients in psychodynamic psychotherapy and defined humor as laughter events that had at least three laugh notes (e.g., ha, ha, ha) and lasted at least three seconds.

A definition of humor, viewed as a perception, by Rosenheim and Golan (1986) indicates that humor requires one to take into account and appreciate what others bring. “Humor can be broadly defined as an approach to oneself and to others that is characterized by a flexible view enabling one to discover, express, or appreciate the ludicrous or absurdly incongruous” (p. 110). It has been hypothesized that tests of humor appreciation looking at people’s ratings of jokes and cartoons represent a completely different construct from that assessed by self-report humor measures (Lefcourt and Martin, 1986).

When looking at humor as a rating, experimenters have rated subjects in a study on the therapeutic effects of client-initiated humor in group therapy. Video recordings of five sessions of a single therapy group were analyzed by having humorous remarks categorized according to humor target: self, other in group, and generalized other (Peterson & Pollio, 1982). In an example of subject and

experimenter rating each other, the effects of therapist-initiated humor on clients' feelings of attraction or liking for the therapist was explored. In the study, video recordings of the sessions were reviewed by the counselor and the client separately (Megdell, 1984).

Considering the dimensionality of humor, an example of humor as a single dimension is Killinger (1976) who defined humor in terms of seven descriptive categories and was classified according to affect as laughter or non-laughter humor. An example of humor as multidimensional is the Multidimensional Sense of Humor Scale (Thorson & Powell, 1993). This scale measures aspects of humor including humor creativity, coping, appreciation of humor, and appreciation of humorous people. An example of humor as being only positive is The State-Trait Cheerfulness Inventory (Leventhal & Safer, 1977). This measure conceptualizes humor as the emotional component and the playful, non-serious character of humor. Finally, an example of humor as both good and bad is Martin and colleagues (2003) Humor Styles Questionnaire. In it they distinguish between helpful and destructive humor. In summary, "humor does not seem to be a unitary trait. Instead, it is best conceived as a group of traits and abilities having to do with different components, forms, and functions of humor" (Martin, 2007, p. 103). Therefore a broad definition is required.

Definition of Humor for the Current Study

The definition of humor for this study was the American Association for Therapeutic Humor (AATH) definition of therapeutic humor, "any intervention that promotes health and wellness by stimulating playful discovery, expression or appreciation of the absurdity or incongruity of life's situation. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing

or coping, whether physical, emotional, cognitive, social, or spiritual" (AATH, 2000). This definition was used because it is agreed upon by the AATH, is broad and has the aim of helping people–the goal of counseling.

There exists many ways researchers have defined and measured humor. These approaches include humor as trait, behavior, perception (appreciation), and rating. Of these, humor as an observer rating (experimenter rating the subject) is considered to be preferred since Ruch (1996) suggested that researchers should broaden their range of methodological approaches. He explains, "we seem to be focusing too much on self-report scales at the expense of behavioral observations, performance tests, peer-nomination, or peer-evaluations, biographical data, and others. Finally, the *comprehensive* definition of the sense of humor still remains the supreme but yet unattained goal" (p. 250). Having observer ratings provides agreement between more than one person and allows the context to be taken into account when looking at humor–which is key. Now that the measurement of humor has been discussed, it is important to see if and how humor actually helps people in general and in therapy.

General Benefits of Humor

The adage of laughter being the best medicine was demonstrated by Norman Cousins (2001). He found that ten minutes of genuine belly laughter lead to a natural body anesthesia that provided at least two hours of pain-free sleep. The health benefits of humor exist in multiple areas such as medical (e.g., the alleviation of pain and increased quality of life in terminally ill patients) and physiological (e.g., an increase in released endorphins, and improvements in natural killer cell activity; as cited in Franzini, 2001). When individuals laugh, they have decreased levels of stress hormones and increased levels of antibodies. During laughter, many body systems

(i.e., cardiovascular, muscular, and skeletal) are activated or exercised (as cited in Sultanoff, 2013).

As for the social aspect of humor, it allows one to be a more pleasing social stimulus in addition to expanding one's network of friends (Ruch, 1998; Salameh & Fry, 2001). It also serves as a positive tool to help build and enhance communication (Dziegielewski et al., 2003). Martineau (1972) described humor as a "social lubricant" that is a powerful and effective. By increasing one's level of social support, the social and interpersonal aspects of humor, such as enhancing personal connections, and health and wellbeing are enhanced (Dean & Gregory, 2004).

Humor strengthens not only physical but mental health (Weinberg, Hammond, & Cummins, 2014), and is associated with health, happiness, and longevity (Seligman, 2004). Humor can reduce or relieve tension and stress through a cathartic effect, and help people become more aware of their reality (Goldin et al., 2006). It provides an effective coping device for stress and is an enhancing and appealing personality trait (Buckman, 1994; Fry & Salameh, 1987; Kuiper & Martin, 1998).

Regarding depression, Sultanoff (1997) suggests that a humorous experience and distressing emotions (i.e., depression, anxiety, and anger) cannot simultaneously occupy the same psychological space. When a person is experiencing humor, emotional distress dissolves. Therefore, a client with depression can learn *experientially* that, for at least a moment in time, the intensity of the depression fades.

Regarding anxiety, Greenwald (1975) found humor to be a useful tool when working with people who felt they were helpless victims in the world. His major goal in therapy was to show people that they have options, choices, and strength. Goldin and Bordan (1999) reported that humor has been used to predict patient adjustment

after hospitalization and can assess schizophrenic patients' difficulties in socialization.

As for psychotherapy, both Frankl (1978) and May (1953) advocated the use of humor to help clients increase self-awareness and learn what they can do to become less anxious and more accepting of themselves and others. According to May, people cannot laugh when anxious or panic-stricken. When humor was used by a sensitive therapist with a talent for playfulness there was a decrease in patient's anxiety and increase capacities for self-reflection, while enabling a true dialogue to emerge in the therapeutic relationship (as cited in Ruvelson, 1988). The benefits of humor span across many domains. However, the research backing it is less.

Benefits of Humor: Empirical Evidence

A popular approach in research with humor is to expose participants to a form of it. Several experiments provide fairly consistent evidence that exposure to comedy results in increased pain threshold and tolerance. Weaver and Zillmann (1994) found that following exposure to comedic material, undergraduates (N = 36) tolerated icy water for longer periods of time than a control group. Weisenberg, Tepper, and Schwarzwald (1995) found volunteer participants (N = 20 per group) to have higher pain tolerance (tested using cold pressor stimulation). Zillmann, Rockwell, Schweitzer, and Sundar (1993) found higher discomfort threshold for cuff pressure at the upper arm for participants that watched a humorous film.

There is some amount of literature on the relationship between exposure to humorous material on stress reduction and anxiety reduction. For example, Abel found humor helps individuals deal with the negative impact of minor daily stresses and negative life events (as cited in Cheng and Wang, 2015). In a six-year study on

the effects of humor on test anxiety, it was found by adding humor into either the test questions or answers that humor had a positive effect on the test results for undergraduate and graduate students (N = 695; Berk, 2000).

Another widespread method to research humor involves studies that examine self-report measures. Studies find that humor is associated with a reduction of symptomology such as stress and depression. Bizi, Keinan, and Beit-Hallahmi (1988) had trainees in a course for combat (N = 159) complete self-report and peer-ratings of humor. Coping with stress was assessed through ratings by commanders and peers, and through final course grades. They found that humor as rated by peers (but not by self-report) was positively related to performance under stress.

Nezu, Nezu, and Blissett (1988) had undergraduates (N = 87) complete scales assessing depression, anxiety, negative life stress, and humor at two time periods. They found that humor served as a moderator of stress for depressive, but not anxiety symptomology. Subjects with a good sense of humor, measured with the Coping Humor Scale and the Situational Humor Response Questionnaire, that encountered high levels of stress between time one and time two reported significantly lower time two Beck Depression Inventory scores compared to those with low humor scores under similar stress levels. The authors found significant life stress X humor interactions, even after premorbid level of depression was controlled.

Another method to looking at humor is viewing it as a trait. Studies that used general trait measures of humor also find that humor is associated with less negative symptomology. Yovetich, Dale, and Hudak (1990) had undergraduate students (N = 53) with high or low sense of humor, measured with the Situational Humor Response Questionnaire, believe they would receive a shock. During the anticipatory period,

subjects listened to a humorous tape, non-humorous tape, or no tape. Dependent variables were repeated measures of self-reported anxiety, heart rate, and zygomatic facial activity. They found people with a high sense of humor had lower anxiety ratings in all conditions. Also, participants in the humor condition resulted in more smiling and lower anxiety, but not lower heart rate. Hence the effect of humor in this study is thought to be primarily cognitive.

Abel (2002) had undergraduate students (N = 258) complete a perceived stress scale, an everyday problems scale, a state anxiety inventory, a sense of humor scale, and a scale assessing their preferred coping strategies. Abel found that high sense of humor groups appraised less stress and reported less current anxiety. Kelly (2002) had undergraduates (N = 140) complete a worry domain questionnaire and sense of humor scale and found that worry was negatively related to sense of humor, thus individuals with a sense of humor are less likely to worry.

When humor is rated as actual behavior, it has been found that laughter promotes relationship well-being, increases positive affect, and is a good coping mechanism. It has been suggested that laughter, through an endorphin-mediated opiate effect, may play a crucial role in social bonding (Dunbar et al., 2012). Kurtz and Algoe (2017) found that shared laughter may communicate to others that we have a similar worldview, which strengthens our relationships. There is a special connection we make with one another when we laugh with one another. They recruited students (N= 116) from a college. After watching a slideshow of GIFs with a confederate (video recording of a person laughing at different times), participants were asked questions such as “How much do you think you would like the other participant?” (1 = Not at all to 7 = A great deal) to get a global evaluation of the

relationship, liking and affiliation. They found that shared laughter promotes relationship well-being, with increased perceptions of similarity most consistently driving this effect.

As for humor and positive affect, Konradt and colleagues (2012) demonstrated the effect of a humor therapy group on older patients suffering from depression, which led to lower levels of state seriousness (as measured by the State-Trait-Cheerfulness Inventory) and higher satisfaction with life scores in comparison to the control group. They had patients (N = 49) complete questionnaires that measured depression, health, cheerfulness, and satisfaction with life. Kuiper, Grimshaw, Leite, and Kirsh (2004) had undergraduate students (N = 137) complete scales that measured humor, self-esteem, depression, anxiety, positive and negative affect, and interpersonal competence. They found that higher levels of coping humor (humor used to cope successfully with stressful life events and experiences encountered by the individual) were linked with significantly lower levels of depression, anxiety and negative affect as well as significantly higher levels of self-esteem and positive affect.

In regard to humor and how it relates to client symptomology, evidence suggests there is a negative correlation. Smith, Ascough, Ettinger, and Nelson (1971) had undergraduate students (N = 215) complete a measure for test anxiety and found that high-test-anxious subjects receiving the non-humorous form of a test performed significantly more poorly than did low or moderate-test-anxious subjects, and at a significantly lower level than did the high-anxiety group that received the humorous form. Humor has also been shown to reduce anxiety and negative mood (Strick, Holland, Van Baaren, & Van Knippenberg, 2009). Strick and colleagues had students (N = 90) perform a picture-viewing task of neutral, mildly negative, and strongly

negative pictures where half of the participants saw a humorous stimulus after the picture. They found that humor served as a complex distraction that exhausted cognitive resources leading to a reduction in negative mood.

Hood (2017) has reviewed the research supporting both the positive and negative effects of humor as a tool in psychotherapy and the actual moderating effects a sense of humor has on stress, anxiety, and depression. The conclusion from his review was that humor has a useful place in psychotherapy; both in the client's own ability to buffer the effects of stress, anxiety and depression and in the therapist's use of humor as a therapeutic intervention. There are clear benefits from being exposed to humor, scoring highly on humor via self-report, having a sense of humor, and laughing. What is important is to look at next is how humor plays out in the therapeutic context.

Theory of Humor on Therapy

The therapeutic benefits of humor have been discussed by therapists from many different theoretical orientations. Some approaches emphasized the importance of fostering a healthy sense of humor; some emphasized training clients to use humor to cope, whereas others relied on the therapist to model a humorous (and more positive) outlook on life (Martin & Ford, 2018). In a wide array of approaches including psychoanalytic therapy, gestalt therapy, provocative therapy, Adlerian therapy, interpersonal therapy, and personal construct therapy, theorists believed that strong, sincere laughter can at times signal a desirable shift in the client (Gupta, 2017). Humor is explicitly a part of at least three types of therapy in counseling. The first is rational-emotive therapy, in which humorous exaggeration and even sarcasm, is used to point out the absurdity of clients' irrational belief systems (Ellis & Grieger,

1986). Next is provocative therapy, where emotional response is provoked in a client that results in changes in their perceptions and actions (Farrelly & Brandsma, 1974; Farrelly & Lynch, 1987). Finally, there is natural high therapy that has the aim of increasing self-actualization–humor being seen as a defining characteristic of self-actualization (O'Connell's, 1981; 1987).

Focusing on the therapist's use of humor, a survey by Franzini (2001) found that 98% of behavior therapists endorsed the use of humor. Greenson (1967) has suggested that the best therapists possess a good sense of humor. By showing a family that the therapists in front of them had a sense of humor, the client were able to humanize the clinicians instead of fearing them (Napier &Whitaker, 1978). Adams and Mylander (1998) suggested that it is crucial for clinicians to have a sense of humor and be open to seeing humor in themselves and their own lives before bringing humor into the therapy process. Corey considered a sense of humor as an essential characteristic in helping a counselor become a therapeutic person (as cited in Maples, 2001).

Fry and Salameh (1987) have identified two likely beneficial side effects of the use of therapeutic humor for the therapists themselves–as a coping device for stress reduction and as a preventive tool for professional burnout. This sentiment has been repeated by Franzini (2001): therapeutic humor may potentially have the positive side effect of preventing or minimizing professional burnout in therapists.

As for how humor relates to the client's functioning, Maslow (1970), Rogers (1980), and Kush (1997) agree that humor is an attribute revealed by a fully functioning person. It is a sign of someone with a healthy psyche when they can laugh at uneventful occurrences throughout their lives and move forward. Corey has also

discussed the importance of humor in mental health when he indicated that individuals with a sense of humor have the ability to laugh, especially at their own foibles and contradictions. When a therapist can use humor with a client, this can indicate that the client is improving (as cited in Maples, 2001). This is an important message for both the counselor and the client (Franzini as cited in Gladding & Drake Wallace, 2016). Humor is a valuable means of learning about an individual's lifestyle, convictions, and how he or she moves through life. One's sense of humor is a rich source of information regarding a client's approach to living. When a client begins to show signs of humor, it can indicate that something is starting to change internally. Therefore, humor can be seen not only as a diagnostic tool but also as a means of recognizing a shift in prognosis (McWilliams, 2011).

One widely discussed benefit from humor is how it changes the client's perspective and how they see themselves. Corey (as cited in Maples, 2001) asserted that a sense of humor "can help clients learn to take themselves less seriously and even laugh at some of the foolishness of their behavior" (p. 153). Corey stated that the appropriate use of humor in counseling has the potential to provide insight and help clients place the events of their lives into a realistic and manageable perspective. A client's sense of humor better enables them to realistically evaluate their problems and perceived "imperfections" (Maples, 2001). Humor can help reorient perceptions (i.e., a less painful perspective of a painful experience) which can lead to more balanced interactions. Regardless of whether a person is able to change or control an event, when the event can be redefined with the use of humor, a sense of control develops. Saper stated therapeutic humor can be used in an educative and corrective sense that assists in promoting cognitive-emotional equilibrium (as cited in

Dziegielewski et al., 2003). Humor helps to see the absurdity in the world around us and be able to laugh at it (Franzini as cited in Gladding & Drake Wallace, 2016). It acts as a cognitive mechanism for gaining perspective and facilitating mental flexibility (Morreall, 1998). It also provides an opportunity to stimulate new ways of perceiving and understanding attitudes, behaviors, and situations (Gladding, 1995) while under less pressure.

"The humorist, like the comedian, helps people see more of reality or look at it from a different perspective…Humor seems to help the client realize that he or she is in tune with his or her experience and, most important, that I understand him or her" (Goldin et al., 2006, p. 397) Using humor in counseling is to move the session along and foster insight and change -not merely to have a mirthful moment. In other words, as Mindess (1971) said "Deep, genuine humor -the humor that deserves to be called therapeutic, that can be instrumental in our lives, extends beyond jokes, beyond wit, beyond laughter itself to a peculiar frame of mind. It is an inner condition, a stance, a point of view, or in the largest sense an attitude to life" (p. 214).

Clients can also use humor as a coping mechanism to avoid conflict, allowing them to remain safe until they are ready to deal with the painful events in life (Dziegielewski et al., 2003). The use of humor can allow the therapist to draw attention to behaviors while affirming the essential worth of the client. A client may also be more motivated to share his or her most inner thoughts, feelings, and conflicts after a humorous comment is made (Gladding, 1995). Mosak (1987) cites one specific use of humor in psychotherapy being that by establishing a relationship, humor helps patients open up and interact with their therapist. Therapists who effectively integrate humor into their therapeutic framework, increase their ability to help clients activate

positive thinking, and generate new, healthier behavior (Gelkopf & Kreitler, 1996).

Another largely discussed benefit of humor use is its impact on affect. Humor within therapy is reported to be associated with many other beneficial outcomes. The stimulation of laughter has been associated with the relief of both tension and depressed feelings. Richman (1995) examined situations where laughter or humor occurred during therapy with depressed and suicidal patients and the main effects were symptom relief and increased cohesion. Within therapy, humor can break a client's resistance, reduce tension, and generate catharsis (Dziegielewski et al., 2003; Gladding, 1995). Humor has helped individuals survive emotional and physical suffering, imprisonment, illnesses, and loss (Granick, 1995). It has a liberating effect on people, provides comfort, and helps to relieve the pain of misfortunes, thereby enabling them to deal with situations in a mature, intelligent, and constructive way. The immediate consequence of therapeutic uses of humor is typically a positive emotional experience shared by the therapist and the client, ranging in intensity from quiet empathic amusement to loud laughter (Franzini, 2001).

Besides the individual outcomes of humor, there are also dyadic outcomes that include how it impacts the therapeutic process. Any therapeutic intervention introduced into the working alliance between counselor and client should enhance the therapeutic process; otherwise, it is a risky distraction. Humor appears to facilitate communication, allowing one to keep the other person's attention on what is being said. It can also make something more interesting when the topic is difficult or dry (Goldin et al., 2006).

Napier and Whitaker suggest humor is known to foster bonding between people and is reported to build the alliance between the client and counselor

(as cited in Wagenseller, 2017). By laughing with the family before beginning therapy, Napier and Whitaker (1978) used humor to build rapport before starting to work with a family. Humor can increase trust in the client-therapist relationship and strengthen the rapport between them (Dziegielewski, 2003). It has been said that as a technique for connecting, staying connected, crossing walls, and for simple human understanding, humor in unsurpassed (Buckman, 1994). According to Falk and Hill (1992) and Prerost (1994), many theorists, regardless of theoretical orientation, find humor useful. They state that counselor humor can be constructive in forming and furthering the therapeutic alliance. A successful injection of humor may be a booster shot for the counseling session and relationship (as cited in Gladding & Drake Wallace, 2016). Hussong (2017) identified a potential benefit of humor utilization in psychotherapy being humor's capacity to enhance the therapeutic alliance. Haig (1986) also listed how humor can constructively be used in therapy via the "formation of the therapeutic alliance: Humor furthers participation with the client in an inner experience involving naturalness and intimacy and can facilitate more gratifying contact with others" (as cited in Hood, 2007, p. 5).

Humor can help build the therapeutic alliance (Gelkopf & Kreitler, 1996; Richman, 1996) and deepen the relationship because it can result in positive accepting, empathy, cohesion, and belonging. If a therapist can use humor from a genuinely warm and caring perspective, it can increase their connection with clients, enhancing the bond between therapist and client. The long-term effects of humor are to shape, define, and change the relationship of the participants. Mahrer and Gervaize (1984) suggested that strong laughter might be an expression of a positive counseling

relationship. Strong laughter was defined as having two defining characteristics: (1) It occurs as a singular and distinctive, low-frequency, discrete event in the session, rather than as a high-frequency stylistic characteristic of the patient's consistent mode of behavior. (2) It is characterized by high energy, strength, saturation and amplitude, and unrestrained expressive openness, rather than low energy and mild expressiveness.

Dimmer, Carroll, and Wyatt (1990) have reviewed the current uses of therapeutic humor, which includes enhancing the relationship, closeness, and empathy between the counselor and client. They believed that even though humor is frequently present in the psychotherapy process, therapists rarely consciously and purposely use humor with therapeutic intent.

Counter examples to humor being beneficial include Rosenheim and Golan (1986) who presented adults in outpatient psychotherapy with a series of audio recordings of therapy sessions in which the therapists either did or did not use humor in their responses to their clients. The participants were asked to rate how helpful and understanding each therapist appeared to be and the degree to which they themselves would be willing to be treated by the therapist. Participants preferred the non-humorous interventions for themselves and rated them as more effective than the humorous ones. Rosenheim, Tecucianu, and Dimitrovsky (1989) reported similar findings in another study using the same methodology with patients diagnosed with schizophrenia in the early stages of remission from an acute psychotic episode. They rated the non-humorous interventions as likely to be more helpful, displaying more empathy, and more likely to strengthen the therapist-client relationship.

Megdell (1984) examined the effects of therapist humor on clients' liking for

the therapist during individual counseling sessions taking place at two alcoholism treatment centers. The results revealed that client liking of the therapists only increased when both the therapist and the client perceived something as humorous. Hence, humor may only be helpful insofar as both the client and the therapist enjoy it together. Poland (1971) observed that humor can facilitate insights, but the strength of the therapeutic relationship must first be addressed. Rosenheim (1974) addressed humor as an "indispensable ingredient" when the therapeutic relationship is sound.

Killinger (1987) studied tape recordings of 85 psychotherapy sessions containing different clients and therapists within two university counseling centers. She compared therapist-client interactions in which the therapist made a humorous comment, to randomly selected control interactions in which the therapist made a nonhumorous comment. Trained judges rated the degree to which the therapists' comments facilitated clients' exploration and understanding and led clients to have a more positive attitude toward their therapist. The results showed that humorous therapist comments did not produce greater benefits than the nonhumorous comments. Conversely, humorous comments that elicited client laughter were as likely to produce significantly less client exploration and understanding as compared to nonhumorous comments. Killinger also found that about 20 percent of the therapists' humor could be categorized as aggressive, which typically changed the discussion topic and interrupted clients' self-exploration. Any lasting negative consequences were typically mitigated through the immediate use of a "recovery statement," which softened the humor in some way. In summary, this study shows the potential risks of the use of humor by therapists and the need for caution.

Despite the discussion on the mostly beneficial aspects humor can have on

both the client and counselor, Martin and Ford (2018) state, “Empirical investigations of the effects of humor as a therapist communication skill are unfortunately quite limited, and the overall findings have not been very promising” (p. 312). Although the use of humor may enhance the therapeutic relationship, Kubie (1971) cautioned that humor may also be harmful to the therapeutic alliance.

Risks of Humor in Therapy

Given the neutrality and inherent ambiguity in humor, a client might misunderstand something resulting in counter-therapeutic, and even harmful humor. An article cited frequently regarding this risk of humor in therapy is Kubie’s (1971) – *The destructive potential of humor in psychotherapy.* Martin and Ford (2018, p. 314) provide a summary of these potential risks:

> *1. A therapist’s use of humor could convey to clients that they do not take their problems seriously.*
>
> *2. Therapists sometimes use humor inappropriately, as a defense against their own anxieties or as a way of showing off their own wittiness.*
>
> *3. Clients too might use humor as an unhealthy defense mechanism, as a way to avoid dealing with their problems or a means of devaluing their own strengths in a self-mocking way (i.e., self-defeating humor).*
>
> *4. Clients could have a maladaptive aggressive humor style. By engaging in humorous interactions with these sorts of clients, the therapist may inadvertently reinforce an unhealthy style of humor.*
>
> *5.When the therapist treats certain topics in a humorous manner, the client might perceive the topics as taboo and not to be discussed seriously.*
>
> *6. Clients might feel pressure to laugh along with a therapist to show that they*

have a "good sense of humor," masking underlying feelings of distress.

7. Therapists' use of humor could make it difficult for the client to express negative feelings or disagreement.

Kubie (1971) states "Humor has its place in life. Let us keep it there by acknowledging that one place where it has a very limited role, if any, is in psychotherapy" (p. 866). Humor has the *potential* to be destructive so it is important to consider is the skill therapists may have to either select humor appropriate to the client or respond effectively to a client's negative reaction to the humor.

Anecdotally, clients using humor as form of deflection to defend themselves appears to be common. Psychoanalytic theory aligns with this because humor was seen as a protective defense mechanism against the challenges and stresses of life (Martin, 2007). Pierce (1994) suggested humor was not appropriate in therapy when used defensively to divert attention away from an emotionally charged problem onto safer topics. Someone who tries to laugh in an uncomfortable situation, especially a serious one, can be avoiding it.

Janus (1975) interviewed 69 comedians who were well known and successful and found they used humor as a defense against anxiety. Clients may mask their depression with humor and use it as a defense mechanism to hide their true feelings. Ella Wheller Wilcox has said "Laugh, and the world laughs with you; weep, and you weep alone". When used defensively to avoid against internal or external threat (Ansell et al., 1981; Kubie, 1971; Zak, 1966), laughter can hinder the therapeutic work and be a barrier to therapy. Clients may laugh when they are nervous because they are trying to balance their own emotions (Aragón, Clark, Dyer, & Bargh, 2015) and do not want other people to really know how they feel.

Humor on Therapy: Empirical Evidence

Studies about humor as a behavior coming from the counselor have shown mixed results. Megdell (1984) examined the relationship between the counselor's initiated humor and the counselee's self-perceived attraction toward the counselor. “Alcoholism clients” (N = 30) had sessions video recorded. Immediately following the sessions, clients rated degrees of attraction to counselors and recorded instances of counselor-initiated humor rated as humorous or not humorous. Humor was defined as those expressions which the particular subjects in each therapeutic dyad identified as being funny, amusing, or comical to him or her personally. Shared humor was operationally defined as those instances during the counseling session when the counselor initiated humor, which the client perceived and rated as humorous. Counselors continuously recorded moments of counselor-initiated humor using a 10-point dial. Clients had more positive regard for the therapist immediately following interactions that both counselor and client found humorous, but not following interactions that only one of them found to be humorous.

O’Brien conducted a study in which he attempted to control the presence of humor in therapy sessions. Ten therapists, seeing two clients each (N = 20), were asked to increase the number of humorous comments made in their sessions to one client, while suppressing humorous comments with the other. The author obtained perspectives of alliance from both therapist and client, and found no relationship between the use of humor and the therapeutic relationship. He does note, however, that the presence of humor, while having no positive impact on the therapist-client relationship, also did not have a negative impact on the therapeutic process (as cited in Meyer, 2007). Meyer (2007) examined heterosexual couples (N = 40) at a couple

and family therapy clinic. Sessions were video recorded and humor was coded by using Salameh's (1983) Humor Rating Scale. In his dissertation, he examined the frequency of helpful humor between session one and session three and the relationship between dropout and the discrepancy in the partners assessment of therapeutic alliance at session one. His main research question was whether the use of helpful humor in the first session of therapy is related to the therapeutic alliance in couple therapy. In other words, does an increased frequency of helpful humor enhance alliance? Therapists' use of humor had little to no relationship with the clients' perceptions of therapeutic alliance at session one or three. However, clients who prematurely terminated therapy were exposed to twice as less the instances of humor compare those who stayed.

On the other hand, studies about humor as a behavior coming from the client have shown positive results. Killinger (1976) carried out a study to examine whether humor is facilitative of therapeutic process. The clients (N = 22) were university students. Humor was defined in Killinger's study in terms of seven descriptive categories and was classified according to affect as laughter or nonlaughter humor. Humor incidents (defined as incidents where laughter behavior occurred or a verbal report of amusement was made) were extracted from audio recordings of therapy sessions and rated by independent judges. Following a therapist's use of one or more of the seven specific categories of humor, the humor was rated in terms of therapist intent in using humor and the facilitation of outcome for the client. Humor was found to be facilitative in promoting a positive therapist-client attitude and in furthering client self-exploration.

Gupta and colleagues (2018) looked at clients (N = 33) in a community clinic.

They coded laughter events–defined as having at least three laugh notes (e.g., ha, ha, ha) and lasting at least 3 seconds. They found that sessions with more reflective laughter (laughter where verbal cues suggested that the client was pondering, thinking, or exploring) were evaluated more positively by clients.

Kneisel (2017) looked at 39 videos from the Alexander Street Library that met the following criteria: must be an authentic, full length, individual, counseling session. Due to the contextual nature of humor, instances of laughter was used as a marker for humor. Each instance of laughter was then coded for topic of conversation, initiation of humor, timing in session, who laughed, the target of the humor, and the type of humor used. Kneisel found laughter to be present to some extent in all of the counseling sessions. There were from 2-46 instances of laughter with a mean of 20.4 instances per session. Assuming a 45-minute session with 20.4 instances of laughter indicates that laughter occurred approximately every 2.2 minutes. The source of humor in about 40% of interactions resulting in laughter did not follow from any obvious conversational event and so was not categorized. Kneisel expected this due to humor's inextricable link to context.

When looking at studies about humor as a behavior coming from both the counselor and client, Marci, Moran, and Orr (2004) found that, in the course of individual psychotherapy sessions, laughter "occurred on an average every three minutes, with clients laughing more than twice as often as therapists" (p. 361). They examined patient-therapist dyads (N = 10) and laugh responses were coded and defined as any highly stereotyped utterance characterized by multiple forced, acoustically symmetric, similar vowel-like notes separated by a breathy expiration in a decrescendo pattern (Provine, 1993). The research on humor in therapy seems to

show that it either makes no difference or has a positive effect under certain conditions or circumstances. Because of this, humor can and should be looked at contextually by how helpful it is to the client.

Current Study

In this study, I looked at the counselor's use of humor because despite the many reported benefits, empirical investigations are limited and there are mixed results when it has been studied. I coded video recordings with another rater because humor requires a non-biased rating of this neutral construct. Therefore humor use by the counselor was studied.

Humor was thought to be related to the working alliance because effective therapists convey an attitude of empathy (Bachelor & Horvath, 1999). Thus, humor can be therapeutic if the therapist uses it in a way to communicating empathic understanding and increase bonding. For over 50 years, research has supported the strength of the therapeutic alliance (see Duncan, Miller, Wampold, & Hubble, 2010; Elkins, 2016; Norcross, 2011; Wampold, 2001) as the primary factor for client change in psychotherapy (Sultanoff, 2013). Although humor should be present in both personal and clinical relationships, its use in therapy is selective and for the benefit for the client.

Humor was thought to be related to symptom improvement because of the short-term boost of positive affect and cognitive reframing of events it provides. It can also act as a coping mechanism and reduce stress. Therefore as there is more positive humor, there would be less symptomology in the subsequent session. For this study, I covaried out symptomology from the session and examined the relation between humor and symptomology in the subsequent session.

Hypotheses

The main research question is if the frequency of positive humor used by a therapist is related to therapeutic alliance in the subsequent session. Also, does humor used in a session of therapy predict client symptomology in the subsequent session? Therefore, the following hypotheses are formulated:

Hypothesis 1a. There is a significant positive correlation of humor in the session and working alliance (total score) prior to the subsequent session.

Hypothesis 1b. There is a significant positive correlation of humor in the session and working alliance (bond subscale) prior to the subsequent session.

Hypothesis 2. There is a significant negative correlation of humor in a session and client symptomology (as measured by depression and anxiety) in the subsequent session after covarying out symptomology from the preceding session.

CHAPTER 3

METHOD

Participants

Clients. The sample consisted of 30 clients (16 female, 14 male) with a median age 22 (M = 23.91, SD = 5.6) at a community clinic. The ethnicities were 53% White, 17% Hispanic/Latinx, 13% Asian American/Asian, the remaining were South Asian/Indian, Native American/Native Alaskan, Asian American/Asian, African American/Black, and prefer not to answer. To avoid any nesting issues when analyzing the data, each client had a different therapist, meaning no therapist had two or more clients. This was done by collecting all the participants seen during the 2018 academic year and systematically removing cases.

Therapists. The sample consisted of 30 therapists (25 female, 5 male), masters and doctoral students with a median age 25 (M = 26.3, SD = 4.78). The ethnicities were 47% White, 17% Hispanic/Latinx, 17% Asian-American/Asian, 13% African American/Black, and the remaining were Middle Eastern/North African, and biracial. Therapists were in their 1st to 5th year of a counselor education masters program or counseling psychology doctoral program. Each therapist had one client each that was coded in this study. Therapists have completed at least one psychotherapy pre-practicum before starting at the clinic. Therapists participated in weekly individual and group supervision. They provided semester long (10-16 weeks) psychotherapy for presenting concerns including mood (sadness/depression), nervousness/anxiety, anger, relationship, family, academic, work/career, and substance use.

Measures

Coding system. To identify an instance of humor, I used Sala, Krupat, and Roter's (2002) definition (p. 272):

> *"A humorous utterance was defined as a meaningful word or phrase that contained mirthful or comic content accompanied by laughter of one or both parties (Consalvo, 1989). For those highly infrequent instances in which there was no such response following a clearly humorous comment, an exception was made to the "presence of laughter" rule and a humorous utterance was coded. Since the coding of humor was largely dependent upon laughter, we defined and coded laughter as an overt verbal response that indicated or suggested amusement or pleasure."*

I and another rater coded each speaking turn of the therapist as either humor (laughter present in response to the therapist) or no humor (laughter not present). Ratios of the number of humor utterances over the total number of utterances were calculated. This coding was done for the middle 20 minutes of each session. A speaking turn is defined as three words or more being spoken between statements by the client.

Working alliance inventory (WAI). To measure therapeutic alliance, this study used the short version of the Working Alliance Inventory (Tracey & Kokotovic, 1989). The original version of the WAI is a 36-item self-report instrument that measures the tasks, goals, and bonding aspects of therapeutic alliance, and emphasizes the degree of mutuality between the therapist and the client. Both the therapist and the client completed the questions independently. The short version contains 12 items from the original 36, with questions being answered along a 7-point

Likert-type scale with values ranging from 1, “Not at all true” to 7, “Very true”. A sample question for the client includes, “My therapist and I trust one another”, while the same question asked of the therapist reads, “My clients and I trust one another”. The scoring format consists of three 4-item, summed subscale scores (Task, Bond, and Goal) and one overall score. The internal consistency for the client score (Cronbach Alpha) is .85-.88 and for the therapist score is .68-.87. These estimates are based on 124 pairs of clients and therapists following the first session of actual counseling at a university counseling center at a large Midwestern state university (Tracey & Kokotovic, 1989). Construct validity of the score is reported to be supported through both rational (expert raters agreed that the items reflect the three constructs) and empirical (multitrait-multimethod analyses) methods (Tracey & Kokotovic, 1989). The total score and subscales were analyzed. The internal consistency on the current sample was $\alpha = 0.95$ for the total scale and 0.95 for task, 0.93 for bond, and 0.78 for goals. The one-week test-retest reliability was $r = 0.75$ for the total scale and $r = 0.64$ for task, $r = 0.75$ for bond, and $r = 0.87$ for goals.

Patient health questionnaire -9 (PHQ9). The scale consists of 9 items, with questions being answered along a 4-point Likert-type scale with values ranging from “0” (not at all) to “3” (nearly every day). A sample question includes, “Feeling tired or having little energy”. Scoring consists of summing the item responses for a total score. The internal consistency (Cronbach Alpha) is .86-.89 (Kroenke, Spitzer, & Williams, 2001). Criterion Validity is .88 (Sensitivity) and .88 (Specificity; Kroenke et al., 2001). “Sensitivity is the ability of a test to correctly classify an individual as “diseased” ” (p. 45) “while specificity is the ability of a test to correctly classify an individual as “disease- free” ” (Parikh, Mathai, Parikh, Sekhar, & Thomas, 2008, p.

46). The PHQ9 was compared to the diagnosis a mental health professional (MHP) who determined the presence or absence of major depression using DSM-IV diagnostic criteria in 580 patients (Kroenke et al., 2001). The test-retest reliability after 48 hours is .84 (Kroenke et al., 2001). The internal consistency on the current sample was $\alpha = 0.83$ (subsequent session) and the one-week test-retest reliability was $r = 0.79$.

Generalized anxiety disorder 7-item (GAD7). The scale consists of 7 items, with questions being answered along a 4-point Likert-type scale with values ranging from "0" (not at all) to "3" (nearly every day). A sample question includes, "Worrying too much about different things". Scoring consists of summing the item responses for a total score. The internal consistency (Cronbach Alpha) is .92. Criterion Validity is .89 (Sensitivity) and .82 (Specificity; Kroenke et al., 2001; Spitzer, Kroenke, Williams, & Löwe, 2006). Similarly, the GAD7 was compared to a MHP diagnosis of 965 patients who underwent structured psychiatric to determine the presence of generalized anxiety disorder using DSM-IV diagnostic criteria. The test-retest reliability after 1 to 2 weeks is .83 (Spitzer et al., 2006). The internal consistency on the current sample was $\alpha = 0.85$ (subsequent session) and the one-week test-retest reliability was $r = 0.66$.

Procedures

I gained access to video data from counseling sessions that occurred in 2018 at a counseling training center (CTC) that provided semester long, low-cost psychotherapy. The video recordings were from clients who have opted into the research and provided consent to use videos. Their videos are saved for three years. Because this study is related to counseling process and outcome, I was able to access

the videos after the fact with IRB approval for this study.

To have comparable data from all cases, I examined 30 cases that have completed at least three sessions of psychotherapy. The session number used to code for humor was randomly selected. I also collected the historical survey data of the 30 clients in order to obtain their GAD7 and PHQ9 scores. From the raw data file, I deleted all the cases that did not consent to video use (73% gave permission). I then organized the rows by client code number and if a client saw more than one counselor, used the second counselor they saw. Following this I organized the rows by counselor code number. If a counselor saw more than one client, I used the second client they saw. This resulted in removing 65 cases. Raters for this study were the author and one master's student. The outside rater was recruited from the counseling program and paid. Before coding recordings, raters were trained with sample recordings, meeting weekly over a 3-month period in an effort to obtain a minimally acceptable inter-rater reliability of .70 . The mean intraclass correlation coefficient (ICC, McGraw & Wong, 1996) was used to do this.

Rating procedure. Due to the inherent subjectivity of humor and laughter, I recruited and trained one judge to meet an acceptable level of inter-rater reliability between them and myself. The rater was given an article that discusses the development of the Humor Rating Scale (Salameh, 1983). Raters met to discuss the literature and coding scheme. The following week, raters watched a video recording together to discuss their observations (i.e., where humor was observed). Next, raters rated the same four recordings, and then met to discuss their independent observations.

Using the Intraclass Correlation Coefficient (ICC), the level of agreement on

these initial four recordings was calculated. After having reached an acceptable level in agreement, the remaining recordings were randomly assigned to the judges. An intraclass correlation was then calculated for all the recordings using ICC3: A fixed set of k judges rate each target. There is no generalization to a larger population of judges (Revelle, 2019).

The middle 20 minutes of all the video recordings was used when coding for humor use (see Appendix D for humor rating form example). An average of the ratings was used when analyzing data. Client symptomology data was exported in a Microsoft Excel document, converted to a .csv file, and analyzed using R. The cost for the professional services for data analysis, typing, transcription, and copying consisted of 40 videos x 20 minutes each = 800 minutes = 13.34 hours. 13.34 x $15/hr = $200 USD.

Analysis

Hypothesis 1. Correlation between therapist humor with client working alliance inventory in subsequent session.

Use 1 tailed Pearson correlations at .05 level.

Relationship of Counselor Humor to Working Alliance

Table 1

Correlation of predicted relationships between humor and working alliance

	1	2	3	4	5
1. Positive Humor	—				
2. WAI (Total)	+	—			
3. WAI (Task)	+	+	—		
4. WAI (Goal)	+	+	+	—	
5. WAI (Bond)	+	+	+	+	—

Note. Utterances were converted to percentages to control for differing number of utterances.

Hypothesis 2. Regressions predicting client symptomology in subsequent session using therapist humor while controlling for premorbid level of depression and anxiety.

Use multiple regression at .05 level (with humor as the predictor and client symptomology as the covariate).

Relationship of Counselor Humor to Client Symptomology

$Depression_{t2} = Depression_{t1} + Positive\ Humor$

$Anxiety_{t2} = Anxiety_{t1} + Positive\ Humor$

Note. $_{t1}$ indicates premorbid levels, $_{t2}$ indicates subsequent session levels

CHAPTER 4

RESULTS

Inter Rater Reliability (IRR)

For the first four videos used to establish IRR, a high degree of reliability was found between raters. The ICC was .985 with a 95% confidence interval from 0.787 to 0.999 ($F(3, 3) = 129.243$, $p < .001$). For the 30 coded videos, a high degree of reliability was found between raters. The ICC was 0.802 with a 95% confidence interval from 0.625 to 0.901($F(29, 29) = 9.114$, $p < .001$).

Humor and WAI

The first hypothesis was to look at the correlation between therapist humor use with client working alliance inventory in the subsequent session using 1 tailed Pearson correlations at .05 level. Prior to running the correlations, two cases were removed because more than 50% of the item responses were missing. The scale mean was filled in for one case missing one item.

Table 2

Correlation comparing humor, working alliance, and symptomology

	M	*SD*	1	2	3	4	5	6	7	8	9
1. Humor	0.04	0.06	—								
2. WAI (Total)	72.5	10.53	-.003	—							
3. WAI (Task)	24.01	3.79	-.062	.954*	—						
4. WAI (Goal)	24.04	3.77	.085	.928*	.851*	—					
5. WAI (Bond)	24.64	3.56	-.076	.921*	.850*	.766*	—				
6. Pre PHQ9	1.04	0.48	.057	-.101	-.079	-.260	-.229	—			
7. Post PHQ9	0.94	0.54	.248	-.287	-.313	-.136	-.423	.785*	—		
Pre GAD7	1.31	0.68	-.285	-.020	-.0290	-029	-.008	.024	-.069	—	
Post GAD7	1.18	0.62	-.102	-.213	-.29	-.146	-.237	.296	.498*	.620*	—

Note. *p < .001

There was no correlation present between humor and any scale: total WAI (r = -0.003, p = 0.507), humor and task WAI (r = -0.062, p = 0.624), humor and bond WAI (r = -0.076, p = 0.649), and humor and goal WAI (r = 0.085, p = 0.333).

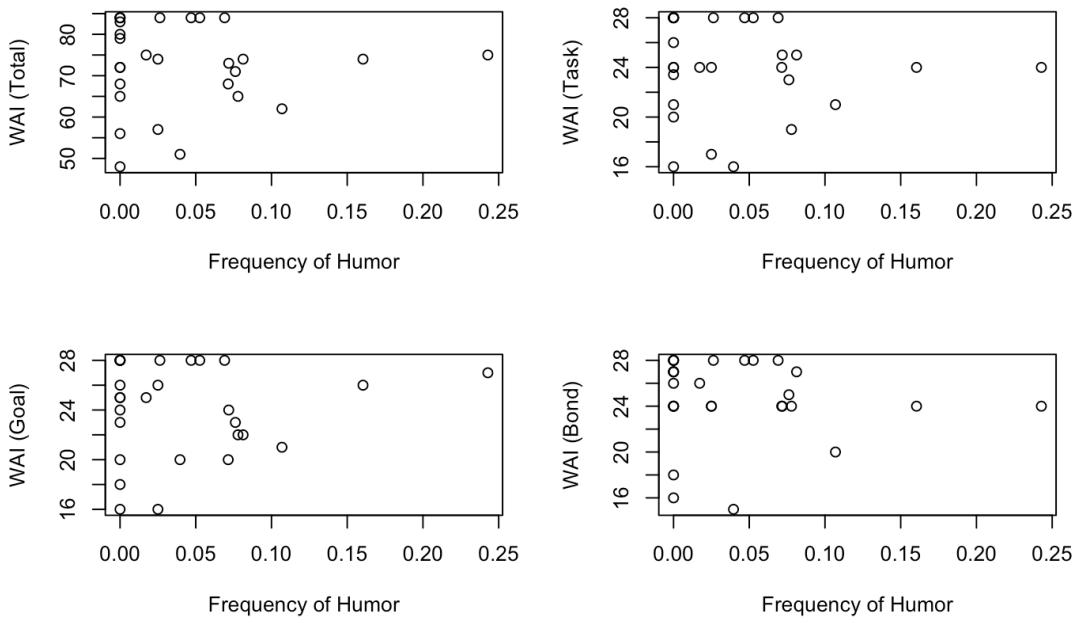

Figure 1. Matrix of scatterplots for humor and working alliance scales

The second hypothesis was to predict client symptomology in a subsequent session using therapist humor while controlling for premorbid level of depression and anxiety using two step hierarchical regression at .05 level (step one only having the depression or anxiety and step two with the depression or anxiety and humor).

Humor and Symptomology

Adding humor did not add significantly to the prediction of PHQ9 (F(1,27) = 2.35, p = 0.137) so there was not association between humor demonstrated in the session and subsequent better functioning as indicated on the PHQ9.

Adding humor did not add significantly to the prediction of GAD7 (F(1,27) = 0.39, p = 0.537) so there was not association between humor demonstrated in the session and subsequent better functioning as indicated on the GAD7.

In summary, this study not did find a relationship between humor and the therapeutic working alliance. Furthermore, humor use did not in this study help to predict client symptomology in the subsequent session.

CHAPTER 5

DISCUSSION

Summary

The focus of this study was to determine if the frequency of humor used by a therapist in a session is related to the therapeutic alliance in the subsequent session. The study also looked at whether humor used in a psychotherapy session predicted client symptomology (depression and anxiety) in the subsequent session. This is important because the study provides empirical research related to humor use in therapy as it relates to the understanding of the working alliance and changes in symptomology.

The first hypothesis was that there would be a significant positive correlation of humor in the session and working alliance (total and bond) in the subsequent session. This was hypothesized because effective therapists convey an attitude of empathy (Bachelor & Horvath, 1999) and humor can be therapeutic if the therapist uses it in a way to communicate empathic understanding and increase bonding. This was examined by coding videos for humor and collecting WAI survey data. One tailed Pearson correlations were used. I found no correlations between humor and working alliance.

The second hypothesis was that there would be a significant negative correlation of humor in the session and client symptomology (as measured by depression and anxiety) in the subsequent session after covarying out symptomology from previous session. This was hypothesized because humor provides a short-term boost of positive affect and can help clients cognitively reframe events. This was examined by using regressions to predict client symptomology in the subsequent

session using therapist humor while controlling for premorbid levels of depression and anxiety. A two-step hierarchical regression at .05 level (step one only having the depression or anxiety and step two with the depression or anxiety and humor) was used. Humor did not add significantly to the prediction of depression or anxiety in the subsequent session. Hence, in the current study humor was not found to have a measureable relationship with the working alliance and client symptomology.

The results of this study did not turn out as expected. This might have occurred because of a restriction of range where a majority of the therapists (70%) had either zero or one utterance of humor during the middle 20 minutes of the session. Therefore, not enough humor was used by therapists in order to see an effect. Sultanoff (1997) has suggested that a humorous experience and distressing emotions cannot simultaneously occupy the same psychological space. Hence, humor reduces symptoms in the moment however may be unable to carry over into subsequent sessions. Another concern is how the survey data was collected. Symptomology data was only collected just prior to the sessions coded for humor use–meaning I do not know the proximal effects of therapist humor use. The working alliance data was collected a week after the sessions coded for humor use which presents confounds.

Humor was looked at from an outside perspective whereas working alliance and symptomology were taken from the client's perspective. The session number that was selected to code for humor was random and so humor use could be "too soon" for some cases where there would be higher frequencies of humor as therapy progressed. Therefore, in the future it would be interesting to see how the client would rate the therapist's use of humor and how this correlates with the working alliance over time.

Limitations

A limitation of the study is that many of the therapists had started seeing clients for the first time and so may not feel comfortable intentionally using humor to build rapport. Laughter has been shown to reduce anxiety and decrease symptoms of depression (as cited in Doll, 2019), however the small sample size may provide too little statistical power in order to find significant results. Additionally 4 of the 30 of the therapists were male and this imbalance may have impacted results as males have said to more often be the "expressers" of humor (McGhee as cited in Meyer, 2007). Given this, a suppression effect may be present because the magnitude of the relationship between humor and the working alliance is reduced.

A major limitation was data collection. The use of humor did not fall along a normal distribution and was positively skewed. The entire counseling session was not coded and I only looked at one session for each dyad which necessarily restricted my variance. For some cases there was also a two-week gap between sessions because of things like Spring break where counselors were unable to see clients. The session number looked at was not consistent and so comparing two therapist's humor use in the third compared to tenth session may vary widely.

Regarding validity issues, humor was rated as a clear behavior (laughter or not), which does not take into account things like nervous laughter. There were a lot of sharp exhales accompanied by a smile that were not coded. When Comedian Jim Gaffigan was asked how he responds to a laugh, he responded by stating, "There's information in the laugh and how someone laughs. It's how you hear it. Most comedians do jokes that aren't test jokes, but you hear how the audience is responding and what their attention level is." (Mitchell, 2018). Raters were not trained in the

subtleties of humor appreciation (i.e., types of laughter, relevant body language, smiling, eye contact, etc.). Humor was also only rated dichotomously unlike Salameh's (1983) 5- point Humor Rating Scale. This may have created a type two error. Therapists may have been using humor to reduce their personal anxiety and so it was not therapeutic.

Smiling was not looked at which reduced the amount of connection between client and therapist accounted for. This could have helped because smiling (and laughter) provides similar benefits whether they are fake or real (Kraft & Pressman, 2012). Smiling is a powerful social lubricant that communicates to others people you are approachable, interested in them, and trustworthy (Suttie, 2019). In the future, it can be helpful to also look at the counselor's laughter in session because voiced laughs are much more likely to elicit positive emotion in the people who hear them (Bachorowski & Owren, 2001).

Due to the many limitations of this study, the results cannot be generalized to other populations. A replication of this study using better data collection techniques would be helpful in accurately determining the relationship of humor use and the working alliance and symptomology.

Implications

The results of this study suggest that humor is not related to the therapeutic relationship and client symptomology. If these results are replicated with better data, it could mean that the theoretical and anecdotal basis of humor is a myth. It could also mean that humor is something difficult and complex to explore and so will remain something elusive. Therefore, one could conclude that humor is a waste of time or look at it as something harmless both the client and counselor can enjoy during

sessions to lighten the mood and help the client in the moment.

According to Doll (2019), it is still unclear how the impact of humor is differentiated from the effects of laughter. To better look at humor in counseling, one method would be to use a more sophisticated rater system (i.e., FACS-coding participants' laughter). Another avenue to take is a subjective client centered approach which may help capture when a client finds something entertaining. This is because having raters only code what they see and hear from sessions does not take into account what the client is actually thinking. Therefore it seems like future research should focus on developing a type of humor appreciation scale for clients to fill out regarding their therapists. By doing this, the focus is shifted from the therapist's use of humor to the client's reception of humor. The client is always the expert of what is going on for them and so can provide the most accurate data as it relates to humor in counseling.

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APPENDIX A

WORKING ALLIANCE INVENTORY

SATISFACTION WITH INTERVIEW

Following are sentences that describe some of the different ways a person might think or feel about his or her therapist. Using the following seven-point scale, please respond to every item with your first impressions of your counselor.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

T=Task; B=Bond; G=Goals

T 1. My counselor and I agree about the things that I need to do in therapy to help improve my situation.

T 2. What I am doing in therapy gives me new ways of looking at my problem.

B 3. I believe my therapist like me.

G 4. My therapist does not understand what I am trying to accomplish in therapy.

B 5. I am confident in my therapist's ability to help me.

G 6. My therapist and I are working towards mutually agreed upon goals.

B 7. I feel that my therapist appreciate me.

T 8. We agree on what is important for me to work on.

B 9. My therapist and I trust one another.

G 10. My therapist and I have different ideas on what my real problems are.

G 11. We have established a good understanding of the kind of changes that would be good for me.

T 12. I believe the way we are working with my problem is correct.

INTERVIEW ASSESSMENT

Following are sentences that describe some of the different ways a person might think or feel about his or her therapist. Using the following seven-point scale, please respond to every item with your first impressions of your client.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

T 1. This client and I agree about the steps to be taken to improve his/her situation.

T 2. This client and I both feel confident about the usefulness of our current activity in therapy.

B 3. I believe this client likes me.

G 4. I have doubts about what we are trying to accomplish in therapy.

B 5. I am confident in my ability to help this client.

G 6. We are working towards mutually agreed upon goals.

B 7. I appreciate this client as a person.

T 8. We agree on what is important for this client to work on.

B 9. This client and I have built a mutual trust.

G 10. This client and I have different ideas on what his/her real problems are.

G 11. We have established a good understanding between us of the kind of changes that would be good for this client.

T 12. This client believes the way we are working with his/her problem is correct.

(Tracey & Kokotovic, 1989)

APPENDIX B

PATIENT HEALTH QUESTIONAIRE – 9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Little interest in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

(Kroenke, Spitzer, & Williams, 2001)

APPENDIX C

GENERALIZED ANXIETY DISORDER – 7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

(Spitzer, Kroenke, Williams, & Löwe, 2006)

APPENDIX D

HUMOR RATING FORM EXAMPLE

Date: MM/DD/YY | **Rater Initials:** AB | **Case #** 01

Time Stamp	Humor (1)	General Therapist Utterances
20:00 START	**—**	**0**
		5
25:03	1	
		10
35:30	1	
		3
38:49	1	
40:00 END	**—**	2

Total Positive Humor: 3 **Total Utterances:** 20