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# A TWO-PAPER EXAMINATION ON THE INTEGRATION OF HUMOR INTO CLINICAL SOCIAL WORK

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## **Abstract**

Humor can be a powerful therapeutic tool in clinical social work: It creates a layer of connection between clinician and client, can strengthen the therapeutic bond and provides a gateway to change on cognitive, emotional, and biological levels. It can help restore a sense of playfulness, lightness, and fun—innate qualities often lost as a result of adverse early experiences, including insecure attachment and trauma. The first paper of this two-paper theoretical dissertation reviews facets of humor development as an integrated social, cognitive, and emotional system that starts in infancy, with the objective of providing clinicians with a theoretical basis for integrating humor into therapy. Humor is examined through the play system as a component of attachment theory, mentalization, and the cognitive/emotional appreciation of incongruities. Theory is linked to practice through clinical vignettes. The second paper focuses more deeply on the clinical application of humor in clinical social work and the ways in which humor can be utilized by clinicians as a therapeutic tool. It addresses therapists' use of self, categories of humor, the importance of increasing mentalization skills to heighten awareness and timing in humorous interjections, the broaden and build theory of positive emotions, recent studies correlating humor, well-being and resiliency, and caveats about using humor.

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A TWO-PAPER EXAMINATION ON THE INTEGRATION OF HUMOR  
INTO CLINICAL SOCIAL WORK

Stephanie Nathanson

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Social Work

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In

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## DEDICATION

For my everything partner, Rick. Without your love, patience and endless good humor, this dissertation would not have been possible.

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## ABSTRACT

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Stephanie Nathanson

Lina Hartocollis, PhD

Humor can be a powerful therapeutic tool in clinical social work: It creates a layer of connection between clinician and client, can strengthen the therapeutic bond and provides a gateway to change on cognitive, emotional, and biological levels. It can help restore a sense of playfulness, lightness, and fun—innate qualities often lost as a result of adverse early experiences, including insecure attachment and trauma. The first paper of this two-paper theoretical dissertation reviews facets of humor development as an integrated social, cognitive, and emotional system that starts in infancy, with the objective of providing clinicians with a theoretical basis for integrating humor into therapy. Humor is examined through the play system as a component of attachment theory, mentalization, and the cognitive/emotional appreciation of incongruities. Theory is linked to practice through clinical vignettes. The second paper focuses more deeply on the clinical application of humor in clinical social work and the ways in which humor can be utilized by clinicians as a therapeutic tool. It addresses therapists' use of self, categories of humor, the importance of increasing mentalization skills to heighten awareness and timing in humorous interjections, the broaden and build theory of positive emotions, recent studies correlating humor, well-being and resiliency, and caveats about using humor.

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## GENERAL INTRODUCTION

This dissertation was based on my own professional experience with a new client several years ago. She was a Colombian nurse's aide named Lucia who sought counseling because her brother had recently died. Over the course of the next several months, it became clear that Lucia had a history of familial trauma as well. What struck me was that despite her background and circumstances, Lucia interspersed humor throughout our sessions. Many clients do not. For Lucia, and for me, humor was part of her way of being in the world—she could no more leave it out of our sessions than I could. I had become more conscious of how I integrated humor professionally and began to explore this topic with colleagues. Did they use humor in therapy? If so, in what ways and to what end? Were some clients naturally more playful than others? Eventually, the literature on humor in therapy led me to focus on certain developmental aspects of humor; this, in turn, led to an examination of the ways in which humor can be used as a therapeutic tool to foster positive change.

Every day in our clinical practice we see clients whose behaviors, personalities, and life situations are reflective of histories of trauma, loss, and shame. While humor does not negate the power of these events, it can temper their sequelae and help facilitate understanding and resolution. Being able to find moments of amusement, to give expression to playfulness, to understand one's place in the larger scheme of things creates resiliency. The interpersonal capacity to share a laugh, share levity, and share positive affect is an important one; it is a strength and a protective factor. The effects of positive emotionality resonate, build, and last longer than the moment (Fredrickson, 2001).

This two-paper examination of the place of humor in clinical social work explores how deficits in the ability to produce and appreciate humor may occur, and argues for its judicious

integration by clinicians. The first paper, “A Developmental Perspective for Understanding the Place of Humor in Clinical Social Work,” examines several developmental components that can influence the ontogenesis of humor. They are mentalization, the play system, and cognitive appreciation of incongruities. Mentalization and the play system are linked through the framework of attachment theory. *Mentalization* can (very briefly) be described as the ability to attribute behaviors to underlying internal states in oneself and others; it starts with parental attunement in the attachment system. Without mentalization, humor would be severely limited; a key element of humor is being able to take an imaginary leap into another person’s mind. As Reddy (2008) succinctly notes, “neither getting a joke, nor joining in laughter, nor making others laugh would be possible if we were unaware of or uninterested in others’ thoughts and feelings” (pp. 183–184). The unwinding of the play system and the security to venture forth is also influenced by attachment. Humor and laughter develop in the context of play (Martin, 2007), and the play state of mind is what brings humor to life. The cognitive enjoyment of resolving incongruities triggers the reward system in the brain and broadens perspectives; security has a role here as well: If not experienced in a safe environment, incongruities can feel frightening. Deficits in any of these developmental arenas can affect the ability to produce and enjoy humor, and they can be partially addressed in therapy through the use of humor itself.

The second paper, “The Bearable Lightness of Being: Integrating Humor into Clinical Social Work,” focuses on how clinicians can create more opportunities for humor through use of self, greater attunement to the inter-relational space, and by allowing—indeed encouraging—a place for play and levity in the therapeutic milieu. This can be achieved in a myriad of ways: humorous (non-aggressive) comments and questions, good-natured teasing, exaggerated body and facial expressions, verbal play, and wordplay. Humor in therapy is not joke telling: It is

about creating positive connection and regulating affect. Whether humor is expressed through divulging a similar experience in a light-hearted way, a mischievous repartee or a playful cognitive challenge, the result generally draws the client closer. When therapists reflect on their internal reactions, their cognitions and feeling states and allow the expression of humor, it exemplifies genuine use of self. Moreover, the client knows she is seen, heard, and understood because the context is relational and personal. Humor is a communication tool par excellence and when used to question, observe, and share is also a mentalizing process, which “in its ideal form . . . enables intimacy, a loving sense of connection with another person” (Allen et al., 2006, p. 33).

In spite of its potential benefits, many therapists, especially new therapists, are leery of using humor. There is the risk that the client may feel belittled, or not taken seriously, and an ill-timed humorous observation or comment can affect the transference process. There are times when humor can backfire, and the second paper addresses this as well. When humor falls flat, it can be turned into a learning experience for both clinician and client.

The goal of this dissertation is to inform clinicians of how the production and appreciation of humor evolves, and how its judicious interjection in therapy can be a catalyst for change on emotions, behaviors, cognitions and/or biochemistry (Sultanoff, 2013). Humor, though not a treatment paradigm, is a powerful integrative tool that can move clients forward toward treatment goals. I intersperse clinical vignettes through both papers that help link conceptual theory to practice. These vignettes illustrate the various ways therapeutic humor can promote positive change through affect regulation, challenging cognitive schemas, modeling verbal and mental playfulness, and increasing and co-creating moments of shared delight. Humor is a part of life and, as such, has its place in therapy.

A DEVELOPMENTAL PERSPECTIVE FOR UNDERSTANDING THE PLACE OF HUMOR  
IN CLINICAL SOCIAL WORK

**Introduction**

Humor is an innate human trait that is both a *product and cause* of connection and joy (positive affect); it can be both spontaneous and planned. Chimpanzees laugh, play, tumble, tease, and can play tricks on one another; rats laugh when tickled (Gervais & Wilson, 2005; Panksepp, 2007) but as far as we know, only humans have the capacity for reflective self-consciousness that allows for mirth and surprise in different temporal zones (Hurley, Dennett, & Adams, 2011). Humans can both remember and share a joke, laugh at previous foibles, and anticipate with pleasure new humorous situations. Humor is an important component of life for most people and, though we can live without it, deficits in humor appreciation and production generally lead to fewer feelings of subjective well-being and life satisfaction (Muller & Ruch, 2011).

In medicine, multiple studies have shown the benefits of humor. It increases tolerance for pain (Weisenberg, Raz, & Herner, 1998), is positively correlated with improved physical and mental health in older adults (Marziali, McDonald, & Donahue, 2008) and may even affect fertility rates (Friedler et al., 2010). Humor can be also be a powerful tool in clinical social work; it can create a level of parity between clinician and client, strengthen the therapeutic alliance, and facilitate change in therapy. The judicious interjection of humor by the clinician can provide relief from feelings of overwhelming sadness, provide the psychic distance necessary to create change, enhance the client's observing ego, and occasionally bring an element of fun and playfulness to what is often a lengthy and serious process.

Operationally, humor can be defined as the willingness to take verbal risks in a playful way and to notice, point out, and take delight in incongruities that are amusing and the enjoyment of running gags and light irony. Additionally, humor usually generates laughter. From a social perspective, humor is a way to lubricate social interactions, establish hierarchies, and clarify intentions (Gervais & Wilson, 2005). In its optimal form, it allows us to laugh at ourselves in a non-deprecating way. On an interpersonal level, to paraphrase Freud on dreams, humor is the quickest way into another person's mind. It can be an instant connection between two people and these connections repeated over time have the potential to form powerful positive relationships. Intrapsychically, humor can provide a buffer between reactivity and reaction. Humor is a protective factor; individuals who have a sense of humor are better able to cope with crisis, and rebound more quickly from adverse situations (McGhee, 2010).

Yet, for all its benefits, many of our clients seem to have lost or misplaced their capacity for humor. Clinically this can present as lack of verbal playfulness, narrowed perspectives, limited use of imagination, and discomfort with feelings of mirth. This theoretical paper posits that being cognizant of some of the etiological factors that account for these presentations will enable social workers to be better informed as to how to re-awaken their clients' innate capacity for humor. This paper will be divided into three sections: The first two sections will review two developmental frameworks and describe how each contributes to humor production and appreciation. The third section will focus on a more cognitive aspect of humor. Each section will contain a clinical vignette illustrating how suboptimal or regressed development in the area may be addressed in therapy, often through the use of humor itself.

The first framework is the play/exploratory system—a behavioral offshoot of the attachment system. This section will explore the connection between secure attachment and the

toddler's ability to venture forth into the world through play and the psychic importance of play and imagination as gateways to humor. The next framework is mentalization and metacognition. Mentalization is the implicit/explicit process of attending to the mental states of oneself and others (Allen, Fonagy, & Bateman, 2008); metacognition is being aware of this ability. Quite simply, without mentalization, the capacity to make an imaginative leap into another person's mind would not be possible and humor could not exist. The third section will focus on the cognitive/emotional pleasure of incongruities. The enjoyment of incongruities is cognitively based and has long been recognized as a major source of humor. However, for an incongruity to be pleasurable it must feel safe; it is in this way that the incongruity theory of humor is connected to attachment security. Incongruities are based on the juxtaposition of cognitive schemas. In order for clients to be able to accept therapeutic interventions that point out faulty schemas in a humorous way, there needs to be a certain level of trust.

Shortcomings in any of these areas can affect humor processing and enjoyment and can be treated experientially in therapy. Clinicians can create moments of "intersubjective delight"—to borrow Diane Fosha's (2008) felicitous phrase— with their clients, and in doing so, increase comfort with verbal play, deepen connection, increase resilience, and provide some psychic distance from pain. The planned and spontaneous use of humor in the therapeutic relationship can break into clients' constricted and reactive way of being in the world and re-introduce the concept of *lightness*, the innate potential for joy that is part of our genetic inheritance. The shared experience of humorous moments judiciously interspersed throughout therapy can, above all, lead to positive change by increasing comfort with levity and positive affect, thereby broadening intrapsychic and interpersonal horizons.

It is a given that humor develops through a multiplicity of other factors, including environment, culture, family structure, and innate traits. These factors, however, are generally outside the therapeutic aegis. What lies within the context of clinical social work, and is a foundational tenet, is viewing our clients and ourselves from integrative perspectives, including biological, psychological, and cultural factors. Humor is part of all three of these factors and to fail to recognize its absence and leave humor out of clinical encounters is to minimize an important aspect of what defines us as humans.

### **The Play/Exploratory System**

From first mutual gazes soon after birth to smiles at 2 weeks to the beginning of laughter at 4 months, infants are designed to connect and delight (Sroufe & Waters, 1976). It is an ongoing, mutually created process as infant and caregiver form bonds of love and attachment. Developed over a 40-year period by John Bowlby, Mary Ainsworth, Mary Main, and others, attachment theory has a simple underlying premise which has been supported by decades of research and practice, and most recently by advances in cognitive neuroscience, and that is: Infants are genetically and behaviorally primed to attach to their caregivers and that disturbances in the nature and quality of these primary relationships can have lasting impact (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1988; Main, 1991; Slade, 2000, 2005).

Ainsworth's seminal studies assessing attachment styles found that securely attached infants were able to wander off and play, knowing their mothers were close by should they feel threatened or unsure (Ainsworth et al., 1978). The infants had a secure base to return to and this knowledge allowed for freedom to explore and play. If the toddler is attached to a mercurial, depressed, or indifferent caregiver, he will modify or distort his feelings in order to maintain the closeness necessary for his survival. Infants as young as 3 months engage in bidirectional

interactions with their caregivers and modify their affect and behaviors based on their caregivers affect displays and behaviors (Cohn & Tronick, 1987; Lester, Hoffman, & Brazelton, 1985, as cited in Tronick, 1989). In affectively positive interactions, the more mothers laughed, the more their infants laughed (Nwokah, Hsu, Dobrowolska, & Fogel, 1994). Infants between the ages of 7 and 11 months engage in actions to make their caregivers laugh and repeat these actions to “deliberately re-elicite previously obtained laughter” (Reddy, 2001, p. 247). This can be viewed as one of the links between proto-humor and humor: the leap from enjoyment of caregiver induced physical (e.g., tickling), and surprise (e.g., peek-a-boo) evoked laughter to the playful goal directed behavior by the infant to elicit a mutually enjoyable moment.

When a toddler is securely attached, the exploratory system can unwind unimpeded and as physical mobility increases, the toddler is able to move around and explore, knowing that he has a secure base to return to for comfort and reassurance. Secure attachment promotes exploration of play, venturing forth in the world, and experimenting with reality (Nelson, 2012). Less secure attachment can result in less play and exploratory behavior (Grossmann, Grossmann, & Zimmermann, 1999). Miczo, Averback, and Mariani (2009) posited that anxiously attached individuals have fewer proclivities to produce humor because their playfulness has been inhibited through insecure/anxious attachment; these individuals’ self-consciousness inhibits humorous risk taking. In their study of 172 adults, Miczo et al. found a negative relationship between attachment anxiety and affiliative (socially positive) humor. Another recent longitudinal study found that 2-year-old children who had been abused engaged in less child initiated play than children who were not maltreated or neglected by their families (Valentino, Cicchetti, Toth, & Rogosch, 2011). Furthermore, toddlers who had been abused engaged in less pretend and social play. Cicchetti and Valentino (2006) noted the following:



As toddlers strive for autonomous functioning, caregivers' ability to respond with sensitivity and tolerance is necessary for successful resolution of this age salient issue. If caregivers are not supportive of this process . . . then the emergence of autonomy in children may be thwarted. (p. 1282)

Humor theorist McGhee (1979) posits that imagination and joyful play lead to later development of humor and that "difficulties can arise when caring adults are unable to accept the liveliness and exuberance of the child's play" (p. 80) or are unable to interact with them in a playful manner. This certainly does not mean that a child's proclivity for and enjoyment of play is determined solely by the nature of attachment. It does, however, reiterate the importance of attachment as a factor in optimal play development. It also points to the profound effect environmental factors (i.e., attachment relationships) have on shaping a child's genetic inheritance. If a child is vulnerable through the trait of behavioral inhibition—characterized by restraint and caution in new situations—insecure attachment will correlate to higher levels of anxiety symptoms over time (Muris, van Brakel, Arntz, & Shouten, 2011). As Nelson (2012) suggests, "When a child's attempts at playful engagement are rebuffed or ignored, or met with hostility, the wounds can run deep" (p. 90). In a quantitative study of perceived parental warmth and rejection in childhood as predictors of humor styles and subjective happiness, the authors found a positive correlation between parental warmth, positive humor, and happiness (Kazarian, Moghnie, & Martin, 2010). Playful engagement with the caretaker encourages both joyful exploration and positive emotional exploration in the child. As Grossmann, Grossmann, Kindler, and Zimmerman note,

Parents' willingness and ability to support their child's exploration sensitively and appropriately provide the child with the realistic self-confidence in his or her competence in new situations. A psychologically secure child is eager to engage in the world, know

that a secure base is available. Supporting secure exploration has much in common with what Ryan and his colleagues call “supporting autonomy in relatedness.” (2008, p. 857)

If we understand one facet of the play system and growing autonomy as risk taking—putting oneself forth in the world—there is a parallel to humor. When humor is used, there is risk taking involved: The humor may fall flat, be misunderstood, and possibly offend. For clients whose confidence to speak up in a humorous fashion and whose ability to verbally play appears compromised, something may have gone awry in the play or exploratory system.

In therapy, one of the ways the play system can be re-animated by the clinician is through the use of humor itself. Through modeling and playfully engaging with the client or drawing her out in a playful manner, the therapist can provide a corrective emotional experience and experientially share a positive affective moment, replicating in therapy a moment analogous to caretaker/child verbal silliness and play. The following vignette is an example.

***Adele***

*Adele, a 25-year-old female was working with her therapist for about two months to manage her mild depression and feeling stuck in her life. The therapist was feeling stuck, too. Adele presented with a generally flat affect and when asked, was unable to recall any details of her childhood. The therapist gave her a homework assignment: Adele was to remember one positive event (i.e., birthday party, school trip, etc.) from her childhood and it would be explored in the next session. The following week, Adele haltingly began to speak about selling small items at her parents’ beach club with two friends and her sister when she was a child. To spur her on, the therapist asked Adele to recount as many details as she could: What sort of things did she sell, how much did they cost, where did she display her wares, who was in charge of the money? After Adele answered each question in a brief manner, the therapist changed tack and started prompting her with playful questions/comments such as “So when did you realize you were a*

*budding entrepreneur?” “It seems you didn’t trust your little sister to be CFO,” and “How did you know what color troll-hair would be popular that year?” Adele began to giggle, smile, remember amusing details, and produce humorous commentary on her own. At the end of the story, both she and the therapist were laughing.*

This story is not particularly funny in the retelling, nor did it draw upon cleverness or humorous storytelling ability on the client’s or the therapist’s part. However, it did require the therapist’s cognition of the client’s affective presentation, verbal hesitancy, and lack of levity, as well as the understanding that drawing out details of a positive memory in a playful way might be potentially productive in order to (a) increase the client’s comfort with risk taking in the safety of the therapeutic dyad, and (b) encourage the client to mine her own playfulness. This process eventually led to genuine joint laughter and the creation of an experience that is humorous in three temporal zones: past, present and future. The positive interactive moment in the present will be remembered in the future and a neutral past event—through narrative restructuring and laughter—will henceforth be recalled as a humorous anecdote. It is an example of what Stern et al. (1998) define as *moments of meeting* through which “past experience is recontextualized in the present such that a person operates from within a different mental landscape, resulting in new behaviors and experiences in the present and future” (p. 918). Therapeutically, the encounter left Adele feeling more connected to her own innate playfulness and to her therapist. Eventually, through repeated encounters of this nature, interspersed throughout therapy, she may be able to take verbal playfulness and increased comfort with risk taking out of the therapeutic milieu and into the world.

### **The Play State-of-Mind and Early Mentalization**

The concept of play as experimenting with reality is central to understanding humor. Play is not just a physical activity; it is a mental one as well. Pretense through pretend play “strengthens a wide variety of mental abilities including attention, memory, language, creativity, perspective-taking, and self-control” (Valentino et al., 2011, p. 1281). The ability to practice risk taking in a safe environment and to let imagination run free occurs during play. As Lemma (2000) notes, playful exchanges in the early years of life promote psychological flexibility. It is Winnicott’s (1971/2001) third space, where fantasy and reality overlap; it is the space between reality and imagination, where one can leap from one idea to another. It can be the space that one jumps over to imagine what another person is thinking and feeling; it is the mentalizing space.

When a child approaches a toy train and makes “choo-choo” sounds as he pushes the toy forward, he is perhaps imagining he is the conductor, or that the train is on a track. He is separating the train idea from the reality of a real train, and is holding the concepts of both the real train and the representational train (the toy) in his mind. When a toddler dresses up as “mommy” and puts on her mother’s hat and scarf, then glimpses at herself in the mirror and laughs, she is also holding two realities: herself as mommy and seeing herself dressing up as mommy. This incipient ability to hold different realities in mind is an early mentalization process.

Prior to mentalizing, infants experience the world first as psychic equivalence (what exists in the mind also exists in the outside world (Allen et al., 2008; Fonagy & Target, 1997)). At around six months, the child connects her sense of agency with her ability to affect and be affected by physical objects and other people, as she develops a sense of herself as a teleological agent. By age 2, she understands that mental agency exists as well, but the distinction between

internal and external reality is still developing (Allen et al., 2008). It is at this age that toddlers are able to create secondary representations that enable them to experience things in different ways (Perner, 1991). The capacity to produce object-based and conceptual humor manifests itself (Hoicka & Akhtar, 2012): A stick can become a spoon, an apron can become a cape. With the acquisition of language, the first playful verbalizations occur and between ages 2 and 3, children can tell the difference between a mistake and a joke, and produce more novel humor in play sessions with parents (Hoicka & Akhtar, 2012; Hoicka & Gattis, 2008).

At about 4 years of age, the child's sense of agency includes beliefs and knowledge that her actions and the actions of others can be influenced by underlying thoughts and emotions and self-concept emerges along with the concept of epistemic (belief-based) mental states (Fonagy, Gergely, Jurist, & Target, 2002); in *theory of mind*, a philosophical and developmental concept, this is known as the intentional stance (Dennett, 1987). Theory of mind is a component of mentalization. A developmental milestone of this ability is the false-belief test, which most children can pass by age four (Allen et al., 2008). The false-belief test demonstrates that children are capable of predicting others' actions based on knowledge that they are privy to that others are not—that is, attributing behaviors to other individuals based on interpreting the knowledge base others have access to, not what the 4-year-olds themselves know (Wimmer & Perner, 1983). Young children can also differentiate what different family members find funny, taking their cues from the social environment (Cameron, Kennedy, & Cameron, 2008).

## **Mentalization**

Mentalization is a cognitive, emotional, and affective process that begins in infancy; it imbues us with the awareness that we have minds and feelings, that others do as well, and that behavior is guided by these underlying states. Allen et al. (2008) defined mentalizing as “imaginatively perceiving or interpreting behavior as conjoined with intentional mental states” (p. 4). The concept, developed in the early 1990s, incorporates theory of mind, psychoanalysis, and attachment theory. Mentalizing can be implicit or explicit. Implicit mentalizing is intuitive, and accounts for the majority of human interactions including the flow in conversations, and understanding the basic gist of situations; it is not unconscious, but it is not a higher order mental state. Explicit mentalizing is a higher consciousness, an awareness of being attuned to what is occurring mentally and emotionally in oneself and others. It is a metacognitive process—an awareness of the process of thinking and monitoring that cognition (Main, 1991). Mentalizing, however, encompasses more than thinking about thinking; it also includes thinking about emotions. In therapy, clinicians engage in explicit and implicit mentalizing to understand and imagine their clients’ mental states and feelings and, in mentalization-based treatment, clients are encouraged to do the same (Choi-Kahn & Gunderson, 2008).

Allen and Fonagy (2003) describe mentalization as a cyclical upward spiral that “originates in secure attachment relationships and secure attachment relationships are conducive to other interactions that promote the refinement of mentalizing” (p. 12). Deficits in mentalization development can lead to challenges in self-regulation and self-awareness, and can compromise the ability to see events from the perspectives of others (Fonagy & Bateman, 2007). Impaired mentalization can inhibit the ability to play with reality, to enter the world of others, and to see things from differing perspectives (Midgley & Vrouva, 2012). These deficits can lead

to profound suffering and restricted worldviews; they can also affect humor production and appreciation.

A central component of humor production is the capability to make an implicit/explicit leap into the mind of another. If the humor is on target—funny and not offensive, just risky enough to shake things up a little—the observations and intuitions into the others’ belief/thought system are correctly assessed. If humor is to be heard and enjoyed, the self has to be secure enough to absorb a different perspective from another mind (i.e., person) and not feel threatened; this ability to understand another’s mind is “difficult if one has not had the experience of being understood as a person with a mind” (Allen & Fonagy, 2006, p. 61). The ontogenesis of this ability is through caregiver reflective function. (Fonagy et al., 2002). *Reflective function* is the operationalization of mentalization and is sometimes used synonymously with mentalization in the literature (Allen et al., 2008).

### **Reflective Function and Contingent Mirroring**

In order to appreciate the minds of others, an infant has to first develop a mind of her own and her sense of personal agency. She depends on her caretaker to “hold” her mind as this process unfolds through the earliest dyadic interactions. Caregivers’ ability to view their baby as a mentalistic agent (i.e., as a human being with her own mind, feelings, and states) is key to this development. To explain this succinctly, Allen et al. (2008) inverted Descartes’ dictum from “I think, therefore, I am” to “I am because Mommy thinks I am” (p. 74). Infants also depend on caregivers to regulate their affects (up and down) over the first few years’ life of until self-regulation begins. Eventually the child comes to know that she is an independent agent with thoughts, feelings, and emotions, and she understands that others have thoughts, feelings, and emotions that might be different from her own.

Reflective function is a key component in the development of the self and it is largely dependent on parental attunement in the attachment system (Slade, 2005). A longitudinal study of 33 children found that securely attached children did better on the false-belief test and were better able to recognize and act upon alternative perspectives of another person (Meins, Fernyhough, Russell, & Clark-Carter, 1998). Later studies have shown the correlation between maternal mental-state commentaries on their infants' behavior known as "mind-mindedness" (i.e., psychological awareness of their infants' mental states) and increased mentalization ability in their offspring (Meins et al., 2002; Shai & Belsky, 2011). Mind-mindedness is described by Meins et al. (2002) as a "mother's explicit use of mental state language to comment appropriately on her infant's state of mind" (p. 1717). Shai and Belsky (2011) posit that this process is not always a verbal one, and that mentalizing occurs through kinesthetic and embodied interactions between caregiver and infant. A study by Slade and colleagues found a correlation between maternal reflective function and attachment security in their infants (Slade, Grienberger, Bernbach, Levy, & Locker, 2005).

Mentalization is an ongoing interactional process. It develops largely through marked and contingent caregiver mirroring of the child's internal states (Gergely & Watson, 1999; Fonagy et al., 2002). In this context, "marked" is the caregivers' representation of the infant's emotion and "contingent" is the accuracy of the response. Gergely and Watson (1999) proposed that parental affect mirroring is natural social feedback training for the infant allowing her to eventually develop emotional self-awareness and control. Fonagy et al. (2002) made a point of the importance of contingency: It is critical to neither over nor under react to the infant. If the caregivers' reaction is too real in mirroring (i.e., if the parent laughs hysterically or cries along with the infant) it can be quite frightening to the infant. As Grienberger, Kelly, and Slade



(2005) note, it is through the regulatory processes of early childhood that allow “gradually for an increase in the child’s ability to self-regulate, and ultimately symbolize his internal experience and to mentalize for himself” (p. 302).

The concept is simple to observe in action: When an infant cries, the caregiver responds by noticing the event, responds with facial and vocal expressions of concern (mirrors the affect but does not cry herself) and soothes her baby. If the baby smiles, the mother reflects back an even bigger smile and may comment, “Now, what are you so happy about?” This process “facilitates the child’s capacity to mentalize his internal experience, which in turn enables him to regulate his affect and distress” (Choi-Kain & Gunderson, 2008, p. 1129). There are other factors that affect mentalization ability as well, including family size and culture, which also influence the intersubjective therapeutic relationship, though in ways that are difficult to clinically assess (Youngblade & Dunn, 1995).

What therapists can do, in a manner similar to parental reflective function, is engage in a contingently responsive mirroring process, reflecting the clients’ emotions back to them in a way that shows no matter how awful their feeling states might be, they are manageable. This helps modulate distress and regulate affect, just as it does for the infant. Therapeutically, this can be achieved in multiple ways; one of which is through humor. In order to use humor in a way that does not backfire (i.e., the client feels insulted, misunderstood, or made fun of) the therapist’s own mentalizing ability must be up to the task. She must be able to mentalize implicitly, explicitly, and have a metacognitive grasp of the entire situation. If this is the case, the therapist can provide psychic distance from whatever is overwhelming/distressing the client at the moment and if she does this through humor, she creates a rivulet of lightness in emotional overload. In the following clinical example, the therapist mirrors her client’s situation.

**Paul**

*A male client in his 30s carries a diagnosis of adult attention-deficit/hyperactivity disorder and makes self-deprecating remarks on a regular basis; he often complains of boredom. The therapist suggests to Paul that he take up an area of interest (photography) and see what comes of it. A couple of weeks later, Paul returns and recounts in a flustered way that he bought a camera, took a one-to-one lesson on how to use the camera, and is still at a complete loss. Paul pauses and looks at his therapist, stating, “I just can’t bring myself to read the 80-page instruction book; I’m terrible at figuring things out. I always have been. I bet that never happens to you.” The therapist could have answered this in several ways, such as addressing the client’s frustration, his projection onto the therapist, or his disappointment in himself. The therapist took all this into account, reached into her purse and pulled out her own smartphone. “You see this,” she said, “it has a dozen functions, but all I do is make and receive calls because I don’t have the patience to read the instruction book—which is a lot shorter than 80 pages.” The client found this amusing and he and the therapist chuckled.*

In the above example of contingent marking, the therapist manages his client’s emotion for him until he is able to do so himself, by mirroring back the feeling (in this case frustration and self-criticism) in a mildly humorous, empathetic way. She empathized with his frustration, recognized it as part of a much larger pattern of thought and behavior, and deliberately integrated her own experience of a similar situation to allow him to see he is not alone. It is possible that the next time Paul is frustrated with an instruction manual, he will be able to recall this brief interaction and the laughter that ended it.

### **Incongruities, Humor, and Faulty Schemas**

In the development of humor, the play system can be understood as the springboard for imagination and risk-taking, and mentalization as a way to understand behavior and broaden perspectives. Another component is cognitive schemas (or constructs), the brain's way of organizing information (Martin, 2007; Piaget, 1963). It is also a process that begins in infancy. Schemas can be relational/affective or cognitive and often, there is an overlap between the two. These mental constructs around which information is organized play a key role in understanding humor. When a novel piece of information does not fit into a previously formed schema or construct, it has to be incorporated in some way or a new category needs to be created; either way, change occurs. This reconciliation process can produce new relational patterns, wider perspectives, and humor. It is one reason why a baby finds her mother putting a bowl on her head (as if it were a hat) hilarious: Her cognitive understanding of the use of a bowl has been challenged in a playful way. Schemas can produce humor when there is an activation of two incompatible scripts (Martin, 2007). This is known as the incongruity theory of humor. This concept has been in existence for centuries. In the late 19th century, Schopenhauer wrote that laughter occurs when objects in the real world and the concept of those objects do not match (as cited by Martin, 2007).

An example of the pleasure produced by incongruity at a very early age, and the subsequent widening of mental perspectives, is illustrated by the following vignette, which occurred while the author was observing her child.

#### ***Nicolas***

*Nicolas, aged two and one half years old, was intently watching a video of a Pinocchio cartoon. At one point in the story, Pinocchio is on Pleasure Island, a cursed*

*amusement park where mischievous boys are turned into donkeys. When his friend starts to turn into a donkey, he sprouts ears, a tail, and hooves. Pinocchio watches this in disbelief, and when he opens his mouth to say something, instead of speech, a giant “Brraaayyy!!” erupts. He quickly puts his hands over his mouth. At this point in the proceedings, Nicolas emits peals of laughter in surprise and rolls on the floor beside himself with delight.*

As Nicolas watched the film, there was an incongruity (human mouth/donkey bray—contradictory cognitive frames). According to McGhee (1979), figuring out the incongruities—cognitive mastery—results in humorous delight. Hurley et al. (2011) put it another way: “Humor happens when an assumption is epistemically committed to a mental space and then discovered to have been a mistake” (p. 121).

However, cognitive mastery through the resolution of an incongruity is not enough to produce pleasure; for humor to occur, the incongruities must be within a developmentally congruent cognitive range (McGhee, 1979). A toddler would not find a riddle amusing, a child of five might enjoy it thoroughly, and it would likely produce a bored eye-roll in a 12-year-old. Two other important components in the incongruity theory of humor are safety (i.e., the incongruity must feel safe and occur in a safe environment) and it must be mutually understood to be playful (Semrud-Clikeman & Glass, 2010). In early work on the development of laughter in the first year of life based on observational studies of 150 infants, Sroufe and Wunsh (1972) found that an infants’ reactions to an incongruous event will be positive if the event is cognitively manageable and interpreted as positive, the inverse being true as well. Resolving an incongruity slowly in a threatening situation does not produce mirth. If a toddler does not feel secure, the incongruity will feel frightening.

Later theorists added the elements of surprise and speed—to the incongruity theory, as necessary components for something to be found humorous (Hurley et al., 2011). Something slowly absorbed is generally not funny (the delayed reaction being the exception) nor is it unsurprising. Incongruity theory leads to the ability to understand events from different viewpoints, what Hurley et al. (2011) referred to as the intentional stance, and is fundamental to humor. The intentional stance is a component of mentalizing (attributing underlying mental states, see p. 14). The authors posit that the more mental spaces we create (i.e., seeing things from varying perspectives) the more opportunities there are for humor, stating “We may find things funny either if they are invalidated mental spaces in our own knowledge representations or if we recognize that they are invalidated mental spaces for another entity’s knowledge representation” (Hurley et al., 2011, p. 145). The concept is an extension of incongruity theory in that amusement arises not only from unexpected juxtapositions or outcomes, but appears when another person acts or reacts according to a mistaken belief. Third person humor arises more frequently because it is easier to see errors in others’ thinking than our own, just as it is easier to observe faulty schemas and behavior patterns in others than in ourselves. Bell, in his 2010 article linking theory of mind, humor, and mental illness, discussed the concept of “theory of mind jokes” as the type of humor dependent on attributing to others’ ignorance, a false belief, or misunderstanding. He illustrated this idea with a cartoon showing a man at a bus stop facing sideways with his hands up in the air as if being assaulted. Standing adjacent is a young man whose guitar stem is poking the man’s back (Bell, 2010). The humor lies in understanding and enjoying the man’s misperception.

As clinicians, we usually do not find clients’ “knowledge misrepresentations” or faulty schemas funny, but we are highly attuned to them, and at times, humor can be a very effective

way of changing them. If the client feels safe with the therapist, then having an incongruity noted in a humorous way, or being challenged on a faulty schema will seem funny because, by nature, incongruous juxtapositions are amusing and for the client (or anyone) cognitive mastery of a new concept or broadened perspective can be a pleasurable experience. Epistemic beliefs are based on experiences and if a clinician can break into a client's epistemic failings through humor and by offering her own perspective in a playful way, she can create an experientially shared positive moment that can facilitate growth and change. The following clinical vignette illustrates a humorous way of breaking into a faulty schema.

### **Laurie**

*Laurie, a 45-year-old female client, had suffered a series of traumas in her early teens. One of the results was the development of a core belief that no matter what she did things would not work out. In sessions, her tendency to "awfulize" was discussed, but it was challenging for her to view outcomes as potentially positive. Laurie was describing an upcoming move she was planning:*

*I hate where I live and I found this nice apartment. But if I put a deposit on it I'll be stuck if it turns out to be a mistake, and I probably can't afford it because I won't be working much longer. I am sure I am going to get fired. But then again I can always count on the inspection to find something wrong. And I can always keep this rental when things don't work out.*

*The therapist responded, "Well, you haven't even moved yet, and you've already planned your escape route." Laurie looked stunned for a moment, and then burst out laughing.*

Laurie's belief system was based on the faulty schema that things "never" work out, and her plan to move was based on not giving up her rental. The therapist, in one line, called

Laurie’s attention to her propensity to plan on the worst happening and, by using the words “escape route,” injected the incongruous association of a prison break. Laurie understood both and was able to laugh because she found it amusing and felt safe with—and understood by—her therapist. Eventually, Laurie would be able to catch her own erroneous schemas and use of exaggerated language, and on occasion, be able to make fun of them herself.

One final clinical vignette illustrates several concepts previously reviewed: using humor to provide perspective through the use of incongruity, mentalization ability, and reflective function; verbal playfulness; and the role of humor as an agent of change.

### ***Violet***

*The client, an attractive well-dressed young woman aged 29, was describing her marriage history. It was the client’s first time in therapy, and her first session. For 9 years, Violet lived with an emotionally abusive husband who was an alcoholic. There was no physical abuse involved until an incident the previous year and it was then that Violet filed for divorce. The couple has a 4-year-old daughter. Throughout their marriage, Violet kept hoping her husband would stop drinking and become more responsible. She berated herself for not “picking better” and was bitter about the outcome. She kept referring to him as a “bad investment” and said her marriage was a waste of time. Thirty minutes into the first session, the atmosphere was dense and laden with Violet’s regret. The therapist then interjected a bit of humor by using very mild sarcasm: “You make your ex sound like a bad stock pick.” This lightly humorous remark caused the client to burst out laughing after a moment of startled surprise.*

This is not a particularly funny anecdote in retelling, and it illustrates the “you had to have been there” in-the-moment aspect of humor. Violet’s reactions illustrate that although she was in extreme distress, her mentalizing ability was intact and thus she was able to see her husband from a different perspective—a humorous one—when the therapist spoke. The use of

metaphor was helpful as well because it momentarily reduced the client's husband to a "thing" and this incongruity produced a burst of laughter. The laughter occurred because of the incongruity but also because Violet felt safe with the therapist and the remark was said in a quick, playful manner. The laughter outburst gave Violet some mental space: Her feelings about her ex-husband became less overwhelming because she was able to think about him differently and in a space of deep distress, a little light entered.

On a metacognitive level, the therapist, while empathizing with Violet's situation, also saw the need to interject some lightness into the situation in order to protect Violet from becoming overwhelmed by her own emotions, especially in the first session. Though Violet felt comfortable enough to share deeply personal elements with her therapist, her degree of affect needed to be regulated or she ran the risk of not returning to therapy, feeling she had revealed too much too quickly. How did the therapist know what to say? Violet gave clues through her use of language and vocabulary (e.g., "bad investment," "bad pick") and had mentioned previously that she had majored in business in college. In addition, Violet spoke about her daughter in a loving, nurturing way and stated she wanted her daughter to have an easier childhood than she herself did; she also described some of her daughter's qualities. This alerted the therapist to two things: Violet was able to acknowledge her daughter as a separate human being (not an extension of herself), and demonstrated a good level of parental reflective function; this was also an indication of Violet's own ability to mentalize and her own relatively high level of attachment security. With this information in mind, the therapist was able to take a calculated risk with a new client and interject humor.

As a result, the therapeutic alliance moved forward on several levels: The client felt heard and understood by her therapist and both enjoyed a "moment of meeting" a co-created



experience of positive affect that resulted in laughter. In the future, the client might occasionally be able to think of her ex-husband as a bad stock pick and, in doing so, relegate him to a lower level of importance, dominance, and control.

### **Conclusion**

Developmentally, from an infant's earliest moments of life, he is genetically designed to connect for survival and his caregivers attunement will not only help him survive, but thrive. His need to connect and natural proclivity for joy are hardwired. Optimally, in the first few years of life, through interactions with his caregivers, he not only develops the ability to know and understand his own thoughts and feelings, but to intuit the thoughts and feelings of others as well. He will explore his world physically and psychically, eventually align internal reality with external reality and, if encouraged, maintain his sense of play and fun. As his social world expands, his ability to enjoy, and produce humor, as well as use it as a social communication tool, will increase. Eventually, humor—mental play—will help cushion him from life's vicissitudes and provide some comfort along the way. The cushion is the internal mental space that allows for holding parallel realities demonstrating that if the present situation is untenable, it can be viewed from other perspectives, including humorous ones.

If this developmental trajectory is impeded or impaired, humor appreciation and production may be affected and, should this manifest in therapy, it can and should be addressed. The theoretical concepts of the attachment system, play system, mentalization and the role of incongruities in the development of humor provide a theoretical basis for the integration of humor in therapy. With an awareness of each component, the clinical social worker can co-create and experience with her client positive affective interactions within the safety of the therapeutic milieu, reinforcing, reawakening, or nurturing the presence of humor, playfulness,

and fun. Through playful coaxing and modeling verbal risk taking, the therapist can activate the client's play system; through mentalizing, she demonstrates how to explore new perspectives and by pointing out incongruities in a light way, she motivates the client to look at her own thought processes.

Used judiciously, and with sensitive clinical judgment, the integration of humor is an important clinical skill. It is unique in that it is enjoyable and this pleasurable aspect is, in and of itself, meaningful. By adding some light humorous moments to the therapeutic relationship, the clinician increases comfort with positive affect, strengthens the therapeutic alliance, and gently broadens her client's understanding of herself, self-and-other, and self in the world. Humor is about seeing things in a different way and conveying that even the most painful situations can be managed. Mahatma Gandhi expressed this concept perfectly when he wrote, "If it were not for humor, I would long ago have committed suicide" (GandiServe Foundation, n.d., para. 2).

We are not all comedians, and the gift of being funny—timing, wittiness, mental agility—is just that, a gift and is rare. However, we all have the capacity to lighten our burdens, perhaps just a little, though viewing most events through a slightly different lens and learning to laugh at them together, and alone. As clinicians we can model and guide our clients through this process through sharing and creating the experience.

## THE BEARABLE LIGHTNESS OF BEING: INTEGRATING HUMOR INTO CLINICAL SOCIAL WORK

### **Introduction**

Although an abundance of literature produced in the past 30 years has provided strong anecdotal and some empirical evidence for the benefits of therapeutic humor (for a review see Sultanoff, 2013; Martin, 2007), yet there is a lack of literature on integrating humor in clinical social work. This is unfortunate because social work, more than other direct-care practices, has a history of emphasizing the common humanity of therapist and client and values the interpersonal relationship as essential for change (Hepworth, Rooney, Dewberry Rooney, Strom-Gottfried, & Larsen, 2006). Humor is not a treatment modality or paradigm, it is an integrative communication tool and when interjected judiciously by therapists can reach clients on multiple levels: cognitive, emotional, and affective. Although this paper focuses on therapist's use of humor, it is not a one-way street: therapeutic humor is an intrapsychic and intersubjective process that is co-experienced. Humor is a great equalizer—finding joint amusement loosens the constraints of the clinical setting as it strengthens the therapeutic alliance. The therapeutic use of humor creates positive affect (Sultanoff, 2002), can light-heartedly and playfully open perspectives and challenge faulty schemas (Hurley et al., 2011; Martin, 2007), help regulate emotions (Salameh, 1983), provide a corrective emotional experience (Wallin, 2007), increase coping skills (McGhee, 2010), and create positive “now moments”—exchanges of insight that move therapy forward (Stern et al., 1998). When used judiciously in the therapeutic milieu, humor can be a catalyst for change.

A humorous interject by the therapist stands out as a communication. Therapeutic moments of humor are analogous to visual punctuation marks, which highlight, underscore,

emphasize, make bold, and italicize moments in therapy that move clients closer to their goals. Eventually, when a client is able to create some distance from her emotional distress through humor, laugh at herself or find humor in her situation, then she is on the road to psychological well being. Humor is considered both a strength and a positive trait (Seligman, Stern, Park, & Peterson, 2005). The ability to narrate one's life in a cohesive manner with occasional humorous interjections is one good indicator of mental health.

For some therapists, integrating humor is a natural process; for others—especially novice therapists— humor is not part of their therapeutic tool kit. For those therapists who already use humor in the therapeutic milieu, this paper hopes to provide a deeper clinical understanding of some of its mechanisms and benefits. Here I depart philosophically from E.B. White who wrote that explaining why something is funny is like dissecting a frog; it does not work and does nothing for the frog. I believe it is better to know why it works. For those clinicians who avoid humor in therapy because they don't think they are funny or are afraid of offending their clients or colluding in an avoidance of pain, the goal of this paper is to increase comfort levels with humor and encourage its use.

While some humor scholars (Franzini, 2001; Prerost, 1994; Salameh, 1994) recommend formal humor training, I propose a different approach to increase therapists' comfort with humor integration. Therefore, the aim of this paper will be to examine three inter-related components of therapeutic humor: (a) being in the moment (spontaneity), (b) attunement (knowing yourself and your client), and (c) playfulness. Being in the moment and attunement are two sides of the same coin and will be explained theoretically through the frameworks of mentalization and clinical use of self. The component of playfulness in therapy is largely verbal but encompasses a range of concepts including imagination, levity, creativity, silliness, and the willingness to take calculated

risks. It is the vehicle through which humor is expressed. Through mentalization, use of self, and play, opportunities for therapeutic humor multiply. Clinical vignettes will be interspersed throughout to illustrate how humor can function to propel positive change and different ways clinicians use humor. The caveats for using humor will be also addressed, as will ideas about what to do when the use of humor backfires. In addition, two powerful humor tools, incongruities and exaggeration, will be explained through vignettes.

### **Being in the Moment, Mentalization and the Therapeutic Relationship**

One element of humor is *spontaneity*, defined as the ability to grasp what is happening in the moment and take advantage of it (Richman, 1996). Franzini (2001) wrote a comprehensive article about humor in therapy and presents an argument for training therapists in its uses as well as its risks. His definition of humor in therapy is succinct: the therapeutic use of humor leads to client improvements in self-understanding and behaviors (p. 171). For those therapists willing to use humor in therapy, Franzini advocates training in various humor techniques, developing sensitivity to humor by clients, and the importance of clinical supervision to guide humor usage. According to Franzini (2001), “You cannot command spontaneity. Similarly, you cannot simply order a therapist, novice or experienced, to be funny” (p. 177). Franzini cites Banmen (1982) on the value of training to increase spontaneity. I concur with Franzini on the importance of clinical supervision and how it can foster humor use, and many of his points regarding humor in therapy also resonate with me. However, I believe spontaneity can be increased, not through humor training per se, but by raising therapists’ attunement to what is happening in the moment and heightening awareness of what is occurring in the inter-relational space. Heightened awareness plus the willingness to take risks creates spontaneity. Spontaneity, combined with playfulness increases opportunities for fun, levity, and humor. I believe “funniness’ is a creative gift—but

therapeutic humor is not necessarily funny. It is context-driven, experiential, and relational: it is a cognitive and emotional connection between two people—this is why humorous episodes often sounds flat in when recounted and/or are hard to remember. The “you had to have been there” aspect of a most humor applies to a great deal of therapeutic humor. Though funny at times, therapeutic humor is more generally more playful, and therein lays its enjoyment and pleasure.

In therapy, humorous spontaneity must be thoughtful and clinically sound (Dziegielewiki, Jacinto, Laudidio, & Legg-Rodriguez, 2003). Though this sounds paradoxical, the answer lies in clinical awareness, attunement to the client, and the ability to be present cognitively, emotionally, metacognitively, and empathically. As is often the case, overlapping concepts can appear simpler in action, as the following vignette illustrates.

***Rachel***

*In an initial interview with a highly anxious 12-year-old girl named Rachel, the therapist began to gather some preliminary information. The child was so uncomfortable with the whole process, that she couldn't stop giggling and squirming on the sofa. After a few minutes, the therapist also began to feel awkward and ill at ease (mirroring the child's affect and highly attuned to her discomfort). Finally, the therapist said with a smile, “You know, I don't know what it is about that couch, but that happens a lot when people sit on it.” The child looked at her and burst into real laughter, and the therapist joined in.*

In the preceding example, the clinician was well aware what was happening with her young client on multiple levels. Cognitively, she knew that initial interviews are uncomfortable and that laughter or nervous giggling can be an anxiety response. Emotionally, she understood Rachel's discomfort and felt it viscerally herself. On a meta-cognitive level, the therapist was aware that all of these processes were occurring simultaneously. She empathized with Rachel's

experience and with one humorous line eased her discomfort, dispelled the tension, and created a positive shared moment.

If we unpack why the line was amusing it was because this creative therapist used incongruity. Rachel's mental framework or schema of what was making her nervous—the weirdness of the situation—was super-imposed by another schema introduced by the therapist: it is the couch's "fault". As Rachel's brain processed this information, trying to reconcile the two incompatible scripts, laughter was the result; this is known as the incongruity theory of humor (Martin, 2007). Non-threatening incongruities trigger the reward system in the brain, and the faster they are delivered, the funnier they seem (Hurley et al., 2011). For an incongruity to be amusing, it needs to be within cognitive range and feel safe (McGhee, 1979; Semrud-Clikeman & Glass, 2010). Rachel was able to laugh because something in her therapist —manner, look, way of being—transmitted the feeling of safety. At the same time, it also communicated that she had been understood.

From a theoretical framework, the vignette above can be explained through the processes of mentalization. Mentalization is a theoretical framework developed by Fonagy and colleagues in the early 90's, bringing together concepts from theory of mind, attachment theory and psychoanalysis. It describes a cognitive and emotional developmental process that begins in infancy; its optimal evolution is largely contingent on secure attachment. Mentalization refers to the ability to be aware of the mental states in oneself and others, and to interpret behaviors based on underlying mental states (Allen et al., 2008). Mentalizing can be implicit or explicit; implicit mentalizing is intuitive, it allows us to get the gist of situations without words, and is analogous to procedural memory. It is connected to empathy. Explicit mentalizing is "conscious, deliberative and reflective (Allen et al., 2008, p. 27); it is verbal. In therapy, clinicians mentalize

implicitly and explicitly to understand and perceive their clients' mental states and feelings, and, in mentalization-based treatment clients are encouraged to do the same (Choi-Kahn & Gunderson, 2008). As clients' ability to mentalize increases, so does their ability to emotionally self-regulate and to understand things from different perspectives. Developing therapists' mentalizing capacity increases the opportunities for the therapist to integrate humor, but as Valentine and Gabbard (2014) note, the clinician's ability to assess what her client may or may not find funny requires "a concerted effort on the part of the therapist to mentalize" (p.79). This is attunement—and is a requisite of almost all therapeutic interventions, including the use of humor.

To explain the Rachel vignette from a mentalizing perspective: the clinician *explicitly* understood what was happening with her client, and her visceral understanding was *implicit*. She was also operating from cognitive and affective knowing—integrating cognition and emotion (Choi-Kahn & Gunderson, 2008). On a metacognitive level, she drew upon her awareness of the above processes while taking into account the beginning phases of treatment, the age of her client and other environmental components. Her response was the integration of multiple ways of knowing, with the added layer of playfulness— otherwise her response might have been a variation of reframing, i.e., "I know how uncomfortable it can be to sit with a stranger in a small room and be expected to talk— it would feel pretty weird for me too". That would have been a fine empathetic answer, but it would not have punctured her client's balloon of emotional anxiety the way humor did. The shared moment of laughter also got the therapeutic alliance off and running.

Fonagy and colleagues developed a short training program in 2002 for psychiatric residents to increase their mentalization skills in order to conduct Short-Term Mentalization and



Relational Therapy (Williams, et al., 2006). The aim was to increase awareness of residents' own internal states and the internal states of their clients based on the underlying assumption that treatment outcome is heavily influenced by the therapeutic relationship. After several permutations, the most successful training program focused on interpersonal relational skills and a key-component was role-playing because it is the gateway to procedural knowledge. With a similar goal, a more recent randomized controlled trial by Ensink et al. (2013) sought to verify whether training novice therapists in mentalization skills would improve their reflective function and clinical efficiency in work with clients with borderline personality disorder. Reflective function (RF) is a measure of mentalization (and at times used at times synonymously with it in the literature). The results of the trial indicated that even brief training resulted in improvements in novice therapists' reflective function skills. Ensink et al. found that reflective function increased considerably with training and that those therapists in the control group who received didactic training actually became less reflective after training. The authors posit that this result is an indication that experiential mentalization training leads to greater ability to connect with clients' emotions and internal experiences in meaningful way (Ensink et al., 2013, p. 535). It is a relational process.

In both experimental conditions, role-playing, analyzing interactions through feedback, and the input of teachers was determined to be an important component in outcomes. Both studies concluded that the experiential part of training is key. In supervisory environments, it is the parallel process between supervisor and supervisee that mirrors the therapeutic process, and consciousness of this can advance clinical acumen, which is especially important for novice therapists or therapists learning new theoretical concepts. In social work, the requirement of process recordings in field training reinforces this function as well: novice social workers write

down their interactions with clients and these are later analyzed and commented upon by supervisors; the intersubjective process is laid bare. Unpopular as process recordings may be among students, they serve a vital function, particularly when role-playing is not offered in supervision or the chance to practice therapeutic interchanges with one's supervisor is not possible. It is also through supervision that greater comfort with humor can be developed: Supervisors can integrate humor with supervisees to provide perspective and ballast during case reviews and, at the same time, model judicious playfulness.

In their comprehensive review of extant literature on the therapeutic relationship and psychotherapy outcome, Lambert and Barley (2001) demonstrated the importance of the therapeutic relationship; it accounts for 30% of positive outcomes; 40% is derived from exo-therapeutic factors and the remaining 30% is divided between expected outcomes (placebo affect) and specific techniques. The authors emphasize the importance of training in relationship skills, especially for beginning therapists, as well as continuing education for licensed professionals (p. 359). In using humor therapeutically the clinician is employing her most attuned relationship skills.

### **Use of Self, Self-Disclosure, and Humor**

As clinical social workers, the concepts of use of self and self-disclosure are familiar and present they are found in most social work textbooks (Shulman, 2006; Hepworth et al., 2006), yet there is some confusion surrounding the terms as they are defined differently in the literature. Dewane (2006), in her overview of use of self in clinical social work, delineated five operational functions of use of self to clarify the issue. They are: use of personality, use of belief system, use of relational dynamics, use of anxiety and use of self-disclosure (p. 544). In Dewane's view self-disclosure is a subset of use of self.

When a clinician shares a humorous experience from her own life or reacts in the here-and-now to what a client is saying, she is revealing something of herself as a person. Arnd-Caddigan and Pozzuto (2008) in their article on use of self in relational clinical social work offer a definition of self as a process, existing in relationships with others in which “the self is continually created, maintained, and re-created” (p. 235). The authors cite Fonagy’s concepts of mentalization or reflective function as critical to this process: the therapist must be aware of her own thoughts, feelings and beliefs and be able to form an idea of her clients’ thoughts, feelings, and beliefs in an ongoing interaction that is flexible and not dictated by therapeutic techniques or outcomes. As Arnd-Caddigan and Pozzuto (2008) suggest, “Use of self becomes a process of continually engaging in reflective function and altering the course of action as engagement dictates” (p. 238). One self acts upon another, and in this way, change occurs. As Bader notes, though therapeutic humor is within the purview of the therapist, its expression “is both cause and effect of the interactive field” (Bader, 1993, p. 25). Bader views humor as part of the clinician’s emotional responsiveness, activated through interactions with the client, and it is a mutative process. Based on the work of Levine (2007), Arnd-Caddigan and Pozzuto (2008) posit that the use of self must feel authentic to the therapist, is created and maintained in clinical interactions, and “must not stray from the prime directive of putting the best interest of the client above all else” (p. 239). Their model for use of self can serve as a guiding principle for those times when the interaction takes the form of a humorous comment, question, or observation, i.e., that the humor should always be interactive, inter-relational, genuine, flexible and attending to the client’s needs. The clinician, before interjecting humor, must keep the client’s mind in mind before taking a playful verbal leap.

The following short interchange is an example of relational self-disclosure, a humorous interjection of thoughtful spontaneity. The therapist shared her own feelings and, in doing so, took a small calculated risk:

*An anxiety-prone female client was complaining of writer's block and how pressured she felt due to an upcoming deadline. Her anxiety only increased her "inability" to write. When prompted by the therapist, she was able to talk about her article topic fluently, ticking off on her fingers the points she wanted to make. After a short pause, the therapist handed her a plain legal notepad and said, "Here, this is a magic pad, write down what you just told me!"*

The therapist's playful remark displayed her own sense of humor and perhaps her own sense of momentary annoyance; she took the risk of offending her client who might have felt she was not being taken seriously. However, the chances of this occurring were low because the therapist knew her client appreciated humor, they had an established alliance and this was not the first time writer's block had come up or the problem of procrastination discussed. The response was relational, transparent and in the moment but not without thought. The humorous line was the therapist's indirect way of saying "Come on, I know you can do this". She was honest with her client, genuinely believed in her writing ability and expressed her feelings playfully. The comment was amusing because it was incongruous as well: pads aren't magic and they don't write themselves, nor is the word "pad" associated with magic. The odd juxtaposition of words added an element of fun and recalls "the magic slates" of childhood, in which images are written and then made to disappear. Relational expressions of humor, such as the one above, are usually hard for clinicians to remember because they are spontaneous and can be quite brief. However, awareness of their utility can augment their frequency.

The previous example illustrates one use of self, which Dewane (2006) might refer to as the use of relational dynamics or use of personality. Another aspect of use of self is self-disclosure. Knight (2012), in her article on social workers' attitudes towards engagement and self-disclosure, cites two types of self-disclosure "here and now" and "there and then". The first refers to disclosures that reveal the therapist thoughts and reactions to the client and to what is occurring in the session. Knight (2012) refers to this type as disclosure as transparency. Here and now (transparent) disclosures are relational. The second type, the "there and then" are "self-involving disclosures" that make reference to related experiences the clinician has had in his or her own life (p. 298). Knight states that most social workers use self-involving disclosure, and studies of this type of disclosure reveal it is less impactful than relational here and now disclosures. Knight cites research conducted by Edwards and Murdock (1994) and Hanson (2005) that indicates therapists are more likely to self-disclose to convey empathy, understanding, disclose qualifications, and to reassure clients. It is likely that self-involving disclosures are more common because it is usually easier to share an anecdote to affiliate than share more of oneself from a relational perspective (the latter potentially exposing more of the clinician's being and vulnerability). Hanson (2005) concluded from her study of 18 clients in therapy, that therapist attunement is the key factor in whether clients find self-disclosure (of any type) helpful.

While most effective therapeutic humor involves relational self-disclosure, humor based self-involving disclosure can be helpful as well as it conveys empathy and can broaden perspectives in a more directly comparative manner. The following vignette is an example of a there-and-then disclosure.

### **Veronica**

*Veronica, a 45-year-old client who had emigrated to the United States from Ecuador, was prone to self-criticism and had challenges accepting her reduced station in life. In Ecuador, she was a high school teacher, in the United States, a nanny. She lamented that after years of studying English she was still far from fluent. She described her frustration to her therapist, who she thought far more intellectually adept, ending with “I bet you couldn’t understand how annoying it is to keep searching for words.” After a moment’s pause her therapist said, “Well, after living 5 months in Brazil I went to a stationary store to buy glue. Not only did I not know the word for glue, I couldn’t think of anything that described glue without using the word “glue” or “sticky” (which I didn’t know either). After 5 minutes of useless charades, I left the store empty-handed.” The client giggled.*

In this example the humor functioned on several levels: the therapist mirrored back and contained the client’s frustration, and in sharing her own language difficulties, was genuinely empathetic. The exchange advanced the therapeutic alliance and helped the client feel more on equal footing. From a Kohutian perspective, the client’s idealized transference is diluted when the therapist describes her own personal struggles (Kohut & Wolf, 1978). Perspective was broadened in two ways: Firstly, not being able to communicate is indeed frustrating but it is not an uncommon occurrence in our mobile society and even smart therapists struggle. Secondly, Veronica’s frustration with language fluency was part of a larger discontent (cultural alienation, being on a lower-socio economic level). By separating out the language issue the therapist helped Veronica compartmentalize one component of her general feeling-state and put it in perspective intrapsychically. It is also the type of self-disclosure that Knight (2012) espouses: “rather than being a spontaneous ‘from the gut’ intervention, self-disclosure should

result from thoughtful need and worker intention” (p. 303). It is an example of deliberate spontaneity.

Whether through ongoing relational use of self or specific self-disclosures, humor is a product of personal interaction and of the moment, its success depends on attunement and awareness. In her review of self-disclosure as an integrative process through various theoretical lenses, Ziv-Beiman (2013) writes in her conclusion that self-disclosure helps consolidate the therapeutic relationship as it advances a range of therapeutic goals. Humor in self-disclosure has the added benefit of producing shared positive affect.

### **Playfulness: The Expression of Humor**

The play system develops in infancy in the earliest dyadic interactions, when mother and baby smile and laugh at each other over exaggerated gestures like funny faces and surprises like peek-a-boo. If the toddler is securely attached, the play system evolves to the point where venturing forth, experimenting with reality and imagining become part of the child’s repertoire of thoughts and behaviors. For some clients, this process is never fully developed or is not expressed due to trauma or other negative experiences. Sultanoff (2013) gives an example of using therapeutic humor with a depressed client as part of her treatment. The client became annoyed with his use of humor because it made her laugh, and this took away her feeling of depression. The exchange provided insight for the client: an awareness of wanting to hold on to the depression, but capable of laughter at the same time.

For some clients, playfulness is not, to use Fredrickson’s term, part of their thought/action repertoire (Fredrickson, 2001), and it can disappear completely under duress. If the quality of playfulness remains subsumed, then a major coping skill is lost. Multiple studies have shown that humor is an integral part of what for many people, makes the vicissitudes of life

manageable (Lefcourt, 2001; Lefcourt & Martin, 1986). A humorous interaction with a trusted therapist can reactivate playfulness through modeling and co-creation of positive affect.

Playfulness offers a view to a different way of being in the world that can increase comfort with levity, creativity, and verbal risk-taking. Co-created positive moments, such as those with Rachel and Veronica, are transformative. Shared positive affect is a product of emotional complicity and can lead to relational closeness—in therapy and outside it.

Humor is a form of play and “playing” with ideas (McGhee, 1999). Verbal wordplay can take many forms. According to Ehrenberg (1991), playfulness and humor in therapy include, among other things, “the use of irony, affectionate kinds of teasing, banter and repartee, joint fantasy” (p.225). It also includes pointing out incongruities and re-framing in a light manner, mild sarcasm (not directed toward the client), paradox, and reflecting back to the client what she may be thinking about an interchange in a playful way (i.e., “I see from the thought bubble over your head that I’m really out on a limb here”). Playfulness may be expressed in gestures such as exaggerated shrugs, raised eyebrows, half-smiles, or a twinkle in the eye. Moments of levity can be expressed in one-liners in the course of therapy, adding instances of mirth without in anyway taking away from seriousness of the issues at hand. Playfulness can also sometimes be physical. In his book on brief therapy working with adolescents, Selekman (2005) gave the following example of physical humor: “I have conducted some family sessions slouched ridiculously low in my chair to mirror the adolescent’s nonverbal behavior, which typically prompts smiles and laughter from the family and the youth” (p. 135). However, therapeutic humor is more often about the technique of playful verbal reframing or questioning that will lead the client to question her own cognitive schemas and/or begin to view them from different perspectives.



The following vignette illustrates how a clinician uses light-hearted verbal teasing to bring her client to a different level of self-awareness. The clinician titrates up her questioning until it reaches a level of gentle parody that her client not only accepts but also finds amusing.

**Olivia**

*Olivia is a 21-year-old female college student, suffering from disordered eating patterns and mysophobia. Her symptoms wax and wane depending on her anxiety levels. She is moving in the direction of learning to eat intuitively—in response to her own body’s needs—but it is a very slow process. In a recent session, Olivia told her clinician that her OCD tendencies had been intensifying with germs. She showers at least once or twice a day, cannot wear the same clothes twice, anything that comes into contact with the outside world is a potential contaminant. In terms of food, she firmly believes that if a particular food makes contact with another food in any way it becomes higher in calories. For example, if a knife is used to cut a friend’s sandwich in half is then used on Olivia’s sandwich her sandwich now has a higher caloric value. After completing a difficult semester abroad Olivia met her father in Rome to travel around for an additional week—instead of returning home (which would have been her preference). In a recent session, Olivia stated that her need to wash her hands after touching anything foreign was becoming really wearing and mentioned getting angry with her father because he asked her to turn the TV off after she had washed up and was in bed under the covers. After pushing the power button off, she had to get up and wash her hands again. In session, she was challenged by her clinician to go further with her cognitions: “So, let’s imagine that after turning off the remote you didn’t wash your hands. What might happen?” Olivia didn’t respond, and the clinician pushed a bit further: “Do you think your body would fall prey to some horrible illness? Olivia began to own up to some “crazy thinking” and her ability to step back and label the*

*thought process was discussed. The therapist then proceeded, “So how many seconds might your hand have been on that remote?” Olivia replied, “Maybe one second.” The therapist continued:*

*So how many germs do you think your one little finger could possibly be exposed to for the nanosecond that it hit the button—just like how many extra calories could you possibly have consumed from that one little spec of sauce or that slightly dirty knife . . . 1/1000th of a calorie?*

*Olivia then chuckled and said, “No, but it’s so hard to make it stop in the moment [from acting on her thoughts].”*

This humorous interlude was used to help Olivia observe just how “crazy” her thought process was and is in line with the therapeutic goal of creating psychic space between Olivia’s obsessive thought patterns and her compulsion to act on them. Part of the effectiveness of the playful teasing was the clinician’s use of Olivia’s own language: she gently mimicked her client’s propensity to parse and measure everything related to food and germs. Linguistically, the clinician went one step further than Olivia—measuring food in fractions of calories, measuring time in nanoseconds. By joking with Olivia over a serious issue that had been the subject of therapy for months, the therapist also lightened the topic a little, giving them both a little breathing room and a play space.

### **Types of Humor**

It is clear that not all types of humor are appropriate in therapy. Although the use of derisive sarcastic, aggressive, or mocking forms of humor may be tempting, especially when the therapist is feeling frustrated or anxious, it is not effective. In 2003, humor scholar Martin and his students developed the Humor Styles Questionnaire, an instrument designed to distinguish

between potentially healthy and adaptive types of humor and unhealthy or potentially detrimental humor (Martin, Phulik-Doris, Larsen, Gray & Weir, 2003; Martin, 2007, p. 211). In the first category are affiliative and self-enhancing humor, in the second aggressive and self-defeating humor. Affiliative humor is employed to facilitate relationships and reduce tension; self-enhancing humor describes humor as a way of looking at life from a humorous perspective and the enjoyment of incongruities. Aggressive humor implies what it says: sarcasm, ridicule, derision; self-defeating humor involves excessive self-disparagement. Research conducted by Kazarian and Martin (2004; as cited in Martin, 2007) has shown that these scales may be culturally driven and that affiliative humor is more oriented toward societies that value interdependence among individuals. It stands to reason that in therapy, affiliative humor is the type that is most beneficial interpersonally and the type that serves to strengthen the therapeutic alliance. In a study examining affiliative and aggressive humor in relation to attachment dimensions and interaction goals, Miczo et al. (2009) found that affiliative humor is positively related to effectiveness and playfulness. The authors also conclude that affiliative humor “is an integrative form of humor that serves to enhance positive feelings and solidify relational bonds” (Miczo et al., 2009, p. 445).

In writing about the therapeutic use of humor with antisocial personalities Martens (2004) suggests using only gentle, social, and constructive types of humor “to stimulate a social and reflective attitude” (p. 352), and noted that the therapist herself may also benefit and stay motivated by the use of humor in interactions with these clients. Occasionally, with clients who have greater ego strength and with whom there is a solid therapeutic alliance, the clinician may use moderately sarcastic humor. However, the sarcasm is not aimed at the client but rather toward a third party (e.g., a person, an institution, a cultural bias) and should always contain an

inherent playfulness. Sarcasm toward a third party is another way of signaling empathy with the client, although it must be used carefully due to the inherent risks of overshooting the mark and relying on sarcasm to quickly build an alliance (e.g., a therapist and mandated client vs. the judicial system). In some cases though, the therapist's use of sarcasm expresses the client's frustration, helping release underlying anger.

***Lynn***

*Lynn's daughter Paula was getting ready to go off to college. Paula has a diagnosis of ADD, and over course of 3 years, Lynn worked with Paula to instill study habits and routine to keep Paula on track academically, an often daunting and exhausting task. Lynn was describing to her therapist (who had worked with both Lynn and Paula) how the last months of senior year Paula had developed "senioritis" and was more distracted than usual. After a particularly rough week, Lynn told her therapist "You know, I really need my glass of wine at the end of the day." Her therapist replied dryly, "Tell me, do you ever feel like pouring the wine over Paula's head?" At which point Lynn burst out laughing.*

In the example given above the line caused laughter and was not offensive because the two had been working together for a length of time and the clinical goals were clear—as well as the practical one at the time—getting Paula off to college. The therapist shared Lynn's affection for Paula, but also her frustration; she was attuned to her client's feelings and to her own. Her familiarity with the situation and the fact that she had conducted family therapy with mother and daughter previously allowed for the sharper edge. The comment might have been too acerbic to use earlier in the relationship, no matter how much tendency for humor the client evinced.

### **Half-Laughs to Full Guffaws**

Laughter and smiles are usually the physiological manifestations of humor, or humorous intent. Gervais and Wilson (2005) describe two types of laughter: Duchenne and Non-Duchenne (named after the 19<sup>th</sup> century French neurologist who made the distinction); the first is spontaneous, the second volitional. Duchenne laughter is associated with mirth and amusement or positive affect (McGhee, 1979; Bacharowski & Owren, 2001). Though Non-Duchenne laughter is learned and can seem artificial, it is the type of laughter most used in everyday conversation and “greases the wheels of social relationships in a variety of ways” (Nelson, 2012, p.24.). Non-Duchenne laughter can also be used in therapy, and can lead to spontaneous laughter and all its attendant benefits. At times, it requires some planning on the part of the therapist, almost as if she is setting the stage for humor. The following vignette illustrates the flow from Non-Duchenne to Duchenne laughter.

### ***Group Humor***

*A clinical social worker was working in a day treatment facility for clients with chronic and severe mental illness. Most clients were indigent, elderly or in late middle aged, and carried a diagnosis of schizophrenia. Their days were composed of a series of classes in self-care, craftwork, medication management, and some sort of entertainment (usually a DVD). Though the staff was friendly and compassionate, there was very little laughter or humor among the clients throughout the day. The social worker decided to create a short activity for the clients while they were waiting to be transported home at the end of the day. The activity was voluntary. Clients were divided in groups of four to six. Three short scenarios were written on pieces of paper, folded, and dropped into a container. One client and the person next to him or her had to enact the scene for about 5 minutes. The scenarios were purposely playful and*

*connected with the clients' lives in some way. After each pair of clients had their turn, the group voted on the most amusing set. A typical scenario would be as follows: Your neighbor keeps borrowing cigarettes and never pays you back. You are down to your last cigarette. How do you handle it?" If one "actor" answered too seriously, he or she was egged on by others in the group to come up with a more playful or playfully realistic line. This was usually accomplished by asking leading questions or through incredulous facial expressions. The enactments never failed to induce, first Non-Duchenne laughter, then Duchenne laughter—as evidenced by tears rolling down cheeks and wheezing laughter (often leading to coughing fits).*

The above example illustrates the use of therapeutic humor for a specific goal: producing and awakening positive affect. The therapist provided the set-up for the intervention and the clients took over. The clients were able to share a part of themselves not often seen: playfulness, silliness and creativity, and the positive effects often spilled over to the next day. Using Non-Duchenne laughter to lead to Duchenne laughter can be done in individual therapy as well (see case vignette of Adele in the first paper, *A Developmental Perspective for Understanding Humor in Clinical Social Work*).

In his article reviewing the use of humor in serious mental illness, Gelkoph (2011), describes its potential benefits; these include up-regulation, facilitating a sense of proportion, and emotional catharsis. In a randomized controlled trial with humor training as an intervention for patients in rehabilitation from schizophrenia, Cai, Yu, Rong, & Zhong (2014) found that patients in the humor group showed less post-test anxiety and depression. The authors note that humor may function as a coping mechanism for this vulnerable population and that it is a relevant intervention because it addresses social skills and communication development (p. 177).

### **Building on the Positive**

The group work in the vignette cited above is an example of the broaden and build theory that was developed by Fredrickson (Fredrickson, 2001; Fredrickson & Branigan, 2005). The theory is grounded in positive psychology and partially based on the work of Isen (2000), who studied the effects of positive emotions for two decades. Fredrickson (2001) showed that positive emotions counteract negative emotions and “produce flourishing, not only in the moment but in the long term as well” (p. 218). In a comprehensive review incorporating affective neuroscience with Fredrickson’s theory of upward spirals of positive emotions countering downward spirals of negativity, Garland et al. (2010) identified two clinical interventions to initiate the process—mindfulness and loving-kindness meditation—both of which are mind-training practices. The result of both interventions is a distancing from emotionality to greater metacognitive awareness—in other words, greater emotion regulation. This result may also be achieved through the therapeutic use of humor, and the relational component between client and clinician is a powerful bridge toward the internalization of humor and one way to help regulate emotion. Humorous interventions lead to a positive shared emotional experience. Positive emotional experiences build on themselves and foster resiliency and outlast the transient emotional states that led to their acquisition (Fredrickson, 2001). In a study based on Fredrickson’s theory, Crawford and Caltabiano (2011) sought to demonstrate that individuals could increase the incidence of positive emotions with all the attendant benefits by intentionally integrating humor into their daily lives. Their small randomized-controlled study comprised of 58 community volunteers, found that those participants who were assigned to a humor skills group demonstrated an increase in positive affect, self-efficacy, optimism, and perception of control (Crawford & Caltabiano, 2011). Strick, Holland, van Barren, and van Knippenberg (2009) hypothesized that another possible reason that humor works to down-

regulate negative emotions is that it requires attentional resources to resolve incongruities, which once figured out, trigger the reward system in the brain. This hypothesis was tested in two separate pilot studies that included 90 college students performing a task on a computer (Strick et al., 2009). The results of the pilot studies indicated that for short-term effectiveness: “The more humour captured attentional resources, the better it served to regulate negative emotions” (Strick et al., 2009, p. 577). The authors also concluded that long and enduring stressors are best regulated using a strategy that focuses on perspective-taking. One strategy that focuses on perspective-taking is therapeutic humor. The therapeutic connection is germane here: the client’s perspective is broadened by the therapist sharing her own perspective or reflecting back the client’s perspective in a way that creates insight. Therapeutic humor is not only cognitive distraction it is an interactive process, which also pulls attentional resources.

### **Caveats of Humor Use and Managing Errors of Judgment**

Yonkovitz and Matthew (1998), in their article on the strategic potential of therapeutic humor, note that during its infancy psychotherapy sought legitimacy based on the scientific medical model of its time—and humor had no place in medicine. More importantly, there was concern that an analyst’s use of humor could interfere with transference and countertransference and be interpreted by the client as hostility. The authors state that though Freud “was a great appreciator of levity and a collector of jokes, he left his early successors with an ambiguous view of humor’s therapeutic legitimacy” (Yonkovitz & Matthew, 1998, p. 47). Kubie, in his oft-cited article of 1971, lists the potential dangers of using humor in therapy from the perspective of a psychoanalyst, writing of the need to protect clients from what is in effect, aggressive use of humor by the therapist. These include the client’s stream of feelings being interrupted by the



therapist's interjection of humor, therapists not recognizing their own use of humor as a defense, using humor at the patient's expense or joining when the patient is using self-deprecating humor.

In the ensuing decades, with the development of the relational and intersubjective schools of therapy, the concept of therapist neutrality has changed (Berzoff, Flanagan, & Hertz, 2011). The idea of the therapist's remaining incognito, the aim of which was to "protect the patient from the therapist's frailties" (Kubie, 1971, p. 863) became less paramount. Indeed, now the pendulum has swung in the other direction and potential risk arises from over-sharing. From quite different theoretical frameworks the message is the same: the lack of awareness, of attunement—of what is happening with the client, with oneself, and having a metacognitive grasp on both processes—can cause missteps in the therapeutic use of humor.

Humor is a communication tool (Martin, 2007; Dziegielewska et al., 2003) and, as such, is a part of most people's daily lives. Withholding humor from therapy altogether artificially creates a communication gap. Lachmann (2003), speaking from a psychoanalytic perspective, goes so far as to say that "The effect of eliminating humour from psychoanalytic treatment is to transform the patient into a cadaver, like the therapist" (p. 289). Lachmann also posits that the legacy of the legitimacy of humor in therapy rests with Winnicott and Kohut—the former recognizing the importance of conjoint and solitary play as a developmental milestone, and the latter viewing creativity, play, empathy, humor, and wisdom as the developmental transformation of archaic narcissism (Lachmann 2003, p. 289).

The concern of inadvertently harming the client with insensitive or even hostile humor is legitimate, but awareness of the potential harm diminishes the possibility that it will occur. Even Kubie (1971) admitted that senior therapists can use humor as a safe and effective tool. I posit that humor is within the purview of novice therapists as well; heightened mentalization skills and

greater self–other awareness creates opportunities for judicious interjections. When humor backfires, the remedy for the attuned clinician is the same as for any interchange that was off target: Explore the miscommunication and apologize if the humor offended. Ehrenberg (1991) reflects on an experience of having her own humor hurt a client’s feelings:

The very process of this exploration together seemed to structure a new experience for her, as it provided her with an opportunity to realize the extent of her own ability to have an impact on me, which had impact and consequence of its own.  
(p. 227)

Just as humor can structure a new experience, so can a failed attempt at humor. Lemma (2000) concurs, stating that even if the humor falls flat, it is not only reparable, but can provide an opportunity for growth in the dyad. There are times in therapy when the client will not verbalize if she feels hurt or is not yet capable of verbalizing negative feelings towards her therapist. In these instances the clinician is left to use her clinical acumen, openly inquire, read body language and facial expressions or guess as to what her client is feeling. This is not the case when an attempt at therapeutic humor fails, as there is no mystery in the lack of a smile or the absence of laughter. Thus, there is no reason for the therapist not to use the opportunity to explore what has occurred.

### **Conclusion**

When used with attunement, awareness and a sense of play, the clinical use of humor is within reach of clinical social workers with varying levels of clinical experience. Practice wisdom is built over time but irrespective of theoretical modality, it rests largely on the ability to be in the moment with the client on multiple levels, to engage relationally, and maintain a meta-perspective. By judiciously interjecting humor into therapy, the clinician is offering her client

the gift of sharing herself and offering genuine connection. Humor makes the client a partner in mentalizing. Humorous moments of shared delight are especially powerful because they allow for the experience of positive emotionality. Eventually, clients may learn to internalize “therapeutic” humor, and use it at times to regulate their emotions, place events in perspective, laugh at themselves and view themselves through a much broader framework, that of being part of the human race, not just an amalgamation of individual hurts and losses. Humor does not exist in a relational vacuum. Even when we laugh alone or shake our heads in bemusement at some external event, we are laughing in relation to ourselves and the urge to share the joke with others is strong. The ability to view oneself and the world with a modicum of lightness—even in times of duress—is a pillar of inner strength.

A final vignette illustrates what can occur when a client begins to internalize therapeutic humor and apply it to her own life, with very little prompting, even when she is distressed. Throughout her course of treatment, Margaret’s therapist interjected humor, quite slowly at first.

***Margaret***

*Margaret, a 40-year-old accountant, has a history of complex trauma that began in childhood. She has formed relationship schemas based on her experiences of being either abused or ignored. She is highly reactive and her vocabulary is dramatic. Present experiences are filtered through the past and her ability to mentalize—imagine the thoughts and feelings of others, and view her own with some perspective—is limited. After a long gestation period, Margaret decided to buy a small home. Unfortunately, she had one unexpected negative experience after another: faulty plumbing, incorrect wiring, unreliable workmen, and mistaken deliveries. In a recent therapy session she was recounting the latest “disaster”—discovering water in her basement. She went on and on about the hazards associated with a wet basement,*

*and what further ills would befall her as a result, catastrophizing about her future. Finally, her therapist said, “Okay, you’ve given me the absolutely worst case scenario, now give me a better case” feeding her the line with a raised eyebrow. After a shocked pause, Margaret grinned wickedly and said, “You mean if I don’t die of mold and mildew?”*

Margaret’s use of humor in this way represents several milestones: a greater capacity to distance herself from her emotions, better awareness of her cognitive distortions, and the ability to poke fun at herself. Margaret recognized her own propensity for exaggerated language and was able to consciously respond in a tongue-in-cheek way: clearly no one dies of mold and mildew.

Furthermore, Margaret mentalized: she assessed her therapist’s thoughts and feelings based on the latter’s question, tone of voice and facial gesture and realized how she (Margaret) must sound from the outside. The use of humor in her response allowed Margaret to become in her own eyes, not a victim of the universe, but a frustrated homeowner. This is the gift of therapeutic humor.

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