Clinical Humor: A Positive Approach Toward Health

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Today I would like to discuss clinical humor and laughter as therapeutic approaches toward one’s emotional and physical well-being and health. President David O. McKay has said, “Everytime a man laughs, he takes a kink out of the chain of life.” We usually associate laughter with some kind of humorous experience. “Laughter is most often described as the overt expression of humor — an indicator that the person is in an ‘amused frame of mind,’ or ‘experiencing something as funny.’” (Keith-Spiegel, 1972, p. 16). Webster has defined humor as “that quality which appeals to a sense of the ludicrous or absurdly incongruous, meriment disposition, mood; to yield to the whims!”

The scriptures are full of examples of laughter as communicating many varied messages such as joy, doubt, or even scorn. For example: Sarah laughed with joy because of having born a child at 90 (Gen. 21:6). But earlier, she laughed in disbelief and doubt that she could bear a child in her old age (Gen. 18:13-15). In Ecclesiastes, we read that there is, “A time to weep, and a time to laugh ...” (Ecclesiastes 3:4). In Proverbs (Proverbs 17:22) we read, “A merry heart doeth good like a medicine: but a broken spirit drieth the bones.” In the Doctrine and Covenants, (Section 59:15), we read, “And inasmuch as ye do these things with thankfulness, with cheerful hearts and countenances, not with much laughter, for this is sin, but with a glad heart and a cheerful countenance.” I would suggest that “not with much laughter” means critically laughing at someone or something. Laughter itself is not sin, but its misuse may be sinful, according to the scriptures. It’s the timeliness and appropriateness of the laughter which is important.

In every relationship, including one where humor is used in the actual therapeutic process, the use of humor has marked potential for negative as well as positive results. The strong professional relationship is most important if humor is to be useful in strengthening and enhancing therapeutic outcome. This author is aware that the way in which humor is employed and by whom used, are two of many important variables for professionals to carefully consider in any decision to use humor in clinical practice. Most of the literature on humor is based on clinical and other observational and professional experience, rather than findings based on experimental data. Rarely, however, is humor as a counselor characteristic mentioned or discussed in most psychology or counseling textbooks.

This paper will focus on the positive and therapeutic uses of humor in clinical practice. Space does not permit an evaluation of the potential hazards of humor, as major emphasis here will be placed on humor and laughter as positive therapeutic tools in the hands of a sensitive therapist.

Humor, as a means of communication, has been called a “social lubricant” and can represent an opportunity for therapist and client alike to share in a meaningful experience which can have therapeutic possibilities. The ability to laugh at oneself is one of the prime characteristics of man, as man is probably the only creature with the ability to laugh or express a sense of humor. Humor has also been described as a paradox. To really be completely effective, humor requires a spontaneity, and even an element of surprise. If we stop to analyze or dissect a funny happening or joke, it may lose its funniness. Play also requires this same element of enjoyment, openness and fantasy, as though to say, “this is just for fun.” Humor is very individual. What seems humorous or funny to one person may not come across in that same way to another person. Humor is often “situation specific.” Humor can represent a way to “break the ice” or begin a counseling relationship, while yet formative. “When one smiles or laughs with the other, as sharply distinguished from laughing at him, one shares a mutual experience” (Rosenheim, 1976, p. 59). Humor can also help one to maintain his sanity, to the extent to which it “moves beyond jokes, beyond wit, beyond laughter itself. It must constitute a frame of mind, a point of view, a deep-going, far-reaching attitude to life” (Mindess, 1971, p. 10). Most clinicians tend to agree that the capacity of a person to deal with life and humor may directly relate to an individual’s psychological adjustment (Hickson, 1977).

But, the ironic part is this — just as humor and laughter can represent a healthy expression of the ego, it has over the years suggested emotional distress or even “madness” within the individual personality (Baudelaire, 1956, p. 115). As Moody (1978, pp. 60-61) points out:

There is an astounding degree of overlap in ordinary language between the words which are used to describe behavior as mentally disturbed and those which are used to describe behavior as humorous. This ambiguity extends even to the word ‘funny’
itself. 'Funny behavior' could just as easily mean disturbed behavior as it could amusing behavior. Comic individuals, actions or indents are typically characterized as 'dizzy,' 'zany,' 'mad,' 'goofy,' 'daffy,' 'crazy,' 'wild,' 'hysterical,' 'insane,' 'madcap,' and so on. These same labels are used at times in informal conversation to characterize actions or thoughts as mentally disturbed. Even in the most recent textbooks or psychiatry, various recognized mental disorders are described or defined by the use of some of the very same terms that are used to characterize people, events, or remarks as funny, humorous, or laughter-provoking. In a number of texts, passages describing the behavior of persons with some mental disorders abound with words like 'ludicrous,' 'silly,' 'whimsical,' 'absurd,' 'ridiculous,' and 'jocular.'

The psychoanalytic theory of humor originated by Sigmund Freud has been perhaps one of the major frameworks for the study of humor in recent years. Freud became interested in jokes when he became aware of the similarity between the technique of jokes and dreams, resulting in his book, Jokes and their Relation to the Unconscious (1905). There are two types of jokes: the harmless joke, and the joke with a purpose or 'tendentious' wit. Civilization has produced repression of many basic impulses, he says, and joking as a socially acceptable way of satisfying these needs. He describes four types of purposeful jokes: the sexual joke; the aggressive, hostile joke; the blasphemous joke; and the skeptical joke. The process is an unconscious one and there is a saving of psychic energy. Freud also developed a theory of laughing at tragedy and death, called 'gallows humor' (Robinson, 1977, p. 14).

The use of humor presents a real challenge to the clinician, in light of the conflicting, foregoing materials. When a client begins to see his own situation in a humorous way, he is closer to understanding and overcoming it as genuine humor can be an important coping mechanism. Much of clinical and hospital humor arises spontaneously from a specific situation and is therefore difficult to describe to others out of context. Spontaneous humor generally comes from ordinary situations and is witty only because of the immediate circumstances of the moment. The specific cases presented are taken from personal experiences and from a variety of writers. Among the variety of theories of humor is the concept of humor as a release from anxiety, tension, and the frustrations of the severe realities of life. Often physicians, psychiatrists, and even attorneys are the butts of many strong and conflicting emotions. The following poem by Richard Armour (1963, p. 33), suggests that today we are more knowledgeable about health and illness than formerly and better able to laugh at it:

A LITTLE LEARNING

Patients once let surgeons cut
Without an if or and or but.
They rarely raised demanding questions
And never offered up suggestions.

Patients once, not long ago,
Believed the doctor ought to know,
Submitted with the best of will,
And trusted in his practiced skill.

But patients now, and patient's wives
Are sharper than a surgeons knives,
And argue over each incision —
They've seen it all on television.

Humor in health and illness serves three major functions: a communication function, a social or behavioral function, and a psychological function. In a health setting, a variety of messages need to be communicated and are usually very serious and filled with emotion. These are: fear, anxiety, anger, embarrassment, concern, frustration, hope, and tragedy. In times of crises, patients and staff are thrown together into intimate and dramatic contacts — without time to develop a personal relationship. Humor provides an easy access to interaction and a shortening of formality and distance between people.

Clinical examples which illustrate attempts to reduce patient and client anxiety and distress through the use of kidding or joking are the following:

When a male patient who was admitted for a biopsy was sent to a gynecological ward because of a shortage of beds, the nurses teased him with, 'You're in for a hysterectomy, of course!' and 'You're the only male on the ward and I thought we were liberated!' (Robinson, 1977, p. 43)

About a year ago ... a young woman suffering from severe anxiety consulted me. It was the first time she had ever visited a psychotherapist and she told me she had been reluctant to come. She had heard that therapists not only failed to help many patients but that they frequently harmed them. The word she used was 'destroy.' 'I have heard about people,' she said, 'who have gone into therapy and been destroyed!' Now I, it is obvious, could have responded in several ways. I could have remained silent and waited to hear what she would say next. I could have told her that I understood how she felt. I could have said, however, that other people felt the same way too. I would say next. I could have told her that I understood how she felt. I could have said, however, that other people felt the same way too. I decided instead, to react in a mildly facetious manner. (Decided, however,
is not the right word. I did react facetiously, but the remark I made was so instantaneous that I cannot claim to have planned it.) What I said was, 'Well, you're in luck. I've already destroyed my quota for this week.' Her response was rich laughter, and I flatter myself into believing it expressed both relief and expanded awareness: relief that she had found a therapist who understood her anxiety not in professional terms but as a fellow human being, and awareness that her fear that I would destroy her was absurd. (Mindess, 1976, p. 336).

Mindess (p. 337) comments further about the use of kidding in counseling:

I recall, for example, responding to a tearful woman's tale about her husband getting drunk, hitting her and threatening to shoot her, then breaking down and begging her forgiveness, with the observation, 'Well, at least your life's not dull.' There is no more evidence, of course, that any particular style of dream interpretation or confrontation or support is superior to its counterparts. It seems important, however, to note that humor as a mode of response is broad enough to be amenable to many different purposes. Both the gentle, supportive therapist and the tough, confronting one can utilize wit as part of their repertoire. It is employed with the patient's improvement as its goal, it can be helpful in more ways than one.

The many jokes and cartoons about psychiatrists tend to make him more human, with human failings. For example:

A cartoon pictures a psychiatrist's office. The patient and psychiatrist are moving the couch across the room. The psychiatrist is saying, 'Frankly, Mrs. Watson, I liked the furniture the way it was.'

Another example of the need to reduce distance between professionals and patients is the example of a Mental Health Center (Robinson, 1977, p. 44).

In the early days of social psychiatry, during the development of one community mental health center, in the attempt to move from an illness orientation to one of "health," and to foster the "blurring of roles," the staff wore ordinary street clothes rather than uniforms. The clinical director, however, insisted that the staff still wear name tags, which spelled out: Jane Doe, R.N., and David Brown, M.D. The staff objected that this violated the intent of the change. The director countered that the patients would feel more secure if they knew who the staff were. The controversy ended very suddenly when one of the day care patients appeared one morning with a name tag which read Mary Smith, N.U.T. The name tags went the way of the uniforms!

A cartoon shows a hospital room with two patients in bed. One is saying to the other, 'Look, you phone down to the desk and ask about my condition, and I'll phone down and ask about yours.'

A get-well card says, 'Remember, it's okay to let your doctor joke with you a little - but, don't let him needle you!'

A few warnings about the use of humor, however, are in order. The therapist must be sure that his wit does not arise from rancor toward his patients and that it represents a genuine laughing together about shared human problems and experiences. I prefer to frame my more confronting and unpalatable comments or interpretations in such terms as, 'We all share . . .' or 'Most of us human beings . . .' For the therapist to be able to gauge how far he can go with which couple is also critically important - a few inches beyond where they are, but not far enough to shock or offend them, is desirable.

Letting matters rest at a humorous level can also be hazardous: It could lead to a later increase in guilt and, thus backfire. I almost always follow up humor with a serious comment about the couple's plight. In the case of the mock serious prescription I might add, depending on circumstances: 'I have been joking a bit with you, but I also mean all this very seriously; the two of you have been deprivings yourselves of possibilities of pleasure and relaxation that you both richly deserve,' (Fitzgerald, 1973, pp. 80-81).

In the operating room and emergency room, where tension is the highest, humor becomes almost a standard pattern of interaction, from single, jocular talk to macabre, risque joking.

Two students were observing surgery for the first time. The shorter one was complaining she couldn't see. The tall one quipped, 'Be glad you're not tall. You have a longer way to fall when you faint!'

The humor between colleagues is very often a self-deprecating one, which is acceptable within status lines but might not be understood in the same vein by the patient. This story making the rounds some years ago may serve as an example.
Two psychiatrists are coming down in the elevator after 'a day in the office. The younger psychiatrist looks weary and somber. The older psychiatrist is whistling cheerfully. The younger man looks over and says, 'How can you be so spry and cheerful after a long day of listening to patients with all their problems and troubles?' The older man shrugs his shoulders and responds, 'Who listens?' (Robinson, p. 72)

Greenwald (1975, p. 116) discusses a humorous treatment approach in dealing with a woman who had trouble talking during therapy:

... I had a patient who had been to five previous therapists who terminated her therapy because she couldn't talk. Two things happened in the first session. First when she came in and couldn't talk to me, I said, 'What's the problem?' She said, 'As long as you're in the room, I can't talk.' I had a closet in my office. I went into the closet and I sat there and she talked pretty well.... I had to sit in the dark closet during her session. Then she decided that I was doing something else in that dark closet, and she told me she didn't want me to sit there any more. So I came out and again she couldn't talk.... I said, 'Were you ever able to talk at home, under any circumstances?' 'No', she said... 'Only when the family was at dinner.' I said, 'So, I'll tell you what. We'll have lunch together. I'll bring in lunch...' 'No, no,' she said. 'Not like that. When the family would be having dinner, I would get under the dining room table, and then I could talk to them 'fine.' Well, I had a big desk, and I said, 'Why don't you get under here?' She replied, 'I can't do that.' So I got under the table and she spoke very well. We had a great session. She came back the next session and she wasn't talking, so I started to get under the desk. She stopped me. 'I'll talk. I'll talk, just don't get under that — table again!' Which was fine until her husband called me two weeks later and said, 'My wife is beginning to hallucinate. Do you know what she told me happened at your office?'

I think it is time we let down our hair and told the truth. We have the urge to rush into print all right, but we who are dying of cancer are not martyrs or saints or holy folk. Frankly, if the truth were told we embarrass our friends and we often bore them! ...

I'm still angry about it all, for I think no one has ever loved living more or had more fun doing it than I, and I want it to go on and on. But if I can't, then I must be truthful and say there are a few advantages in living only half a lifetime. Besides the end of good, death also means the end of the tribulations — no more holding in the stomach, no more P.T.A., no more putting up the hair in pin curls, no more cub scouts, no more growing old. (Beland, 1965, pp. 89-91).

Greenwald (1975) describes one of his patients who had the capacity for turning every single triumph of her life into a dark disaster:

She was a temporary teacher who was taking an education course which she needed to get her permanent license. She kept complaining during the entire semester about how poorly she was doing in this course, how awful it was, and how stupid it was, and how she would be drummed out of the educational field at the end of this course. Then, one day, she called me and said, 'Do you know what that (guy) did? He gave me an A plus in the course!'

I was all prepared. I knew that the next session I was in for a big depression. And she had a special costume for that. She'd come dressed all in black.... When she entered the room, I knew what to expect. She was sitting in the corner as she came in and started to complain. I didn't say anything for awhile. I just sat there and sighed. She talked her little lines. 'Oh,' I said, 'it must be terrible.' She looked at me for a moment, then continued, and I said, 'Well, maybe I could help you, but what's the use? You're only going to die! That was something she always says. And it went on this way a little bit longer.... Suddenly, she turned on me and she said, 'You know ... you're acting just like me. How do you put up with me?' She got the point and for the rest of the session, maybe because she was angry, she wasn't depressed.

I must emphasize the importance of really understanding the person if you use humor in your sessions. Because if you don't, it can be destructive, it can be mocking, it can be cynical, it can be painful. (p. 115)

Humor has the potential to be a valuable communication tool available to the therapist in furthering insight, monitoring dynamic states, and in catalyzing higher levels of adaptive processes. In sum, humor
can very well function as an important variable in the counselor’s repertoire of helping response modes and techniques. (Hickson, p. 66)

HUMOR IS A FUNNY THING

Humor is a funny thing,
it causes smiles and snickering;
It lets life’s losers feel they’re winning,
Leaves them chortling, smirking, grinning.

Yet is also makes us see
That we are silly, you and me;
Absurd and awkward, foolish too,
Ridiculous — especially you.

REFERENCES


Hickson, J. “Humor as an Element in the Counseling Relationship.” Psychology. (14) 1977, pp. 60-68.


