USING HUMOR IN PSYCHOTHERAPY WITH OLDER ADULTS: AN EXPLORATORY STUDY

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By

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CERTIFICATE OF APPROVAL

I certify that I have read USING HUMOR IN PSYCHOTHERAPY WITH OLDER ADULTS: AN EXPLORATORY STUDY by Deborah Leila Cohen Levine, and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the Doctor of Philosophy in Clinical Social Work at The Sanville Institute.

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Abstract

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This is an exploratory study examining when, how, and why psychotherapists use humor in treatment with older adults and the impact on both clients and therapists. It seeks to bridge the gap between the small body of literature regarding the use of humor in treatment, and the writings regarding older adults and humor. The eight participants report that in their experience, humor is effective in establishing and enhancing the therapeutic relationship, assessing client functioning and client progress, making interpretations, reframing, developing, and strengthening coping skills. They indicate that the use of humor may be problematic if therapists only use it to create a pleasant atmosphere or for their own pleasure; if clients use humor to avoid looking at certain issues or to please the clinician; or if the humor insults the client or creates a breach.

The participants see older adults as individuals but are aware that as a group they suffer from many loss-related circumstances: physical abilities, relationships, roles, finances, and meaningful activities. While the participants generally consider older adults to be more open to humorous exchange, they also acknowledge that life circumstances may contribute to greater isolation, loss of resiliency, or depression. The participants' descriptions of their experiences using humor in treatment with older adults point to the power of humor in creating

attunement in the therapeutic relationship and "moments of meeting" that enhance positive affect and reduce negative affect.

The clinicians in this study are highly experienced and close in chronological age to older adulthood. Humor is also provisionally seen by the participants as helpful in preventing burnout when dealing with client circumstances that may engender painful countertransference experiences.

Dedication

To my favorite empathic humorists:

David Cohen (of blessed memory)

Rosalyn Cohen

Ken Levine

Matt Levine

and Annie Levine

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Therapy is a bi-directional process. I have learned an enormous amount from my clients and am grateful and honored that they have been willing to share so much of themselves with me.

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CHAPTER I: INTRODUCTION

Why do people seek therapy? Individuals, couples and families generally consider treatment because they are in emotional distress. In their struggles to obtain relief they may share material with the clinician that is often shameful, frightening, or painful. The therapeutic process must be respectful and treat the clients' needs seriously. Some, therefore, might take issue with injecting "levity into such a grave and solemn enterprise" (Saper, 1987, p. 365). Nevertheless, clinical literature indicates that a judicious use of humor may have a beneficial role to play in treatment. Even Freud (as cited in Franzini, 2001) is reputed to have told analysands the occasional joke, when he felt it to be appropriate.

Each therapeutic relationship is unique based on the particular client or clients. How humor is approached will depend on the nature of the therapeutic relationship, the particular individual or family's needs, and the therapist's personality or style. The clinician must pay attention to the biological, psychological, and social elements of the client system. Work with older adults may include consideration of a number of particular factors. Clients may have sophisticated life experience and competencies, strengths, and maturity. Nevertheless, from tiny indignities to the deeply felt death of a life partner, accommodating to loss is often a primary theme of older adulthood. Therapists must also consider their own responses to issues of aging when working with this population. The use of humor may be valuable in this context as well.

There is some literature regarding the experiences of clinicians who have used humor in psychotherapy but not specifically with older adults. There are writings regarding humor and older adulthood, but none examine the use of

humor in treatment. This study seeks to consider the gap in the literature by exploring the subjective experiences of psychotherapists who use humor in treatment with older adults. A qualitative approach of grounded theory will be used.

Background

How are we to understand the concept of "humor" in this project? As the essayist E.B. White (1977/1999) notes, "Humor can be dissected as a frog can, but the thing dies in the process and the innards are discouraging to any but the pure scientific mind" (p. 303). It is often difficult to discern what it is about a phrase or scene that tickles us. Nevertheless, in order to begin to understand the experience of clinicians using humor in psychotherapy, we need a common understanding of terms.

The Oxford English Dictionary (Brown, 1993) defines humor as "that quality of action, speech or writing which excites amusement; facetiousness, comicality; the faculty of perceiving and enjoying what is ludicrous or amusing" (p. 1278).

Theories about what makes something humorous divide into four basic categories: superiority, relief, play and incongruity. Superiority theory goes back to Ancient Greece, where tragedies involved the flaws of royalty, but comedies involved the failings and problems of "inferiors." Hobbes (1881) develops a more extensive notion of laughter as arising from a comparison of one's superiority over the weaknesses of others. The German word *schadenfreude*, which describes taking pleasure from the misfortunes of others, captures the flavor of superiority theory.

Spencer (1860), Darwin (1872), and Freud (1905/2003) were advocates of relief theory. They see laughter as a discharge of pent-up psychic energy. In *The Joke and Its Relation to the Unconscious*, Freud (1905/2003) describes both abstract (or innocent) jokes, where the goal is simply pleasure, and "tendentious" jokes, which allow for the expression of repressed sexual or aggressive energy in a more socially acceptable way. According to this thinking, the laughter represents a release or discharge of "unacceptable" feelings.

Humor was first defined as play by Eastman in 1921. He believes that "humor, wit, and mirth are all *playful* rather than serious activities" (p. 15). For Eastman, humor in human beings is an extension of the play of animals. He cites the "proto-laughter" of chimps (when tickled) as a form of humor. This notion has been supported by chimps like "Washoe" who learned American Sign Language, and actually signed puns (Gamble as cited in Martin, 2007, p. 3). Looking at humor as a form of play invites us to think of Winnicott's work. Winnicott (1971/2005) used humor and jokes in the treatment of both children and adults. He, too, considers humor to be a kind of play. Weisfield, Berlyne, and Fry (as cited in Martin, 2007) also write about the close connection between humor and play.

Schopenhauer (1886), Kierkegaard (2004), and Koestler (1978) were proponents of incongruity theory. They describe humor as a response to the incongruous, the surprising, the odd, or the absurd. Martin (2007), a contemporary researcher, supports this theory by defining humor as "an idea, image, text or event that is in some sense incongruous, odd, unusual, unexpected, surprising or out of the ordinary" (p. 5).

How a humorous notion is received is based, in part, on timing, both in terms of the delivery of the notion, and in terms of the context. Comedic actors are well aware that appreciation of comedy is intimately related to the feeling tone of the audience. Their response to the same comedic material will change with the circumstances. There is significantly less laughter at comedy performances following tragic events, such as after a major disaster, than might occur on a day when the stock market rises dramatically.

Anthropologists report that humor exists in all cultures and may be the result of evolutionary design (Apte, 1985; Solomon, 1996). However, appreciation of humor is bound by the particular culture and by history. A humorous statement in a play by Aristophanes may have been enjoyed more by an ancient Greek audience than by a group of twenty-first century high school students. A cartoon that is considered hilarious in the Czech Republic may not be as amusing in Myanmar. As Keith-Spiegel (1972) wrote, "Humor exists in all cultures, but ... humor styles cannot always be shared or enjoyed cross-culturally" (p. 13). When using humor, sensitivity to timing and cultural differences is particularly critical.

Martin (2007) describes three types of humor: prepackaged "jokes" or anecdotes (Henny Youngman's "Take my wife, please" would be an example), spontaneous humor created intentionally during a conversation such as word play, irony, or puns, and accidental or unintentional humor such as someone slipping on a banana peel.

"Humor has cognitive, emotional, physiological, and behavioral components. Not all of these components are necessarily present in every occurrence of humor" (Solomon, 1996, p. 251). Humor is often viewed as the predecessor to laughter. Franzini (2001) draws "a distinction between humor as a

construct versus laughter as a behavioral event" (p. 172). He sees this difference as having research implications. Ventis (1987) comments, "The disputed cathartic effects of laughter are not critical for possible therapeutic effects of humor" (p. 155). However, there has been a great deal of recent research on the impact of laughter in treatment and in everyday life. Provine (2000) and Nelson (2008) see the shared laughter as the critical factor. Nelson uses attachment theory as a basis. There are also biological sequaelae to a good laugh. For the purposes of this study, the focus will be on the impact of humor in the treatment of older adults. Laughter will also be explored as it relates to humor.

How do we define older adulthood? The average life expectancy has shifted dramatically in this country in the past hundred years. In 1900 it was 45; today it is 80. Adults are living longer, and are often healthier for a longer period of time. Results from the Long Beach Longitudinal Study, reported in the September 2007 edition of *Psychology & Aging* indicate that today's average 74-year-old performs as well on cognitive tests as an average 59-year-old did in the previous generation (Zelinksi & Kennison, 2007). Nevertheless, in the United States, older adulthood is often defined by eligibility for full Social Security at 65. For the sake of simplicity, older adults is this study will be considered those 65 and above.

The Research Questions

This study uses a qualitative approach to examine the subjective experiences of therapists using humor in psychotherapy with an older adult population. The following questions are considered:

How is humor used in therapy with older adults; when and why does a therapist choose to use humor with those clients?

Do therapists find that humor can have a beneficial and/or harmful effect on ongoing psychotherapy with older adults?

Is the experience of using humor in therapy different with older adults than it is with younger people?

From a subjective point of view, what effect does using humor in psychotherapy have on the therapist?

As the research focuses on the subjective experiences of therapists, it uses a grounded theory approach (Glaser & A. Strauss 1967; Corbin & A. Strauss, 2008). The data consist of interviews with therapists who were asked to consider their practice with regard to humor and older adults. The information was analyzed using the constant comparative method of qualitative data analysis. (Glaser & A. Strauss, 1967).

CHAPTER II: LITERATURE REVIEW

The focus of this study is on the clinician's experience of using humor in therapy with older adults. The literature reviewed includes concerns that may apply to potential benefits of humor; the use of humor in psychotherapy; issues pertaining to older adults; the use of humor in treatment with older adults; countertransference issues that may be stimulated when working with this population; and the impact humor may have on the therapist.

Potential Benefits of Humor

The benefits of appreciating and generating humor are supported in the literature. Humor may serve as a "social lubricant" easing and reducing distances between people (Graham, 1995). Individuals meeting for the first time often feel more comfortable if they can both find a story or a quip amusing. Birner (1994) comments that "a good joke tranquilizes and soothes . . . and may serve as a positive addition to the general social atmosphere" (p. 80). Mulkay (1988) sees humor as a valuable form of interpersonal communication as it plays with incongruities and contradictory ideas, and can relay a message in an indirect or non-confrontational manner.

Humor may also be useful in helping people learn new information. Teachers inform us, anecdotally, that humorous mnemonic devices can help students remember lists of English kings or the names of chemicals. Isen (1993) reports that people show improvement in a variety of cognitive abilities when they experience positive emotions including comedy-induced amusement. Using humor also facilitates learning among elderly students (Safford, 1991).

Several theorists see humor as serving a socially adaptive function. According to Weisfield "The adaptive functions of humor as playful cognitive

activity in a social context appear to be an extension of the original functions of mammalian physical play into the realm of cognition" (as cited in Martin, p. 186). Frederickson's (2001) "broaden and build theory" describes the adaptive function as related to the positive emotion generated by humor and mirth. Frederickson proposes that positive emotion broadens and builds an individual's ability to develop creative and varied solutions for dealing with life's challenges (see also Frederickson & Joiner, 2002).

When prominent journalist Norman Cousins was diagnosed with a rare and painful arthritic ailment, he found that watching Marx Brothers movies had an analgesic effect. Cousins' 1979 book, *Anatomy of an Illness* led to a growing popular belief that humor and laughter could have an impact on health and healing. Bennett and Lengacher (2006) reviewed the literature regarding the influence of humor and laughter on health. They found empirical data difficult to obtain and concluded "More work is needed before broad claims can be made concerning an effect of humor upon health outcomes" (p. 190). Other researchers have come to similar conclusions (e.g. Martin, 2001).

Another popular belief is that humor can help moderate stress. This is better supported by theory and research. Freud (as cited in Martin, 2007) sees an individual's ability to use humor as "the ego's victorious assertion of its own invulnerability" (p. 35). Alexander (as cited in Bergler, 1956) describes humor as a way to comfort oneself in a disagreeable situation. The revised edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2001) refers to the use of humor as one of the highest ego defenses. Most recent research studies have been correlational rather than directional, nevertheless they do support the idea that using humor can mediate the impact

of stress and limit negative feelings. A series of experiments by Lefcourt and Martin (1986) confirm that people who see themselves as having a good sense of humor appear to be able to deal with stresses more successfully. The results of a study in which college students were asked to "create a humorous narrative" while watching a stressful film revealed that the ability to produce humor had a "significant stress-buffering effect" (p. 292). Kuiper, Martin, and Dance (1992) correlated (self-reported) sense of humor measures with positive and negative life events, and prediction of positive or negative affect. "Besides helping one to maintain one's positive moods during times of stress, a sense of humor seems to enhance the enjoyment of positive events" (Martin, 2007, p. 293).

There are several hypotheses for the positive impact of humor in coping with stress or painful experiences. Humor involves incongruity, playfulness, and multiple interpretations. It therefore provides individuals with a way to shift perspective and reappraise a situation, to see it from a "new and less threatening point of view" (Martin, 2007, p. 19).

The use of humor as a way of gaining mastery over a painful situation is supported by Ford and Spaulding (1973), who interviewed the survivors of the *USS Pueblo* who had been held captive in Korea. Those who used humor as a coping strategy reported better psychological adjustment. Similarly, Henman (2001) interviewed American soldiers who had been POWs in Vietnam. They, too, emphasized the importance of humor to maintain morale, elicit positive feelings, and remain resilient. A report on soldiers in an intensive combat training course in the Israeli army showed positive correlations between peer-rated humor and higher peer ratings of performance under stress (Bizi, Keinan, & Beit-Hallahmi, 1988).

There may also be a role for humor in healing from losses. A longitudinal study on bereavement by Bonanno and Keltner (1997) reveals that widows and widowers who could smile and joke about their deceased partners after six months were less likely to struggle with grief symptoms at 14 or 25 months after their loved one's death. Stein, Folkman, Trabasso, and Richards (1997) find similar predictions of psychological well being in bereaved caregivers of AIDS patients.

Intimate relationships may also be enhanced by humor. Using self-report scales, Hampes (1992, 1999, 2001) has performed studies correlating sense of humor with feelings of intimacy, empathy, and trust in others. He indicates that humor supports the success of intimate relationships by assisting in the management of stress. R. H. Lauer, J. C. Lauer, and Kerr (1990) note that couples in long-term happy marriages often attribute their marital satisfaction to shared humor. Gottman (1994), who studies couples at the University of Washington, indicates that partners report greater marital closeness when they feel that their spouses appreciate their humor. The results of a study conducted by Gottman, Coan, Carrere, and Swanson (1998) suggest that humor may offer a way of regulating emotions in one's partner.

Not all use of humor has a positive impact. Martin (2007) describes four categories of humor: aggressive, self-defeating, affiliative, and self-enhancing (pp. 279-281). He sees aggressive humor as a way of administering criticism in a socially acceptable manner. Performances by "insult comedians" would be examples of aggressive humor. Martin indicates that aggressive humor can be harmful and insulting in most circumstances, except, as noted above, useful under extreme stress, such as war. He defines self-defeating humor as a form of

denial. In using self-defeating humor, an individual makes bitter jokes about his limitations, perhaps to keep others from commenting first. It is quite different from self-enhancing humor where people are amused "by the incongruities of life . . . even in the face of stress or adversity"(pp. 279-281). Martin views self-enhancing humor as the most effective in buffering stress, and affiliative humor as the most effective in positive interpersonal relations ("social lubricant"). Aggressive and self-defeating humor produce less positive feeling and may be less effective in dealing with stress.

Humor in Psychotherapy

Franzini (2001) promotes the notion of teaching therapists the risks and uses of humor in treatment. He describes therapeutic humor as "both the intentional and spontaneous use of humorous techniques by therapists . . . which can lead to improvements in the self-understanding and behavior of the clients" (p. 171). Franzini practices cognitive behavioral therapy, but other schools of thought also recommend the use of humor in treatment. Martin (2007) provides references supporting the therapeutic benefits of humor from psychoanalytic, Adlerian, cognitive-behavioral, rational-emotive, and strategic family therapy theorists. Kohut (1966) also sees humor as a mature transformation of narcissism.

Freud writes about jokes, wit, and humor; however, Grotjahn (as cited in Ronne, 2007) was the first analyst to write about the positive use of humor in psychoanalysis. He regards the value of humor to be that of allowing the clinician and client to create and maintain a good connection despite whatever painful affects and material the client raises. Thus, his work speaks to humor's role in the enhancement of the therapeutic relationship.

Since Grotjahn, several writers have described how the judicious use of humor may enrich the therapeutic alliance. According to Lazarus (2006) humor "enhances rapport" in treatment (p. 401). Bader (1994) believes that humor "help[s] the patient feel safer, and provide[s] an alternative model of mature relatedness" (p. 43). Poland (1994b) writes that "integrated, appropriate, spontaneous humor is indicative of a high degree of alliance between the patient and the therapist" (p. 176).

A number of therapists provide examples of the role humor plays in developing the therapeutic alliance. Barry (1994) describes a situation in which a laugh at his own expense made him "more human" to his client. His mildly self-deprecating tale helped his client feel safer in treatment. He believes that it "clearly further[ed] the analysis" (p. 73). Bader (1994) discusses his work with an angry, dissatisfied, and insulting patient. When the therapist began bantering with his client, a shift took place in the therapeutic relationship. The client became more self-reflective and able to examine the kind of binds in which he put others. The experience created "the beginnings of a spirit of collaboration" (p. 34). Kaplan (2006) describes a very fragile client with excruciating stressors who understood his use of humor to mean that she was healing. "I knew that I must be getting better if you could relax and be humorous" (p. 400).

These descriptions are supported by the work of Marci, Moran, and Orr (2004) at Massachusetts General Hospital who measured skin conductivity in clients and therapists simultaneously during moments of laughter in psychotherapy sessions. Skin conductivity implies an emotional response that may not be reflected in outward behavior. Patients laughed twice as often as therapists, although therapists exhibited increased skin conductivity even when

they did not laugh. The study indicates that laughter in sessions, and perhaps the humor that preceded it, creates a shared physiological arousal in the therapeutic relationship.

Humor can also assist in the development of the therapeutic relationship by making "a potentially grave situation appear not only nonthreatening, but amusing" (Giovacchini, 1999, p. 93). Salameh (as cited in Franzini, 2001) sees humor as "'the best gift' we can offer our clients because it implies that with a more positive view problems are solvable" (p. 172). Lazarus (2006) notes that a careful use of humor can "reframe various troublesome events so that a positive spin is gained that the proverbial silver lining comes into view" (p. 401).

This is similar to the role than humor may play in enhancing ego strengths. Poland (1994b) believes that "the play, the sense of pleasure comes from the sense of mastery" (p. 15). Birner (1994) views humor as "one of the finest tools a therapist can employ to help the patient gain an appropriate reality sense" (p. 86). These writers see humor as enriching the therapeutic relationship by allowing clients to feel safe and to trust the therapist; and by reframing certain situations to permit clients to gain new perspective or mastery over troubling issues.

As a pediatrician, Winnicott (1958/1975) observed infants "playing" with a shiny, metal tongue depressor, and creating a game or a fantasy with it, at their own pace. With slightly older children, he would draw a "squiggle" and invite the child to continue, observing what and how they choose to draw. Winnicott came to see play and humor as critical both to individual development and to the process of psychotherapy with children and adults.

> Playing facilitates growth and therefore health; playing leads into group relationships; playing can be a form of communication in psychotherapy, and, lastly, psychoanalysis has been developed as a highly specialized form of play in the service of communication with oneself and others. (p. 56)

Sanville (1991) expands on Winnicott's view that psychotherapy takes place in the overlap of the therapist's and the patient's play spaces by developing the concept of "the playground" of psychotherapy. She believes in the "powerful self-righting tendency in human beings" that can be liberated if the therapist creates "a suitable playground" to allow clients to "play out and redo any past experiences" (pp. 85-86). This safe and comfortable playground invites creativity and humor. Sanville gives the example of an analytic patient on the couch, who looked down and noticed a small statue of Freud on the table. "He's looking at my feet!" she remarked, amusing both herself and her therapist (p. 76).

Nelson (2008) writes about the role of laughter in therapy as an attachment experience. Using neurobiological evidence, she describes it as a "right-brain to right-brain bonding experience," (p. 46) which may serve as a connection, provide caregiving and affect regulation, enhance the therapeutic alliance, and promote healing. Nelson differentiates between laughter and humor. She agrees with Provine (1993), whose research reports that most "laughter is not a consequence of structured attempts at humor such as joke-or storytelling" (p. 295). While Nelson sees the shared laughter, rather than the humor, as the enhancing function of the therapeutic relationship; *something* precedes the laughter. The *something* might be classified as humor of the spontaneous *you had to be there* variety.

Lemma (2000), a British psychoanalyst, describes the structure of humor as dependent on incongruity, surprise, and timing. For her, the feeling of

"heightened affective moments" (p. 148) in therapy is similar to the experience of humorous communication. Lemma's thinking about humor in treatment combines the affective shifts that are proposed in attachment theory with the playfulness and transitional space of Winnicott (1971/2005). Lemma states:

> Humour [*sic*] essentially transforms the original expectation and takes us to a new space and, even if only temporarily, our affective state is altered . . . . Humorous exchanges between patient and therapist therefore provide one of the richest opportunities for the experience of moments of meeting and, I would like to propose, are essentially mutative. (p. 149)

Like Winnicott and Sanville, Lachmann (2008) believes that play and humor can "establish an atmosphere in which [a client] would feel both understood and able to bring up self-reflectively aspects of her way of relating to the world" (p. 104). He also values the role that humor can play in enabling patients and therapists to deal with "shame ridden" aspects of the patient's life. In addition, Lachmann writes about the role of humor in the transformation and regulation of affect, which he sees as critical in the therapeutic process. "The therapist-patient dialogue also includes humorous, ironic and creative interventions as vehicles for connecting with and transforming affect" (p. 17).

Humor may protect the therapeutic alliance "when a light touch is valuable for a tentative approach to a troubled area" (Zwertling 1955, p. 105). Some clinical material may be better illuminated by using an indirect rather than a confrontational approach. Grotjahn (1957) indicates that humor "renders acceptable an interpretation that otherwise could not be made" (p. 190). Loewenstein (as cited in Bergmann, 1999) commented that "the right joke, told at the right moment may be used *instead* of an interpretation, when a patient's sense of humor makes him accessible to a particular type of joke: (p. 25) This does not

imply that the therapist have a stand-up comedy routine, but that occasionally, the punch line, or theme of an amusing story may clarify a situation in a more effective way. Birner (1994) notes, "The use of humorous feelings can dramatically and forcefully point to a psychological truth and add to the classification of unconscious communication" (p. 85). Grotstein (1999) describes this use of humor as a "shorthand parable to replace what would otherwise be a much longer interpretation" (p. 81). But Grotstein also notes "the most favorable use of humor is on the occasion in which it is not being used as a technique but rather, when it spontaneously springs up improvisationally in either the analysand or the analyst" (p. 84).

Kubie (1994) strongly warns against the use of humor in psychotherapy. Elements of his powerful indictment are often cited as cautions to clinicians. Kubie states:

> Humor has a high potential for destructiveness . . . the mere fact that it amuses and gives a pleasant feeling is not evidence that it is a valuable experience for the patient or that it exerts on the patient an influence toward healing change. (p. 95)

The clinician must be discriminating about the choice of using humor or risk that the patient may realize "how easy it is to use humor as a mask for hostility" (Kubie, 1994, p. 96). Kubie is not alone in this concern. Marcus (1994) notes that "patients not infrequently use humor as a means of trivializing the serious import of material they bring to mind in the course of psychotherapy" (p. 113). Therapists must be aware of the source of joking and deal with it appropriately. Clients may also be too quick to comply with what they think the clinician wants. Some patients may have used humor to enliven their families. They may subconsciously believe that it is their responsibility to enliven the

therapist, as well. Similarly, Kubie warns that a patient may "seduce the therapist out of his therapeutic role" (p. 102).

Kubie (1994) also fears that the patient may not be able to determine if the therapist is serious, or "only joking." In that case, it would be difficult for the client to sincerely reveal and examine his pain. It also makes it "impossible for the patient to express any resentful components" (p. 97). Kubie worries that if the client was mocked or teased as a child, humor might retraumatize a patient. All of these dangers speak to the therapist's need for mindfulness, consultation, and self-discipline, particularly with countertransference issues (Friedman, 1994; Baker, 1999). "The questions for the analyst are the same as they would be for the patient. Why now? What does the particular use of humor mean" (Poland, 1994a, p. 20)?

One of Kubie's (1994) concerns is that humor "impairs the therapist's necessary incognito" (p. 99). This implies a more sterile form of neutrality than has been used in contemporary psychotherapy. Poland (1994a) makes a case for a more intersubjective view. "While the analyst's narcissism and drives must be tamed, it seems unrealistic and even destructive to think an analysis could pass with no sense of the analyst's humanity ever revealed" (p. 22). Therapists practicing from self-psychological, intersubjective, object-relations, relational, or attachment theories, as well as those who use a systems or Feminist perspective acknowledge that while we endeavor to keep our personal lives to ourselves for the client's sake, we cannot remain completely in hiding. Our use of humor is also part of the relationship.

An additional concern about using humor is cultural context. Tseng and Streltzer (2001) write extensively on culture and psychotherapy. They believe

that "culturally relevant therapy requires the therapist to adjust, expand or modify his or her understanding and method of treating each patient by considering the patient's ethnic and cultural background" (p. 10). Therapists must take care that they understand whether the client's culture supports the use of humor. The results of research by Jordan and Carter (2004) suggest that:

> High levels of humor will not reduce stress symptoms in Asian students in the United States attending the ILUNO Program . . . When counseling multicultural clients, it should be recognized that some cultures accept humor more readily than others." (n. p.)

Martin (2007) questions the literature on humor and therapy as "based on case examples and clinical impressions. . . . [There is a need for] empirical research examining the effectiveness of humor-based interventions or the types of humor that may be appropriate or inappropriate for therapy" (p. 349). The problem with empirical research is that it generally cannot capture the *quality* of the experiences of therapists or clients. Aside from the 2004 study by Marci, Moran, and Orr, which examined the physiological experiences of the therapeutic dyad, it is primarily from reports of the therapist-client experience that we have learned about the effect of humor in the treatment.

Over the past 35 years, there have been a dozen doctoral dissertations examining the role of humor in psychotherapy. Several themes have emerged from this research regarding the role of humor: as a way of assisting in the development of rapport between the therapist and client (Buckman, 1980; Carozza, 1986; Koelln, 1987; Olson, 1996; Major, 1999); as a diagnostic and assessment tool (Buckman, 1980; Carozza, 1986; Koelln, 1987; Major, 1999); as a way of decreasing client anxiety (Buckman, 1980; Major, 1999); and as a means of helping change perspective (Buckman, 1980; Carozza, 1986; Koelln, 1987; Major,

1999). Two of the studies comment on the role of humor in enhancing client self-esteem (Buckman, 1980; Major, 1999). Two researchers see the use of humor as an advantage with "resistant" clients (Carozza, 1986; Major, 1999). One of the researchers notes that humor enabled clinicians to communicate on multiple levels (Carozza, 1986).

Treatment Issues With Older Adults

Older adulthood consists of a combination of experience, losses, and wisdom. Our culture tends to focus on the losses: of physical abilities, of relationships both social and intimate, of energy, of meaningful work, of roles, of homes, of financial well being, and of cognitive abilities (Knight, 2004; Berk, 2003). Not every older adult will experience the same losses or losses of the same magnitude. It is the *meaning* of the particular loss for the particular individual that will be significant. Griffin and Grunes (1990) write, "An increasing body of evidence indicates that psychological adaptation in old age is related to the ability to maintain a highly stable and continuous self-representation in the face of a variety of life transitions" (p. 270).

"Life span psychology" takes a different view of aging. It focuses on the role of greater life experience and competencies, increased cognitive complexity and maturity (Knight, 2004). Erikson (1963) describes the task of older adulthood as developing ego integrity (accepting past experiences and disappointments), which would result in the earning of "wisdom." While Erikson does not specifically define wisdom, a contemporary author's description may be helpful: "a clear-eyed view of human nature and the human predicament; emotional resiliency and the ability to cope in the face of adversity; an openness to other possibilities; forgiveness; humility, and a knack for learning from lifetime

experiences" (Hall, 2007, p. 24). Charles, Mather, and Carstensen (2003) have studied emotional regulation in older and younger adults. Contrary to a popular view of older adults as rigid, the older subjects in the study seem to be able to recover from unpleasant moments with greater ease than their younger counterparts. They know that nothing lasts forever, not even bad feelings.

These general issues may have an impact on those older adults who seek psychotherapy. Atiq (2006) describes five areas of practice with older adults: restoration of a positive self-concept; dealing with loss; dealing with aging, illness, and possible dependence, dealing with death and dying; and transference and countertransference. He writes, "aging well depends on the ability to mourn for the self, which opens up possibilities and freedom in the years that are to come" (p. 4).

This is consistent with Griffin and Grunes' (1990) view that the goal of therapy with older adults is the maintenance of a sense of self that may have been undermined by undesired changes. "In effect, the therapeutic relationship serves as a temporary replacement for the functions that had hitherto been performed by constancy-sustaining objects in the patient's psychosocial world" (p. 278).

Cohler and Galatzer-Levy (1990) believe that "the clinical psychoanalytic method should be of particular benefit in understanding this maintenance of personal coherence in very late life, just as it has been important in clarifying the significance of interiority in middle age" (p. 237). The authors see the empathic method of inquiry and a reworking of personal narratives as particularly useful in treatment with this population.

Knight (2004) might view Atiq's formula as a "loss-deficit" model, "which portrays the normative course of later life as a series of losses and the typical response as depression" (p. 5). The goal of therapy in such a model is to assist older adults in "adjustment to the natural losses of late life and grieving for them" (p. 21). Knight integrates the "loss-deficit" model with the research from "life span psychology" into a "contextual, cohort-based maturity, specific challenge model" of treatment.

> Older adults are seen as more mature than younger ones in certain important ways but also are recognized to be facing some of the hardest challenges that life presents to adults, including adjusting to chronic illness and disability as well as frequently grieving for others. (p. 5)

This framework does not consider loss as natural to older adults, simply more frequent. It also requires an understanding of the context in which individual older adults live, and the different values and experiences they may have had. In some ways, understanding of context and cohort differences for older adults is the same as understanding differences of other cultural groups. Without patronizing older clients, Knight (2004) comments that biological shifts may require the need for clinicians to "slow down the therapeutic conversation and rely less on the client's inferential reasoning abilities and to recognize the client's greater maturity, expertise based on life experiences, greater cognitive and emotional complexity, and more mature coping strategies" (p. 45).

Regardless of some of the commonalities in developmental and cohort experience, in treatment, each client's individual needs and strengths must be considered. Jacobowitz and Newton (1990) feel that treatment with older adults requires:

> . . . identifying underlying motivational needs and conflicts that came into being during childhood; recognizing the defensive systems of the character structure that became crystallized during early adulthood and became enmeshed with lifestyle; considering the particular psychosocial context of their current environment; and finally realizing that psychological strength . . . can in many cases, be rechanneled to promote gratifying changes during the later years. (p. 328)

In order to perform all of these tasks successfully, clinicians need to take their own reactions to client material into consideration. "Acknowledging countertransference feelings can help us come to a deeper understanding and appreciation for each person's and each family's own processes" (Genevay & Katz, 1990, p. 19).

Older Adults, Humor, and Treatment

Facing and accepting mortality is a major issue for older adults. In his 1966 paper, "Forms and Transformations of Narcissism," Kohut speaks to this primary existential concern. He describes six mature transformations of narcissism: empathy, sense of humor, creativity, transience (the acceptance of one's mortality), and wisdom. Kohut states that humor can be used in the acceptance of transience, providing a sense of quiet inner triumph. Further, Kohut defines wisdom as the ability to contrast the "utter seriousness and unrelieved solemnity of approaching the end of life by transforming the humor of their years of maturity into a sense of proportion, a touch of irony toward the achievements of individual existence" (p. 269). According to Lachmann (2008), Kohut "considered humor and especially irony to provide an invaluable perspective about the vicissitudes of life" (p. 9).

A number of other writers have considered the benefits of humor for coping with issues of aging. Humor allows for the mastery of the unmasterable, which is particularly important for people who may feel increasingly vulnerable.

Kohut (1966), Schlesinger (1979), and Lachmann (2008) understand humor to be in the service of mastery. Fry (1986) states that "elderly people can take greater control of their life experiences by enhancing the role of humor in their lives" (p. 89). Martin (2007) believes that humor in older people may have "to do with coping with stress and maintaining a humorous outlook on life" (p. 266).

Simon (1990) finds that older adults who described themselves as using humor as a coping strategy may not necessarily score higher on "life satisfaction" surveys, but do score higher on "morale." Adams and McGuire (1986) report on the effects of humor on mood and perceived pain among older residents of a long-term care facility. Watching humorous movies daily seemed to improve residents' mood in the moment. Celso, Ebener, and Burkhead (2003) learned that older adults in assisted living facilities were better able to use humor as a coping strategy if they were in better health. Solomon (1996) correlated measures of "aging well" with five measures of humor. Humor was positively related to "aging well" and to interactions with family members. "The correlations between humor and perceived control suggest that humor may affect aging well indirectly through perceptions of control" (p. 265). Some of the results harken back to the Lefcourt and Martin (1986) studies where students were asked to create humor to buffer stress.

In her article, "Humor and the Mental Health of the Elderly" Volcek (1994) considers humor "a key component is building increased self-confidence," which she believes can help older adults deal with difficult "environmental conditions, particularly health, housing and companionship" (pp. 119-120). Similarly, humor may be particularly valuable in helping older adults gain mastery over painful disappointments.

> Humor can be seen to deflect the painful truths of biological decline and inevitable death and thus, as Freud suggested, to convert the unbearable into the humorous--and so to master, in the mind at least, that which eventually will prove to master us. (Datan, 1986, p. 162)

Prerost (1993) theorizes that "the well-developed sense of humor can maintain the older adult's perception of self-control or mastery over life situations that promote stress" (p. 22). The therapist may be able to help older adults use humor to regain a sense of self. Prerost, therefore, developed a strategy to enhance humor production with older adults.

Despite losses, Charles, Mather, and Carstensen (2003) believe that older adults are actually better able to regulate their affect than younger people are. But not all older adults have this ability. Nelson (2008) points to laughter as a "now moment" where therapists may help clients regulate affect. Perhaps old jokes in treatment work the same way. Seltzer (1986) asks: "Do shared old jokes reinforce a cohort cohesiveness? Do we have favorite old jokes—a form of nostalgia—as we have favorite old tunes" (p. 132)? If so, then perhaps the use of this type of humor brings about "moments of meeting" (Stern, 2004) in treatment, which may promote healing. Davidson (as cited in Hall, 2007) postulates that older adults who can self-regulate emotions may have learned how to do so by using cognitive (left brain) techniques. Perhaps older clients can learn to use humor to self-regulate affect.

Some recent studies question whether older adults are as able to get the joke. Schaier and Cicirelli (1976) found that while people in their seventies did not choose the appropriate punch-line as well as people in their fifties, they thought the jokes were funnier. Shammi and Stuss (2003) also noted that older adults did not pick out the punch line as accurately, but that there was not a

difference in appreciation of humor. Mak and Carpenter (2007) replicated part of the Shammi and Stuss study, and confirmed their results. However, there are questions about this type of study. Martin (2007) acknowledges that older adults may have grown up in a different time with different cultural norms and expectations, and therefore not respond to the punch lines as expected by the experimenters . It may not matter whether older adults get the correct punch line if they appreciate the humor.

Countertransference Issues

Every day clients share emotionally laden material with their therapists. Clinicians must consistently bear witness to areas that they might find painful. Butler and Lewis (1977) describe six areas that may create negative countertransference in working with older adults: therapists' fears about their own aging; fears about the fragility and mortality of their clients; therapist's own conflicts with parents and grandparents; concerns that older adults will not be able to change; desire not to waste therapeutic time; and concern that colleagues may devalue their efforts.

Muslin (1992) speaks of civilian reactions to therapy with older adults. When working with this population, therapists may have to face issues of their own mortality, their own diminishing capabilities, issues of dependency, helplessness, caregiving, and unease about suicide. He also describes countertransference reactions which may be more diagnostic.

Clinicians may have difficulty dealing with clients who struggle with chronic physical problems that may not be remediable. Helping people accommodate to ongoing physical issues is "different from seeking the complete remission from acute depression" (Knight, 2004, p. 22). The idea that clinicians

may not be able to return clients to "pre-illness mood levels," may lead to feelings of inadequacy which can "manifest themselves in the reverse as rescue fantasies" (Arbore, 1990, p. 49).

Altschuler and Katz (2002) note additional areas that may not be as commonly identified as countertransferential concerns. These include feelings about older adults and "sexuality, intimacy, HIV / AIDS, incest, abuse, personality disorders and chronic mental illness . . . sibling issues, older parent remarriage, older adults as emotionally abusive, substance abuse, lesbian, gay, bisexual, and transgender identity" (pp. 76-78).

All of these concerns may be stressful for the clinician. Knight (2004) comments: "watching older people whom you like and know with the intimacy of therapy become more and more disabled is one of the most difficult aspects of psychotherapy with the elderly" (p. 91).

Genevay and Katz (1990) point out that "professional stress and burnout occur when countertransference is overlooked" (p. 14). They also observe that ignorance of countertransference issues may lead to overhelping or underhelping; extending treatment beyond a client's need, or ending it too soon (p. 15). Similarly, Knight (2004) notes that therapists "often hate to say goodbye to older people. They express fears that the older person will be lonely, will feel deserted, or is too frail to survive without support" (p. 94).

Giovacchini (1999) also speaks about therapists' feelings and suggests that the use of humor may have a salutary effect.

> Therapists can feel deeply about their patient's plight, but to be effective clinicians, they must have hope, not to be overwhelmed by despair and maintain cautious optimism. This is a serious but not grim attitude, and its purpose is eventually to construct a

> transitional space in which humor can play an increasingly significant role. (p. 107)

A few references in the literature imply that humor may have an impact on therapists' countertransference as well. Grotjahn (as cited in Ronne, 2007) believes that "humor can help the analyst from becoming flooded or overloaded with toxic emotions . . . [and] can protect both individual and the dyad from overwhelming affects" (Paragraph 19). Family therapists Napier and Whitaker (1980) comment that the positive use of humor in therapy can help keep the therapist sane. Lemma (2000) also notes that "humour [*sic*] is a potentially useful strategy for staff whose work may be rewarding but it is also, undeniably, emotionally taxing" (p. 118). Westburg (2003) studied the use of humor in skilled nursing facilities. She references Moran and Massam who suggest that increasing the use of humor might help staff members to cope with stressors that cannot be eliminated. Fry and Salameh (1987) conclude that "the introduction of humor would reduce the occurrence of burnout, would provide therapists with an effective antidote to stress and frustration, and would encourage a richer (more colorful, less self-critical) attitude toward oneself" (p. 323).

CHAPTER III: METHODS AND PROCEDURES

The purpose of this study is to explore how therapists working with older adults think about and use humor with this population. The central concerns are: how therapists see the use of humor with older adults in treatment; how, why, and when they use humor; how they find it beneficial; how they find it problematic; differences they experience in using humor with this population as opposed to using it with younger people; and the effect that using humor in therapy has on the clinicians. This chapter describes the processes and procedures used to guide my study of the phenomenological data.

Design

The focus of the study is the therapists' experience using humor in treating older adults as reported in open-ended interviews inviting their thoughts about practice. A qualitative approach to the research is a natural choice for analyzing data gleaned from interviews exploring the subjective experience of therapists. As Corbin and A. Strauss (2008) note: "Qualitative research allows researchers to get at the inner experience of participants, to determine how meanings are formed" (p. 12). This is also an appropriate method for performing exploratory research into areas that may not have yet been examined, such as using humor in therapy with older adults.

Qualitative research is a "nonmathematical process of interpretation, carried out for the purpose of discovering concepts and relationships in raw data and then organizing these into a theoretical explanatory scheme" (A. Strauss & Corbin, 1998, p. 11). There are several qualitative strategies. This study applies the grounded theory method to examining data. Originally developed by sociologists Glaser and A. Strauss in 1967, grounded theory is particularly useful

in the social sciences, where rich detail regarding experiences may provide greater explanatory power than statistical information. It is inductive, rather than deductive.

> *Inductive analysis* involves *discovering* patterns, themes, and categories in one's data. Findings emerge out of the data through the analyst's interactions with the data, in contrast to *deductive analysis* where the data are analyzed according to an existing framework. (Patton, 2001, p. 453)

Developing grounded theory begins with methodically organizing the descriptions of experiences into discrete categories, out of which concepts and themes emerge. The categories are then "systematically interrelated through statements of relationship to form a theoretical framework that explains some phenomenon" (Hage as cited in Corbin & A. Strauss 2008, p. 55).

The nature and style of the research interviews has an impact on the generation of experiential data. Using semi-structured interviews based on Mishler's (1986) work, I explored the experiences of clinicians who work with older adults, systematically organizing that data into thematic and conceptual categories, and working to develop increasingly complex and abstract views of the relationships between those categories to enhance understanding of the clinicians' experiences.

Participants

Nature of the Sample

The qualitative approach does not require a large sample, however participants need to be chosen in a "purposeful," way; that is, chosen "deliberately in order to provide information that can't be gotten as well from other choices" (Maxwell 2005, p. 88). Eight experienced psychotherapists who treat older adults and use humor in treatment were recruited for the sample.

Participants who seemed to be able to provide a great deal of descriptive information were chosen. Patton (2001) would call them "information-rich" cases: "Cases from which one can learn a great deal about matters of importance and therefore worthy of in-depth study" (p. 242).

The size of the sample was based, in part, on the information gleaned. Data collection in qualitative research is not a static process. As the information is explored, new categories and concepts emerge, and new questions are generated. "This circular process continues until the research reaches the point of saturation; that is, the point in the research when all the concepts are well defined and explained" (Corbin & A. Strauss, 2008, p. 145).

Variation in the participant population was sought in terms of profession, as well as age, gender, and ethnicity in order to develop data across a wider therapist population and, therefore, potentially offering more credible results. Psychotherapists were recruited from several different professions: licensed clinical social work, licensed marriage and family therapy, licensed psychology and board certified psychiatry. The participants identified themselves as using humor in psychotherapy. Each of the participants is an experienced psychotherapist. "Experienced" was initially defined as having been in practice for at least five years with older adults.

Recruitment

Participants were recruited through recommendations from colleagues, and from the memberships of professional organizations. A letter describing the research project was sent to colleagues asking for recommendations for potential participants (see Appendix A). Although an advertisement was prepared for professional journals (Appendix B), there were enough participants available

without advertising. A letter was sent to potential participants, whose names I received from colleagues, describing the focus and methods of the research project (see Appendix C), a consent form for them to review (see Appendix D) as well as a short descriptive questionnaire asking about their practice with older adults (Appendix E). After selecting the initial participants, I called each of them to set up a comfortable and convenient time and place for the interview. For those not initially selected, a letter was sent out thanking them for their interest (see Appendix F).

Data Collection: The Interview

A research interview is more than a set of simple queries and responses. It is a live interaction between people. Holstein and Gubrium (1995) see interviewing as an active, meaning-making process.

> Meaning is not merely elicited by apt questioning nor simply transported through respondent replies; it is actively and communicatively assembled in the interview encounter. Respondents are not so much repositories of knowledge—treasuries of information awaiting excavation—as they are constructors of knowledge in collaboration with interviewers. (p. 4)

Open-ended semi-structured interviews were used to gather the data. Using this style permits participants to explore their thoughts and feelings about humor, treatment, and older adulthood in a format that allows them to express their individual ideas. By using the same basic questions and probes (see Appendix G), I attempted to ensure that the data gleaned would be full of "thick description" (Geertz, 1973). "Open-ended questions and probes yield in-depth responses about people's experiences, perceptions, opinions, feelings, and knowledge. Data consist of verbatim quotations with sufficient context to be interpretable" (Patton, 2001, p. 3). The interviews were all recorded on audiotape, then transcribed to assure accurate recording of data. The data

gathered was reconstructed into categories to try to conceptualize their significance. Polkinghorne (2005) writes "the purpose of the exploration of remembered events is not to produce accurate recalls but to provide an occasion for reflection on the meaning these events have for the participant" (p. 143).

The style of the interviews was informed by Mishler's (1986) view of interviewing as a conversation between speakers. He cautions the interviewer to pay attention to "culturally shared and often tacit assumptions about how to express and understand beliefs, experiences, feelings and intentions" (p. 7). If the participants feel comfortable, the data gathered will be richer and more useful. "To come to a more adequate understanding of what respondents mean and to develop stronger theories as well as more valid generalizations in interview research, we must attend to the discursive nature of the interview process" (p. 65).

Polkinghorne (2005), too, expresses concern about the nature of the interview. He notes that "the welfare of the participants must be the primary concern in the production of qualitative data. In addition to maintaining the confidentiality of participants, researchers need to proceed with sensitivity and concern" (p. 144).

The Interview Guide

Creswell (2003) suggests the use of an interview protocol for qualitative interviews. The protocol consists of an opening statement to the participants, "key research questions, problems to follow key questions, transition messages for the interviewer, space for recording interviewer's comments, and space in which the researcher records reflective notes" (p. 190). As part of the opening

statement I described the purpose of the project, reviewed the consent form, and reviewed the format (i.e. taping the interview, and potentially using direct quotes from the interview). I also insured that the participant understood that any identifying data would be disguised, and that all tapes would be destroyed. I generally let the participant lead, telling his or her own narrative. If there were areas that had not been raised spontaneously, or needed clarification, I tried to wait for appropriate opportunities to raise them, so as not to interrupt the participant's flow of ideas. Occasionally, I summarized the participant's ideas, and sought approval of the summary.

Topics for the Interview Guide

Based on the literature in the field regarding the use of humor in psychotherapy, and previous dissertations that look at humor in treatment generally or with other groups of people (see Chapter 2), several areas of inquiry arose. As my interest is in both in the use of humor in treatment and in any particularities of that use with older adults, I began by asking participants about their work with older adults. This was followed by questions regarding the therapists' thinking and experiences with older adults in their own lives. There were questions about the use of humor in treatment in general, and the use of humor in treatment specifically with older adults. I also asked about specific life issues of older adulthood, and the impact on the treatment, as well as on the clinician. The list of questions varied, due both to the individual participant's narrative and flow, and to new questions raised by previous interviews.

Data Analysis

The data collected from the interviews was analyzed according to the *constant comparative* method originally developed by Glaser and A. Strauss

(1967). This method is the basis of developing grounded theory. "While there are many analytic strategies, two stand out. These are asking questions and making comparisons" (Corbin & A. Strauss, 2008, p. 68). As data is collected, the researcher continuously inquires about the meanings of the statements and of individual words, and creates categories to begin to understand the material presented. New data is compared with previously collected data to "sensitize researchers to possible properties and dimension that are in the data but remain obscure" (p. 77), to develop new categories and new questions, to help researchers move more rapidly from the level of description to abstraction, and to force researchers to examine their own basic assumptions (p. 77). The results of each interview have an impact on the interviews that follow. The integration of categories, and the analysis of them may begin to generate theory.

Each of the interviews was audio taped. Listening to the tapes several times before transcribing them provided a sense of the particular interview and the participant's unique voice. Specific themes began to emerge from each. The interview was then transcribed, along with notes describing tone of voice, pauses, particular facial expressions, etc. before the next participant was interviewed.

The development of grounded theory depends on a set of systematic and methodical coding procedures for the data. Each interview was scrutinized line by line to build categories, and eventually relationships between categories, to allow greater abstraction and conceptualization. There are several styles of coding; grounded theory focuses on the use of "Open, "Axial" and "Selective" coding. Open coding is the process of breaking data apart and developing categories and themes from the data. It is open in that exploration is made

without prior assumptions. Corbin and A. Strauss (2008) also note that this process takes place at the same time as "one is qualifying those concepts in terms of their properties and dimensions" (p. 195). Codes may be named by the researcher or developed out of the actual phrases or terms that participants used in the interviews. Called *in vivo* codes, they have the advantage of presenting the data with a flavor that is closer to the participant's experience.

Axial coding depends on building connections between and within categories to develop a stronger theoretical thrust, and are "termed 'axial' because coding occurs around the axis of a category" (A. Strauss & Corbin, 1998, p. 123). In a later edition of *Basics of Qualitative Research* (2008), Corbin and A. Strauss note that open and axial coding take place simultaneously; that while open coding breaks the data apart, axial coding puts it back together by relating the categories conceptually. Selective coding continues the process of developing structural relationships between core categories and related categories that can be integrated to develop the construction of theory.

Presentation of the Data

The data is presented in Chapter IV, which is an overview of the research. It describes the participants (while carefully disguising them to protect anonymity), mentioning their similarities and differences, and describes the categories and subcategories that emerged from the data, along with illustrations from the data. The use of *in vivo* codes helps to capture the flavor of the participants' experience.

Chapter V is a discussion of the implications and potential significance of the research. It also explores the limitations of the study. Chapter V attempts to integrate the original research questions, the literature, and patterns developed

from the analysis of the data.

Reliability and Validity

Reliability and validity are concepts that are used largely in quantitative research. In that context, they refer to the rigor of the research design. A study is considered reliable if the measuring device or procedure is accurate and if the study can be replicated. Essentially validity means that the researchers measured what they promised to measure and that another researcher using the same protocols would get similar results.

These methods of measurement are less successful with qualitative research. Even Corbin and A. Strauss (2008) struggle with defining an appropriate set of measurements. They ask

> Are we judging for "validity" or would it be better to use terms like "rigor" (Mays & Pope, 1995), "truthfulness," or "goodness" (Emden & Sandelowski, 1999), or something called "integrity" (Watson & Girad, 2004) when referring to qualitative evaluation? (p. 297)

Ultimately, Corbin and A. Strauss go back to Glaser and A. Strauss (1967) to come up with a description of "credible" research.

> If the research findings are "credible"; that is, believable or plausible and "applicable" in the sense that findings can be readily used because the findings provide insight, understanding, and work with diverse populations and situations . . . then it seems to me that all this philosophical debate about "truth," "validity," and "reliability" is superfluous. (Corbin & A. Strauss, 2008, p. 301)

If the interpretations of the data accurately describe the phenomenon being investigated and the project provides rich, thick description it may be termed "truthful" or "credible." These are the standards this research attempts to meet. Mishler (1986) cites Cronbach, who states "Scientific quality is not the principal standard; an evaluation should aim to be comprehensible, correct, and complete,

and credible to partisans on all sides" (p. 113). Participants were selected with care as "the validity and trustworthiness of qualitative research is related to the selection of viable sources that promote a deepening of the understanding of the experience inquired about" (Polkinghorne, 2005, p. 141).

Limitations

The study is limited by availability of participants. Participants were required to be experienced, use humor in psychotherapy, and see older adults. The study represents the experiences and conceptions of the therapists; however, it is an exploratory study limited by the number of participants.

Polkinghorne (2005) notes that research that is dependent on participant self-reports has an inherent limitation in that the immediate experience is edited by the passage of time and by the re-telling (p. 138). Because the research focuses on the *experience* of clinicians, self-reports are an effective way to explore the clinician's process.

Another potential limitation is the researcher's bias. The researcher's pleasure in the use of humor may be designated as a bias. I was drawn to this topic hoping to learn more about how psychotherapists experience using humor with older adult clients. The goal of the study is to explore the thoughts and feelings of the participants and identify the essential themes and variations from their experiences.

CHAPTER IV: RESULTS

Participants

This chapter presents the results of interviews conducted with therapists exploring their use of humor in psychotherapy with older adults. A description of the eight participants in the study, and demographic information about them is followed by the data, which is divided into six general categories: general issues regarding the use of humor in therapy, potential benefits, potential harm and repair, developmental issues of older adulthood, humor in psychotherapy with older adults, and countertransference issues. Four of these are divided into specific subcategories. To protect the participants' confidentiality, each of them has been assigned an alphabet letter for citation purposes. The quotes are cited by the participant's assigned letter only.

All of the participants are psychotherapists recruited from several different professions: clinical social work, marriage and family therapy, psychology, and psychiatry. Each of them indicated prior to the study that they use humor in their practice of psychotherapy and that they treat older adults. The participant group consists of seven women and one man; six are licensed clinical social workers, one is a board-certified psychiatrist, and one is a licensed psychologist who also holds an LCSW. One of the participants is in her fifties, five are in their sixties, one is in her seventies, one is in his eighties. All of the clinicians have a great deal of experience, varying from 20 to over 50 years. Six of the clinicians come from a Jewish background, one has Irish roots, and one is African-American.

The participants also hold different theoretical viewpoints. While all have had psychodynamic training, some have shifted their thinking and the

modalities in which they practice. Nevertheless, each of them feels that humor fits in nicely with the theories to which they subscribe. One participant sees the relational approach as "a supple non-regulated way of thinking, and so humor will occur. It emerges the more spontaneous and more authentic the interaction is" (G). Another integrates Cognitive Behavioral techniques with a psychodynamic view. A third participant identifies herself as "a strong systems thinker." A fourth participant integrates Eriksonian and Gestalt thinking with systems work, which she describes as "much more along the lines of improvisational theater" (F). A fifth interviewee uses a "Strengths perspective" with a Feminist cultural orientation. Despite their varied theoretical and treatment modalities, each of the participants values the use of humor in psychotherapy with older adults.

General Issues Regarding the Use of Humor in Therapy

How does the clinician use humor in psychotherapy? One of the participants is an academic as well as a therapist. She acknowledges the 2007 work of Truax and Carkhuff, which identifies genuiness, respect, and accurate empathy as critical characteristics for successful therapeutic work, regardless of the clinician's theoretical orientation. Whenever she uses humor in treatment, she endeavors to meet those criteria (D). Other participants who did not refer to Truax and Carkhuff also recognize these elements as important in successful therapy. All the participants feel that humor must resonate empathically with the client. Four mentioned the need for the humor to be "genuine"; six others believe that it must be "respectful."

Every interviewee sees the client's ability to appreciate humor as critical to the clinician's successful use of it in the treatment. "It has to be there, in them to

some degree before you can do it" (A). "A lot depends on the person's ego strengths, and where they are, and how much they trust" (H). Three of the clinicians point out that "some days, people who really enjoy humor may not be in the mood for it" (F).

Five participants indicate that the "humor has to be initiated more from the patient" (G), that they "usually go with whatever direction they [clients] are going in first" (C). However, three of the therapists contend that there are times when they will "deliberately lift the mood . . . when people don't need to go there." For example, one participant may strategically lighten the tone at the end of a session to prevent a client from leaving in a highly anxious state (D).

Types of Humor

Two of the participants see the use of humor with clients as a form of play. "We tease and joke" (A). Four more therapists use banter, or repartee with their clients. "You start bantering in a funny way and then you have that light moment that can open up other things" (E). One of the clinicians described the value of bantering with a client using puns. "There was humor and it had a relational quality" (G).

Self-deprecating humor is valued by half of the participants. "The fact that I can laugh at myself is comforting to them, because I'm not taking *myself* as seriously" (F). Although this participant is the youngest in the study, she jokes with clients about her own "creeping into early old age and the body not working well" (F).

Not all the humor used in treatment is gentle. Exaggeration, facetiousness, absurdity, outrageousness, paradox, sarcasm, and irreverence are used to reframe or provide a new perspective. One of the participants described an

interchange with a client whose family had great difficulty communicating directly. The client complained that her children, who live locally, do not call her, but may send brief e-mails. The therapist facetiously suggested that the family come in for a session with each member bringing their laptop computers and "we'll sit around in a circle having you talk to them on your laptops." She believes that "by exaggerating at that moment, the client got it!" (A) Two of the participants see their style of humor as cynical. Three are particularly careful because their humor can be sarcastic. Another therapist makes particular use of black humor. "Black humor honors their distress, honors the depression, honors the sadness in a way that gentle humor might not" (F).

Five of the participants report using what they consider to be appropriate jokes in treatment. One uses a memory joke with older clients (B). Another uses "wake-up jokes" to help reframe (F). A third tells funny stories, "and I *do* have some jokes" (D). Another therapist described a situation with a client who told *her* jokes at the end of sessions. "No matter how heavy, she would always reconstitute and tell me a joke." The therapist decided that she "wanted to have a different kind of exchange" with the client, and prepared several jokes, choosing an appropriate one to end the session. Her use of the joke changed the dynamic of the treatment (C).

Culture, Context, and Ethnicity

Half of the participants specify paying attention to the culture, context, and ethnicity of clients when using humor. "I have to understand something of that person's culture, life experience and context" (D). This interviewee also discussed the role of humor in particular cultures as a form of protection. "It's been said of African-Americans that culturally we have used humor in the face of

extraordinary pain. If you didn't laugh it off, you'd be on your knees in tears all the time" (D). In addition, she thinks that ethnic humor can be used across cultures to help the client feel that the therapist "knows something about me." Although she is African-American, she has said "Oy Vey" to Jewish clients, with good results. However, she cautions that the therapist must "watch very carefully" to be sure the client is comfortable. Another participant, whose client felt close to her because they share an Irish heritage, called the client "a stubborn old Irishwoman" in response to her client's reports of repetitive self-damaging behaviors. After awhile, the client would describe an unsatisfactory exchange with a family member and conclude ironically, "Yes, I know. I'm a stubborn old Irishwoman" (B).

"Older adults have different humor borne out of their culture" (F). Older adulthood may be viewed as a different culture; this arena will be considered in the section regarding psychotherapy with older adults.

Potential Benefits of Using Humor in Treatment

As an Assessment Tool

Even at the beginning of treatment the therapists in the study report paying careful attention to their clients' use of humor, or responses to their own use of humor. Six participants described using it as a way of assessing their clients' anxiety, depression and strengths. "The capacity to have some humor is a very telling part of a therapeutic sort of an evaluative conversation" (G). For those who see humor as strength, finding it in clients implies a higher level of functioning. "Having humor is highly correlated to the capacity to cope adaptively in difficult situations" (D).

Three participants specifically use it in early sessions as part of an initial assessment "to kind of suss out what will take the anxiety level down and see if that works." One might also make light remarks about misplacing her glasses ("Without these nothing exists") or the temperature in the office ("Can you see your breath yet?") to evaluate the client's level of anxiety and discomfort (B).

Clinicians also use humor to determine limitations. Some clients are too anxious, angry or frightened to use or appreciate it initially. One participant discussed a client who was too angry at her mother to find a light remark about her funny (C). Another described a client who is "a very frightened person," and therefore, the therapist believed she could not appreciate humor in therapy (H). Interviewees felt that some illnesses sap a client's ability to use or appreciate humor, Parkinson's disease, for example (F). There are also some depressions that participants felt could not be moved at all by humor. "If even the blackest of black humor isn't making any impact here, that's the hallmark"(F).

Four clinicians view a client's ability to begin to use humor as an indicator of progress in the treatment. "Her use of humor was a sign of growth, letting me know it's [the therapy] is working" (C). "When he began to smile at the jokes, the healing began" (F). One participant noted that a client began to use and appreciate humor as she recovered from grief. She began to wryly refer to her late husband as "The Saint" (B). Despite long experience in the field, or perhaps because of it, one therapist feels "it's hard to know" if the use of humor influences the progress of treatment (H).

Strengthening the Therapeutic Relationship

All eight participants describe or allude to using some kind of light humor with clients in the very early phase of treatment both to "create a comfort level,"

and to "get to know them" (E). "A very gentle joke is a good way of breaking the ice and making me into less of a stranger and less of a formidable professional" (F).

Four interviewees state that they use humor initially to help "familiarize the client with the process in a safer way" or "to lighten their fear and anxiety" about it. One participant feels that light, self-deprecating humor helps "normalize and humanize the process" (F). In addition, she believes that "humor needs to be tailored to age, to the generation to what you think they might find funny, especially at the beginning of a relationship."

Most participants in the study see the use of humor as both growing out of and helping develop the therapeutic relationship. The therapist's use of humor provides "a great leveling"; "it says 'I'm a person, too'" (B). One therapist speaks of the use of self-disclosing humor as leading to a "non-pathological position" (D). Another participant believes that humor in sessions implies "a dialogue rather than a treatment. There's nobody sick here" (G). The use of banter and repartee are also considered methods of strengthening the relationship.

Participants speak of the use of humor as helping create "an alignment," or "a connection" (C). One describes humor in therapy as developing the "capacity to be in tune" (D). Several clinicians say that the successful use of humor is "very intimate, because it's just between the two of us" (H). Certain amusing phrases or metaphors become "shorthand" for a close connection and a kind of understanding; "a recognition of something we both know" (H). Half the clinicians in the study indicate that trust and safety are increased when the use of humor is successful. While one of the participants describes using humor in a way that helps strengthen the therapeutic bond, and sees it as an "intimate kind

of thing," she also has questions about whether humor actually influences progress (H).

Each of the participants indicates that laughter can be valuable in a therapeutic encounter, but is not required for the use of humor to be effective. More critical is the feeling of *connection in the moment* between the therapist and client. "Smiling, change in body language; it doesn't have to be so intrusive as laughing" (A). "We're not necessarily laughing . . . sometimes it's just a look, just an interval, definitely a way to connect" (C). "Some people don't laugh . . . the eyes are smiling although the mouth is not moving at all" (F). One of the participants described having a client throw a tissue box at him in response to a humorous interpretation, which he views as underscoring the connection between them (G).

As a Therapeutic Technique

All of the participants feel that humor may serve as a useful therapeutic technique. "Humor is a good part of your armamentarium. To *learn* how to use humor, to *see* that it can be helpful" (F). There are a number of ways in which clinicians use humor "with a clinical purpose" (D); for example, to "break down barriers" (A) between therapist and client and "develop trust" (C).

Six of the participants indicate that they use it to "lighten." One states that humor "lightens the fear and anxiety about how deep, how terrible" (D). Another described a client who cannot tolerate the pain of processing his emotional burden week after week. The therapist lightens up the occasional session to provide the client with some breathing room; although she believes "I could bring it back if I wanted to" (C). The client has expressed relief and is then able to return to deeper work the following week. Another clinician describes

needing to lighten sessions for *herself* when some of the material is too painful. She uses "funny metaphors to get past the heaviness" to enable her to rebalance and "get back to work" (E).

Therapists also use humor to illustrate or illuminate. One participant talks about finding "something that might amuse both of us and illuminate things" (G). They use humor to allow clients to "step back and have a different perspective on their life, and laugh at things rather than be continually depressed" (C). Another way of looking at this technique is as reframing. "The clinical way of seeing the humorous side of something is a reframe. Think differently, behave differently, feel differently" (D). Two of the participants speak of using humor to "shake up the client's story" and "break up old patterns" (E).

Participants report that the therapist's use of humor may help the client learn to utilize it as a coping strategy. "My using humor, modeling humor and identifying for them that it's an effective coping strategy is therapeutic" (D). Another therapist views humor as "a great way to learn" (H). Half of the participants employ humor to help clients gain mastery over their pain, whether it is "diffusing rage," "ventilating" (F), or bringing them "above loss" (A). One therapist uses humor to "express concern" about potentially dangerous client behaviors "without being scary." She described an older client who does not get enough sleep but insists on driving anyway. She has asked him to call her on those days so that she may avoid being on the road. "He laughs and says, 'I guess you mean I shouldn't be driving'" (H).

All of the clinicians make reference to the effectiveness of using humor to make interpretations. An interpretation using humor is seen as "less of a body

slam" (B) or "giving an oblique angle to something" (H). "If it's couched with a joke, you're not changing the import of your interpretation, but it's an easier pill to swallow, and tastes better when it comes back up when you're alone" (F). One participant discussed a client who accepts "a lot of things that I would say that he might not accept if it was not done in a way that was sort of humorously said" (H).

Humorous interpretations or humorous metaphors used for interpretative purposes can become symbolic or a "shorthand way of talking about how someone deals with something" (H). Several participants described ironic phrases that clients used initially that became a theme in the treatment. One client would ironically ask "Ya' think?" when his therapist pointed out self-harming behaviors he might change. Both the therapist and the client continued to use that phrase throughout his treatment to indicate his growing recognition of the meaning of his behavior and a connection they shared (C). Interviewees note that clients playfully repeat back humorous phrases, metaphors or even body language that the therapist had used originally, indicating their understanding. This playful use of the same phrase may also been seen as reflecting the intimacy of the therapeutic relationship.

Several participants mentioned the importance of timing when using humor in therapy. "Timing, I think is everything in effective psychotherapy . . . if the timing is off, the whole thing is missed" (D). In describing the timing and humor in a session, most of the participants speak of "the right moment," "the spontaneous moment," "intuition," and "improvisation." "Some of the very best therapy is improvisation" (F). Most of the participants do not plan ahead before using humor, but one acknowledges that there may be some forethought. "It *is*

spontaneous, but in a way, I've been thinking about it for awhile" (C). Three of the participants point out that the therapist needs to be sensitive to how the client is feeling at a *particular* moment. "Some days people who really enjoy humor may not be in the mood for it" (F).

Although the participants report that humor can be a useful technique, one of the participants clearly stated what the others implied, that "you can't isolate the humor from the therapy. It is not a discrete entity that is introduced into an otherwise humorless field. It's sort of blended" (G).

Particular Issues for Which Humor May Be Useful

Six participants find humor to be particularly helpful in dealing with repetitious thoughts or behaviors. One clinician sees the "injection of humor to lighten...to distract from the rumination and obsession" (D). Another described a situation with a client who makes false assumptions and then acts on them to her own detriment. The therapist had been to the dentist prior to a session; during the hour she found herself touching her numbed molar with her tongue. Whenever she did this, her client assumed that the clinician was falling asleep, and that she, the client, must have been boring. After they clarified the misunderstanding whenever the client made an assumption, the participant put her tongue on her molar. The client would chuckle or nod, and it became a symbol in the treatment (B).

Participants use humor to work with clients who get "stuck in their thinking" or "stuck in their patterns" (E). Humor can be used to "break down a fixed idea" (E) or provide clients with a "different cognitive set" (D). One of the participants noted that people who often say "yes but, yes but" to

interpretations, suggestions, etc. may be able to acknowledge the interpretation if it is "couched in a joke" (F).

According to half of the participants, humor is also helpful with control issues. "Humor punctuates the fact that you have no control" (F). It helps clients deal with their disappointments and feelings of failure. Similarly two of the participants use humor to help clients with issues of needing to be "perfect" (A; C).

Three participants describe humor as a "clinically useful tool for depression" (D). One speaks of using it to help clients "move out of a depressed place" (C). Four feel that humor "lightens fear and anxiety" (D) and serves as a "leavening, an anxiety-diminishing thing" (G).

Most of the participants employ humor with clients who are having difficulty in relationships. Two of the clinicians use it to help clients deal with anger, "making the unspeakable bearable" (F). One uses humor "when patients do things that are not good for them" (H).

Six interviewees believe that humor can help clients explore issues more deeply. For one participant, the client was initially uncomfortable with the use of humor, "and then we discussed what didn't feel good, and found a deeper level" (C). Another participant felt that through humor a client's "sense of loss was revealed" (A). A third participant used a wry Dorothy Parker quote to point out that a client was using "superficiality as a defense against depth" (G).

Six out of eight participants describe using humor for issues specifically related to aging. These issues will be covered in the section on Older Adulthood.

Caution: Potential Harm and Potential Repair

Almost all of the participants acknowledge a danger in using humor just for the comfort or shared pleasure of it, rather than to encourage the client's progress in treatment. "We can joke our way through a session and may relieve suffering but not necessarily accelerate insight" (G). "We can get engaged in a game and don't go anywhere" (B). "If *all* we're doing is laughing, what are we doing?" (F)

Participants are careful to avoid humor that is "not in their [clients'] best interest...doing it for yourself" (A). One admitted, "Sometimes I'm pleased with how witty I am, and I have to be careful" (H). Another expressed concern about becoming a smart aleck or show off (F). One of the participants summed it up by saying "I don't like it if it's a throw away piece in the therapy, it needs to be purposeful" (C).

Another significant concern is that the humor might "create a breach" in the bond between the client and therapist. The client might feel "out of tune" with the clinician. Six of the participants indicate that humor could be harmful if it "minimized their pain" (D), was "interpreted as mocking or attacking" (A), was "heard as dismissive" (B), or "trivialized somebody's experiences" (H), such as "pain around discrimination" (D).

Participants listed a number of scenarios that might preclude the use of humor: a client who is "paranoid or one in great pain" (G), a client who looks for "hidden meanings or might obsess," a client who "might feel naked" (H), or a client with Asperger's, Parkinson's or schizophrenia (F). Three clinicians expressed concern about using humor with clients in the early stages of grief.

The participants disagree about humor's potential for causing harm. One participant indicates that he would not use humor with someone suffering from a terrible illness, however another reports that she uses "the blackest of black humor" with cancer patients on a regular basis with great success. One clinician initially said that she would not use humor with a client with a hearing problem, as it would be "risky," however later in the interview, having given it additional thought, she indicated that she actually *had* used humor with that client to good effect.

Three of the participants would not use humor if they feel that the *client* is using humor as a defensive maneuver or as maladaptive coping (C; D). One of the participants noted that she would not use humor to "distract from the sadness" (F). Two of the therapists acknowledged that they would try to avoid using humor with clients they did not like.

Four participants described situations in which their use of humor could have been harmful, but they were able to make a repair with the client. Timing is very important here, "If I don't deal with it right away, then it can brew...and it could take a few sessions to get back on track" (C). One of the participants advises "you have to look *very* carefully for any non-verbal, startle, tense not happy. Then you've got to recover and make an observation" (D). Another clinician apologized to a client, "I have unintentionally offended you" but reported, "some people were able to tell me they appreciated it, others told me and I stopped" (F). She also noted that "laughing at *myself*" sometimes heals the breach that might have been created through the use of humor.

Developmental Issues of Older Adulthood

There is a general feeling among the participants that older adults have more of a "sense of humor and wisdom" (A), which affords them greater perspective. "What I know theoretically is that many older adults find humor in some of their youthful angst" (D). They have a "seasoned comfort with laughing at themselves" (C). They have gotten to a place where they have "really gone through lots of stages, which gives them amazing perspective and affords more cynicism and flexibility" (E). Interviewees find many older adult clients to be more playful and more flexible than younger clients. However, there is a concern about the type of humor older clients appreciate. "Older adults have different humor borne out of their culture, what they grew up with what they enjoy.... I try to tailor it" (F).

The two eldest practitioners have some reservations about making generalizations about older adults. One began by speculating that older adult humor is "more ironic or jaded" but then thought of a younger client who enjoys irony and recanted saying that "age is not a deciding factor" (G). The other stated, "I'm sure there are some differences, it depends upon the person. With older people, it's more personality than age" (H).

Using Humor in Psychotherapy With Older Adults

Particular Treatment Issues

Five of the participants see the major theme of older adulthood as loss. "It's pretty daunting to be old and confront your losses, your capacities, the losses of people and the losses of roles" (E). Seven participants spoke specifically of the loss of health and physical capabilities or "the ravages of time" (G). Two of them described the difficulty in "making meaning" at a time in life when

physical impairment may preclude many activities and meaningful roles have been involuntarily curtailed.

Several participants comment on the "depression and isolation that sometimes accompany aging" (B). One of the participants observed that narcissistic insults may be created by living in a "society where you're not seen as a fountain of wisdom, people dismiss what you know" (F). Along with these feelings, older clients often struggle with rumination, regrets and disappointments. They may be "disappointed by friends or children" (B).

One therapist considered the experience of feeling as if one has "seen it all and heard it all before," which she believes is different from depression (F). Seven of the participants spoke about the ultimate existential problem: "death issues are more imminent" (G).

How and When Humor Is Useful in Psychotherapy With Older Adults

Most of the participants indicate that they find humor to be particularly useful in treatment with older adults. As mentioned above, there is a general feeling that older adults may be more flexible and playful, which may encourage therapists to include humor in the therapy. One participant models using levity with older adults (E). Another encourages older clients who begin to use humor in sessions "not to look back with sorrow and sadness, but with a level of humor and awareness" (D). A third participant describes tossing puns back and forth with a client who was almost 90. "There was humor and it had a relational quality" (G).

Participants say that they try to use references or types of humor that older clients would appreciate. "Older adults have different humor borne out of their culture, what they grew up with, what they enjoy.... I try to tailor it." As an

example, this therapist commented that she would never use a reference from the television show, *South Park*, with an older adult (F).

Four clinicians mention using humor to "lighten" some of the issues mentioned above: physical impairment, depression, isolation, anger, and disappointment. "I'm even more inclined to use humor with older adults . . . mainly because they *need* that levity" (E). "Humor is incredibly necessary for all the physical ills, things that ail us with older age" (F). Two of the therapists use the Bette Davis aphorism "Old age ain't no place for sissies" (F; G) to help older clients gain perspective. Participants use levity to help older adults "lighten the anger" (A) regarding "fate" (G) or other disappointments. "Humor makes the unspeakable bearable" (F). For older people who feel invisible with friends and family, "having humor is a way of reminding people of your importance, your existence, your history" (F). "There is a special gift in using humor with older adults. They are experiencing so much loss at certain times. Humor really helps bring them above that loss . . . it kind of shifts them" (A).

Several participants view older adults as being particularly subject to repetitive or ruminative thoughts and behaviors. Therapists report that humor is useful in this regard. "With older adults, humor is helpful to bring them to the point of appreciating that they're still in the rut of certain behaviors; to allow them to reflect and change in a laughing way" (B).

However, three of the participants described at least one client who seemed to "cross over a bridge" close to the end of their long lives, and for whom humor was no longer effective in treatment. In each case, the client had been able to use and appreciate humor previously for the alleviation of symptoms and to make changes. One of the clients had experienced a great deal of loss about 20

years prior, and had been able to use humor throughout the healing process. She suffered no cognitive impairment; nevertheless, in the last few months of her life it was no longer possible for her to use or appreciate humor (A).

One of the older participants questions whether there is any difference between using humor with older or younger people. While she has used humor successfully with older adults she believes "it depends on the person" (H).

Countertransference Issues in Working With Older Adults

Personal and Professional Experiences

Almost all the participants indicate that they had had good experiences as young people with older adults. Two state that those relationships had been among the "most significant experiences of my childhood" (B). The participants also report that many of the older adults that they had known in their families and communities had had a sense of humor. Two of the participants had limited experiences with older adults and as a result there was a "necessity on my part to make contact. Through the course of my professional and private life I've been drawn to older people from my lack of having had that" (E).

It is not surprising, then, that all of the participants have always felt a level of ease in dealing with older adults. Participants found "many of them interesting and colorful" (H), and respected them as "interesting people" who have "been through interesting times" (F). One clinician was "more comfortable with older patients, and they were always comfortable with me" (C).

How Countertransference Changes With the Age of the Therapist

While all of the participants interviewed have always used humor with clients, "it's easier for me to connect with them than when I was younger. What I might make humor about would apply to me also" (B). "It's different now that

I'm older . . . we're paralleling our growth. Lightness has happened here" (C). "We have a kind of camaraderie" (G).

This level of comfort has an impact on practice. "As I've gotten older, I've gotten braver. The capacity to take more risks increases. You're not as afraid that every word you say is gonna affect their lives" (E). "I might disclose more with the elderly. It isn't as profoundly intrusive as it might be with a 30 year old" (C). "The context of my humor has shifted as I have aged" (D).

However, issues of "aging, loss of mobility, loss of health" (B) may provoke uncomfortable countertransference reactions. "Sometimes I can't go there because I'm feeling some emotion around that myself" (C). "Sometimes I can't be funny because the countertransference is too close" (B). "When I was just 40...there was a separation between me and the client...and as I turn 60 that separation is gone and it becomes more frightening and I'm more vulnerable" (A).

One participant who has had health issues in the past few years sometimes finds herself irritated with clients who are "stuck." "Come on, life is short, do you want to spend whatever time you have left doing *that*?" (B)

Another participant acknowledges that when he and certain clients trade humorous remarks, there may be a *can you top this?* quality. He postulates that with certain clients of his own age there is a "fraternal" quality to the countertransference that encourages that competitive use of humor (G).

The Therapist's Use of Self

Seven out of the eight participants have always used humor in treatment and have always used it with older adults in part "because I am funny; it's part of my personality" (D). "It just comes naturally" (A). Three of the participants

acknowledge that they have used it more appropriately as they have become more experienced. "Initially, I was more of a smart aleck" (F).

Most of the participants find themselves more willing to take risks using humor and believe they use it more effectively as they have gained more professional knowledge and experience. Two of the participants spoke directly to the use of humor as part of the "professional and creative use of self" although "it is not typically brought forward in the training of a clinician" (D). "Effective therapists always use their humanness" (G).

One of the participants disclosed that although she sees humor as valuable in the treatment, there are days "when I'm feeling flat, it's a gauge for me of how I'm doing as a therapist" (F).

Does Using Humor in Treatment Help the Clinician?

Most of the participants report that using humor in treatment with older adults is not only a good therapeutic tool but is also helpful to the clinician. "As a therapist, I think humor also becomes a coping strategy for a lot of us. Not everyone has that capacity. I wonder if they burn out sooner" (E). Another participant sees using humor as a "release of tension" for the clinician (A). A third participant comments on the "reparative" aspect for the therapist of using humor in a session (C). A fourth one notes that it is "helpful in just bearing up under the impact" that the "helplessness, or the rage or the disgust" can engender (F). A fifth clinician believes that "Humor is a balm" (G). Three of the participants also spoke of using humor in "debriefing" or consultation following a session, as perhaps having a protective aspect for clinicians.

CHAPTER 5: DISCUSSION

"I use humor because I like it," Friedman (1994) writes about his practice of psychotherapy. "I like to laugh and I enjoy helping other people laugh. This makes it easy for me to think of appropriate jokes. But it is also a danger. I have to discipline myself not to use humor indiscriminately" (p. 49). I also use humor because I like it and have had good experiences with it in practice with older adults. The choice of research topic was based on my own intuition and experiences indicating that it could be valuable, but I hoped to develop a more reasoned understanding of how highly experienced psychotherapists think and feel about using humor in their treatment of older clients.

There is a small body of literature regarding the use of humor in therapy. There is also a small group of writings regarding older adults and humor. This exploratory study interviewed eight highly experienced clinicians in an attempt to bridge the gap between the two areas by considering the use of humor in therapy with older adults. Seven of the eight interviewees treat adults of all ages; only one primarily practices with older clients. All of the participants have had at least 20 years of experience. Five of them would be considered older adults by the parameters set for this study (age 65); the other three are fairly close to that age. The original focus was the impact of humor on the clients and their treatment; however, based on the exploration of the literature, I also began to wonder about the impact on the clinicians who use humor in therapy with older adults. This became another area for consideration. The research questions look at why, how, and when therapists use humor in treatment; their ideas about the potential benefits as well as the potential pitfalls; the differences between using

humor with older adults and with a more general population; and what effect using humor in therapy has on them.

It is not surprising that all the participants report that humor can be beneficial in therapy with older adults inasmuch as they agreed to be a part of this study. The therapists believe that humor can be useful in orienting clients to treatment, assessing client strengths, helping clients develop mastery, enhancing the therapeutic relationship, illuminating issues, providing new perspectives, and making interpretations. How and when therapists choose to use humor varies with the experience of the clinician as well as their assessment of the individual client. They also report using appropriate caution to avoid harming clients. Participants vary in their views on the differences between using humor with a general population and with older adults. They agree that using humor in treatment has an impact on them also, but there are some variations in their ideas about the meaning and value of that impact. It is striking how closely their responses parallel the existing literature.

Participants also describe what they see as some of the potential differences between using humor with older adults and using it with a more general population. They agree that using humor in treatment might also have a beneficial or protective effect on the therapists themselves. All of that was somewhat expected and gratifying. What developed out of the data, however, is a slightly different picture. At the risk of spoiling the punch line, what seems to emerge is the idea that the most powerful use of humor comes out of the impact on the therapeutic relationship, and the "now moments" (Nelson, 2008) or "moments of meaning" (Stern, 2004) within it.

Chapter V presents a summary of the results divided into categories and subcategories with some references to the reviewed literature, followed by an interpretation of the results including some references from additional sources, and by a discussion of the limitations of the study and suggestions for future research.

Summary of the Results

Potential Benefits of Using Humor in Psychotherapy

For people who have no previous experience with psychotherapy other than what they have encountered in the media, the prospect of treatment is often anxiety producing. They may fear what might be revealed in this mysterious process, as well as the process itself. I have observed that older adults calling for treatment for the first time tend to have less first-hand knowledge of therapy and seem to be more uncomfortable about the prospect. This may be a cultural issue: fewer of their friends and family members may have acknowledged seeking this kind of help. They often express concern that engaging in therapy implies that they cannot manage their lives appropriately or that they are seriously mentally ill. Therapists use their individual styles, based on the theories and modalities to which they subscribe, to orient new clients to treatment. Almost all the participants in this study specified their use of light, innocuous humor at the beginning of therapy to help familiarize new clients with the process as well as with the specific therapist and the therapist's style. They intuitively recognize what Graham (1995) reported, that mild humor can be a "social lubricant."

The early use of "light humor" seems to have a second function. Participants monitor a client's ability to use or appreciate humor to assess anxiety, depression, ego strength, and coping style. Their view that humor is

correlated with the "capacity to cope adaptively" is supported by the literature. They evaluate the client's ability to appreciate humor as a potential coping skill.

How do participants use humor for evaluative purposes? One of the therapists described Sidney, an older man seeing her for the first time, as someone who had been anxious and depressed since the death of his wife three years prior. He initially sought advice from his primary care physician, who responded, "Well, man, you've just got to pull yourself together!" Sidney's distress was exacerbated; if he had been able to "pull himself together" he would already have done so. His daughter insisted he seek therapy. After telling his story in the first session, the clinician teased, "Well why *don't* you pull yourself together?" At first Sidney was alarmed, but the therapist smiled and said, "I'm only kidding, you've come to the right place." He immediately relaxed, which the therapist saw as an indicator of some ego capacity. Had he remained frightened and perplexed, or appeared more anxious she would have evaluated him differently and proceeded with treatment in a different way. The participant's gentle teasing implied that she understood his dilemma and gave credence to his anxious feelings. The interaction facilitated the establishment of a therapeutic alliance.

The evaluation process continues during the treatment. Participants also report that they see clients' *developing* ability to tolerate and use humor in sessions as a measure of progress. Clients may not be able to use or appreciate it during the early stages of mourning, for example. But, when the woman who had been grieving the loss of her husband began to refer to him, wryly, as "The Saint," she unconsciously revealed that her experience of the initial loss was less searing and she could tolerate examining the complexity of her married life and

her place in it. Sometimes the clients report that humor in sessions has let them know that progress is being made. Kaplan (2006) describes a fragile client who recognized that she must have been improving because Kaplan was able to use some humor with her (p. 400).

While participants report using clients' ability to appreciate humor as a way of assessing their ego strength, coping skills, and progress in treatment, a client's inability to use or appreciate humor may have diagnostic value as well, particularly if he had been able to appreciate it at an earlier time. He may be more anxious or depressed or may have some new physical illness or some new issues that have an impact on his coping ability. One of the participants described a particularly striking example of this. She had known her client, Shirley, for many years. Now in her 90s, Shirley had maintained a sense of humor and a zest for living despite significant losses (deaths of her husband and brother, and the murder of her only son). She enjoyed sharing appropriate and amusing stories or jokes. Her therapist had a warm feeling for her and would often respond to her humor by saying, "Shirley, you've made my day." At a point about six months before her death, Shirley could no longer appreciate or generate humor in sessions. Her therapist reported that it was not a simple depression but that her client seemed to have "crossed a bridge." The crossing had an impact on the clinician as well. It was painful for the therapist to bear witness to the changes in her client. Humor was no longer an element in their relationship and could no longer be used for the client's benefit. The relationship had been inexorably changed.

Shirley is not the only example of this shift; two other participants described clients who had previously revealed a sense of humor, but towards the

end of their lives were no longer able to go there. When the client lost that ability, the therapeutic relationship was altered. Only three out of the eight participants spontaneously reported this phenomenon, which will be considered further in the Interpretation section.

All of the participants interviewed and almost all of the authors cited in Chapter II see the use of humor as a potentially valuable therapeutic technique or a "good part of your armamentarium." Interviewees use humor to "lighten" fear, anxiety, or depression. They report using it to help clients gain mastery over disturbing or painful experiences, thoughts, and feelings. One of the participants specifically models the use of humor for clients, "identifying for them that it's an effective coping strategy." Another participant describes using humor to help the client "move out of that depressed place." Sometimes therapists will use humor after a number of excruciating sessions to allow a client to "breathe" and to continue with the process.

Participants report that lightening and reframing are particularly useful techniques for helping clients deal with disturbing repetitive thoughts and behaviors, or for clients who "get stuck in their patterns." The participant, who puts her tongue on her molar whenever her client makes an assumption, injects humor to "lighten or distract from the rumination and obsession." As the client's assumptions are a repetitive behavior that often results in disappointment and familial conflict, this momentary slapstick physical joke helps break into that pattern "bringing new possibilities." Control issues and issues of perfectionism may also be processed using lightening and reframing. Similarly, Lefcourt and Martin's (1986) students, who were asked to create humorous narratives,

essentially reframed their view of the negative threat presented in that experiment, and may, therefore, have experienced less stress.

All of the participants in the study describe using humor to make interventions. As Loewenstein (as cited in Bergmann, 1999) commented, "The right joke, told at the right moment may be used instead of an interpretation" (p. 25). There is always a danger that a powerful interpretation will be perceived as threatening or confrontational and the client may become defensive or rejecting. A humorous interpretation is both "easier to swallow" and more transformative ("tastes better when it comes back up"). Anne, a 62-year-old, divorced client of mine, has a difficult relationship with her only son, Nick; which is exacerbated when she shares personal information with her daughter-in-law, Mary. Mary immediately reports to Nick, who becomes enraged with Anne and cuts off contact between her and his family. Anne is then devastated. Several months ago I casually referred to Mary as Mata Hari. Anne's eyes opened wide, and she laughed for several minutes. She now uses this humorous notion as a coping strategy: "Every time I think of Mary as Mata Hari I laugh to myself, and remember not to tell her things she can use against me."

All of the participants interviewed see the role of humor in developing and enhancing mutuality and trust in the therapeutic relationship. "The biggest piece of humor is the joining." Interviewees report that mildly self-deprecating humorous remarks by the therapist are "normalizing and humanizing" for the process. Several speak of humor as creating "an alignment," a "connection," or "a certain bond" with clients. The "capacity to be in tune, accurate empathy [is] an aspect of using humor judiciously in therapy." Some of the authors whose works were reviewed in Chapter II also credit humor with enhancing the bond

between client and clinician (Grotjahn, as cited in Ronne, 2007, n. p. ; Lazaurus, 2006; Barry, 1994; Bader, 1994; Poland, 1999b).

Grotstein (1999) describes using humor as a "shorthand parable to replace what would otherwise be a much longer interpretation" (p. 81). Several participants also spontaneously identified humorous remarks as shorthand in the treatment. Often it will be the client who refers to it to indicate the development of self-understanding. ("I know, I'm just a stubborn old Irishwoman.") The shorthand of using amusing phrases or facial expressions that are understood only by the client and therapist develops an intimacy that is "just between the two of us" in the therapeutic relationship. It is also reminiscent of studies of long-term successful marriages where a phrase or a nickname will be a reminder of something only the couple shares and results in a particular moment of closeness (Gottman, 1994; Hampes, 1992).

The participants describe these moments as occurring "spontaneously," "intuitively," or "improvisationally." They all feel that the humor *arises from* the treatment rather than being *imposed on* it. "I don't think my humor is practiced. It's in the moment." While several of the participants use jokes, they all describe them as jokes that are germane to the specific interaction and help develop a greater feeling of connection.

Sometimes these moments result in laughter, but the participants in this study describe the feeling of *connection in the moment* between therapist and client as critical to developing the therapeutic relationship and promoting progress in treatment. Several researchers have examined the role of laughter in therapy and believe that it is the shared laughter that is mutative in treatment (Nelson, 2008; Provine, 2001). The participants in this study report that laughter

is helpful and pleasurable, but not required. "Sometimes it's just a look, just an interval, definitely a way to connect." The research by Marci, Moran and Orr (2004), where skin conductivity was measured in clients and therapists during sessions, revealed that there is a physiological change in both when they laugh together. However, on some occasions they both experienced shifts in skin conductivity although the therapist did not laugh. This might imply that the *appreciation* of humor together is what makes the difference. The shared experience of enjoying the humor may create greater attunement. The goal of the attunement is to enhance positive affect and minimize negative affect.

While the moment for using humor seems to arise spontaneously, there is something critical about the timing of a therapist's choice. "Timing is everything in effective psychotherapy," one of the participants stated unequivocally. When asked about the timing of humor in treatment, two of the participants responded with the old joke: "What's the secret of comedy?" [without taking a breath] "TIMING!" Indeed, both the punch line of a joke and the appreciation of a humorous remark are dependent on the appropriate sense of timing. Successful timing in treatment and in comedy requires sensitivity to the feeling tone of the moment. Is the audience ready? "A lot of this has to do with the mood of the patient and where the patient is." One of the participants advises, "Pay attention to the moment and go with what the moment offers."

Participants speak of "bantering" with clients. Banter is a kind of word play, almost the verbal equivalent of a game of badminton (badminton rather than tennis or volleyball, because there is something lighter and less intense about banter). They see their playfulness with clients as another way of developing the therapeutic relationship. Bader's (1994) repartee with his angry

client facilitated a more equal and meaningful relationship in which the client was able to become self-reflective and begin to deal with more primitive feelings and experiences. Winnicott (1958/1975) sees the opportunity for a client to be able to "play" in treatment as crucial to developing an authentic sense of self. He included humor and play in his therapeutic work with adults as well as with children. Sanville (1991) builds on Winnicott's work in depicting her treatment as a kind of "playground" in which the client can be free to develop his or her own form of play. On another level, Frederickson and Joiner (2002) have determined that play "builds physical, socioemotional, and intellectual skills, and fuels brain development" (p. 172). As the participants described their use of humor in treatment, their choices seem to encourage playful "moments of meeting" that invite affective restructuring.

Potential Harm in Using Humor in Psychotherapy

Despite its playful aspects, psychotherapy is a serious business in which clients explore their vulnerabilities, fears, and unconscious processes to a veritable stranger, seeking healing and transformation. Kubie (1994) strongly disapproves of the use of humor in treatment. "The mere fact that it amuses and gives a pleasant feeling is not evidence that it is a valuable experience for the patient or that it exerts on the patient an influence toward healing change." (p. 95) All the participants express similar concerns. "We can joke our way through a session and may relieve suffering but not necessarily accelerate insight."

Six participants specify being cautious about clients feeling that they are being mocked and perhaps experiencing the humor as humiliating, shameful, or dismissive. It seems intuitive that psychotherapists would try to avoid injuring

clients. Perhaps the other two did not think it necessary to comment on such an obvious concern. Kubie (1994) and others warn against this danger.

Therapists avoid humor with clients who use it for defensive purposes or as a "maladaptive form of coping." One of the participants describes a charming man who, when dealing with painful material, stops and asks "Don't you have that magic pill? That's why I'm here, for the magic pill!" Marcus also wrote about this problem in 1994, cautioning therapists that clients could use humor to "trivialize" their own experiences and avoid working in treatment.

Participants do not always agree on areas for which humor could be beneficial. The two participants with the greatest length of experience indicate that they would not use humor with a client who is very ill, for example, with cancer. However, another interviewee, who works with a significant number of cancer patients feels that humor can be judiciously used to help make "the unspeakable bearable." She sees the use of "black humor" as empowering and energizing in the face of illness. The idea of black humor as empowering is supported by the studies of POWs and others in extreme situations (Ford & Spalding, 1973; Henman, 2001; Bizi, Keinan & Beit-Hallahmi, 1988). The two participants with the greatest length of experience are more cautious in this choice; however, they are also more cautious in other choices.

While the participants report sensitivity about cultural issues, by and large, the humor that they describe is culturally parallel to that of the clients, providing a feeling of community or closeness. The African-American participant reports using "Oy Vey" with Jewish clients, but she is the only one to indicate a cross-cultural use of humor. She also jokes with older African-Americans about "the devil;" encouraging them to keep the devil from winning.

"Laugh at the devil, cause he hates that!" But "the devil" is part of their shared culture. An older African-American client might not be willing to joke about "the devil" with a younger Asian therapist. The client whose therapist called her a "stubborn old Irishwoman" might not enjoy that intervention from a Latino clinician. Tseng and Streltzer (2001) believe that "therapists of any ethnic background can work effectively with any ethnic minority elder. What is required is a willingness to understand the culture, to learn the history of the specific ethnic group" (p. 216). "Understanding the culture" would include learning about the appropriate use of humor with the particular ethnic group. Participants also express concern about clients whose cultural experience might preclude their ability to appreciate humor.

Several participants are cautious about having humor create a *misalignment* between them and the client. They worry about "creating a breach" or being "out of tune" or "out of sync" with the client. Baker (1999) and Friedman (1994) suggest mindfulness and self-discipline to avoid this kind of rupture. The potential damage caused by a breach is another reminder of the importance of attunement in a therapeutic alliance and the significance of the repair of such a breach.

Participants endeavor to use humor in the client's best interest, rather than "doing it for yourself." But there are times when the therapist may be the only beneficiary. One acknowledges, "Sometimes I'm pleased with how witty I am and have to be careful." Another reports that she occasionally uses humor when she is overwhelmed by a client's pain and has to revisit the painful situation to make repairs afterwards. Half of the participants described situations in which their use of humor might have been harmful to the treatment, but they were able

to make repairs. "You have to look very carefully for any non-verbal, startle, tense, not happy. Then you've got to recover and make an observation." Participants in the study found that repairs have to be made quickly, or "they can brew" and cause long-term damage to the therapeutic relationship and the treatment itself. Lachmann and Beebe (as cited in Lachmann, 2008) report on the value of repair in the relationship between babies and their primary caregivers. Research on the primary relationship has significant impact on the therapeutic relationship as well. If a disregulation between therapist and client can be repaired, it can help build resilience and expand the client's capacity for affective expression, as it does in a baby whose primary caregiver makes an appropriate repair.

Using Humor in Psychotherapy With Older Adults

Issues and Treatment

Some of the participants in the study feel that it is easier to use humor in treatment with older adults, suggesting that older clients are "more playful" than a lot of younger people and that "more teasing" may take place. One of the therapists believes that "humor is not as intrusive with older adults." At the same time, participants acknowledge that humor appreciated by their older clients might be very different from what younger clients might enjoy. Older adults might almost be considered a separate cultural group. The therapist needs to be alert to what might be appreciated by her particular clients.

The participants in the study generally view older clients as having a "seasoned comfort with laughing at themselves." "They've gotten to a place in life where they have really gone through lots of stages which gives them amazing perspective and affords more cynicism and flexibility." Some of the

work of Charles, Mather and Carstensen (2003) supports these impressions. The subjects in their studies seem to be able to recover from unpleasant moments with greater ease than college students can. Life span psychology, focusing on the role of greater life experience and increased cognitive complexity in older adults corroborates the participants' reports (Knight, 2004). However, when older adults present themselves for treatment it is usually because their resiliency has failed, at least for the moment. There are certain issues that are more prevalent among an older population, and which, therefore, practitioners see more frequently in their consulting rooms.

Atiq (2006) describes five major areas of practice with older adults: dealing with loss; dealing with aging, illness, and possible dependence; restoration of a positive self-concept; dealing with death and dying; and transference and countertransference. The participants in this study independently commented on the same issues. Five of them see the major theme of older adulthood as coping with loss. Seven specify the loss of health and physical capabilities. As one of the participants remarked, "It's pretty daunting to be old and confront your losses, [the loss of] your capacities, the loss of people and the loss of roles." Participants use humor to help clients master and accommodate to their losses, or "bring them above loss." As Fry (1986) writes, "Elderly people can take greater control of their life experiences by enhancing the role of humor in their lives" (p. 89).

All the participants use humor in working with clients who are dealing with some of the physical limitations of aging. They see humor as "incredibly necessary for "all the physical ills...'cause they're not fun." One of the participants is "more inclined to use it with older adults because they *need* that

levity." Another participant specifically uses "black humor" with issues of illness. The eldest and the youngest participants lightly cite the Bette Davis aphorism, "Old age ain't for sissies" with clients. The phrase is not only mildly amusing, but also gives the impression that the client is not alone with his physical losses; that his experience is shared by others, particularly by his therapist. It enhances the therapeutic alliance.

One of the participants discussed a 98-year-old woman who complains in every session about physical and social problems. Her therapist began to tease her by saying, "Miriam! Look at me! You're 98 years old! Of course you have dry skin and problems with your hip! I'm much younger than you are and *I* have dry skin and problems with *my* hip." At first Miriam was surprised, but gradually began to chuckle and can now self-reflect just a bit. She occasionally asks, "Did I just say something funny?" When the therapist responds positively, Miriam is pleased that she is still able to make her therapist laugh and feels less helpless. If she has the power to amuse her therapist, then Miriam has more of a sense of agency in her shrinking world. She may be losing many of her relationships, and physical abilities, but if she can still make her therapist laugh, then she is still *in the game*. Research by Solomon (1996) suggests, "Humor may affect aging well indirectly through perceptions of control" (p. 265).

As older adults find themselves more potentially dependent, they often have more disappointments in relationships. Sometimes the disappointments have a repetitive quality, for example a parent who has often been critical about the behavior of adult children, and now must depend on these children for certain physical supports. "With older adults," one of the participants notes, "It's

helpful to bring them to the point of appreciating that they're still in the rut of certain behaviors, and have them reflect and change in a laughing way."

One of the participants has a client we'll call Siobhan, who repeatedly gets into arguments with her husband's care providers and with her own adult children. As a result, the care providers quit regularly, (the children cannot). In many sessions, Siobhan complains that she simply cannot get people to understand her situation and do her bidding. Early in the treatment she had noticed on one of her therapist's diplomas that the therapist had a Gaelic middle name. As a result, Siobhan had expressed a feeling of closeness. After one of her altercations with a new care provider, the therapist burst out, "You're just a stubborn old Irishwoman!" Both Siobhan and her therapist had a long moment of attuned laughter. In the sessions that followed, after reporting on a repetitive behavior, Siobhan would chuckle and say, "I know, I know. I'm a stubborn old Irishwoman." Her self-reflection may have had an impact. She seems to be having these altercations less frequently.

The number and nature of the losses experienced by older adults can lead to a shift in a sense of self and the meaning of one's life. Participants discussed the difficulties for clients in making meaning in their lives when physical impairment may preclude many activities and meaningful roles that clients have enjoyed. One of the participants uses humor to help clients "be open to the possibilities, especially when you feel like time is failing you, or your hip is failing you. It's nice to believe that there are possibilities that can inject more pleasure in life." The participant who bantered in puns with the 90-year-old client found that it gave the client the feeling that she was still able to play and could still be an equal. "So there was humor and it had a relational quality," the

participant reports. The humor allowed the client to feel that she was still *in the game*. Older clients have reported to me that the ability to make jokes or decisions helps them feel like their lives continue to have meaning. Similarly, Griffin and Grunes (1990) see the goal of therapy with older adults as the "maintenance of a sense of self that may have been damaged by undesired changes." (p. 279)

Participants describe clients with "depression and isolation that sometimes accompany aging." Often the depression and isolation are specific to an individual, but there are also more global issues. One of the participants is concerned about older adults who are living in a "society where you're not seen as a fountain of wisdom, people dismiss what you know." Clients sometimes describe feeling invisible or patronized by younger people. Lightening or reframing these issues may be helpful. Humor in the treatment may offer the opportunity to feel attuned to and understood by at least one other person in a positive way. One of the participants introduced the use of humor in groups. She suggests that it might be easier for group members to use humor with each other as they are more equal and less powerful than the therapist. I have observed that humor in groups of older adults seems to restore a sense of a positive empathic community that may have disappeared as clients have lost loved ones and friends.

In the interviews, seven of the participants specifically discussed the ultimate existential problem: "death issues are more imminent." As one remarked, "It's more poignant because you have fewer years left." Participants feel that judiciously used humor can help clients wrestle with their concerns about the limitations of time and let go of regrets. As Datan (1986) writes,

"Humor can be seen to deflect the painful truths of biological decline and inevitable death...and so to master, in the mind at least, that which eventually will prove to master us" (p. 162). Similarly, Kohut (1966) writes that humor could be used in the acceptance of transience, providing a sense of quiet inner triumph.

The Therapist's Experience Treating Older Adults

The therapists in this study.

The participants for the study self-selected; that is, when approached, they were open and willing to discuss their use of humor in the professional practice of psychotherapy. They were also open to discussing their own personal histories as well as what goes on in their consulting rooms. The participants were comfortable looking at experiences with clients that were successful, and experiences that may have been problematic. They were willing to discuss countertransference issues that may not have presented them in the best clinical light. All exhibited a sense of humor. The results of the study reflect their willingness to be open and playful. It is possible that this limited group of therapists is unusual in this way.

Seven out of eight participants see their use of humor with clients as part of their "professional and creative use of self." One of them states, "Effective therapists always use their humanness. I use it [humor] because I *am* funny. " Another sees humor as "part of my personality." A third feels that humor is part of her "connection to people."

There are two other unusual features about the clinicians in this study: they have all been in practice for at least 20 years, and are all over 58 years of age. Six out of the eight therapists had meaningful early relationships with older

adults other than their parents. Each of them reports enjoying those relationships in statements ranging from finding older people to be "interesting and colorful" to enjoying the "most significant experiences of my childhood." Those who had known older people in their childhoods also comment that the older adults in their acquaintance had a sense of humor. The two participants who had not had those experiences in their own families seem to be drawn to them in the community. All of the participants report comfort in working with older adults.

Countertransference issues.

In general, the participants note that it is easier to use humor with older adults now that they are older. "As I've gotten older, I've gotten braver . . . you're not as afraid that every word you say is gonna affect their lives." In some ways this greater sense of freedom simply comes with the territory: as therapists gain experience they often feel freer to take reasoned clinical risks. But this greater ease may also have to do with the nature of the alliance. "It's easier for me to connect with them now than when I was younger." "We have a kind of camaraderie." There is very little in the literature on the countertransference experience of older therapists. H. M. Strauss (1996/2001), who was 81 when her essay, "Working as an Elder Analyst" was originally published, seemed to have generally comfortable connections with clients of a certain age.

Muslin (1992) writes about civilian reactions to therapy with older adults. When working with older adults, clinicians may have to face issues of their own mortality, their own diminishing capabilities, issues of dependency, helplessness, caregiving, and unease about suicide. Knight (2004), observes, "Watching older people whom you like and know with the intimacy of therapy become more and more disabled is one of the most difficult aspects of psychotherapy with the

elderly" (p. 91). This may be particularly true as the therapist ages. As the participants in this study have gotten older they report that it is easier to use humor but sometimes more painful to be with the client. "When I was just 40 . . . there was a separation between me and the client . . . and as I turn 60 that separation is gone and it becomes more frightening and I'm more vulnerable."

Therapists have found that there are areas that require particular attention Half the participants acknowledge using humor for self-protection because the client material might be either too close to their own experiences or simply too painful. "Sometimes I just can't go there because I'm feeling some emotion around that myself," one of the participants admits. Another participant has used humor to "help me get past" some of the painful material, and returns to it later with the client when she is better able to approach it. The reverse may also be true. "Sometimes I can't be funny because the countertransference is too close."

Given some of the extraordinarily painful material that older clients may bring to the consulting room, and some of the parallels in the lives of the therapists, could the use of humor also protect the therapist? Franzini (2001) suggests, "Therapeutic humor might have the positive side effect of preventing or minimizing professional burnout in therapists" (p. 170). Six out of eight participants agree that using humor also helps the clinician and may protect from burnout. One of the participants remarked, "There's always at least one or two incidents where there's some lightness...and that's very reparative." Another noted, "It releases tension and allows you to appropriately join." A third participant cautioned, "It's always the client's problem" but "your life needs to have some lightness to it" in order to protect from clinician burnout.

Interpretation of the Results

It is striking how closely the results match the literature reviewed. Both the participants and the authors see similar benefits and cautions of using humor in therapy. Both view loss and potential resilience in older adult clients. Both the participants and the literature seem to value the role of humor in enhancing the therapeutic relationship. While the participants in this study hold different theoretical views, their responses strongly suggest that the important vehicles for healing and change are the therapeutic relationship and the attuned moments between therapists and clients that take place in a playful, open atmosphere allowing for affective regulation. According to Muslin (1992), "The therapeutic bond is of special importance in therapy with the elderly" (p. 108). The power of the participants' interpretations, and the value of their other interventions all seem to come from the "moments of meeting." Humor enhances the therapeutic relationship and assists in making some "moments of meeting" possible. For this particular group of clinicians working with older adults, the comfort of the therapeutic relationship and the power of attuned moments may also be enhanced by their similar ages.

Clients seek treatment in the hope that their symptoms will be ameliorated with the assistance of a person whose education, theoretical model, and skill set provide professional expertise. The relationship is inherently unequal in that the focus is always on the needs of the client. However the results of this study imply that the relationship is bi-directional: both the clinician and the client are affected by it.

These ideas bring to mind an Intersubjective/Relational approach, which considers the capacity for intimacy, mutuality, and reciprocity in psychotherapy.

Stolorow, Atwood, and Brandchaft (1994) see the developing organization of the child's experience as a property of a child-caregiver system of *mutual* regulation. The intersubjective perspective pictures both developmental relationships and therapeutic relationships as co-creations. They draw on the 1988 work of Beebe and Lachmann, who state "An intersubjective field is a system of *reciprocal mutual influence* ... not only does the patient turn to the analyst for selfobject functions but the analyst also turns to the patient for such functions, although hopefully in a less archaic way" (as cited in Stolorow, Atwood, & Brandchaft, p. 37). A colleague's therapeutic relationship with Dora, an 82 year-old, widowed, retired kindergarten teacher, might be an example. Dora has had physical and relational losses, but is devoted to her only grandson and his two children. They are moving to a distant city and their potential absence threatens her role as "grandma," (a role that allows for creative, playful relationships). Her clinician is attuned to the meaning of the loss, and also to Dora's feelings that she will lose her value in the world along with it. When the therapy enables Dora to recognize her strengths, she begins to adapt by making plans to volunteer in a local program with young children, and perhaps to visit her family. She reports that her life has regained some meaning. Her therapist feels gratified, and also feels a certain hope and optimism that change and healing are possible. The therapist's appreciation enhances Dora's experience and sense of herself in the world.

It seems obvious, but the intersubjective approach recognizes that what the therapist brings to the room in terms of life experience, training, and temperament will have a deciding factor in how she responds to the client or what she chooses to respond to. If the therapist has an active sense of humor, that

will be brought along. If the client has a playful sense of humor, that will also enter the treatment. If the therapeutic environment encourages spontaneity and play, as Winnicott and Sanville advise, the mutative power of the treatment relationship will have a better chance for success. A professional comedy writer sought formal psychoanalysis many years ago. After she made a few witty remarks, her analyst scolded, "Young lady, this is *not* The Tonight Show." She immediately looked for another analyst who could appreciate *all* the parts of her, not just her "Oedipal issues." (T. Silverman, personal communication, October 10, 2007)

The early relationship has an influence on the therapeutic alliance. Lachmann (2008) considers therapeutic transformation to be a "process that's bi-directional and co-created by the therapist and patient" (p. 11). He uses the work he did with Beebe looking at infant-mother interactions as a basis for understanding the treatment that takes place in consulting rooms. Parents help babies regulate affects and arousal to allow for a feeling of safety, contentment, and pleasure. Babies cue parents with affective reactions. When there are disregulations or lapses in parental empathy, the baby's expression of discontent will (hopefully) trigger a repair by the caregiver, and the baby can return to a comfortable state. The baby's comfort usually results in a relaxed feeling for the parent too. Mutual regulation takes place between them. If the baby cannot be comforted, the mother may remain on high alert and the baby may remain disregulated until the mother can find an affective solution. These repairs are critical for the development of resiliency and a feeling of safety in the world (Beebe & Lachmann, 2002). A. M. Schore and J. R. Schore (2008) also describe the impact of affective reregulation.

Fonagy and Target (1998) suggest that the primary caregiver's use of irony, humor, and skepticism provide a balance to the baby's distress. A mother may respond to a hungry baby's ongoing irritation while she warms his bottle with ironic teasing. "What's the matter? Is the bottle taking too long? What's wrong with that bottle anyway? Maybe we can make it warm up by making funny faces at it!" Often, the baby will be intrigued by the mother's humor and may be able to cope. The humor takes the edge off the suffering and makes it seem manageable, much like the therapist using irony to reframe a client's discomfort.

Issues of affective disregulation continue although a client may be 70, 80, or 90 years away from the primary caregiving relationship. Miriam's complaints about her itchy skin or achy hip remind us of a cranky, disregulated baby. When her therapist uses ironic teasing Miriam feels heard, and is surprised into a new affective state. Her chuckles indicate Miriam's reregulation. Her therapist smiles in response. And so it goes.

The primary caregiver of an infant does more than take the edge off the negative, she also expands the affective spectrum by introducing positive experiences. Watching a mother with a baby at the park gives us a sample of what this might look like. The baby is in a swing, facing the mother. The mother gently pushes the swing away from her, teasing the baby as she does. The baby enjoys the motion and grins or giggles. The mother appreciates his pleasure and smiles back. The dance continues. Neurobiology supports the role that play and humor have in the initial mother-child relationship. This is replicated in the therapeutic relationship. The therapist is attuned to the client, remaining empathic to the negative affect while also introducing positive affect, when

appropriate, with similar neurobiological results. These affective experiences expand the client's capacity for affective functioning (A. M. Schore, 2003).

Although all of the participants and most of the literature view the use of humor as a valuable technique in the treatment, one of the therapists wisely comments, "You can't isolate the humor from the therapy." Both in their descriptions of client interactions and in their definitions of the value of humor in treatment the participants report that the most effective use of humor is when it is seamlessly integrated into the therapeutic relationship. "It has to be there" in the client, "the moment has to be right;" it has to arise *from* the moment, not be imposed *upon* it for the humorous phrases or interventions to be successful in therapy.

Right from the beginning, the use of humor speaks to the development of a reciprocal relationship. When the therapist gently teases Sidney, and he relaxes, she feels that he has some ego capacity, and has a beginning understanding of how she will work with him. Sidney immediately senses that the therapist is on his side and that the process will not be open-heart surgery without benefit of anesthesia. "It releases tension and allows you to appropriately join." The bi-directional therapeutic relationship is being developed.

Both the benefits and harm of using humor in treatment have an impact on the therapeutic relationship. Participants (and the literature) describe the value of using humor in making interpretations. For clients like Anne and Siobhan the humorous interpretation created a more powerful affective shift in the moment that has long-term implications. The potential for harm also speaks to the role of humor *in* the therapeutic relationship. One of the great concerns is that unempathic humor might create a misattunement, or a misalliance. If the

client feels "out of sync" with the therapist, he may withdraw, act out, or even leave treatment. These possibilities also support the notion that the significant impact of humor (both good and bad) is on the therapeutic relationship and the "moments of meeting" within.

Lemma (2000) writes: "Humorous exchanges between patient and therapist [provide] one of the richest opportunities for the experience of 'moments of meeting' and I would like to propose, [they] are essentially mutative" (p. 149). These moments are described as arising "spontaneously," "intuitively," or "improvisationally." The participants in the study all feel that the humor *arises from* the treatment rather than being *imposed on* it. "I don't think my humor is practiced. It's in the moment."

While the moments for using humor seem to arise spontaneously, there is something critical about the timing of a therapist's choice. In considering her intuitive use of humor, one of the therapists said, "It *is* spontaneous, but in a way I've been thinking about it for awhile." Another commented on "debating for a second," before choosing to make a humorous interpretation. Although the therapist's choice to use humor seems to be improvised, it may be more intuitive, based on theory, practice, temperament, and knowledge of the particular client. The moment arises out of the empathic connection in the relationship. Lachmann (2008) writes, "Many of my interventions were thought about prior to my offering them, but playfulness and humor were spontaneous and on the level of my procedures" (p. 108). While several of the participants use jokes, they all described them as jokes that are germane to the specific interaction and help develop a greater feeling of connection. The moments arise out of and also deepen the therapeutic relationship. As Lachmann (2008) notes, "Through humor

and spontaneity we can also achieve an incomparable degree of intimacy that is hard to match through other avenues" (p. 93).

Ethel, one of my older clients, has had many disappointments and losses, beginning with the death of her mother when she was seven years old. Often, I find myself using humor to reframe her perception of an insult by one of her family members. In one session she asked, "Do all your clients make you laugh this much?" I explored what that notion meant to her. She reported feeling appreciated in a new way. The use of humor made her feel more closely connected. It also helped reregulate her affect.

When the therapist uses humor in a session to "let the client breathe" something is taking place in the relationship. The therapist is attuned to the client and senses that he is overwhelmed by heavy feeling (and may have been for a week or two). The therapist's use of humor lets the client know that she is aligned with him. It also allows him to affectively reregulate. He experiences some relief ("I needed it. I needed it.") The therapist, too, can reregulate, and may enjoy the lighter session and the opportunity to see her client from a different perspective. In the next session the client is better able to tackle some of his more despairing feelings. These therapeutic dance steps strengthen the relationship and allow for more significant work to be done ("going deeper in to the process").

In this situation the participant correctly assessed her client's need for a "break." But sometimes a disregulation may occur in the therapy. The therapist may use humor in a way that is not appreciated or make an interpretation that the client is not ready for. One of the participants commented that humor can be "very reparative." It is possible that the therapist's use of a humorous remark

may repair the breach and thereby reregulate the client's affective state. The client's experience of having a break in empathy repaired may also help build resilience. Like the mother who can soothe an irritable baby, the therapist's successful effort to repair the breach has an impact on her as well.

The participants in this study were generous in their willingness to expose their use of humor when *they* needed a break. Half of the participants acknowledged that they have used humor for self-protection when they have had difficult reactions to painful material. "As a therapist, I think humor also becomes a coping strategy for a lot of us. Not everyone has that capacity. I wonder if they burn out sooner." The therapeutic relationship should always be client-focused, but it is a human relationship all the same. One of the benefits of the relationship in therapy is that as a human being the therapist may have empathy for the client's human experiences. One of the potential hazards is that the therapist may struggle with countertransference issues. Does the momentary use of humor provide a temporary release for the therapist *and* the client or damage the relationship by turning away from the real issues? The participants in this study seem to have enough self-awareness to be able to recognize when they might use humor purely for self-protection, and make reparative efforts in the same session or a future session. If a repair can be made in a timely way, it can help build resilience and expand the capacity for affective expression in the client, as it does in a baby whose primary caregiver makes an appropriate repair.

In the interviews, the participants largely focused on the benefits of humor in treatment with clients who had a sense of humor. Only three mentioned caution with clients who may not have had one. Despite proceeding carefully with new clients, there may be some who just "don't get it." For

example, what if Sidney could not appreciate humor? We assume that if clients do not seem to "get it," the clinician will choose a different path. One of the participants commented "no one has ever complained" about the use of humor. Even with "light innocuous" humor to introduce the process of treatment and to access the client's capacity for coping, the therapist needs to pay careful attention to the client's reactions, and *lack of* reactions. Just because he does not complain does not mean that the client can make a good connection to the therapist and to the process. This is an area that might benefit from further research.

Only one participant described making a humorous remark that she felt went "absolutely nowhere." Her client, Esther, was a very angry 65-year-old woman. While she provided supervision of her 95-year-old mother's care, it was with great resentment. Her own daughter was about to give birth to Esther's first grandchild in Dallas. Before leaving town to be with her daughter, Esther said to her therapist, "Just watch, I'm gonna go to Dallas, and she's gonna *do* it." Esther was implying that her mother would die rather than allow her any pleasure of her own. In fact, the mother did die while she was gone. The therapist made a light remark harkening back to Esther's previous comment. "And I was expecting her to smile. And she absolutely didn't, she just got angrier. Not at me, but the anger was at her mother." Esther was so angry with her mother, that no lightness was possible for her at that time. The remark was intended to both join and to reframe. While it did not create a misattunement, Esther was unable to allow the irony to mitigate her anger. She did, however, interpret the comment as if it confirmed the alignment between her and her therapist. Although the participant may have misread Esther's ability to appreciate the lightness, the

bond that had been established between them allowed Esther to feel validated by the remark.

Many of the issues and clinical interventions are similar for older and younger adults. As Muslin (1992) writes, "Psychotherapy is psychotherapy for all ages" (p. 200). However, the older adults treated by the participants seem to have greater struggles with issues of loss, sense of self, and transience than their younger counterparts. Seven out of eight participants believe that humor encourages therapeutic change for older adults. However, one of the older clinicians demurred: "It's hard to know exactly what promotes change." The two eldest participants also express uncertainty as to whether differences exist in the humor used by older and younger adults. "I'm sure there are some differences, it depends upon the person. With older people it's more personality than age." Each client is, of course, an individual with an individual personality; it is possible that for these clinicians it may be less comfortable to make generalizations about people in their own age group. Nevertheless, this slight dissonance reminds us not to generalize about an age or cultural group at the expense of the particular client.

If the therapist and client are in a similar age group that may also have an impact on the treatment. A few of the therapists articulate feeling more confident, and "braver" as they have greater experience. This is a fairly typical response to having seen many more clients, learning additional theory and developing skills. Surgeons also feel more secure about performing angioplasties or appendectomies as they perform more of them. But surgeons and therapists differ in that surgeons are also dependent on their physical capabilities, and their skills decline past a certain age. Therapists can continue to form meaningful

empathic relationships with clients, and may continue to develop their capacities.

"It's different now that I'm older . . . we're paralleling our growth. Lightness has happened here." The particular group of clinicians interviewed for this study find that while they have always enjoyed humor and have been able to use it successfully in treatment, being closer in age to their current older clients makes their use of humor less threatening. As they have matured as therapists, they "might disclose more with the elderly now." "The context of my humor has shifted as I have aged." There is a joining: it's about *us* rather than about *you*. The therapeutic relationship is enhanced by the sharing. When the participant reminded 98-year-old Miriam, that her own knees hurt, there was a kind of empathy that arose from sharing an uncomfortable experience, although the participant is considerably younger than 98. This kind of sharing enhances the therapeutic relationship, and also creates a "moment of meeting." Both the client and the therapist may feel that "I know that you know that I know" (Stern, 2004).

Although the benefits of humor have been described by psychoanalysts (Poland, 1994a, 1994b; Grotstein, 1999) humor may be perceived as an element most often used in supportive therapy. Despite the range of treatment options for adults of different ages there may be a tendency for some therapists to offer only supportive therapy to older clients. In the face of so many losses, and the limitation of time, some therapists (and clients) may feel that this is the treatment of choice. However, if it is the *only* choice offered, it may dismiss and patronize the client. For some clients, supportive work is the best practice, but it is important not to generalize based on a client's age. Several authors have written about the benefits of psychoanalytic work with very frail older adults (e.g.,

Muslin, 1992; Cohler & Galatzer-Levy, 1990; Jacobowitz & Newton, 1990). The literature and the participant responses indicate that humor can be useful in both supportive and more analytical treatment.

Muslin cautions the therapist against becoming "jocular in reacting to one of the patient's deficits" which might be interpreted as "patronizing" and likely to induce shame (1992, p. 195). When therapists of a certain age imply that they also experience these deficits and treat them lightly, they empathically join the client rather than patronize or shame him. The therapist indicates that she is in the same boat, although she may be steering it.

Only one of the participants mentions using a humorous remark when she wants to express concern about an older client's behavior. As both vision and reaction time are compromised by age, older drivers need to be more vigilant. Her client, Alex, who drives without getting enough sleep, presents a problem for himself and for others. When she asks him to call her before he gets in his car so that she can avoid being on the road, she lets him know in a gentle and smiling way that his behavior is dangerous. The therapist's humor allows him to accept a remark that he might have rejected had it been made more directly. Kohut also described a situation with a younger analysand who drove recklessly. He used irony and defied the patient's expectations by saying that he was "going to give him the deepest interpretation he had so far received in his analysis: 'You are a complete idiot'" (as cited in Lachmann, 2008, p. 16). Kohut's patient was a much younger person. His choice implied a more paternal relationship. If the patient were killed in a car crash, analysis would be useless. Kohut created a necessary affective shift in the therapeutic relationship. Alex would have been highly insulted by such a bold use of irony; it would have created a

misattunement in the therapeutic alliance. The participant's use of humor expressed concern for him and implied that his dangerous driving could injure *her* as well. Her choice was more respectful of her client's perception of himself and acknowledged reciprocity in the therapeutic relationship.

Participants report evaluating client growth and change by noting a *greater* appreciation for humor. But the reverse may also be true. When Shirley, the 90-year-old client could no longer appreciate humor, she seemed to cross a bridge, indicating that something had changed for her. Something also changed in the therapeutic relationship. Although humor remained part of it's history, it was no longer a part of the immediate therapeutic alliance. This change was painful for the therapist. Two other participants reported this phenomenon. One indicated that she "came the closest to sinking" when she could not offer her client "a better spin" on his terribly painful and unchangeable situation.

Neither the literature nor the other five participants described this experience with clients. However, I recall a similar encounter that took place over twenty years ago. A client of mine who had been known for his charming and wry sense of humor, was dying of Multiple Myeloma. As a general practitioner for 50 years, he had a better understanding of his prognosis than his oncology team did. In the last few weeks of his life, in extreme physical pain, he too, seemed to draw inward. His ability to be verbally playful was severely limited. While there are many stories of older adults maintaining their humor until the end, these few reports of a shift speak to the importance of the therapist remaining exquisitely attuned to the client's feeling tone and to her own responses. Perhaps the "bridge crossing" has some physiological and

neurobiological origin which nudge clients to begin the process of disengaging from intimate relationships.

None of the participants mentions being taught or encouraged to use humor in treatment or to see its use as part of a "professional self." A recent article in the *New York Times* discusses the discomfort of a psychiatry intern regarding the use of humor with patients. During his medical rotations he was comfortable and successful using humor with patients, but in the psychiatry department things shifted.

> I had a vague sense that prompting a patient to laugh could sometimes be therapeutic. But when is it safe — let alone useful — to joke with a psychiatric patient? . . . . the patients seemed to have enough trouble relating to me without having to decode the nuance of humor. It seemed too risky, too ripe for misunderstanding. (Brody, 2008)

Ultimately, the young intern experimented and found gentle humor to be useful even for psychiatric patients in his service.

In teaching and training, it would be helpful to legitimize the role of humor in affect regulation for the client and also for the new clinician. There is very little about this in the literature. Franzini promotes the notion of teaching therapists the risks and uses of humor in treatment (2001). Lachmann (2008) comments "Unlike empathy, humor, spontaneity and creativity can't be taught although they can be liberated through life experience or in therapy" (p. 87). It would certainly be valuable to teach clinicians to use their personal gifts (including humor) in the therapeutic relationship, but it might be a mistake to encourage clinicians who do *not* have the ability to create humor to try to create it. In order to use humor in therapy, the clinician must feel comfortable with her own playfulness. She must use her power for the client's good, rather than simply for her own entertainment. She must be clinically attuned enough to

understand when the client can appropriately process a humorous remark. While the relationship is bi-directional, the therapist cannot use the client as a captive audience. For some clinicians, it may be possible to "liberate" their ability to appreciate a client's use of humor, but if they do not have the skills or the capacity, they should not be encouraged to try playing with the heavy equipment.

There is a familiar joke about the "Comedians' Retirement Home" where several residents are sitting on a porch. After awhile, one man calls out "42." The others laugh. Another calls out "18." The others laugh again. A third calls out "51." There are a few chortles. A fourth man calls out "27." There is dead silence, not even a snicker. "27," he says again, louder. After a few minutes the fourth man says, "What's the matter? Why didn't anyone laugh?" One of the others replies, "We didn't like your delivery." Seltzer (1986) asks, "Do shared old jokes reinforce a cohort cohesiveness? Do we have favorite old jokes—a form of nostalgia—as we have favorite old tunes?" (p. 132) Do favorite jokes promote attunement? There may be a kind of joke appreciated by a particular group of people, no matter how often it's heard, and as the "Retirement Home Joke" indicates, *how* the joke is told, *how* the humor is presented will make the difference between appreciation and silence. *How* the therapist uses humor, and *when*, will be as important as her choice of humorous words, looks, or gestures.

As one of the participants notes, there may not be any significant clinical differences between using humor with older adults and younger ones. The power of the relationship, the ability to play, and affective moments may be the same for all generations. However, the specific material that may bring a smile to an older person's face may not be the same as one might use with a teenager. The

particular issues that often bring an older adult to treatment may be more responsive to humor for reframing and for connecting on an affective level. For older adults who may not have much laughter in their lives other than what they see on television, it may also provide a pleasant interlude. As long as the humor is used in the service of and with attention to the affective state of the client it is unlikely to do harm and may do a great deal of good.

Other Considerations and Suggestions for Future Research

This is an exploratory study, the results of which imply that humor is beneficial in psychotherapy with older adults. The sample of therapists includes men and women, people of different ethnicities, and people of different ages. All of the participants have had long careers as clinicians. The research is limited by size and location. The interviews may have been affected by the attitude of the interviewer and of the participants that humor might be useful in treatment. It is striking how closely the participants' responses parallel the existing literature on the subject. However, further research with a much larger and more varied group would be necessary to develop any hard and fast conclusions. Ideal studies would include interviews with both clinicians and clients, going far beyond the parameters of this limited, exploratory research. Below are some areas for future consideration.

Not every client can appreciate humor. We assume that if clients do not seem to "get it," the clinician will refrain from using humor. One of the participants commented that "no one has ever complained,"(about the use of humor) but I later wondered about this. If a client sees a therapist who does something that makes him uncomfortable (perhaps making light remarks) in the first session, does he tell the therapist that he is uncomfortable? Does he return to

that therapist? Even when the therapist pays careful attention to the clients' reactions or *lack of reactions* to the "light, innocuous" humor, does she understand the impact on the client? It would be interesting to learn what those clients' experiences are like in the first session, and the impact the slight disconnect might have on the therapeutic alliance. If the client and therapist have begun to develop an alliance, would the comedic misunderstanding have a different effect? Just because "no one ever complained" does not mean that the therapist's use of humor was helpful to the client. This arena is a good one for further study. It would be valuable to be able to interview clients as well as clinicians to develop a greater understanding of the bi-directional meaning of the humor in the treatment. What was the therapist's perception of the client's reaction? What was the client's feeling? How did the client view the therapist, and the possibilities for a therapeutic experience? Perhaps this research could be part of a larger study on how the therapeutic alliance is developed or a study on clients who leave treatment after one session.

Does an older client respond differently to a therapist with graying hair or wrinkles? We know that younger clients may be uncomfortable describing issues they think might be inappropriate for older ears. H. M. Strauss (1996/2001) writes about the discomfort some of her younger clients seemed to exhibit when discussing sexual issues with her. Does the age of the clinician have an ongoing impact on the therapeutic relationship, or is it just part of the initial orientation, like the color of the therapist's eyes? This study focuses on the therapists' experiences in working with older people, but it might be valuable to interview older clients as well. How do they interpret the humor that is shared by the therapist? Do they ever feel patronized (as Muslin suggested they might)? Do

they feel that the relationship is enhanced by the therapist's age? Some older people calling for treatment have refused to see younger clinicians, indicating that they cannot imagine a younger person having enough history to be able to "understand" them. Further study with older clients might be helpful in learning more about their feelings concerning the age of their therapist in developing a therapeutic relationship. Therapists and potential older clients might be interviewed prior to treatment, during treatment, and at the end of treatment to determine what, if any, impact the age of the therapist might have had on the development of the therapeutic relationship.

This research benefited tremendously from interviewing clinicians who have had a great deal of experience and were able to reflect on and articulate their feelings about older clients in the present as well as in the past. However, time and erudition may have an impact on clinicians' reports of experiences using humor with older adults 20 years ago. In order to examine this phenomenon more effectively, it would be valuable to interview both older and younger clinicians about their experiences using humor with older clients. A study evaluating the use of humor with older adults might interview clients as well as older *and* younger therapists to examine how humor is used and experienced by the therapeutic dyads.

Looking at older adults as a group is almost like considering a different cultural cohort. Their life experiences may be very different from those of their grandchildren. What they find humorous may be different as well. The participants in the study indicate some awareness of and sensitivity to age-related cultural differences but some additional examination of how older and younger therapists approach using humor with older adults would expand our

understanding. Again, it would be most helpful to include the experiences of older clients in this research. When do they enjoy humor in treatment? When do they feel it enhances the relationship? When do they feel as if they are being patronized? It would be helpful to pay attention to cultural issues, as well. Are there clients whose culture precludes having younger people make jokes with them?

Learning more about cross-cultural humor in psychotherapy would be valuable in understanding more about the therapeutic relationship. In this study, participants largely discussed their experiences with people of similar cultures. Research involving both therapists and clients in cross-cultural dyads would be helpful in developing this knowledge.

The data and the literature raise other areas of study, two of which have to do with memory. There are a few studies indicating that older adults may not be as able to "get the joke" as well as younger people (Shammi & Stuss, 2003; Mak & Carpenter, 2007). The jokes in those studies, and the "correct" cartoon panels seemed questionable to me (and to several others). But it is possible that due to hearing impairment, or mild cognitive impairment, some older adults *are* slower to grasp the punch line. None of the participants in the study indicated that this situation interfered with their use of humor in treatment. I sometimes slow the pace of a session with an older client, or enunciate more clearly, but have never found there to be a problem in the client's level of appreciation of humor or feeling of connection.

To observe this phenomenon from another viewpoint, consultation was sought with a professional stand-up comedienne who has worked both with older populations (in Florida retirement communities) and in Las Vegas with

more varied audiences. She too, does not see any difference in level of appreciation between older and more varied audiences, both with her own shows and in observing other comedians (E. Boosler, personal communication, October 28, 2008).

Another question that surfaced after the interviews had been performed also had to do with older adults and memory impairment. In my experience working with people diagnosed with mild to moderate dementia, sometimes clients are able to make spontaneously amusing remarks. They were not just recycled old jokes ("42" or "27"), but appropriate to the discussion of the moment. Further research into humor, memory, and therapy would be valuable to learn more about appreciation of humor, despite changes in the brain. Neurobiological research would provide important data about this.

Most of the participants agree that using humor in treatment with older adults helps the therapist to continue working without becoming overwhelmed by painful affective and concrete client experience. Using humor seems to protect the therapists from burnout. The critical factor may be remaining appropriately attuned to the clients' needs, issues, and temperament; and not using humor solely for self-protection. There is not a great deal of material in the literature regarding the role of humor in protecting the clinician from burnout. Further research with a larger sample, and more attention to countertransference might lead to valuable data on the therapeutic process.

Like Friedman, I enjoy humor and like to encourage others to use it *if it can be valuable for them and their clients*. Like most of the participants in the study, I grew up surrounded by older adults who enjoyed using humor. It was encouraged, particularly in the face of stressors and potential pitfalls.

The use of humor in psychotherapy has often been pathologized. As Lachmann (2008) says, "After all, psychoanalysis was invented by obsessionals to treat hysterics" (p. 91). But humor has often been useful and appreciated in my own practice as well as those of the participants. In a women's therapy group, where the average age is 84, one of the group members has remarked on several occasions, "I just love this group, first we laugh and then we cry, and then we laugh again."

Appendix A

Letter Seeking Participants

Deborah Levine, LCSW
829 Thayer Avenue
Los Angeles, CA 90024

Phone: (310) 474-8228 ***E-mail: DCLevine@gmail.com***

Dear ,

I am writing to ask your help with finding participants for an exploratory study on the use of humor in psychotherapy with older adults. This research is for a doctoral dissertation under the supervision of Dr. Judith Schore at The Sanville Institute.

Licensed therapists who have been in practice for at least five years and who use humor, and treat older adults are invited to participate. Clinicians will be interviewed to explore their experiences and perspectives about the role of humor in treatment.

If you know anyone who might like to participate, I would very much appreciate it if you would pass this letter along to him or her.

Please let me know the names of therapists who express an interest, and a way that I may reach them.

Thanks for all of your help.

Sincerely,

Deborah Levine, LCSW

Appendix B

Advertisement Seeking Participants

A Study on the Use of Humor in Psychotherapy with Older Adults

An exploratory study of the use of humor in psychotherapy with older adults will be conducted by Deborah Levine, LCSW. This research is for a doctoral dissertation under the supervision of Dr. Judith Schore at The Sanville Institute. Humor may be a useful tool in psychotherapy with older adults. This study will help all clinicians who work with older adults understand more about the role of humor in treatment.

Therapists who have been in practice for at least five years who use humor and treat older adults are invited to participate. Clinicians will be interviewed to explore their experiences and perspectives about the role of humor in treatment.

Please call or e-mail Debby if you are interested in participating or if you would like more information.

e-mail: DCLevine@gmail.com
phone: (310) 474-8228

Appendix C

Letter to Prospective Participants

Deborah Levine, LCSW
829 Thayer Avenue
Los Angeles, CA 90024

Phone: (310) 474-8228 *E-mail: DCLevine@gmail.com*

Dear ,

Thanks for expressing an interest in my doctoral research.
As you know, I am conducting an exploratory study on the use of humor in psychotherapy by experienced clinicians with older adults. This research is under the supervision of Dr. Judith Schore at The Sanville Institute.

I suspect that humor may be a useful tool in therapy with older adults. By interviewing therapists about their experiences with treating older adults, and their use of humor I hope to develop more systematic information to promote a better understanding of therapists' thinking and treatment with this population and the potential benefits using humor with them.

I will ask you to think about and describe experiences you have had using humor in therapy with older adults, and to think about some general ideas such as when and how you use humor and some of the responses you have observed. I will also ask you how you have felt about your clients when humor was used.

The interview will take about an hour (perhaps an hour and a half) at a location that is convenient and comfortable for you. I will audiotape the interviews to be as accurate as possible about recording your ideas. I will heavily disguise any reference to you or your clients, but may use quotes from the interviews that refer to the ideas at hand to provide a real flavor of your thought process.

A very brief questionnaire and a copy of The Sanville Institute consent form are enclosed. If you are interested in participating, please send back the questionnaire in the enclosed envelope. I'll call you to discuss the interview. At the time of the interview, you will need to sign the consent from.

I am very excited to hear your experiences and perspectives and will call you in the next week to try to set up a time and place for an interview.

Thanks again for your interest in the topic, and in participating.

Sincerely,

Appendix D

The Sanville Institute Informed Consent Form

I, _____, hereby willingly consent to participate in the study "An Exploratory Study on the Use of Humor in Psychotherapy with Older Adults." This doctoral research project will be conducted by Deborah Levine, LCSW under the direction of Judith Schore, PhD, Principle investigator and faculty member, and under the auspices of the Sanville Institute.

I understand the procedures to be as follows:
The study will focus on the therapist's thoughts and perceptions about using humor in the treatment of older adults. My participation in this study will involve responding to questions in an interview that will last about an hour to an hour and a half. My participation in this interview is completely voluntary. I may answer questions as fully as I choose. I may refuse to answer a question, or to end the interview at any time. The interview will be tape recorded to help with the analysis of the information provided. The recording will be kept confidential and will only be available for data analysis to the researcher. Any notes, tape recordings or records of this interview will be used for data analysis and will not include my name or any identifying information. Any tapes, notes and records of the interview will be destroyed after the interview material has been analyzed. If information from the interview is disclosed in the dissertation reporting on the research to illustrate findings, care will be taken so that neither I nor any other person is identified.

I am aware of the following potential risks involved in the study:
The risks of my participation are minimal, perhaps consisting of some slight discomfort or embarrassment in disclosing areas of personal or professional vulnerability or self doubt.

Provision to be made in case of emotional discomfort:
I may refuse to answer any questions, or may refuse to continue the interview at any time. I may withdraw from participation in the study after the interview has been completed. Any identifying information will be removed to protect my anonymity, and the anonymity of any case material I discuss. If I continue to feel emotional discomfort following participation in the study, amelioration in the form of professional help will be made available to me.

I understand that I may withdraw from the study at any time. I understand that this study may be published and that my anonymity and confidentiality will be protected—that is, any information I provide that is used in the study will not be associated with my name or identity.

Signature:_____ Date_____

If you would like a copy of the results of this study, please provide your name and address:

Name_____

Address_____

Appendix E

Preliminary Questionnaire

A EXPLORATORY STUDY OF USING HUMOR IN PSYCHOTHERAPY WITH OLDER ADULTS

Participant #_____

What is your professional licensure?

Licensed Clinical Social Worker _____

Marriage and Family Therapist _____

Psychologist _____

Psychiatrist_____

How long have you been in practice?

How long have your worked with older adults?

Do you subscribe to a particular theoretical modality?

If so, which one?

Have you had experiences using humor in psychotherapy?

Appendix F

Letter to Prospective Participants Not Chosen

Deborah Levine, LCSW
829 Thayer Avenue
Los Angeles, CA 90024

Phone: (310) 474-8228 *E-mail: DCLevine@gmail.com*

Dear ,

Thanks for expressing an interest in my doctoral research exploring. the use of humor in psychotherapy by experienced clinicians with older adults. This research is under the supervision of Dr. Judith Schore at The Sanville Institute.

I very much appreciate your interest in the project and your willingness to be interviewed. At this time, I have enough participants for this small study. Should I need additional participants, I hope that I may be able to call on you at a later time. Thanks again for your interest in the topic.

Sincerely,

Appendix G

Interview Schedule With Prompts

Introduction:
Thank you for agreeing to this interview and for participating in my research project. This is a small doctoral study exploring how experienced therapists think and feel about using humor in treatment with older adults. I'm interested in your experiences and thoughts about this population and using humor.

Before we begin, let's take care of the housekeeping details. Participation is completely voluntary and you may answer as many or as few questions as you choose. You may also stop at any time. I may use quotes from the interview to provide a real flavor of your experience, but will carefully disguise the parties and the details. In order to help analyze the data accurately, I'm asking you to allow tape recording of the interview. Would that be ok? Of course, I will destroy any tapes or notes as soon as the data is analyzed.

There are no right or wrong answers, just your thoughts and experiences.

Schedule with Prompts:

I see from your questionnaire that you have been working with older adults for X years. How did you get into it?
--Could you talk a bit about your personal experiences with older adults?

Tell me about your use of humor in therapy.

Tell me about your use of humor in therapy with older adults.

Could you describe some examples of your use of humor in therapy with older adults?
--Where do you think it was coming from?
--How did you decide to use it?
--How did it influence the therapeutic relationship?
--How did it influence the treatment?
--Would you do things differently if you had the chance?

--Can you tell me about *when* you have humor in therapy with older adults?

--Can you tell me about *how* you have used it?

--Can you tell me about *why* you have used it?
--Are there particular issues that invite it?

Is the experience of using humor different with this population?

Do you believe humor is beneficial in therapy with older adults?
--How can you tell?

Do you believe humor can be harmful in therapy with older adults?
--How can you tell?

What effect does using humor in therapy with older adults have on you?
--Are there countertransference issues that engender your use of humor?
--Do your feelings about a particular client's situation have an impact on your choice?
--Does the use of humor in a session have an impact on you?

Appendix H

THE SANVILLE INSTITUTE

PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

Title of Research Project: An Exploratory Study of Psychotherapists' Use of Humor in Treatment with Older Adults

Principal Investigator: Judith R. Schore, Ph.D.

Investigator: Deborah Levine, LCSW

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the *Student and Faculty Handbook)*, and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study

_____ Are not "at risk"

__X__ May be considered to be "at risk", and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Judith R Schore PhD Date 5-1-08
Signature of Principal Investigator

Deborah Levine, LCSW Date 5-1-08
Signature of Investigator/date

Action by the Committee on the Protection of Research Participants:

Approved ✓ Approved with Modifications _____ Rejected _____

Ph.D. Date 5/28/08
Signature of Representative of the Committee on the Protection of Research Participants

Approved:

Judith Kay Nelson, Ph.D. Date 5/28/08
Signature of Dean

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