Putting the Fun Back into Dysfunctional: Is the use of humour in Rational Emotive Behaviour Therapy a desirable condition or an amusing aside?

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The use of humour in REBT was strongly endorsed by its creator, Albert Ellis and has been by many other REBT practitioners. However, whilst many other aspects of REBT have been studied and researched extensively and while there is much that has been said on the use of humour in psychotherapy in general, precious little research exists on its use specifically in REBT. This article outlines a brief history of humour and reviews some of the literature that exists on the subject. Finally, it makes some suggestions for future research into the use of humour in REBT.

Key Words: REBT, CBT, humour, review article

Introduction

"A man went to a psychiatrist seeking treatment for depression: 'I cry a lot. I can't sleep. I am very unhappy. I don't enjoy anything. My life is totally miserable. Can you help me?' The psychiatrist replies, 'I can cure your depression, but what's the use?'"

The above is a joke offered up anecdotally by Tallmer and Richman (1993) in the therapy room, to a client, for therapeutic end-point and to (as they claim), good effect.

REBT posits that humour is a desirable condition for therapeutic change (Dryden and Branch, 2008). This article aims to endorse that viewpoint.

It will first offer a brief synopsis on the historical views of humour and then move on to a review of research that touches on therapeutic alliance, cognitive and therapeutic change and views of self-worth.

This will be followed by a call for research: five suggestions for future scientific investigation, (specifically on the use of humour in REBT), that build on previous studies.

Humour is considered an important trait. Several theorists claim its use as an indicator of good mental health; whilst several have noted the paucity of research in this area.

Many others outside of therapy also attest to its importance. As Mahatma Ghandi once famously said, "If I had no sense of humour, I would long ago have committed suicide."

A brief history of humour

The notion of humour and its effects on our mental and physical health come to us from out of antiquity, and is even mentioned in The Bible, where it says, "a merry heart hath a cheerful countenance, but a broken spirit drieth the bones." (Proverbs 17:22 KJB).

According to Richman (2002), "The field of humour is a study in itself, with extremely wide applications. It is found in all human activities: literature, art, folklore, teaching, and all forms of healing." (p166).

Until the 19th century, the body was said to be composed of four basic substances, or "humours," namely (and somewhat disgustingly), blood, black bile, yellow bile and phlegm.

Several theorists, including Surkis (1993), Lothane (2008a) and Lemma (2000) have traced

the etymology of the word humour. It originally meant, "moist," or "moisten."

Over time, humour came to mean any fluid or juice of either an animal or a plant, but, as Surkis (1993) noted, it became especially associated "any of the four fluids or cardinal humours formally considered responsible for one's health and disposition." (p126).

A balance of these fluids made for a good humour, while an imbalance made for ill humour. As Lothane (2008a) stated, "black bile was seen as the cause of black moods, or depressions." (p180).

According to Robinson (1983), "the recognition of the benefits of humour by physicians in the Middle Ages and to the 19th century is described by Moody (1978) and also in a classic book by a physician, James Walsh (1928)." (p112).

After that, in English at least, humour acquired the meaning by which we understand it today. Both Surkis (1983) and Lothane (2008b) quoted the Webster's Dictionary definition of humour, thusly:

> "That quality in a happening, an action, a situation or an expression of ideas, which appeals to a sense of the ludicrous or absurdly incongruous; the mental faculty of discovery, expressing or appreciating ludicrous or absurdly incongruous elements in ideas, situations, happenings or acts" (Webster's, 1949).

Humour has had a funny old time of it over the years. In fact, as Richman (2002) noted, "theories of humour and laughter have abounded in the philosophical literature for some 2,500 years, from Plato to Aristotle to the writings of sociologists, psychologists, and physicians of the present." (p166).

According to Plato, who wrote about it in *Philebus*, humour was a form of malice directed towards people who were considered powerless, while Lemma (2001), noted that in the *Poetics*, "Aristotle also draws attention to the feeling of superiority and the attendant wish to mock and deride, found in humour." (p26).

And, as Saper (1987), Lemma (2001), and Lefcourt (2002) all noted, in 1651, the philosopher Thomas Hobbes, in *Leviathan*, also argued that humour was aggressive and hostile and that "imperfect" people laughed at those less fortunate than themselves.

However, it wasn't all doom and gloom on the humour front. The Ancient Greeks thought that comedy would make the crops grow. Richman (2002) argued that there may be a link between this ancient function and the present-day notions of humour's restorative powers.

As Lothane (2008b) stated, "the generic concept of drama, which in Greek means action, has two genres: tragedy and comedy. Tragedy provides catharsis; comedy provides relief." (p233).

However, According to Gelkopf and Krietler (1996), the positive view of humour and, by association, laughter, as enhancing the quality of life of mind and body is essentially a new development.

Goldstein (quoted in Gelkopf & Krietler, 1996) said that, "up to the end of the 19th century, in most Western countries, laughter was considered impolite, sinful and even detrimental to spiritual and physiological well-being." (p236).

However, McGhee (1983b) stated that one popular modern conception of laughter, as a means to reduce built-up energy or tension, was first advanced by Spencer in 1860.

In psychology, one man who devoted a lot of thought to the subject of humour, was Freud.

In 1905, he wrote a seminal work entitled *Jokes and Their Relation to the Unconscious* and, in 1928, a paper called, simply, *Humor*.

He compared humour to dreams, considered it to be a release of energy no longer needed for repressive purposes, thought it a defence mechanism and linked it to aggression and sexuality.

Mosak and Manniacci (1993) said, he who laughs is releasing pent-up energy which has its

basis in sexual and aggressive drives, while Surkis (1993) said, as a defence, humour followed the task of guarding against the origin of pain from inner sources.

According to Richman (2002), "Freud compared humour to dreams. Both operate at more than one level . . . both permit the expression of forbidden drives, thoughts and attitudes. Jokes, however, perform a social function, whereas dreams do not." (p167).

Bader (1993) said it was because jokes were seen by Freud as a disguised expression of hostile and sexual impulses, that psychoanalysts today view humour with such suspicion.

However, Freud also saw the healing side of humour, as Lothane (2008a) noted, "Freud . . . defined humour . . . as a means of obtaining pleasure in spite of the distressing affects that interfere with it." (p183).

He surmised that not everyone was capable of the humorous attitude and called it a rare and precious gift.

As Birner, (1994) stated, "Freud indicated that there was a great value in humour . . . Humour is the emotionally healthy way of dealing with the problems and dilemmas of life, as opposed to unhealthy ways such as drug addiction, depression, neurosis, and psychosis." (p81).

Scientific research in support of the use of humour

Much evidence of the positive effects of humour in psychotherapy is anecdotal in nature, with therapists giving accounts of humorous interventions and their outcomes. However, despite there not being as much rigorous scientific testing in this area as in other areas of psychotherapy, there is literature enough to be reviewed and discussed in relation to REBT.

The use of humour is good news for those who specialise in couples therapy.

Ziv and Gadish (1989; cited in Lemma, 2000) studied the effects of humour on marital satisfaction in 50 married couples. On the husband's side, marital satisfaction was linked to perceptions of their wives sense of humour. Sadly, the results the other way around, were inconclusive. However, Blumenfield and Alpern (1986; cited in Lemma, 2000) reported similar results linking marital satisfaction with humour, while Keltner and Monarch (1996; cited in Lemma, 2000) found that couples who used humour while dealing with mutual conflicts experienced less distress whilst discussing them and increased relationship satisfaction after.

Elsewhere, Coser (1959; cited in Banmen, 1982) found that patients who used humour found it easier to adapt to becoming hospital patients and communicated their fears and feelings concerning their stay more effectively. Coser (1960; cited in Lemma, 2000) also found that staff that used humour whilst working in a psychiatric hospital experienced better group cohesion and less stress.

Solomon (1996; cited in Lemma, 2000), in a study involving 155 adults aged 20 to 94, found humour was positively related to ageing well and a feeling of personal control.

But what about humour used in the therapy room? Rogers (1957, cited in Overholser, 2007) argued that the therapeutic alliance was central to effective psychotherapy. REBT theory also places importance on building and maintaining a strong therapeutic alliance. But, does humour have a positive affect on this alliance?

Whilst not strictly psychotherapy, Levinson, Roter, Mullooly, Dull and Frankel (1997; cited in Sultanoff, 2002) found that patients who experienced humour from their doctors filed fewer lawsuits against them.

In another study, Sala, Krupat and Roter (2002), investigated the extent to which various types of humour, as used by both patients and doctors (such as light, tension-releasing and self-effacing), affected patient satisfaction levels during their visits. They found that, although patients generated humour slightly more often than their doctors, humour produced by each was "significantly greater" in high satisfaction than in low satisfaction visits and

that doctor-generated humour was consistent with positive rapport.

In an earlier study, Squier (1996; cited in Sala et al., 2002), found that humour reinforced a sense of equality between patient and doctor, helped develop a positive relationship and fostered a sense of control and healing for the patient.

More firmly routed in the therapy room, meanwhile, Banmen (1982) stated, "humour breaks the ice between therapist and client . . . allows a therapist to be more human, minimising the therapeutic distance which too often exists between therapist and client." (p84).

In one study, Labrentz (1973; cited in Saper, 1987) found that humour had a positive impact on the initial client-therapist relationship whilst, in another study, (1974; cited in Banmen 1982), he exposed clients to four conditions (one of them humorous) before an initial therapy session. Those on the receiving end of the funny stuff rated the relationship with their counsellor significantly higher that those in the other three groups.

Hubert (1974, cited in Saper, 1987), found that therapist-introduced humour had a positive effect on both the client's perception of the relationship and their levels of discomfort.

But, can humour have a positive affect on emotions, behaviours and symptoms? Enough research seems to think so.

Lefcourt (2002), using two scalar measures developed earlier in Martin and Lefcourt (1984; cited in Lefcourt, 2002), found that humour had a moderating effect on stress.

The Situational Humour Response Questionnaire (SHRQ) asked people how often and to what degree they used humour in situations that could be as irritating as they might be amusing (ranging from not being amused at all to laughing out loud), while the Coping Humour Scale assessed their deliberate use of humour to alter difficult circumstances.

The series of studies supported the hypothesis that people with a good, as compared to a poor, sense of humour took both themselves and their life experiences less seriously and had a predicted effect on laugher during interviews, self-esteem, positive mood, mirth expressed during failed experiences, funny comments produced simultaneously during tests of creativity and more.

The results, however, were sex-specific. As Lefcourt (2002) noted, "The SHRQ seems to be more predictive of male humour, whereas the CHS is more predictive of female behaviour. These sex specific findings have also emerged in subsequent research." (p151).

Later, Porterfield (1987; cited in Lefcourt, 2002), used the SHRQ and CHS and found that while elevated humour was associated with lower scores on measures of depression, no interactions were found between humour and stress in the prediction of depression, indicating humour as a correlate, but not a moderator of moods displayed during stressful situations.

However, Nezu, Nezu and Blisset (1988; cited in Lefcourt, 2002), again using both the CHS and the SHRQ, found significant effects and interactions between stress and humour in the prediction of depression.

In another study, Kuiper and Martin (1993) investigated the relationship between a sense of humour and cognitive appraisals and reappraisals of a potential stressful event, namely an exam.

The authors found that students with high scores on the coping humour scale appraised the exam as a more positive challenge than the low humour students. And, according to Kuiper and Martin (1993), "in their reappraisals, high humour subjects ratings of importance and positive challenge were positively related to performance on the exam, whereas for low humour subjects this relationship was negative." (p81).

Also, in predicting performance on the next exam, the high humour people adjusted their expectations based on performance in the previous exam, while the low humour people did not. Finally, humour was negatively related to both perceived stress and dysfunctional standards for self-evaluation.

However, not all studies found the same affects of humor on stress. Safranek and Schrill (1982; cited in Lemma 2000 and Gelkopf & Krietler, 1996), found that neither humour use nor humour appreciation moderated the effects of the life events on depression, while Anderson and Arnoult (1989; cited in Lemma, 2000) found that it did not exert any effect on depression in the face of stressful situations.

But, Thornson, Powell, Sarmany-Schuller and Hampes (1997; cited in Lemma, 2000), developed a new humour scale and found it positively correlated to optimism and self-esteem and negatively with depression.

Rim (1988; cited in Sultanoff, 2002) found humour positively correlated with particular coping styles and Danzer, Dale and Klions (1990, cited in Gelkopf and Krietler, 1996) found that exposure to humorous audiotapes decreased depression.

And Witztum, Briskin & Lerner (1999) found that humour, combined with drug therapy led to positive changes in symptoms for chronic schizophrenia patients.

They developed a form of persuasion therapy, based on REBT, that used logical arguments as its basis. They subjected patients to either this or humour therapy. While the logical arguments group did not record visible improvement, the same humour therapy group did.

According to Witztum et al. “This approach appealed to them, raised self-esteem; and they likewise gained confidence in their own ability to form judgments. The fact that humour made an impact on the patient's cognitions demonstrated that patients with disturbed thought processes could be influenced in ways which improved coping.” (p233).

Laugh, and the world laughs with you; weep, and you weep alone, as the saying goes. And there may be some scientific truth to this age-old bon mot. Bonanno and Keltner (cited in Lefcourt, 2002), found that bereaved people who smiled and laughed as they talked about their nearest, dearest and recently departed were judged more attractive and appealing than those who remained solemn. They found that people who laughed about difficult or dreadful experiences became more approachable.

Meanwhile, Nezu, Nezu and Blisset (1988; cited in Lemma, 2000), Richman (1996, cited in Sultanoff, 2002), and others, all found that a sense of humour was positively correlated both with increased social support and being liked by others.

Lemma (2000) noted that interpersonal support is critical in recovery from depression, while Sultanoff (2002) stated: “As individuals experience humour, they feel emotionally lifted and connect well with others.” (p117).

Thorson, Powell, Sarmany-Schuller and Hampes (1997; cited in Sultanoff, 2002) found that people who experience distress tend to withdraw and disengage from relationships and opportunities, whilst individuals who experience humour become more energized and attentive and pursue connections with others, thus changing their behaviour.

Humour can also have an impact on views of self-worth and self-efficacy.

According to Overholser (1992; cited in Gelkopf & Krietler, 1996), high scorers on the coding humour scale have higher self-esteem and Martin, Kuiper, Olinger and Dance (1993; cited in Gelkopf & Krietler, 1996) noted that higher levels of humour, “are related to a more positive self-concept, assessed by actual-ideal discrepancies, self-esteem and standards of self-worth evaluation.” (p242).

Darmstadter (1964; cited in Banmen, 1982) and Goldsmith (1973, cited in Banmen, 1982), both found positive correlations between humour ratings and psychiatric patients ego-strength levels.

Kavanagh & Bauer (1985; cited in Lemma, 2001) and Salovey (1987; cited in Gelkopf & Krietler, 1996) found that humour contributed towards increased feelings of self-esteem, a sense of self-efficacy and more enjoyment of events and activities. And Schiffenbauer (1974; cited in Gelkopf & Krietler, 1996) found humour strengthened the enjoyment and pleasant-

ness of objects, activities and events.

If you want to gauge a person's levels of self-esteem, pay them a compliment; if you want to gauge their levels of mental health, tell them a joke.

Several theorists, including Bader (1993), Banmen (1982), Birner (1994), Derks, Lewis and White (1981) – who discussed comparisons of ration and category scales of humour – McGhee & Goldstein (1993a), Prerost (1989), Salameh (1983) – who even developed his own five-point humour rating scale for assessment purposes – Strean (1994), Sultanoff (2002) and many others have all argued that humour can be used as a diagnostic tool.

Goodman (1983) reports that many psychiatrists ask patients to tell them their favourite joke as a way of getting to their client's inner thoughts, while Barnett and Apostolakos (1954, cited in Banmen 1982) used cartoons for a similar purpose.

Dryden (2001) quite often tells jokes to gauge his patient's humour quotient (likening it to an analyst making trial interpretations), and then adjusts his humour delivery accordingly.

And Harrelson and Stroud (1967; cited in Banmen, 1982) found that patients who displayed hostile, distant humour in their early therapy sessions, replaced it with non-hostile, warm humour in later stages.

So, if what research there is suggests that humour is an effective therapeutic change tool, it could also be argued that it is, therefore, a desirable condition. However, with such a small amount of empirical testing in psychotherapy generally and next-to-nothing in REBT specifically, humour appears as a rich seam, ready for the scientific plundering.

Call for research

As Dryden and Branch (2008) have noted, REBT posits humour as a desirable core condition, alongside empathy, unconditional acceptance and congruence.

But is this indeed the case? Do REBT therapists consider it a desirable quality and/or condition? If so, how many think that and how many actually use humour in their sessions?

This article suggests research to build on the work of Sala et al. (2002) who investigated the use of patient-doctor humour, and Lemma (2000) who asked 20 psychoanalytic therapists if they used humour (60 per cent said they did, but 80 per cent of those said they would be reluctant to share such interventions with their supervisors) by approaching 100 REBT therapists and assessing their use of humour through a series of five-point Likert scale items. Ranging from strongly disagree to strongly agree, the items could include the following:

- Humour is a desirable therapeutic core condition in REBT
- Humour is a desirable quality for therapeutic change
- Humour is an important part of your practice

Humour is a regular part of your practice

This paper also proposes asking the therapists for several examples of humorous interventions and their outcomes. The therapists would then be asked to rate their use of that humour according to Salameh's (1983) five-point humour rating scale (which ranges from destructive to outstandingly helpful).

However, therapy is not about the therapist, but about the client. No matter what REBT posits about the use of humour, it's not worth using if the clients don't like it. Again, building on the work of Sala et al. (2002) and Banmen (1982), this paper proposes a study on the use of humour in REBT as experienced by the client. It suggests contacting 100 clients who have received REBT with humour and sending them questionnaires. Again, using Likert scale items and, again, incorporating Salameh's (1983) humour rating scales, these would include the following:

- You received humour in your REBT sessions

- You enjoyed the use of humour in your REBT sessions
- You did not enjoy the use of humour in your REBT sessions
- The use of humour enabled you to build a positive working relationship with your therapist
- The use of humour made for a negative working relationship with your therapist
- You liked the therapist more for his use of humour
- You liked the therapist less for his use of humour
- Humour improved your understanding of certain aspects of REBT
- Humour helped you work on your problems
- Humour did not help you work on your problems

  Humour helped you to affect a change on your beliefs

And from Salameh (1983):

- You consider the use of humour in your therapy to be destructive
- You consider the use of humour in your therapy to be harmful
- You consider the use of humour in your therapy to be minimally helpful
- You consider the use of humour in your therapy to be very helpful

  You consider the use of humour in your therapy to be outstandingly helpful

There have been several studies that have assessed the effects of humour on cognition but, can humour affect those specific cognitions (unhealthy beliefs) that REBT places at B in the ABCDE model of psychological health?

This article proposes two experiments to directly assess humour's effects on a person's beliefs at B.

These studies not only build on the work of Lefcourt (2002) and Kuiper and Martin (1993) in studying the affects of humour on stress, but also Porterfield (1987; cited in Lefcourt, 2002) and Nezu et al. (1988; cited in Lefcourt, 2002), who studied the effects of humour on depression.

The study into anxiety proposes a sample of 100 people who are about to experience a real-life stressful event (for instance, a driving test). After testing for anxiety, via the Beck Anxiety Inventory (BAI), the subjects would be randomly allocated to one of four groups: REBT (one group with a humorous slant, the other without); another group to receive simply "humour" in the form of funny films to watch in lieu of therapy and one group on a waiting list as a control.

The subjects would be handed the SHRQ and CHS questionnaires developed by Martin and Lefcourt (1984; cited in Lefcourt, 2002) as well as a series of questionnaires detailing REBT-specific statements such as "I absolutely must pass my driving test," and "I would prefer to pass my driving test, but I don't absolutely have to pass my driving test," together with statements concerning unhealthy and healthy derivative beliefs, such as awfulising, anti-awfulising and so on, plus other anxiety and healthy concern-related beliefs based around performance and asked to fill them out before the test and before the therapy/humour and then before the test but after the therapy/humour (at which point they would also re-receive the BAI) with the prediction that REBT delivered with humour will have had a significantly greater impact on altering the client's unhealthy beliefs.

Building on the work of Safranek and Schrill (1982; cited in Gelkopf & Krietler, 1996) and Anderson and Arnoult (1989; cited in Lemma, 2000), the study on depression would be similar, but without the use of an "event" such as the driving test. A sample of 100 people suffering from depression would be offered REBT. After being tested for depression via the Beck Depression Inventory (BDI), they would be randomly allocated to one of four groups: two

groups of REBT (one with a humorous slant, the other without), a group given humorous films to watch in lieu of therapy and a waiting list as a control.

The participants would be given the SHQA and CHS, as well as questionnaires detailing RECBT-specific belief statements dealing with depression, and asked to fill them out before the therapy/humour and again after the therapy/humour (at which point they would also re-receive the BDI). The prediction is that REBT delivered with humour will have had a significantly greater impact on altering the client's unhealthy beliefs about depression.

The final study proposed by this article focuses specifically on self-worth. Can REBT delivered with humour have a greater effect on specific unhealthy beliefs centred around self-damning (as in "I am useless", or "a failure", or "totally without worth" and so on) and help affect a shift to their healthy counterparts (as in, "I am not totally worthless or useless, I am a worthwhile but fallible human being.")

This would build upon the work of Overholser (1992; cited in Gelkopf & Krietler, 1996), Goldsmith (1973, cited in Banmen, 1982) and others, who all found positive correlations between humour, a sense of self-worth and feelings of self-efficacy.

This experiment would sample 100 subjects (50 male, 50 female, from various backgrounds, of various ages), who have all reported feelings of inadequacy and low-self worth and randomly allocate them to one of three groups: REBT with humour, REBT without humour, and a waiting list as a control.

Again, the participants would be given a series of questionnaires/self-report measures, centred around notions of self-damning and self-acceptance, given six sessions of therapy, with the measures being filled out before and after. The predicted result being that humour-led REBT would have a greater impact on statements of unconditional self-acceptance than REBT without humour.

Conclusion

The aim of this article was to discuss the research that exists on the use of humour in psychotherapy and to suggest future research into its use in REBT.

The research that exists, though sparse, appears to support the notion that, as long as its use has a therapeutic end-point, humour is both an effective and desirable quality in psychotherapy generally and REBT specifically.

Like Ellis (1977), Sultanoff (2002) argues that, "humour in psychotherapy can be particularly powerful because it has the potential to activate changes in all four of the core aspects of the human experience (emotional, behavioural, cognitive, and physiological) that are targeted by the major theoretical approaches." (p140).

Albert Ellis often said that people disturb themselves, not just by taking themselves seriously, but by taking themselves too seriously and stated (1977) that, "if neurotics take themselves, others and world conditions to solemnly, why not poke the blokes with jolly jokes? Or split their shit with wit? (p2).

It can be argued that REBT is crying out for some shit-splitting scientific research.

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