PSYCHOTERAPIA 2 (181) 2017
pages: 65–74

Maria Kmita, Aleksandra Bronowicka, Anna Moszczyńska,
Renata Zych, Krzysztof Małyszczak

HUMOUR AND LAUGHTER THERAPY

Division of Psychotherapy and Psychosomatic Medicine
Department of Psychiatry Wroclaw Medical University

group therapy
laughter therapy

Summary

Objectives: The paper discusses the benefits of including a laughter therapy into group psychotherapy. Methods: The laughter therapy session was experimentally included in group psychotherapy. Laughter therapy consisted of various carefully designed humour-related tasks. The patients and the laughter therapist were observed via two-way mirror by experienced psychotherapists and a psychiatrist. The assessment of the experiment was based on the opinions of all three parties: patients, observers and the laughter therapists were documented.

Results: Patients enjoyed laughter therapy and, except one patient, took an active part in it. Patients were enthusiastic about this type of therapy and expressed willingness to participate in laughter therapy again. The therapy provided a two-tier liberation for patients: a liberation from their problems and from a typical therapy. It provided a return to childhood, evoking feelings of levity and spontaneity. It also strengthened in-group integration. The laughter therapy helped to unlock conscious experiencing of previously suppressed positive feelings in paranoid patients who experienced some ambivalence after laughter therapy.

Conclusions: Laughter therapy can constitute a valuable part of group psychotherapy. Future research can explore the effects of implementing elements of laughter therapy in different parts of traditional group therapy

Introduction

There are many definitions of humour, but the simplest explanation of what humour is seems to be given by Rancer and Graham [1], who sees humour as a relational activity manifested by relationship between parties. Social nature of humour appears to be obvious. As Martin put it [2] humour is a universal human activity occurring in all sorts of social contexts. Even laughter, on its own, is a form of social communication used to express one's positive emotions and to evoke positive reactions in others [2]. Looking at humour from relational perspective is particularly important as it is a tool facilitating relationships whereas depression is linked to relational problems [3].

Humour can occur in spontaneous communication during therapy, among patients or between patients and therapists. It is also possible to introduce humour to therapy by means of specially prepared workshops. Such an initiative can enrich an existing therapy programme for example for patients suffering from depression. Such workshops can be organised in the form of laughter yoga or laughter therapy (humour therapy). It is important to note the difference between laughter yoga and laughter therapy. Laughter yoga is about exercising diaphragm, laughing on demand, infectious laughter. As organisation Laughter Yoga (www.laughteryoga.org) puts it [4] laughter yoga is not based on humour or jokes, but is connected with breathing exercises. Thus laughter in laughter yoga is not a spontaneous reaction to jokes but is in a way physiologically forced and then maintained by the group.

As for laughter therapy, it seems best to describe it as humour therapy or humour workshops. Its participants are given tasks that trigger laughter and also influence their humour. It means that the workshops participants laugh at the tasks they are asked to do but also create own humour joking about the tasks and what they associate with or joking about each other. Such workshops allow for creating humour situation between patients and their therapist. Laughter therapy we talk about in this paper uses comedy and cabaret projection to relax patients and as an introduction to subsequent tasks. The tasks are varied, sometimes are focused on returning to childhood and use gadgets and games for children and on other occasions they represent intellectual challenges and creativity exercises. Humour workshops, although new in Poland, in Western world have been practiced for some time now. For instance Dr Steven M. Sultanoff, owner of Humour Matters (www.humormatters.com) [5] is a psychologist who uses humour in his therapy and also trains medical personnel and mental health professionals in the use of humour in psychotherapy and for the maintenance of good mental health. Sultanoff uses jokes, anecdotes, cartoons, props and also experiences that illustrate how humour can change our thinking, behaviour and feelings.

The aim of both laughter yoga and laughter therapy is patient's/ participant's laughter. Laughter therapy in addition to triggering laughter, gives a chance to discover, appreciate and create humorous situations. Laughter is a spontaneous reaction to what workshop participants experience. During such workshops humour can help participants in communication and integration being their joint experience. As Sultantoff puts it, the most dramatic benefits of humour are not in laughter but in the cognitive and emotional management that humorous experiences provide [6].

Humour in psychodynamic psychotherapy

It would seem that the concepts of humour and psychodynamic therapy, developed on the ground of psychoanalysis, are contradictory. Sultanoff [6] wrote that the integration of humour (something cheerful) with something as serious as psychodynamic psychotherapy may seem like a peculiar idea. The situation of crossing transference and countertransference, often negative on both sides, does not encourage the introduction of emotional elements like humor between patient and therapist. In classical Freudian psychoanalysis and some of its modifications, such as Melanie Klein's [7] relationship theory, the therapist tries to understand and convey his understanding through therapeutic interventions. This limits the contact with the patient to a highly conscious area controlled by the superego. Psychoanalysts Donald Winnicott [8] and Wilfred Bion [9] observed and described the consequences of traumatic experiences that patients cannot understand because they are idiosyncratic without social and cultural symbolism. It can be said that the intensity of traumatic experience closes them in the patient and prevents its intersubjective symbolization. This kind of experience in therapeutic contacts trigger in the therapist, through projective identification, his own experiences and associations, which are then projected onto a patient who does not understand them and treat as alien and intrusive. In situations where the symbolic code in therapeutic contact varies considerably, the possibilities for agreement are small, such as in psychotic states. A similar situation, but more hidden, occurs in the treatment of patients with early developmental personality disorders. Stern published in 1938 a concept of pathology "between" psychosis and neurosis which he called "borderline". Patients with this type of pathology were not able to use psychoanalysis as a treatment method, primarily because of the development of a "negative transference" [10]. Nowadays such patients are the majority in the day care departments for neurotic and personality disorders which requires searching for other than intellectual therapeutic conversation ways for establishing contact and other methods leading to expression of unsymbolized internal states. A broad group of such methods is psychodrama, allowing experiencing without excessive interpretation. As Pawlik [11] said, psychodrama can be both an independent treatment of psychiatric disorders and it can enrich psychoanalytic process with a deep, emotional experience that is difficult to obtain otherwise. Laughter therapy can also play a similar role.

Sultanoff [6] mentions the important benefits of inclusion of humour in psychotherapy: it helps to look at life's challenges from a different perspective. It can also be a tool for

communicating and confronting minimal stress on interpersonal relationships; it can change the emotions of patients, their behaviour, cognitive and physiological processes, it is also a diagnostic tool and a medium for building and strengthening therapeutic relationships. Similarly Nasr [12] argues that humor strengthens the bond between patient and therapist - it is more likely that patients who laugh with their doctors feel more connected to them, follow their advice and are more satisfied with their encounters.

Goldin and Bordan [13] show that by using humour in relation to the patient, the therapist offers the patient an alternative view of the patient's experience and creates a syringe that has therapeutic value. Thus, in addition to strengthening the relationship between the therapist and the patient, humour becomes a tool for assessing the level of pathology in the patient. What's more, it offers the patient less painful perspectives for his or her poignant experiences, enriches the patient's social repertoire, and provides a method for controlling stress [13].

Goldin and Bordan analysed the therapist's use of humour during therapy when humour helped patients to perceive the absurdity of their beliefs, to trigger their desire to question their own merits, to become aware of their own choices, and to question the patient's destructive approach to the problem. Goldin and Bordan note that sensing the optimal moment can be crucial for effective use of humour in therapy. They claim that if it is used too quickly, the therapist may be seen as incompetent or insensitive to the patient's problems. If humour appears too late, it may seem unrelated to the current topic of therapy [13].

Martin [2] emphasizes that healthy humour (e.g., non-aggressive, not self-deprecating) is an important component of general mental health. The author mentions that experimental research supports the view that humour is a mechanism that regulates emotions. Short-term effects of humour include: increased positive feelings of euphoria and well-being with perception of control and control and reduction of negative feelings such as anxiety, depression and anger. Martin points out that there is little evidence of long-term psychological benefits of exposure to comedies or laughter sessions over a period of days or weeks. He argues at the same time that such a state of affairs may be related to the fact that humour is not integrated into the daily experience of research participants. He also suggests that it is possible that humorous interventions would be more profitable if they were to increase the frequency of humorous situations and laughs spontaneously during everyday interactions, influencing the way people react to current experiences, thus affecting more effective regulation of emotions. It would probably require training people to adopt

a more humorous outlook on their daily lives and to create humour in their interactions with others.

Laughter therapy in the day care department for neurotic and personality disorders

The Day Care Department for Neurotic and Personality Disorders of the Psychiatry Clinic of the Medical University of Wroclaw uses group psychodynamic psychotherapy as the main method of treatment. Groups are closed and last for 12 or 13 weeks. Every day on weekdays there are 2 group therapy sessions of 1.5 hours each with a half-hour break. Sessions have a fixed structure, for the first 45 minutes, one of the patients has a group session with one of the 2 therapists (selected by the patient), the next 45 minutes are devoted to reflections and free comments by the group members. One day a week is devoted to nonverbal activities in the form of psychodrama, games and play. To assess the suitability of laughter, we included it in non-verbal activities as one 1.5 hour long session.

We decided to introduce laughter in the second part of therapy cycle when the symbiotic needs of the group would weaken and the following would occur: the individuation, the distance to individual and group experiences, and the therapeutic alliance. We were concerned that in the initial phase of therapy where symbiotic and paranoid threads predominate, the participants would use humour therapy as a way to relieve transient frustration, as it is usually the case in early nonverbal sessions.

Our next doubt was whether laughter therapy would not violate the growing individualism and the withdrawal of the symbiotic needs of the depressive process. In the final phase of therapy, regression and separation processes are emerging which could be potentially disrupted too. Finally, we included laughter therapy in the second session of the 8th week of therapy (that in total lasts 12 weeks). Patients were informed about laughter therapy session at the beginning of the whole therapy and later during the session preceding it. The participants of the group during previous psychodrama in spontaneous expressions expressed a great curiosity about the laughter therapy which aroused their imagination.

During the first session, the patients participated in the psychodrama titled "Conversation with my father" which triggered feelings of sadness, emptiness and longing. Some patients experienced that psychodrama in very intense way, hence we wondered how laughter therapy would affect the group process and the experiences of individual patients. The laughter therapy was led by a laughter therapist, a qualified humour researcher. She prepared the following activities

for the patients:

- watching „Mr Bean" (episode: Do-it-yourself), eating popcorn, drawing a plan of own flat using left hand and exchanging the drawings with other patients in order to guess the meaning of particular elements of the drawings
- watching a sketch by Ireneusz Krosny titled: „Jesteś szalona" [You are crazy] and inventing in groups of 4 funny walks
- tasks for groups of 2 or 3:
- playing mini table tennis
- playing in maxi badminton
- slalom forward and backwards between skittles carrying an egg on a giant spoon
- playing „Twister"
- reading a book with jokes
- creating stories using names of random items placed in the box(sling, deodorant, tights etc.), reading own story in front of other patients

It is important to note that that particular laughter therapy did not mention patients' problems. None of the tasks concerned patients' illnesses, feelings or experiences. During laughter therapy the chairs were rearranged in a circle, patients sat close to each other, their chairs touched. The relaxed form of the session, freedom in choosing activities, encouraging patients to experience different activities stimulated spontaneity, creativity and clearly relaxed the patients. It was a novelty for the patients that the therapist waited for all patients before starting the session. It was a message that participation of each and every patient was important. Carrying out the tasks required from patients on different planes and taking up different postures: exercises on the floor, curling up, hunching, extending arm high above one's head, standing on toes, sitting on the chair, walking backwards. In order to freely play maxi badminton, some patients moved to corridor (just outside the room).

Our observation showed that at the beginning of the session (when watching the film) only few patients reacted to it with laughter. Those were the patients who were able to contain different contradictory emotional states or dissociated themselves from negative emotions, trying not to experience them. The possibility to eat popcorn facilitated adaptation to the session convention. Patients shared popcorn with each other and took on a role of cinema viewers more easily. Later

during that session all patients, except one, took active part in the activities. They spontaneously formed groups. At the beginning they selected group members based on who they liked, however later patients who were usually in oppositional relationships, started cooperating too. It was clear that it was the most fruitful cooperation, awaking lively positive emotions. Patients encouraged and invited each other to participating in subsequent tasks. With time we noted that the type of chosen activity became more important for the patients than the fact who they performed it with. There was a lot of noise during the session but the patients were not bothered by it. Some patients enjoyed moving, changing bodily positions. We observed some competition, a need to test oneself in terms of physical fitness. Moving during the session triggered positive emotions and gave a boost of energy even to withdrawn patients.

Observing the session from behind a two-way mirror, we had an impression that patients were experiencing levity, were spontaneous and full of energy characteristic for childhood. In the context of earlier psychodrama session and longing for father that occurred in the group, the laughter therapy resembled playing with a parent.

The day after the laughter therapy, the patients during the initial round expressed a willingness to participate in a laughter therapy again. They talked about the activities that took place during the laughter therapy, they commented on spontaneity and involvement of other patients who were not that spontaneous earlier. The patient who did not take part in the laughter therapy session was criticised for lack of openness by a patient who took part in the laughter therapy superficially and with a big unconscious fear requiring unwinding. Both of those patients used projection and in a situation of great tension exhibited paranoid reaction. The patient who expressed the criticism left to do individual work showing lack of trust to the group. She talked about defences by distancing and formalizing and the fear of direct contact. The therapists understood the patient's reflections were the result of a confrontation with her own spontaneity experienced during laughter, and individual work with therapist was the means to reduce fear of revealing spontaneity. The individual decisions of group members are always "immersed" in a group context, so it can be assumed that the group as a whole was facing anxiety over fun and the experienced joy.

In the following days, individual sessions were attended by people who were previously characterized by large, paranoid, or passive-aggressive resistance. They talked about the need for close contact, trust and care as well as the frustration of those needs resulting from their anger,

grief and resignation. They referred to the paradoxical and incomprehensible, in their opinion, discrepancy between perceiving loved ones as good and bad at the same time. The statements of the patients did not yet contain a synthetic ambivalence, but rather a relation of good and bad experiences, clearly mentioned together, which predicted the beginning of the process of acquiring ambivalence.

The reaction of the group in the days following laughter sessions had an oscillatory dynamics - immediately after the classes, the controlling superego suppressing the expression of joyful, libidinal experience was activated. Patients in the day care department of neurosis are deeply psychologically traumatized, and in order to function in everyday life, they separate traumatic areas by means of defence mechanisms: envy, denial, displacement, splitting, projection and dissociation. During the laughter therapy session the patients dependent on the laughter therapist were encouraged and, more clearly, "seduced" by the prospect of fun and joy. After the laughter session they went home, stayed with their own experiences, and being unable to maintain a cheerful mood, they activated normal defences. The sessions the next day after laughter therapy were with other therapists, which further aggravated the shame and guilt (they were having fun with another person), and became angry with the patient who did not participate in laughter (who remained "innocent"). Therapists accepted the laughter experiences which reduced the blocking activity of the superego. It is worth mentioning, however, that the therapists contained the controlling group reaction of the superego, giving patients freedom, but they themselves had trouble processing it, which resulted in its displacement to a supervisor with restrictive psychoanalytic orientation. The consequence was the separation of the therapeutic team into "permissive" part and "restrictive" part and long discussions between them.

It seems that laughter unlocked in some patients a combination of conscious experiencing with unconscious good experiences, previously suppressed or denied. Those good experiences were too painful to survive (due to their sparsity) and were dissociated. Laughter, to a certain extent, allowed them to return and, consequently, strengthen the integration process.

Conclusions

Despite therapists' concerns, the laughter therapy session was well received by the patients. They willingly took part in it, did not resist it (apart from one paranoid patient who consistently refused to take part in all nonverbal activities). At the beginning, while watching 'Mr Bean', we noted a transitional phase characterised by boredom, anger and resistance that yielded to amusement- still during the film. The patients resembled sad, resentful children who finally let parents amuse them.

It is important to note that the laughter therapy session was run by a qualified humour researcher so it was not joking during therapy described by Bloch or Kubie [14, 15]. It was similar to situation described by Sheesley et al [16], where laughter therapy (not humour or joking during therapy) increased the efficiency of social phobia treatment [16].

Patients' reactions showed that laughter therapy can serve to rediscover their inner child (see Patterson [17] and Miller [18]). Humour due to its link to play can provide a temporary return to a child's world and this can give patients momentary levity and restore their ability to enjoy playing [19]. After all „in humour and in play the superego takes a holiday!" [20, p. 17].

Humour provides a psychological liberation [21], which in the aforementioned laughter therapy session was expressed in patients' enthusiastic and involvement in the activities. It is possible that their behaviour was not just caused by a playful and innovative session format but also the lack of some elements characterising other therapeutic sessions such as analysis problems of individual patients. Thus the presented laughter therapy provided a dual liberation. Firstly, it liberated patients from thinking about their problems. Secondly, it provided a liberation from a typical therapy. It can be argued that a laughter therapy can be a counterbalance to the rest of sessions in a group therapy. It is some kind of springboard not only due to its form but also content.

Nevertheless, the differences between ordinary therapy and laughter therapy may represent a 'discotheque after funeral" to the patients. This can cause extreme emotions in patients- firstly euphoria and then anxiety or sadness. An occurrence of enjoyment straight after experiencing sadness, resentment and anger was a precious emotional experience relativizing negative mood. Thus in future laughter therapy could be distributed more evenly for instance by implementing some activities from laughter therapy into other therapeutic sessions. Humour then could serve as a way to communicate and discuss different problems thus it could help patients on a daily basis to look at their problems from a different, more positive perspective (see Goldin and Bordan [13])

and as suggested by Martin's [2] teach patients how to use humour in everyday life.

Nasr [12] notes that humour and laughter are underutilised and underreported in therapy partly because they represent a burgeoning research area. Future research can broaden our knowledge about benefits of using humour in therapy especially if they describe both short and long term results of humour use and take into account patients' opinions.

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E-mail address: maria.kmita@umed.wroc.pl