Laughter and Humor in the Therapy Room and the Impact on Security, Reliability, and Compassion

Sally Openshaw

Keynote Address
8 May 2025
International Integrative Psychotherapy Association (IIPA)
12th Professional Education Conference:
Security, Reliability, Compassion: The Essence of Integrative Psychotherapy
Ljubljana, Slovenia

Abstract

This keynote was chosen because there is a paucity of literature on the topic of humor use in therapy. The presentation identifies humor as a therapeutic skill and provides the reader with some ideas around competence and incompetent use in therapy. When humor is used purposefully, it enhances connection, but when used without thought, it can create distance and confusion.

Keywords

Laughter, humor, disparaging, competence, incompetence

My interest in laughter and humor began as an oncology nurse, looking after children with leukemia. I learned about Patch Adams, the clown who worked in hospitals and laughed with children. The impact he had on their wellbeing and on their broken immune systems was evident.

A few years later, I became a teacher of nurses, and my manager had a PhD in humor therapy. She always sent memos with cartoons on them, and she was fascinated by the impact of humor on learning. She made it her mission to get laughter into the nursing curriculum. As part of our team building, self-care, and tension relief, she held laughter lunches once a week. It was one of the busiest jobs I have done, but it was also the one where I felt the least stressed and most connected to the team. I think the glue that bonded us all was that shared laughter.

Later, when I did my MSc in human sexuality, I decided to explore this topic further in my thesis. I looked at the process of trainee sex therapists learning about the use of humor as a therapeutic skill. I had noticed the danger of using humor in couple work that Schnarch (1990) warns about. He suggests humor can be experienced as hostile and sarcastic, can unbalance alliances, and can be a high-risk venture. I support his view, having noticed humor can disrupt therapeutic relationships when couples were in conflict and there was no humor between them. Attempts at humor, by either party, or myself, were often misunderstood as attacks or hurtful comments and were often powerfully reacted to. They created distance and anger. Over time, and as communication and therapy continued, I noticed by about session six the humor was returning. It was less of an explosive bomb in the therapy space but rather something that brought connection, shared fun, closeness, and playfulness. With sex therapy clients, the humor was generally used differently. It was used to cover anxiety, awkwardness, and embarrassment and as an avoidance of the pain (Openshaw, 1995).

Falk and Hill (1992) categorized the type of humor used by therapists using grounded theory and identified 11 key groupings:

1. Revelation of truth – to challenge assumptions the client has about themselves, others, or nature.
2. Exaggerated/simplification – the therapist exaggerates or over-simplifies the client's situation or understatement of fact, thoughts, or feeling.
3. Surprise – the therapist brings up something unexpected.
4. Disparagement – therapist ridicules the client, putting them down, mocking or criticizing at the client's expense.
5. Release of tension – the therapist uses humor with tension-filled or tabooed subjects.
6. Incongruity – the therapist creates a comic affect by juxtaposing two or more ideas or frames of reference that are not typically put together.
7. Word play – the therapist uses words in a way that is foolish, nonsensical, inane, puns, or slapstick.
8. Non-verbal humor – the therapist uses facial expression, posture, or other nonverbal clues to impose a comical edge to interventions.
9. Anecdotal – the therapist relates a funny story or parable that highlights the universality of human experience to aid understanding.
10. Other humor – therapist statements that contain humor but do not fit anywhere else in the list.
11. Non-humorous interventions – therapist interventions that are not humorous.

Falk and Hill's categories can be useful when we want to evaluate our use of humor in our therapy. For instance, we can find many of these types of humor in the classic comedy sketch "New Therapy," in which Bob Newhart plays a psychotherapist meeting a new client who is worried about being buried alive in a box (Leddy, 2001). The therapist sets out clear conditions for the shared work and then proceeds to give advice. His advice, which he screams at the client, is to "STOP IT!" He repeats this advice to every new problem she presents. She objects, until eventually he says that if she does not do the work, then she *will* be buried alive in a box.

In this sketch, the therapist uses exaggeration, sarcasm, surprise, novelty suggestions, disparaging comments about her making notes, incongruity, nonverbal humor with his facial expressions, and reveals some truthful statements to the client. The sketch is an example of how *not* to use humor in therapy; it is so extreme that it makes the audience laugh for its nonrelational approach.

What I discovered in my research was that there was a paucity of literature to guide people on the therapeutic use of humor. The training course did not address this topic as a part of either verbal or non-verbal communication. The trainees in my research (Openshaw, 1995) felt ill-prepared and acknowledged that initially they made some terrible mistakes using humor to relieve tension (usually their own). They also learned that if humor was used to cover up their own countertransference, it was unhelpful and led to therapeutic rupture in the relationship. When humor was spontaneous and not purposeful, when there was no consideration of therapeutic gain, it often ended up being seen by the therapists as sarcastic or a put down that added distance; laughing at, rather than with, the client (Openshaw, 1995).

The literature also showed that humor can be aggressive and shocking and can lead to misunderstandings (Kubie, 1971). This view is supported by Mann (1991), who adds that disparaging humor is elusive. Usually, it is a display of power dynamics, including ridicule, put down, and one-up and one-down positioning. Prejudice and judgement often manifest in humor use. This sort of humor use will not increase safety and will have an edge that is not compassionate.

When the humor was reliable and worked well in therapy, my sample of trainees found it increased connection and closeness, built rapport, provided a shared sense of an "us," became a short-circuit to self-awareness (often uncovering the ridiculousness in habitual behavior) (Cade, 1986), created an atmosphere of play, provided a sense of perspective, and provided a gentle insight. It allowed emotional freedom of expression and created spontaneity and lightness that were welcomed (Openshaw, 1995).

In my research, I included supervisors' views to triangulate the material provided by the trainees. The supervision feedback identified the following themes as a way of measuring therapist reliability and competence with humor. They agreed that a competent learner is aware of their own sense of humor, is confident using humor in practice, is natural when using humor, uses it to facilitate rapport, can provide rationale for its use, is aware of impact on clients and their responses, and can evaluate the effectiveness of it as an intervention (Openshaw, 1995). This is purposeful humor use—a compassionate way to be with your client.

In contrast, an incompetent therapist uses humor as a means of avoidance or diffusing essential tension. This unhelpful use of humor has patterns of repetitious use (may be reliably used but not with good purpose), is cruel or sarcastic, puts others down, or becomes part of power struggles. It demonstrates poor self-awareness and confuses clients (Openshaw, 1995).

Let me give you a clinical example of an incident where a connected "us" was created. I had a client who was using my collection of animals for a piece of work on family systems. She picked up one and talked about how it represented her mother. She said she did not know what this animal was—an interesting metaphor for how she experienced her own mother as being changeable, hard to know, inconsistent in her form, and unpredictable. I looked at this animal, and I said (in all seriousness), "I do not know what this animal is called." I acknowledged with compassion how true this was for her real experience of her mother. She asked me to hold the animal and get it away from her, to contain it, to put it into a cage.

She passed the creature to me. As I was building the fences to erect around the animal, I was curious to know if this animal had a name. I turned it over to read what was written. I said, with great confidence, "Oh! it does have a name—it is a madachino, I've never heard of that."

There was a pause, and then she started to laugh. It got bigger and louder, and I found it infectious myself joining in, even though I still did not know what was so funny for her. The moment felt very shared and connected. Eventually, through her tears of joy, out through guffaws, she said, "Made in China!" Note to self—I must wear my glasses for fine reading.

That connection was so important to her: laughing together brought closeness, she saw my own ridiculousness, and she referred to her mother as Made in China for the rest of the five years of our joint therapy. It eased her pain to hold this connected shared memory of laughing with me alongside the loneliness and pain of the inadequate mother she had experienced. In that moment we played together, we shared the freedom that Abrams (1997) suggests is essential for connection.

Making space for that small part of us and enabling an inner child release (Hart, 2024, p. 278) is a perfect antidote to the inner critics who say: "don't be silly, pipe down, that's stupid." Humor and laughter are exactly what the inner critic does not like. Play is done for its own sake—it's not about achievement. It stimulates imagination. The shared joy is in the moment—the shared doing and being together and not about competence or task or finishing or achieving.

Let us look at the relational nature of laughter: noticing who is around and how they look. Now I ask that you make a purposeful effort to raise the corners of your mouths. Just feel the change, let the corners rise up, notice how it feels, notice any memories that come forward, notice the people around you whose mouth corners are turning up, and notice the impact on connection.

Now let us take this a bit further. Pick someone sitting next to you. It does not matter if you speak different languages—laughter usually transcends language. Decide who will be person A and who will be B. Person A has the task to make person B laugh only by using their facial expression and any noise they want. The task of person B is to resist until they can't anymore.

Now switch over: person B makes person A laugh.

What do you notice in your body? How did the laughter of others impact on you? What did it do to you when the other person did not join you in laughter? Smiling begins at six weeks in babies. From a few weeks old, a baby's laugh can be hopeless and uncontrolled. Watching

YouTube clips of babies laughing can be a useful resource for some clients. Laughter is a pre-verbal means of communication. By nine months children have already learnt how to use humor in an exaggerated way. At five to six years old, children are at the age when they naturally laugh the most.

We cannot rely on the presence of laughter to let us know that humor is present between us and our clients. Laughter has been categorized into seven subsections by Giles and Oxford (1970), and in appreciation of this work, there needs to be understanding of the motivation behind the laughter in each unique circumstance. We need to inquire, and we sometimes need to stand back and not join, particularly when the laughter is avoidant or part of a shame response. (I will laugh at myself before the pain of you laughing at me.)

1. Laughter is a humorous response (find it funny)
2. Laughter is a social response (expectation to laugh from others)
3. Laughter is an ignorant response (not getting the joke—cover our ignorance)
4. Laughter is an anxious response (teasing)
5. Laughter is a derisive response (put another down)
6. Laughter is an apologetic response (self-deprecation)
7. Laughter is a tickling response (physical response) (Giles & Oxford, 1970)

Laughter has an impact on our bodies. It makes people feel good. A real good belly laugh can make cortisol drop by 38%, decrease adrenaline by 70%, and increase endorphins by 29% (Hart, 2024, p. 275).

Hart continues to say one to two hundred laughs a day are equivalent to 10 minutes jogging, and she identifies this as her preferred form of exercise. Laughter helps relaxation, improves circulation, and releases natural endorphins into the body circulation. The immune system is positively affected by laughter. Even fake laughter has the same effect, which is why yoga laughter is becoming popular.

We need to consider relational security when we use laughter with clients. Shearer (2016, p. 22) warns us that when emotional suffering and distress stifle the patient's capacity for humor, then therapists may well tread softly indeed, for fear of being misperceived as mocking or cruel. This would not enhance a sense of safety. Eastop (2021, p. 91) helpfully reminds us that we have to be attentive to the transferential issues that arise between us and our clients. The relational history of needs met, and not met, and the client's patterns of accommodation and coping provide a here-and-now guide to the client's current needs in the therapeutic relationship. You can watch for examples of this in practice, seeing the client who laughs or smiles at something that is painful—this is learned behavior of accommodating what others may need and want and the avoidance of their own painful experience inside.

This is why I encourage you to inquire about laughter, humor, and joy in clients' lives. An assessment of their sense of humor is one way to relationally attune to your client, to really understand what appeals to them, what makes them smile, and what sorts of humor build connection and prevents distance between them and another. Some of the inquiry questions I use are: What appeals to their sense of humor? Who are the people they laugh the most with? How is it for them to be around people who they can laugh with and feel safe? What does it do to their sensations in their bodies? What impact does it have on memories they create? What were the "funny" stories that got told over and over again in their family (and were they actually funny)?

My family tells the "funny" story of how my two-year-older brother gave me petrol to drink when I was a baby in a pram. That story was never funny; it was about neglect, not noticing danger, and not protecting me.

I remember the teasing at school; it was not kind, it was not respectful. I remember my protests and the retort: "Can't you take a joke?" Yes, I can, but that one was not funny. Developmental sense, models of humor in your family, and responses from others to laughter and joy are such important experiences to understand. Discover the client's sore spots—the sort of humor that has a powerful impact—then track back along the significant incidents that caused them distress and pain. As a therapist, we need to pay attention to past experiences

where shaming through careless or purposeful humor use has occurred. Birkebaek (2014, p. 38) writes about how shame can drive us out of relationships. She identifies that a child can conclude "something is wrong with me." This can be reinforced by an audience who joins in with the joke at the expense of the child. This opens up the space for clients to tell their story, to be heard, to express their pain, and to have their experiences validated. This exploration can help them see the gap where a protective other could have been to stop this level of ridicule.

Laughter memories can also be reliably used to stimulate a positive mood state and change in body experience. Ask a client to remember a positive experience that can be used as a resource. This resource can be used as a positive memory by the therapist if the client needs to return back to their window of tolerance, or it can be used by the client for the same purpose when away from the therapy space. In trauma work this can be a useful distraction to help return the person into a window of tolerance if they have been triggered by a memory. It is possible to pendulate between the trauma memory and the humor memory as a way of expanding tolerance, to stay with the pain of the trauma.

I have a strong positive memory from when I was 12. We were at my grandparents' place for Sunday lunch. It was quite a formal occasion. In the gap between courses, one of my brothers told me that my Grandma was turning into a raspberry. He whispered, take a look at her chin, and sure enough tiny little hairs were sprouting. I noticed a giggle beginning, and at that moment I caught my brother's eye across the table. He lifted one brow as if to say, "See? Told you so." As my grandmother began to serve up pudding, I saw the raspberries. That was it. I lost it. My giggle got out of control and started to escape, and the more I was asked why I was laughing, the more I lost control. I tried to hold it in, but the force was too much. Biting my cheek did not help; it had to come out. There was no way I could tell them all what was so funny. Even now, when I serve up raspberries, I think of her chin and my love for my naughty brother, and I smile to myself.

How about we end with some yoga laughter. I am going to divide the room into two parts. Section A: your job is to go as deep as you can and say the words "Ho, ho, ho!" Section B: you are to go as high as you can, and say the words "He, he, he!" Let's just practice that. OK, now I am going to complicate it by adding in section C. Section C: you need to add "Ho, ho, ho, he, he, he, zigger, zigger, zigger, la, la, la, ooh." The brain does not know the difference between what is real and imagined.

"The trouble with humor is that not enough therapists take it seriously" (Mann, 1991). I think this quote is important because Mann is suggesting we look at this issue with a serious eye on our own competence. We need to consider the purposeful use of humor as part of our own skill set. We need to critique our own uses within therapy session and identify therapeutic gain from using humor between ourselves and our clients.

I support the view expressed by Ravella (1988) that the opportunities created by humor do not lie in the dictate that we should use it, but in the realization that we do not need to avoid it.

I invite us to look at skillful use of this human condition in our work and here at this event. I wish for you all that you find moments of laughter and joy over the next few days, lock your internal critics up in your hotel room with a kind minder, and let there be healthy play at this conference.

Sally Openshaw is a Certified International Integrative Psychotherapist, Trainer, and Supervisor. She works in private practice in the UK. She specializes in working with people with sexual and relationship difficulties. She is currently semi-retired to enable her to have more time to write a book on erotic transference and counter-transference.

References

Abrams, R. (1997). *The playful self: Why women need play in their lives*. Fourth Estate.

Birkebaek, R. (2024). The journey from shame to self-agency. *International Journal of Integrative Psychotherapy*, *15*, 37–42.

Cade, B. (1986). The uses of humor in therapy. *Family Therapy Collections*, *16*, 64–76.

Eastop, D. (2021). Schizoid phenomena and relational needs. *International Journal of Integrative Psychotherapy*, *12*, 89–113.

Falk, D. R., & Hill, C. E. (1992). Counsellor interventions preceding client laughter. *Journal of Counselling Psychology*, *39*(1), 39–45. **https://doi.org/10.1037/0022-0167.39.1.39**

Giles, H., & Oxford, G. S. (1970). Towards a multi-dimensional theory of laughter causation and its social implication. *Bulletin of the British Psychological Society*, *23* (79), 97–105.

Hart, M. (2024). *I haven't been entirely honest with you*. Penguin.

Kubie, L. S. (1971). The destructive potential of humor in psychotherapy. *American Journal of Psychiatry*, *127*(7), 861–866. **https://doi.org/10.1176/ajp.127.7.861**

Leddy, B. (2001, May 12). New therapy (Season 6, Episode 24) [TV series sketch]. In D. Salzman (Executive Producer), *Mad TV.* QDE.

Mann, D. (1991). Humor in psychotherapy. *Psychoanalytic Psychotherapy*, *5*(2), 161–170. **https://doi.org/10.1080/02668739100700211**

Openshaw, S. (1995). *An exploration into the process of learning about the use of humor as a therapeutic skill by a group of trainee sex therapists* [Unpublished master's thesis]. Southbank University & University of London.

Ravella, N. F. (1988). The serious business of humor in therapy. *Journal of Strategic and Systemic Therapies*, *7*(2), 35–40. **https://doi.org/10.1521/jsst.1988.7.2.35**

Schnarch, D. M. (1990). Therapeutic uses of humor in psychotherapy. *Journal of Family Psychotherapy*, *1*(1), 75–86. **https://doi.org/10.1300/j085V01N01_07**

Shearer, A. 2016. *Why don't psychotherapists laugh? Enjoyment and the consulting room*. Routledge.