

**Humor in Therapy:
Expectations, Sense of Humor, and Perceived Effectiveness**

by

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Abstract

Research has shown that humor holds valuable power to increase psychological well-being. The present study explored: (1) the perceived effectiveness of humor as a therapeutic tool based on the social influence model; and (2) how the relationship between self-reported sense of humor and ratings of counselor attractiveness, effectiveness, and expertness is moderated by expectations of humor in counseling in a non-clinical sample. Participants completed a measure of expectations of humor in counseling, the Multidimensional Sense of Humor Scale, and also completed the Counselor Rating Form-Short Form in response to two brief excerpts from therapy sessions which demonstrated humorous and non-humorous therapeutic interventions. Research questions addressed the relationships between sense of humor and ratings of counselor effectiveness (including attractiveness, trustworthiness, and expertness); and the differences in these relationships at different levels of expectation of humor in counseling. Results indicate that there is a significant relationship between sense of humor and ratings of counselor effectiveness for some humorous therapeutic interactions. There also emerged significant moderating effects of expectation of humor on the relationship between sense of humor and counselor ratings for CRF-S total scores as well as for scores on expertness and trustworthiness for this vignette. Responses to open-ended questions highlighted mixed reactions to use of humor in psychotherapy, and indicated that it may be an intervention to be used with caution.

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Hooray! Huzzah! It's finally done!
Post-Dissertation life has now begun—

My family and friends will sure be surprised
When I call them up and have no whines
About format, confusion, and SPSS—
(I owe them for helping me through my distress...)

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Table of Contents

Abstract.....	ii
Acknowledgments.....	iii
List of Tables	vi
List of Figures	vii
Chapter I: Introduction	1
Chapter II: Literature Review	7
What is Humor.....	8
Functions and Benefits of Humor	13
Humor and Individual Differences	18
Counseling and Humor	21
Perceptions of Therapists.....	35
Counselor Effectiveness and Outcome	38
Summary of the Literature.....	51
Purpose.....	52
Research Questions	53
Chapter III: Method	55
Development of the Expectations about Humor in Counseling Scale.....	55
Development of Humorous and Non-Humorous Clinical Vignettes.....	56
Participants.....	58

Measures	60
Procedure	62
Chapter IV: Results	64
Chapter V: Discussion	81
References	91
Appendix A: Demographic Information	105
Appendix B: Expectations about Humor in Counseling	107
Appendix C: Vignettes X1 & X2	112
Appendix D: Vignettes Z1 & Z2	117
Appendix E: Counselor Rating Form-Short Form	120
Appendix F: Multidimensional Sense of Humor Scale	123
Appendix G: Recruiting Materials and Information Letters	125

List of Tables

Table 1: Description of the Variables	64
Table 2: Pearson Correlations between Counselor Rating Form-Short Form scores and Expectation of Humor in Counseling Scale scores	64
Table 3: Relationships between Counselor Rating Form-Short Form scores and Multidimensional Sense of Humor Scale scores.....	66
Table 4: Multiple Regression of Total CRF-S score.....	71
Table 5: Multiple Regression of CRF-S Expertness score.....	73
Table 6: Multiple Regression of CRF-S Trustworthiness score.....	75

List of Figures

- Figure 1: Interaction of Expectations about Humor in Counseling and Multidimensional Sense of Humor Scale scores on Vignette X2 Counselor Rating Form-Short Form-Total Scores 72
- Figure 2: Interaction of Expectations about Humor in Counseling and Multidimensional Sense of Humor Scale scores on Vignette X2 Counselor Rating Form-Short Form-Expertness Scores 74
- Figure 3: Interaction of Expectations about Humor in Counseling and Multidimensional Sense of Humor Scale scores on Vignette X2 Counselor Rating Form-Short Form-Trustworthiness Scores 75

I. Introduction

*Humor is the great thing, the saving thing after all.
The minute it crops up, all our hardnesses yield, all our irritations,
And resentments flit away, and a sunny spirit takes their place.
--Twain, 1897*

Statement and Significance of the Problem

Humor has a long-standing position as an element of health in many realms. In popular culture, literary and entertainment figures tout the importance of humor in navigating the struggles of their characters and in their real-life experiences (Chopra, 2008; Davis, 2008; Twain). In medical communities, humor is noted as an important feature of bedside manner, relationship forming, recovery, pain management, and physiological health (i.e., digestion, biochemistry, muscle strength) (Adams & Mylander, 1998; Berger, Coulehan, & Belling, 2004; Cann & Calhoun, 2001; Godfrey, 2004; Mauger, 2001; Sala, Krupat, & Roter, 2002; Scott, 2007; Thorson & Powell, 1993b). These benefits of humor are explored further below.

Within the mental health community, the use of humor is not widely accepted despite findings and anecdotal evidence that humor can be a healthy way to perceive the world and cope with distress (Amada, 1993; Bennett, 1996; Ellis, 1977; Goldin, & Bordan, 1999; Goldin, et al. 2006; Kubie, 1971; Kuhlman, 1984; Lemma, 2000; Maples, et al., 2001). There seems to be a difference between the potential benefits of humorous therapeutic interventions, as found in the literature, and their reported use and endorsement. This is a problem because one aim of mental health providers is to aid clients in developing the cognitive and emotional resources to

cope with life's stressors. The absence of humor from a therapists' repertoire of techniques may be a dis-service to clients who would benefit from humorous interventions.

There are, likely, many factors that contribute to this gap. One of the main problems is the paucity of research empirically supporting the use of humorous interventions. While some research exists regarding specific populations (i.e. individuals with schizophrenia, women with personality disorders, substance abuse clients) (Golan, Rosenheim, & Jaffe, 1988; Megdell, 1984; Rosenheim, 1989; Rosenheim & Golan, 1986) and their reactions to humorous therapy techniques, there remains little to no empirical evidence that reflects the usefulness of therapeutic humor within the general population. Some of the reasons for this include humor being difficult to pin-down, the interventions being regarded as risky in the professional population due to possible harm, and a general uneasiness or stigma around talking about humor within professional communities (i.e., ideas such as: therapists aren't supposed to laugh, or if you're laughing, you're not doing real work in therapy) (Kubie, 1971; Lemma, 2000; Sinason, 1996).

Within this overall idea of effectiveness of therapeutic humor there are individual variables that may have a role in explaining some of the variance in effectiveness scores. One of these variables is the sense of humor of the individual. Research has shown that sense of humor scores are linked to life stress, coping, anger, personality correlates (e.g., extraversion, introversion, openness to experience), and depression (Cann & Calhoun, 2001; Cann, Norman, Welbourne, & Calhoun, 2008; Casado-Kehoe, Vanderbleek, & Thanasiu, 2007; Martin, 1998; Roesch, Wee, & Vaughn, 2006; Thorson & Powell, 1993a; Thorson & Powell, 1993b), but there is no research that explores links between sense of humor and therapy or perception of therapeutic effectiveness. Just as other interventions are found to be well-suited for clients with particular personality traits and communication styles (Westwood & Ishiyama, 1990), humor

may be an empirically sound intervention for clients who perceive themselves as high on sense of humor.

Considering humor as a therapist quality, it is important to remember that perceptions of therapist qualities may also influence ratings of effectiveness. Cultural ideas about therapists are thought to influence perceptions about acceptable therapist behavior (Lemma, 2000). It is possible that stereotypes of stoic, unresponsive therapists may also drive some of the hesitancy to embrace humor by the public and the professional therapeutic community. The relationship between public expectations of humor as a good therapist quality and therapist use of effective humorous techniques has not been explored directly.

Expectations have been found to play an important role in many areas of human interaction, including counseling and psychotherapy. Client expectations about their role and the counselor's role in therapy have been found to relate to effectiveness of treatment and satisfaction with outcomes. Unrealistic client expectations have been found to be detrimental to the therapeutic process, including premature termination, poor therapeutic alliance, and lessened counselor influence (Tinsley, Bowman, & Barich, 1993). A deeper understanding of client expectations of humor in therapy is needed.

Humor in itself is often referred to as a social lubricant, meaning that it eases social situations and interpersonal relationships. Evolutionary perspectives discuss the development of a sense of humor as a necessity for survival in social beings (Tierney, 2007; Weisfeld, 1993). With humor under the umbrella of social interaction, the therapeutic effectiveness of humor can be easily examined within the social influence model of therapy (Strong, 1968). This model (explored in detail below) acknowledges the importance of social cues and status as an element of any human relationship, including that of therapist and client.

By exploring all of these variables—individual differences in expectations of humor in therapists, self-reported sense of humor, and perception of therapist effectiveness—we can gain a more complete understanding of some of the possible benefits of therapeutic humor. We can also build on the existing literature to identify some of the client variables that may predict usefulness and effectiveness of humorous therapeutic interventions with clients. Ultimately, this study raises awareness of perceptions of humorous interventions in the general population, and enhance the current theoretical, speculative, and anecdotal literature with empirical support.

Context of the Literature Review

The current literature on humorous therapeutic interventions provides mixed results. Among specific pathological populations (schizophrenic and neurotic clients), only those that had experienced humor in therapy previously found humorous interventions to be effective (Rosenheim, 1989; Rosenheim & Golan, 1986). The authors speculate that individuals who had never experienced humor in therapy did not expect it and, therefore, did not rate it highly. Conversely, a qualitative investigation of the experiences of current clients revealed that clients enjoyed the humor in therapy and those that did not experience humor in therapy wished that they had or reported terminating therapy due to the lack of humor (Bennett, 1996). These clients reported that humor was something that they valued in their daily life, and therefore, in therapy. One study of college students found that humor intended to facilitate counseling was as effective as no-humor, and more effective than non-facilitative humor (Foster & Reid, 1983).

The literature review that follows provides a framework for the present study and the theoretical underpinnings of why some clients might respond more favorably to humor in the therapeutic process than others. Theoretical frameworks for humor and sense of humor are briefly explained, as well as a review of the research to date concerning the various dimensions

of the sense of humor and its correlates with health, mental health, and personality. In addition, humor's significance to the mental health field and psychotherapy is explored from both the advocates' and the opponents' perspectives about this controversial intervention.

It seems that humor—as a useful tool or as an instrument of harm—transcends theoretical orientation. For this reason humor in therapy can be studied as an element of social influence within any theoretical framework of therapy. The role of social influence in humor and in therapy is explored as a transtheoretical model for therapeutic effectiveness.

Purpose of the Current Study

As mentioned above, literature from various fields of health and psychology suggest that humor is an important element of being human and being healthy—mentally, physically, and interpersonally. Within the field of psychology and mental health, one of the goals is to utilize interventions and increase skills that will help clients increase satisfaction in the parts of their lives that are not meeting their needs—mentally, physically, and interpersonally. It seems, then, that there is a connection missing between humor, which has been empirically proven to be healthy in many ways, and therapy. This study expands on the research of Foster and Reid (1983) that found humorous interventions to be equally effective as no-humor in therapy. The present study looks deeper at those that rate the use of facilitative humor to be effective by identifying key individual differences (expectations about humor in therapy & sense of humor) that may be used to identify individuals who would benefit from humor in therapy. This study also expands the age and regional data on humor and therapy by using online data collection methods that will reach a larger segment of the population than previous studies of humor in therapy.

The present study explores the extent to which personal expectations of humor in therapy and sense of humor influence ratings of counselor effectiveness.

II. Literature Review

Laughter is the jam on the toast of life. It adds flavor, keeps it from being too dry, and makes it easier to swallow.
— Diane Johnson

The average adult laughs less than 17 times in a day; the recommended ideal is 200 times (Maricopa Advanced Technology Education Center, 2006; Scott, 2007; Stuart, 2007). People want to be the funny one so badly that 81% of college students rate themselves as having an above average sense of humor (Cann & Calhoun, 2001). Humor has been connected to a number of important human functions—social acceptance, coping, and physical and mental health, among others (Cann & Calhoun; Casado-Kehoe, Vanderbleek, & Thanasiu, 2007; Martin, 1998; Tierney, 2007; Weisfeld, 1993). The benefits of humor are seen in infants (Bergen, 1998; Nelson, 2008), across cultures (Kalliny, Cruthirds, & Minor, 2006; Lemma, 2000), and across species (Weisfeld). Due to the varied and far-reaching benefits associated with humor, it has become a subject of much theoretical and research literature as health professionals and social scientists try to define it, measure it, and find out where it comes from so that we can get more of it. While results of investigations show that links between humor and health are strong (Cann & Calhoun; Godfrey, 2004; Thorson & Powell, 1993b), acceptance of studying and endorsing therapeutic humor in mental health has been less than overwhelming. The medical community more openly embraces these links, with some doctors incorporating humor into regular hospital routines (Adams & Mylander, 1998), and even regular physician visits (Godfrey, 2004; Sala, Krupat, & Roter, 2002). Some physicians incorporate elements of humor, such as a joke of the day, or writing prescriptions for humor, into their practice (Godfrey, 2004). Humor as a

therapeutic tool in the counseling setting, however, remains a controversial subject despite evidence that humor is a natural part of mental health (Casado-Kehoe, Vanderbleek, & Thanasiu, 2007; Franzini, 2001; Megdell, 1984; Richman, 1996) and interpersonal connection (Lemma, 2000; Nelson, 2008). The argument for training and using humor in therapy is one that is made repeatedly (Goldin, et al. 2006; Goldin & Borden, 1999; Richman, 1996), but there is little empirical evidence to support claims that humor is an effective tool that should be endorsed and utilized by counselors and psychologists regularly.

What is Humor?

It is no secret that humor comes in many forms, and can carry many meanings, which makes it hard to define (Bergen, 1998; Cann & Calhoun, 2001; Manke, 1998; Martin, 1998; Thorson & Powell, 1993b). Often people associate humor with behavioral cues, such as laughter. There are several problems with this tactic. The first is that there is no explanation for the cognitive process of getting the joke (Sultanoff, 2003; Thorson & Powell, p. 799). In addition, laughter itself very often has nothing to do with being amused. People laugh because they are nervous or afraid, as in troops going into battle (La Fave, 1972; Thorson & Powell), and people laugh as a social cue, or even to try to get ahead in the workplace (Tierney, 2007). In addition, physiological measures such as heart rate increase and galvanic skin response have been found to occur at times when individuals rate things as humorous, even when they are not laughing (Langevin & Day, 1972). Therefore, it is difficult to name overt behaviors, like laughter, as necessary and sufficient for humor because there are mental and physical responses to humor that are not overt.

According to the Oxford English Dictionary, humor is “that quality of action, speech, or writing which excited amusement; oddity, jocularly, facetiousness, comically, and fun” (2010).

Humor is all things, in all forms, that give us pleasure and enjoyment. Humans appear to be hard-wired for humor, in that we seek pleasure, starting with laughter and tickles at four months of age (Bergen, 1998; Peterson & Seligman, 2004; Weisfeld, 1993). Sultanoff clearly categorizes the elements of humor in noting that it “is a complex interaction involving...physiological response (laughter), emotional response (mirth), and/or cognitive response (wit)” (2003, p. 113).

Sense of humor, however, is an all-encompassing term that includes personal variations in all aspects of amusement. Different aspects of the sense of humor develop as a person is “rewarded”—socially or literally—in an area of humor (Thorson & Powell, 1993b). Humor appreciation and comprehension include being able to enjoy, interpret, or get the joke (Peterson & Seligman, 2004; Sultanoff, 2003; Thorson & Powell). Humor creation involves developing jokes and is related to humor expression, which includes mainly behavioral measures of humor—laughter, smiling, verbal humor, slapstick humor, making captions for cartoons, etc. (Ziv & Gadish, 1989). Individuals who excel at creating humor have been noted as scoring high on intelligence tests and, it has been argued, meet the criteria for giftedness (Fern, 1991).

Coping using humor involves facing difficult situations by finding something amusing in them (Freud, 1960; Peterson & Seligman, 2004; Thorson & Powell, 1993b). Investigation of comedians, clowns, and children gifted in humor production often reveals childhood trauma or familial unrest (Fern, 1991; Martin, 1998). Self-awareness is an element of sense of humor that includes the individual’s perception of herself and the extent to which she embodies the other aspects of humor discussed here—i.e., able to get or generate humor (Decker & Rotondo, 2001; Thorson & Powell). Research on sense of humor and sense of self reveals that being considered a humorist by the self and peers is related to a higher self-concept in females (Ziv, 1981), and also that humor is one way that human services workers (firemen, correctional officers, etc.) are able

to better make sense of immediate events in the broader environment (Tracy, Myers, & Scott, 2006). Sense of humor, then, is highly individual, influenced by both environment and biology (Bergen, 1998; Carbelo-Baquero, Alonso-Rodriguez, & Valero-Garces, 2006; Kalliny, Cruthirds, & Minor, 2006; Manke, 1998; Martin, 1998; Payne, 2005; Thorson & Powell, 1993b; Weisfeld, 1993; Wilson, Rust, & Kasriel, 1977).

Research and assessment of sense of humor often examine one aspect of sense of humor (i.e., appreciation) on a continuum from high to low (Thorson & Powell, 1993b), often in regards to specific types of humor—self-depreciating, aggressive, affiliative, sexual, incongruent, word play, positive, negative, etc. (Holmes & Marra, 2006; Kalliny, Cruthirds, & Minor, 2006; Weisfeld; Wilson et al 1977; Yip & Martin, 2005). A more comprehensive measure of the sense of humor comes from Thorson and Powell (1993b), and aims to measure a wider range of elements that may be present in a person with a good sense of humor. The Multidimensional Sense of Humor Scale (MSHS) draws on past research and measures the following elements of the personal sense of humor: 1) humor production and creativity; 2) playfulness and sense of whimsy, *joie de vivre*, the ability to have a good time; 3) the ability to use humor to achieve social goals; 4) recognition of humor; 5) appreciation of humor; and 6) use of humor as an adaptive or coping mechanism (Thorson & Powell.). This measure reflects the notion that the sense of humor is far-reaching, influencing the person's way of viewing the world and serving many functions more than previous measures that provided information on only one dimension. There are many scales that measure single elements of sense of humor, for example, the Coping Humor Scale, the Situational Humor Response Questionnaire, and the Humor Styles Questionnaire (for a comprehensive list of humor scales, see Peterson & Seligman, 2004).

Sense of humor is more like a way of being in the world, an attitude towards life and a general temperament. In this way, our ideas about sense of humor are influenced by the ancient idea that temperament, mood, and health are affected by the four main fluids, or humors, in the body (Oxford English Dictionary, 2010). Hippocrates, Plato, and Aristotle were among some of the first to contribute to the humeral theory of disease (American Institute on Unani Medicine (AIUM); Wooten, Nutton, & Arikha, 2007). In this model, illness is caused when there is an imbalance in the four bodily humors: blood, phlegm, yellow bile, and black bile. These ideas permeated the medical community in Greece, Rome, the Middle East, and in Elizabethan times in Europe. Some healing philosophies still use these ideas of balance as a cornerstone in the practice of medicine even today, such as Unani and Aruvedic medicines (AIUM; Wooten, Nutton, & Arikha, 2007). This grounding in the medical use of humor is the foundation for the use of the word humor as an indication of personality or mood (e.g., He is in good humor). Each of the four humors corresponds to a personality type: blood—sanguine, yellow bile—choleric, phlegm—phlegmatic, and black bile—melancholic (Holmon, 1980; Wooten, Nutton, & Arikha, 2007). So, in this model, Hamlet, who is described as melancholy, would be thought to have an imbalance caused by too much black bile. The audience is aware of the type of person who is melancholy and can make some judgment about his mannerisms, personality, and sense of humor (Wooten, Nutton, & Arikha, 2007). Similar constructs are used even today to describe people, with an emphasis on their humor, or way of being in the world (i.e., hopeful, angry, apathetic, calm, depressed) (Oxford English Dictionary, 2010). A person's humor can influence her reputation and interactions with others, as evidenced by research involving the social aspects of humor (Holmes & Marra, 2006; Peterson & Pollio, 1982; Tierney, 2007).

In addition to defining the constructs of humor and sense of humor, there have been many theoretical explanations for why people find different things humorous. These theories fall into three main categories; Psychoanalytic, Incongruity, and Superiority/Disparagement.

Psychoanalytic theories are based on Freudian ideas of humor as a defense mechanism to avoid unpleasant emotions and as an expression of repressed drives—i.e., a person who finds aggressive humor funny normally represses aggression (Freud, 1960; Martin, 1998). Research in this area, however, has found evidence that suggests the opposite—people endorse types of humor that are *expressed*, not *repressed* (Martin).

Incongruity theories focus on the cognitive aspects of humor and thinking of two events in a new or unexpected way. This kind of humor makes ties between right and wrong, and can be used to teach moral and social standards to children. Monro (1988) highlights an example of this in a play on words from Oscar Wilde, “Working is the curse of the drinking classes,” which is incongruent from the original saying, and also provides an opportunity to look at social norms (para. 14). Studies using these theories have found links between humor, creativity, and intelligence (Casado-Kehoe, Vanderbleek, & Thanasiu, 2007; Martin, 1998).

Superiority/disparagement theories are based on the notion that people will laugh at or make jokes about those who they consider to be inferior (McGhee & Lloyd, 1981). Research in this area has found some evidence that members of a group will laugh more at jokes about another group—e.g., men laugh more at jokes about women, rich people laugh about poor people, and White people laugh about Black people (Martin, 1998). Effects of humor have also been found to vary across situations and humor has been found to correlate with measures of self-esteem (Martin; Weisfeld, 1993). These theories begin to speak to the functional aspects of humor.

Functions and Benefits of Humor

The human race has one really effective weapon, and that's laughter. --Twain, M.

Humor serves many functions for humans. In the advertising world, humor is used as a tool to increase ad memorability (Kellaris & Cline, 2007). People tend to respond favorably to humor that is relevant to the product being sold and unexpected (i.e. the Taco-Bell Chihuahua or a famous athlete with a milk-mustache) (Kellaris & Cline). Similarly, using humor in educational settings has been found to create a positive learning environment and promote retention of material (Dziegielewski, Jacinto, Laudadio, & Legg-Rodriguez, 2003). More universally, humor helps us meet some of our evolutionary human needs.

Social realm. As the theoretical explanations of humor suggest, it has multiple functions beyond helping us enjoy ourselves. Viewed from an evolutionary standpoint, humor and laughter play an important role in social development, which is essential for human survival. Laughter helps youngsters learn to play with one another and stimulates euphoria circuits in the brain (Tierney, 2007). This play that seems to occur only when a child feels safe, often involves tickling. This helps us learn to defend our vulnerable and sensitive areas when we do not feel safe (Weisfeld, 1993).

The socialization that begins with shared laughter as a social lubricant (Manke, 1998; Martin, Puhlik-Doris, Larsen, Gray & Weir, 2003; Tierney, 2007) grows into other kinds of jokes and word play that also teach valuable lessons for getting along in life. For example, through humor we learn social norms that help gain acceptance (Weisfeld, 1993). Laughing at someone with toilet paper on their shoe is funny because that is not where toilet paper belongs (incongruity) and also provides a lesson about the importance of being aware of your surroundings and personal appearance.

Humor is often used to define and strengthen social groups (superiority/disparagement). Negative humor, like ridicule or mockery, aimed at other groups establishes who is an outsider (Tierney, 2007). Positive humor or shared jokes can stimulate laughter that strengthens rapport, morale, and cohesion within a group. In the workplace, this often means increased productivity and is a measure of good leadership (Holmes & Marra, 2006). In group therapy, humor aimed at an other that is not in the group (society, another group, etc.) facilitates more group work than humor that targets a group member (Peterson & Pollio, 1982).

Laughter also seems to stimulate a sense of emotional connectedness in a way that is not as threatening or awkward as displays of other emotions (i.e. sadness). In describing the atmosphere on the set of a comedy, Green noted that

There is something that almost feels more intimate about laughing with people than crying with them. Because crying almost feels dirty in a way when you don't know someone very well. But when you're laughing, there's something connecting everybody in the room. (Davis, 2008, p. 39)

Humor in the medical community. Within the medical world, doctors are trained on bedside manner, and patient satisfaction is reported to be higher with physicians who incorporate humor into office visits (Sala, Krupat, & Roter, 2002). Patch Adams, a physician intent on offering humor and fun as a component of any healthcare has created the Geshundheit! Institute—the first silly hospital (Adams & Mylander, 1998; Berger, Coulehan, & Belling, 2004). Other prestigious hospitals have followed suit with humor wards, carts, and clown units (Adams & Mylander). More subtle uses of humor in the medical setting suggested to put clients at ease and create a more relaxed atmosphere include joke-a-day calendars, smiles-to-go jars (filled with quotes, anecdotes, and jokes to take with you), encouraging construction of Humor First Aid Kits (a la Norman Cousins, see below), and writing prescriptions for laughter along with medication (Godfrey, 2004).

In addition to environmental effects, laughter has been shown to have positive effects on healing and body systems. Laughing and humor increases the flow of feel good chemicals in the brain (i.e. endorphins, catecholamines), and lowers cortisol levels, which means less stress, and can stimulate the immune system (Adams & Mylander, 1998; Cousins, 1979; Mauger, 2001; Scott, 2007). All of this research is on the heels of Norman Cousins' account of his personal prescription of Marx Brothers movies to alleviate the pain of his terminal illness, stating that "10 minutes of belly laughing leads to two hours of pain-free rest" (Adams & Mylander; Berger et al., 2004; Cousins, 1979). The positive effects of the laughter, a positive atmosphere, and high doses of vitamin C helped Cousins recover from an illness that his doctors believed would be fatal.

Humor and mental health.

Tragedy requires less knowledge of the human heart than comedy. --Madame de Stael

A great deal of evidence establishes a relationship between humor and increased levels of personal well-being. Lenny Bruce is credited with the equation that "laughter = pain + time" (Chopra, 2008, 11; Zaslow, 1999) which highlights the role of humor in coping with life's stresses in a healthy way. Humor as a coping mechanism is linked to the ability to create distance from a stressful situation, and is a component of successful aging (Martin, 1998; Thorson & Powell, 1993b). Longitudinal studies found that mature defenses, including sense of humor, predict greater levels of mental and physical health, life satisfaction, job success, and marital stability, as well as less mood disturbance in stressful times, and the ability to see obstacles, such as exams, as challenges rather than threats (Cann & Calhoun, 2001; Cann, Norman, Welbourne, & Calhoun, 2008; Martin). Findings using the Multidimensional Sense of Humor Scale (MSHS) also suggest that there is a positive relationship between age and humor creativity, coping humor,

humor appreciation, and a more favorable outlook towards humor in general (Thorson & Powell).

Additionally, humor training among college women has been found to reduce anger levels (Thorson & Powell, 1993b). As noted previously, the resilient effects of humor have been examined in professional comics and clowns who report having negative family situations as children, and developing their humor as a means for gaining support and coping with stress (Fisher & Fisher, 1981 as cited in Martin). Positive coping skills are widely accepted as indicators of “good” mental health and resiliency, and it seems that humor has been treated as a positive coping skill in many ways (Cann, et al., 2008; Casado-Kehoe, Vanderbleek, & Thanasiu, 2007).

A study of 7th and 11th graders found that humor can be used as a way to act out for someone not so self-assured (as in a psychoanalytic defense mechanism), or as a sign of creativity in a high-functioning, self-assured person (Martin, 1998). Therapeutically, this aspect of humor makes it an effective assessment tool, or intervention starter. Engaging in dialogue with the client about *why* something that they did or said was funny can provide clues about their intellectual development (Bergen, 1998). Also, in more Gestalt methods of intervention, calling attention to humor behavior (e.g., “I noticed that you laugh as you tell me about your low test score...”) is one way of helping the client raise self-awareness (Corey, 2005). In addition, positive correlational relationships have been found between sense of humor scales, ego strength, and reality testing in clinical populations (Banmen, 1982). Mike Myers, a well-known comedian, reflects on his training in comedy and in the philosophy that “comedy equals truth and truth equals spiritual growth... ‘ha-ha’ is related to ‘ah-ha,’ the sound one makes upon the realization of truth” (Chopra, 2008, p. 11).

These elements of humor make it an effective therapeutic tool (Manke, 1998). Teaching people how to “let a smile be [their] umbrella” (Thorson & Powell, 1993a, p. 13) through approaches that use humor in problem focused therapy and cognitive restructuring is linked to greater life satisfaction in Asian and Caucasian American samples (Roesch, Wee, & Vaughn, 2006). More sophisticated or elevated use of humor points out the ridiculousness of striving for perfection, or expecting it from others (Rothstein, 1999), and is related to higher levels of self-esteem, less discrepancy between real and ideal self-concepts, and greater stability in self-concepts over time (Martin, 1998). Maslow even posits that a healthy appreciation of non-masochistic or superior humor is characteristic of self-actualized individuals (Martin), and the ability to laugh at oneself is considered healthier than laughing at others (Thorson & Powell, 1993; Weisfeld, 1993). These findings, combined with developmental ideas about humor evolution (Bergen, 1998; Weisfeld, 1993), as well as the evidence that sense of humor scores increase with age (Thorson & Powell, 1993a) seem to indicate that time is an important factor in human development of different kinds of humor appreciation. Sense of humor has also been found to be directly related to levels of depression (Porterfield, 1987). This indicates that a sense of humor and using humor to cope with daily living is an important tool for increasing and maintaining mental health.

Hampes (2005) found significant relationships with different kinds of humor and clinically significant characteristics in college students. Shyness and loneliness were associated with higher levels of self-deprecating humor and lower levels of affiliative humor and self-enhancing humor. These findings are significant to the current research because individuals who seek help from counselors and therapists often report loneliness and shyness (and the things that

go with them—i.e., poor social skills, negative affect) as part of their presenting problem. Humor modeling and training in therapy, then, may be important tools in working with these individuals.

Summary

Historically, humor has been an important part of the human condition. Definitions of humor are complex and include both things that are humorous as well as descriptions of sense of humor and personality or temperament. In addition, humor has been found to have several evolutionary and health benefits that enable us to learn skills (e.g., making friends, learning social norms) and maintain physical and mental health (i.e., coping with stress, increasing the immune system). The theoretical explanations for the function of humor in humans include humor as a defense mechanism, humor as a method for creating social groupings, and humor as a way to highlight inconsistencies. These theoretical groundings for humor seem to point to humor as a natural candidate for use in counseling and psychotherapy as a way to facilitate self-exploration and change.

Humor and Individual Differences

With so many benefits associated with humor, saying, “He has a grand sense of humor’ is almost synonymous with: ‘He is intelligent, he’s a good sport, and I like him immensely’” (Martin, 1998, p. 15). Since humor appears to be a widely prevalent, functional aspect of human existence, it is no surprise that the idea of humor as an element of personality emerged as early as 1798, when Kant included humor in variables to the *sanguine* temperament (Ruch, 1998). From Kant through the ages, personality characteristics have been attributed based on elements of humor. In theory and in research, humor is repeatedly linked with different aspects of personality variation. Freud’s theory of the comic, for example, maintains that those with a greater sense of humor have a less demanding and critical superego, demonstrate supportive

parenting in childhood, use less neurotic defenses, and are more readily able to take on a less serious frame of mind and escape the stress of adulthood (Martin, 1998).

Everyone, it seems, has ideas about what goes along with having a great sense of humor. These ideas seem to be desirable, and many people rate themselves as having above average senses of humor (Cann & Calhoun, 2001). Cann and Calhoun conducted a study to find out what other personality traits are assumed to go along with having a “well-above average,” “typical,” or “below average” sense of humor. Those deemed “well-above average” were thought to be imaginative, creative, friendly, pleasant, clever, sociable, fun-loving, soft-hearted, and good-natured. In terms of the Big Five personality characteristics as measured by the NEO-Five Factor Inventory (extraversion, neuroticism, openness, agreeableness, and conscientiousness) (Costa & McCrae, 1992), hypothetical individuals identified as having a “well-above average” sense of humor scored high on agreeableness and extraversion, and lower on conscientiousness. Hypothetical individuals labeled as “below average” on sense of humor were thought to be lower on openness and high on conscientiousness traits like organized, self-disciplined, and neat.

The results for these hypothetical individuals do translate into real life. Studies of actual people and their sense of humor and personality traits reveal associations that are similar. High extraversion is related to high sense of humor in both the Big Five model and Eysenck’s Psychoticism Extraversion Neuroticism (PEN) model. Openness and, to a lesser extent, agreeableness and sensation-seeking are also positively related to sense of humor scores. High sense of humor scores also were related to lower scores on neuroticism and depression (Cann & Calhoun, 2001; Martin, 1998).

With results consistently in favor of the extroverts, one might be tempted to feel sorry for those lonely, depressed, humorless introverts. This, however, is not the case. More sophisticated

instruments that measure multiple dimensions of sense of humor, like the MSHS, are striving to debunk the all-or-none thinking about sense of humor. Eysenck (as cited in Martin, 1998) found that personality characteristics correlate with the type of humor enjoyed rather than presence or absence of a sense of humor. Extroverts were found to enjoy more sexual and simple jokes and introverts preferred more cognitive, complex, non-sexual jokes. Openness is related to sense of humor scores in general and also to type of humor appreciated. Individuals with high openness scores prefer nonsense humor and creating more humor, and individuals with low openness scores prefer incongruity-resolution humor (Martin). In addition, preliminary tests with adolescents reveal that humor use is not situation specific, and so it is possible that a person could score very high on a sense of humor measure, like the MSHS, and yet report very limited participation in humorous interactions (Manke, 1998). So, an introvert could very well have a very high sense of humor, but not engage in the observable behaviors as much.

A study of the MSHS (Thorston & Powell, 1993b) and the personality correlates found some other interesting differences related to humor. Some of the highlights include:

- Women generate less humor than men
- Women use humor to cope more than men, perhaps demonstrating Obrdlik's (1942) hypothesis that minorities use more coping humor
- Increased age correlates with increased humor creativity, coping humor, and humor appreciation
- High sense of humor scores correlate with less deference (respect for social conventions) and lower on order (propriety, organization)
- High humor—especially creation—is related to high dominance, found also by McGhee (1980) in children
- High coping humor and high humor appreciation relate to low aggression
- High humor scorers and lower quartile scorers demonstrate differences in outlook, use of humor for coping, and deference—low scorers are more cynical, and fit less into society
- Those who use coping humor more are less introspective
- In the highest scoring humor quartile, results showed less exhibitionism and less aggression compared to overall humor

These results are interesting in that those with the highest sense of humor scores overall tended to be drawn to less aggressive humor than the lower scorers. While results are correlational here, it could be argued that these results support Maslow's idea that an evolved sense of humor is related to a self-actualized person. This person would appreciate less aggressive, less discriminatory humor, while maintaining high levels of self-esteem, and mental health.

Summary

Research involving personality traits and humor/sense of humor reveal that having a good sense of humor is considered a desirable trait. High sense of humor is also related to some of the well-established "Big Five" personality traits, indicating high scores on openness, agreeableness, and extroversion and low scores on neuroticism and depression. Research with sense of humor scores, again, points to humor as an element of positive coping with life stressors and a positive outlook on the world. Humor as it interacts with personality structure and individual differences seems to be a worthwhile part of mental health and a method of alleviating stress and anxiety related to depression and other mental health problems. There is no research linking sense of humor to counseling outcomes.

Counseling and Humor

Two things seem clear about laughter in psychotherapy: it occurs; and it can have positive or negative effects on the therapeutic relationship and the therapeutic process.

--Nelson, 2008, p. 45

Given that humor has been shown to affect mental health and is an important element of personality differences, it seems natural that humor would have an established place in counseling and psychotherapy. There seems to be a rift, however, in the professional ideas about humor as a therapeutic tool—some boasting the positive effects, others warning of potential

dangers. These debates appear to be long-lasting, and based primarily on anecdotal and theoretical data.

The Advocates

Numerous individual psychologists have spoken out, advocating the use of humor in therapy and the techniques that they claim have been successful for them (Ellis, 1977; Goldin et al., 2006; Lemma, 2000; Nelson, 2008; Richman, 1996). It is interesting to note that the advocates of therapeutic humor represent a variety of theoretical orientations and styles (i.e., Ellis is the creator of rational Emotive Behavior Therapy, Freud is the father of psychoanalysis, Adler is the founder of Adlerian therapy, Lemma is a psychoanalytic therapist, Franzini represents behavior therapy, Schnarch is a marriage and family therapist, Watzlawick is a creator of brief therapy for families). The use of humor seems to be transtheoretical—with no theory stating that humor cannot be used in intervention.

A study of behavior therapists found that many of them endorsed formal use of humor (Franzini, 2000). It has also been said that traditional psychoanalytic therapists find humor useful, as did Freud, who often used the favorite joke technique to access inner thoughts (Banmen, 1981; Franzini; Freud, 1960). Ellis (1977; Halasz, 2004) spoke strongly in favor of the use of humor for Rational Emotive Behavior Therapy (REBT) as a means to increase self-awareness. Humor seems to fit with his ideas that “psychopathology consists of taking life and ourselves too seriously...and...that a major purpose of psychotherapy is to undermine people’s over-seriousness” (1977, p. 262). Humor is also applicable in cognitive-behavioral therapy, as a way to raise awareness of a client’s irrational cognitive processing (Richman, 1996). Adler regarded humor as an effective tool to keep “tension in treatment as low as possible” (Rutherford, 1994, p. 212) and as a way to model handling life stresses in a lighter way. Viktor

Frankl employed humor in logotherapy through use of “paradoxical intention” in which the client and therapist join forces in making fun of the symptom (Lemma, 2000; Richman, 1996). One example of this is instructing depressed clients *not* to laugh at a joke because it does not fit with symptoms of depression (Rutherford, 1994). Humor techniques used in conjunction with existential therapy have been praised as beneficial for increasing “holistic health” (Maples, et al., 2001, p. 58) with clients from diverse backgrounds (Native American, Latino, and African American). Korb (1988), a psychoanalytic therapist noted that humor is a tool that can facilitate the “unraveling of the unconscious and the integration of the elements thereof with the conscious” (p. 50). She speaks to humor as an invitation to open deeper content that was not coming out with other interventions.

Many definitions of therapeutic humor have emerged in the last 50 years. The Association for Applied and Therapeutic Humor (AATH, 2000, Homepage, para. 5) endorses therapeutic humor as

Any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life’s situations. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual. Specific interventions that have been categorized as therapeutic humor techniques include explicit joke or riddle telling, recognizing the absurd, extreme exaggerations, spontaneous punning, illustrations of illogical reasoning, therapist self-depreciation, repetition of amusing punch lines, demonstration of common human weakness, humorous observations of social interactions, critical humor to promote change—banter, teasing, and being provocative, using nicknames, and imagery (Bennett, 1996; Franzini, 2001; Kuhlman, 1984; Mosak & Maniaci, 1993).

Watzlawick (1983) identified healthy humor as the ability to laugh at a situation or personal attribute in a therapeutic and non-defensive way. This is in line with Maslow's (Dziegielewski, et al., 2003; Martin, 1998) incorporation of humor and laughing at oneself in the definition of self-actualization. Allport also identified insight and humor—that is, being able to see oneself as an object—as key aspects of his mature personality (Allport, 1966). Similarly, Korb (1988) notes that humor is essential for growth and maturation. Lemma (2000) cites many experiences (her own and those of others) of psychotherapists in viewing this healthy humor as “a patient's capacity for humor as prognostically encouraging and its absence as significant...its presence indicates some degree of readiness to reveal the thoughts and feelings which it attempts to simultaneously disguise” (p. 152). This readiness to find expression for painful or difficult thoughts is a sign of ego strength and readiness to begin work. Some therapists may argue that only when a client is able to engage in comic pleasure is she ready to begin the work of therapy (Lemma, 2000). Similar thoughts are echoed by others who endorse humor as diagnostically significant in both assessing treatment needs as well as when it is time for termination (Dziegielewski, et al., 2003; Mosak, & Maniaci, 1993; Nelson, 2008; Schnarch, 1990). Many of these advocates endorse humor as a therapeutic technique similar to any other intervention, noting that it is a skill that can be trained and developed along with clinical judgment (Dziegielewski, et al., 2003; Lemma, 2000; Schnarch, 1990).

Therapeutic utility. Messer and Winokur (1980) note that different theoretical approaches to therapy may employ different treatment modalities and world visions, including tragic, ironic, romantic, and comic. This is in line with Bader's (1994) postulation that therapists with different theoretical orientations will most likely have different approaches towards the use of humor in

therapy. What is interesting, however, is the way that elements of humor are sewn into most of the different world views.

The discussion of world vision and its impact on therapy (Messer & Winokur, 1980) does not directly address the use of humor as a therapeutic intervention, however, three of the visions themselves—ironic, tragic, and comic—lend themselves to some of the various uses of humor as a therapeutic tool. It seems that in the ironic world vision, internal contradiction and paradox are highlighted (Messer & Winokur). These devices parallel one of the major traits of humor theory—incongruity. Recognizing the incongruities of the self and the human condition is an element of therapy and of mature, healthy humor. The idea of paradox shows up in clown therapy as well (Carp, 1998).

In the tragic world vision, “pain and pleasure are inextricably mixed” (Messer & Winokur, 1980, p. 823). In this view, humor (or pleasure) as part of an understanding and acceptance of emotional pain makes sense. Finding humor in the conflicts that are part of all human existence and the choices that we make in the midst of them, again, point to healthy, mature use of humor of the kind exemplified in Maslow’s (Martin, 1998) view of the healthy humor of a self-actualized person.

These two views—the ironic and the tragic—are linked by Messer and Winokur (1980) to a psychoanalytic frame. The humor in these conditions is more than just a happy ending; it is an ability to understand the complexities of life and being human and enjoy that understanding. This is a concept that lies at the base of many ideas about therapy, including becoming fully functioning (Adler, 1956; Carlson, Watts, & Maniacchi, 2006), becoming self-actualized (Maslow), and becoming psychologically mature (Allport, 1966).

The comic vision of the world is linked to behavioral therapy. Comic, in this sense not meaning funny or humorous, but more “familiar, controllable, and predictable” (Messer & Winokur, 1980, p. 823). This kind of comedy is akin to Shakespearean comedies that end in a marriage, or happy event—the way they are supposed to. The parallel to humor here would be more in-line with less sophisticated types of humor designed for a laugh and not necessarily a deeper understanding of the human condition—bodily humor, perhaps, or slapstick. The distinction made by Messer and Winokur seems to be one of getting better (psychoanalysis) vs. feeling better (behavior therapy). Each is found to have its place in therapy, often working in concert with one another. Broadening that line of thinking would recognize that many kinds of humor would have their place in therapy, shaped by the worldview of the therapist and the client, with clients choosing therapists that operate from a similar frame as themselves (Messer & Winokur). Some evidence of this was found by Bennet (1996) in his qualitative examination of humor in a small sample of current clients.

Bennet (1996) interviewed 30 clients and found that most reported some kind of humor in therapy. Analysis of the client comments revealed mostly positive reactions to humor in therapy, and revealed nine themes, including: 1. Humor helped clients change behavior in a positive manner; 2. Humor improved the relationship between the client and therapist; 3. Humor helped clients continue therapy; 4. Humor reduced tension or stress; 5. Humor changed clients’ perceptions; 6. Humor reduced client defense mechanisms or opened client to new ideas; 7. Humor was evaluated positively; 8. Humor was evaluated negatively; 9. Humor was not experienced in therapy. Those that reported no humor expressed that as a negative experience, indicating that they would have liked to have humor as a part of their treatment. Some clients indicated that they had terminated therapy with previous therapists due to lack of humor making

them feel uncomfortable. Therapists in this study indicated that they used both planned and spontaneous humor in working with their clients, and client reports demonstrate that they perceived and appreciated all types.

Simon (1995) explored his use of cartoons with images about broad human themes that are open to client interpretation as a tool for establishing the frame and goals for therapy. Open-ended cartoons—like other projective methods (e.g., Rorschach, Thematic Apperception Test)—are open to interpretation and can provide diagnostic insight as well as explore thoughts and feelings in a way that minimizes the power-differential and establishes rapport. A client reflected at the end of therapy that the cartoons “do relate to your own problems because they are truthful...it made me realize that if I can laugh about that, why couldn't I laugh about my own problems and do something about it” (Simon, 1995, p. 195). In this way, using the cartoons can help make daunting problems seem manageable.

This sentiment is echoed by Odell (1996) in explanation of his own Silliness Factor. While it is true that clients may have understandable fears and anxiety about therapy and therapists, Odell posits that a humorous therapist can send the message that their problem is not intimidating, instead, it is manageable. Silliness here is employed as a means of changing patterns and dynamics with individuals, couples, and families. Receiving a homework assignment to do something silly often presents an opportunity for disrupting problem patterns (Odell). Disrupting the patterns present in cycles is thought to be one important element of change in many theoretical orientations—such as family systems (Napier, & Whitaker, 1978) and object relations (Masterson, 1990). Silliness, or play, is an important part of building intimacy and communication in relationships (Dziegielewski et al., 2003) and has even been found to be more important to relationship satisfaction than sex (Casado-Kehoe, Vanderbleek, &

Thanasiu, 2007). In relationships with other people, playfulness that is not mean-spirited or demeaning can help de-escalate the stress response, communicate a sensitive point, increase creativity in problem solving, and refocus people in reality (Casado-Kehoe, Vanderbleek, & Thanasiu, 2007).

Odell (1996) also encourages the therapist to maintain a sense of humor themselves as a buffer against burnout and to keep their job interesting. Payne (2004) also does this in his review of the book *Quickies: The Handbook of Brief Sex Therapy* (Green & Flemons, 2004) as he reminds treatment providers that a silly title does not mean superficial content, and that humor interspersed in serious content can be therapeutic.

Humor can be used in therapy explicitly as an assessment tool. As mentioned above, ability to engage in humor can be an assessment of intellectual and interpersonal functioning (Bergen, 1998; Lemma, 2000; Mosak & Maniaci, 1993). Additionally, exploring a favorite joke or use of humor in the family of origin can be a gateway into other critical incidents or disputes in the clients' life (Freud, 1960; Korb, 1988; Lemma, 2000; Mosak & Maniaci, 1993). Knowledge of what a client or group laughs at or finds humorous, can "provide a good deal of insight into what [they] stand for and what [they] are trying to do, and such insight would seem a helpful addition to the interpretive skills of the therapist" (Peterson & Pollio, 1982, p. 49). Schnarch (1990) discusses client's use of humor and joke telling within therapy as a demonstration of the changes that were occurring in the client's life and the decrease in symptomology.

Humor in the therapeutic space can also be an experience that facilitates change, especially for clients who lack other positive interactions in their interpersonal lives (Lemma, 2000; Nelson, 2008). Well-timed, spontaneous humor provides a way of being with the client in

a real and human way that can allow for an “‘authentic’ meeting... communications that reveal a personal aspect of the self that has been evoked in an affective response to another” (Stern et al., 1998, p. 916). These affective responses are likened to developmental heightened affective exchanges or moments of meeting (Lemma, 2000; Nelson, 2008) that occur between babies and caregivers and are thought to aid the organization of emotional development and interpersonal interactions. These moments are created when there is an “element of surprise or unpredictability” (Nelson, p. 44) and both parties experience heightened joy and stimulation. Similarly, such moments in therapy allow the client to have a corrective experience, of sorts, where “each partner creates something unique and authentic” (Stern as cited in Nelson, 2008, p. 44) and can begin to facilitate change. In Adlerian Individual Psychology, these moments of human-to-human interaction in therapy spark social interest in the client and carry over into other areas of living (Adler, 1956; Carlson, Watts, & Maniaci, 2006). There are many kinds of action-oriented and experiential therapies that are incorporated into psychotherapy (i.e. cinematherapy, bibliotherapy) (Orchowski, Spickard, & McNamara, 2006). Humorous interventions can be seen as experiential because the client and the therapist are engaged in a real moment where learning takes place. This may be related to the heightened emotional response.

Within group therapy, humor has been found to have many positive effects on the group process and the work of a group. Gladding (2003) notes that humor has been found to help group members bond, relieve tension and hostility, encourage creativity, and add to a successful working phase. Scogin and Pollio (1980) found that long-lasting groups use humor more frequently and for longer amounts of time than groups that don’t last. Specific interventions in group therapy may invite members to share a funny experience around some insight. Similar to humor in other contexts, the goal of humor in groups is to take “advantage of paradoxes within

the group, discrepancies, the unpredictable, the unanticipated, universal truths, the absurd, and the familiar” (Napier & Gershenfeld, 1989, p. 408).

Peterson and Pollio (1982) found that humorous remarks that targeted others in groups can serve both therapeutically enhancing and distracting functions. Humor with other group members as the target seem to distract from the task at hand and draw the group away from effective work, while humor directed at someone or something not in the group enhanced the therapeutic work of the group (Peterson & Pollio). These findings endorse the idea that humor increases connections with others and can unite groups in a common purpose.

Many of the advocates for using humor in therapy provide personal successes with individual clients using humorous interventions. More often than not, these anecdotes relate some kind of interpersonal breakthrough with difficult or resistant clients in which a humorous event (by the therapist or client) created an opportunity for the therapist and client to join, therefore forming a therapeutic relationship (Korb, 1988; Lemma, 2000; Mosak & Maniaci, 1993; Nelson, 2008; Schnarch, 1990). A strong therapeutic relationship has been noted by many as one of the main factors of change in therapy, accounting for 30% of change (Greenberg, Constatino, & Bruce, 2006; Jonker, De Jong, de Weert-van Oene, & Gijs, 1999; Norcross, 2002; Thomas, 2006). Because of the importance of the therapeutic relationship, the contributions of humor to the building of that relationship—and relationships in general—warrant acknowledgement. Use of humor in relationships of all kinds is related to relationship satisfaction, closeness, and effective resolution of conflict (Cann, et al.,2008). Schnarch (1990) relates the use of humor in initial therapy as helpful “since most systematic patterns are multiply determined, the optimal clinical approach is a single intervention, having multiple impacts, congruent on each relevant dimension [rather than a series of unidirectional interventions]” (p.

77). Humor itself tends to consist of many levels—conscious and unconscious—and, therefore, can serve many purposes at one time: redirecting towards productive work, creating a pleasant experience, shared enjoyment, instillation of hope, and displaying empathy (Korb, 1988; Mosak & Maniaci, 1993; Schnarch, 1990).

There are many techniques or uses for humor in therapy, and a clinician may draw on any number of them depending on the client and the presenting problem. In this way, the use of humor in therapy is akin to the use of humor in advertising explored by Kellaris and Cline (2007) in that certain kinds of humor will work better among different audiences. These authors differentiate audiences on their Need for Humor—an individual difference that dictates how much energy a person will put into understanding the humor in a situation (Kellaris & Cline). There is no research that illuminates the differences in Need for Humor in audiences who find therapeutic humor to be effective.

The Opponents

While the use of humor in therapy is often commended by some, the support remains largely theoretical, editorial, or anecdotal in nature. There exists very little empirical evidence to strengthen the pro-humor argument. Anti-humorists argue that the dangers of using humor in therapy (e.g., inappropriate content, bad timing, different sense of humor, etc.) outweigh the potential benefits (Saper, 1987). Critics argue that the use of humor in therapy carries with it so many contingencies (i.e. therapist and client comfort levels with humor, strength of the therapeutic relationship, etc.) that there is greater potential for destructiveness and harm than for good (Shaughnessy & Wadsworth, 1992), and it is a technique that is best left untouched by therapists.

While there are positive aspects of humor in therapy and in general, the dangers of humor can be devastating. Just as humor can be used to strengthen group alliances, it can also be used to alienate others (Peterson & Seligman, 2004; Schnarch, 1990). Kubie (1971) points out that an atmosphere of frivolity may be off-putting to some clients, or that they may recognize humor as a façade for hostility and become confused by the therapists' words and actions. He also argues that using humor has the potential to lessen the therapists' credibility in the eyes of the client by humanization of the expert, or make the client feel under attack. In group therapy, groups are encouraged to notice how and when humor is used to ensure that it is not used as a distraction or as a way of insulting (Gladding, 2003; Peterson & Pollio, 1982), or perhaps sub grouping.

Still others are concerned that the work of therapy may be put on hold in order for the therapist to get to the punch line (Baker, 1993; Kubie, 1971; Pierce, 1994). Along these same lines, it may become difficult for some clients to see the message in the humor if it is not clear. Kellaris and Cline (2007) note that irrelevant humor used in advertising will often detract from the product so much that audiences remember the joke, but not what they were supposed to buy—resulting in a waste of time and resources for advertising. If the same idea is related to therapy, the client may remember the joke from the therapy session, but not how it relates to their presenting problem or therapeutic goals.

Some therapists resist reacting to humor generated by clients, as it is seen as a way for the client to distract from the work of therapy (Pierce, 1994). Engaging in surface-level jokes or banter that is not related to the presenting problem takes up time and energy in the therapeutic space (Goldstein, 1987). In fact, surface-level humor that was not related to client content was rated as less effective than no humor (Foster & Reid, 1983). In group therapy, clients use self-depreciating humor and humor targeted at other group members as a way to refocus the group

away from therapeutic work (Peterson & Pollio, 1982). In this way, humor is used as a manipulation tool or a way to stay distant from the work of therapy, to “not participate in conversation, a way of psychologically closing oneself off from the ongoing proceedings” (Goldstein, 1987, p. 9).

Common Ground

There is a consensus among the advocates and the opponents of using humor in therapy that humorous interventions are not appropriate for all clients. The use of humor with clients should be done with delicacy and awareness of timing and pacing, the client’s past, and the appropriateness of the joke (Maples, et al., 2001; Richman, 1996; Rutherford, 1994; Shaughnessy & Wadsworth, 1992). This is true for many kinds of therapeutic interventions that are considered risky, and therapists need to understand the individual differences that affect the overall effectiveness and utility of therapeutic humor. Currently, there is little research that explores the characteristics of individuals that respond favorably to humorous interventions. Facilitative humorous interventions were found to be as effective as non-humorous interventions by college students (Foster & Reid, 1983), demonstrating that there are individuals who find humor to be effective. These findings are supported by Bennett’s (1996) qualitative analysis as well as the anecdotal literature described above. Excerpts from participants in Bennett’s analysis indicate that individuals who value humor highly in their daily lives were more likely to terminate therapy due to lack of humor in the therapeutic setting and find the therapist ineffective. This high value on humor may be indicative of high sense of humor in these individuals, and would mean that high sense of humor could predict higher effectiveness ratings for humorous therapeutic interventions.

Some understanding of individuals who do not find humor effective in therapy has been found. There is some evidence that individuals with current symptoms of major depression experience and regulate their reactions to humor and other positive stimuli differently than individuals with no depressive symptoms (Reed, Sayette, & Cohn, 2007). These individuals seemed to quickly regulate positive reactions to humor and replace positive affect reactions (e.g., smiles) with negative affect reactions (e.g., sadness, frown). These results suggest that humor used with severely depressed clients would not be effective early in therapy, as the content may quickly be turned around or the pleasant effects discounted. There is also limited research with schizophrenic clients that shows that these clients prefer non-humorous interventions when asked to rate them, unless they have had previous experience with humor in therapy themselves (Rosenheim, 1989). This finding suggests that clients do not expect to have humor in therapy, and, therefore, assume that it will be ineffective as an intervention. Only those who had experienced the positive effects of a therapist who used humor found the humorous interventions more desirable. None of these studies included measures of sense of humor, so it is unknown what role the client's sense of humor has in these perceptions of effectiveness.

Summary

The debate about using humor in counseling and psychotherapy with clients has support from both sides—those who advocate for the use of humor and those who oppose it on the grounds that it is a dangerous and risky intervention. The supporters come from varied theoretical orientations, backgrounds, and continents. They cite personal experiences in therapy that have helped clients in a number of ways—from establishing or repairing a therapeutic relationship to redefining realistic expectations about what it is to be human. The opponents also represent an established group concerned about the potential dangers of using humor in

therapy—namely doing harm to clients through misunderstanding of the humor, and distracting from therapeutic work. Both the supporters and opponents of using humor in therapy note that it is not a technique that will be successful with every client, and therapists need to understand their clients before engaging in humor with them. There is a need for research that helps in understanding the individual differences of people who will and will not benefit from humorous interventions. Sense of humor is one such difference that may influence the effectiveness of humorous therapeutic interventions.

Perceptions of Therapists

People's perceptions of what a therapist is like may, in part, fuel some of the resistance to humor in therapy. The image of a stoic White man with a pointy beard, a couch, and a clipboard as a therapist may be changing given the emergence of new media that makes the process of therapy more accessible. Shows like "Celebrity Rehab with Dr. Drew" or "Sex with My Parents," both on cable television networks, give an inside view of some of the interventions that may happen in some kinds of therapy. Despite the efforts of informal Dr. Drew-type therapists in a transparent climate, the perception of a "therapist" as someone who very seriously and somberly probes hidden feelings and secrets persists. Many people continue to view therapists as cold or distant (Orchowski, Spickard, & McNamara, 2006), which is consistent with reactions that the current researcher has received when discussing this research on humor in the therapeutic setting. People often express surprise at the topic, insinuating that therapy is absent of humor.

Even in training programs, many students shy away from using humor with their clients—or at least hide those tapes from supervisors—for fear that they will be reprimanded

Lemma, 2000; Pierce, 1994). Korb, (1988) noted that “there is both conscious and unconscious suppression and repression out of fear of the ‘psychoanalytic police’ ... Sometimes when colleagues discuss humor they begrudgingly and defensively acknowledge its occasional use as accidental” (p. 48). Baker (as cited in Lemma, 2000) posits that the scarcity of literature about humor in psychotherapy may be a sign that therapists are more inclined to keep their use of humor private in order to avoid criticism. Even Kubie, the most often cited denouncer of humor in therapy, noted that his colleagues who advocate for humor will “almost never report his own humor in his account of therapeutic sessions. He forgets it, hides it, and reports seriously what he actually presented to the patient with humor” (1971, p. 865). Lemma herself (2000) conducted an informal qualitative survey of psychodynamic therapists, 60% of her sample indicated that they used humor in some way in their therapy, and 80% of those reported that they would be “very reluctant to share such interventions with their supervisors” (p. 122). Reasons for this included concern that using humor would be regarded as not working in therapy, or as avoidance of painful content and affect, and also that using humor would break the neutral role of the therapist. Among the reasons for not using humor included concern that it would be misinterpreted by the client, lack of opportunity, and also that it is “incompatible with an analytic attitude” (p. 123). Freud, in his formal writing, is known for advocating for firm boundaries and keeping the person of the therapist out of the therapeutic dyad (Lemma, 2000; Orchowski, Spickard, & McNamara, 2006; Sultanoff 2003). However, accounts from his clients and students repeatedly report that he often violated his own rules and interacted humorously with his clients (Goode, 2002; Korb, 1988; Lemma, 2000; Sinason, 1996; Shaughnessy, 1995). It is interesting that one of the major contributors to the current therapist stereotype did not conform to it himself. Lemma questions if the current training model discourages humor as a way of

connecting with clients in therapy. This internalization of the therapist as neutral and slightly inhuman may encourage these views in the general public, which creates further expectations that humor will not be present in therapy.

In addition to formal training, mainstream media may have a role in creating and maintaining the idea of the “therapist” as non-humorous. Orchowski, Spickard, and McNamara (2006) report that the media is often the main source of information for the public about mental health treatment. This contributes to “mental health illiteracy” (p. 506) regarding symptoms and appropriate treatment. Since 1906 therapists have often been portrayed in film as an easy way to learn a great deal about a character in a short amount of time. Film portrayals of therapy often give unrealistic snapshots of the work of therapy (e.g., showing quick fixes instead of long-term change), and dramatic—often unethical—therapist relationships. These dualistic images reveal mental health professionals to be either bad people who are cold, disorganized, and manipulative (Palumbo, 2008); or good people who fall in love with you or become your buddy. Public images of therapists do not clearly depict the process of therapy, leaving the general population to believe that all treatment involves advice-giving, and exploration of past trauma (Orchowski et al., 2006).

It is interesting to think how the messages from training programs and the media influence therapists’ ideas about themselves. Countertransference to the media images may impact a therapists’ own identity (Orchowski et al., 2006). In thinking about humor, it is possible that therapists themselves internalize these images of highly caricatured therapists and that fuels some of the hesitancy to embrace humor openly. Drawing from Messer and Winokur’s (1980) ideas about clients choosing therapists that share their worldview, it is easy to picture a potential client with a high value on humor or a high sense of humor as part of their worldview being

deterred from seeking therapy at all, given the common perception of therapists in the media. Sense of humor, for these individuals, is an important part of their identity and would, therefore, be an important part of a positive therapeutic experience for them. These ideas about therapists and therapy may influence expectations about counseling and therapists from clients have a significant impact on the effectiveness and outcomes of therapy itself (Greenberg, et al., 2006; Lambert & Barley, 2001).

Counselor Effectiveness and Outcome

While there is relatively little literature concerning humor in therapy, other controversial interventions that reveal an element of the personhood of the therapist have been explored. For example, therapist self-disclosure has been found to have positive effects under a variety of conditions (Fox, Strum, & Walters, 1984; Goode, 2002; Myers & Hayes, 2006). Clients have rated self-disclosure from their therapists as some of the most helpful interventions in therapy (Hill, as cited in Goode, 2002); and clients seeing therapists who self-disclosed were found to like the therapist more and show less distress after four sessions (Barnett & Berman, as cited in Goode, 2002). Despite the positive outcomes in therapeutic alliance and lowered distress, self-disclosure is regarded as a risky intervention due to the potential harm in refocusing the session on the therapist rather than the client and disclosing impertinent information, or engaging the therapists' countertransference to client issues (Hill, 2004). Self-disclosure and humor are further linked in that self-disclosure is sometimes seen as a genuine meeting between two people, and can create an intimate bond that helps the client feel more connected to the therapist and therapy (Goode, 2002). This is similar to the idea of moments of meeting described by Lemma (2000) in regards to humor.

Therapists that self-disclose part of their personhood (e.g., previous experience as a client in therapy), and engaged in these moments with clients were rated as more intelligent, likeable, warmer, and courteous—among other positive things—as well as seen as having a stronger therapeutic relationship (Fox, et al., 1984). Clients in this study expected more positive results from the therapists that engaged with clients as a person, and it is possible to expect that similar positive expectations would emerge from therapists using humor in a similar way.

Expectation

Expectations of ourselves and others are an important part of human interaction. As Yogi Berra once said, “I wouldn’t have seen it if I didn’t believe it” (as cited in Greenberg, et al., 2006, p. 658). Tinsley, Bowman, and Barich (1993) describe expectancies as “cognitively mediated predispositions to behave in a particular way in a given situation...therefore, expectations are important influencers of the perceptual process, judgmental processes, learning, and behavior” (p. 46). If a person believes or expects that something will happen, then they will view the world through a lens that is sensitive to information that confirms that belief or expectation, this is called a confirmation bias (Baumeister & Bushman, 2008). Research has shown that expectations play a role in many situations, including therapy.

Expectation has been referred to as somewhat of a self-fulfilling prophecy (Baumeister & Bushman, 2008; Levy & Leifheit-Limson, 2009) in many ways. Older adults primed with negative stereotypes about their cognitive or physical abilities performed worse than their peers who were primed with positive stereotypes (Levy & Leifheit-Limson). Similarly, women who were reminded of their gender or gender identity (female) prior to an assessment of their attitudes towards the arts or mathematics tended to demonstrate attitudes that were consistent to

stereotypes about women in these areas (i.e., women are bad at math; women are good at the arts) than participants in the control condition (Steele, 2006). In both cases, participants were reminded of positive or negative expectations related to groups that they belong to, and this expectation manifested itself in their performance.

Expectation has also been found to have an effect on success, especially in academics. Elliott (2009) reports on the importance of expectation to attend college in young children. This research discriminates between aspiration (i.e., the desire to do something) and expectation (i.e., the belief that is possible in reality), and found that most children aspire to attend college, while significantly less children expect to attend college. Expectation, in this case, is a better predictor of behavior than aspiration; children who expect to go to college are more likely to finish high school and actually attend college than those that aspire to attend college but do not expect it to happen (Elliott). The source of expectations is often external; for example, the stereotypes described above are often fueled by media messages, and parents have a role in creating expectations. Parental expectations for achievement in academics were found to have the strongest relationship of all parental involvement in children's academic performance (Fan & Chen, 2001).

People have also been shown to perform better when their expectations match the reality of the situation. For this reason, some institutions of higher learning implement a "Learning Contract" that explicitly outlines what students will learn and how they will learn it (Goodman & Beenan, 2008). This kind of contract is a "specific set of shared expectations between the students and the institution about learning" (Goodman & Beenan, p. 531). In a learning environment, having explicit expectations hold the institution accountable to provide what they

say they will, as well as enhance educational goals for students beyond broad, socialized expectations about college (i.e., the education will help me get a job).

Within therapy, as in education and performance, expectations are important predictors of treatment outcome and attitudes. One study found that African-American students at predominantly Black universities hold different expectations about counseling than African-American students at predominantly White universities (Kemp, 1994). Namely, students at predominantly Black universities expected more openness and responsibility, more acceptance, confrontation, direction, genuineness, nurturing, self-disclosure, and more tolerance, trustworthiness, and expertness than students at predominantly White universities (Kemp). The authors speculate that some of the difference comes from the expectation that at the White university, students will see a White counselor, and at the Black university, students will see a Black counselor. This research on expectancies may help explain why minorities make up only 10% of mental health clientele (Center for Mental Health Services (CMHS), 2004). If people are not expecting to have their needs met or feel comfortable, then it makes sense that they will avoid entering counseling or therapy at all. It also demonstrates how background and culture can impact expectation, and how expectation may play a role in not seeking treatment.

Individuals have expectations about what the client's role in therapy will be, as well as the role of the therapist (Glass, Arnkoff, & Shapiro, 2001; Patterson, Uhlin, & Anderson, 2008). These preconceptions may be shaped by personal experiences or cultural factors (e.g., media exposure, family attitudes towards counseling), and they may be flexible (Glass, et al.; Patterson, et al.), but they will have an impact on the course of treatment. Client expectancies have been noted to account for 15% of the outcome of therapy (Greenberg, Constantino, & Bruce, 2006; Lambert & Barley, 2001), and there is a large body of research devoted to various kinds of client

expectancies, including expectations for change, ideas about their self-efficacy for completing treatment tasks, ideas about what kinds of things they will be required to do in therapy, and what kinds of things their therapist will say and do (Glass, et al.; Greenberg, et al.). It has been argued that mental health facilities and practitioners should be aware of their client's expectations and attend to them in order to "reduce patient apprehension and enhance...effectiveness" (Hartlage & Sperr, 1980, p. 288). A survey of counseling psychologists in practice revealed that psychologists view unrealistic client expectations as detrimental to therapy most of the time (Tinsley, et. al., 1993). Counseling psychologists responded to problems with client expectations measured by the 17 subscales of the Expectations About Counseling-Brief Form (EAC-B), and reported that the most common unrealistic expectations are related to their personal commitment (i.e., how much work they—the client—will have to do in therapy) and counselor expertise/facilitative conditions (i.e., how directive the therapist will be, how nurturing the therapist will be, how much the therapist will self-disclose). These unrealistically high expectations were found to be detrimental to therapy for many reasons, including poor communication between client and counselor, premature termination, decreased motivation to work in therapy, and decreased influence of the therapist (Tinsley, et al., 1993).

Some research has explored the qualities that clients expect in a "good" or "ideal" therapist. Hartlage and Sperr (1980) found large overlaps in qualities that current clients found desirable and undesirable in therapists. Desirable traits that were endorsed by 50% or more of the participants included "makes a good impression, can be frank and honest, appreciative, friendly, helpful, big-hearted and unselfish, considerate, self-confident, sociable and neighborly, and warm" among others. Qualities considered undesirable (90% or more endorsement) in a therapist included "easily embarrassed, easily led, impatient with other's mistakes, bossy, shy, timid,

dictatorial, somewhat snobbish, and distrusts everybody” among others (see Hartlage & Sperr, 1980 for complete lists). Another study, conducted with a sample of inpatients in substance abuse treatment, revealed that their ideal therapists are described as dominant, extravert, responsible and not introverted or dependent (Jonker, et al., 1999). This research suggests that there is broad consensus around traits that are expected in an effective therapist, and many of them include positive traits that reflect the therapists’ personhood (e.g., friendly, sociable, extravert) and match with personality variables found to correlate with high sense of humor (see discussion above). Humor itself, as a trait, is absent from the list (“sarcastic” shows up in the undesirable traits, but sarcasm is not one of the methods of humor that are endorsed by advocates of using humor in therapy, as it often has as its goal to alienate or ridicule a target). It may be beneficial to explore the place of humor in client expectancies of therapists and how these expectancies influence the relationship between sense of humor and perceived effectiveness of humorous interventions. This knowledge can help shape interventions to maximize therapeutic effectiveness.

Many studies concerning expectations about counseling and individual differences have been completed using the EAC-B (Tinsley, 1980). For example, men with differences on a measure of gender role conflict were found to have different expectations about counseling (Schaub & Williams, 2007). Men who were restrictive in emotionality were found to have low expectations for their role in taking responsibility in therapy and high expectations for counselor directiveness and expertness. These kinds of expectations have been found to negatively impact the therapeutic alliance, as the men expect directiveness and the counselor expects the client to engage in therapy and self-disclose (Al-Darmaki & Kivlighan, 1993 as cited in Schaub & Williams, 1993). Men who reported high levels of success, power, and competition expected

higher levels of personal commitment, and also expected the counselor to respond in a very nurturing and expert way. Again, the men in the study may have unrealistically high expectations of the therapists' role in therapy, which can be detrimental (Tinsley, et al., 1993). These findings were replicated in a study that found that women and men score significantly different on 14 of the 17 subscales of the EAC-B, with men expecting higher levels of directiveness, empathy, and self-disclosure (Carter, 1996).

Craig and Hennessy (1989) found some evidence that expectations about counseling are related to an underlying and stable personality differences and stages of conceptual functioning. Clients at lower conceptual stages expected more direction from the therapist, while clients at higher levels expected to enjoy the counseling interview more and to like the therapist more. Clients in the middle stages of conceptual development expected more support, while those at other stages expected more self-disclosure and more friendliness (Craig & Hennessy, 1989). It is unclear how humor would fit into this conceptual framework, and what kinds of humor clients at different conceptual levels would expect or benefit from.

Effectiveness of an intervention is related to the client's receptiveness to it, which is based on their expectations (Glass, et al., 2001). It is possible, then, that clients who expect humor in a therapeutic setting will find a humorous intervention more effective. Research has also shown that individuals who have had therapy before have different expectations than first-time clients (Craig & Hennessy, 1989). This may also carry over into humor, as previous research investigating humorous interventions with clients with schizophrenia found that clients who had previously experienced humor in therapy rated humorous interventions as more appealing than other interventions (Rosenheim, 1989). It is unknown if this finding transfers to general populations. One study found that people with hysterical and depressive personality

types (as measured by the MMPI) had impartial reactions to humorous interventions, while obsessive personalities had negative reactions (Rosenheim & Golan, 1986). This study did not address previous therapy experience, client expectation of humor, or sense of humor.

While interest in the area of client expectations about counseling and counselors is high, and expectations are accepted as having an important impact on seeking treatment and effectiveness of treatment (Tinsley, et al., 1993), humor is not addressed in the literature as an element of counseling expectations. It is possible that low expectations of humor in counseling would keep someone from seeking treatment if humor is something that they valued. It is also possible that someone with high expectations of humor would terminate early or be dissatisfied with treatment if their expectations were not met (Bennett, 1996). Client characteristics also are important in forming expectations, and it is reasonable to believe that client expectations about humor in therapy interact with their individual differences, such as their sense of humor, in order to determine effective outcomes. Following the guidance of Hartlage and Sperr (1980), it is important to understand client expectations about humor in counseling in order to attend to them therapeutically.

Social Influence Model

Human beings are social creatures. We are influenced by those around us—their status, their mannerisms, their style of interacting. This social influence has been studied in a number of ways; some of the more famous examples of influence include Stanley Milgram's (1963) study of obedience and Asch's (1956) study of conformity and social desirability. In both of these landmark studies, the influence of an authority figure (Milgram) or a group of others (Asch) was shown to influence the behavior of the participant to act in ways that were contradictory to their moral or factual beliefs.). It is impossible for clients and therapists to escape the social influence

that they have on each other. The Social Influence Model (Strong, 1968) has been used frequently to study therapist effectiveness.

The social influence of helpers is highlighted by the power differential (perceived or actual) that clients might feel in the presence of a therapist—perhaps due to the therapists’ favorable reputation or other characteristic of social status (Egan, 1984). In social influence, a highly credible communicator will be able to persuade others to change their opinions and thoughts without causing the person to doubt themselves or have dissonance (Strong, 1968). Cognitive dissonance is the psychological discomfort that arises in a person when someone expresses an opinion that is different than their own. Reactions to cognitive dissonance include changing your opinion to match the other person, discrediting the other person, reducing the importance of the issue, working to change the other person’s opinion, and increasing thoughts that support your original opinion (Baumeister & Bushman, 2008; Strong, 1968). You can get someone to change their opinion by controlling the other forms of dissonance reduction listed above (i.e., the person is unable to discredit you, the person has no reason to want to reduce the importance of the issue, and no desire to find more evidence to support her original opinion) (Strong, 1968).

Strong connected this social influence of opinion change to the counseling process through evaluating the credibility of therapists on three levels: Expertness—as evidenced by diplomas, certificates, titles, reputation, and demonstration of rational knowledge (p. 217); Trustworthiness—as evidenced by known honesty, social role, sincerity and openness, perceived lack of motivation for personal gain (p. 218); and Attractiveness—as shown by liking, compatibility, and similarity of background, opinions, etc. (p. 219). These perceived influences are then used by the therapist to engage clients in the therapeutic process and then change their

thoughts, feelings, and behaviors (Egan, 1984). In Strong's two-phase counseling model, counselors high in these three areas are able to involve the client in the counseling process and reduce the chances that the client will use other ways to decrease her dissonance (phase 1), and then use this influence to implement change in the client (i.e., in cognitions and behaviors) (phase 2) (Kurdalak, Linton, & Daugherty, 1998; Strong, 1991; Strong 1968).

The elements of the social influence model (expertness, trustworthiness, & attractiveness) have been used to examine the effectiveness of a myriad of counseling techniques and counselor styles since its creation. The Counselor Rating Form (Barak & LaCrosse, 1975; LaCrosse, 1980) was created for the purpose of measuring the three domains, and was then shortened (Counselor Rating Form-Short Form (CRF-S)) (Corrigan & Schmidt, 1983). These measures have allowed researchers and therapists to understand client reactions to a variety of therapist techniques and qualities that have been thought to effect therapy outcomes.

One area that has been researched using the social influence model is information known about a therapist and the effect on ratings of attractiveness, expertness, and trustworthiness. For example, one study found that knowledge of a female counselor's sexual orientation (heterosexual or lesbian) did not significantly affect college student's ratings of her on the CRF-S (Kurdalak, Linton, & Daugherty, 1998). Other areas of research involving social influence and therapists include therapeutic interventions and behavior. For example, therapists who use profanity were rated as less expert, even if matching client's use of profanity (Kottke & MacLeod, 1989).

In an analogue study of therapist self-disclosure and therapeutic alliance, Meyers and Hayes (2006) found that when the therapeutic alliance is positive, therapists who self-disclose general information in relation to client content ("I remember in my undergrad days, I wasn't

much of a drinker either..." (p. 177) were found to be more expert than those who did not self-disclose. When the therapeutic alliance is weak, however, therapist self-disclosures of any kind were found to be related to ratings of low expertness. In this study, self-disclosure did not affect ratings of trustworthiness or attractiveness, although other studies of therapist self-disclosure link self-disclosure to ratings of attractiveness and trustworthiness (Meyers & Hayes, 2006).

Additionally, participants who had previous experience with self-disclosure in therapy rated the therapists higher and judged the sessions to be deeper. This study highlights the many individual factors that can have an impact on the perceived social influence of the therapist. Interestingly, many of the findings with self-disclosure parallel previous findings with humor (i.e., higher ratings if there is previous experience as a client) as well as assumptions about humor (i.e., importance of relationship) that are not yet supported with research.

Within social influence research, it is important to remember that clients' individual differences affect counselor ratings. In a study involving the rating of high and low-social influence counselor tapes, Black and less-educated individuals rated the low-social influence counselor higher on attractiveness, trustworthiness, and expertness than did White and highly educated individuals (McKay, Dowd, & Rollin, 1982). This study highlights the importance of understanding client variables when using social influence to facilitate change.

Humor, social influence, and outcome. In examining the role of humor in social influence, research has shown that there are, indeed, links. This is not surprising, given the evolutionary theories of humor as a social lubricant and important component of interpersonal relationships, as discussed above. Humor has been shown to increase the likeability of a communicator, and communicators who are liked have been shown to be more influential with others (O'Quin & Aronoff, 1981). O'Quin and Aronoff examined the role of humor in social

influence in a bargaining task and found that humor increased positive evaluation of the task, reduced tension, and resulted in the participants settling for less money. This demonstrates the influential power of a likeable figure. Humor in a bargaining task was likened to Henry Kissinger's humorous negotiation style, and the notion that "when you are engaged in serious business...that sort of levity is a big help" (O'Quin & Aronoff, 1981, p. 355). It is reasonable to hypothesize that some of that levity could help in the serious business of therapy—more specifically, in raising the attractiveness of therapists in the perception of others.

Clients' attraction and liking for their counselors has been found to be significantly related to positive outcome (Megdell, 1984). Results showed that instances of shared humor—that is, the counselor initiated it and the client also found it humorous—increased the client's ratings of liking and attraction in clients with alcoholism. This is important in the establishment of the relationship and positive outcome ratings, perhaps even in continuing treatment with this difficult population. Client ratings did not decrease during periods of non-shared humor—that is, when the counselor tried to be funny but client did not find them humorous (Megdell), which demonstrates that attempting to use humor is not necessarily detrimental to the counseling process.

Humor that is meaningful to the counseling process has also been found to influence counselor ratings in a non-clinical sample. Foster and Reid (1983) found that counselors who used facilitative humor in an analogue session were rated as being more likeable, approachable, and able to provide understanding than counselors who used non-facilitative humor. Facilitative humor rated as effective as using no humor in the counseling session. This research provides evidence that using humor that is pertinent to the counseling and client content is an effective

way to enact the components of social influence. It did not, however, address the individual differences (such as sense of humor) that might also affect the ratings of counselors.

In a qualitative analysis of 30 clients' experiences with humor in their therapy experience, humor was considered an important facilitative component to the therapy (Bennet, 1996). The clients who reported no humor in current therapy expressed some desire that humor be included, and many clients reported terminating previous therapy because the therapist did not include humor in therapy, and it was an important part of their self-concept. This suggests that the client's own sense of humor was an important factor in their assessment of their therapy experience. While the social influence model was not directly used in this study, it is evident that the use of humor had positive effects on the outcome of therapy in many of these cases.

While it seems that many clients with mild to moderate symptoms view humor as a favorable and facilitative part of the therapy experience, there are no studies to date that examine individual differences, namely, the sense of humor, of individuals who view humorous interventions positively. It is important for the professional community to understand the populations that might benefit from humorous interventions in order to utilize them and individualize treatment effectively for each client.

Summary

Much of the work of therapy is to stimulate change in clients in their thoughts, feelings, or behaviors. When changes are perceived by the client, the therapy is thought to be effective and regarded as having a positive outcome. Some of the important factors that affect effectiveness and outcome include client expectations about therapy and therapists. Expectations about humor in therapy and as a therapist quality are absent from the literature, although related characteristics show up repeatedly (e.g., likeable, sociable).

One important theory about change in therapy revolves around ideas of the social influence of the therapist. In this model, therapists who rate high in areas important to social interaction are able to use this social positioning to influence change in clients. Humor has been linked to social processes in many areas of social and interpersonal psychology, and seems to play a role in ratings of counselor effectiveness as well.

Summary of the Literature

Ideas about humor, and humor itself, seem to be far-reaching and somewhat universal. The benefits of humor have been found in the medical community, in the social world, and in many elements of mental health. Humor can be a buffer against stress, a coping skill, and a way to improve digestive health. There has been research to link humor with personality profiles and individual differences. These findings often show that there are differences in the types of humor enjoyed by different people (e.g., men and women, socioeconomic classes), and in the way that it is expressed (i.e., extraverts create more humor, women use it to cope), but it seems that everyone has some connection to humor in their lives.

Despite this fact, humor is not openly used or accepted in the mental health community as a therapeutic intervention. There are people who advocate for its acceptance, and people who oppose it for being risky. It is possible that the public perception of therapy as “serious business about serious issues” does not allow for an expectation of humor in therapy, and expectations play a vital role in the effectiveness of therapy and a positive result at the end. Little is known about the expectations of therapists as “humorous,” but there is research that indicates that clients who do not experience humor in therapy will terminate early (Bennet, 1996), and that clients who have previously experienced humorous therapy rate it higher than non-humorous therapy (Rosenheim, 1989). Perhaps this is a reflection of being given an opportunity to create

new expectations of therapists based on experience and not just media images of “therapist” caricatures.

Socially, humor is an important skill for relationship building and maintenance. It enables us to form groups and secure romantic attachments. Within therapy, too, there are social elements that facilitate change. Many of the qualities that are found to be socially desirable relate to humor and sense of humor. It is likely that the influence of humor will carry over into therapy and that the use of relevant humor in therapy will influence ratings of the therapist on the elements of the social influence model (attractiveness, trustworthiness, expertness). There is some evidence that use of humor in therapy results in higher ratings of effectiveness, but there is no research that expands on these findings in describing, understanding, and predicting populations that will benefit from therapeutic humor.

Purpose

The purpose of this investigation was to expand the existing body of evidence concerning therapeutic humor. Building on the findings of Foster and Reid (1989) that humor that is consistent with client content and therapeutic goals is as effective as using no humor, the present research sought to identify an important characteristic (i.e., sense of humor) of individuals who find therapeutic humor to be effective. In addition, the present study also works to help understand the influence of expectations about humor in therapy on the relationship between sense of humor and effectiveness. Research in this area has identified many qualities that are related to humor, but not humor directly. Using the social influence model to collect reactions to therapists’ use of humor also allowed investigation into Kubie’s (1971) hypothesis that use of humor will result in low scores of expertness. The present research examined the question of whether sense of humor is a significant predictor variable and whether expectations of humor in

counseling acts as a moderator variable between sense of humor and scores on the Counselor Rating Form-Short form scores of expertness, trustworthiness, and attractiveness. Additionally, this study examined responses to humorous and non-humorous therapeutic interventions in an effort to understand reactions to therapists in a non-clinical sample.

Research Questions

Paucity of research regarding the impact of sense of humor on ratings of humor use by therapists and expectations about the use of humor in therapy indicates that the relationships between these two areas warrants further research.

The following questions were tested among participants who read a vignette that includes a humorous therapeutic intervention:

1) Are there differences in ratings of counselor effectiveness (CRF-S scores) for vignettes that include humor and vignettes that do not include humor?

2(a) What is the relationship between scores on the sense of humor scale and scores on ratings of counselor effectiveness (total CRF-S) for vignettes that include humor and vignettes that do not include humor?

2(a.1) What is the relationship between scores on the sense of humor scale and scores on the attractiveness scale of the CRF-S for vignettes that include humor and vignettes that do not include humor?

2(a.2) What is the relationship between sense of humor scores and ratings of expertness for vignettes that include humor and vignettes that do not include humor?

2(a.3) What is the relationship between sense of humor scores and ratings of trustworthiness for vignettes that include humor and vignettes that do not include humor?

3(a.1) Is the relationship between sense of humor and ratings of expertness different at different levels of expectation of humor in counseling?

3(a.2) Is the relationship between sense of humor and ratings of trustworthiness different at different levels of expectation of humor in counseling?

3(a.3) Is the relationship between sense of humor and ratings of attractiveness different at different levels of expectation of humor in counseling?

III. Method

In order to answer the research questions, it was necessary to do two things: 1) Create a measure of Expectations about Humor in Counseling (EHC) and determine adequate reliability; and 2) Develop clinical vignettes including humorous therapeutic interventions and non-humorous interventions.

Development of the Expectations about Humor in Counseling Scale

Although many researchers have studied expectations of counseling and psychotherapy, no measures have included humor as one of the factors. In order to assess expectations of humor specifically, it was necessary to create a measure that would do this reliably. The Expectations about Humor in Counseling (EHC) scale consists of eight items measured on a 7-point Likert scale ((1) Not True to (7) Definitely True) embedded in 17 unrelated items concerning expectations about counseling. Participants rated how much they expected a counselor to possess certain traits and engage in certain behaviors. The 17 items were taken from the Expectations About Counseling—Brief Form (EAC-B) (Tinsley, 1980 used with permission from the author). These items were from the seven subscales that measure Counselor Attitudes and Behaviors on the EAC-B. These subscales include acceptance, confrontation, directiveness, empathy, genuineness, nurturance, and self-disclosure. The eight items that make of the EHC were the only ones included in analysis; the others were included in the presentation in order to mask humor as the variable of interest.

The eight items that make up the “humor” scale were constructed to match the other items in form. The items were created following a thorough review of the literature and the

elements of humor that are thought to be important when using humor in therapy (see Appendix B). The items reflect themes in the literature concerning humor in therapy such as learning how to laugh at yourself as a component of healthy humor (Martin, 1998; Watzlawick, 1983), humor helping clients remember points made in therapy (Bennett, 1996), and reports of positive experiences from clients with therapists who demonstrated sense of humor and joking (Bennett; Lemma, 2000).

Preliminary Reliability Check

In order to check the reliability between of the Expectations About Humor in Counseling (EHC) scale, 71 individuals were recruited from undergraduate courses at Auburn University. Participants included 15 males and 56 females between 19 and 46 years of age ($M = 22.62$ years). Sixty-three of the participants identified as Caucasian, four as African American, two as Asian/Pacific Islander, one as Hispanic/Latino, and one as other (unspecified). Twenty-four of the participants had been a client in counseling or therapy in the past, and 47 had not. Two participants did not answer all items, and were not included in the analysis, resulting in a final sample size of 69.

The researcher used the coefficient alpha to assess the internal consistency reliability of the eight items. A coefficient alpha of .938 was obtained, suggesting that the items comprising the scale are internally consistent.

Development of Humorous and Non-Humorous Clinical Vignettes

In order to assess reactions to humorous and non-humorous therapeutic interventions, it was necessary to create vignettes of counseling sessions. One of the vignettes was adapted from Goldin and Bordin's (1999) article concerning the use of humor in therapy, and the other vignettes were created by the researcher based on humorous therapeutic techniques described in

other sources (Nevo, 2001; Salameh, 2001; Lemma, 2000; Mosak & Maniacci, 1993; Metcalf & Felible, 1992; Schnarch, 1990; Ellis, 1977). The vignettes depict excerpts of counseling sessions for two different clients, Ms. X (see Appendix D) and Ms. Z (see Appendix C). Humorous (X2 & Z2) and non-humorous (X1 & Z1) versions were created for each client. They were then reviewed by three professionals in the field of Counseling Psychology and revised until all of the professionals agreed that the vignettes were realistic depictions of possible counseling sessions.

Preliminary Manipulation Check

In order to ensure that the humorous vignettes were perceived to contain humor and the non-humorous vignettes were perceived to contain no humor, a manipulation check was performed at the same time as the reliability check described above.

Vignettes were presented as a transcript with a brief introduction of the client and the client's presenting problem. Following each vignette, participants responded to one question (To what extent does the counselor use humor with the client?) on a five point Likert-type scale ((1) Not at All to (5) A Great Deal). This information was used to ensure that participants perceived humor in the vignettes, and also to ensure that there was a difference in perception of humor between the humorous and non-humorous versions of each vignette. Participants were randomly assigned to one of two groups. The first group (n = 35) responded to vignettes X2 and Z1 and the second group (n = 36) responded to vignettes X1 and Z2.

A series of independent samples t-tests were completed. The first was between the responses to X2 (humorous) (n = 36, M = 3.39) and X1 (non-humorous) (n = 33, M = 1.09). The results indicated that significantly more humor was perceived in the humorous vignette ($t(67) = -16.175, p < .01$). Similarly, the responses to Z2 (humorous) (n = 34, M = 2.50) and Z1 (non-

humorous) ($n = 33$, $M = 1.03$) also indicated that significantly more humor was perceived in the humorous vignette ($t(68) = 10.059$, $p < .01$).

Finally, all humorous and all non-humorous responses were compared in a second round of independent samples t-tests. Responses to the X2 humorous vignette ($n = 36$, $M = 3.39$) and Z2 humorous vignette ($n = 34$, $M = 2.50$) were compared. The results indicated that there were significant differences in the amount of humor perceived in the two vignettes ($t(68) = -4.671$, $p < .01$), with the X2 humorous vignette having more humor. Last, the non-humorous X1 vignette ($n = 33$, $M = 1.09$) and non-humorous Z1 vignette ($n = 33$, $M = 1.03$) comparison indicated that there were no significant differences in the amount of humor perceived in these two vignettes ($t(67) = .898$, $p > .05$).

The results indicated that all measures demonstrate adequate properties to be used with confidence in the test of the hypotheses and research questions. It is notable that the X2 humorous vignette was rated more humorous than the Z2 humorous vignette, but does not exclude it from use in the final battery of questionnaires. The important thing in this initial analysis is that the humorous vignettes are significantly more humorous than their non-humorous counterparts, and both were.

Participants

Based on the number of variables included in the study, a minimum sample of 200 participants (50 in each of four ordered groups) was needed (Faul, Erdfelder, Lang, & Buchner, 2007). The final sample included 228 members of the general population, ranging in age from 19 to 75 ($M = 34.17$). The sample consisted of 44 males and 183 females. Two-hundred-six (206) participants identified as Caucasian, eight as Hispanic/Latino, six as Asian/Pacific Islander, three as African American, three as Biracial, and two as other (Middle Eastern, Euro American). One-

hundred-fifteen (115) participants had been a client in counseling or psychotherapy now or in the past and 113 had not.

Participants were solicited using snowball sampling through the Facebook social networking website. The website has over 42 million members consisting of mixed gender and varied age demographics (Corbett, 2009). The researcher began the snowball recruitment of individuals registered on the social networking website to participate in the online survey using a variety of methods. 1) The researcher established an open group on Facebook that appeared when members searched for groups involving research, dissertation, and open groups. Any member of Facebook was able to view the invitation to participate (Appendix G) and follow the link to the survey. 2) The researcher posted messages including the invitation to participate to members of general, nonspecific open groups on Facebook. The groups included met specifications set by the researcher, which included: having at least 100 members and did not include any exclusionary criteria for group participation (e.g., a group for “People in Iowa” would not be used, nor would a group for “Catholics”, etc.). Groups that received messages included: The Six Degrees of Separation Group—The Experiment (5,500,544 members), four general open groups titled “Groups” (1,903 members; 515 members; 268 members; 207 members), The Nameless Group Against All Offensive Groups (77,002), The Open Beats Group (352), and Big Boy Fan Club (2403). 3) The researcher placed an advertisement through Facebook that appeared for any user aged 19 or over who speaks English and is in the United States (See Appendix G). The advertisement included a link to the survey and the invitation to participate. The advertisement ran from September 13, 2009 through September 23, 2009 and from September 25, 2009 through October 5, 2009 and in that time showed up 345,763 times to Facebook users while they were logged in and active on the site. The researcher paid for the

advertisement per 1,000 impressions and had a budget of \$5.00 per day for a total of \$100.00. Participants were asked to forward the invitation to participate and link to the survey to any interested parties. Participation was voluntary and anonymous. In compensation for their time, a one dollar donation was made to the National Multiple Sclerosis Society for each completed survey (a total of \$232.00).

Measures

Participants read two clinical vignettes and completed five instruments. The instruments included a demographic questionnaire, a measure of expectations about humor in counseling, two administrations of the Counselor Rating Form-Short Form (CRF-S) (Corrigan & Schmidt, 1983), and the Multidimensional Sense of Humor Scale (MSHS) (Thorson & Powell, 1993).

Demographic questionnaire. (Appendix A). The demographic questionnaire included items such as age, gender, ethnicity, and previous experience as a client in therapy. Responses serve as the descriptive measures and as components of correlational analyses. The items on this measure were created by the researcher, based on the needs of the study. (See Appendix A)

Expectations about Humor in Counseling (EHC). (Appendix B). The expectations about humor in counseling measure consists of eight items measured on a 7-point Likert scale embedded in 17 other items about expectations of counseling. Participants rated how much they expect a counselor to possess certain traits and engage in certain behaviors. The eight items of interest make up the Expectations about Humor in Counseling (EHC) scale, and were shown to have adequate reliability ($\alpha = .938$). The remaining 17 items were taken from the Expectations About Counseling—Brief Form (EAC-B) (Tinsley, 1980, used with permission from the author).

Counselor Rating Form-Short Form (CRF-S). (Appendix E). Participants completed the CRF-S (Corrigan & Schmidt, 1983, used with permission from the authors) after each vignette

that they read. The CRF-S is a 12-item measure of three dimensions of social influence of counselors: expertness, attractiveness, and trustworthiness. There are four items for each dimension included in the measure. A Likert scale ((1) Not Very to (7) Very) is used to score each item, resulting in possible total scores of 4 to 28 for each dimension, and an overall score of 12 to 84.

The measure was developed based on the Counselor Rating Form (LaCrosse, 1980), which included 12 items for each dimension. The measure was validated with a sample of 133 college students and 155 clients from outpatient mental health centers. Split-half reliabilities were: expertness = .90, attractiveness = .91, and trustworthiness = .87. Confirmatory factor analysis validated the three-factor structure of the construct. A three-factor oblique model was the best fit for the data, with high factor loadings (>.75) (detailed information available from Ponterotto & Furlong, 1985; Corrigan & Schmidt, 1983). This measure has been widely used in research about counseling (Meyers & Hayes, 2006; Kottke & MacLeod, 1989; McKay, Dowd, & Rollin, 1982). This measure was chosen for use in this study based on its high reliability, efficiency, and ability to measure the construct of social influence.

Two additional questions were included following the vignette asking the participants if they would consider seeing such a therapist (Yes, No, or Unsure), and also an open-ended question, “What do you think that the counselor did or said that was particularly helpful or unhelpful?”

Multidimensional Sense of Humor Scale. (Appendix F). The MSHS is a 24-item self-report measure using a Likert scale ((0) Strongly Disagree to (4) Strongly Agree) that assesses four separate dimensions of sense of humor: humor generation or creativity, uses of humor as a coping mechanism, appreciation of humor, and attitudes towards humor and humorous persons

(Thorson & Powell, 1993). The measure was created by Thorson and Powell based on the idea that sense of humor is a multi-faceted construct that cannot be measured simply by a behavioral (e.g. laughter) or any other unidimensional measure. This scale was created to gain a broader perspective of an individual's sense of humor based on six empirically supported elements. These elements include: "1) humor production and creative ability; 2) playfulness or a sense of whimsy, *joie de vivre*, the ability to have a good time; 3) the ability to use humor to achieve social goals; 4) recognition of humor; 5) appreciation of humor; 6) use of humor as an adaptive or coping mechanism (Thorson & Powell, 1993, 18). The broad spectrum of this scale makes it a good fit for this research, as it measures sense of humor in its entirety, and not just one area.

Construction of the scale has included multiple trials with hundreds of university students. The trials began with 124 items and 6 hypothesized factors. Responses in each trial were validated through factor analysis and re-tested until the 24 items consistently revealed the same 4 factors. The final trial consisted of 234 participants ($M = 26.0$ years, 74 men, 160 women) who completed the same 29 items. This final factor analysis found that 5 items did not load at .50 or higher, and the Cronbach Alpha reliability was .92. Scores on the scales did not reflect any age or gender correlates.

Procedure

Following IRB approval and completion of the preliminary checks, members of the social networking site Facebook were invited (via the three avenues described above) to participate in the current research electronically. An electronic survey was created on a secure data collection site (Zoomerang) and the link and invitation to participate were circulated via Facebook.

Measures appeared in the same order—demographics, expectations, vignette, CRF-S, vignette, CRF-S, and MSHS.

Participants were asked to read two excerpts from therapy sessions (one non-humorous (X1 or Z1) and one humorous (X2 or Z2)) (See Appendices C and D). The development of the vignettes is described above. Vignettes were presented as a transcript with a brief introduction of the client and the client's presenting problem. The humorous vignettes were found to be perceived as significantly more humorous than the non-humorous vignettes in an initial test of manipulation (see above).

Participants were randomly assigned to one of four "groups" based on their answer to the question "What day of the month is your birthday? A) 1-8 B) 9-16 C) 17-23 D) 24-31." The first group (n = 64) responded to vignettes Z2 (humorous) then X1 (non-humorous), the second group (n = 51) responded to Z1 (non-humorous) then X2 (humorous), the third group (n = 59) responded to X2 (humorous) then Z1 (non-humorous), and the fourth group (n = 54) responded to X1 (non-humorous) then Z2 (humorous). This system was developed to reduce any order effects. Data was accepted until an adequate sample size (n = 50 in each group) was reached.

IV. Results

The research questions were addressed based on the responses of 228 individuals to the EHC, two clinical vignettes followed by the CRF-S, and the MSHS. A description of sample responses can be found in Table 1. Also, in addition to the relationships addressed in the research questions, 24 Pearson correlations were completed to assess the relationship between EHC scores and CRF-S total scores and subscale scores for all four clinical vignettes. These results can be found in Table 2.

	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Range</i>	<i>α</i>
EHC	228	30.39	11.59	8-56	.946
X1 CRF-S	118	55.61	13.38	16-84	.967
X2 CRF-S	110	57.45	13.71	15-84	.961
Z1 CRF-S	110	62.76	9.99	32-84	.934
Z2 CRF-S	118	58.67	15.34	14-84	.972
MSHS	228	67.73	12.73	17-96	.917

<i>Vignette</i>	<i>N</i>	<i>CRF-S Total</i>	<i>Expertness</i>	<i>Trustworthiness</i>	<i>Attractiveness</i>
Non-Humorous	228	.167*	.116	.174*	.179**
X1	118	.094	.057	.081	.129
Z1	110	.297*	.206*	.326**	.270**
Humorous	228	.386**	.355**	.356**	.382**
X2	110	.401**	.420**	.316**	.375**
Z2	118	.376**	.310*	.388**	.388**

Note: ** = significant at .01 level; * = significant at .05 level

Research Questions

The following research questions were posed:

1) Are there differences in ratings of counselor effectiveness (CRF-S scores) for vignettes that include humor and vignettes that do not include humor?

A paired samples t-test was conducted to compare the effectiveness scores for humorous and non-humorous vignettes for each participant. To do this, scores for both non-humorous vignettes (X1 & Z1) were combined and scores for both humorous vignettes (X2 & Z2) were combined. Total CRF-S scores included the sum of the scores on the three subscales (attractiveness + trustworthiness + expertness). According to the creators of the instrument, total scores should be interpreted before individual subscale scores, and differences interpreted with caution. There was no significant difference in total CRF-S scores for humorous ($M = 58.10$, $SD = 14.52$) and non-humorous ($M = 58.97$, $SD = 12.41$) vignettes ($t(228) = -.810$, $p > .05$, *ns*). These results suggest that there were no differences in ratings of counselor effectiveness between counselors that use humor and those that do not. Further analysis of individual subscales was not necessary.

2(a) What is the relationship between scores on the sense of humor scale and scores on ratings of counselor effectiveness (total CRF-S) for vignettes that include humor and vignettes that do not include humor?

To assess the relationship between sense of humor scores and ratings of counselor effectiveness, two Pearson correlations were calculated for CRF-S total scores (attractiveness + expertness + trustworthiness) for non-humorous vignettes, and also for humorous vignettes, and scores on the MSHS. For this analysis, CRF-S scores for non-humorous vignettes (X1 & Z1) were combined, and CRF-S scores for humorous vignettes (X2 & Z2) were combined. Analysis

Table 3: Relationships between Counselor Rating Form-Short Form scores and Multidimensional Sense of Humor Scale scores

<i>Vignette</i>	<i>N</i>	<i>CRF-S Total</i>	<i>Expertness</i>	<i>Trustworthiness</i>	<i>Attractiveness</i>
Non-Humorous	228	.107	.109	.158*	.034
X1	118	.093	.066	.176	.027
Z1	110	.130	.166	.145	.039
Humorous	228	.174**	.154**	.182**	.155**
X2	110	.358**	.323**	.387**	.285**
Z2	118	.016	.008	.004	.035

Note: ** = significant at .01 level; * = significant at .05 level

began with the total CRF-S scores as outlined by the creators of the instrument. A weak, non-significant relationship was found between CRF-S total scores and scores on the MSHS for both non-humorous vignettes ($r(226) = .107, p > .05, ns$) (See Table 3). A positive and significant relationship was found between CRF-S total scores and MSHS scores in response to humorous therapy vignettes ($r(226) = .174, p < .001$). There is a relationship between sense of humor and scores of effectiveness when humor is present, but there is no significant relationship when humor is not present.

Further analysis of the relationship between CRF-S scores and MSHS scores was completed by calculating four Pearson correlations for the CRF-S total scores for each vignette and the total score on the MSHS. Three of the four vignettes yielded weak, non-significant relationships (Z1: $r(108) = .130, p > .05$; Z2: $r(116) = .016, p > .05$; X1: $r(116) = .093, p > .05, ns$) (See Table 1). For these vignettes, there was no significant relationship between sense of humor and ratings of counselor effectiveness. Further analysis of the CRF-S subscales for these vignettes was not necessary, but is included here for informational purposes.

A moderate positive, significant relationship was found between MSHS scores and CRF-S scores for humorous vignette X2 ($r(108) = .358, p < .001$) (See Table 3). There was a relationship between sense of humor and scores of counselor effectiveness for this vignette.

2(a.1) What is the relationship between scores on the sense of humor scale and scores on the attractiveness scale of the CRF-S for vignettes that include humor and vignettes that do not include humor?

To assess the relationship between attractiveness ratings of therapists (based on CRF-S subscale scores) and sense of humor (based on scores on the MSHS), two Pearson correlations were calculated using these scores. First, scores on the attractiveness subscale of the CRF-S for non-humorous vignettes (X1 & Z1) were combined, as were the attractiveness scores for non-humorous vignettes (X2 & Z2). A weak, non-significant relationship was found between attractiveness scores and scores on the MSHS for non-humorous vignettes ($r(226) = .034, p > .05$) (See Table 3). A weak but significant relationship was found between attractiveness scores and MSHS scores in response to humorous therapy vignettes ($r(226) = .155, p < .05$). There was a relationship between scores of attractiveness and sense of humor when humor was present, but there is no relationship between scores of attractiveness and sense of humor when humor was not present.

Further analysis of the relationship between attractiveness scores and MSHS scores was completed by calculating four Pearson correlations using the attractiveness scores for each vignette and the total score on the MSHS. Three of the four vignettes yielded weak, non-significant relationships (Z1: $r(108) = .039, p > .05$; Z2: $r(116) = .035, p > .05$; X1: $r(116) = .027, p > .05, ns$) (see Table 3). In these vignettes, there was no relationship between scores of attractiveness and sense of humor.

A weak but significant relationship was found between MSHS scores and attractiveness scores for humorous vignette X2 ($r(108) = .285, p < .001$) (See Table 3). There was a relationship between scores of attractiveness and sense of humor for this vignette.

2(a.2) What is the relationship between sense of humor scores and ratings of expertness for vignettes that include humor and vignettes that do not include humor?

To assess the relationship between expertness ratings of therapists (based on CRF-S subscale scores) and sense of humor (based on MSHS scores), two Pearson correlations were calculated using these scores. First, scores on the expertness subscale of the CRF-S for non-humorous vignettes (X1 & Z1) were combined, and scores for humorous vignettes (X2 & Z2) were combined. A weak, non-significant relationship was found between expertness scores and scores on the MSHS for non-humorous vignettes ($r(226) = .109, p > .05, ns$) (See Table 3). A weak but significant relationship was found between expertness scores and MSHS scores in response to humorous therapy vignettes ($r(226) = .154, p < .05$) (See Table 3). There was a relationship between ratings of expertness and sense of humor when humor was present, but there was no relationship when humor was not present.

Further analysis of the relationship between expertness scores and MSHS scores was completed by calculating four Pearson correlations using the expertness scores for each vignette and the total score on the MSHS. Again, three of the four vignettes yielded weak, non-significant relationships (Z1: $r(108) = .166, p > .05$; Z2: $r(116) = .008, p > .05$; X1: $r(116) = .066, p > .05, ns$) (See Table 3). In these vignettes, sense of humor was not significantly related to ratings of counselor expertness.

A moderate, significant relationship was found between MSHS scores and expertness scores for humorous vignette X2 ($r(108) = .323, p < .001$) (See Table 3). There was a relationship between ratings of expertness and sense of humor for this vignette.

2(a.3) What is the relationship between sense of humor scores and ratings of trustworthiness for vignettes that include humor and vignettes that do not include humor?

To assess the relationship between trustworthiness ratings of counselors (based on CRF-S subscale scores) and sense of humor (based on MSHS scores), two Pearson correlations were calculated using these scores. First, scores on the trustworthiness subscale of the CRF-S for non-humorous vignettes (X1 & Z1) were combined, and scores on the trustworthiness subscale for humorous vignettes (X2 & Z2) were combined. A weak, yet significant, relationship was found between scores of trustworthiness scores and scores on the MSHS for non-humorous vignettes ($r(226) = .158, p < .05$) and also for humorous vignettes ($r(226) = .182, p < .001$) (See Table 3). There was a relationship between ratings of counselor trustworthiness and sense of humor when humor was present and also when humor was not present.

Further analysis of the relationship between trustworthiness scores and MSHS scores was completed by calculating four Pearson correlations using the trustworthiness scores for each vignette and the total score on the MSHS. Again, three of the four vignettes yielded weak, non-significant relationships (Z1: $r(108) = .145, p > .05$; Z2: $r(116) = .004, p > .05$; X1: $r(116) = .176, p > .05, ns$) (See Table 3). In these vignettes, sense of humor was not significantly related to ratings of counselor trustworthiness.

A moderate, significant relationship was found between MSHS scores and trustworthiness scores for humorous vignette X2 ($r(108) = .387, p < .001$) (See Table 3). There was a relationship between ratings of counselor trustworthiness and sense of humor for this vignette.

3(a.1) Is the relationship between sense of humor and ratings of expertness different at different levels of expectation of humor in counseling?

3(a.2) Is the relationship between sense of humor and ratings of trustworthiness different at different levels of expectation of humor in counseling?

3(a.3) Is the relationship between sense of humor and ratings of attractiveness different at different levels of expectation of humor in counseling?

In order to address the final three research questions, it was first necessary to see if the relationship between sense of humor and total scores on the CRF-S is different at different levels of expectation of humor in counseling. As outlined by the creators of the CRF-S, interpretations should be made first using total scores and then subscales. In order to conduct this analysis, scores on the expectations of humor in counseling scale (EHC) and the MSHS were centered by subtracting the mean from each score. Next, a variable was created that represented the interaction between EHC scores and MSHS scores (EHC*MSHS).

Four multiple regression analyses were done to test the interactions in each vignette. First, total scores on the CRF-S were entered as the dependent variable. In the first step, scores on the MSHS and the EHC scale were entered. In the second step, the interaction of MSHS *EHC was entered.

For vignette Z1 (non-humorous), a main effect was found that explained 9.6% of the variance in total CRF scores, $F(2, 107) = 5.656, p < .01$. The addition of the interaction explained only an additional .6% of the variance, $F(3, 106) = 4.016, ns$. For this vignette, only the EHC scale scores had a significant effect on the variance of CRF-S total scores, indicating that further analysis of the moderation effect was not necessary.

For vignette Z2 (humorous), a main effect was found that explained 16.2% of the variance in total CRF scores, $F(2, 115) = 11.112, p < .001$. The addition of the interaction explained only an additional 1.6%, $F(3, 114) = 8.214, ns$. For this vignette, only the EHC scale scores had a significant effect on the variance of CRF-S total scores, thus, further analysis of the moderation effect was not necessary. It is notable that expectation of humor scores explained more of the variance for this humorous vignette than its non-humorous counterpart.

For vignette X1, there were no significant main effects, with just 1.3% of the variance explained in step 1 of the regression, $F(2, 115) = .732, p > .05$. The addition of the interaction explained only an additional 3% of the variance and was also not significant, $F(3, 114) = 1.168, p > .05, ns$. Further analysis of this vignette was not necessary.

For vignette X2, a significant main effect was found that explained 25.1% of the variance in CRF total scores, $F(2, 107) = 17.947, p < .001$. The addition of the interaction accounted for an additional, and significant, 4.3% of the variance, $F(3, 106) = 14.744, p < .001$ (see Fig. 1; Table 4).

<i>Predictor and Step</i>	β	<i>t</i>	<i>p</i>	<i>SE</i>
1. EHC	.436	4.197	.000	.104
1. MSHS	.320	3.597	.000	.089
2. MSHS*EHC	-.019	-2.549	.012	.008

An examination of the simple slopes was done to probe this significant interaction (Aiken & West, 1991). To do this, separate variables were created for the moderator (EHC) that were + 1 and - 1 standard deviation from the mean, resulting in high and low levels of the moderator

(High EHC and Low EHC). Next, interaction terms were created that included the new variable and the predictor variable (e.g. MSHS*High EHC; MSHS*Low EHC).

A regression analysis was done by first entering total scores on the CRF-S as the dependent variable. Next, scores on the MSHS and the High EHC variable were entered. Finally, the interaction of MSHS *High EHC was entered. This was repeated with MSHS* Low EHC. Results revealed that higher levels of expectation of humor in counseling (EHC) were associated with a weaker relationship between sense of humor (MSHS) and ratings of counselor effectiveness (CRF-S) ($\beta = .009, p < .001$) as compared with lower levels of EHC ($\beta = .437, p > .05, ns$). Individuals with high expectation of humor did not have significant differences in their ratings the counselor higher at different levels of sense of humor. The significance of the interaction and main effects for this vignette warrants further analysis of the expertness, trustworthiness, and attractiveness subscales as outlined in the questions below.

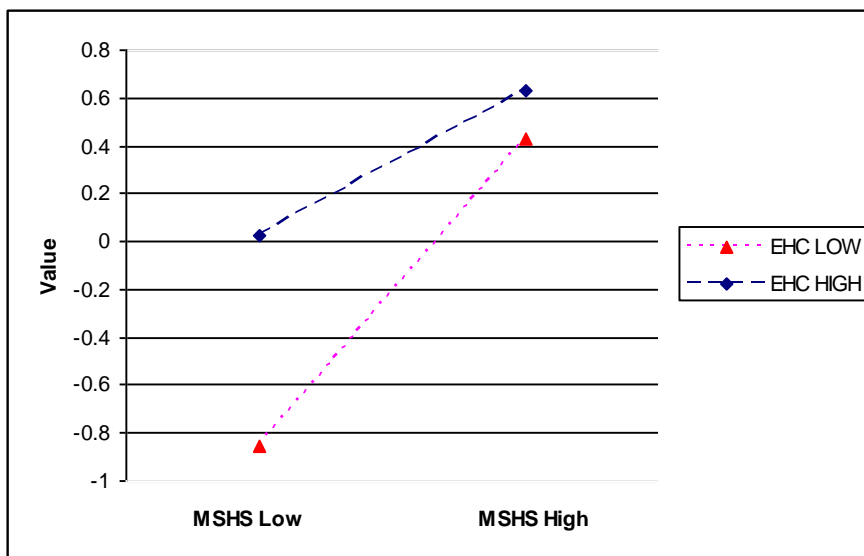


Figure 1. Interaction of Expectations about Humor in Counseling (EHC) and Multidimensional Sense of Humor Scale (MSHS) scores on Vignette X2 Counselor Rating Form-Short Form—Total Scores.

3(a.1) *Is the relationship between sense of humor and expertness different at different levels of expectation of humor in counseling?*

To test this relationship, a multiple regression was done by entering scores on the expertness scale for vignette X2 as the dependent variable, EHC and MSHS scores were entered in step 1, and the interaction EHC* MSHS in step 2. Analysis revealed a significant main effect, with the predictor variables in step 1 accounting for 24.6% of the variance in expertness scores, $F(2, 107) = 17.458, p < .001$. The addition of the interaction in step 2 accounted for an additional, and significant, 3.9% of the variance, $F(3, 106) = 14.051, p < .05$ (see Figure 2; Table 5).

Table 5: Multiple Regression of CRF-S Expertness Score

<i>Predictor and Step</i>	β	<i>t</i>	<i>p</i>	<i>SE</i>
1. EHC	.176	4.481	.000	.039
1. MSHS	.105	3.135	.002	.034
2. MSHS*EHC	-.007	-2.388	.019	.003

Examination of simple slopes for this interaction was done by completing a regression analysis. First, scores on the expertness scale of the CRF were entered as the dependent variable. In the step 1, scores on the MSHS and the High EHC variable (procedure described above) were entered. In step 2, the interaction of MSHS *High EHC was entered. This was repeated with MSHS * Low EHC (procedure described above). Results revealed that higher levels of expectation of humor in counseling (EHC) were associated with a weaker relationship between sense of humor (MSHS) and ratings of counselor expertness ($\beta = -.013, p > .05, ns$) as compared with lower levels of EHC ($\beta = .392, p < .001$).

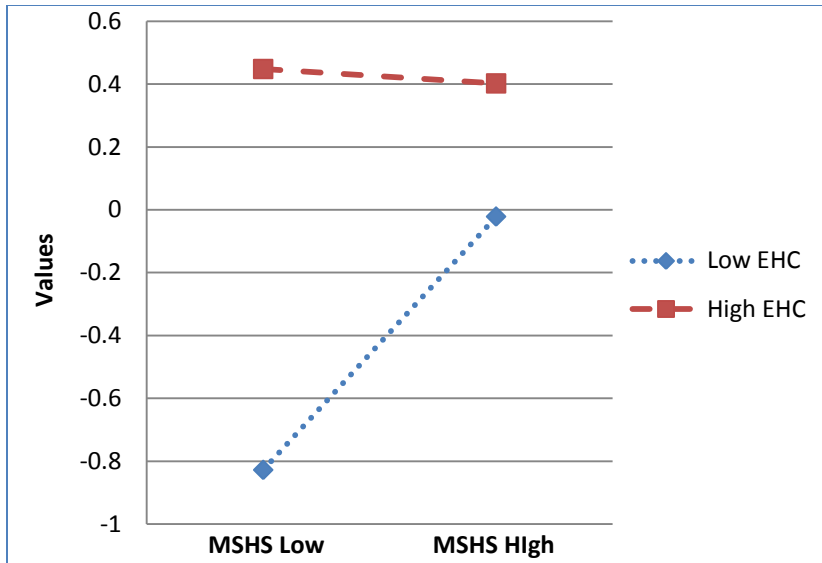


Figure 2. Interaction of Expectations about Humor in Counseling (EHC) and Multidimensional Sense of Humor Scale (MSHS) scores on Vignette X2 Counselor Rating Form-Short Form—Expertness Scores.

3(a.2) Is the relationship between sense of humor and trustworthiness different at different levels of expectation of humor in counseling?

To test this relationship, a multiple regression was done by entering scores on the trustworthiness scale for vignette X2 as the dependent variable, EHC and MSHS scores in step 1, and the interaction EHC *MSHS in step 2. Analysis revealed a significant main effect, with the predictor variables in step 1 explaining 25.3% of the variance in trustworthiness scores, $F(2, 107) = 18.091, p < .001$. The addition of the interaction in step 2 explained an additional, and significant, 4.8% of the variance, $F(3, 106) = 15.164, p < .05, ns$ (see Fig. 3; Table 6).

Predictor and Step	β	t	p	SE
1. EHC	.143	3.842	.020	.037
1. MSHS	.127	3.999	.000	.032
2. MSHS*EHC	-.007	-2.685	.008	.003

Examination of simple slopes for this interaction was done by completing a regression analysis. Scores on the trustworthiness scale of the CRF-S were entered as the dependent variable. In step 1, scores on the MSHS and the High EHC variable (procedure described above) were entered. In step 2, the interaction MSHS *High EHC was entered. This was repeated with MSHS* Low EHC (procedure described above). Results revealed that higher levels of expectation of humor in counseling (EHC) were associated with a weaker relationship between sense of humor (MSHS) and ratings of counselor trustworthiness ($\beta = .028, p > .05, ns$) as compared with lower levels of EHC ($\beta = .478, p < .001$).

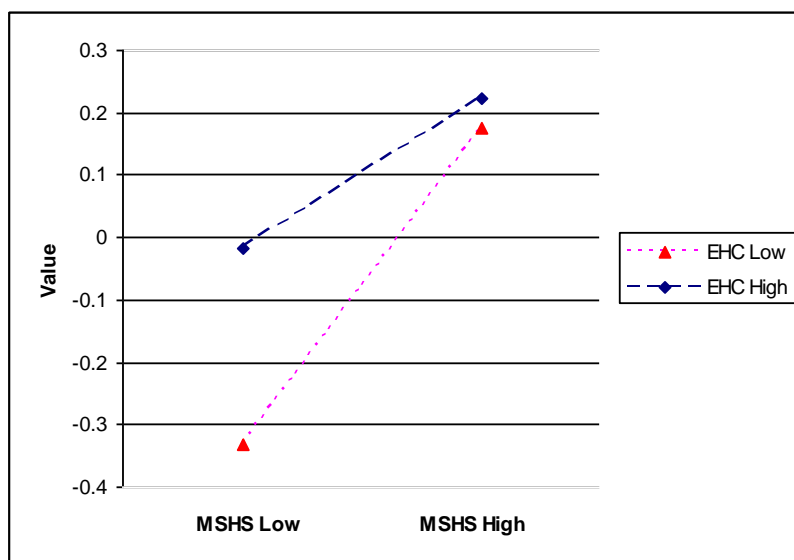


Figure 3. Interaction of Expectations about Humor in Counseling (EHC) and Multidimensional Sense of Humor Scale (MSHS) scores on Vignette X2 Counselor Rating Form-Short Form—Trustworthiness Scores.

3(c) Is the relationship between sense of humor and attractiveness different at different levels of expectation of humor in counseling?

To test this relationship, a multiple regression was done by entering scores on the attractiveness scale for vignette X2 as the dependent variable, EHC and MSHS scores in step 1, and the interaction EHC* MSHS in step 2. Analysis revealed a significant main effect, with the predictor variables in step 1 explaining 15.8% of the variance in attractiveness scores, $F(2, 107) = 10.030, p < .001$. The addition of the interaction in step 2 explained only an additional 2.7% of the variance, $F(3, 106) = 8.004, p > .05, ns$. Only the EHC score had a significant effect on the variance of attractiveness scores. No further analysis of the moderation effect was needed.

Ancillary Analyses

Responses to the two additional questions following the CRF-S were examined to see how frequently participants responded in certain ways. For the first question (“What did the counselor do that was particularly helpful or unhelpful?”), the number of responses that included an allusion to “humor” or “used humor” were counted for each vignette.

In response to vignette Z1 (non-humorous), none of the comments noted that the therapist used humor. One person stated, “At least he wasn’t patronizing or a joker.” Another noted that, “The counselor seemed somewhat detached, less interested in the client’s situation. Seemed to be doing everything by the book instead of connecting with the individual.” Other themes that emerged in the comments were noting that the counselor gave suggestions (12 comments), was direct (8 comments), and repeated or reflected back to the client (6 comments). Several of the comments about the directness of the counselor came from the group that saw this vignette after the humorous one, and they noted things like, “was more direct with comments to the patient,”

and “I liked this direct approach much more than the last scenario. No humor and asking the direct questions that needed to be asked,” indicating that some participants were comparing the vignettes. Overall, 19 responses indicated explicitly that they thought the counselor did something helpful, the mean MSHS score for these respondents was 64 (SD = 16.66; Range: 17-95). This was slightly higher than the overall mean for all MSHS scores (M = 67.76, SD = 12.62, Range: 17-96). Eight (8) responses noted that the counselor was unhelpful, the mean MSHS score for these respondents was 74.25 (SD = 9.04; Range: 63-86). This is higher than the overall MSHS mean score of 67.76, which may suggest that there is a relationship between sense of humor scores and individual evaluations of helpfulness for this counselor.

In response to vignette Z2 (humorous), participants seemed to have polarized reactions. Ten (10) responses included explicitly that the counselor used humor or a joke. Thirty-two (32) responses explicitly stated that the anecdote was positive or helpful, 25 responses stated that it was explicitly unhelpful, and 9 responses noted that there was a story or anecdote but did not identify if it was helpful or unhelpful. Twenty-six (26) responses noted that the counselor referenced God or religion in the anecdote. Most of these responses (25) indicated that the religion reference was a turn-off to an otherwise helpful story. Thirty-eight (38) responses noted that the counselor did something positive or helpful, the mean MSHS score for these respondents was 69.81 (SD = 12.35; Range: 46-96). This was only slightly higher than the overall mean for all MSHS scores (M = 67.76, SD = 12.62, Range: 17-96). Thirty-two (32) responses noted that the counselor was unhelpful, and the mean MSHS score for these respondents was 66.81 (SD = 11.41; Range: 41-92). This is only slightly lower than the overall MSHS mean of 67.76. This indicates that there is no relationship between sense of humor scores and reflections of helpfulness in these responses.

In response to vignette X1 (non-humorous), no participants mentioned humor or jokes. Thirty (30) participants explicitly noted that the counselor was helpful, the mean MSHS score for these respondents was 67.6 (SD = 14.4; Range: 30-92). This is almost equal to the overall mean of 67.76. Nineteen (19) responses explicitly stated that the counselor was unhelpful or “did not do anything,” and the mean MSHS score for these respondents was 69.16 (SD = 14.51; Range: 40-89). This is slightly higher than the overall mean of 67.76. Twenty one (21) responses noted that the counselor reflected or restated things that the client said, some of these then indicated that this was helpful and validating for the client, while others noted that this was unhelpful since it was not leading to a solution or was not directive enough. The other common theme in the responses was noting that the counselor let the client do most of the talking/helped the client be more expressive, 16 comments noted this.

In response to X2 (humorous), 23 responses explicitly noted the presence of humor in the interaction (i.e., used humor, jokes, sarcasm), and 2 responses noted that the therapist smiled. Ten (10) of the responses that noted the humor also stated that it was unhelpful (e.g., “I feel like the humor overshadowed the point the counselor was trying to make. She was warm and I’m sure sincere but I’d rather have had a direct piece of advice than for it to be covered in humor”). Six (6) of the responses that noted the humor also stated that it was helpful (e.g., “They were able to use humor to make it easier for the client to discuss the negative aspects of her relationship”). Eight (8) responses directly named the “Oscar” comment, and 6 of those reflected a negative reaction to it (e.g., “I thought the Oscar comment was a little over the top”), the other 2 responses were positive (e.g., “...I did like the Oscar comment the counselor used. It was appropriate and relieved some of the tension”). Three (3) responses directly referenced the “kick the habit” comment, two of those were negative (e.g., “kick the habit sounds as if the counselor

is attempting to persuade the client by making leaving the BF the appropriate choice”), and one was positive (e.g., “I did like the ‘kick the habit’ comment in regard to the client feeling she was addicted to her boyfriend”). Overall, 24 comments explicitly stated that the counselor was helpful, the mean MSHS score for these respondents was 71.88 (SD = 10.68; Range 43-95). This is higher than the total mean MSHS score of 67.76. Thirty-nine (39) comments noted that the counselor was unhelpful or had a negative response, the mean MSHS score for these respondents was 65.62 (SD = 11.57; Range 31-83). This is slightly lower than the overall MSHS mean of 67.76.

Responses to the second question (“If you were having problems in your own life, would you go see this counselor?”) were examined for frequency of “yes,” “no,” and “unsure” responses. These responses were coded as 1=yes, 2=no, 3=unsure in SPSS. In response to vignette Z1, 64 participants responded “yes” (58.2%), 9 participants responded “no” (8.2%), and 37 participants responded “unsure” (33.6%) (n = 110, M=1.75, sd=.93). In response to vignette Z2 (humorous), 51 participants responded “yes” (43.2%), 31 participants responded “no” (26.3%), and 36 participants responded “unsure” (30.5%) (n = 118, M=1.87, sd=.85). In response to vignette X1, 51 participants responded “yes” (43.2%), 30 participants responded “no” (25.4%), and 37 participants responded “unsure” (31.4%) (n = 118, M=1.88, sd=.86). In response to vignette X2 (humorous), 37 participants responded “yes” (33.6%), 33 participants responded “no” (30.0%), and 40 participants responded “unsure” (36.4%) (n = 110, M=2.10, sd=.84). A chi square analysis revealed that the proportion of “yes,” “no,” and “unsure” responses differed significantly between vignettes, $\chi^2(6, N = 456) = 22.25, p < .001$. Despite the significance found in the interactions between sense of humor and ratings of counselor

effectiveness above, more respondents were ambivalent about seeing the counselor in X2 than any other vignette.

V. Discussion

This study investigated the relationships between sense of humor, expectations of humor in counseling, and ratings of counselor effectiveness based on the social influence model (including expertness, trustworthiness, and attractiveness). Past research involving humor, expectation as related to outcome in therapy, and social influence, indicated that there may be significant relationships between these variables.

The main research questions of this study addressed relationships between sense of humor scores and ratings of counselor effectiveness, and further examined the moderating effects of expectation of humor in counseling on those relationships. Sense of humor was found to have a significant relationship with scores of counselor effectiveness (total scores and all three subscales) for one of the humorous vignettes. For this same vignette, expectation of humor in counseling moderated the relationship for total effectiveness scores, expertness scores, and trustworthiness scores. Additionally, the eight items that make up the Expectation of Humor in Counseling scale were found to have consistently high reliability in two separate non-clinical populations, meaning that they may be sound items to be used in future research.

The results of this study provide several notable results, beginning with overall ratings of counselor effectiveness. The results of this study, namely that there were not any truly significant differences in ratings of effectiveness for humorous and non-humorous counselors, reinforce the findings of Foster and Reid (1983). They also found no differences in effectiveness between using facilitative humor and using no humor. These findings imply that it is difficult to strongly endorse or condemn the use of humor in therapy based on ratings of effectiveness. This finding,

combined with other findings—such as highly polarized, diverse, and some strong negative reactions in participant comments—endorses the potential risk involved in using humor as a therapeutic intervention, though it also holds the potential to be helpful for some individuals. The present study was intended to discover some individual predictors that might help clinicians understand clients who may benefit from using humor—sense of humor and expectations of humor in counseling.

Looking more closely at the relationship between sense of humor scores and ratings of counselor effectiveness provides a jumping off point for exploration of individual differences and perception of humor in the counseling relationship. The positive, significant relationship found between sense of humor scores and ratings of effectiveness (in CRF-S total scores, as well as all three subscales—attractiveness, trustworthiness, and expertness) for the two examples of therapists that use humor included in this study indicates that as self-reported sense of humor scores increase, so did the various ratings of counselor effectiveness for counselors that used humor. This means that if the client has a relatively strong sense of humor, and humor is present, then the humor may make a difference in their opinion of counselor effectiveness. This connection may be consistent with Bennett's (1996) finding that clients who report highly valuing humor were also more likely to terminate counseling if humor was not present, however the current study did not address termination.

If humor is not present, however, then that relationship disappears. There was no significant relationship between sense of humor scores and ratings of counselor effectiveness for the vignettes that did not include humor. This means that ratings of effectiveness are not always tied to sense of humor. The caution to psychotherapists and counselors is to take into account the extent of the client's sense of humor before engaging humor as a therapeutic intervention.

One of the concerns from therapists, especially Kubie (1971), about using humor in therapy is the question of perception of therapist expertness and professionalism. The results found in this study indicate that there is a significant relationship between sense of humor and ratings of expertness when humor is present in counseling. As individual sense of humor scores rise, so did ratings of counselor effectiveness when humor was present. Humor, it seems, may make a difference in assessing the professionalism of a counselor or therapist for individuals with a relatively high sense of humor when humor is present. This finding does suggest that humor is not a mode of increasing professionalism across the board with all clients.

The fact that positive, significant relationships were found between sense of humor and all subscales of counselor effectiveness (trustworthiness, expertness, and attractiveness) for the vignettes including humorous interventions highlights the role of humor in social relationships and social influence. This seems to be especially true for individuals who rate themselves as high on sense of humor. As demonstrated by previous studies of humor in social situations, it appears that these results support the idea of humor as a kind of “social lubricant” and a way to begin forming social relationships (Manke, 1998; Martin, et al., 2003; Tierney, 2007; Weisfeld, 1993). It is possible, then, that for individuals who value humor a great deal (i.e., are high on sense of humor) having humor as a factor in therapy may help strengthen the therapeutic relationship, which has been found to influence therapy outcomes (Lambert & Barley, 2001). As noted above, however, when humor was not present, these relationships weakened or disappeared entirely.

When looking at each vignette individually, there seemed to be something unique about the counselor in vignette X2. This is the only vignette that individually showed significant relationships between sense of humor scores and all subscales on the measure of therapist effectiveness (trustworthiness, attractiveness, and expertness). This is both surprising and

affirming in many ways. This was surprising because it was expected that both humorous vignettes would yield similar results on these scales—that is, either both would be significant or both not. However, the responses to the open-ended questions highlighted the complexity in studying humor and responses to it. For example, several respondents seemed to have polarized reactions to the mention of a religious figure in a humorous anecdote, and this may have impacted the ratings of effectiveness for humorous vignette Z2. It seems that, in addition to the strength of a person's sense of humor, the types of things that they find humorous may have an impact on how effective they find the humor to be. The counselor in vignette X2 utilized less explicit forms of humor than the anecdote in Z2, so it could also be that more subtle uses of humor in therapy are just a little safer, and possibly more effective than using explicit jokes. This is not something that was analyzed in this research. Additionally, this supports the findings from the preliminary reliability check that showed that vignette X2 was rated as funnier than vignette Z2. If funniness is at all related to effectiveness in regards to relationship with sense of humor then this result is consistent. That would be a question for examination in further research.

It is notable, though, that both humorous vignettes elicited highly polarized reactions—both positive and negative—from participants. This supports the arguments that humor should be used with caution and it is best to know your client and be able to anticipate their reaction before using anything too strong. It is also possible that the more subtle moments of humor, such as those in X2, seemed more spontaneous and less contrived than the explicit joke or storytelling in Z2. This could be related to the moments of meeting described by Lemma (2000) and others who describe effective humor in therapy being authentic, in-the-moment reactions to client content, affect, and the therapeutic relationship. It did not appear that sense of humor scores had any relationship to open-ended comments about counselor helpfulness or unhelpfulness. It is also

important to notice the significant differences to the question “would you go see this counselor?” for each vignette. The highest proportion of “yes” answers and lowest proportion of “no” answers was for vignette Z1 (non-humorous), while X2 and Z2 (both humorous) received the highest proportions of “no” answers. This demonstrates that clients were unsure or uninterested in having humor as part of treatment for themselves. This finding again highlights to clinicians the potential dangers of using humor as a therapeutic intervention.

One limitation of this study is that there is no way of knowing what extraneous factors were influencing people’s reactions to the counselors in the vignettes. For example, as presented, the counselors in all vignettes were not assigned a gender, however, it was clear in the open-ended responses that many people ascribed a “he” or “she” to the counselors. There are some differences in the way humor is used and perceived by men and women (Johnson, 2010), so the imagined gender of the counselor may have impacted ratings .

The second part of the analysis looked at expectation of humor in counseling as a moderator for the relationship between sense of humor and ratings of effectiveness. This means that the intervention was differentially effective for individuals high and low on expectation of humor (Frazier, et al., 2004). Again, vignette X2 was the only one to yield significant results for expectation of humor as a moderator for the relationship between sense of humor scores and ratings of counselor effectiveness (for total CRF-S scores, the expertness subscale, and the trustworthiness subscale). For each of these subscales and total CRF-S scores, factoring in the moderating effect of expectation of humor in counseling significantly changed the relationship between sense of humor and CRF-S scores. For individuals with high scores of expectation of humor (that is, they expect the therapist to use humor as an intervention and in therapy in general) the relationship between sense of humor and effectiveness was not significant for

vignette X2. Ratings of counselor effectiveness for this counselor were generally higher from individuals with high expectations for humor in counseling, regardless of their sense of humor score. For individuals with low expectation of humor in counseling (that is, they expect very little humor in therapy), the relationship between sense of humor and ratings of counselor effectiveness was significant. This means that there was greater variability in the scores of counselor effectiveness across sense of humor scores for those with low expectations of humor. The significance of this finding is limited, but suggests that for individuals with a relatively high expectation that humor will be part of treatment, the presence of this kind of humor may influence opinions of counselor effectiveness.

There are many factors that may be influencing expectations of humor in counseling, as discussed in the introduction. These include media images of therapists, past experiences with therapists, and perhaps even stereotypes of therapy and preconceived notions that it must be serious at all times to be helpful. Further research is needed on this particular expectation and the clinical significance of this finding. It is possible that humor for these individuals would be most effective in therapy only after a strong relationship had been formed, and their expectations explored with the therapist in order to set the tone for therapy. These results also support the idea that if you expect something and get it, there is a positive reaction—clinically resulting in positive outcomes (Greenberg, Constantino, & Bruce, 2006; Lambert & Barley, 2001).

In general, the results do not support an endorsement of humor in therapy for all clients. However, it does seem that humor may influence opinions of effectiveness for some individuals. Those who expect humor and rate themselves as high on sense of humor seem to be a group that may benefit from an increased use of humor in therapy.

The other general piece of information gleaned from this research, particularly of interest to practitioners and training programs, is that some people expect some humor in therapy. The mean score on the EHC was 30.39 (sd = 11.59), demonstrating that the average answer to the questions about humor was 3.79, or in between “Somewhat True” and “Fairly True.” Perhaps information like this about what clients expect in the way of humor can help us, as therapists, worry less about the “psychoanalytic police” (Korb, 1988). The hope would be for the therapeutic community to acknowledge these results as an indication of the importance of learning about each client as an individual, and then to use humor appropriately with them in the experience of being human.

Future Research

Due to the lack of clinical studies of humor in therapy, there is no question that future research is needed in this area in order to determine effectiveness and need for humor in therapy. One area that could be explored is different kinds of therapeutic humor. This study used only two vignettes which portrayed humor and there are obviously questions about how adequately the domain of humor in therapy was sampled. Perhaps qualitative methods could be utilized to better analyze and understand reactions to humor. Ideally, this research would take place in the context of actual therapy in order to increase the applicability of the results.

Conducting research on the use of humor within actual treatment settings would also allow for investigation of the influence of the therapeutic alliance on ratings of effectiveness of humor. It seems that the therapeutic alliance was an important factor when researching similar constructs in therapy, such as therapist self-disclosure (Goode, 2002; Hill, 2004).

The results of this study indicate that expectation of humor may have a stronger relationship with ratings of counselor effectiveness than sense of humor. Future research is needed to expound on this finding, as it was not the focus of this research.

Limitations

There are several ways that the present study could be improved upon.

Measures. As it existed in the present study, the question of “would you see this counselor if you were having troubles in your own life” consisted of just three response options (yes, no, and unsure). Statistically, this question could have been more valuable and resulted in a stronger analysis if response options would have been offered in a 5 or 7-point Likert-type scale (i.e., How likely would you be to see this therapist if you were having troubles in your own life? 1= Not at all to 5= Absolutely).

The moderation analysis of current study could have been made stronger by providing more response options in the dependent variable (CRF-S). More responses in the CRF-S would have made it more sensitive to detecting moderation effects. Frazier, Tix, and Barron (2004) recommend having as many response options in the dependent measure as the product of response options of the predictor variable and the moderator. In the case of this study, the predictor variable was the MSHS, which has five response options, and the moderator variable was the EHC, which has seven response options. Ideally, then, there should have been at least 35 response options between the dichotomous items of the CRF-S to best detect moderation effects. For example, one item on the CRF-S would look like:

FRIENDLY

Very ----- Not Very

In this example, each dash represents one response option. Frazier, Tix, and Barron describe the ability to create scales that are sensitive to mouse clicks on measures completed on the computer, which can be made to detect any number of responses. In creating such response options, one would have to proceed with caution in order to maintain the integrity of the psychometrics of the instrument as created.

Greater precaution could have been taken in creating the humorous vignettes for this study. Preliminary tests were completed on a population at a large, public university in a predominately White, Christian area. It seems that the preliminary test did not allow for the detection of strong responses to the allusion to religion/God in vignette Z2. It is possible that including this as one of the humorous vignettes may have skewed the results of effectiveness, and especially expertness for that vignette, and humor overall in this study. It is possible that stronger relationships between sense of humor and effectiveness may have emerged if a different example of humor had been used.

The eight items on the EHC were minimally tested before use in this research. Consistently high Cronbach alpha scores may indicate that the measure could be useful with more testing, but it is not appropriate for use with clinical samples at this time. There is no indication of how actual clients would respond to the idea of humor in a therapeutic setting.

Analysis. This study conducted several Pearson Correlations as part of the analysis. It is possible that some of the significance found here was due to chance.

Sampling. In looking at the responses to this study, it seems that collecting data (voluntarily) about geographical location would have been helpful and interesting in thinking about the generalizability of these results. Additionally, geographical data could also be used to inform future research on humor and investigation of culture and types of humor. Given the

method of online data collection used in this study, it is possible that responses were completed anywhere in the world.

Additionally, over 50% of the participants in this study are now or have been at one time a client in counseling or psychotherapy. The significance of this was not explored here, but may serve as a factor in ratings of effectiveness of humorous interventions.

It is unknown if the participants in this study were or were not clients in counseling or psychotherapy. This fact makes it difficult to generalize to a clinical population because there are multiple factors that could influence the effectiveness of humor in clinical work. Clients may not find the humor funny, may not react to it, or may use it to distract from the clinical work. Additionally, there are many client populations that would not be appropriate for humor use in counseling or psychotherapy. Individuals with autism or other social problems may not benefit from humor as part of their treatment.

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APPENDIX A

Demographic Information

General Information

Please provide the following general information. Responses are anonymous.

- Gender:
 - Male _____
 - Female _____
 - Transgender _____
 - Other _____

- Age: _____

- Ethnicity:
 - Asian/Pacific Islander _____
 - Hispanic, Latino _____
 - Hispanic, non-Latino _____
 - Caucasian _____
 - African-American _____
 - Biracial _____
 - Other _____

- Have you ever been a client in counseling or therapy?
 - Yes _____
 - No _____

APPENDIX B

Expectations About Humor in Counseling

Expectations About Counseling

DIRECTIONS

Pretend that you are about to see a counselor for your first personal counseling interview. We would like to know just what you think the counselor will be like. On the following pages are statements about counseling. In each instance you are to indicate what you expect the counselor to be like. The rating scale we would like you to use is printed at the top of each page. For each statement, mark the space corresponding to the number which most accurately reflects your expectations

Your responses will be kept in strictest confidence. Your answers will be combined with the answers of others like yourself and reported only in the form of group averages. Your participation, however, is voluntary. If you do not wish to participate in this research, do not complete the surveys.

When you are ready to begin, answer each question as quickly and as accurately as possible. Finish each page before going to the next.

Please answer each question using the following scale. Circle the number that reflects your response:

	1	2	3	4	5	6	7
Not True		Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

THE FOLLOWING QUESTIONS CONCERN YOUR EXPECTATIONS ABOUT THE COUNSELOR:

I EXPECT THE COUNSELOR TO...

- Explain what's wrong.

1 2 3 4 5 6 7

- Tell me what to do.

1 2 3 4 5 6 7

- Know how I feel even when I cannot say quite what I mean.

1 2 3 4 5 6 7

- **Use humor to motivate me to change.**

1 2 3 4 5 6 7

- Praise me when I show improvement.

1 2 3 4 5 6 7

- Make me face up to the differences between what I say and how I behave.

1 2 3 4 5 6 7

- **Help me laugh at myself.**

1 2 3 4 5 6 7

- Like me.

1 2 3 4 5 6 7

- Give encouragement and reassurance.

1 2 3 4 5 6 7

- **Joke with me.**

1 2 3 4 5 6 7

1	2	3	4	5	6	7
Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

I EXPECT THE COUNSELOR TO...

- Help me to know how I am feeling by putting my feelings into words for me.

1 2 3 4 5 6 7

- Be a “real” person not just a person doing a job.

1 2 3 4 5 6 7

- **Laugh with me at times.**

1 2 3 4 5 6 7

- Talk freely about himself or herself.

1 2 3 4 5 6 7

- **Use humor to make points.**

1 2 3 4 5 6 7

- Frequently offer me advice.

1 2 3 4 5 6 7

- Be honest with me.

1 2 3 4 5 6 7

- **Have a good sense of humor.**

1 2 3 4 5 6 7

- Like me in spite of the bad things that he or she knows about me.

1 2 3 4 5 6 7

- Point out to me the differences between what I am and what I want to be.

1 2 3 4 5 6 7

1	2	3	4	5	6	7
Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

I EXPECT THE COUNSELOR TO...

- **Use humor to help me understand myself better.**

1 2 3 4 5 6 7

- Be friendly and warm towards me.

1 2 3 4 5 6 7

- Discuss his or her own attitudes and relate them to my problem.

1 2 3 4 5 6 7

- **Help me see the humor in a serious situation.**

1 2 3 4 5 6 7

- Make me face up to the differences between how I see myself and how I am seen by others.

1 2 3 4 5 6 7

APPENDIX C

Non-Humorous Clinical Vignette Z1

Humorous Clinical Vignette Z2

Non-Humorous Clinical Vignette Z1

Please read the following interaction between the counselor and the client carefully and answer the question that follows.

Ms. Z is a 20 year old female college student. She originally came to counseling because she was feeling lonely and isolated on her college campus. She is inclined to find lots of reasons to avoid making changes in her life. She reports a strong working relationship with her counselor, and this interaction is taken from her fourth counseling session.

Ms. Z: It just seems like everyone else is having fun all the time—hanging out and doing things. All I ever do is homework, and sometimes I talk to my family, but that just makes me sadder because they are far away.

Counselor: So, you're feeling really lonely and maybe left out.

Ms. Z: Yeah. Exactly. Like I'm not a part of it.

Counselor: Were you able to look at some of the campus organizations that you might be interested in, like we talked about last week.

Ms. Z: Well—I thought about it. But I had some papers to work on and lots of reading to do this week, so I didn't get around to it.

Counselor: OK, so finding out ways to become a part of something was not your priority this week.

Ms. Z: Yeah. I had too much schoolwork.

Counselor: It's great that you are really focused on doing well academically, but I wonder if there are any other things that might be keeping you from getting involved in activities.

Ms. Z: Um...I'm not sure. Like what?

Counselor: Well, it could be almost anything. For example, sometimes people have a hard time doing something new because they are afraid that it won't work out the way that they want it to.

Ms. Z: But what if it doesn't? What if I never make friends? It's scary to think about that...I mean—you have to talk to me, but other people don't...

Counselor: It is really scary to actually participate sometimes. Tell me some more about what's scary about it for you.

Humorous Clinical Vignette Z2

Please read the following interaction between the counselor and the client carefully and answer the question that follows.

Ms. Z is a 20 year old female college student. She originally came to counseling because she was feeling lonely and isolated on her college campus. She is inclined to find lots of reasons to avoid making changes in her life. She reports a strong working relationship with her counselor, and this interaction is taken from her fourth counseling session.

Ms. Z: It just seems like everyone else is having fun all the time—hanging out and doing things.

All I ever do is homework, and sometimes I talk to my family, but that just makes me sadder because they are far away.

Counselor: So, you're feeling really lonely and maybe left out.

Ms. Z: Yeah. Exactly. Like I'm not a part of it.

Counselor: Were you able to look at some of the campus organizations that you might be interested in, like we talked about last week.

Ms. Z: Well—I thought about it. But I had some papers to work on and lots of reading to do this week, so I didn't get around to it.

Counselor: OK, so finding out ways to become a part of something was not your priority this week.

Ms. Z: Yeah. I had too much schoolwork.

Counselor: You are reminding me of Nick when we talk about this.

Ms. Z: Who's Nick?

Counselor: Well, Nick lived his whole life being the best person he could be. He also wanted to please God. He was kind, loving, always doing good deeds--anything God asked of him. But Nick was poor—he sometimes had a hard time giving his family all they needed—so one day God was thanking Nick for all of his good deeds and Nick said, “God, I work hard to serve you and be a good person, and I am happy to do it, but my family is suffering. Why don't you let me win the lottery?” And God replied, “You are a good man. But Nick, you have to get a ticket!”

Ms. Z: (smiles) Ah....you can't win if you don't play. And I can't make friends if I don't leave my room. But it's kinda scary to think about that...I mean—you have to talk to me, but other people don't...

Counselor: It is really scary to actually participate sometimes. Tell me some more about what's scary about it for you.

APPENDIX D

Non-Humorous Clinical Vignette X1

Humorous Clinical Vignette X2

Non-Humorous Clinical Vignette X1

Please read the following interaction between the counselor and the client carefully.

Ms. X is a 24 year old teacher. She originally came to counseling because she was feeling under lots of pressure about her job and her relationship. She feels that her boyfriend demands too much from her, and she is inclined to try to keep other people happy all the time. She reports a strong working relationship with her counselor and this interaction is from their fourth counseling session.

Ms. X: Things have just not gotten any better. At school there are all of these budget cuts looming, and they may have to fire some teachers. Everyone says that I should be fine, but I can't help but be worried about it, at least a little. And even though I'm really stressed out about work, my boyfriend just doesn't get it. He's always wanting me to do things for him—like always picking something up or fixing dinner. It doesn't sound like a big deal, but it ends up taking all my time, and if I ask him to do anything he never will. Not take out the trash, not fix dinner, nothing.

Counselor: So it sounds like you are really being pulled in several directions.

Ms. X: I am. And it's like I can see that he is no good for me and the relationship is basically dead, but I am stuck in this rut of always doing everything for him and never saying no. It's like a bad habit.

Counselor: Tell me more about what it's like to be stuck.

Ms. X: Nothing ever changes. It just seems like he doesn't even care about the relationship at all—he just likes to know that I'm always there. He never wants me to go out on my own or with friends from work and it is so annoying because I don't want to just be with him all the time. So then we fight, and we'll go out with *his* friends, and he doesn't have a problem with it. I mean, I am fed up with it, and stressed out about work, and sure, I can *act* “together” all the time, like nothing ever bothers me...

Counselor: But the truth is that you are quite bothered.

Ms. X: I am! It's like I spend all of my energy keeping everyone thinking that my life is “on track” or whatever, but inside I am freaking out.

Counselor: I wonder if there is something that you'd like to be doing with your energy instead?

Humorous Clinical Vignette X2

Please read the following interaction between the counselor and the client carefully and answer the question that follows.

Ms. X is a 24 year old teacher. She originally came to counseling because she was feeling under lots of pressure about her job and her relationship. She feels that her boyfriend demands too much from her, and she is inclined to try to keep other people happy all the time. She reports a strong working relationship with her counselor and this interaction is from their fourth counseling session.

Ms. X: Things have just not gotten any better. At school there are all of these budget cuts looming, and they may have to fire some teachers. Everyone says that I should be fine, but I can't help but be worried about it, at least a little. And even though I'm really stressed out about work, my boyfriend just doesn't get it. He's always wanting me to do things for him—like always picking something up or fixing dinner. It doesn't sound like a big deal, but it ends up taking all my time, and if I ask him to do anything he never will. Not take out the trash, not fix dinner, nothing.

Counselor: So it sounds like you are really being pulled in several directions.

Ms. X: I am. And it's like I can see that he is no good for me and the relationship is basically dead, but I am stuck in this rut of always doing everything for him and never saying no. It's like a bad habit—like I am addicted to him.

Counselor: I've got a feeling if it's that bad, you'd like to *kick* the habit.

Ms. X: (*Smiles*). Wouldn't that be nice! Sometimes I think that I would like to...or at least know what's going on. It just seems like he doesn't even care about the relationship at all—he just likes to know that I'm always there. He never wants me to go out on my own or with friends from work and it is so annoying because I don't want to just be with him all the time. So then we fight, and we'll go out with *his* friends, and he doesn't have a problem with it. I mean, I am fed up with it, and stressed out about work, and sure, I can *act* “together” all the time, like nothing ever bothers me...

Counselor: (*Counselor smiles*) With all that acting, it sounds like you deserve an Oscar.

Ms. X: (*Smiles, nods in agreement*). I totally do! It's like I spend all of my energy keeping everyone thinking that my life is “on track” or whatever, but inside I am freaking out.

Counselor: I wonder if there is something that you'd like to be doing with your energy instead?

Adapted from: Foster, & Reid, J. (1983). Humor and its relationship to students' assessments of the counselor. *Canadian Counselor*, 17(3), pp. 124-129.

APPENDIX E

Counselor Rating Form-Short Form

Counselor Rating Form – Short (CRF-S)*

Now, please rate several characteristics of the counselor you just read about. For each of the following characteristics, there is a seven-point scale that ranges from "not very" to "very." Please mark the point on the scale that best represents how you view the counselor you just read about..

Though all of the following characteristics are desirable, therapists differ in their strengths. We are interested in knowing how you view these differences.

* Corrigan, J. D., and Schmidt, L. D. (1983). Development and validation of revisions in the Counselor Rating Form. *Journal of Counseling Psychology*, 30, 64-75.

not very FRIENDLY (A)* very
_____ : _____ : _____ : _____ : _____ : _____

not very EXPERIENCED (E) very
_____ : _____ : _____ : _____ : _____ : _____

not very HONEST (T) very
_____ : _____ : _____ : _____ : _____ : _____

not very LIKABLE (A) very
_____ : _____ : _____ : _____ : _____ : _____

not very EXPERT (E) very
_____ : _____ : _____ : _____ : _____ : _____

not very RELIABLE (T) very
_____ : _____ : _____ : _____ : _____ : _____

not very SOCIABLE (A) very
_____ : _____ : _____ : _____ : _____ : _____

not very PREPARED (E) very
_____ : _____ : _____ : _____ : _____ : _____

not very SINCERE (T) very
_____ : _____ : _____ : _____ : _____ : _____

not very WARM (A) very
_____ : _____ : _____ : _____ : _____ : _____

not very SKILLFUL (E) very
_____ : _____ : _____ : _____ : _____ : _____

not very TRUSTWORTHY (T) very
_____ : _____ : _____ : _____ : _____ : _____

*Subscale items are denoted to the right of each item. A = Attractiveness, E = Expertness, T = Trustworthiness

Additional Items

If you were having some problems in your own life, would you go to see this counselor?

- Yes
- No
- Unsure

What do you think that the counselor did or said that was particularly helpful or unhelpful?

APPENDIX F

Multidimensional Sense of Humor Scale

Multidimensional Sense of Humor Scale

Please indicate how much you agree with each item below about yourself.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I'm regarded as something of a wit by my friends.	0	1	2	3	4
2. I can say things in such a way as to make people laugh.	0	1	2	3	4
3. My clever sayings amuse others.	0	1	2	3	4
4. People look to me to say amusing things.	0	1	2	3	4
5. I use humor to entertain my friends.	0	1	2	3	4
6. I'm confident that I can make people laugh.	0	1	2	3	4
7. Other people tell me that I say funny things.	0	1	2	3	4
8. Sometimes I think up jokes or funny stories.	0	1	2	3	4
9. I can often crack people up with the things that I say.	0	1	2	3	4
10. I can ease a tense situation by saying something funny.	0	1	2	3	4
11. I can actually have some control over a group by my uses of humor.	0	1	2	3	4
12. Humor helps me cope.	0	1	2	3	4
13. Use of wit or humor can help me master difficult situations.	0	1	2	3	4
14. Coping by using humor is an elegant way of adapting.	0	1	2	3	4
15. Trying to master situations through use of humor is really dumb.	0	1	2	3	4
16. Humor is a lousy coping mechanism.	0	1	2	3	4
17. Uses of humor help to put me at ease.	0	1	2	3	4
18. I can use wit to help adapt to many situations.	0	1	2	3	4
19. I appreciate those who generate humor.	0	1	2	3	4
20. I like a good joke.	0	1	2	3	4
21. Calling somebody a comedian is a real insult.	0	1	2	3	4
22. I dislike comics.	0	1	2	3	4
23. People who tell jokes are a pain in the neck.	0	1	2	3	4
24. I'm uncomfortable when everyone is cracking jokes.	0	1	2	3	4

APPENDIX G

Recruiting Materials and Information Letters

Recruitment in FOUN Classes

Hello. My name is Teresa Blevins and I am a doctoral candidate in Counseling Psychology. I am here today to ask for your help in creating a measure to help find out about people's expectations about counseling. I will hand out a short questionnaire to everyone that includes some general questions about you and what you expect in counseling. It does not include any identifying information and there are no wrong answers. You are not required to complete the survey for any benefit in this class, but your participation will help make an instrument that is high in quality for future research. It will take you about 10 minutes to complete the questionnaire. I will be back next time your class meets to collect the completed questionnaires. Thank You

(Note. THIS FORM IS NOT VALID UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT.)

**INFORMATION LETTER
for a Research Study entitled**

“Expectations About Counseling: Reliability Study for a New Measure”

You are invited to participate in a research study to examine expectations about counseling. The study is being conducted by Teresa Blevins, B.A. under the direction of Randolph Pipes, Ph.D. in the Auburn University Department of Special Education, Rehabilitation, and Counseling/School Psychology. You were selected as a possible participant because you are age 19 or older and are enrolled in a course at Auburn University.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to complete a Demographic Information Sheet. You will also be asked to complete a brief measure about your expectations about counseling and to read and respond to two clinical vignettes. Your total time commitment will be approximately 10 to 15 minutes.

Are there any risks or discomforts? There are no risks associated with participation in this study. If you experience any psychological discomfort, please contact Student Counseling Services at 334-844-5123.

Are there any benefits to yourself or others? There are no direct benefits for participating in this study.

Will you receive compensation for participating? You will not receive compensation for your participation.

Are there any costs? If you decide to participate, you will not incur any costs.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation, and Counseling/School Psychology, the Department of Educational Foundations and Leadership Technology.

Your privacy will be protected. Any information obtained in connection with this study will be confidential. Information obtained through your participation may be *published in a professional journal or presented at a professional meeting as part of a large data set. Individual responses will not be identifiable.*

If you have questions about this study, please ask them now or contact Teresa Blevins, B.A. at blevi01@auburn.edu. A copy of this document will be given to you to keep

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334)-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP

Principal Investigator Date

Invitation to Participate
(for use on Facebook groups and messages)

You are invited to participate in a research study about psychotherapy. This study is being conducted by Teresa Blevins, B.A. I am a doctoral candidate under the supervision of Randolph Pipes, Ph.D. at Auburn University. The purpose of this study is to understand attitudes about psychotherapy and how they relate to personality traits. Your participation in this study will help provide more information about how psychotherapy can be more effective.

The survey is confidential and will take about 15-20 minutes to complete. For each completed survey, \$1 will be donated to the National Multiple Sclerosis Society. You may withdraw participation at any time. The current study has been approved by the Auburn University Institutional Review Board (IRB). For more information regarding IRB approval and contact information, please click on the survey link below.

If you are interested in participating in this study, please follow the link below or cut and paste the following hypertext into your browser window:

<http://www.zoomerang.com/Survey/?p=WEB229ME5UBZNP>

This link will take you to the consent form and questionnaire.

Please forward this e-mail announcement to others who may be interested in participating. Thank you in advance for your help with this research project!

Sincerely,

Teresa Blevins, B.A.
Doctoral Candidate in Counseling Psychology
Auburn University
2084 Haley Center
Auburn University, 36849
blevi01@auburn.edu

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 See all
 Ad performance glossary
 What happens when I choose to "Edit Ad"?
 What can I do if my ad was disapproved?
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Campaign Name: Teresa's Dissertation
 Ad Name: Teresa's Dissertation
 Status: Completed
 CPM Bid: \$0.35
 Suggested bid: \$0.32 - 0.39 USD

Targeting:
 edit
 who live in the United States
 age 18 and older
 who are single, in a relationship, engaged or married
 interested in men or women who speak English (US)
 who are not already connected to Teresa's Dissertation Research!

Preview
 Teresa's Dissertation
 Online research study needs your insight and expertise. Complete our survey (Partnership!) Take a quick survey and earn \$1 for Multiple Sclerosis!
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Daily stats for the week of: Sep 13

Date	Imp.	Clicks	CTR (%)	Avg. CPC (\$)	Avg. CPM (\$)	Spent (\$)
09/19/2009	17,474	6	0.03	0.83	0.29	5.00
09/18/2009	17,304	5	0.03	1.00	0.29	5.00
09/17/2009	17,463	6	0.03	0.83	0.29	5.00
09/16/2009	17,199	6	0.03	0.83	0.29	5.00
09/15/2009	17,427	8	0.05	0.63	0.29	5.00
09/14/2009	17,305	11	0.06	0.45	0.29	5.00
09/13/2009	0	0	0.00	0.00	0.00	0.00
Lifetime	173,235	71	0.04	0.70	0.29	50.00

Choose a graph: Clicks

Done
 Proposal 10-22-09.d... Facebook | Ad: Ter...

Dept. of Special Education, Rehabilitation, Counseling/School Psychology
Auburn University 2084 Haley Center Auburn, AL. 36849-5222

INFORMATION LETTER
for a Research Study entitled
Psychotherapy: Attitudes and Personality

You are invited to participate in a research study to understand attitudes about psychotherapy and how they relate to personality traits. The study is being conducted by Teresa Blevins, B. A., under the direction of Randolph Pipes, Ph.D. in the Auburn University Department of Special Education, Rehabilitation, Counseling/School Psychology. You are being invited through your participation on Facebook or affiliation with someone on Facebook who sent you the invitation, you must be 19 years of age to participate.

What will be involved if you participate?

Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to complete a survey that includes questions about yourself and your responses to two psychotherapy vignettes. Your total time commitment will be approximately 15-20 minutes.

Are there any risks or discomforts?

I do not believe that there are any significant risks or benefits for participation. However, if you experience any adverse effects in completing the questions, please contact your local mental health provider.

Are there any benefits to yourself or others?

Your participation in this study will help provide information about how psychotherapy can be more effective. In addition, for each completed survey, \$1 will be donated to the National Multiple Sclerosis Society.

Are there any costs?

There are no costs associated with participation in this study.

If you change your mind about participating, you can withdraw at any time by closing your browser window. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Once you've submitted anonymous data, it cannot be withdrawn since it will be unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University or the Department of Special Education, Rehabilitation, Counseling/School Psychology.

Any data obtained in connection with this study will remain anonymous. We will protect your privacy and the data you provide by using a secure data collection site and secure server, as well as not collecting computer IP addresses during survey completion. Information collected through your participation may be used to fulfill an

