Survival of the Wittiest

by Terry Marks-Tarlow
Along with art and science, humor was considered by the late psychologist Arthur Koestler (1964) to be the third pillar of creativity. To create a joke is to bring together disparate things in a novel way. To understand a joke is to connect with the sheer pleasure of solving a little problem. Frank Howard Clark once commented, “I think the next best thing to solving a problem is finding some humor in it.” Implicitly humor brings a sense of play and openness into relationships that can be invaluable to their fabric. Within psychotherapy, through clinical intuition we navigate the rhythms of humor. Whether initiated by the patient or therapist, humor offers an invitation to play within intersubjective realms, while communicating implicitly about the nature of the therapeutic bond itself.

Every therapist, along with each person, has a unique sense of humor, which intuitively guides some portion of our interventions. To share humor within psychotherapy can help to forge trust and positive experiences within an attachment relationship. To utilize and receive humor requires the idiosyncratic use of language that capitalizes on the highest capacities of the right brain. How and when clinical intuition prompts therapists to use humor as a powerful tool is the subject of this chapter.

It is no wonder that humor comes naturally into our offices, because humor is an important part of childhood play right from the start of life. As discussed in the last chapter, when a mommy tickles her baby’s belly, she behaves like a mock predator pretending to violate the baby’s personal boundaries, yet her real intention is to deliver fun and pleasure instead. Laughter, as it connects to this humorous act of imagination, is deeply wired into our brains subcortically. Laughter tunes into amygdalar regions, which are the arbiters of safety versus danger and deep processors of humor from the start (Watson, Matthews, & Allman, 2007).

In this chapter, I begin with a discussion of the evolutionary roots of laughter and humor to bolster the necessity of clinicians taking this topic seriously. I then shift to psychotherapy, where humor can buffer pain to within tolerable limits, provide safety to approach shameful topics, and help to diffuse aggression away from violent levels. Ampèl clinical examples are provided. Like any other tool, humor can be used for good or poor treatment, and in addition to covering its positive sides, this chapter also explores its misuses and even abuses. Within psychotherapy humor can be abused if dispensed in service of avoidance, numbing, dissociation, or humiliation.

What’s So Funny?
Franzini (2001, p. 171) described therapeutic humor as both an “intentional and spontaneous technique of leading to improvements in self-understanding and behavior of clients.” This formulation acknowledges the important quality of spontaneity surrounding the production of humor. Yet this otherwise cognitive definition is limiting in two ways. First, the definition implies that humor is an intervention produced by the therapist in order to illuminate or otherwise change the patient. Yet as we shall see, humor is an intuitive form of play during psychotherapy that is often initiated by the patient. Second, Franzini’s definition implies that humor has a conscious impact on patients, whether it is produced intentionally or spontaneously. I propose differently—that the use of humor during psychotherapy need not be consciously produced.
or even consciously recognized. Instead, humor within psychotherapy, including its close relative, laughter, involves primarily implicit, and not explicit, communication. Specifically, humor during sessions involves communication that surrounds and highlights the current state of the therapeutic relationship.

Whether initiated by the patient or by therapist, I suggest that humor arises intersubjectively from the relational unconscious. What is more, the primary function of humor is to signal, through enactment, an emotionally relevant aspect surrounding the nature or quality of the bond itself, whether indicating safety or danger, progress or impasse, crisis or breakthrough. For example, a patient evading topics and deflecting with jokes might indicate the perception of danger. By contrast, affectionate ribbing surrounding shared humor, even around painful issues, could indicate the desire for or safety of connection. Clinical cases sprinkled throughout this chapter provide other examples in detail.

**Laughometers**

Robert Provine is a researcher who is interested in the social and biological functions of humor-related behavior. In the introduction to his book Laughter (Provine, 2000), he lamented that his colleagues all too often refuse to take this topic seriously. Yet ethological research reveals that laughter is built into the very foundation of the mammalian brain. Laughter is a closed circuit, like coughing or sneezing, which may be triggered by environmental factors, but whose form is specific to each individual and does not depend on experience (Panksepp, 1998). Laughter is shared by many social mammals, including some surprising ones (see Figure 5.1), a topic further explored later in the chapter.

If such a thing existed as a laughometer that could measure wit and mirth through the course of a day, I would guess that each one of us would display a unique pattern of humor and merriment. If we were to collect time-series data to measure the pauses between incidents of either producing or responding to humor, I further speculate that the fluctuations would reveal a pattern of consistent inconsistency across all time scales, whether measured in minutes, hours, days, or weeks. If so, this would be the classic power law, a nonlinear statistical distribution found throughout much of nature, including human nature (Marks-Tarlow, 2004, 2008a). Power laws signal identity by revealing what remains constant underneath and despite continual, often unpredictable, surface change. If our reliance on humor were to follow a power law, then as an aspect of personal identity, its fluctuations and unique exponent for each person would resemble power law exponents previously measured for self-rated self-esteem, along with feelings about our bodies (Delignières, Fortes, & Ninot, 2004).

Given the possibility that humor is an important aspect of personal identity, within clinical work I suspect that each therapist uses humor idiosyncratically as a clinical tool. Furthermore I surmise that each of us turns to wit or laughter more with certain patients than with others, and more during certain stages of treatment than during others. And if all of this is so, these rhythms of humor that punctuate each clinical hour are navigated intuitively, as we feel our way through the contours of intersubjective space and time.

**To Laugh, Perchance to Communicate**

Whether patients have a sense of humor and how they use or abuse humor can be di-

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**Figure 5.1**

The photographer noted, “I hadn’t met this pony before and as I put the camera up, this was his response!” Everything about this picture suggests an amused horse, but is the horse actually feeling this emotion or is this the projection of an amused viewer? (Public domain, courtesy of Rachel C)
agnostic. Humor involves the play of social imagination. And just as the absence of imaginative play can indicate autism in young children, so the inability to participate in the social reciprocity of humor can indicate autism or Asperger’s syndrome in adults (Neihart, 2000). Consider the words of Temple Grandin, a famed, high-functioning autistic woman who wrote eloquently in her autobiography, Thinking in Pictures, about what it is like to grow up outside of normal social patterns:

When several people are together and having a good time, their speech and laughter follow a rhythm. They will laugh together and then talk quietly until the next laugh cycle. I have always had a hard time fitting in with this rhythm, and I usually interrupt conversations without realizing my mistake. The problem is that I can’t follow the rhythm. (quoted in Provine, 2000, p. 35)

Allan Schore (personal communication) has suggested that symbolic humor is produced and appreciated by the high right-cortical hemisphere. The right hemisphere mediates spontaneous facial expressions in reaction to humor, including smiling and laughter (McGilchrist, 2009). It is the right hemisphere that understands the point of a joke (Coulson & Wu, 2005). Meanwhile, humorlessness in patients can indicate an overactive left hemisphere. This is confirmed by research showing that neurological damage to the right hemisphere often results in the literal interpretation of jokes (see Figure 5.2; McGilchrist, 2009; Tucker, Watson, & Heilman, 1984).

In my clinical experience, people who suffer moderate levels of anxiety sometimes appear humorless. Todd was a good example of a Type A personality who was efficient, productive, and had a strong work ethic. But Todd had a problem in knowing when to stop working. Even during social occasions or personal conversations, this young man, who seemed much older, tended to plod through endlessly. Todd carried tension continually in his face, including a jaw that perennially seemed locked down tight. Even without coffee, Todd was a “fine grind,” by keeping his teeth grinding and his nose to the grindstone, indicating little time left to waste on silly jokes. Yet Todd’s humorless style seemed more about sympathetic arousal and high pressure to race into the future than about anxiety per se.

I have noticed another type of anxious person who presents in the opposite way. Perhaps indicating a person more easily distracted by her own internal states, this sort of individual’s very body seems to jitter naturally, as if caught in a perpetual laugh. Gilda, one of my former patients, was an example. As she got more nervous, instead of sweating bullets, she sweated out jokes, releasing tension while communicating implicitly, “If I can laugh at myself, and if I can convince you to join in, then there is at least one thing right and safe in the world. But only for a moment, until I crack the next joke.” For people like Gilda who evidence an insecure, anxious attachment style, humor can become a central aspect of interactive emotional regulation.

Whether or not patients invite us to join in and whether or not we laugh along with them speaks volumes about the nature of the therapeutic relationship. Consider the social behavior of a patient named Blair, a young woman who laughed loudly every time I opened the door to the waiting room at the beginning of a session. Blair regularly continued her nervous laughing as she entered my office and passed alongside me to take a seat on the couch. During this extended period of time, I found nothing funny going on, and I did not find myself intuitively
inclined to laugh along with Blair. In fact, I experienced the whole sequence as painful, which easily seeped into annoyance, which, to my horror, would crescendo into downright hostility on my part, all before Blair had even said a word.

To share a laugh during therapy can be an intimate moment. Yet with Blair, there was nothing shared or intimate about these laughing moments. In fact, had I laughed along, I imagine my participation would have been received as weird and completely “off.” I imagine that implicitly I would communicate derision. By laughing when nothing was funny, I would be mocking my patient for her social awkwardness, making fun of her discomfort. Either that or I would be perceived as laughing at my own private joke that had nothing to do with Blair’s presence.

True humor involves an intuitive understanding, if not mastery, of social rhythms. Because Blair’s use of laughter did not involve humor at all, I regularly found that my access to my own intuitive side was completely blocked during these opening sequences. Instead, I was very consciously deliberating about how to respond. This included a lot of self-restraint to not express the anger and frustration, if not derision, I often felt. I could feel my lips drawn into a tight line, as if to ensure that nothing that resembled a laugh or snide remark would leak out. I received the solitary guffaws of my patient quite self-consciously, by bracing for the discomfort of the moment. My body perceived Blair’s communication as a mixed message. Rather than as an invitation to share in the fun, I felt pushed away and even tricked, through being teased and left out of a gesture I would ordinarily feel motivated to join (who does not adore a good laugh?).

And all of this transpired in the brief few seconds at the start of psychotherapy. Meanwhile, intuitively I sensed this young woman was far too caught up in her own discomforts to be conscious of any implicit communications or emotionally laden reactions on my part. I also sensed Blair would never purposefully send or receive such messages. As a result, I regularly felt guilt at my own hostility, experiencing myself as assaulting my patient with feelings of discomfort and irritation. Along with these secondary feelings, Blair became the innocent victim in my eyes, and I the guilty perpetrator. Dooley (1941) wrote of the relationship between humor and masochism. Indeed Blair was quite self-effacing in style. And this gave way to yet another, tertiary set of feelings—hoping and attempting to empty myself of annoyance as quickly as possible, in order to “get on with” the “real stuff” of psychotherapy.

But I am sure the astute reader recognizes immediately that all of this is the real stuff. Much of Blair’s work in psychotherapy surrounded the recognition of her need and efforts to reclaim her personal power in relationships. Insofar as the sequence at the beginning of each session mirrored the internal world of my patient, my own reactions partly revealed Blair’s habit of regularly trying to empty herself of the bad feelings. This held especially true for despair and annoyance at her husband, whose avoidant style left him attempting to evade and vacate himself from true contact. Indeed, this was Blair’s presenting complaint upon entering psychotherapy. She felt ignored, disrespected, and unhappy in her marriage, but she was unsure what to do about it.

When it comes to the realm of intuition, I am continually astonished by how much can be implicitly known and experienced without conscious thought. Consider the parallels between tiny moments in these opening minutes of our interpersonal ritual and Blair’s larger-scale struggles with her husband and within herself. I am equally as astonished by how many words it takes to flesh out these micro-moments of implicit exchange! I suspect this ratio between the brevity of an implicit event and the length of its explicit description might be especially high whenever humor comes into the picture. Humor serves vital emotive, relational, and communicative purposes, partly by functioning as an intuitive bridge in the gap between lower, primitive subcortical circuity and higher prefrontal areas, those pinacles of symbolic sophistication.

In the case of Blair, laughter was an expression of defense, forming a barrier to contact rather than as an invitation into mu-
tual engagement. There was little spontaneity about the laugh, which had become thoroughly scripted into our encounter. There was no humor behind the laughter, which instead signalled a kind of self-de-basement. All in all, I experienced this opening ritual as quite stale, “inspiring” me to follow suit and lose my own spontaneity. Clearly, with so much transpiring during this first nonverbal (avoidance of) contact, such implicit exchanges are in themselves important topics of discussion. How and when such issues are brought to explicit light becomes itself a matter of intuitive feel.

Laugh and the World Laughs With You

As a contrasting example to the use of laughter as a defense against contact, I would like to return briefly to the case of Sylvia from Chapter 4 (Clinical Intuition in Psychotherapy), the young lady who ritualized the start to every session by manipulating my furniture to suit her current state of mind. During psychotherapy with Sylvia, I laughed a lot, and I often experienced our mutual laughter as a way to bond in service of interactive regulation. As mentioned, Sylvia had informed me early in our treatment that her first therapist, whom she visited as a teenager, had little sense of humor. This was a deal breaker, because of the central importance humor took on to Sylvia as the gold standard of intelligence and wit. Even in high school, Sylvia had been seriously attracted to comedy. She loved stand-up and aspired to be funny herself as a primary expression of her identity, as affirmation of her wit, and as testimony to her own high intelligence. From my point of view, that her previous therapist denigrated this side of Sylvia by interpreting instead of joining in the humor reflected either a personality mismatch between the two of them or poor clinical judgment on the part of the therapist (see Figure 5.3). Intuitively, I felt so clean about joining in and clear that my immediate love for Sylvia’s wit, along with my willingness to partake in her wordplay and creative manipulation of ideas, was a major way that the two of us got into sync from the get-go.

That humor serves to align minds and brains is confirmed by the existence of laughter contagion. Although there is danger in laughter contagion if it serves to humiliate others during a mob mentality, there is a more innocent side to the phenomenon that partakes in delightful mutuality and even self-agency. As a little girl of 6 or 7, I regularly played a game with my best friend that illustrates this. One of us would signal the start of the game by declaring “Ha!” in a flat monotone. The other would respond with an equally flat “Ha!” Then together we would up the ante by declaring “Ha, ha!” which was usually enough to launch the two of us into a fit of uncontrolled laughter. These giggle-fests could last for minutes on end, including unpredictable outcomes like falling off the chair or winding up under the table. There was secret pleasure to be had if we succeeded in drawing a parent or another adult into the game, making them laugh so hard they would grab at their bellies or even rush to the bathroom to pee.

Provine (2000) documented some astounding epidemics of laughter contagion, including a famous episode in 1962 near Lake Victoria, in what is now Tanzania, at a missionary school for girls between the ages of 12 and 18 years old. The episode started when three girls began laughing so hard that they also cried while experiencing agitation. These laugh attacks lasted between minutes and a few hours at a time, with as many as four episodes in a day. The symptoms quickly spread to 95 out of 159 students. The crisis reached the point where
the school was forced to close its doors for a period of months.

But things did not stop there. The afflicted girls sent home served as agents who spread the laughing epidemic still further. By the time the incidences abated approximately two and a half years later, a total of 14 schools had closed with more than 1,000 people affected in what was determined to have a psychogenic, hysterical origin. In the case of the laughing school girls, little appears constructive surrounding this sort of contagion. Later in this chapter Ramachandran’s theory regarding the evolutionary origins of laughter helps to shed light on the positive side of emotional contagion.

**Softening Into Pain**

Max Eastman declared humor to be “the instinct for taking pain playfully.” In order to demonstrate this function of humor, especially as it relates to relational communication, I would like to relay the story of Sir James Matthew Barrie, the author of the famous children’s classic Peter Pan (1904). Peter Pan is a lot more edgy, complex, and even tragic than the shiny Disney movie variety would have us believe. In The Case of “Peter Pan,” or the Impossibility of Children’s Fiction (1984), Jacqueline Rose especially made this case by observing Peter Pan’s obsessive ruminations on “the question of origins, of sexuality, and of death.” Indeed, there is true irony in the contrast between Neverland as a myth of childhood innocence and imagination versus Barrie’s dark musings representing a retreat into fantasy in the face of early relational trauma.

Consider some facts of Barrie’s early life. He was born the ninth of ten children in the Lowland village of Kirriemuir, in Forfarshire. Barrie’s father was a handloom weaver, and his mother was the daughter of a stonemason. Trauma struck the family twice when two of Barrie’s siblings died during infancy. Barrie’s mother recovered by submerging herself in the rest of this large family. Barrie’s mother loved to read adventure tales to her children in the evenings, including stories about pirates. But another tragedy struck, from which full recovery proved impossible. When Barrie was 7 years old, his older brother David died in a skating accident. David had been his mother’s favorite child, and the accident proved the breaking point for Barrie’s mother. She fell into a depression and took to her bed, never fully to rise out again.

Of all the remaining siblings, Barrie was the most distraught and affected by his mother’s afflicted state of mind. Barrie spent endless hours trying to entertain, amuse, and rouse her from her depressive stupor. He became quite desperate in his attempts to gain her affection. He would, for example, dress up in his dead brother’s nightshirt while imitating David’s particular manner of whistling. In fact, Barrie became thoroughly obsessed with his mother, documenting these details in an adoring biography devoted entirely to her (Barrie, 1896/2011), which he published after her death.

Apparently Barrie’s mother insisted that “good little boys don’t grow up. They go to Heaven like David, where they can be with their mothers forever.” In a horrific instance of mind/body confluence, Barrie never did grow up physically. His total height never exceeded 5’3“. Although he sported a bit of facial hair, he never developed secondary sexual characteristics. Finally Barrie reputedly never consummated his own marriage, while also becoming thoroughly preoccupied with sadomasochistic sex, evidenced by kinky stories he wrote in his private journals. In response to so much early relational trauma, Robert Sapolsky (1998) speculated that Barrie suffered from psychogenic dwarfism, a hormonal growth disorder whose onset typically occurs between the ages of 2 and 15 in response to extreme stress—in particular, emotional deprivation.

Here we see both concretely, at a physical level, as well as socially and emotionally, how Barrie’s life became severely stunted. Given this early history, it is little wonder that Barrie wrote about Peter Pan who lives in Neverland where boys never grow up, for Barrie never grew up himself. We easily detect resonances of early attachment issues and forms of play in the story of Peter Pan itself. Despite Barrie’s deep emotional disturbance, or perhaps alongside it, he continually reverted to humor, both to represent trauma as well as to take refuge from it (see Figure 5.4). When it comes to the
role of laughter in processes of both hurting and healing, the following line as drawn from Peter Pan is both poignant and haunting: “When the first baby laughed for the first time, the laugh broke into a thousand pieces and they all went skipping about, and that was the beginning of fairies.”

The Dark Side of Humor

In Barrie’s case, we easily detect humor as an attachment-related communication both of desire and loss in response to Barrie’s emotionally deadened, and lost mother. Barrie’s humor served both as a refuge and a defense from relationally triggered pain. Within psychotherapy, humor is also used intuitively as a form of implicit communication regarding the state of the therapeutic bond. Humor-laden, implicit communications sometimes involve enactments designed to ward off expectations of being hurt, shamed, or misunderstood. In such cases, humor here, too, is used as a defense against true contact, including the experience of vulnerability this often brings. This certainly held true for Blair’s solo laughter.

The potential dark side of humor, including sarcasm and mockery, easily gives humor a negative rap in therapy. While many have written about the positive uses of humor in psychoanalysis (e.g., Fabian, 1982; Mosak, 1987; Sands, 1984; Saper, 1988), Lawrence Kubie (1971) has warned of its destructive potential. Danger exists in using humor as a means to dilute contact, avoid pain, sidestep conflicted emotions, or collude with patient defenses. Children readily use laughter to humiliate and shame other children for differences or because of a lack of social graces. Unfortunately, the contagious nature of laughter often means that groups of children will join in the derision and chiding once someone starts, even if they are little inclined to start the incident themselves.

Provine (2000), one of the rare empirical researchers on the topic of laughter, concluded that it often serves as a social signal of dominance or subservience. After failing to produce many laughs under laboratory conditions, Provine and a bevy of undergraduate student assistants went into shopping malls and other public arenas to track and study the occurrence of laughter within normal social discourse. Under these naturalistic conditions, the group continually found themselves surrounded by laughter. Surprisingly, only 10 to 20% of pre-laugh comments were estimated by the research assistants to be even remotely humorous. Instead, laughter tends to serve as a form of social punctuation. Laughs follow gender patterns, with girls laughing more often than boys, and boys evoking more laughs than girls. Laughs tend to come at the end of statements, and the temporal segregation of laughter from speech provides evidence that different brain regions are involved in the expression of cognitively oriented speech versus the more primitive, emotion-laden vocalization of laughter.

Provine drew on ethnological studies to document the flexible, strategic use of laughter for displaying hierarchical structure within particular cultural contexts:

In southern India, men belonging to a lower caste giggle when addressing those of a higher caste. Other aspects of “self-humbling” are well developed among Tamil villagers of low caste (Harijan), but are exercised only when dealing with powerful persons of higher caste. When dealing with a landlord, for example, a Harijan may giggle, speak with unfinished sentences, mum-
ble, appear generally dim-witted, and when walking, shuffle along. Yet this same Harijan may suddenly become shrewd and articulate when dealing with less powerful people. (p. 30)

The use of humor to establish dominance or to express submission reinforces its darker side and negative uses (see Figure 5.5). Indeed, a mocking, sarcastic tone rarely has a constructive role during psychotherapy. But even here, every rule has its exception, as I demonstrate next in the tale of a psychology intern, Elizabeth Lutz, who effectively used mock disdain intuitively to shift dynamics within a group of low-functioning, highly resistant patients. Lutz was serving as a counselor during a weekly group meeting at a residential program. Her job was to help the low-functioning members learn to live independently within a large apartment-complex setting. This was the first group meeting following the New Year, and there were only a few individuals present, as many members were still away on vacation. Those who were around had been in the program for at least 4 years, coming very regularly to the group, although Lutz had not seen some of them for months.

The residents met to speak about problems and receive input geared toward solutions from other group members. But this night was different. Lutz immediately sensed that all five participants were locked into defensive patterns, while resisting addressing their problems. In fact, even before Lutz arrived they appeared to be busily denying having problems at all. When the fledgling therapist sat down to join the group, Lutz announced a plan to talk about goals for the upcoming year, an idea that met with groans and eye rolls.

The most vocally resistant person was Natalie, and Lutz chose Natalie to begin the evening. This thirtysomething woman had been in the program for many years. Lutz felt instinctively drawn to addressing Natalie’s patterns of resistance, which seemed to be blocking her further progress. In general, Lutz tended not to be directive in group, shying away from choosing the topic or who would speak. But during this particular evening, Lutz’s intuition took her elsewhere. She continually surprised herself, first by singling out Natalie for group attention and then by picking out one of Natalie’s goals—to be in the outreach program—and asking her point-blank how she had not yet accomplished this goal. Lutz was downright shocked at herself. This kind of negative phrasing was something she would ordinarily stay clear of. But on this evening Lutz’s clinical intuition called out for a different technique.

Natalie answered Lutz’s challenge by making comments so vague in content that nobody else in the group had any idea what she was talking about. Natalie had said, “I didn’t tell people what I was doing, so I thought I was being independent. But it turns out I was wrong and wasn’t supposed to do that. It would have been more independent for me to let other people help, like what I’d been told to do.”

Lutz asked in a gentle but joking tone, “Does this have anything to do with an incident of flooding that I happened to hear about?”

Natalie looked surprised. “How do you know about that?”

Power differences between therapist and patient can be painful to patients, especially if power has been abused in the family history. To declare the beginning and end of a session is often a place where therapists reserve the full right to power. This cartoon reverses the picture by upping the ante and elevating the patient’s power, in the case of the Grim Reaper. This elegant reversal is funny partly because it accords with the existential truth that we therapists are never really in control of much, plus a greater authority sometimes does sit in the chair opposite to us. Reversal is an important aspect of humor that is particularly relevant to psychotherapy because people often seek treatment to reverse conditions over which they feel helpless. (© 2011 Victor Yalom/Psychotherapy.net)
“You should know by now that I know everything. . . . So why don’t you explain what happened to the others? They might not be quite so well informed. In fact, they’re looking pretty puzzled by what you just said. Take a look around at their faces.”

Christine piped in: “Yeah, what are you talking about?”

Natalie appeared to look toward Lutz for permission to explain because the group has confidentiality rules. Lutz encouraged her with, “This is your story to tell. Tell it if you wish. I certainly think it’s pretty funny!” “I guess you’re right. Looking back, it is funny!”

Natalie launched into the tale of moving from her last apartment in the complex into a new one. She had been told to let the manager, Helen, take care of the move. But Natalie confessed that she had been so excited about moving that she couldn’t wait and so she got her friends to help instead. When mentioning this aspect of the story, initially Natalie was poised to defend her own actions, but then she sheepishly switched gears to state that her actions had been premature.

Realizing that Natalie was leaving out a critical bit of information, Lutz prompted, “Wasn’t there a bit of water?” Natalie laughed. “I’ll say. The toilet flowed over!” “And what did you do in response to that, Natalie?” “I closed the door to the bedroom so it wouldn’t get out into the hallway.” “I bet that worked about as well as it does in the movies,” Lutz countered. Natalie looked at Lutz sideways with a grin. “You got that right!” The entire group burst into peals of laughter.

“So what happened next? How did you get help?” Lutz was aware of bringing Natalie back to task by confronting her defenses and habitual patterns of hiding the truth, which kept Natalie from clarity, both in her relationship to others and in her relationship to herself.

“I told the leasing office there was a leak . . .” “Ahhhhhhhh.” “I didn’t know they couldn’t do nothin’ without Helen’s permission.” “Hmmm. . . . Oh really? And how long have you lived here!?” “Well, okay, the truth was that I really didn’t want to tell Helen. I knew she was gonna get real mad.” “So you didn’t tell the leasing office there was a flood?” “No, I just told ’em there was a leak.” With mock sternness, Lutz implored, “So you didn’t really tell anyone what was going on?” “Nope, I didn’t tell nobody nothin’.” “Then what happened?” “They called Helen on Monday. You shoulda seen her face!” Natalie starts to laugh. “I never want to see that look again!”

Christine, the group member who had originally asked for clarification, laughed so hard she started falling out of her chair, murmuring along the way, “I just keep seeing the toilet flooding over!” “No,” responds Natalie, “it’s Helen’s face that’s so funny!” “No,” rebuked Christine. “It’s the toilet! I see the toilet!” “I’m telling you—you never want to see Helen look like that again!”

“Have the carpets dried yet?” Lutz asked, shifting gears in hopes of solidifying the ground (so to speak). Natalie started to laugh again. “Yeah, the carpets finally dried,” she said. “Ah . . . so, looking back, how would you explain what happened, Natalie?” “I was too excited to do what I was told. When things went wrong, I made it all worse, because I didn’t get the help I needed.” “And what did you learn from all of this? Is there something you would do differently to change your behavior in the future?” Without missing a beat, Natalie responded, “I intend to be more honest.” Everyone seemed satisfied with this exchange, and so the group moved on to another person. The story above illustrates how Lutz used humor to break through Natalie’s defensiveness around being honest and owning her mistakes, both with the group and with Helen, the apartment manager. Lutz continued to use dark humor in what followed.
Suddenly Natalie interrupted the next person who had started explaining her goals for the New Year, interjecting, “I’m gonna go to the pier tonight with my parents. We’re gonna celebrate my big move together.”

Responding to her enthusiasm rather than to the interruption, Lutz asked, “And are you going to play skee ball?”

“What’s that?” Natalie asked innocently.

Lutz glanced at Natalie, and then gave her a disgusted sniff while raising her eyes and eyebrows with a smirk as if to say, “I won’t even deign to give you a response or look at you.” Meanwhile even Lutz was again shocked at her own behavior as a therapist, which seemed so totally out of character.

But Lutz proved to have her finger right on the pulse of the group. Natalie responded with an uproarious laugh. This caused the whole group to roar with delight in turn. Meanwhile no one wanted to tell Natalie what skee ball was. It was as if everybody was complicit with the positive side of Lutz’s gesture—the invitation to enter the huge, exciting world outside in order to find out for herself. And even with her own question about skee ball remaining unanswered, Natalie nonetheless smiled, relaxed, and turned her attention fully to the next group member.

By rolling her eyes and thereby mirroring the members’ gestures at the start of the session, Lutz used humor initially to join the group where it started, in order to break the tension that was evident in the initially resistant group. Later, Lutz playfully used a similar kind of mock humor to set a boundary around Natalie’s interruption. Again her humor served to further bond the group. A key aspect of clinical intuition involves feeling your way through the intersubjective thicket to determine when humor serves to deepen versus when humor serves to block the therapeutic bond and capacity for inner work.

The psychoanalyst Philip Bromberg uses the phrase “safe surprises” for those key moments of meeting between a therapist and patient where something new emerges. A safe surprise is also one important way to view humor (see Figure 5.6). A common cognitive theory suggests that the origins of humor are in expectations that are violated. As therapists, in order to keep things fresh, slightly unsafe, and continually new, we intuitively play on the edge of patient expectations. Elizabeth Lutz used humor unexpectedly and without precedent to continually violate the expectations of group members. In this case, a series of safe surprises helped everyone to drop their defensive stances, become more cohesive, and attend to clinical business.

Therapists have historically had a love/hate relationship with humor, jokes, and laughter during therapy. Some have eschewed the use of humor by focusing on its defensive functions to ward off true contact. Others have focused on it as a powerful intervention. These polarized stances implicate the power of humor as an intervention, whether in service of helping or harming things. There are no rules that can be applied in all cases about when, how, and with whom to use humor. In fact, there is something inherently violating about the very attempt to systematize, analyze, or prescribe the details of what naturalistically emerges unbidden and spontaneously as an act of interpersonal creativity.

Therapists should not stand apart from the process and get too analytical. Instead, they must immerse themselves in the process to feel their way through each moment.
And all the while it behooves all therapists to heed E. B. White’s warning, as expressed in the preface to A Subtreasury of American Humor (1941): “Humor can be dissected as a frog can, but the thing dies in the process and the innards are discouraging to any but the pure scientific mind.”

Humor in Service of Rupture and Repair

In Lutz’s story, feigned mockery on the part of the therapist proved successful in breaking through patient defenses. In the case I am about to describe, my spontaneous impulse toward humor proved disastrous, revealing its potential to do harm. I wish to revisit a patient described earlier, Gus, introduced in Chapter 2 (Clinical Intuition in Psychotherapy) as the man who, at times, experienced himself as a woman. Earlier, this case illuminated the gap between explicit and implicit levels of therapy. You may recall that my gut reaction to Gus’s request to help rid him of this experience was a complete protestation at a body level. Despite explicitly claiming he had little interest in self-exploration, Gus implicitly acted differently. Not only did he set up a first appointment with me, but also he wound up fearlessly pursuing in-depth psychotherapy for years.

As described in Chapter 2 and elsewhere (Marks-Tarlow, 2011), Gus’s symptoms shifted and morphed along with our work together. The incident I am about to relate happened one day when Gus was describing the latest permutation of his experience at a body level. Despite explicitly claiming he had little interest in self-exploration, Gus implicitly acted differently. Not only did he set up a first appointment with me, but also he wound up fearlessly pursuing in-depth psychotherapy for years.

I replied, “It’s all weird!” I meant that the detail about which Gus was perseverating was no weirder than any other aspect of his broadly unusual experience. This was meant to be a reassurance that Gus had little need to hone in and pick at himself the way he was. But obviously this was not how Gus took my remark, which sounded to him instead like I was calling the whole of him plain weird. Needless to say, this mistake on my part was very hurtful. In the very next session, Gus declared that it was better for him not to discuss this sensitive side of his inner life any longer during psychotherapy. Fortunately we had built enough mutual trust that Gus had the good sense and courage to let me know how he felt and to hang in there while we hammered out the pain and anguish.

My willingness to admit my mistake without hesitation or defensiveness, to talk about it openly, and to apologize for being so careless as to trigger such pain and shame proved a first in Gus’s relationships. My ownership of responsibility for my part in our dynamic stood in sharp contrast with his previous relationships, especially his narcissistic mother or his current wife, who refused to talk about anything of emotional significance between them, much less take responsibility for her part in the dynamic. Despite Gus’s vow at that point never to discuss his female side again, in the end, the episode proved a remarkable opportunity to go through rupture and repair. Ultimately the whole sequence solidified our mutual trust, allowing us to continue working at even deeper levels.

We both realized that Gus had worked through the episode thoroughly in light of a more recent occurrence. When Gus first came to see me, I asked if he had told his wife about his inner experience of feeling like a woman. Not only had he not told his wife, but at that point in time Gus could not imagine ever telling anyone about this aspect of his inner life. Gus believed he would lose his wife if he did so, and he held resolutely to this conviction for years. However, it all shifted, when in the wake of his heightened self-acceptance, Gus decided to reveal his innermost secret to a cousin. This occurred after his cousin had rebuked Gus for not sharing more of himself with her. She asked him point-blank about his “dark side,” and Gus decided that it was time to disclose his deepest secret.

During our session, when Gus reported his most recent email exchange with his cousin, he said with a deadpan expression, “Laurie just wrote me an email declaring me
the ‘sanest’ member of our family.”

Upon hearing Gus’s news, I burst into a peal of laughter. Almost immediately Gus joined in the hilarity, the two of us laughing together on and on. When we had finished literally wiping the tears off our faces, Gus said, “I asked Laurie’s permission to tell you. I predicted to her that you would respond to this news with laughter.”

“You were right! I couldn’t help it. The irony is too beautiful, especially when thinking back to your longstanding fears that if you told anybody your secret, they would immediately reject you for being totally weird and crazy.”

“Not only does my cousin think I’m sane, but she also mentioned admiring, if not envying, my form of adaptation. In fact, as she struggles with her own recurrent illness, and some really painful cancer treatments, Laurie admits wishing she could be more like me.”

“You see, this is the beauty of having shared your deepest, darkest secret with another human being. Not only is she countering your worst fears, but despite your disbelief, she’s giving you the highest compliment.”

“It’s all I can do to keep from dismissing my cousin’s remarks immediately. What she writes seems so absurd!”

“Well, I’m here to tell you that they aren’t absurd at all! I can see how you would appear ever so sane from her perspective. Precisely because you dissociate away from uncomfortable emotion, to her you appear level-headed, if not saintly. You remain understanding and compassionate to others and never seem to lose your cool, regardless of how much others lose theirs. All your distress gets tucked away so nicely, deep down inside, where it doesn’t appear to hurt anyone, yourself included—very sane indeed!”

“Hmmm. I’ve been so caught up in feeling weird and freaky, this perspective turns it all upside down.”

“Life often appears stranger than fiction. Sometimes all we can do is toss up our hands, surrender to the absurdity of it all, and keep on laughing.”

In Gus’s tale, our ability to laugh together about our previous rupture felt truly healing. In fact, the rupture itself now seemed terribly funny when juxtaposed with the story involving his cousin. Right from the beginning, Gus had taken a big emotional risk in telling me about his experience of feeling like a woman. He feared my responding to him the way the previous therapist did—by showing him the door and referring him out to a gender disorder clinic. This felt to Gus like “forget it; go somewhere else—you’re too weird for me.” Instead, I welcomed Gus into my office. Still, I was only a stranger. Had I rejected him, it would have hurt, but it would have been nothing like the risk he felt when he shared his inner life with his cousin. If Laurie had responded with revulsion and expulsion, Gus would have experienced this as intolerable. But beyond her acceptance, to have his cousin express quite the opposite—to be enthralled with Gus’s coping, to consider it clever and a thing worthy of envy—was something he had dared not consider might happen.

Gus knew I would find this story unbelievably funny. That he was able to laugh long and hard with me was not just a quirk or a brushing off of serious business or another defensive reaction. To me, the capacity to laugh together in the wake of trauma indicates something else more fundamental, as I hope to reveal in the next clinical vignette.

Laughing Our Way to Safety

When Goldie first came to see me, she looked frail, with her face pale and drawn, her body thin and tight. In fact, it appeared as if Goldie had stopped breathing altogether. Goldie’s father had died suddenly and unexpectedly when Goldie was a mere 10 years old. Goldie had absolutely adored her father, who remained so high on a pedestal in Goldie’s mind that no real man could compare. Only upon entering her late thirties did Goldie date seriously at all. And then she met Jake, whom Goldie perceived to be the man of her dreams. He was funny, smart and wooed her ceaselessly. After a romantic courtship of 15 months, the two tied the knot.

Two weeks later the fighting started and had not stopped since. In the subsequent years a side of Jake came out that took Goldie by complete surprise. She had not the slightest hint that Jake had the capacity to be so sarcastic, biting, aggressive, con-
trolling, and unrelenting.

“I began wondering ‘Who is this guy?’” Goldie explained to me, after many years of trying to chalk the problems up to various circumstances.

But the fighting continued and after a month, Goldie insisted that they go to couple’s therapy. During that first session when the marriage counselor said to Jake, “Whoa, why are you talking to your wife with such a harsh tone?” Goldie knew she was in serious trouble. She wondered if she had made a mistake. But she hung in there, had two children, struggled with raising them, and then struggled with her health, getting a rare type of digestive disease, which was all-consuming and which had brought out the best in her husband, who himself had struggled with physical pain and health concerns his whole life.

Now years later, Goldie sought individual psychotherapy, feeling tired, confused, and depleted. On the outside, by all appearances, she had everything. But on the inside Goldie had completely lost her way by the time she found a path to me. I could see that Goldie was in a state of hyperarousal continually. It was hard for her to relax, even in her own home, because she never knew when the next criticism or attack would come. And on top of it all, her husband simply did not understand her concerns. He was an ex-heroin addict devoted to the 12 steps but very wary of emotion. He simply saw himself as “the way I am.” To Jake, Goldie appeared “ungrateful” and “selfish” for not appreciating all his hard work and all that he provided materially.

Everything felt “like work” to Goldie, including her children, both of whom suffered from developmental delays. Goldie feared the worst. The more she worried, the more stressful became the home environment.

Finally, the point came when both children were launched to school. The stage was set for Goldie to focus on herself. But on the very first day her second child was in school, Goldie fell into a state of unexplained dizziness, and it eventually got so severe that she became completely preoccupied with visiting specialist after specialist.

Given that none of the doctors found a physiological basis for her symptoms, from my end I took “therapeutic license” to declare this a “healing crisis.” I spoke to Goldie about feeling metaphorically dizzy at not being so weighed down by the special needs of one or both children at home. I waited patiently. Slowly the symptoms diminished. During the first session that Goldie did not begin with an updated description of symptoms, here is what transpired.

“My husband and I had a really intense talk this weekend. He said, ‘Goldie we’re going to have to have sex at some point,’ and this opened up a talk about intimacy. About how hard it is; how much work it feels like; how different it feels for each of us. I tried to explain my own experience. How lonely it is for me. How hard it is that Jake doesn’t seem to understand my feelings. And, sure enough, all he could do was to go back into his song and dance about how hard he works to provide for us and how ungrateful I am.”

“At least this was a conversation and not a heated argument.”

“Yeah, that was different.”

“You know, especially with your younger daughter diagnosed ‘on the spectrum,’ I’ve been thinking that your husband might have a similar condition. He seems so utterly incapable of getting inside of your head to feel the world from your point of view.”

“That’s so true!”

“You know, there are two kinds of empathy. One kind is emotional—Jake’s ability to feel what you feel. The other is cognitive—Jake’s ability to reason about your experience. That part he has. He knows you’re unhappy, but because he’s missing the feeling part, he makes up stories about why you’re unhappy from his own point of view.”

“Oh my God, you’re so right! I’m having a lightbulb moment.”

“You’ve not considered that his lack of empathy is actually a disability on his part before, have you?”

“No, I haven’t.”

“So then the question becomes, can you live with this?”

After expressing much sadness about the tragedy of this through a veil of tears, and then exploring together whether Goldie might get deep understanding from other sources, my intuition prompted me to say, “You know Goldie, no matter what,
no matter who you marry, there’s always something really, really wrong.” And Goldie looked at me with wide open eyes as if hearing this idea for the first time. Sheeishly she asked, “Is that really true?”

“Yes, it’s really, really true. For everyone.”

Then after a beat when we just looked each other straight in the eyes, suddenly and spontaneously, the two of us burst out into the deepest of laughs simultaneously. In fact, we both laughed so hard that again we were crying. And during the first semblance of a pause in the laughter, I took it upon myself to add, “And whatever that thing is that is wrong, it always feels like it could kill you.” This, of course, only added to the hilarity.

Goldie summed up the importance of what happened by concluding, “You know, that’s the first time in 8 years I’ve been able to laugh about my marriage.”

And with this laughter came a breath of fresh air where none was to be had previously. Clinical intuition guided me to state what could have easily been experienced as highly controversial, if not stupid—first, that every relationship retains a tragic flaw; second, that we easily experience such flaws as fatal. In relationships as in life broadly, timing is everything. Only clinical intuition can guide us through these delicate affairs. Clinical intuition allows us to take social risks when we implicitly sense the moment is ripe. After Goldie released her externalizing defenses enough to relax into her own role within the marriage dynamic, intuitively I sensed the safety to inject a little grim humor to further loosen her idealism about how her husband should act and what marriage should feel like. My dark humor prompted Goldie to focus inside herself, on emotional challenges of how to make peace with her husband’s flaws or alternatively to decide that she cannot. Perhaps the capacity to laugh about our relationship struggles is diagnostic of the capacity to retain perspective.

**Laughter as a Bottom-Up Response**

An increasing number of therapists are approaching psychotherapy from the bottom up or by working directly with the body and its response. Techniques such as somatic experiencing (Levine, 1997, 2008) and sensorimotor psychotherapy (Ogden et al., 2006) operate under the theory that trauma gets frozen and held in the body in the form of unexpressed emotions and incomplete actions. If this is the case, then no amount of top-down, talk therapy will touch this deepest level in which trauma is held. Patients are encouraged to reprocess their experiences by completing actions and discharging emotions that have been pent up. When a patient automatically jokes or laughs at the end of a sequence involving intense autonomic nervous system dysregulation, it can be a “sign” that the discharge of blocked or dissociated emotion is complete, that re-regulation has been integrated into the nervous system, and that the healing of that “piece” is complete (Ogden et al., 2006). And so it was with Goldie. After years and years of feeling victimized because her husband had no emotional empathy for her, the tables were turned. Goldie realized that in some critical ways it had been she who lacked empathy for him.

**The Origins of Laughter**

As mentioned earlier, Jaak Panksepp is a neurobiologist who for decades has been interested in the affective experience of animals. A number of years ago, along with a star graduate student, Panksepp made a remarkable discovery relevant to this chapter. If you take a rat into the palms of your hands, turn it over onto its back, and then tickle its belly, the rat responds by laughing. The laugh takes the form of a high-pitched chirp, at around 50 hertz, far too high for the normal human ear to detect. Perhaps this is why no one suspected that rats could laugh before, or maybe Panksepp was right during an interview he gave to the American
Panksepp speculated that the field of animal emotions largely has been disregarded and underfunded because people do not want to believe that their emotional experiences overlap so thoroughly with that of animals (see Figure 5.7). Somehow this compromises human dignity. But like it or not, the realm of laughter is one we share not just with the “higher” primates but also with mammals as “lowly” as a rat.

Vilayanur Ramachandran (2011) hypothesized on why laughter might have evolved in the animal kingdom by setting forth what he called the False Alarm Theory. Here is an animal illustration. Imagine a leopard enters the territory of a troop of monkeys. Just as with humans, the right amygdala of the monkey is sensitively geared toward picking up danger. When on the alert, an animal will automatically cock its head to the left because danger is most easily detected in the left visual field. The first monkey to pick up the sight or scent of the leopard will instantly vocalize its fear with a scream. Because fear is contagious throughout the animal kingdom, the monkey’s warning will be picked up and reverberate throughout the troop until all animals are properly alerted.

But what happens if a monkey makes a mistake about the presence of a leopard? Or what if the predator moves beyond the bounds of danger? There also needs to be a signal to the rest of the troop that the coast is clear. Ramachandran speculated that laughter and its contagion provide the needed release from the monkeys’ collective state of fear, vigilance, and behavioral orientation toward seeking safety. Through laughter, the monkeys can signal that the coast is clear for the troop to return to other sorts of monkey business. Through laughter, the monkeys can indicate that no predator is near and danger has passed. The fact that laughter is contagious also makes sense in this context. Just as fear contagion allows alarm to pass quickly through the troop, so, too, does relief as signalled by laughter contagion. Finally, humor, along with fear, is registered in the same subcortical emotion-detecting structure of the brain, the amygdala.

From a neurobiological point of view, as mentioned previously, laughter, like the cough, hiccup, or retch, is a closed program, with its origins deep in the subcortical roots of the mammalian brain (Panksepp, 1998). Input from the environment and postnatal experiences activate the program but do not shape the circuit, which remains a fixed sequence akin to reflexes or other stereotyped behavior. From a biomechanical point of view, human beings laugh in staccato bursts that are emitted only during exhalations. A wide range from two to around ten “ha-ha” bursts punctuates a single outbreath. Try it to feel this. By contrast, chimps laugh both during the inhalation and exhalation phase of a breath. The one-to-one correspondence between the “hee-hee” linked to each of the chimp’s inhalations and exhalations results in a pantlike pattern. Try making this sound as well. Provine (2000) speculated that this difference in laughs between humans and chimps is highly significant. In fact, he hypothesized that it illuminates, if not explains, why humans can use their vocal cords to talk, while monkeys cannot. Because humans have a looser coupling between breathing and vocalizing, they can modulate their exhalations during laughter in just the way necessary for speech. Meanwhile, the tight coupling between breath and laughter in chimps and other primates leaves no wiggle room for the play of air through the vocal cords that is required for
Tickled Pink

Human infants emit their first true laugh at around 3 or 4 months, a seminal event that occurs in conjunction with the tickle instinct in parents, as was demonstrated in the case of Macy and her baby. The impulse to tickle a baby’s belly or toes is an early manifestation of later rough-and-tumble play. This is a universal urge that humans share with chimps, gorillas, and other primates. As part of his investigation of laughter, Provine wondered how the tickle instinct that begins in infancy continues to play itself out during the life span. So Provine and his undergraduate students conducted a survey by interviewing people of all ages.

Results indicated that interest both in tickling and being tickled is primarily a young person’s sport. Respondents younger than 40 years old were more than 10 times more likely to report having been tickled during the previous week than those 40 and older, with 43% of younger respondents reporting being tickled versus only 4% of older respondents. According to Provine, this sharp drop-off in the “mammalian triad of tickle, touch and play” means that older people neither feel very ticklish in their bodies nor are interested in tickling as an expression of affection, except toward small babies. As for younger people, incidences of tickling or being tickled are most likely to occur with intimate others, including relatives, lovers, and close friends. For teenagers and people in their twenties, tickling is most connected with courtship rituals. Tickling especially is a handy, nonverbal way to approach a potential romantic partner. In this manner, consensual tickling relates to courtship rituals and sexual foreplay.

Provine noted that the link between tickling and sex seems less speculative when we consider that the Dutch word for clitoris is krittelaar, which means “the organ of being tickled or titillated.” After all, tickling involves a rhythm of reciprocity that necessarily implicates an other. As mentioned, it is impossible to tickle oneself. And the intensity of the tickle experience varies inversely with a person’s control over and predictability of the touch stimulus. Provine suggested that the response to a tickle requires a nonself detector in the brain, which signals the presence of an outside influence by comparing the body’s own sense of itself through proprioception with outside stimulation perceived though exteroception. The less predictable the stimulus, the greater the “nonselfness” or otherness that was perceived.

With babies, during the introduction of otherness through tickling, the line between pleasure and pain is quite thin. The episode remains pleasurable as long as the tickling event remains consensual. Indeed, an attuned parent knows when to retreat from touch to allow the baby to recover. Just as the misattuned parent can trigger fussing, crying, and eventual terror in babies through unwanted touch, there is also a connection between nonconsensual tickling and sadomasochistic sexual rituals (see Figure 5.8). The use of bondage and feathers to set up tickle torture blends with other fetishes, such as attraction toward feet or being stepped on. These fetishes shade into heavier forms of sadomasochistic bondage and even sexual torture.

Throughout the ages, nonconsensual tickling has also been used as a form of torture, even to the point of death. Nonconsensual tickling as torture relates to the potential invasion of personal space by predators. Ticklishness in all our most sensitive areas—under the armpits, around our ears, necks, middle torsos, or private parts—evolved as a mechanism to detect and flick away invading creatures such as bugs, snakes, or scorpions. Tickling simulates the invasion of larger, perhaps carnivorous, predators in an
arena that is safe. And in these origins, we can see, too, how tickling and accompanying laughter relate to the relief and pleasure of false alarm predation.

From this vantage point, my work with Goldie appeared to be an embodiment of the False Alarm Theory as it operates among humans. For 8 years, Goldie had gotten more and more frozen in her body and in her marriage. She was continually in a state of hyperarousal in the presence of her husband where she found it literally, as well as figuratively, difficult to breathe. By conceiving of Jake as capable of extending empathy but withholding it on purpose, this only made her feel worse and more constricted inside. At the point of recognizing that Jake could not help himself, that he had a blind spot that prevented him from extending empathy, she let go of some defensive bracing and released much pent-up emotion. Through the outbreathing of laughter, Goldie found relief and a safe spot on which to stand and reexamine her marriage, however temporary that relief was to her.

From the standpoint of Stephen Porges’s polyvagal theory (2011), laughter can seal the deal of release or repair by emerging when the patient moves from a primary stance of defensive fight, flight, or freeze back to the safety of full social engagement. This kind of safety is no small feat, and as clinicians we should recognize the importance of laughter as a signal in this regard.

Perhaps this fundamental safety and relief out of which laughter sometimes emerges connects with the recent social phenomenon of laughter yoga. Put simply, laughter yoga uses laughter in the context of a social group as a complete well-being workout. The brainchild of Dr. Madan Kataria, a physician from Mumbai, India, the first laughter club was launched in 1995, with now over 6,000 social laughter clubs existing in approximately 60 cities (a good example of how to laugh is shown in Figure 5.9).

Combining unconditional laughter with yogic breathing (pranayama), anyone can laugh for no reason. By simulating laughter as a body exercise by using eye contact and childlike playfulness, social engagement through laughter quickly becomes contagious. Who knows, perhaps social contagion will spread to psychology as well, so that a new school of laughter therapy will arise.

Wrap-Up

Clinical intuition frequently expresses itself in idiosyncratic ways, including our sense of humor. William James asserted that “common sense and a sense of humor are the same thing, moving at different speeds. A sense of humor is just common sense, dancing” (1890). This chapter revealed the many faces of humor within psychotherapy as guided by clinical intuition. Whether initiated by the patient or therapist, humor represents an invitation to communicative play that holds the potential to open up new realms of mutual bonding and exploration.

The holiness of laughter has universal resonances. The laughing Buddha is an ancient Chinese folklore figure who should not be confused with the historical Buddha, Siddhartha Gautama, the founder of Buddhism. The laughing Buddha is usually depicted as a fat and bald man who carries his scant possessions in a cloth sack. While lacking in material wealth, the laughing Buddha symbolizes happiness, plenitude, and the wisdom of contentment. To rub his belly is believed to bring wealth, good luck, and prosperity. (Public domain, courtesy of Maurizio Jaya Costantino)
humor represents an emotionally evocative and expressive form of communication, as intuitively wrought, running alongside the content of our narratives.

Clifton Paul Fadiman suggests, “A sense of humor is the ability to understand a joke—and that joke is oneself.” Indeed, some assert that humor in and of itself has healing properties. Norman Cousins (1979) claimed to heal a life-threatening illness through megadoses of Vitamin C along with promoting a positive attitude by watching old movies and laughing uproariously. Cousins started a revolution in patient activism, partly through the use of humor to boost the body’s capacity for healing. Research reveals that laughter, joy, and positive emotions generally reduce stress and boost immunity (e.g., Borins, 2003; Miracle, 2007; Snowden, 2003). These positive states help to prevent illness and ease its recovery. Indeed, the whole movement of positive psychology suggests that something very profound exists in the mind/body relationships among enjoyment of life, well-being, and longevity.

Stand-Up for Mental Health, an organization formed in 1995 in Vancouver, Canada, is spearheaded by David Granirer. The members consist of mentally challenged people, some of whom have serious diagnoses, who are trying to laugh their way back to mental health through stand-up comedy centered upon their own conditions. Videos of the members’ performances can be seen on YouTube, while a documentary about the training and a comedy road trip is also available for viewing. Perhaps the plight of these noble individuals embodies Irwin Cobb’s assertion that “humor is merely tragedy standing on its head with its pants torn” or Groucho Marx’s quip that “humor is reason gone mad.” The intuitive use of humor for self-reflection can help to ground us, even if we feel lost and have strayed far from our inner vision.

In order to bring home the relevance of this chapter to you and your clinical practice, consider the following:

• Whether young or old, when we gaze at ourselves in the mirror, most of us look at or search for wrinkles on our faces. When gazing at your face in the mirror, what habitual emotion or emotions do the lines indicate? Do your lines speak of sorrow or worry? What about laugh lines? If this is hard to determine, try making exaggerated sad, worried, or gleeful expressions on your face to see which wrinkles get picked up most.

• When was the last time you had a belly laugh? Can you remember? If so, how long ago was the episode? What made you laugh? What about a time you laughed so hard you cried? If you cannot remember, why not?

• Did you laugh often as a child? What did this state of affairs reflect about your childhood? Do you laugh more or less now? Why? How do you feel about this?

• How important is humor to you personally? What about in a mate or close companions?

• What about professionally? Do you cultivate humor consciously in your work with patients? If so, can you remember the last time you laughed deeply with a patient? What was being communicated about the nature of your relationship?

• If you do not cultivate humor consciously, would you like to do so or are you content with your level of seriousness?

Humor is one aspect of creativity that is intuitively expressed and borne of the imagination. The next chapter addresses other aspects of inner vision and imagination as cornerstones in the healing process.


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Clinical Intuition in Psychotherapy
THE NEUROBIOLOGY OF EMBODIED RESPONSE
Terry Marks-Tarlow

A systematic look at the role of “gut feelings” in psychotherapy.

What actually happens in psychotherapy, outside the confines of therapeutic models and techniques? How can clinicians learn to pick up on interpersonal nuance, using their intuition to bridge the gap between theory and practice? Drawing from 30 years of clinical experience, Marks-Tarlow explores the central—yet neglected—topic of intuition in psychotherapy, sharing clinical insights and intuitions that can help transform traumatized brains into healthy minds.

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Encouraging therapists to bring their own unique senses of humor to clinical practice, she explains how the creative neural powers of playfulness, embedded within sensitive clinical dialogues, can move clients’ lives toward lasting positive affective growth.

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Part of the Norton Series on Interpersonal Neurobiology, this wonderful guidebook will help clinicians harness the power of spontaneous intuitive thinking to transform their therapeutic practices.

ENDORSEMENTS & REVIEWS

“This book is a superb synopsis of psychotherapeutic experiences, and a delight to read. With a flowing and sensitive narrative, spiced with selections from modern affective and cognitive neurosciences, Marks-Tarlow’s clinical skills and insights offer new ways to envision how disturbed minds can be guided toward positive self-realizations, through the transformative power of social joy. She shows, by example, how to harness personal habits of bodily self-care and psychological well-being to maximize affective intuitions that help restore traumatized brains to healthy minds.”
— Jaak Panksepp, Baily Endowed Professor of Animal Well-Being Science, College of Veterinary Medicine, Washington State University

“I would recommend this book to any seasoned or emerging clinicians and also to students who are just beginning or are continuing their studies the field. . . . [R]eading this book provided me with the biological background and clinical examples needed for me to feel more secure to go beyond (but not abandon) the theories and to trust my natural capabilities.”
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“A thoughtful, practical, and moving account of the importance of intuition and empathy in psychotherapy. This book contains many enlightening, and touching, real-life examples of how often the delicate process depends on the wise therapist having the courage to be vulnerable, and to know how ‘not to know.’”
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