THE RELATIONSHIP BETWEEN THERAPISTS’ USE OF HUMOR AND THERAPEUTIC ALLIANCE

DISSERTATION

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Among all the aspects of the therapeutic process that have been discussed in the literature, therapeutic alliance has emerged as a critical component. The vast majority of research on therapeutic alliance has been based within an individual psychotherapy framework, and there remains a paucity of research on this concept from a couple and/or family therapy perspective. Concomitantly, the use of humor by therapists and its effect on the therapeutic process is an area of study that has been given little attention by researchers. The purpose of this study was to investigate the relationship between the use of humor within couple therapy and therapeutic alliance. The sample for this study included 40 couples presenting as clients at a large midwestern university Couple and Family Therapy clinic. Clients and therapists completed the Working Alliance Inventory (WAI), a 12-question self-report questionnaire that assesses one’s perspective on therapeutic alliance, after sessions one and three. Participants agreed to have their first-session videotape saved for analysis, which were coded using the Humor Rating Scale, an observational scale developed to assess the frequency and type of humor used by a therapist. It was hypothesized that the frequency of helpful humor used by a therapist would be directly related to therapeutic alliance at sessions one and three, reduced premature termination, and less discrepancy in alliance scores among male and female partners in therapy.
The use of humor seemed to be important to the therapists in this study in regards to therapeutic alliance, with significant correlations between therapists’ WAI scores and the use of humor at both sessions one and three. Conversely, therapists’ use of humor had little to no impact on the clients’ perceptions of therapeutic alliance at session one or three. Also, the results displayed a significant difference between the amount of humor used in the first session between those clients who prematurely terminated therapy and those who did not, with the latter exposed to nearly twice the instances of humor. The frequency of humor was not shown to play a role in whether couples displayed a split alliance.
Dedicated to my wife and daughter
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CHAPTER 1

INTRODUCTION

“Laughter is the closest distance between two people” – Giacomo Leopardi

Among all the aspects of the therapeutic process that have been discussed in the literature, therapeutic alliance has emerged as a critical component, recognized by most clinicians and researchers as important, if not necessary, for successful treatment (Bordin, 1979; Pinsof & Catherall, 1986; Rait, 2000). Research has shown that this aspect of the therapist-client relationship is significantly related to treatment outcome regardless of what particular theoretical framework is being applied, and these findings are assumed to be consistent within individual, couple, and family psychotherapy (Garfield, 2004; Jones & Cumming, 1988; Martin, Garske, & Davis, 2000). However, the vast majority of research on therapeutic alliance has been based within an individual psychotherapy framework, and there remains a paucity of research on this concept from a couple and/or family therapy perspective.

Concomitantly, the use of humor by therapists and its effect on the therapeutic process is another area of study that has been given little to no attention by researchers. However, theorists and clinicians have long debated its efficacy (Fry & Salameh, 1993; Salameh & Fry, 2001; Strean, 1994). Within this body of literature, authors have discussed various potential benefits including (but not limited to) strengthening the
therapist-client relationship, expanding a client’s awareness and objectivity about their problems, and reducing a client’s anxiety about the therapeutic process (Ellis, 1977; Epstein, 1998; Mindness, 1971; Olson, 1994; Salameh, 1983; Ventis, 1987). Conversely, there is also much written against the use, or misuse, of humor in therapy, warning against the use of sarcasm, the possibility of clients’ misinterpretations of humor, and the damaging effect of the use of humor on the therapeutic relationship (Fry & Salameh, 1987; Kubie, 1971; Poland, 1971). While many authors discuss the “appropriate” use of humor in therapy and its benefits, others argue that humor should not be used at all or sparingly at most. Regardless of one’s stance on the use of humor in therapy, one common factor among all the various claims made about humor is that they are based almost entirely on anecdotal evidence, with little to no empirical research supporting them. While remaining unanswered, the need for such research has not gone unrecognized, as many in the field have long called for studies to investigate its effectiveness as a therapeutic tool (Franzini, 2001; Saper, 1987).

**Purpose**

The purpose of this study was to investigate the relationship between the use of humor within couple therapy and therapeutic alliance. Such a study responds to the problem that exists within both the study of couple therapy and the study of the use of humor in therapy; that is, the paucity of research that exists in both areas. Concerning therapeutic alliance in couple therapy, both current theory and existing research demonstrate the formation of such alliance as predictive of outcome (Bourgeois, Sabourin, & Wright, 1990; Heatherington & Friedlander, 1990; Johnson & Talitman, 1997; Knobloch-Fedders, Pinsof, & Mann, 2007). Knobloch-Fedders, Pinsof, and Mann
(2004) point out that researchers are currently beginning to focus more attention on both moderators and mediators of the therapist-client relationship, as a current problem within the field is that there is a lack of research on how exactly a good alliance develops. That is, it is assumed that alliance is important, but how does one go about creating it? The use of humor can be considered as such a variable in the process of alliance formation.

Concerning the use of humor in therapy, the lack of research is certainly problematic, but more specifically the literature reveals competing assertions about both the efficacy of humor and its potential impact on therapeutic alliance (Franzini, 2001). This study helps determine what humor’s impact is on therapeutic alliance, while simultaneously addressing the need for more research on this concept within a couples framework.

*Alliance in Couple and Family Therapy*

Indeed, “…family therapy is a complex process that requires therapists to simultaneously attend to the needs of multiple individuals as well as to the systemic processes that govern family interactions” (Robbins, Turner, Alexander, & Perez, 2003, p. 534). The same could also be said for couple therapy, as alliance needs to be negotiated between the therapist and both partners. The therapist working in this dynamic develops an alliance with each partner individually as well as with the couple as a “whole”. In turn, each partner has his/her own unique perception of alliance with the therapist that is being influenced by the other partner, resulting in a multifaceted process being negotiated in the room. There has been a recent increase in research on alliance from a couple and family therapy perspective, and the results of the studies that have been done indicate that alliance in couple and family therapy develops and operates in a unique way (Garfield, 2004; Johnson & Greenberg, 1985; Robbins et al., 2003).
Bordin (1979) brought what psychoanalysts called the “working alliance” to the forefront by suggesting that it is the key to successful treatment. He conceptualized the working alliance as including three features, including 1) agreement on goals, 2) assignment of tasks, and 3) development of bonds. The latter, Bordin noted, involves a certain level of trust and attachment between the therapist and client, the degree of which varies depending upon the model of therapy being applied. Many of the studies concerned with therapeutic alliance, and the measures developed for use within those studies, are based on this conceptualization of alliance.

As a field, couple and family therapy has always recognized the importance of the relationship between the clients and therapist. In doing so, however, the major theories that dominate the field adopted their own terminology to describe how this relationship develops and what the particular stance of the therapist should be. Minuchin (1974) discussed the process of joining with the family, in which the therapist becomes a figurative member of the family itself. Fostering understanding and acceptance with each family member so that the therapist is not viewed as an unwanted outsider incapable of restructuring the family facilitates this process. Bowen (1978), when working with couples, spoke of the formation of a therapeutic triangle, and highlights the importance of a therapist not taking sides, but rather remaining an objective coach-like figure in the room. One theory of change within the field that does use the term alliance specifically is emotion focused couples therapy (Johnson & Greenberg, 1985). This therapy involves a nine-step process, the first of which is the creation of “alliance” with the couple, which from this perspective means developing the equivalent of a secure parent-child attachment with the client.
Pinsof and Catherall noted that, given the emergence of therapeutic alliance as such a major component of psychotherapy in general, the field of couple and family therapy would be wise to incorporate the concept. Indeed, it could serve as part of a common language between individual psychotherapy and couple and family therapy. They recognized that a theory and definition of alliance based solely on individual psychotherapy might not be sufficient when considering the treatment of couples and families. They introduced what is to date the most comprehensive definition of a therapeutic alliance, on which this study will rely, that integrates the individually focused work of Bordin with a systemic perspective. They define therapeutic alliance as “that aspect of the relationship between the therapist system and the patient system that pertains to their capacity to mutually invest in, and collaborate on therapy” (Pinsof & Catherall, 1986, p. 139). They suggest that alliance functions on three reciprocal and interdependent levels, which include 1) the individual alliance, which consists of the relationship between client and the therapist, 2) the subsystem alliance, which consists of the therapeutic relationship between systems that may exist within a family (such as “parents” or “children”) and the therapist, and 3) the whole-system alliance, which is the therapist’s alliance with the whole family system.

Based on these concepts, Pinsof and Catherall (1986) argued that a couple and family therapist could potentially have what they referred to as a “split” alliance or an “intact” alliance with a family. A split alliance occurs when the therapist develops unbalanced alliances between subsystems within the family. For example, a therapist may have a strong therapeutic alliance with the “children” subsystem, and a weak alliance
with the “parent” subsystem. An intact alliance, then, occurs when there is a balance of alliance between subsystems. At the couple level, a split alliance would occur when the therapist develops an unbalanced alliance between the two partners. Further, Pinsof and Catherall hypothesized that a split alliance would lead to premature termination and/or treatment failure unless the stronger alliance is with the more powerful subsystem. Indeed, research is just beginning to explore and show support for this notion (Garfield, 2004; Robbins et al., 2003).

Humor in Therapy

Fry, a leading researcher in the psychological and physiological effects of humor and advocate of humor’s use in therapy, wrote that “definitive professional psychotherapy as a scientific modality goes beyond positive rapport, but it cannot exercise its best efficacy until positive rapport is established between caregiver and patient” (Fry, 2001, p. 211). This statement speaks to the importance of the client-therapist relationship, of which Fry argued can be nurtured by humor. Among those who propose that humor can facilitate the development of therapeutic alliance, it is also often mentioned that one must consider the paradoxical nature of humor and understand the difference between what Salameh (1983) refers to as “destructive” humor and “helpful” humor. That is, humor, just as any therapeutic tool, has the potential to be abused. Kubie (1971), perhaps the most outspoken against the use of humor in therapy, believes that humor is destructive to the therapist-client relationship, and suggests that its use remain limited, especially among inexperienced therapists. He stated that humor is usually perceived by the clients as masked hostility, and serves as a defense for both the therapist and client’s anxieties. Also, while depending on the client’s history, he warns that a
therapist’s humor is usually perceived as being “…heartless, cruel, and unfeeling” (Kubie, 1971, p. 39). Pierce (1994), agreeing with Kubie (1971) that humor should not be used as a method of aggressing towards a client, added that humor can be used by clients and therapists to divert attention about serious issues, and stated that only humor relevant to the therapeutic purpose be used.

Franzini (2001) points out that, despite the lack of research, those who promote the use of humor in therapy often mention the benefits to the therapeutic relationship. It was Martineau (1972) who referred to humor as a “social lubricant”, describing it as a powerful and effective means for an individual to emotionally join with another, or to move into a group, such as a child wanting to join others on a playground. Kuhlman (1984) agrees with the ability of humor to enhance all human relationships, and argued that the therapeutic relationship, then, would also be augmented by its use in therapy. In fact, several in the field of couple and family therapy have discussed the positive role of humor in therapy specifically (Cade, 1986; Madanes, 1987; Odell, 1996; Schnarch, 1990). Schnarch (1990), speaking within a context of couple therapy specifically, suggests that the use of humor helps develop a “private language” with a couple that is an essential part of treatment alliance. An “inside joke” that one individual shares with another (or a therapist with a couple) can serve as a powerful emotional connection between people through, as Schnarch (1990) describes it, the fostering of a self-reinforcing common history, and a symbolic language only known within the therapy room.
Defining Humor in Therapy

For the purposes of this study, the definition of humor, which invites a certain degree of subjectivity, is taken from the American Association for Therapeutic Humor (AATH), which states that therapeutic humor is “any intervention that promotes health and wellness by stimulating playful discovery, expression or appreciation of the absurdity or incongruity of life’s situation. 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” (Franzini, 2001, p. 171). It is important to the note that humor can take many forms, including the use of metaphor, playful symbolism, exaggerations, jokes, expressions, and even physical movements.

Theoretical Basis

As Salameh (1983) suggests, there is no specific theoretical framework that the use of humor in therapy is tied to, yet many theorists promote its use within their own theoretical context, such as Haley (1963), who applies the use of humor in his “therapeutic paradox”, and Whitaker (1976), whose therapy was described as the “therapy of the absurd”, relying on humorous interjections to increase a family system’s level of anxiety. Theoretically, this study is based on Samaleh’s (1983) position that the use of helpful (as opposed to destructive) humor enhances the therapeutic process. More specifically, the therapist’s use of helpful humor with a client benefits the development and maintenance of therapeutic alliance, and therefore has a positive impact on therapeutic outcome.
The strength in this approach is that while it recognizes the potential for humor to be a positive force in the room, it does not deny, but rather explicitly identifies, what types of humor should not be used by a therapist. According to Salameh (1983), destructive humor includes sarcastic and vindictive humor directed at the client and/or the presenting problem. Such humor was described by the aforementioned writings of Kubie (1971), in that it diverts from the therapeutic process, and is destructive to the therapist-client relationship. Helpful humor, in addition to positive interaction, promotes a level of understanding between the therapist and the client. At its most helpful, the use of humor allows for cognitive restructuring. That is, the client is offered both insight and an exploration of new perspectives in a playful manner (Salameh, 1983).

The main research question explored by this study is if the use of helpful humor in the first session of therapy is related to the therapeutic alliance in couple therapy. That is, does an increased frequency of helpful humor enhance alliance? Such a study adds a significant contribution to the literature concerning the study of humor. In addition, as research into therapeutic alliance in couple therapy is just beginning to emerge, it adds to the body of literature that focuses on therapeutic alliance in couple therapy. Specifically, this study addresses the question of which therapist behaviors help to facilitate the formation and maintenance of a productive therapeutic alliance. As aforementioned, the use of humor by a therapist has been the focus of myriad anecdotally based writings that, regardless of the opinion put forth, address the need for research in the area. Further questions, as well as specific hypotheses, are discussed following a review of the relevant literature.
CHAPTER 2

REVIEW OF THE LITERATURE

Therapeutic alliance and the use of humor in psychotherapy share a common history, as their origins can both be traced back to psychoanalytic thought (Bordin, 1979; Freud, 1916). However, while both theory and research have progressed in regards to therapeutic alliance, the use of humor in therapy has been advanced by theory, philosophy, and anecdotal evidence, with little research to support authors’ claims. The following is a review of the literature in both areas, beginning with therapeutic alliance, from its psychoanalytic roots to advances in re-conceptualizing the concept in terms of couple therapy.

Psychoanalytic Origin

Bordin (1979) emphasized that his conceptualization of the working alliance is rooted in individual psychoanalytic therapy. The earliest of these origins is traced to Freud, whose concept of transference was central to therapeutic change (Gaston, 1990). Freud was the first to note that it was the relationship between client and therapist that made change possible, serving as the foundation from which the client and therapist conspire to struggle though fixations and repressed projections. Sterba (1934) contended that a therapeutic relationship is formed between the therapist and the “rational ego” of the client. That is, the therapist strokes the ego of the client in an effort to form a bond
Menninger (1958) focused on what he called the “therapeutic contract” as being the main vehicle for change in therapy. This contract involves a degree of cooperation between therapist and client on the goals for resolving the presenting problem, as well as an understanding of the tasks to be worked on in therapy. Greenson (1967), before Bordin’s (1979) conceptualization, used the term “working alliance” to describe the client’s efforts in therapy in cooperation with the therapist. That is, clients carry a certain degree of motivation and willingness to work with the therapist, and positive change can occur if this is facilitated and maintained.

Through these influences, Bordin (1979) redefined the working alliance not as a concept that relies on the positive negotiating of transference between client and therapist, but as a general process of therapy that could be applied to different therapeutic modalities that is necessary for change to occur. Through his aforementioned goals, tasks, and bonds, the client and therapist form a mutual and reciprocal relationship. Indeed, current research supports Bordin’s (1979) conceptualization, with findings that support the idea that therapeutic alliance is a broad concept that is present across modalities.

In a recent meta-analysis, Martin, Garske, and Davis (2000) reviewed 79 studies that investigated the relationship between therapeutic alliance and treatment outcome. These studies varied in the types of treatment provided, the types of measures used to measure alliance and outcome, the time when alliance was assessed, and in publication status (21 of the studies were unpublished at the time of the study). They found a consistent moderate relationship between alliance and outcome, and concluded that this relationship does not appear to be influenced by other moderating variables. These findings reflect the theory that alliance is an integral component necessary for successful
treatment, and demonstrates its influence across various types of treatments. It is important, however, to note that the majority of the studies involved in this meta-analysis were individual therapist-client treatment modalities, not including the couple or family therapy perspectives. This is perhaps not the fault of the authors, however, as there is little empirical research in this area. Indeed, the essence of the therapeutic relationship is based on theory, research, and practice from an individual therapy perspective.

*Alliance in Couple and Family Therapy*

Gaston (1990) cites four dimensions of the therapeutic alliance that are critical to consider in both couples and family therapy, including 1) the clients’ bond with the therapist, 2) the clients’ ability/motivation to work effectively, 3) the therapist’s empathy, and 4) the agreement on both goals and tasks between clients and the therapist. Indeed, many theorists have recognized the importance of forming an alliance with clients during the beginning stages of therapy, collectively known as the process of “joining” in couple and family therapy (Rait, 2000).

Satir (1967) proposed that it is critical to form a safe, secure environment in which clients can feel comfortable enough to begin to look at themselves objectively. Paramount to her work was the understanding of the family members that she did not take any one person’s “side”. That is, she stressed that a therapist, in addition to being very warm and supportive, needs to join with the family as a system, and delegate compassion and understanding on an impartial basis.
Whitaker (1976) conceptualized his joining to the family system as critical to therapy, and explained that unless that therapist has successfully infiltrated the family system and gained their trust, work would be futile. His position in the system, once joined, was to be as a coach, influencing systemic change by inducing an increase in anxiety to facilitate free emotional expression.

**Analysis of Couples’ and Families’ Therapeutic Alliance**

A recent issue of the Journal of Marital and Family Therapy (JMFT) featured a special section dedicated to therapeutic alliance. One of these studies examined the relationship of alliance as a moderator in therapeutic outcome using families dealing with child abuse and/or neglect (Johnson & Ketring, 2006). The authors cited the theoretical framework of Pinsof and Catherall (1986), which incorporates the interpersonal dimension to Bordin’s (1979) goals, tasks, and bonds dimensions, referred to collectively as the “content” dimension. Also, the authors used a measure developed by Pinsof and Catherall (1986), the Family Therapy Alliance Scale (FTAS), which was designed specifically for work with a therapist and three or more individuals in the room. They found that alliance was related to post treatment level of both symptom distress and level of violence. Specifically, it was found that while goals, tasks, and bonds subscales were all related to outcome in this study, the higher the level of violence in the family at the onset of treatment, the more important the bonding subscale was. This was interpreted as meaning that a family with more violence may need a therapist who presents as more warm and trusting for change to occur.
In addition to the scale developed to measure alliance at the family level of analysis, Pinsof and Catherall (1986) also developed a scale specifically designed for use with couples, either married or unmarried. The Couple Therapy Alliance Scale (CTAS) assumes two people in the room with the therapist and, like the FTAS, relies on individual self-report from the clients, and asks the client how they perceive the alliance as an individual, about other individuals involved in therapy (i.e., a spouse or partner’s perception), and finally about their perception of the alliance between the therapist and the group or couple as a whole. Thus, the scales are assessing the interpersonal dimension that includes the aforementioned individual, subsystem, and whole-system aspects. The authors conducted preliminary analysis of the CTAS, and found that the scale displays adequate rate re-rate reliability ($r = .79, p < .005$). Perhaps more interestingly, they found that clients were very reluctant to say anything negative about the therapist or the process of therapy in general. The development of such a scale is important, in that it offers researchers interested in using couples and families as the unit of analysis a means to do so, and is driven by a more systemic theoretical foundation than previous measures.

*Empirical Evidence*

There are research findings that indicate therapeutic alliance’s importance to the outcome in couples therapy. Johnson and Tatilman (1997) found that indicators of therapeutic alliance accounted for approximately 22% of the variance, while Bourgeois, Sabourin, and Wright (1990) found that alliance accounted for approximately 6% of the variance. Both studies used a reduction of marital distress as the indicator of client outcome.
As displayed by JMFT’s inclusion of a section dedicated to therapeutic alliance in a recent issue, the body of research in this area, while still lacking, is indeed growing. Garfield (2004) argues that recent research done at the couple level carries with it several novel clinical considerations. Citing a study by Symonds and Horvath (2004), he suggests that it is important for therapists to form what he calls a “meta-alliance” with couples. Symonds and Horvath (2004) found that it was the partners’ agreement on their perception of alliance to their therapist that was more important and a better predictor of successful treatment outcome, as opposed to individual assessments of alliance. That is, positive outcome was more likely when both partners agreed that alliance was low than when there was disagreement between the partners. This research supports the earlier hypothesis of Pinsof and Catherall (1986), who posited that a split alliance would be predictive of treatment failure. In describing a “meta-alliance,” Garfield (2004) states that the therapist must gain a level of understanding about the couple’s loyalty dimension specifically, so that one can assist the couple in avoiding loyalty conflicts, and keep the focus and priority of treatment on marital and/or relationship issues.

In addition, Garfield (2004) offers that special consideration needs to placed on both issues of family-of-origin and gender and their impact on therapeutic alliance when working with couples. In their study, Symonds and Horvath (2004) found that when male partners displayed a stronger individual therapeutic alliance than female partners, successful treatment outcome was more likely, dependant on the couple developing a positive alliance together as well. In a study investigating the formation of therapeutic alliance in couple therapy, Knobloch-Fedders and colleagues (2004) tested the predictive validity of marital distress, individual symptoms, and family-of-origin experiences. Their
study included 35 couples, and alliance was measured at both session one and session eight in order to evaluate the progression of alliance in treatment. The authors found that, as predicted, higher levels of marital distress was related with lower alliance ratings at session one, and the level of distress was also able to predict alliance for both male and female partners at session eight. Interestingly, higher levels of family-of-origin distress were predictive of the couple displaying a split alliance at session one. In particular, men with family-of-origin problems displayed poorer alliance at session one, while women with higher levels of family-or-origin problems displayed poorer alliance at session eight. This interplay, Garfield (2004) asserts, suggests that a more intense engagement with a male partner at the onset of therapy, while simultaneously engaging a female partner, may lead to a more positive therapeutic alliance with the couple.

Indeed, the research does seem to show support for Pinsof and Catherall’s (1986) premise that a split alliance within couple therapy is predictive of premature dropout and/or treatment failure (Heatherington & Friedlander, 1990). Robbins, Turner, Alexander, and Perez (2003) conducted a study on the association between alliance and dropout within families that were dealing with adolescent behavioral problems. The therapists in this study used Functional Family Therapy (FFT) in their treatment. FFT is a phase-based treatment that has been shown to be efficacious in intervening with adolescents with behavioral problems. Also, FFT pays special attention to the therapist-client relationship, as clinicians are directed to develop a “balanced” therapeutic alliance with their clients, facilitated by the development of trust, and offering mutual value and respect to clients. Their study included 34 families, among whom 14 were classified as treatment dropouts, while 20 were treatment completers. As predicted, the treatment
dropouts displayed higher rates of unbalanced (or split) alliances with the therapist. Specifically, the authors found that a split between father and adolescent alliances in two-parent homes was significantly related to dropout, while mother-adolescent split alliances did not show such significance. The authors note that such a finding is critical in understanding how there are important systemic interplays between clients and the therapist when there is more than one individual in treatment. Also, it displays the important role gender may play within couple and family therapy, as described by Garfield (2004), Knobloch-Fedders, Pinsof, and Mann (2004), and Symonds and Horvath (2004).

Werner-Wilson, Michaels, Thomas, and Thiesen (2003) state that in couple therapy there may be aspects of the “therapy conversation”, which they suggest is influenced by gender, that may impact therapeutic alliance. In reviewing two studies by Werner-Wilson (1997) and Werner-Wilson and Davenport (2003), they find that female clients seem to display higher bond scores than male clients, showing that female clients are potentially more emotionally invested in couple therapy. Also, they find that therapists who are perceived more as “leaders” in the room positively impact therapeutic alliance for both men and women. The notion of the therapy conversation is reminiscent of Schnarch’s (1990) notion that humor can be used as a means to develop a “private language” with the couple. Creating such a language could also potentially enhance the “whole-system” alliance through its nature as a shared emotional experience and history between the therapist and the couple as a whole.
Formation of Therapeutic Alliance

Bischoff and Sprenkle (1993) reported that within couple and family therapy there is a higher rate of premature termination (dropout) than in individual psychotherapy. For this reason, much attention has been focused on the early formation of therapeutic alliance and its relationship to therapeutic outcome. Findings show that it is the early development (and maintenance) of therapeutic alliance that is predictive of outcome (Horvath & Greenberg 1989; Horvath & Greenberg, 1994; Johnson & Talitman, 1997).

Pinsof and Catherall (1986) suggest that between session three and session six is ideal for assessing therapeutic alliance, while others have found that it is the first session that is critical for the formation of a working alliance (Sexton, Hembre, & Kvarme, 1996; Sexton, Littauer, Sexton, & Tommeras, 2005). Johnson and Talitman (1997) found that the assessment of alliance at session three was predictive of outcome, and indeed this seems to be the time in treatment when therapeutic alliance has been assessed most frequently in couples therapy (Bourgeois et al., 1990; Heatherington & Friedlander, 1990; Johnson & Greenberg, 1985). Overall, the research has indicated that the early formation of therapeutic alliance is critical (Horvath & Symonds, 1991), and that its early assessment can be predictive of therapeutic outcome.

Humor’s Role in Therapy

The lack of research recognized, it would seem that humor has potential as a positive therapeutic tool based on relevant related research. Ackerman and Hilsenroth (2003) provided an exhaustive review of therapist characteristics that positively influence therapeutic alliance. They report that flexibility, honesty, respect, trustworthiness, confidence, warmth, interest, and openness were all personal characteristics that
predicted positive alliance. Also, they note that techniques such as exploration, accurate interpretation, and facilitating open expression of affect are positively related to alliance. Certainly, the expression of humor, while not mentioned by Ackerman and Hilsenroth (2003), would seem to be associated with an individual who is perceived as being warm and caring, and humor has long been established as a cognitive mechanism for gaining perspective and facilitating mental flexibility (Morreall, 1998). Morreall suggests that, at the level of the individual, embracing a “comic vision” as a perspective from which to view life allows for a person to become more mentally flexible. As opposed to the “tragic vision”, through which an individual will view life as an individual struggle, comedy sees life as a social adventure. Cognitively, tragedy embraces mental rigidity, whereas comedy invites flexibility (e.g., simple vs. complex conceptual schemes, stubbornness vs. open-mindedness) (Morreall, 1998).

_Psychoanalytic Origins of Therapeutic Humor_

Much like therapeutic alliance, interest in the use of humor in psychotherapy began with Freud (1916). The basis for Freud’s theory is that there is an internal economy of psychic energy, which is released during the humorous episode resulting in amusement/enjoyment. Fundamentally, the person is able to shift perspectives on a given situation, allowing for what once was seen as serious to be viewed in a more trivial light. It is this shift in perspectives that causes the resulting buildup of energy, which is then expelled in the form of laughter. Freud acknowledged the presence of two distinct forms of wit, each having its own unique advantage for the individual.
In “tendential” wit, the person is allowing for the release of an economy of sexual and/or aggressive desires or thoughts. The inhibitions the individual experiences are the result of the society/culture in which one exists. Humor, in the form of a joke or some other means, is the socially acceptable medium through which the person can expel his/her otherwise prohibited ideas, allowing for a temporary release of built-up energies in the form of laughter. In “harmless” wit, pleasure is taken in the individual’s ability to regress to a more childlike state of mind. There exists an opportunity for the person to momentarily cease thinking in terms of rationality, morality, and logic, and to embrace a more nonsensical mode of cognition. The change in cognitive functioning is the source of the amusement/enjoyment one feels from such an experience.

Freud also theorized that humor has the capacity to reduce the stress, anxiety, or other negative response and individual feels towards a given situation. In fact, Freud held humor in very high regard, stating that it is the greatest of all the defense mechanisms a person can utilize (Freud, 1916). Indeed, several researchers have shown that humor does allow for such a reduction (Lefcourt & Martin, 1986; Martin, Kupier, Olinger & Dance, 1993; Martin & Lefcourt, 1983). Just as Morreall (1998) discussed the importance of embracing the “comic vision” throughout one’s life, Freud recognized the impact humor could have on the psychological state of the individual through what he called the “saving in feeling”. The “saving” occurs when a person is faced with a situation which would otherwise result in some strong negative emotion. Instead of the negative outcome, the individual is able to use humor to reduce the perceived seriousness of the situation. By way of this purposeful reduction of the threat, the person is better able to cope with the situation.
Humor and Therapeutic Alliance

While the potential association between the use of humor in therapy and therapeutic alliance is mentioned consistently, there are currently no published empirical studies dedicated to exploring this relationship specifically. A search for humor and alliance on the PsychInfo database yielded only one unpublished dissertation. O’Brien (2001), citing the lack of any empirical research in this area, conducted a study in which he attempted to control the presence of humor in therapy sessions. Ten therapists, seeing two clients each, were asked to increase the number of humorous comments made in their sessions to one client, while suppressing humorous comments with the other. The author obtained perspectives of alliance from both therapist and client, and found no relationship between the use of humor and the therapeutic relationship. He does note, however, that the presence of humor, while having no positive impact on the therapist-client relationship, also did not have a negative impact on the therapeutic process.

A main problem with this study may lie with how O’Brien (2001) attempted to “control” for humor in his study. Indeed, as Franzini (2001) notes, methodological issues are indeed an obstacle new researchers in humor will need to overcome. In this study, however, it seems that the spontaneous nature of the expression of humor lends itself immune to either a purposeful increase or purposeful restriction of its use without somehow impacting the session. Nonetheless, it is encouraging that such a study has been undertaken.

Saper (1987), who has stated that research on humor’s use in therapy would be “formidable, if not impossible” (Saper, 1987, p. 366), cites another unpublished dissertation that attempted to investigate the relationship between humor and the
therapeutic alliance. In this study, Golub (1979) used hired actresses to play the roles of counselor and clients, each of whom were given scripts to read from. The “clients” were asked to evaluate the “counselor” in terms of comfort, satisfaction, and climate, and were presented with either a humorous or non-humorous presentation by the therapist. The study yielded no significant results, and displayed no difference in the clients’ preference for either a humorous or non-humorous counselor. Again, there are significant methodological issues at play, as one cannot generalize the assessment of hired actresses to a situation based in reality.

Despite the paucity of evidence, there are those, such as Rancoli (1974) that state that humor will help foster a degree of mutuality between the therapist and the client, strengthening the alliance. Buckman (1994) discusses the potential role of humor in couple therapy specifically. She states that humor has two main purposes for the therapists in couple therapy, the first of which is a tool to help reduce the tension and offer the clients an acceptable means of expressing strong emotions that the partners cannot readily express towards one another. This aspect speaks directly to the findings of Ackerman and Hilsenroth (2003) that the therapist who encourages the open expression of affects and fosters exploration helps develop positive therapeutic alliance. Second, she says that humor can be exposed as the strongest defense mechanism that exists within a couple’s relationship. She suggests that an “overuse” of humor by partners is a sign that their emotional intimacy has been disabled, and they are avoiding true connection with one another.
Social Aspects of Humor

One aspect of humor that research has addressed is its function as a social phenomenon. Given that the foundation for therapeutic alliance is the human relationship, this area of study is relevant in that it displays the social nature of humor. Martineau (1972), recognized humor as “a pervasive phenomenon in the social fabric of most, if not all, societies” (p. 101). In nearly every type of human interaction, there is the capacity for humor, as well as an analysis of that behavior and the emerging social structure. In his social-categorization theory, Henri Tajfel (1982) offers a framework from which one can gain an understanding of the ways in which humor can be associated within intergroup-behavior.

According to Tajfel, there are four key constructs that are linked to intergroup behaviors: (1) social categorization, (2) social identity, (3) social comparisons, and (4) positive group distinctiveness. Individuals develop a network of cognitive categories, (social categorization), attempt to define their membership within the various categories, (social identity), as well as make evaluations of the characteristics assigned to various positions within those categories, (social comparisons). It is possible to propose that a sense of humor may be included among the evaluative characteristics within individuals’ comparisons (Sherman, 1988). However, humor, upon analysis from a sociological perspective, forms a societal paradox. On one end, it serves as an interpersonal lubricant for the formation and facilitation of social relationships, while on the other, a source of interpersonal friction allowing for a socially expectable means of personal disengagement (Martineau, 1972).
Sherman (1988) conducted a study that examined the relationship between humor and social distance based on social facilitation theory, which states that as an interpersonal communication behavior, humor facilitates social interaction. Same and cross-gender influences were a focus of the study, as well as the question of whether social distance measures would be predictive of humor perceptions, or if humor perceptions are predictive of social distance.

The subjects for the study included three fourth-grade classrooms (mean age of the students was 9.6 years of age). The study was conducted in late spring, allowing for the children to have become familiar with one another over the course of the school year. To measure social distance amongst the children, they were administered a sociometric measure, rated on a 5-point Likert-type scale. Each child had an opportunity to both give and receive a rating from every other child in the classroom. The measure ranged from (1) “Would like to have him/her as one of my best friends,” to (5) Wish he/she were not in this room.” Similarly, the children were asked to rate one another in regard to how humorous they perceived one another to be. Results of the study showed that cross-gender ratings of social distance were significantly higher than same-gender ratings. Cross-gender ratings that females received from males were significantly higher (indicating greater social distance) than the scores males received from females. Additionally, same gender humor ratings were significantly higher (more perceived humorousness) than were cross-gender ratings.

The data revealed that children who were perceived as being more humorous by their peers were also seen as being less socially distant. Also, it was found that children of the same gender rate each other as being more humorous and less socially distant than
children of the opposite-sex. Using a model-fitting procedure Sherman (1988) was able to statistically confirm that social distance was predicted to be a function of the interpersonal perceptions of humorousness. The author concluded that those children who have mastered both the production and appreciation of humor may be more attractive to and accepted by their peers in the classroom.

This same relationship between humor and social relationships is apparent in an earlier study conducted by Masten (1986). The author evaluated several different aspects of humor and examined their relationship to several areas of social competence. Her study followed the findings of Ziv (1984), who found that adolescent humorists were more popular than their peers who were less humorous, and also they were more likely to be acknowledged as possessing leadership skills by their teachers.

Subjects for the study were 10-14 year old junior-high school students. The study involved three measures of humor behavior and the following measures of social competence, including: (1) peer reputation, (2) intelligence, and (3) competence. To evaluate the students’ humor capabilities, funniness ratings of cartoons of varying difficulty were administered to the children. Having the children describe the humor they found in the cartoons assessed humor comprehension. Creative humor ability was measured by having the children produce humorous captions and ideas on demand.

Consistent with previous research, it was found that humor was related to social competence through the demonstration of intellectual ability in both humor behaviors and competent functioning. While the results indicated that humor displayed a positive relation to school competence, there was little relation to disruptiveness as judged by peers or teachers. This finding contradicted those reported by Damico and Purkey (1978)
who suggested that “class-clowns” in eighth-grade, while rated by their teachers as possessing leadership skills, were also rated as being more unruly. Superior humor production, comprehension, and mirth were all associated with academic and social competence. Humor production, in particular, was negatively correlated with feelings of isolation. Masten (1986) concluded that humor may be related to competence through peer relations, either by humor behaviors influencing peer reputation or being influenced by peer relations or, most likely, by both.

The lack of empirical data associating humor with therapeutic alliance presents researchers with the challenge of connecting related relevant research findings that may be applied to the therapeutic environment, and factors that influence therapeutic alliance in particular. While not applied within a therapeutic context specifically, the above studies do highlight the ability of humor to serve as a facilitator of social relationships. They demonstrate that in other social situations, those individuals who are seen by others as facilitators of humor are received in a positive manner, and helps foster perceptions of competence and acceptance. Again, Ackerman and Hilsenroth (2003) recognized such features highlighted by this research as qualities possessed by therapists who are successful in developing healthy therapeutic alliance.

*Salameh’s Helpful versus Destructive Humor*

Salameh (1983), in an effort to increase research on the use of humor’s effect in the therapeutic process, developed the *Humor Rating Scale* as a tool that could be used to rate live or videotaped psychotherapy sessions. As aforementioned, it is Salameh’s view that humor can indeed be helpful to the therapeutic process (Salameh, 1983). However, he does not ignore the warnings of Kubie (1971), that the use of humor by therapists
could be destructive to therapeutic alliance if used in the wrong way. For that reason, Salameh defines specifically what is meant for therapeutically helpful and destructive humor.

Destructive humor is defined as humor that is at worst vindictive and degrading towards the client, often used in a moment of anger and/or frustration by the therapist. Also defined as destructive humor is that which does not focus on the clients needs and is often followed by redemptive comments. That is, the therapist may have had no intention of degrading the client, and quickly follows an attempt at humor with an “I was only joking” remark to help soothe the moment (Salameh, 1983).

Helpful humor can take several forms, and is at least humor that is not necessarily focused on the client or the presenting problem, but rather attempts at creating a warm, inviting therapeutic atmosphere, perhaps to reduce anxieties or questions about the therapeutic process (Salameh, 1983). It is argued that humor becomes more helpful when it focuses on the problem specifically, assisting the client(s) to view their problems from an objective perspective, and perhaps fostering what Schnarch (1990) described as a private language between client(s) and therapist around the problem. At its most helpful, humor involves an interplay between client(s) and therapist, focusing not only on the problem at hand but also leading to new insights and solutions (Salameh, 1983).

Hypotheses

In lieu of the research reviewed, more research questions concerning this study and specific hypotheses are presented. As mentioned previously, the main research question asks if the frequency of helpful humor used by a therapist in the first session is related to therapeutic alliance. Further, is the use of helpful humor in session one related
to therapeutic alliance at the third session? As aforementioned, much research in therapeutic alliance focuses on either the first and/or third session as critical periods for its formation (Bourgeois et al., 1990; Heatherington & Friedlander, 1990; Johnson & Greenberg, 1985; Sexton et. al., 1996; Sexton et. al., 2005). Such a relationship would show that the use of such humor has a lasting quality that impacts the progression of alliance, not just at the initial onset of therapy. Also, does humor used in the first session of therapy predict dropout-status? And finally, does the frequency of humor predict less discrepancy in therapeutic alliance amongst partners? That is, as the research has shown that split alliances have a negative impact on therapy, can it be shown that humor that is directed towards the couple as a whole (rather than at either one partner or the other) promotes an intact, rather than split, alliance?

In response to these questions, this study analyzed the following hypotheses respectively, including 1) the frequency of helpful humor at session one will be directly related to therapeutic alliance at session one, 2) the frequency of helpful humor at session one will be directly related to therapeutic alliance at session three, 3) the frequency of helpful humor at session one will be associated with decreased rates of dropout among couples in therapy, and 4) the frequency of helpful humor directed at the couple will be related to less discrepancy in the partners assessment of therapeutic alliance at session one.
CHAPTER 3

RESEARCH METHODS

Sample
The sample used in this study included 40 heterosexual couples presenting as clients at a couple and family therapy clinic at a large Midwestern university that serves as an on-campus training clinic for doctoral students enrolled in the Couple and Family Therapy program. The couples included were part of a larger ongoing study at the clinic to study premature termination. Participation in this larger study was voluntary, with clients asked to consent to participate separate from their consent for treatment. While all sessions at this clinic are videotaped and those tapes are saved for training and supervision purposes, clients were asked to consent to have their first-session videotapes saved for future research. In the larger study clients were asked to complete an intake packet, and complete brief after session questionnaires after sessions 1 through 6. For the purposes of this project first session videotapes were used to code for use of humor and the after session questionnaires for therapeutic alliance for session one and three were used.

Within this sample, 66% were married \((n = 27)\), 25% were cohabitating \((n = 10)\), 2.5% were currently separated \((n = 1)\), and 5% classified themselves as single \((n = 2)\). The mean age for males was 32.1, ranging from 21 to 62 years of age \((SD = 8.78)\). The
mean age for females was 30.4, ranging from 20 to 56 years of age ($SD = 7.78$).

Approximately 84% of the sample classified themselves as Caucasian ($n = 67$), 6.3% as African-American ($n = 5$), 2.5% as Asian ($n = 2$), and 2.5% as Hispanic ($n = 2$), with 5% of the participants classified as “other” ($n = 4$).

In regards to level of education, 7.5% of the women ($n = 3$) had at least a high school diploma or GED equivalent, 80% had either some college or had completed a bachelor’s degree ($n = 32$), while 12.5% ($n = 5$) had a master degree or higher level of education. In terms of education, 2.5% of the males ($n = 1$) had less than a high school education, 10% ($n = 4$) had completed high school or GED, 77.5% of the males ($n = 31$) had either some college or had completed a bachelor’s degree, and 10% ($n = 4$) reported having a master degree or higher level of education.

*Therapists*

This study included eight therapists, all of whom were enrolled in the Couple and Family Therapy doctoral program at the time of their participation in this study. Six of these therapists were female and two were male. The median age of therapists was 29, with a range of 25 to 44 ($SD = 6.92$). All therapists had a masters degree in a related field, with three having masters degrees in Marriage and Family Therapy, one in Counseling, one in Social Work, one in Clinical Psychology, and two in Human Development and Family Science.

*Procedure and Instruments*

As aforementioned, the sample of couples for this study was taken from a larger study, which included couples, individuals, and families. That study was interested in collecting first-session videotapes and self-report data on therapeutic alliance from
sessions one through six. All clients at the clinic completed an intake before the first session that gathers information on demographics, treatment history, marital satisfaction and commitment, differentiation of self, stress, and psychological symptoms. If clients chose to participate in the study, they received $10-$15 off their first session fee, depending on their level of participation. Clients could choose to not participate at all (option 1), to complete after-session questionnaires after sessions 1-6 (option 2), to have their first session videotaped saved for analysis (option 3), or to complete the after-session questionnaires and have their first-session videotape saved for analysis (option 4). Clients received $10 off their first session fee for options 2 or 3, or $15 for option 4. As this study is concerned with only couple therapy, only those clients presenting as such were included in this sample, yielding a total of 40 couples. Therapists also completed after-session questionnaires after sessions one through six if their clients chose to do so. This brief questionnaire was a measure of therapeutic alliance, the Working Alliance Inventory, described below.

**Working Alliance Inventory**

To measure therapeutic alliance, this study used the short version of the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989, see appendix A). The original version of the WAI is a 36-item self-report instrument that measures the tasks, goals, and bonding aspects of therapeutic alliance, and emphasizes the degree of mutuality between the therapist and the client. Both the therapist and the client complete the questions independently. The short version contains 12 items from the original 36, with questions being answered along a 7-point Likert-type scale with values ranging from 1, “Not at all true” to 7, “Very true”. A sample question for the client includes, “My therapist and I
trust one another”, while the same question asked of the therapist reads, “My clients and I trust one another”. Scoring consists of summing the item responses for a total score. Fisher and Corcoran (1994) report that the WAI exhibits very good discriminate and convergent validity, and also good reliability in terms of internal consistency, reporting alphas of .87, .82, and .68 for the goals, tasks, and bonds subscales. The short version reported even higher internal consistency, with alphas of .90 for tasks, .92 for bonding, and .90 for goals. Within this study, the WAI yielded alphas of .86 for the tasks subscale, .91 for the bonding subscale, and .87 for the goals subscale. Fischer and Corcoran (1994) also report an internal consistency coefficient of .98 using Chronbach’s alpha for the composite scale of the short form.

**Humor Rating Scale**

The Humor Rating Scale (HRS) (Salameh, 1983, see appendix B) is an observational rating scale that was developed for the purposes of expanding the research on the use of humor in therapy. It rates the therapist’s use of humor on a five-point scale ranging from 1, “destructive humor” to 5, “outstandingly helpful humor”. Each higher level of humor is assumed to surpass the previous. According to the author, destructive humor is both sarcastic and vindictive, and is essentially an attack on the client by the therapist.

Conversely, the highest level of humor displays a deep level of understanding between the therapists and the client(s), and serves to enhance the client’s understanding of the problem while promoting self exploration and new perspective-taking. Designed to foster theoretically based empirical research on the use of humor in therapy, the HRS has never been used in any published (or unpublished) study, yet several authors have
mentioned it specifically as a valuable tool to use in future studies (Dimmer, Carroll, & Wyatt, 1990, Franzini, 2001). Due to the inherent subjectivity the HRS, it was necessary to recruit and train judges to meet an acceptable level of inter-rater reliability.

**Raters’ Recruitment and Training**

Raters for this study included the author as well as one master’s student and two undergraduate students. The raters were recruited voluntarily, choosing to participate as students who had expressed interest in gaining research experience. Before coding tapes, raters were trained meeting weekly over a four-month period in an effort to obtain a minimally acceptable inter-rater reliability of .70.

First, all raters were given a literature packet that provided an overview of use of humor in therapy, which included an article of how humor is used as a communication tool by couples and therapists (Buckman, 1994), a literature review of research on the use of humor in therapy (Franzini, 2001), and an article that discussed the development of the Humor Rating Scale (Salameh, 1983). Raters then met to discuss the literature.

The following two weeks, raters watched first-session videotapes together to discuss their observations (i.e., where humor was observed, what type of humor was being observed). Next, raters were paired into groups of two, with each group rating the same tape, and then meeting the following week to discuss their independent observations. This procedure was repeated for four tapes, resulting in an additional 8 weeks of training. Finally, each rater independently rated four randomly assigned tapes.

Using the Intraclass Correlation Coefficient (ICC), the level of agreement on those initial four tapes was .85, .89, .99, and .88, respectively. Having reached an acceptable level in agreement, the remaining 36 tapes were randomly assigned to the
judges. To insure an acceptable level of agreement throughout the study, the remaining 36 tapes were divided into two sets of 18, with one pair of judges assigned to independently code one set of 18, and the other pair of judges assigned the other set of 18 tapes. An intraclass correlation, then, was calculated for each tape (see table 3.1). The ICCs ranged from .78 to 1.00, with 35% \((n = 14)\) of the sample reaching 1.00 (100% agreement).

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**TABLE 3.1: INTRACLASS CORRELATION COEFFICIENTS \((N = 40)\)**

**Coding**

It was necessary for the author to create the Humor Rating Index as a tool for judges to use to collect data (see Appendix C). This index allows a rater to record a timestamp of when a humor event occurs, what type of humor was observed according to the Humor Rating Scale (Salameh, 1983), and to whom the humor used by the therapist is directed (couple, male partner, female partner). All first-session videotapes were then divided into two 20-minute sections, including both the first and last 20 minutes of each tape. Raters reported each instance of humor by indicating the time the humor event
occurred, and then reported what type of humor was used by the therapist. It is important to note that instances of humor used by the therapist included those times when a therapist responded to a client’s humor. That is, the therapist did not have to begin a humorous reciprocal exchange in order for the humor to be coded. In addition, raters reported to whom the humor was directed.

Analysis

The first hypothesis stated that the frequency of helpful humor would be related to positive therapeutic alliance at session 1, while the second hypothesis stated that the frequency of helpful humor would be related to positive therapeutic alliance at session 3. On the HRS, a rating of 3, 4, or 5 indicates a helpful humor response. In regards to these first two hypotheses, the data was analyzed using the Pearson product-moment correlation coefficient. Included in these analyses were each tape’s frequency of helpful humor along with male and female partners’ as well as therapists’ WAI total score at session 1 and 3, and their scores on each of the three subscales (goals, tasks, and bonding). The analysis became more complex for the third and fourth hypotheses.

The third hypothesis stated that the frequency of helpful humor would be associated with lower dropout amongst couples within the first three sessions. Data on the clients included five categories of termination status, including: 1) still in therapy, 2) agreement about termination, 3) client left against therapist recommendation, 4) client no-showed, and 5) client was referred to another clinic. A client leaving therapy against a therapist recommendation or a client no-showing (that is, having an appointment scheduled but then never coming and ending therapy ambiguously) were considered “dropout”. Clients were first put into one of two groups, dropout (coded “0”) and non-
dropout (coded “1”), creating a dichotomous categorical dependent variable. An independent samples t-test was then used to determine if there was significant difference between the humor frequency means of those clients who dropped out of therapy and those who did not drop out. A logistic regression model was then used to show if the frequency of humor helps to predict dropout status.

The fourth hypothesis stated that the frequency of helpful humor directed towards the couple would predict less discrepancy (i.e., less “split” alliance) in alliance scores amongst couples. It is important to keep in mind that this study gathered information on therapeutic alliance from three perspectives, including the therapists and each individual client. In addition, the coding scheme for humor allows for the analysis of to which partner more humor was directed. That is, data is collected on whether the therapist’s humor was directed towards one partner individually or to the couple as a whole.

The underlying theory is that too many instances of humor directed toward one partner and not the other will have a destructive effect on the therapeutic alliance. For example, if the therapist continues to share humor with a husband throughout a session, he/she may be unknowingly establishing a better rapport, or perhaps a “private language” to use Schnarch’s (1990) terminology, with only him, perhaps neglecting the female partner. Difference scores on therapeutic alliance were analyzed, as well as the frequency of couple directed and individually directed instances of humor.

In order to do so, it was necessary to establish what a “discrepancy” means. That is, how is it known if there is enough “difference” in scores to label it a discrepancy? Also, how much of this difference could be attributed due to measurement error? For these purposes, the Reliability of Change Index (RC) was used (Jacobsen & Revenstorf,
The RC was designed to measure significant change in psychotherapy while accounting for measurement error. The RC is calculated by dividing the difference between two scores (for example, pre-test and post-test scores) by the standard error of that difference. Jacobsen and Truax (1991) stated that an RC score greater than 1.96 ($p < .05$) is statistically significant, indicating change that goes beyond what could be expected by fluctuations due to measurement error.

In this study, the RC is being used to determine if a difference between female and male partners’ therapeutic alliance scores are indeed different, therefore indicating a split in the alliance. The difference between therapeutic alliance scores was calculated for both session one and session three, and these difference scores were each then individually divided by the standard error. Thus, for each client, RC scores were calculated, and clients could then be assigned to two groups: those who showed a split (RC > 1.96) and those who did not (RC < 1.96), creating a dichotomous categorical dependant variable. For both session one and session three RC scores, independent sample t-tests were used to analyze the differences in the humor frequency mean scores for those clients who expressed split alliance compared to those who did not.
CHAPTER 4

RESULTS

Descriptive Statistics

The data revealed that there were no observed instances of therapists using what Salameh (1983) defined as either destructive (level 1) or harmful (level 2) humor. That is, when humor was used, it was observed as at least minimally helpful (level 3). There were also no observed instances of outstandingly helpful (level 5) humor. Overall, the mean observed humor type was 2.74 (SD = .93), which includes 4 cases in which there was no observed humor. When those cases are excluded, the humor type ranges from 3.00 to 3.30. As displayed in Fig. 4.1, the majority (60%) of humor was observed as level 3.

FIG. 4.1: DISTRIBUTION OF HUMOR MEAN TYPE.
As mentioned above, 10% \((n = 4)\) of the cases were void of humor. The frequency ranged from 0 to 15.50, with an overall mean of 5.67, and a standard deviation of 4.38. In 70% \((n = 28)\) of the cases therapists were observed as using 7.00 or less instances of humor.

**Hypothesis One**

The first hypothesis, which stated that the frequency of helpful humor would be correlated with positive therapeutic alliance at session one, was partially supported by the data. From the therapists’ perspective of alliance, the frequency of humor was significantly related to the bonding subscale \((r (20) = .63, p < .01)\), the tasks subscale \((r (20) = .56, p < .01)\), and the overall therapeutic alliance score \((r (20) = .65, p < .01)\). That is, the more therapists used humor in the first session, the more likely they were to perceive their clients as liking and trusting them. In addition, therapists were more likely to agree that what they were working on therapy was correct, and displayed, overall, a more positive perception of therapeutic alliance.

There was a non-significant but positive trend on the goals subscale \((r (20) = .38)\). Therapists who used humor more often in the first session were more likely to agree that they shared common therapeutic goals with the clients, but not to the same extent as the tasks or bonding subscales. The data did not support the first hypothesis from either the female or male partners’ perspectives. The correlation matrices displaying the relationships analyzed for hypothesis one can be found below. Table 4.1 includes the therapists’ perspective of therapeutic alliance, table 4.2 displays the female partners’ perspective of therapeutic alliance, and table 4.3 displays the male partners’ perspective of therapeutic alliance.
<table>
<thead>
<tr>
<th>Humor Frequency Mean</th>
<th>Pearson Correlation</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Pearson Correlation</td>
<td>.654(**)</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td><strong>Bonds</strong></td>
<td>Pearson Correlation</td>
<td>.634(**)</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Pearson Correlation</td>
<td>.379</td>
<td>.082</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td><strong>Tasks</strong></td>
<td>Pearson Correlation</td>
<td>.562(**)</td>
<td>.006</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td></td>
<td>22</td>
</tr>
</tbody>
</table>

**TABLE 4.1: CORRELATIONS BETWEEN HUMOR AND THERAPISTS’ PERCEPTION OF THERAPEUTIC ALLIANCE.**

**CORRELATION IS SIGNIFICANT AT THE 0.01 LEVEL (2-TAILED).**

<table>
<thead>
<tr>
<th>Humor Frequency Mean</th>
<th>Pearson Correlation</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Pearson Correlation</td>
<td>.082</td>
<td>.667</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td><strong>Bonds</strong></td>
<td>Pearson Correlation</td>
<td>.060</td>
<td>.755</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Pearson Correlation</td>
<td>.195</td>
<td>.301</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td><strong>Tasks</strong></td>
<td>Pearson Correlation</td>
<td>.011</td>
<td>.953</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>

**TABLE 4.2: CORRELATIONS BETWEEN HUMOR AND FEMALE PARTNERS’ PERCEPTION OF THERAPEUTIC ALLIANCE.**
TABLE 4.3: CORRELATIONS BETWEEN HUMOR AND MALE PARTNERS’ PERCEPTION OF THERAPEUTIC ALLIANCE.

<table>
<thead>
<tr>
<th></th>
<th>Humor Frequency Mean</th>
<th>Pearson Correlation</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>total</td>
<td></td>
<td>.067</td>
<td>.721</td>
<td>31</td>
</tr>
<tr>
<td>bonds</td>
<td></td>
<td>.047</td>
<td>.802</td>
<td>31</td>
</tr>
<tr>
<td>tasks</td>
<td></td>
<td>.026</td>
<td>.890</td>
<td>31</td>
</tr>
<tr>
<td>goals</td>
<td></td>
<td>.122</td>
<td>.513</td>
<td>31</td>
</tr>
</tbody>
</table>

**Hypothesis Two**

The second hypothesis, which stated that the frequency of helpful humor would be correlated with positive therapeutic alliance at session three, was partially supported by the data. From the therapists’ perspective on alliance, the frequency of humor was significantly related to tasks subscale of the WAI ($r (11) = .63, p < .05$). That is, the more instances of humor a therapist used in session one was associated with the therapist feeling that what they were working on in therapy was correct. There were non-significant positive trends on the therapists’ total therapeutic alliance score ($r (11) = .53$) and the bonding subscale ($r (11) = .49$). This data show that a therapist’s use of humor in session was related to a more positive overall perception of therapeutic alliance and to feeling that the clients liked and/or trusted them. The frequency of humor was not
significantly related to either female or male partners’ WAI scores at session three. The correlation matrices displaying the relationships analyzed for hypothesis two can be found below. Table 4.4 includes the therapists’ perspective of therapeutic alliance, table 4.5 displays the female partners’ perspective of therapeutic alliance, and table 4.6 displays the male partners’ perspective of therapeutic alliance.

<table>
<thead>
<tr>
<th>Humor Frequency Mean</th>
<th>Pearson Correlation</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Pearson Correlation</td>
<td>.527</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.064</td>
<td></td>
</tr>
<tr>
<td>Bonds</td>
<td>Pearson Correlation</td>
<td>.487</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.092</td>
<td></td>
</tr>
<tr>
<td>Goals</td>
<td>Pearson Correlation</td>
<td>.015</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.960</td>
<td></td>
</tr>
<tr>
<td>Tasks</td>
<td>Pearson Correlation</td>
<td>.634(*)</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.020</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 4.4: CORRELATIONS BETWEEN HUMOR AND THERAPISTS’ PERCEPTION OF THERAPEUTIC ALLIANCE.
* CORRELATION IS SIGNIFICANT AT THE 0.05 LEVEL (2-TAILED).
### TABLE 4.5: CORRELATIONS BETWEEN HUMOR AND FEMALE PARTNERS’ PERCEPTION OF THERAPEUTIC ALLIANCE.

<table>
<thead>
<tr>
<th>Humor Frequency Mean</th>
<th>Pearson Correlation</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>-.137</td>
<td>.565</td>
<td>20</td>
</tr>
<tr>
<td>Bonds</td>
<td>-.025</td>
<td>.918</td>
<td>20</td>
</tr>
<tr>
<td>Goals</td>
<td>-.247</td>
<td>.293</td>
<td>20</td>
</tr>
<tr>
<td>Tasks</td>
<td>-.067</td>
<td>.779</td>
<td>20</td>
</tr>
</tbody>
</table>

### TABLE 4.6: CORRELATIONS BETWEEN HUMOR AND MALE PARTNERS’ PERCEPTION OF THERAPEUTIC ALLIANCE.

<table>
<thead>
<tr>
<th>Humor Frequency Mean</th>
<th>Pearson Correlation</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>.296</td>
<td>.205</td>
<td>20</td>
</tr>
<tr>
<td>Bonds</td>
<td>.176</td>
<td>.458</td>
<td>20</td>
</tr>
<tr>
<td>Goals</td>
<td>.378</td>
<td>.100</td>
<td>20</td>
</tr>
<tr>
<td>Tasks</td>
<td>.291</td>
<td>.212</td>
<td>20</td>
</tr>
</tbody>
</table>
**Hypothesis Three**

The third hypothesis, which stated that the frequency of helpful humor at session one would be associated with less dropout, was supported by the data. According to their termination status, clients were assigned to either a “dropout” or “non-dropout” group, creating a categorical dichotomous dependent variable. An independent-samples t-test was administered, using the frequency of humor as the test variable, and dropout status as the grouping variable. The analysis included 37 couples, with 3 missing termination data. Twenty-one couples were assigned to the dropout group, with the remaining 16 in the non-dropout group. The humor frequency mean for dropouts was 3.87 \((SD = 3.67)\) while the mean for non-dropouts was 7.20 \((SD = 4.15)\). Levene’s test for equality of variances yielded an F value of .002 and p-value of .961, meaning the assumption of equal variances was met for the sample. The mean difference for this sample was \(-3.33 (t (35) = -2.59, p = .014)\). Therefore it can be concluded that within this sample, there was a significant difference between the amount of humor used in the first session between those who dropped out of therapy and those who did not. Those who stayed in therapy experienced more humor in their first session than those who terminated therapy prematurely. The group statistics can be found in table 4.7, while the results of the independent-samples t-test can be seen in table 4.8, below.

![Table 4.7](image)

<table>
<thead>
<tr>
<th>Dropout</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humor Frequency Mean Yes</td>
<td>21</td>
<td>3.87</td>
<td>3.67</td>
<td>.802</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>7.2</td>
<td>4.15</td>
<td>1.04</td>
</tr>
</tbody>
</table>

**TABLE 4.7:** GROUP STATISTICS FOR DROPOUTS/NON-DROPOUTS BASED ON HUMOR FREQUENCY MEAN.
<table>
<thead>
<tr>
<th></th>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
<td>t</td>
</tr>
<tr>
<td>Humor Frequency Mean</td>
<td>Equal variances assumed</td>
<td>Equal variances not assumed</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-2.54</td>
</tr>
</tbody>
</table>

TABLE 4.8: INDEPENDENT-SAMPLES T-TEST: FREQUENCY OF HUMOR AND DROPOUT STATUS GROUPING.

Having significant differences between means for dropouts and non-dropouts, a logistic regression model was used, analyzing the ability of the frequency of humor to predict dropout status. The model included 37 (92.5%) couples, with 3 cases missing termination data. Twenty-one cases were designated as dropouts, while 16 were designated as non-dropouts. The null model’s overall predication rate was 56.8%. The p-value of the frequency of humor was .015, indicating that this variable would be significant in the model.

The chi-square analysis, \( X^2 (1, n = 37) = 6.25, p = .012 \), revealed that the full model was statistically significant. (See table 4.9 for the omnibus tests of model coefficients). The model correctly predicted 64.9% of cases (an increase of 7.9%). Fifteen cases were observed to be dropouts and were correctly predicted as dropouts, while 6 cases were observed to be dropouts and were predicted as non-dropouts (71.4% correct). Nine cases were observed to be non-dropout and predicted to be non-dropouts,
while 7 cases were observed to be non-dropouts and were predicted to be dropouts (56.3% correct). That is, the model including the frequency of humor was better at predicting dropout status, while being better at predicting dropouts than non-dropouts. The p-value for the frequency of humor in the full model was .023. Table 4.10 displays the classification table for the full model, while table 4.11 displays the results of the full model.

<table>
<thead>
<tr>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>6.252</td>
<td>1</td>
</tr>
<tr>
<td>Block</td>
<td>6.252</td>
<td>1</td>
</tr>
<tr>
<td>Model</td>
<td>6.252</td>
<td>1</td>
</tr>
</tbody>
</table>

**TABLE 4.9: OMNIBUS TESTS OF MODEL COEFFICIENTS.**

<table>
<thead>
<tr>
<th>Observed</th>
<th>Predicted Dropout</th>
<th>Percentage Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Yes</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>7</td>
</tr>
<tr>
<td>Overall Percentage</td>
<td></td>
<td>22</td>
</tr>
</tbody>
</table>

**TABLE 4.10: CLASSIFICATION TABLE FOR FULL MODEL (INCLUDES HUMOR FREQUENCY).**

<table>
<thead>
<tr>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HaFreq</td>
<td>.220</td>
<td>.097</td>
<td>5.142</td>
<td>1</td>
<td>.023</td>
</tr>
<tr>
<td>Constant</td>
<td>-1.467</td>
<td>.641</td>
<td>5.249</td>
<td>1</td>
<td>.022</td>
</tr>
</tbody>
</table>

**TABLE 4.11: VARIABLES IN THE EQUATION (FREQUENCY OF HUMOR).**
Hypothesis Four

The fourth hypothesis, which stated that the frequency of helpful humor directed at couples, would be related less split alliance among couples, was not supported by the data. The sum scores of the direction of instances of humor were 165 for couples, 39.5 for male clients, and 31.5 for female clients. That is, 69.9% of the humor used by therapists in the first session was directed at the couple, 16.7% was directed at male clients, and 13.3% was directed at female clients. The mean frequency of humor (the average number of instances of humor per first session) for couples was 4.13 \( (SD = 3.28) \), .99 for males \( (SD = 1.12) \), and .79 \( (SD = .93) \) for females. Descriptive statistics for the distribution of humor can be seen in table 4.12.

<table>
<thead>
<tr>
<th></th>
<th>Couple</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>40</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>4.13</td>
<td>.99</td>
<td>.79</td>
</tr>
<tr>
<td>Median</td>
<td>3.75</td>
<td>1.00</td>
<td>.000</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>3.28</td>
<td>1.12</td>
<td>.93</td>
</tr>
<tr>
<td>Range</td>
<td>12.50</td>
<td>5.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Minimum</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>Maximum</td>
<td>12.50</td>
<td>5.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Sum</td>
<td>165.00</td>
<td>39.50</td>
<td>31.50</td>
</tr>
</tbody>
</table>

TABLE 4.12: DISTRIBUTION OF HUMOR DESCRIPTIVE STATISTICS (COUPLE, MALE, AND FEMALE DIRECTED HUMOR).

Upon analyzing the first session, it was observed that 18 couples displayed a split alliance, while 10 did not. That is, using the RC index, 18 couples had a calculated RC greater than 1.96, indicating a statistically significant difference in the WAI scores. Upon analyzing the third session, it was observed that 12 couples displayed a split alliance, while 6 did not. Session one data included 28 couples, while session three data included
only 18 couples. Descriptive statistics for session one and session three split alliance statuses can be seen in table 4.13, while descriptive statistics for session three split alliance status can be seen in table 4.14.

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Split</td>
<td>10</td>
<td>25.0</td>
<td>35.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Split</td>
<td>18</td>
<td>45.0</td>
<td>64.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>70.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>12</td>
<td>30.0</td>
<td>35.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**TABLE 4.13: SESSION ONE SPLIT ALLIANCE STATUS DESCRIPTIVE STATISTICS.**

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Split</td>
<td>6</td>
<td>15.0</td>
<td>33.3</td>
<td>33.3</td>
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<td>18</td>
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<td>100.0</td>
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<td>22</td>
<td>55.0</td>
<td>33.3</td>
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<tr>
<td>Total</td>
<td>40</td>
<td>100.0</td>
<td>100.0</td>
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</table>

**TABLE 4.14: SESSION THREE SPLIT ALLIANCE STATUS DESCRIPTIVE STATISTICS.**

Two independent-samples t-tests were administered, using the frequency of helpful humor directed towards couples as the test variable in both tests, and split alliance status as the grouping variable in both tests, with the first test using session one data, and the second using session three data. The first analysis included 28 couples, with 18 couples in the split group, and 10 in the no-split group. The couple-directed humor frequency mean for splits was 3.46 ($SD = 3.45$), while the mean for no-splits was 4.03 ($SD = 3.12$). Levene’s test for equality of variances yielded an F value of .365 and p-value of .551, meaning the assumption of equal variances was met for the sample. The
mean difference was \(-.57\) \((t\ (26) = .428, \ p = .672)\). Although the mean for the no-split group is slightly higher, the results indicate no significant difference between the two groups (see Table 4.15 for group statistics, and Table 4.16 for t-test results).

<table>
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<th>Std. Error Mean</th>
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<tr>
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<td>18</td>
<td>3.46</td>
<td>3.45</td>
<td>.813</td>
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TABLE 4.15: GROUP STATISTICS FOR NO-SPLITS/SPLITS BASED ON HUMOR FREQUENCY MEAN (SESSION ONE DATA).

<table>
<thead>
<tr>
<th>Code</th>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
<th>95% Confidence Interval of the Difference</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
<td>t</td>
</tr>
<tr>
<td>CoupleHa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal</td>
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<td></td>
<td></td>
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<td>variances</td>
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<td>.551</td>
<td>.428</td>
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<tr>
<td>assumed</td>
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<td></td>
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<tr>
<td>variances</td>
<td>not</td>
<td>assumed</td>
<td></td>
</tr>
<tr>
<td>not</td>
<td></td>
<td>assumed</td>
<td></td>
</tr>
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</table>

TABLE 4.16: INDEPENDENT-SAMPLES T-TEST: FREQUENCY OF HUMOR AND SPLIT ALLIANCE STATUS GROUPING FOR SESSION ONE DATA.

The second independent samples t-test included 18 couples, with 12 couples in the split group, and 6 in the no-split group. The couple-directed humor frequency mean for splits was 2.83 \((SD = 2.62)\), while the mean for no-splits was 4.25 \((SD = 3.67)\).

Levene’s test for equality of variances yielded an F value of .71 and p-value of .413,
meaning the assumption of equal variances was met for the sample. The mean difference was \(-1.42\) (\(t(16) = .95, p = .357\)). Similar to session one data, the no-split group is higher, yet the results indicate no significant difference between the two groups (see Table 4.17 for group statistics, and Table 4.18 for t-test results).

<table>
<thead>
<tr>
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<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
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<td>4.25</td>
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<td>1.50</td>
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<td>CoupleHa Split</td>
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<td>2.83</td>
<td>2.62</td>
<td>.757</td>
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**TABLE 4.17: GROUP STATISTICS FOR NO-SPLITS/SPLITS BASED ON HUMOR FREQUENCY MEAN (SESSION THREE DATA).**

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<th>RCgroup</th>
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<th>Std. Deviation</th>
<th>F</th>
<th>Sig.</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
<th>Mean Difference</th>
<th>Std. Error Difference</th>
<th>95% Confidence Interval of the Difference</th>
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<tr>
<td>CoupleHa Equal variances assumed</td>
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<td></td>
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<td>7.66</td>
<td>.624</td>
<td>1.42</td>
<td>1.68</td>
<td>-2.48</td>
<td>5.32</td>
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</tbody>
</table>

**TABLE 4.18: INDEPENDENT-SAMPLES T-TEST: FREQUENCY OF HUMOR AND SPLIT ALLIANCE STATUS GROUPING FOR SESSION THREE DATA.**
Chapter 5

Discussion

This study yielded significant findings in an area of study that is largely untouched by researchers. In the case of such a study, even findings that are not statistically significant can be considered important. Three out of the four hypotheses were at least partially supported by the data. While such findings are promising, the exploratory nature and other limitations to this study make it impossible to generalize to other populations, but they certainly lay a foundation for replication and/or future research questions concerning the efficacy of the use of humor in psychotherapy.

The findings supported the theory proposed by Salameh (1983), that the use of helpful humor in therapy is beneficial to the therapeutic process. It is interesting to note that in this study there were no instances of harmful humor (neither levels one or two) observed by the coders. Concomitantly, there were no observed instances of level five, or “outstandingly helpful” humor. Considering only those cases where humor was observed, the mean type of humor ranged from 3.00 to 3.30 (see fig. 1), with the vast majority of humor used of the level three, or “minimally helpful” type. However, revisiting the Humor Rating Scale (Salameh, 1983) may help explain this phenomenon.
According to Salameh (1983), a minimally helpful level of humor (level three) is displayed when the instance of humor attempts to create a warm, inviting therapeutic atmosphere, perhaps to reduce anxieties or questions about the therapeutic process. It is not until humor begins to focus more specifically on the problem itself that it reaches higher levels of helpfulness. Theoretically speaking, if what is observed is mainly minimally helpful instances of humor, as the data from this study reflect, then its impact would be assumed to be, at best, minimally detectable. It would also be logical to argue that with such humor present, one would not find a damaging effect of the use of humor on the therapeutic process, such as those mentioned by Kubie (1971). Indeed, with three out of the four hypotheses partially supported, it can certainly be argued that these findings support the theory that humor of the correct type can be beneficial to the therapeutic process, and to the formation of therapeutic alliance in couple therapy specifically.

**First Hypothesis Findings**

The first hypothesis was supported from the therapists’ perspective of therapeutic alliance. Of the three subscales, the bonding subscale was the most strongly supported ($r = .63$), which makes intuitive sense when one considers the questions (e.g., “I believe my client likes me”). Interestingly, this was not reciprocated from the clients’ perspectives, as both females’ and males’ bonds scores displayed very little correlation to the therapists’ use of humor. In fact, a review of the correlation matrices for hypothesis one reveals virtually no relationship between the use of humor and the clients’ perspectives on any aspect of therapeutic alliance. This finding of non-significance is significant in lieu of the warnings of the proposed danger of using humor in psychotherapy, however. If Kubie’s
(1971) assertions were correct, then one would expect to see a negative correlation between the use of humor and therapeutic alliance, at least from the clients’ perspectives. Finally, the lack of level four, or “very helpful” humor, could explain the findings of hypothesis one as well, specifically on the tasks and/or goals subscales of the WAI. Such humor reflects to the client a deep understanding of the problem by the therapist, and perhaps would be necessary for a relationship to be expressed.

An alternative consideration for the findings of hypothesis one (and two, for that matter) is that it may be that therapists, while indeed observed to have used humor, may not have been using humor as a tool per se, but rather as a means to alleviate their own anxiety. The therapists in the study, while varied in their years of experience, were students in a doctoral program. It could by hypothesized that some of the therapists included in this study experienced a heightened level of anxiety with their clients, especially in the first session. With humor as a possible means of relieving some of this anxiety, it makes sense that with those clients where humor was used, therapists “felt better” after those sessions, and displayed higher scores on the WAI. With no data on the clients’ use of humor, this could also explain why to the clients, the use of such humor, which would be expected to be of the “level 3” type, made no difference according to the WAI scores. To test such a hypothesis, one would need to analyze the clients’ use of humor as well, with a greater use of humor by the clients, then, expected to be related to higher scores on a measure of therapeutic alliance. That said, it is important to note that regardless of the reason why the therapists in this study used humor, its use did not have a negative effect on the clients’ perception of therapeutic alliance.
Second Hypothesis Findings

The second hypothesis’ findings nearly mirrored those of the first, with some notable differences. Again, a significant correlation is found from the therapists’ perspective, this time only on the tasks subscale of the WAI. The overall correlation dropped from .65 to .53 (no longer significant), and the bonding subscale was also non-significant, while both displayed a positive trend in their respective correlations. Once again, there are no significant relationships displayed between the use of humor and the clients’ perspective of therapeutic alliance, this time at session three. Without any information about the humor that was used in session three (or session two, for that matter), it is difficult to propose what may or may not have changed about the therapeutic process. That said, little changed about the participants’ views on therapeutic alliance, and it is important to note that once again, there were no significant negative correlations at session three either, once again supporting the position that it is not sufficient to simply state that humor in and of itself may be destructive to the therapeutic process.

Third Hypothesis Findings

With research showing that early formation and maintenance of therapeutic alliance is related to therapeutic outcome (Horvath & Greenberg 1989; Horvath & Greenberg, 1994; Johnson & Talitman, 1997), as well as other findings that suggest the premature termination (dropout) rate is higher within couple and family therapy (Bischoff & Sprenkle, 1993), the findings of the third hypothesis display an interesting effect of the use of humor on the dropout rate of this sample. At the least, this data shows that among the couples included in this study the use of humor certainly did not negatively impact a client’s chances of premature termination. That is, this data did not reveal a pattern of
clients dropping out of therapy because they perceived their therapists as not taking their role seriously, which is a danger professed by Rogers (1963), who argued that the work of therapy is supposed to be “serious”, and humor has no place in such work. Conversely, the data instead display the use of humor in a positive regard, with those clients in the non-dropout group exposed to nearly twice the average amount of helpful humor from their therapists.

The regression equation used in the third hypothesis showed that the frequency of humor was of modest, albeit significant, help in predicting dropout status. That is, based on knowing how much or how little humor was used in the first session was valuable information (for this sample) in whether or not a client prematurely ended therapy. This is, of course, not to suggest that the use of humor is by any means the only, and therefore a necessary ingredient, in facilitating the therapeutic process. Rather, it was shown by this data to be an effective tool the therapist could use, at least in regards to retention. Perhaps there was something about the clients in the dropout group where humor was not used, some underlying factor or set of factors, that led to a therapeutic environment not suitable for humor. Certainly in the first session not every presenting couple and their problem is conducive to the use of humor.

Fourth Hypothesis Findings

The reliability of change index was first developed to help determine if a certain psychotherapeutic treatment was effective, or if perceived change in clients’ conditions could be explained to large extent by measurement error (Jacobsen & Traux, 1991). It was employed in this study to determine whether or not there was indeed significant difference between partners’ WAI scores, which defined a “split” in the alliance. The
data displayed no significant difference in the use of first-session helpful humor between those who displayed such a split and those who did not, although there was a modest improvement in the correlation when analyzing split alliances at session three.

Of interest is the therapists’ ability within this sample to evenly distribute their humor among the clients. That is, nearly 70% of humor was observed as being directed towards the couple in a general sense, while the remaining instances of humor were evenly split between male and female partners. Such an even distribution could reflect the training received by these therapists, as there would no doubt be a tendency to view the “client” as the couple, and not two individuals that need their individual attention.

This hypothesis attempted to support the notion proposed by Schnarch (1990), that through the use of humor clients and their therapists form a “private language” that is their own. It may be, though, that if such a “private language” develops, that a level of humor higher than three would facilitate it. That is, humor used by the therapist that deals with the specific problem the couple is dealing with and/or instances of humor that challenge new perspectives and change. Such is not the nature of level three humor, and it could be that the first session is not a good place to look if one expects to find it. For instance, it may be the case that after only the first session of therapy, the clients have not yet clearly communicated to the therapist what their specific problems are. Indeed, the clients themselves may not understand what the “real” problems are in their relationship. Hence, it is possible that for many clients it is only after a number of sessions that level four or five humor is even possible. If that is the case, an analysis of the use of humor beyond session one would be necessary to illustrate the efficacy of higher levels of humor.


Limitations

This study was limited by several factors. First, the sample (40 couples) was rather small, and became even smaller when analyzing the data due to missing and or incomplete data sets. For example, if one considers a single variable, such as the males’ total WAI score, one can see this drop in sample size. At session one, there were 9 cases with missing data, and upon examining session three data on the same variable, there are 20 missing cases. Also, there were a very limited amount of therapists included in the study (8), and among those only two were male. It has been suggested that males are more often the “expressers” of humor (McGhee, 1979), and having such an imbalance in the male to female ratio of therapists may have had an impact. In addition, there could be an underlying factor of gender at play. In Sherman’s (1988) social distance study, it was found that males rated their own gender as being both more humorous, and likewise for females. That said, male partners may have perceived male therapists as being more humorous, or more accepting of their humor than female partners, and vice versa.

This study took its sample from a larger study in which only the first-session videotape was included, and was limited by that parameter. That is, while therapeutic alliance data was obtained at session one and session three, the frequency of humor was observed only at session one. Therefore, when analyzing therapeutic alliance scores at time three, it was impossible to know what happened to the therapeutic process in regards to humor.

Another limitation may have been the raters themselves. With the exception of the author, these raters were not therapists and may not have been able to understand or “see” the subtleties involved in the use of humor by therapists. As mentioned above, therapists’
use of humor could have been to relieve their own anxiety. Perhaps raters who were more experienced therapists or who were supervisors for training programs would have been able to catch the distinction between humor used to relieve anxiety and humor used as a tool for joining. This would be an important distinction for further study.

Finally, it is recognized that attempting to identify and define the use of humor is a highly subjective task. Indeed, while the Humor Rating Scale was designed for this purpose specifically nearly two decades ago, and mentioned as a valuable tool for researchers interested in humor (Dimmer, Carroll, & Wyatt, 1990; Franzini, 2001; Salameh, 1983), it has never been employed. Considerable effort at obtaining and maintaining a high interrater-reliability was made in this study, so that the scale could be shown to be a valuable tool for future research.

In addition, in coding the videotapes, the camera was not always set at a predetermined angle, sometimes showing everyone in the room, and other times displaying only the therapist or only the clients. Humor can take many forms, including the use of metaphor, symbolism, exaggerations, jokes, expressions, and physical movements. Certain subtleties that could interfere with the interpretation of an instance of humor could have been overlooked, or an instance of humor could have been missed altogether.

Future Research and Summary

Indeed, future research is needed in this area. While a replication of this study would be helpful to better understand the findings, there are also several important considerations for future research in this area. First and foremost, it must be recognized that the study of humor in therapy has relied almost solely on anecdotal evidence, case
studies, and philosophical papers. While Saper’s (1987) warning that research into the use of humor in therapy would be formidable if not impossible is recognized, there are tools, such as the Humor Rating Scale (Salameh, 1983) that one can employ.

One area of interest for future research would be to examine how the use of humor progresses in psychotherapy. As aforementioned, this study did not include data on how the frequency and/or type of humor fluctuated as therapy progressed. Theoretically, one would expect a greater frequency of higher levels of humor (four or five) as therapy progressed as it focuses more on the specific problem and/or goals of the client. Conversely, one might also observe a greater frequency of more damaging levels of humor in later sessions. During a first session, it may be that both clients and therapists are often on their “best behavior”, and many therapists may simply be getting to know their clients or conducting simple information gathering that may or may not focus on the client’s presenting problem.

Also of interest would be to gain an understanding of how clients use humor in therapy. Pierce (1994) suggested that clients might use humor in order to divert attention away from the problem. Clients may also use humor as a means of lowering their own levels of anxiety, or in an effort to communicate an otherwise difficult message to their partner and/or the therapist. Perhaps there is a certain amount (or type) of humor that is specifically damaging to the therapeutic relationship, or harmful to the process by blocking a therapist’s attempts at setting tasks and/or setting appropriate goals for the client. There is also undoubtedly a reciprocal environment in the room, and in regards to humor it may be that a therapists’ use of humor leads to a client’s greater use of humor. Certain therapists may gauge whether or not to use humor by clients’ early reactions to it.
It was mentioned above that not every first session is conducive to the use of humor. There may be a relationship between a client’s presenting problem and/or level of distress, and the degree to how successful the use of humor by a therapist is received. For example, clients who are clinically depressed may respond differently to a presentation of humor than a client presenting with communication problems with their spouse. There is currently no research concerned with clinical diagnosis and the appreciation of humor in psychotherapy. If one is concerned, however, with the impact the use of humor has on the formation and maintenance of therapeutic alliance, it behooves researchers to explore this area as well.

In summary, it is hoped that this study can serve as a foundation for future research in this area, and that others heed the call for more studies to be done. True to the scientific method, the findings of this study resulted in more questions than answers, but offered some interesting insight into how therapists use humor in therapy. The use of humor seemed to be important to the therapists in this study in regards to therapeutic alliance. Also, the therapists’ use of humor early in the therapeutic process had little to no impact on the clients’ perceptions of therapeutic alliance. While it is not known how the therapists’ use of humor changed and progressed throughout therapy beyond session one, there was a significant difference between the amount of humor used in the first session between those clients who prematurely terminated therapy and those who did not, with the latter exposed to more instances of humor. Indeed, there is much to be learned concerning the role humor plays in psychotherapy, and its potential impact on therapeutic alliance specifically. The questions of researchers cannot be satisfied by anecdotal evidence alone, as the time has come to take humor seriously.
APPENDIX A

WORKING ALLIANCE INVENTORY
WAI: Short Version

Below are 12 questions about your relationship with your therapist. Using the following scale rate the degree to which you agree with each statement, answer in the space to the left of the item.

1 = Not at all true
2 = A little true
3 = Slightly true
4 = Somewhat true
5 = Moderately true
6 = Considerably true
7 = Very true

1. _____ and I agree about the things I will need to do in therapy to help improve my situation.

2. What I am doing in therapy gives me new ways of looking at my problem.

3. I believe _____ likes me.

4. _____ does not understand what I am trying to accomplish in therapy.

5. I am confident in _____ ‘s ability to help me.

6. _____ and I are working towards mutually agreed upon goals.

7. I feel that _____ appreciates me.

8. We agree on what is important for me to work on.

9. _____ and I trust one another.

10. _____ and I have different ideas on what my problems are.

11. We have established a good understanding of the kind of changes that would be good for me.

12. I believe the way we are working with my problem is correct.
APPENDIX B

HUMOR RATING SCALE
Humor Rating Scale

Level 1: Destructive Humor

Therapist humor is sarcastic and vindictive, eliciting client feelings of hurt and distrust. Therapist abuses humor to callously vent his/her own anger towards clients or the world and is consequently insensitive to and unconcerned with the impact of his/her humor on clients. Therapist humor may judge or stereotype clients; its caustic quality denigrates clients’ sense of personal worth, leaving them with a typical “bitter aftertaste” reaction. Since the therapist’s use of humor is destructive and retaliatory in nature, it tends to significantly impede client self-exploration and divert the therapeutic process.

Level 2: Harmful Humor

Therapist humor does not manifest the blatant client disrespect found at level 1, but is still not attuned to client needs. Therapist mixes the irrelevant use of humor with its abuse, at times introducing humor when it is inapplicable to the issues at hand. The therapist may follow up his/her abuse of humor with a “redemptive communication” that essentially acknowledges the inappropriateness of the previous abusive comment and attempts to make verbal or nonverbal amends for it. Overall therapist humor is harmful and incapable of facilitating the therapeutic process since it is indiscriminate and invalidated either by missed timing or by the attempt to redeem derisive comments.

Level 3: Minimally Helpful Humor

Therapist humor does not question the essential worth of individuals and is adequately attuned to client needs. Humor is used for and not against client as a means of reflecting their dilemmas in a concerned yet humorous manner. Therapist humor promotes positive therapist-client interaction, yet remains mostly a reaction to clients’ communication rather than an active or preferred therapist-initiated mode of communication.

Level 4: Very Helpful Humor Response

Therapist humor is substantially attuned to clients’ needs and to helping them identify new options. Therapist humor may expose or amplify specific maladaptive behaviors yet simultaneously conveys a respect for clients’ personhood. It facilitates clients’ self-exploration while inciting them to recognize and alter dysfunctional patterns. The educational, comfortable, and enjoyable nature or therapist humor stimulates a positive and candid client-therapist relationship. Nevertheless, therapist humor still lacks some of the intensity, timing, and graphic language characteristic of level 5 humor responses.

Level 5: Outstandingly Helpful Humor Response

Therapist humor conveys a profound understanding of clients, is characterized by spontaneity and excellent timing, and challenges clients to live to their fullest potential. Therapist humor reflects his or her emotional and cognitive freedom used to facilitate clients’ emotional arousal and cognitive restructuring. It generates significant self-exploration and accelerates the process of client change by defining problems, condensing and symbolizing therapeutic process material, identifying new goals, and promoting constructive alternatives. The creative nature of therapist humor can elicit decisive existential insights and encourages clients to develop their own humor along with attitudinal changes.
APPENDIX C

HUMOR RATING INDEX
# Humor Rating Index

1 – Destructive  2 – Harmful  3 – Minimally Helpful  4 – Very Helpful  5 – Outstandingly Helpful

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</table>

## Humor Frequency Total

- Time 1: 
- Time 2: 
- Combined:

## Rating Mean

- Time 1: 
- Time 2: 
- Combined:
LIST OF REFERENCES


Epstein, B. (1998). Humor in behavioral and cognitive therapies. Symposium conducted at the annual meeting of the Association for the Advancement of Behavior Therapy, Washington, DC.


