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The Healing Power of Laughter: The Applicability of Humor as a Psychotherapy Technique With Depressed and Anxious Older Adults

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The nation’s older adult population is steadily increasing in numbers as the Baby Boomer generation ages over time. Mental health providers are encountering older adults who are presenting to therapy with problems related to depression and anxiety. The authors demonstrate how empirically-supported treatments such as Cognitive-Behavioral Therapy, Problem Solving Therapy, and Interpersonal Therapy are effective in treating older adults within the individual and group counseling setting. Humor as a therapeutic tool is introduced as an easily integrated instrument of positive change through several case studies as depicted by the authors.

KEYWORDS older adults, depression, anxiety, individual counseling, group counseling, humor

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One of the greatest challenges that mental health professionals face in today’s world is how they should approach problems that arise in our older adult population. This is becoming especially significant in the United States where millions of our Baby Boomers are quickly approaching their fifth and sixth decades of life with full intentions of living years longer. Health problems accompany this increase in years, especially regarding mental health issues. The general prevalence of later life mental health problems hovers around 10%. The large bulk of these problems involves depression and anxiety.

Therapy at late life demands more than an application of empirically supported treatments for adults; it requires a human connection beyond empiricism. Therapists and researchers alike are just now learning that optimal attention must be committed to tailoring clinically supported techniques to make the best impact in the emotional health of older adults.

In this article we highlight the utility of the best empirically supported treatments at late life—Cognitive Behavioral Therapy (CBT), Problem Solving Therapy (PST), and Interpersonal Therapy (IPT)—and highlight the importance of psychoeducation and the therapeutic alliance in bringing about positive change in clients. In this effort, we accentuate humor as an integral part of therapy to aid in the emotional healing of our clients. We also present two cases; the use of humor that originates from the group and is nurtured by the therapist, and an individual therapy case that targets a single client where humor is directed by the therapist. Both client-directed humor nourished by the therapist and therapist-directed humor serve the higher goal of positive change in therapy.

**REVIEW**

We have progressed from the position that older people are no longer educable nor can they benefit from psychotherapy (Freud, 1905). We once “knew” that our ways of being in the world were determined by the struggle between the id, ego, and superego; that only thoughts determined our psychological health; and that we now seem to be victims of genetic or neurotransmitter configurations, unregulated amygdalas, and overdeveloped frontal lobes. In the twenty-first century, the therapist can provide more than “symbolic giving.” The special needs of the elderly are no longer best encapsulated in distinctive themes (e.g., loss, increased dependency, existential approach of death), age-specific reactions (e.g., survivor guilt at having outlasted others), and “aging” therapy needs (e.g., more time-limited goals, greater amount of positive benefit, as well as a slower pace and lack of termination). These issues matter now, but only at the margins.

Psychotherapy with older adults has altered measurably during most recent decades. The process has become very egalitarian and cooperative. As psychotherapies merge due to time and feedback in all systems, CBT and
related therapies, PST and IPT, have had the wisdom of humanizing their agendas. Equally, traditional or psychodynamic psychotherapy has had the wisdom of goal directing its efforts with operationalized targets. Both have the advantage of motivational interviewing or going with the resistance. Both have the advantage of the vast field of case-based interventions, as well as the transparent “faults” of modern medicine and suspect psychiatric models. Both have the advantage of knowing that psychiatric care is complex and change is difficult to maintain.

Success in treatment with older adults is attainable but requires changes in the practice, scope, and longevity of their care. Better models of psychological care at late life involve carefully derived and case based modular interventions. This is so because the modal problems at late life—anxiety, depression, somatization, and cognitive decline—are truly interrelated with all emotional disorders having a similar underlying structure. Smartly, the components of CBT, including PST and IPT, represent modules that best address this contamination of disorders. They are simple, learnable, and reasonably effective. There is, therefore, a soft consensus on a unified approach to treating problems at late life. At base, this involves core psychotherapeutic responses of experiencing the emotion, changing the cognition, and behaviorally acting.

In this process, case formulation is critical. At later life any symptom can be engineered by permutations of multiple situational factors amid multiple causal paths. The mental health clinician formulates cases based on confirming and disconfirming data to determine whether selected empirically supported variables (e.g., cognitive distortions, medically related problems, poor self-control, ineffective problem solving, and low rate of positive reinforcement) are relevant, operative, and meaningful to a particular client. The mental health clinician can utilize differing ways to implement a given clinical technique. For example, cognitive restructuring can be augmented by use of behavioral experiments to test the validity of a belief, suggesting added bibliotherapy, being a model, aggressively refuting error in thought, being didactic in form, assigning homework, using visualization techniques, and empowering caregivers, to name a few. Throughout, the alliance and its supports (like humor) are necessary accouterments of the process.

The process in such a therapy dance is given below where monitoring, then diagnosis, then the application of nomothetic treatments are applied. Should this fail, an individual program can be applied. This process is so central to the empirically supported change process of psychotherapy that it is advocated and promulgated in most teachings of the basics of psychotherapy. Figure 1 outlines this process more specifically.

There are many features of therapy that are critical for later life clients. We discuss the most important ones and posit that an intriguing part of both is humor. These two components are emphasized because they set the scaffold for care, commitment, and action on behalf of self. They also
empower other elements of care, such as the compliance of the client and the involvement of family members.

Psychoeducation

There is no more important element in psychotherapy than psychoeducation. It is the core of non-impulsive, shoot-from-the-hip therapy policy that sets the stage for careful therapy. It is a “watch and wait” process. It allows for the intervention to take place with good information, a sense of direction and perspective, as well as an increased sense of commitment. It is the placebo effect in action, for the better. Therapy often fails because the client is set in motion too quickly, unknowingly, and only minimally committed.

Depression is a complex, diverse condition, with different antecedent causes and manifestations. As the clinical trials show unequivocally, only a fraction of the most severely depressed clients respond to serotonin-enhancing antidepressants. Often medication fails because the cause of that illness is different in unique people, and because the psychoeducation of the process of change itself is short-changed. Going over depressive symptoms and showing the connection to living, coping, and to biological markers are invaluable. The human enhancement of a therapist encouraging the client and providing different perspectives of a therapeutic problem, often with humor, has the power to play a critical role in a client’s growth.

Setting the stage for treatment is also important:

Your treatment is important and we will address all aspects of care. We need to assess your particular problem and rule out all the other possible noise. We also need to see what else is involved with your unique problem. I have several things in mind—psychotherapy, case management, as well as some cognitive training. Also, we will monitor...
you carefully over the months. This therapy will work but it may take longer and it may have to be adjusted as needed. Finally, I do not want this process to be excessively heavy or serious. I want us to be connected and to have some light moments too as this will allow the process to unfold best.

The older adult is sometimes mystified by psychological symptoms and cannot translate these to real symptoms. Psychoeducation facilitates the strategies of CBT, PST, and IPT by setting the necessary components of acceptance and understanding in the conceptual realm. The therapeutic reach of the therapist is extended for older adults. This starts with psychoeducation made optimally appealing with core alliance elements such as humor.

Alvidrez, Arean, and Stewart (2005) examined the impact of a brief psychoeducational intervention on treatment entry and attendance for clients referred for psychotherapy. This included a 15-minute individual psychoeducational session about what all therapy entails. This brief intervention proved helpful in the numbers who entered therapy and those that dropped out. This pre-intervention is potentially important as the watch and wait strategy implies that careful preparation is necessary and at times sufficient for change.

Scott & Hyer (2014) outlines this method and the importance of this process, arguing for the critical elements of the therapeutic alliance and humor. The complete model is shown in Table 1.

### Table 1: Treatment Model

**“Watch and Wait” Step Care Process:**

- Establishing rapport and a strong alliance is critical.
- Validate position and concerns (as if the position is the correct one, one that is psychologically appropriate, and the choice is the only one that could be made).
- Use of humor and perspective.
- Establish some relief or hope of relief.
- Be believable/likeable as a therapist: placebo rocks!!!!
- Monitor outcome targets for many problems, practical, and psychological.
- DO NOT pick one best treatment at the outset: Rather, recognize how clients present with and experience depression, apply and reapply objective measures of treatment response, and make changes until the client improves.
- Track outcomes. Use these as lab values. Do not accept “fine” as an outcome or marker of depression. If you are not measuring something, it has not occurred. Clients get better who just receive monitoring.
- Use therapy modules.
- Establish a steady state where there is some degree of relief over time. Wait for a steady state when symptoms remain as a response and over some weeks through psychotherapy, medications, or both.
- Change treatment to suit the person.
- Feedback on client change also works for the therapist.
- Use a team—Client, family, primary care provider, mental health consultant, care manager.
- Problems recur—therapy is a long-term commitment as you are in it for the long haul.
Alliance

A critical task of mental health therapy for older adults is to create a therapeutic alliance. Over 90 studies show that the treatment alliance has a correlation coefficient $\rho = 0.46$, effect size $= 0.21$. Several authors (e.g., Hyer, Kramer, & Sohnle, 2004) have shown that the path from cognition to outcome in older adults in therapy is independently mediated by the alliance and by homework. No surprise here; get the older adult to like you and to work outside of therapy, and change is likely. Rapport building and guided intervention strategies should always be in play. At a practical level, a key in most of the therapies at late life is to assure the connection between current symptoms and problems in adjustment and living. CBT, PST, and IPT do this well; in fact, it is a signature feature of these therapies. If this is done within an empathic frame, the possibility of change increases. As therapists who work with older adults know, therapy ruptures are subtle but influential. The need for the alliance and an alliance watch is paramount. The following are examples of alliance-based care elements:

- Clients like advice (79%)
- Talking to someone interested in me (75%)
- Encouragement and reassurance (67%)
- Talking to someone that understands (58%)
- Installation of hope (58%) (Norcross, 2010)

Humor

If a key element to the efficacy of psychotherapy for older adults is the therapeutic alliance, a central feature is humor. Humor plays an integral role in the development of a positive therapeutic alliance between the therapist and the client. With a depressed client, one sees an extremely guarded and reluctant person who is now in treatment. Depression seduces the person to ruminate over negative thoughts and causes them to be less inclined to be open to pleasant experiences. The result is an inhibition in solving problems. Life is stuck. Humor “unsticks” this stance. It becomes in effect the centerpiece of the therapeutic alliance. One of the best ways to ease a client’s apprehension toward therapy and to create common ground in the alliance is to share laughter.

Psychotherapy for older adults addresses multiple issues, mixing the physical, social, and emotional difficulties in the client’s life. Goals of therapy include improving quality of life despite physical or mental illness and promoting healthy behaviors despite numerous barriers. The many topics covered in therapy during late life are indeed serious and are often difficult to discuss. Adding humor is an effective tool to improve therapy for both the client and the therapist. Humor is therapeutic when it allows the client
and therapist to enjoy a greater rapport, to facilitate honest discussion, to reduce intimidation within the client, and to allow for healthy perspectives on difficult situations. To encourage humorous interactions, some clinicians even suggest incorporating elements from “humor therapy” as a therapeutic tool. This ranges from telling fond biographical memories to self-effacing humorous remarks.

These interactions can increase positive emotions and encourage sharing during therapy (Franzini, 2001). As a weekly intervention, humor therapy sessions have been shown to reduce chronic pain, decrease feelings of loneliness, increase happiness, and increase life satisfaction in a residential, cognitively normal population of men and women ages 65 to 95 (Tse, Lo, Cheng, Chan, Chan, & Chung, 2010). As chronic pain is a problem for many older adults, combining humor with psychotherapy may be a valuable, no-side-effect tool to reduce their pain and therefore increase the effectiveness of other interventions such as behavioral activation. As nursing homes continually attempt to increase activity in residents, humor is often suggested as a beginning to help implement and maintain programs.

Because of the myriad physical and mental challenges clients face as they age, it is also important to consider more impaired populations, such as clients with Alzheimer’s disease and depression. Walter et al. (2007) examined the influence of combining humor therapy with psychopharmacotherapy for older clients suffering from these two prevalent diagnoses. For later life depressive participants, quality of life, mood, and ability to perform instrumental activities of daily functioning improved significantly as a result of combining medication with humor therapy. These clients also had a significant decrease in depression scores. The same positive results were also seen in the drug-only depressive group of clients as well, but depressed clients who received combined therapy had the highest quality of life after eight weeks of therapy. Although there is much research still to be done regarding the incorporation of humor into current psychotherapy methods, humor within psychotherapy may help to increase functionality and improve quality of life for older clients who are suffering from a variety of mental and physical illnesses.

GROUP CASE EXAMPLES

Humor has proven to be effective in group therapy settings in creating a therapeutic bond between the group leaders and members. In addition, humor has served as a way of seeking that silver lining in otherwise negative situations that have occurred in the lives of our group members. Our particular CBT-focused psychotherapy group consists of about 10 older adults, mostly women, who have been identified as suffering from clinical depression and/or anxiety. Clients are experiencing depressive symptoms that have
originated after a multitude of negative experiences that are common to late life. Several of our group members are dealing with the death and/or extended illness of a life-long spouse, friend, or other family member. Other group members are experiencing feelings of loneliness or isolation while some are dealing with the financial stressors of balancing costs of living with limited resources. Some of our group members are experiencing frustration or helplessness regarding issues of family dynamics and past trauma that has yet to be resolved. However, the bond between our group members has allowed the magic of laughter to serve as a healing agent that can soothe our clients’ souls and propel them toward becoming more open to positive experiences.

One group member, “Sally,” is a Caucasian female in her early 70s who serves as one of the primary caregivers for both a son who has experienced a traumatic brain injury and her husband who has been diagnosed with Alzheimer’s disease. This client has voiced feelings of helplessness, frustration, worry, and exhaustion that have unfortunately become a common sentiment in the world of caregiving. During one of our group sessions, this particular client was sharing a story about the stress that she experiences as a result of driving back and forth to check on her husband and her son who both have assisted living arrangements about 45 minutes away from where the client lives. As this client is especially anxious, she became visibly agitated and tearful while expressing her feelings of exhaustion.

After a few minutes, one of the newer group members spoke up. This new group member chimed in with her vibrant yet soothing voice and told Sally that she “better stop running around like a roadrunner before she runs off the cliff. Even the Road Runner has to rest!” The group immediately responded with bursts of laughter after this group member’s comment. Her comment cut through the tension in the room and allowed Sally a chance to smile while also having a chance to internalize this lesson about the importance of self-preservation and prioritization. The group continued to share stories about the Wile E. Coyotes in their own lives. The group was able to effectively process the issue of setting boundaries and not falling prey to some of the manipulations of others who try to run us to death like the poor Road Runner.

Another group member with whom humor has proven to be effective is “Beatrice.” Beatrice is an African-American female in her late 60s dealing with clinical depression. Beatrice lives with her son but is alone for most of the day due to the nature of his work. She also lacks transportation. As a result, this client has voiced strong feelings of isolation and helplessness due to living in a rural area. Behavior activation and increasing social activity were therapeutic goals for Beatrice. During one group session, Beatrice had just returned from a week-long vacation with one of her close cousins. Beatrice told us all about her time “in the country” with her cousins. When doing
so, several of the other group members commented on how “radiant” and “happy” Beatrice appeared while sharing tales of her time with her family.

While with her cousins, Beatrice had the opportunity to socially engage with old friends and share enjoyable meals with family. To our surprise, Beatrice brought up how she had run into an old flame while working at her family’s general store during this vacation! While talking about this old flame, Beatrice started blushing and giggling all while our other group members began to playfully tease her. One group member burst out, “Woo Beatrice, see what happens when you get out of the house! You turn all hot stuff on us and find yourself a new boy toy!” While the group was still doubling over in laughter from this story of mature puppy love, everyone was able to provide feedback to Beatrice about the positive effects of her seeking social interaction and becoming acquainted with new and old friends.

Beatrice’s change in demeanor for the better following her visit with her close cousins served as a demonstration of the power that behavior activation has in improving depressive symptoms in our group members. Humor stimulated the awareness of change.

Humor has proven to strengthen the positive therapist–client relationship that has served as an integral part of the success of our group therapy sessions. While each of our group members has individual issues, a strong and supportive therapeutic alliance is the common ground on which our clients are making progress in improving their emotional lives. One of our group members named “Samantha” has been actively grieving over the death of her adult daughter “Rita” who died two years ago following complications from diabetes. Samantha is a Caucasian woman in her early 80s whose remaining family pressured her into transitioning to an assisted living community after her daughter’s death. Before Rita passed away, she and Samantha had shared an apartment and accompanied each other everywhere, which created many positive mother–daughter memories.

When Samantha first arrived to our group, she often expressed that she felt extremely lonely, heartbroken, and lost since Rita’s death. For Samantha, life had lost its meaning and her grief infiltrated every part of her life. Sharing laughter helped Samantha feel more comfortable with the group during her first few weeks of attendance and the trusting environment that was fostered by our therapeutic alliance made it easier for Samantha to become more transparent about her grief with other group members. Once Samantha had the opportunity to openly process her feelings about her recent relocation and Rita’s death, Samantha began to share that she was ready to make a change toward less depression-ridden days. Samantha’s willingness to change partnered with our trusting and supportive therapist–client relationship proved to set the stage for change. Using therapeutic storytelling, Samantha began to create a positive outlook on life by integrating memories of Rita’s easygoing and caring spirit into her daily life. The group was able
to get Samantha to see that Rita would see her mom as Eeyore-like and not as Sophia-like (from *Golden Girls*) with her joi de vivre and hilarious wit.

While Samantha opened up almost immediately to the group, one of our group members named “Lorraine” was initially more tight-lipped. Lorraine is a Caucasian woman in her early 60s who has been plagued with various physical ailments and negative experiences regarding her father for most of her adult life. During her first month in the group, Lorraine was discreet regarding her personal issues but a valuable and timely source of practical advice for other group members. Lorraine’s ability to trust others with intimate details of her life had been marred by past emotional abuse at the hands of her father and men with whom she had shared destructive romantic relationships.

Oftentimes the success of a therapeutic alliance in a group setting relies on a therapist’s ability to help create an authentic sense of camaraderie amongst group members based upon common experiences. Such was the case in enabling Lorraine to become more emotionally transparent and open about her relationship with her father. At the beginning of one group session, Lorraine surprisingly revealed that she was experiencing heightened feelings of distress because her father, who lives across the country, was becoming more obstinate and oppressive than usual during his frequent phone calls to her. Lorraine expressed uncertainty as to how to resolve this issue of incessant phone calls from her father, especially taking into account their reportedly less than positive history. Other group members were asked whether or not any of them had experienced a strained relationship with a parent and what tools they used to maintain respectful discourse with their parent. Two fellow group members responded with stories of how their relationships with their own parents had been more dramatic than an episode of *The Young and the Restless*. At this point all members began sharing their feelings of isolation due to the emotional vacancy of their parents.

Lorraine brightened up and became less self-deprecatory. Lorraine found strength through hearing others’ accounts of some of their complicated interactions with their parents. This validation of her feelings and realization that our group was a “safe” place for her to share her story prompted Lorraine to unburden herself and share what events had occurred to cause continuous stress in her relationship with her father. Lorraine’s transparency allowed the group the opportunity to appreciate that she too was capable of creating boundaries with her father that would allow for positive contact but not infringe upon her independence and happiness. All suggestions from the group leaders were consistent with Lorraine’s personal preferences with what she wanted her relationship with her father to look like. The sense of trust and genuineness that are the core of an affirmative therapeutic alliance enhanced by humor propelled group members to disclose and process their experiences in a way that was beneficial for everyone involved.
INDIVIDUAL CASE EXAMPLE

In this case the therapist is non-formulaic in the application of humor, thereby unwrapping possibility for the client. The therapist organizes the miracle of conversation with lightness and heaviness, with focus and frolic, and with rigid monitoring and boundless possibility. Disclosure, connection, positivity, genuineness, respect, and humor make this work. In the case example below, we see the value of humor as provided by the therapist.

One client named “Jane” benefitted greatly from humorous interactions throughout her individual sessions. Jane is a Caucasian woman in her 80s who lives alone and is very independent. She came to our office presenting with depression and more recently concerns about her general health. Her pain had begun to interfere with her sleep and her daily functioning, and her need to take pain medication felt unusual and excessive. We began by evaluating where her pain was centralized and the degree to which she was impaired, and then responded to her concerns about her pharmacotherapy regimen. After learning that she was only taking two mild forms of pain medication, and only as directed, we told her briefly that her medications were on the mild end of the spectrum, but that with her being a troublemaker she was probably an addict all the same. She responded with a slow smile and a chuckle and said “well, maybe I am,” and continued to laugh. After this, she seemed more comfortable bringing up her medical concerns and voicing concerns about pain, even though her vulnerability seemed to conflict with her wish to remain independent and unburdened by excessive medication.

By incorporating a humorous overstatement of her normal reaction to pain and her prescribed medication, Jane saw that her worries were unfounded and began to take some ownership of handling her pain and health. Although we were not able to rid her of the chronic pain that required her mild and reasonable dependence on medication, we were able to lighten the extremely heavy task of discussing what it means to grow older and experience pain for most of the day. In the next few sessions, the same joke continued while discussing her hobbies. Jane stated that she loved mint and would pick some mint leaves to put in her pocket while she gardened, stating that as soon as she sniffed a little bit of mint, she was ready to go for the day. We noted how nice it was to have a simple pleasure like mint leaves, and then suggested that maybe it was not an addiction to painkillers that we should worry about, but her addiction to mint leaves. Jane laughed and laughed, and seemed to enjoy that she could speak about both the positive and more distressing parts of her day in a lighthearted manner.

As with any therapeutic tool, it is extremely important to gauge the client’s responses to humor in order to decide whether incorporating client-focused, situation-focused, or therapist-focused humor into psychotherapy would be an appropriate fit. For Jane, her inclination was naturally to poke
fun and present herself as sort of a rebel, always responding to inquiries about her week with “it was tolerable” with a wink. She was a delightful client who was comfortable with poking fun at herself and being picked on occasionally. She seemed to enjoy therapy when there was light and humorous nudging toward the desired outcome for the session.

CONCLUSION

Older adults are unique in some ways. At the risk of stereotyping, older adults want to unburden themselves of depression and anxiety. They hunger for lightness and perspective. They have the gift of chronology and need a sense that now life can be seen from a benign perspective. The path to this realization can be made expeditious through humor. The therapeutic alliance is key and humor is a central component of this.

In this article, we demonstrated the importance of a positive therapeutic alliance in improving the mental health of our clients. It is during the beginning stages of the therapeutic alliance that trust is formed, belief in the client’s ability to seek positive change is reinforced, and a sense of hope and understanding permeates a client’s soul and propels them to transform themselves. As we have suggested, humor has the ability to serve as a platform from which clients can become transparent and be less afraid of the feeling of vulnerability that can accompany sharing one’s personal life stories. The humorist and musician Victor Borge noted that “laughter is the shortest distance between two people.” For the client seeking help, sharing a smile and genuine laughter can amplify the curative effects that our discipline’s researched-based techniques can have on their emotional health.

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