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PATIENT LAUGHTER AS A FUNCTION OF ANTECEDENT THERAPIST VERBAL BEHAVIOR

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Curriculum Studiorum

Patricia Ann Gervaize was born in Syracuse, New York on October 27, 1949. She received the Bachelor of Arts degree, magna cum laude, in psychology in 1974 from the University of Vermont, Burlington, Vermont. She received the Masters of Education in Counselling in 1975 from the University of Vermont, Burlington, Vermont.

Abstract

There are indications in the clinical and clinical/theoretical literature that low frequency, high intensity patient laughter is a valued in-therapy event, one which is compatible with and welcomed by practitioners of many different psychotherapeutic approaches. The interest in this particular type of patient laughter evidenced in the clinical and clinical/theoretical literature has not been matched by research investigation and, while clinicians report on a slowly growing body of techniques and methods which seem to precede patient strong laughter, there has been no empirical study of these clinically generated 'hypotheses'. The purpose of the present investigation was twofold: to organize the methods and techniques described predominantly by clinicians into a set of categories of therapist verbal behavior and then to determine, on the basis of the examination of actual psychotherapy sessions in which low frequency, high intensity patient laughter occurred, whether or not the categories of therapist verbal behavior preceded this particular type of laughter. Sixty incidents of patient hearty laughter were isolated from the University of Ottawa Psychotherapy Tapr Library which consists of approximately 280 hours of individual, adult psychotherapy conducted by 15 experienced therapists from various therapeutic approaches. The three therapist statements preceding each incident of strong laughter were categorized as falling either within the group of eight predicted categories or an 'other' category, as were the three therapist statements preceding 30 incidents of patient non-laughter, and 30 incidents of patient mild laughter. Results indicated that the predicted categories

did occur before incidents of hearty laughter, but not before incidents of non-laughter or mild laughter. Immediately antecedent to patient hearty laughter, 73% of therapist statements fell within the predicted categories as compared with non-laughter (3%) and mild laughter (10%). Two statements before hearty laughter, 37% of therapist statements fell within the predicted categories as compared with non-laughter (0%) and mild laughter (10%). Three statements before hearty laughter, 38% of therapist statements fell within the predicted categories as compared with non-laughter (3%) and mild laughter (0%). The most frequently occurring categories included; (1) Defined impulsive behavior by patient or other, (2) Carrying out risk behavior as/for patient, (3) Excited reinforcement of risked behavior, (4) Ridiculous explanation-description of patient, and (5) Directed risked behavior towards therapist. The implications of these findings for practitioners and researchers were explored.

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Introduction

Within the field of psychotherapy, increasing attention has been given to patient laughter as a therapeutically important event, and to therapist methods which are instrumental in promoting this event (e.g., Ellis, 1977, 1981; Farrelly & Brandsma, 1974; Frankl, 1966; Greenwald, 1975, 1976; Haley, 1963; Klein, 1974; Mindess, 1971, 1976). This trend is exemplified in an entire theme issue of the Journal of the American Academy of Psychotherapists (volume 16, number 4, 1981) dedicated to this topic.

Although clinical attention to patient laughter is increasing recently, there is essentially no research on therapist methods related to patient laughter, no systematic summaries of the scattered clinical or theoretical literature on patient laughter, and no intact body of literature on either patient laughter or related therapeutic methods. In terms of theory, research, and clinical study, the current status of patient laughter seems to be limited to an appreciation of its significance in psychotherapy and to scattered references to therapeutic methods of bringing it about.

Accordingly, one of the purposes of the present study is to provide a summary organization of the clinical, theoretical, and research work relative to patient laughter and therapeutic methods of promoting this event. The second purpose is to examine patient laughter in order to identify antecedent therapist verbal behaviors, especially those which emerge from a review of the clinical, theoretical, and research literatures on the subject.

Chapter I

REVIEW OF THE LITERATURE

The purpose of this chapter is first to review the clinical, theoretical and research literatures in regard to patient laughter as an event in psychotherapy. Is patient laughter regarded as a significant event? Is its occurrence regarded as therapeutically desirable? From the viewpoint of theory, of clinical practice, and of research, what are the considerations for treating laughter as significant and therapeutically desirable? Are there kinds of laughter, some of which are regarded as therapeutically desirable and some of which are not? Are there therapeutic conditions under which laughter is regarded as therapeutically desirable or not? The first purpose of this chapter is to review the conceptual status of laughter as an event in psychotherapy.

The second purpose is to review the literature on the therapist methods or techniques for promoting laughter which has characteristics held as therapeutically significant and desirable on the basis of the clinical, theoretical and research literatures. Following discussion of these two major topics, the first chapter will conclude with a provisional statement of the hypothesis to be investigated in the present study.

Patient Laughter As An Event In Psychotherapy

As a focus of study, laughter has a rich history which is typically described as having roots in the writings of Plato and Aristotle (cf. Chapman & Foot, 1976). Reviews of laughter as a human phenomenon deal with such topics as the various meanings of laughter, the attempts at categorizing the conditions under which it occurs in daily life, issues of the distinctiveness of laughter to human beings, and the cultural, anthropological, and social psychological aspects of laughter (Bergler, 1956; Chapman & Foot, 1976). However, these reviews do not touch, except indirectly, upon the role or significance of laughter in psychotherapy. Within the field of psychotherapy, there are no comprehensive reviews of the theoretical, clinical or research status of this event. Accordingly, it is the purpose to review and organize these literatures with regard to the status of laughter as it occurs within psychotherapy with special consideration to the significance and desirability of patient laughter.

The Desirability of Patient Laughter in Psychotherapy: Clinical Theory

One strategy in assessing the therapeutic desirability of patient laughter is to explore the deeper or symbolic meanings of various kinds and types of laughter. For example, within psychoanalysis certain kinds of laughter, occurring under certain conditions, are held as the symbolic expression of unconscious hostility (e.g., Freud, 1960; Grotjahn, 1970). Interpreted in this way, laughter is held as significant but not necessarily

as a desirable event to be brought about in the session. There are many reviews of the deeper meanings and symbolic significances of laughter (e.g., Bergler, 1956; Koestler, 1964; Plessner, 1970). While these reviews lean in the direction of holding patient laughter as significant and perhaps desirable, it is not the intent here to justify study of this event on the basis of its deeper or symbolic meanings. Such a strategy seems confined to a psychoanalytic approach to laughter and is supervened by theoretical, clinical and research considerations which bear more directly upon the event itself rather than the justification of its more unconscious, deeper, and symbolic aspects. Accordingly, we may turn to a consideration of the desirability of patient laughter from the perspective of the theoretical and clinical literatures, and from the research literature.

Laughter as significant but not therapeutically desirable. In general, the occurrence of laughter is regarded as significnat in psychotherapy. However both the clinical and theoretical literatures identify several kinds of laughter as conspicuously not desirable events. For example, some laughters may be significant mainly in their inappropriateness. Typically such laughter is seen as pathognomic of serious psychological disturbance and, accordingly, far from a welcomed or desirable event to be brought about in psychotherapy (DSM-III, 1980; Levine, 1976; Noyes & Kolb, 1963). This kind of laughter is not an isolated event, but rather occurs as a characteristic of the patient who is suffering from serious emotional illness.

Laughter is also regarded as significant but not desirable when it occurs as a characteristic defensive style in which the patient, for example, entertains the therapist, sidetracks, or disarms the therapist (Ansell,

Mindess, Stern, & Stern, 1981; Kubie, 1971; Levine, 1976; Paul, 1978). Once again, this kind of laughter is a characteristic trait, habit, or style rather than an isolated event occurring under a given condition.

The commonality underlying these two kinds of laughter is their occurrence as a characteristic style of the patient. It is noteworthy that laughter as a characteristic style of the patient has been identified as the singular exception to laughter as a welcomed and desirable therapeutic event (Ansell et al., 1981; Polster & Polster, 1976). Accordingly, this kind of laughter will be expressly identified as outside the domain of study in the present research. However, with this exception, laughter is generally conceptualized as both significant and desirable within psychotherapy. We turn now to a review of the ways in which the theoretical and clinical literatures identify laughter as a welcomed and desirable event in psychotherapy. It is noted that the focus of study in what follows is laughter as a fairly singular, discrete event rather than laughter as a characteristic style of patients.

1. Laughter as an index of a therapeutically desirable shift in the patient's self perspective. In many approaches, laughter is conceptualized as indicating a welcomed and desirable shift in the patient's way of perceiving, thinking about, relating to, or organizing such meaningful self components as self-concept, feelings, attitudes toward life, symptoms and problems, interpersonal relationships, and personal constructs. The therapeutic value of this shift in perspective is highlighted across such approaches as psychoanalytic therapy, direct decision therapy, Gestalt therapy, provocative therapy, Adlerian therapy, interpersonal therapy, natural high therapy, and

personal construct therapy (e.g., Greenwald, 1975; Kris, 1940; Mindess, 1976; O'Connell, 1981; Poland, 1971; Reik, 1964; Shaw, 1960; Sullivan, 1954; Viney, 1983).

In response to a statement by the therapist, typically that of interpretation, laughter is likewise regarded as an index of a significant and desirable shift in perspective. Generally this shift is taken to indicate a deeper or unconscious acceptance of the interpretation (Grotjahn, 1966; Poland, 1971; Rose, 1969). Or the laughter is understood as itself a meaningful reaction to the interpretation, and occurs as a significant subject of further interpretation (Freud, 1960; Grotjahn, 1966; Rose, 1969; Rosenheim, 1974).

One reason, then, for regarding laughter as a welcomed and desirable therapeutic event is that it is taken as an index of a shift in the patient's perspective. This shift is significant, and it is valued across a wide range of therapeutic approaches.

However, it is to be noted that such laughter is not a characteristic style of the patient. Instead, it stands as a relatively discrete event. What is more, this laughter is marked by a moderate or strong energy; it has some force or intensity to it. Finally, it is not restricted to any one kind of accompanying feeling or emotional state. As an index of therapeutically desirable shift in perspective, the laughter may be accompanied with buoyant and pleasant feelings or with emotions of discomfort and agitation.

2. Laughter as an instrumental component of the process of therapeutic change. Across many approaches, therapeutic change is held as including a component of heightened feeling or emotion; this is especially central to

logotherapy, feeling-expressive therapy, Daseins therapy, Daseinsanalysis, Gestalt therapy, existential therapy, existential analysis, humanistic therapy, intense feeling therapy, provocative therapy, holistic therapy, psycho-imagination therapy, encounter therapy, bioenergetics therapy, cathartic therapy, crisis mobilization therapy, phenomenological therapy, emotional flooding therapy, client-centered therapy, implosive therapy, primal therapy, experiential therapy, and others.

Laughter is typically regarded as one means of expressing such strong feeling or emotion, as exemplified in the following description of the kinds of strong feelings or emotions which emanate from the deeper personality processes in the course of therapeutic change:

> "There are four basic kinds ... the explosion into genuine grief ... explosion into orgasm ... explosion into anger ... (and) there is the explosion of joy, laughter, joie de vivre. These explosions connect with the authentic personality, the true self" (Perls, 1970, pp. 14, 18).

Strong laughter has been especially conceptualized as an instrumental component of the very process of therapeutic change by clinical theorists including Harman (1981), Jackins (1965), Mahrer (1978, 1983), Nichols and Zax (1977), Olsen (1976), and Perls (1970). As exemplified by these clinical theorists and the above approaches, therapeutic change requires the occurrence of heightened feeling or emotion, and strong laughter qualities as one kind of strong experiencing. The key role of laughter in this regard is given in the following clinical axiom for provocative therapy:

> "It has been necessary to remind students that if the client is not laughing during at least part of the therapeutic encounter, the therapist is not doing provocative therapy" (Farrelly & Brandsma, 1974, p. 95).

It is underscored that the essential characteristic of laughter as an instrumental component in the process of therapeutic change lies in the strength of the feeling or emotion of laughter. Nevertheless, this second reason for valuing laughter as a welcomed and desirable event likewise excludes laughter as a characteristic style of the patient, includes stong laughter, and is not restricted to any kind of accompanying feeling or emotion, pleasant or unpleasant, light or serious.

3. Laughter as an index of movement away from a problem-state and toward a valued goal state. Laughter is conceptualized as an indication that movement is occurring in the patient's larger personality state, specifically movement away from the problem or pathological state and in the direction of a valued goal state of psychological health. More specifically, it is taken as an indication of movement away from a state characterized by such constructs as fear, anxiety, rigidity, depression, withdrawal, and toward a state characterized by more energy, freedom, zest, openness, inner harmony, awareness and acceptance (e.g., Harman, 1981; Jackins, 1965; Jasnow, 1981; Kris, 1940; Levine, 1976; Olsen, 1976; Perls, 1970; Viney, 1983). These clinical theorist's are representative of the broad array of therapeutic approaches which hold to the desirability of laughter conceptualized in this manner. For example, within psychoanalytic therapy the state change is from fear of to mastery over: "What was feared yesterday and mastered is laughed at today" (Kris, 1940, p. 213), while a personal construct approach conceptualizes the change in terms of the more positive flexibility of constructs (Viney, 1983).

Once again, the welcomed desirability of this laughter refers expressly to strong laughter, is independent of the nature of the accompanying feeling or emotion, and excludes laughter as a characteristic style of the patient during the session.

4. Laughter as an expression of a therapeutically valued goal state. In many approaches, laughter in psychotherapy is conceptualized as a direct expression of a valued end or goal state. The specific constructs used to describe this goal state reflect the breadth of approaches which value laughter for this reason: e.g., actualization, psychological health, personal growth, integration, authenticity, maturity, adjustment, healthy outlook on life (cf., Greenwald, 1975; Mahrer, 1978, 1983; Mindess, 1976; O'Connell, 1981; Shaw, 1960).

For O'Connell (1981), a psychotherapy growing out of both an Adlerian and Jungian theory of personality holds humor and laughter as one mark of the actualized goal state of both personality development and therapeutic change. From a more orthodox Adlerian approach, Shaw (1960) likewise regards laughter as one expression of the highest plateau of personal growth and development through psychotherapy. According to Greenwald (1975) and Mindess (1976), this valued goal state is one in which the person has achieved a deeper and broader outlook on life, one which enables the person to grasp the comedy, the absurdity as well as the tragedy, the suffering in life; "... the patient who perceives the irony, absurdity, or outright comedy of his or her predicaments has achieved a wider, more flexible, more uplifting and therefore more desirable outlook on life" (Mindess, 1976, p. 335). Across many therapies, there is a valuing of a goal state whose manifest expression includes

laughter. However, as earlier, this welcomed laughter is not the characteristic style of the laughing patient; instead it refers to laughter as a more or less singular discrete event, associated with an array of feelings or emotions, and of some strength or amplitude.

5. Laughter as an expression of a warm and accepting patient relationship toward the therapist. In the back-and-forth interaction of psychotherapy, patient laughter is conceptualized as an expression of a warm and accepting relationship toward the therapist. More than a sign of acceptance of the therapist's substantive statement, laughter is seen as the expression of a developing intimacy, a reduction in emotional distance, a warmth and acceptance. Although noted as such in many therapies, it is especially highlighted in such approaches as feeling-expressive therapy (Pierce, Nichols, & Dubrin, 1983), provocative therapy (Farrelly & Brandsma, 1974), some schools of psychoanalytic therapy (Grotjahn, 1970; Rose, 1969; Rosenheim, 1974), existential-humanistic therapy (Bugental, 1979), direct decision therapy (Greenwald, 1975), and Gestalt therapy (Polster & Polster, 1973).

As before, this way of conceptualizing laughter refers to laughter as a discrete event rather than a characteristic style of the patient, covers an array of underlying feelings or emotions, and is of some strength and energy.

Clinical theory identifies one kind of patient laughter as expressly devoid of therapeutic desirability. This is laughter as a characteristic patient style or habit or behavioral trait in the session. With this notable exception, clinical theory provides a set of interrelated conceptual bases for regarding laughter as a welcomed and desirable event in psychotherapy. This

laughter occurs as a more or less singular, discrete event, with moderate or strong energy or strength, and covers an array of accompanying or underlying feelings or emotions. This laughter is held as therapeutically desirable across a broad band of psychotherapeutic approaches and may be taken as representative of virtually all schools of therapy. We now turn to the therapeutic desirability of patient laughter from the viewpoint of research.

The Desirability of Patient Laughter in Psychotherapy: Research

One line of reasoning is that if laughter can be shown to be a positive event in general, then it ought to be desirable to facilitate laughing in psychotherapy. This seems to be a rather equivocal justification for the value of laughter in psychotherapy and, in fact, there are no studies which make the link from laughter as a positive event in general to laughter as therefore a desirable event in psychotherapy.

However, some studies have examined the physiological concomitants and effects of laughter (e.g., Fry & Stoft, 1971; Godewitsch, 1976; Jones & Harris, 1971; Scheff, 1979). The general question is whether laughter is related to a state of good physical health. Because the linkage to laughter as a desirable event in psychotherapy is so loose and equivocal, these studies are essentially irrelevant to our question. Nevertheless, the interested reader is directed elsewhere for general research studies and anecdotal reports on the relationship between laughter and good physical health (e.g., Biermann & Toohey, 1980; Bresler, 1979; Cousins, 1976; Mazer, 1981; Moody, 1978; Scheff, 1979).

Another line of reasoning is that a relationship may be established between patient humor and psychological health; then, to the extent that laughter is an expression of humor, therapy may aim at bringing about laughter. But this line of reasoning is thin, and it provides little or no research basis for establishing the desirability of patient laughter as a therapeutic event. Nevertheless, there is a body of research on the relationship between humor in general and such personality variables and dimensions as ego strength, reality contact, empathy, and psychopathology. it must be underscored that this research strategy is virtually irrelevant to the question of the therapeutic desirability of patient laughter.

What are the highlights of this body of research? Humor has been linked to subjects' ego strength (Darmstadter, 1965; Goldsmith, 1963; Grossman, 1966; Roberts, 1958), degree of reality contact (Roberts & Johnson, 1957), and empathy (Epstein & Smith, 1969; Roberts & Johnson, 1957). Humor is more characteristic of normals than hospitalized psychiatric patients (Levine & Abelson, 1959; Levine & Redlich, 1960; Roberts, 1958). Although interesting, research on the relationships between humor and personality dimensions is not fruitful for assessing the therapeutic desirability of patient laughter.

What kinds of research strategies would bear more directly on the question of the desirability of patient laughter in psychotherapy? One strategy is to investigate the relationship between patient laughter and positive therapeutic outcomes. Although there are no studies which follow this paradigm, there are two studies which follow a more general strategy. If laughter is regarded as one of a few indices of the expression of strong

feeling, then relationships may be explored between the expression of strong feeling and positive therapeutic outcome.

There are two studies on this question. One is by Nichols (1974), and the second by Nichols and Bierenbaum (1978). Both used actual psychotherapy patients and therapists, and both reported significant relationships between the expression of strong feeling, with laughter as one index of strong feeling, and positive therapeutic outcome. It is interesting that both studies excluded laughing as a characteristic style of patients, and focused upon the same kind of laughing regarded as therapeutically desirable from the perspective of clinical theory, namely laughing as a discrete occurrence, laughing as an event with some strength, and laughing associated with an array of underlying feelings or emotions.

It is also noteworthy that laughter is almost axiomatically accepted as a desirable event in the clinical literature, that clinical theory has provided extensive and ample conceptual bases for holding patient laughter as a desirable therapeutic event, and that only two studies have examined the desirability of patient laughter.

Characteristics of Patient Laughter as a Valued In-Therapy Event

What are the characteristics of that kind of patient laughter which is held as a valued in-therapy event? There is remarkable uniformity within and between the clinical, theoretical, and research literatures on this question. The latter two domains have already been discussed to some extent. In addition, the characteristics of valued in-therapy patient laughter may be

taken from commentary on therapy transcripts, case discussions, and clinical vignettes of patients in therapy (e.g., Bugental, 1979; Farrelly & Brandsma, 1974; Greenwald, 1975, 1976; Polster & Polster, 1976; Shorr, 1972; Yassky, 1976). Combining these three literatures, the following characteristics define laughter as a valued in-therapy event, and the target of the present investigation:

It is not a characteristic style of the patient. Whether the laughter is of high or low intensity, regardless of the nature of the accompanying or underlying feeling or emotion, laughing as a characteristic style of the patient is expressly excluded as a valued in-therapy event. This is laughing which occurs with high frequency throughout the session, and occurs as a parameter of the patient rather than an in-therapy event.

It is not regarded as a valued in-therapy event because it is considered, for example, as a pathognomic indicator of a psychological disturbance (cf., DSM-III, 1980; Levine, 1976; Noyes & Kolb, 1963), or as one of many forms of a continuing defensive style (cf., Ansell et al:, 1981, Kubie, 1971; Levine, 1976; Paul, 1978). For whatever reasons, such high-frequency characteristic laughter is expressly identified as outside the bounderies of laughing as a valued in-therapy event from the combined perspectives of the clinical, theoretical, and research literatures (e.g., Ansell et al., 1981; Bugental, 1979; Harman, 1981; McGhee, 1979; Nichols, 1974; Nichols & Bierenbaum, 1978; Polster & Polster, 1976; Yassky, 1976).

It is a discrete, low frequency, singular in-therapy event. All three literatures define valued and desirable patient laughter as a low frequency, discrete in-therapy event. That is, this kind of laughter occurs not as a

continuing characteristic of the patient, but rather as a meaningful part of an immediate therapeutic situation or event. Something is occurring within the therapeutic session, and laughter is understood as a component of or reaction to that situation or occurrence. There is a spontaneity, an immediacy to this kind of laughter. Accordingly, the first of a set of three defining characteristics of therapeutically valued and desirable laughter is its occurrence as a low frequency, discrete therapeutic event (Ansell et al., 1981; Bugental, 1979; Greenwald, 1975; Grotjahn, 1966; Harman, 1981; Kris, 1940; Levine, 1980; Nichols, 1974; Nichols & Bierenbaum, 1978; Nichols & Zax, 1977; O'Connell, 1981; Olsen, 1976; Perls, 1970; Poland, 1971; Polster & Polster, 1976; Rosenheim, 1974; Shaw, 1960; Viney, 1983; Yassky, 1976).

It has strength, energy and intensity. Laughter is regarded as welcomed and therapeutically desirable when it is strong. This is variously referred to as laughter which is hard, cathartic, of heightened intensity, high amplitude, high energy, loud, explosive, heartfelt (e.g., Bugental, 1979; Downing & Marmorstein, 1973; Grotjahn, 1970; Malamud, 1976; Nichols, 1974; Nichols & Bierenbaum, 1978; Nichols & Zax, 1977; Lifschitz, 1981; Shorr, 1972). This laughter's strength is relative to the patient's own baseline energy level, and expressly excludes mild or lower strength chuckles, giggles, snickers, and the like.

It may be accompanied with an array of feeling or emotional states. As a singular in-therapy event, occurring with a measure of strength and energy, laughing is understood as being accompanied by a broad array of emotions and feelings. Whereas ordinary laughing in daily life is most often understood as signifying a pleasant feeling state (Bergler, 1956; Chapman & Foot, 1976;

McGhee, 1979), this is not necessarily so in psychotherapy. As one consideration, psychotherapeutic laughter has been clinically studied in its deeper aspects so that manifest buoyancy may be the surface indicator of a deeper and perhaps unconscious emotional state of anger, punitiveness, hurt, frustration or similar feeling states which are not lightly pleasureable (Bergler, 1956; Freud, 1960; Grotjahn, 1970; Koestler, 1964; Plessner, 1970). In psychotherapy, whether at the manifest or deeper levels, whether the focus is on the attendant behaviors (from clenched fists to tearfulness, from spontaneously gross bodily movements to facial expressions), this kind of welcomed and desirable therapeutic laughter is understood as accompanied with a broad array of feelings and emotional states (e.g., Farrelly & Brandsma, 1974; Greenwald, 1975; Harman, 1981; Jackins, 1965; Jasnow, 1981; Kubie, 1971; Levine, 1976; Mindess, 1976; Paul, 1978; Rose, 1969; Rosenheim, 1974). As long as the laughter is singular and low frequency, as long as it is strong and high energy, therapeutically desirable laughter is not restricted to pleasant or happy feelings or emotional states, but rather is taken as accompanied by a broad array of feelings and emotions.

Research Options Generated by the Current Theory, Practice, and State of Research Knowledge

Given the current state of clinical theory, practice, and research, what are the important research avenues to be investigated? The current status of patient laughing as a desirable event justifies and calls for a number of

needed lines of investigation. What are these options, and on what basis may a selection be taken?

Clinical practice rests on a presumption that the occurrence of strong patient laughter is welcomed, is desirable for therapeutic change. In practice, across many approaches, the question is how to bring about this highly valued and desired patient event. Indeed, the vacuum of research is highlighted by the increasing attention recently attributed to the need for systematically examining the ways of bringing about patient laughter (e.g., Ellis, 1977, 1981; Farrelly & Brandsma, 1974; Frankl, 1966; Greenwald, 1975, 1976; Haley, 1963; Klein, 1974; Mindess, 1971, 1976). This trend and growing need is also exemplified in a theme issue dedicated to this avenue by the Journal of the American Academy of Psychotherapists (volume 16, number 4, 1981).

Clinical theory likewise provides a conceptual foundation for the therapeutic desirability of strong patient laughter, and opens the way for research investigation of the means of bringing about this event. Across a variety of approaches, there are several theoretical bases for stamping strong patient laughter as a desirable therapeutic event. Accordingly, clinical theory likewise invites research on the ways of bringing about patient laughter within psychotherapy.

If clinical practice and theory both authenticate strong patient laughter as desirable, then one reasonable option is to investigate ways of bringing this about in psychotherapy. Indeed, this is the option to be pursued in the present research. In the section to follow, the current state of

research on this question will be reviewed. However, it is important to note that this is only one major research option available for investigation.

A second avenue of research focuses on the desirability of strong patient laughter. Although clinical practice acknowledges the desirability of strong patient laughter, and although clinical theory provides a conceptual foundation for its desirability, is there sufficient research basis for accepting strong patient laughter as desirable? Only two studies are relevant here, and neither focuses directly on patient laughter. It may be concluded that the research basis is slender and calls for further investigation. Accordingly, a second research avenue is both justified and pointed toward by the state of clinical practice, clinical theory, and research, namely research on the question of the deisrability of strong patient laughter in psychotherapy.

Both options are open, available, soundly based and justified. To pursue either option is to acknowledge the need for pursuing the alternative. If the second option is selected, one reason is that it is important to confirm the desirability of strong patient laughter before investigating ways of bringing about this event in psychotherapy; the problem is that this is an expression of a philosophy of science which holds that clinical practice should await sufficient research confirmation of the underlying presumptions and theoretically based conceptual structure. If the first research option is selected, one reason is that strong patient laughter is conceptually grounded, is highly prevalent in clinical practice, and the research need is to carefully and rigorously investigate the ways of bringing this event about. As will be indicated in the subsequent section, there is an almost bewildering

lack of organization and study of the manifold ways of bringing about this valued and desirable event. However, the problem in this option is that the very desirability of this event has yet to be confirmed by research.

Given these two major research options and the considerations in pursuing each, the selected choice is to examine the former, i.e., the ways of bringing about or facilitating the occurrence of strong patient laughter in psychotherapy. However, it is acknowledged that a systematic interest in this area leaves open the research investigation of the desirability of strong patient laughter in psychotherapy.

These are proposed as the two major research avenues put forward by the current state of clinical, theoretical, and research literatures on laughter as a therapeutically welcomed and desirable therapy event. In addition there are several secondary research lanes corollary to these major ones. Some of these will be cited as closure to a review of the current status of therapeutic laughter, but it is understood that the selected research option is that of investigating the methods of bringing about or facilitating patient laughter which is not a characteristic style of the patient, which is a low frequency, singular event, which has strength, energy and intensity, and which may be accompanied by an array of feelings or emotional states.

(1)One corollary line of research selects out the psychotherapeutic approaches, and asks questions about laughter by first taking into account possible differences among therapeutic approaches. For example, what ways of bringing about laughter are characteristic of given approaches? How do several approaches differ in their ways of bringing about laughter? Or, questions may be generated by parcelling out the outcomes for different schools of therapy.

For example, if laughter is desirable, how does its occurrence vary over several different approaches? When sessions include laughter, how do the indices of positive outcome distribute themselves over different therapeutic approaches?

These questions are corollary to the two major research avenues in that they are based upon a presumption that laughing is therapeutically desirable, and that it is profitable either to examine the ways of bringing it about or to refine outcome study by dividing outcomes along the lines of different approaches to therapy. It appears that studying laughter as related to different therapeutic approaches either begs the major research questions or offers a possible refinement in examining these two major research options.

(2) A second corollary line of research focuses upon the patient or client variables in relationship to the two major research options. For example, one may inquire into the relationship between patient laughter and such standard patient variables as degree of psychopathology, psychodiagnosis, or personality dimensions such as ego strength, emotional expressiveness, or covert aggressiveness. However, this line of research is based on a presumption that patient laughter is desirable, and it adds little or nothing to the question of how it is brought about in psychotherapy.

(3) A third corollary line of research focuses on a comparison of patient laughter with non-patient laughter. For example, patient laughter in psychotherapy may be compared with the laughter of patients in their daily lives outside of the therapeutic context, or with the laughter of non-patients. While this may illuminate the possible distinctiveness of patient laughter in therapy, it presumes the therapeutic desirability of

patient laughter while contributing little or nothing to a study of the ways of bringing it about in therapy.

(4) A fourth corollary line of research focuses upon patient laughter itself and examines either accompaniments of this event or directions of change over the course of psychotherapy. For example, one might study the nature and content of patient verbal behavior which accompanies or is consequent to patient laughter, the nonverbal, behavioral, linguistic, or neurophysiological accompaniments of laughter, or the changes in the amount and frequency of laughter over the course of psychotherapy. This line of study is based on a presumption that patient laughter is desirable and that it is important for psychotherapy to facilitate its continual occurrence.

Each of these corollary lines of research is interesting. But they are secondary to the two major research options generated by the current state of the theoretical, clinical, and research knowledge. One option is to examine the proposition that low-frequency, discrete, strong patient laughter is a therapeutically desirable event. Although proclaimed so by the clinical and theoretical literature, the research base is only preliminary at the present time. The second option, the one selected in the present research, is to investigate the therapeutic methods and operations which are linked to the occurrence of low-frequency, singular, strong patient laughter. This is a major research option which paves the way for corollary lines of study and also the major alternative research option. Accordingly, the next section focuses on how this laughter is held as brought about in the process of psychotherapy.

II. Therapists' Verbal Behaviors Antecedent to Patient Laughter

There is no organized review of therapist operations and methods linked with the occurrence of therapeutically desirable patient laughter. In setting forth such a review and provisional categorization, some preliminary considerations are in order.

Preliminary Considerations

The domains from which the data are drawn. As noted above, the valuing of singular strong patient laughter cuts across many therapeutic approaches. Therefore, the antecedent therapist behaviors are drawn from a broad distribution of therapeutic approaches.

In examining these approaches, indications of what therapists do prior to singular strong patient laughter will be drawn from the clinical literature, the theoretical literature, and the research literature. In large measure, indications will be taken from the clinical literature, including clinical discussions of patient laughter, case vignettes and excerpts involving laughter, and descriptions of therapeutic sessions in which patient laughter occurred. Secondly, indications will be taken from the theoretical literature. Although this literature is less rich in providing data on the antecedent operations and methods of therapists, some suggestions may be derived from theoretical propositions on the desirability of discrete strong patient laughter. In addition, the few research studies will also be examined for suggestions.

Finally, the review will be expanded to include not only the literature related to therapist operations and methods in relation to strong patient laughter, but also in relation to strong patient feeling expression in general. Strong patient laughter is generally regarded as one index of the expression of strong or heightened feeling expression and, as such, indications will also be taken from this larger encompassing domain.

Accordingly, the domains of data will include the clinical, theoretical, and research literatures on strong patient laughter and strong patient feeling expression across the array of therapeutic approaches in which strong patient laughter is held as therapeutically desirable.

Limitations and restrictions: Toward a definition of antecedent therapist verbal behaviors. The domains of data described above almost exclusively pertain to verbal behavior rather than nonverbal behavior. Verbal behaviors of the therapist generally include the nature or content of the actual statements as well as some indication of the way these words are spoken. For example, these literatures may include suggestions about such dimensions as voice quality, pitch and volume, style and tone. All of these dimensions and parameters will be examined in organizing the verbal behaviors of the therapist. However, the present review will not include nonverbal behaviors. Although these may be acknowledged to be significant aspects of therapist behavior, the above domains of data provide so little indication of the nature and role of nonverbal behaviors that they will be excluded from the present organization. Thus the provisional categorization will not include such nonverbal dimensions and parameters as therapist posture, body movements, eye contact, physical touch, and the like.

A second limitation or restriction expressly pertains to the meaning of antecedent. Throughout the literature on therapist operations and methods which are held as preceding singular strong patient laughter, these are limited and restricted to those which occur almost immediately prior to the patient's laughter. The window is opened to include therapist statements a little before the patient's laughter, from the immediately preceding therapist statement to those occurring within the last minute or so. Neither the clinical, theoretical nor research literatures speak of the influence of therapist statements or patient-therapist interchanges occurring much earlier in the session or in previous sessions. While it may be acknowledged that the complex of accumulating therapeutic events and processes over a series of sessions may have determining effects on the occurrence of a singular, strong patient laughter, the present meaning of antecedent is limited and restricted to more or less immediately antecedent therapist statements.

Accordingly, the review and provisional categorization of therapist methods and operations will, in accord with the pertinent literature, be restricted and limited to those therapist methods and operations which are verbal and more or less immediately antecedent, rather than nonverbal and a remotely occuring complex of earlier therapeutic determinants.

Therapeutic Procedures Linked with Patient Strong Laughter

From the clinical, theoretical, and research literatures, what is a provisional categorization of the therapist verbal behaviors antecedent to instances of patient laughter which is singular and strong? The subsequent

section will expand the question to include therapist verbal behaviors antecedent to patients' expression of strong feeling in general, rather than strong laughter in particular.

The use of humor. Patient laughter is believed by many authors to occur as a consequence of the therapist's use of humor (Ansell et al., 1981; Ellis, 1977, 1981; Farrelly & Brandsma, 1974; Greenwald, 1975, 1976; Grotjahn, 1970; Killinger, 1976; Lathrop, 1981; Mindess, 1971, 1976; Narboe, 1981; Rose, 1969; Rosenheim, 1974). In other words, patients laugh because therapists tell jokes, make witty remarks, or do something which strikes the patient as funny.

Discussions of the therapeutic use of humor tend to address two issues: (1) The underlying conditions for its use. These include the conveying of a generally humorous attitude toward life (Ansell et al., 1981; Greenwald, 1975, 1976; Mindess, 1971, 1976), and also toward the patient himself or herself (Ansell et al., 1981; Greenwald, 1975, 1976; Mindess, 1971). (2) Guidelines toward the expression of humor. These include set patter (Harman, 1981; Rautman, 1981), funny songs (Ellis, 1981) and spontaneous jokes (Narboe, 1981), as well as the humorous use of sarcasm, mimicry, irony, and distortion (Farrelly & Brandsma, 1974). These two issues may be discussed in turn.

(a) Underlying conditions for the use of therapist humor. There are many prescriptions concerning the use of therapeutic humor given predominantly in the clinical literature. Basically, these prescriptions address the attitudinal stance or posture expressed by the therapist.

The therapist is enjoined to convey a humorous attitude toward life in general. The attitude is that life is a tragic-comedy and humor is a way of dealing with it (Greenwald, 1975; Mindess, 1971). "... the extent to which our

sense of humor can help us to maintain our sanity is the extent to which it moves beyond jokes, wit, laughter itself. It must constitute a frame of mind, a point of view, a deep-going, far-reaching attitude to life" (Mindess, 1971, p. 10). Greenwald (1975) describes how this life attitude affects therapeutic process and movement by enhancing a positive understanding and frame of reference: "If you look at a Chaplin movie, you can dissolve into tears at its profound tragedy. But if you turn it just one degree the other way, it is a hilarious comedy-farce. I like to help the people I work with see the absurdity, the hilarity, the farce of life, and to enjoy it" (p. 116).

The therapist's use of humor is also to convey a positive, welcoming fondness for and liking of the patient (Ansell et al., 1981; Farrelly & Brandsma, 1974; Greenwald, 1975; Rautman, 1981). In other words, humor should only be used if the therapist genuinely has good feelings about the patient. "A long time ago I decided not to work with people I couldn't stand, because if you can't stand somebody and you express that in humor, you're in trouble, and they're in even worse trouble. Your humor must be based on your liking of people and your appreciation of them" (Greenwald, 1975, p. 115). This position is also stressed by psychoanalysts who discuss the use of humorous interpretation (Grotjahn, 1970; Poland, 1971; Rose, 1969; Rosenheim, 1974).

(b) Guidelines toward the expression of therapeutic humor. Among the general guidelines for the expression of therapeutic humor is the use of set stories, funny homilies, and anecdotes (Harman, 1981; Rautman, 1981). More unusual is the use of outrageous songs which Ellis (1981) sings both to and with his patients when they express 'irrational beliefs'. For example:

"MAYBE I'LL MOVE MY ASS
(to the tune of Charles Harris, After the Ball)

After you make things easy,
And you provide the gas;
After you squeeze and please me,
Maybe I'll move my ass!
Just make life soft and breezy,
Fill it with sassafras!
And, possibly, if things are easy,
I'll move my ass!" (Ellis, 1981, p. 34).

More typically, therapists are advised to joke in a spontaneous way in keeping with the immediate, ongoing process of therapy (Ansell et al., 1981; Farrelly & Brandsma, 1974; Narboe, 1981). The therapist usually does this in the form of one-liners. For example, Mindess (Ansell et al., 1981) describes how he responded to a patient who expressed concern that therapy would destroy her: "Well, you're in luck. I've already destroyed my quota of clients this week" (p. 12).

Farrelly and Brandsma (1974) have proposed an organized set of guidelines by which therapists can be humorous. Farrelly is the originator of an approach he calls 'provocative therapy', and a central ingredient of this approach includes the use of humor. His guidelines include the following: (a) exaggeration, (b) mimicry, (c) ridicule, (d) distortion, (e) sarcasm, (f) irony, and (g) jokes.

Exaggeration. Farrelly exaggerates the patient's ideation, affect, behavior, relationships, and goals into a larger-than-life form. He does this through the use of parody or caricature. For example, when a patient of dull-normal intelligence announced she wanted to be the next Carol Burnett, Farrelly acted out an exaggerated caricature of what this patient would be like standing in front of a microphone saying words such as 'duh, uh,' being inept and very tense (p. 101).

Mimicry. Farrelly mimics the patient's behavior, ideation, tone of voice. For example, when a patient threatened him with the possibility of an impending seizure, he announced that he too was subject to seizures and mimicked one complete with shaking, trembling, baring and clenching of teeth (pp. 101-102).

Ridicule. Farrelly differentiates between two types of ridicule. In one type, the therapist ridicules himself or his role as therapist. In the second type, the therapist ridicules not the patient, but characteristics of the patient's behavior; delusions, hallucinations, thinking patterns. For example, Farrelly might parody the role of the all-knowing therapist, or he might make fun of his own body. In relation to the second type of ridicule, Farrelly advises such things as entering into the delusional system of the patient. For example, when a supervisee of Farrelly's reported that her patient claimed to be the mistress of Christ, Farrelly advised "(that the student) ridicule the patient's ideation by claiming that she, the student, was Christ's real, favorite mistress" (pp. 102-107).

Distortion. Farrelly suggests the use of humorous psychological misinterpretations, off-base reflections, and clumsy, deliberate misunderstanding of what the patient says. The therapist distorts explanations. For example, in this excerpt from one of Farrelly's sessions:

> "C. (Slowly, in a puzzled tone): What's the matter with me? I must be promiscuous?
>
> T. (Warmly, "supportively" patting the patient on her knee): You're not promiscuous, you just have a 367-day-a-year estrus cycle" (p. 109).

Sarcasm. Farrelly couples sarcasm with teasing expressions and gestures, a sort of affable, teasing pseudo-hostility. For example, when a promiscuous patient lands a job, he says "(Suspiciously and with a sarcastic tone): Oh yah, how did you persuade him to hire you, Sweetheart?" (p. 110). Farrelly indicates that it is essential to use a playful tone with a patient when being sarcastic.

Irony. Farrelly describes irony as the therapist's assuming a pretense of ignorance, using words to express other than the literal meaning, and indicating the incongruity between the actual situation that is occurring and the desired situation. For example, when a patient has been placed in seclusion for assaulting other patients, and is yelling obscenities at the staff, Farrelly reports the following interchange to typify the irony of the actual versus desired situation:

> "T. (Sidling up to the grill, in full view of the patient; chortling loudly): Atta girl! You've got 'em on the run! They're scared shitless of you now, the sonuvabitchin' bughousers and that crazy freak! Keep it up, don't let 'em break you (through clenched teeth) No matter what! No matter how long they keep you in there!
>
> Pt. (Laughing in mid shout): Aw, go to hell, Frank! You ain't locked up in here. It's easy for you to say that. You try it, if you like it so goddamn much.
>
> T. (Cringing, looks furtively up and down hall, drops his voice to a conspiratorial whisper): Not me! They broke my spirit long ago, but I always have hopes that they'll finally meet somebody they can't break (suddenly glaring furiously, raising his voice in a fanatical shout) No matter what tortures they ...
>
> Pt. (Laughing: interrupting in a conversational tone): Careful, they'll put you in here next. Aw, piss on it, I'm shaping' up and shippin' out" (pp. 110-111).

Jokes. By jokes, Farrelly means the one-liners and punch lines described earlier. The provocative therapist uses jokes whenever possible (pp. 111-113).

In general, therapist humor is held as a means of facilitating patient strong laughter. It is comprised both of content and a way of being (including therapist manner, attitude, tone and quality of voice). Instead of treating humor as a separate category or set of categories, both the content and way of being of humor will be incorporated into therapist verbal behaviors which are generated from a comprehensive survey of the clinical, theoretical, and research literatures on therapist verbal behaviors antecedent to patient strong laughter.

Accordingly, the following seven categories are proposed as a provisional organization of therapist verbal behaviors antecedent to patient strong laughter. These categories are mutually exclusive, representative of a broad array of therapeutic approaches, include the elements of therapist humor where appropriate, and constitute an initial provisional attempt to categorize the ways in which therapist verbal behaviors are linked to the consequent occurrence of patient laughter which is singular, strong, and held as therapeutically desirable.

(1). Directed interpersonal risk-behavior. Strong patient laughter is held as occurring as a consequence to the therapist's direction for the patient to carry out an interpersonal risked behavior (Downing & Marmorstein, 1973; Shorr, 1972). The patient is directed to carry out the behavior immediately, within an imagined or fantasied scene in the therapy session itself. The behavior is interpersonal in that the therapist directs the patient to carry out the behavior in relationship to some other imagined or

fantasied person, generally a significant other individual. Finally, the directed interpersonal behavior is risky, i.e, anxiety-engendering, threatening, atypical for the patient. The behavior may consist of saying words to the other person, or yelling, or carrying out a physical action. For example:

> "(Therapist) Imagine holding your mother's face in your hands and scream the most impossible phrase at her ... he paused for several minutes and said, "This is too hard, Joe". I urged him on. Then he let go a scream, "I AM NOT YOUR PUPPET. I AM MY OWN MAN!" He ... cried for a moment, then he burst into hysterical laughter" (Shorr, 1972, p. 74).

When the therapist directs the patient to carry out an interpersonal behavior which constitutes a risk for the patient, the rather immediate consequence is held as strong laughter.

(2) Defined impulsive behavior by patient or other. Close (1970), Shorr (1972) and Farrelly and Brandsma (1974) indicate a second category of therapist verbal behaviors which is to be followed by strong patient laughter. This category consists of the therapist defining (describing in detail) an impulsive behavior, i.e., one which is threatening, ordinarily blocked and defended against, may be dangerous or outlandish, shocking, or rooted in primitive material. The defined impulsive behavior is regarded as carried out by either the patient or a significant other. Typically, the therapist's verbal behaviors and tone convey a context of impulse pleasure and acting out. When the therapist carries out this category of verbal response, these authors hold that the consequence is patient laughter.

For example, Close (1970) describes an intervention which preceded laughter by a patient who tells about refusing to hang up his shirts because the rattling of hangers might disturb the other patients:

"Look, I'll tell you one way you might be able to get your shirts hung up. If you go out to the TV room and turn the TV up full blast, then you could dash madly back to your room before anybody turned it down, and the TV would drown out the rattling of the hangers ... Wait a minute, I've got another idea. If you really wanted to do this right, you could set off the fire-alarm ... that would get the staff all upset, as well as the patients, and you would have plenty of time to hang your shirts up" (p. 195).

Similarly, the therapist may define the impulsive behavior another person might carry out. For example, in this excerpt from Farrelly and Brandsma (1974):

"C. (With an air of marked independence) I can do without men! (piously) I'll just become closer to God.

T. (Reminiscing; off-handedly): Reminds me of a friend, recently divorced. Of course, he had sexual feelings - not like you. But anyway, he said that his divorce had really brought him closer to God. Of course I agreed with him - with one small exception ... (pause) ... I just wondered how it was to crawl between the sheets with God.

C. (Blushes and laughs)" (p. 111).

(3) Ridiculous explanation/description of patient. The therapist offers an explanation or description of the patient or the patient's behavior in a way which is ridiculous. That is, the explanation or description is extreme, exaggerated, wild, far-fetched, unrealistic, burlesqued. Typically, the context includes a playful confrontation, interpretation, or encounter. This category of therapist verbal behaviors antecedent to patient laughter is described by Farrelly and Brandsma (1974), Greenwald (1976), Kopp (1964), Poland (1971), Whitaker, Felder, Malone, and Warkentin (1962), Ansell and his co-workers (1981), Guinan (1981), Rosen (1953) and Searles (1963).

(4) Instruction to carry out affect-laden behavior with heightened intensity. This is considered a common therapist method of promoting strong

patient laughter, and is described by clinicians such as Bugental (1979), Downing and Marmorstein (1973), Jackins (1965), and Polster and Polster (1976). The method consists of instructing the patient to carry out affect-laden behaviors, and to do so with increasingly heightened intensity. This may consist of instructions to "say it again, louder", to scream and yell the affect-laden words or phrases, to hit or pound or kick with increasing intensity.

(5) Carrying out the threatening behavior as/for the patient. Kopp (1974) and Shorr (1972) are representative of clinicians who hold that strong patient laughter is the consequence of a fifth category of therapist verbal behaviors. In this category, the therapist carries out or acts out behaviors which are threatening to the patient, and the therapist does so within the role of patient. That is, the therapist carries out these behaviors as or for the patient. These behaviors are threatening, risky, impulse-ridden, bothersome for the patient who is described as on the verge of or immediately coping with these behaviors. For example, when the patient is having a fantasied confrontation with her mother and is too threatened to indicate to her mother that she is having sex, the therapist says, "I'm having sex, mother!" (Shorr, 1972, p. 80), and the consequence is strong patient laughter.

(6) Risked being of the other person or entity. The therapist instructs the patient to risk being the other person or entity. As described especially by Jackins (1965) and Malamud (1976), this category of therapist verbal behaviors promotes strong laughter when role-playing or being the other person or entity includes a measure of risk, i.e., includes some threat in the sheer being of that other person or entity, or in the acting out of some impulse.

This category of therapist verbal behaviors is taken from the Gestalt method of being the other person or entity; the patient is to be or role play significant other individuals, objects, parts of oneself. For example, Malamud describes the use of this method in promoting strong laughter in a patient for whom the role-playing of God carries considerable personal risk and impulse pleasure:

> "Dr. M.: Now this time would you mind standing on this chair and playing God ... As God, I'd like you to say something to any of them, or all of them. It's up to you. Make a statement as God" (Malamud, 1976, p. 234).

(7) Excited reinforcement of risked behavior. Farrelly and Brandsma (1974), Guinan (1981), and Van der Post (1975) describe another category of therapist verbal behaviors designed to promote strong patient laughter. When the patient expresses some kind of risked behavior, the therapist responds with excited pleasure. This is understood as simple reinformcement by means of expressed excitement, approval, welcoming, and pleasure. Typically, the patient's behavior includes a large measure of risk; it is perhaps new or somewhat dangerous, unusual or impulse-threatening.

For example, Farrelly (Farrelly & Brandsma, 1974) describes an interchange with a patient who meekly enters his office, unsure of herself and looking confused. The therapist pretends to be confused about which chair she should sit in until, finally, "Pt. (Suddenly straightening up, frowning; loudly and forcibly.) "Aw, go to hell! I'll sit where I want!!" (p. 181). Farrelly excitedly welcomes the behavior, expresses pleasure, and the patient bursts into laughter.

Clinical theory provides a basis for a provisional set of the above seven categories of therapeutic procedures which are held as antecedent to strong patient laughter. As an initial framing of these procedures, care has been taken to organize the body of writings which discuss and which report specific ways of promoting patient strong laughter.

Research studies on therapeutic procedures linked with patient laughter. Are there any research studies relating to a linkage between any of the proposed categories of therapist behaviors and patient strong laughter? On the basis of research, may additional categories be considered? As stated earlier, there are only two empirical investigations in which patient laughter is examined within the context of actual psychotherapy (Nichols, 1974; Nichols & Bierenbaum, 1978). Results of these two studies indicated that strong laughter is one consequence of the use of therapeutic techniques which are believed to result in the expression of strong feeling in general.

The therapeutic techniques employed in both studies were based on an approach called "re-evaluation counseling" (Jackins, 1965). These techniques included role playing, repetition of affect-laden phrases, and expressive movement such as kicking and beating a couch. Nichols (1974) and Nichols and Bierenbaum (1978) report that laughter occurred as one consequence of the use of these techniques. They do not state how frequently patients laughed, nor do they link specific techniques to the patient's laughter. However, these investigations provide some support for two of the above seven categories taken from the clinical literature: instruction to repeat affect-laden behavior with heightened intensity, and risked being of the other person or entity.

A related paper (Killinger, 1976) explored the consequences of therapist humor. The pertinence to the present study lies in the presumption that patient laughter is an indicator of therapist humor, that is, patient laughter may include therapist humor among its antecedents. Data analysis was incomplete at the time of presentation at the International Congress on Humor and Laughter (Cardiff, 1976). Accordingly, this paper may be taken as a soft indicator that patient laughter and therapist humor are linked, although it must be noted that this was not the focus of the study itself.

All in all, research offers little if any data on the categories of therapist statements linked to subsequent patient laughter. These categories are generated predominantly from the clinical theoretical literature. However, it must be recognized that the above seven proposed categories are derived from writings which are expressly concerned with the occurrence of strong patient laughter. In an effort to confirm or extend this provisional list, a complementary and somewhat overlapping body of literature which focuses on therapist procedures and methods held as promoting strong feelings in general will be reviewed. Throughout this literature, strong laughter is commonly treated as one component of strong feeling expression.

Therapeutic Procedures Linked With Patients' Expression of Strong Feeling

There is a body of literature on therapeutic procedures for the promotion of strong feeling, with laughter as one behavioral component of strong feelings (e.g., Harman, 1981; Jackins, 1965; Mahrer, 1978; Nichols & Zax, 1977; Olsen, 1976; Perls, 1970; Polster & Polster, 1976). Given the above

list of seven categories of therapist verbal behaviors for promoting strong patient laughter, the question is whether these categories are further supported or complemented with additional categories by examining therapist procedures for promoting strong feeling in general.

Therapeutic methods and procedures for promoting the expression of strong feeling in patients have been available for nearly 100 years, and there are many contemporary psychotherapies in which the expression of strong feeling plays a central role. Thus there is an extensive clinical theoretical literature in which approaches and their procedures are described. Among these approaches are primal therapy (Janov, 1970), feeling-expressive therapy (Pierce, Nichols, & Dubrin, 1983), experiential-focusing therapy (Friedman, 1982; Gendlin, 1962, 1978), experiential psychotherapy (Mahrer, 1978, 1983), bioenergetic therapy (Lowen, 1975), implosive therapy (Stampfl, 1976), re-evaluation counseling (Jackins, 1965), psycho-imagination therapy (Shorr, 1972), Gestalt therapy (Perls, 1970; Naranjo, 1976), some of the existential therapies (Berg & Steinberg, 1973; Bugental, 1979), Reichian analysis (Reich, 1949), and crisis mobilization therapy (Bar-Levav, 1976).

Most of these approaches have their own vocabularies for describing what therapists do to promote strong feelings (Nichols & Zax, 1977), and it is possible to describe procedures within the vocabulary of each approach. However, although the language used to describe the various techiques differs, the therapist procedures themselves may have extensive commonalities. For example, Shorr, a psycho-imagination therapist, and Stampfl, a behavior therapist, both instruct patients to attend to an anxiety provoking imaginary scene. Shorr labels this procedure "describe the most awful thing" (1972),

while Stampfl labels the procedure "presenting the conditioned stimuli" (Stampfl & Levis, 1973).

At the level of specific therapist procedures, and given the above list of seven categories of therapist procedures for promoting patient strong laughing, the purpose is to confirm or complement these seven categories. Accordingly, the working intent is to examine therapist procedures for promoting strong feeling within the organizational framework of the derived seven categories for promoting strong patient laughter. The following, therefore, is a list of six categories of therapist procedures for promoting patient strong feeling. Particular attention will be given to those which seem instrumental in promoting strong patient laughter as one component of strong patient feeling in general.

(1) Instruction to carry out affect-laden behavior with heightened intensity. Similar to one of the categories above, strong feeling is brought about by means of instructions for the patient to carry out affect-laden behavior with heightened intensity. This procedure is common and is discussed and described by clinicians and clinical theorists such as Berg and Steinberg (1973), Bugental (1979), Gendlin (1978), Janov (1970), Lowen (1975), Rose (1976), and Shipley (1979). It includes instructing the patient to repeat affect-laden words and phrases, to speak and behave with heightened loudness and amplitude. It also includes the use of heightened intensity through physical movements including hitting, kicking, beating, and so on. This category of therapist verbal behaviors is found in such therapies as Gestalt therapy, primal therapy, experiential therapy, bioenergetic therapy,

feeling-expressive therapy, re-evaluation counseling, Reichian analysis, and others.

(2) Directed interpersonal risk behavior. A second category is also coterminal with one of the categories for promoting strong patient laughter. It consists of directing patients to carry out risky or risked behavior (i.e., behavior which is anxiety-engendering, threatening, atypical for the patient). The behavior is to be carried out immediately, within an imagined or fantasied scene within the therapeutic session itself. It is to be interpersonal in that it is to be carried out in relationship to some other imagined or fantasied person, generally a significant other individual. As a means of promoting strong feelings (including strong laughter), this category of therapist verbal behaviors has been discussed and described by, for example, Downing and Marmorstein (1973), Fagan (1973), Jackins (1965), Pierce, Nichols, and Dubrin (1983), and Shorr (1972). It is found in Gestalt therapy, experiential psychotherapy, and feeling-expressive therapy, among others.

(3) Descriptive clarification of threatening situation. The clinical theoretical literature on the promotion of strong feelings includes a common category of therapist verbal behaviors consisting of careful and detailed descriptive clarification of a situation which is threatening or anxiety-producing for the patient. In increasingly vivid detail, the therapist describes and clarifies a particular situation which is especially threatening and bothersome to the patient. This procedure is quite common to experiential therapy, feeling-expressive therapy, implosive therapy, psycho-imagination therapy, primal therapy, and many others in the family of therapies which promote strong feeling. However, neither the clinical theoretical discussions

nor the writings on clinical therapeutics link this procedure with the promotion of strong laughter. Therefore, it will not be added to the above list of seven categories of therapist verbal behaviors which are held as leading to patient strong laughter.

(4) Directed risked behavior toward therapist. The procedure consists of directing the patient to carry out a risked (threatening, impulse-ridden, anxiety-producing, unusual) behavior toward the therapist himself or herself. For example, the therapist may direct the patient to hit the therapist, yell at the therapist, hug or push the therapist, be sexual or aggressive toward the therapist. This procedure is common across bioenergetic therapy, Gestalt therapy, re-evaluation counseling, and virtually every therapy which aims at promoting heightened feeling. It is especially discussed and described by Berg and Steinberg (1973), Bugental (1979), Friedman (1982), and Whitaker, Warkentin, and Malone (1959), among others.

Not only is this procedure central to the promotion of strong feeling, but it is expressly cited as effective in the promotion of strong patient laughter as one component of strong feeling. Accordingly, this is one category of therapist verbal behaviors, taken from the literature on the promotion of strong-feelings, which is to be added to the list of categories of therapist verbal behaviors which are held as promoting strong patient laughter.

(5) Encountering. Encountering consists of emotionally charged interactions between therapist and patient, especially those characterized by straightforward confrontations and openly expressed genuine feelings. Typically, these culminate in emotional clashes. Although encountering is a primary procedure for eliciting strong feelings in patients, those who are the

major proponents typically exclude strong patient laughter as one of its consequences (e.g., Bugental, 1979; Schutz, 1967, 1973; Whitaker, Warkentin, & Malone, 1959). As a specific procedure, it is not included as a category of therapist verbal behaviors leading to patient strong laughter.

(6) Being the other person or entity. This procedure is perhaps most commonly found in Gestalt therapy in which the patient is instructed to "be" or role-play some other person or object or part of self (e.g., Perls, 1973; Levitsky & Perls, 1970; Naranjo, 1976). It is also found in other therapeutic approaches (e.g., Casriel, 1972; Jackins, 1965; Malamud, 1976; Moreno, 1959). In this procedure, the therapist might instruct the patient to "be your mother", "be the watch", "be your ten year old self". Ordinarily, the other side of this procedure includes instruction for the patient to carry out the interaction between the role-played other person or entity and the patient himself or herself (Downing & Marmorstein, 1973; Fagan, 1973; Naranjo, 1976; Perls, 1970). Although this procedure is used to promote strong feeling, its specific utility in promoting strong laughter has already been incorporated in the earlier category of "risked being of the other person or entity", and therefore does not call for an added category.

From the several categories of procedures for bringing about strong feeling, a few confirm those in the list of categories of therapist procedures for promoting strong laughter. However, one of these may be added to the list, namely "directed risked behavior toward therapist". Accordingly, that list may be extended to eight categories. Turning from a review of the clinical theoretical literature on the promotion of strong feelings to the research

literature, the question remains that of inquiring into either confirmation or complementation of the list of eight categories for promoting strong laughter.

Research literature. As reviewed earlier, the only studies of procedures for promoting strong feeling in patients are those by Nichols (1974) and Nichols and Bierenbaum (1978). There are additional psychotherapy research investigations within the framework of approaches which are characterized by the expression of strong patient feeling, e.g., implosive therapy (Hogan, 1966; Levis & Carrera, 1967) and experiential-focusing therapy (Gendlin, Beebe, Cassen, Klein, & Oberlander, 1968), but these studies do not examine procedures for promoting strong feeling and therefore are not pertinent to the present research.

Nichols (1974) and Nichols and Bierenbaum (1978) wanted to determine whether certain therapist techniques, based on Jackins' (1965) re-evaluation counseling, brought about the expression of strong feeling in patients. These techniques included therapists instructing patients to role play, to repeat affect-laden phrases, and to use expressive movements such as kicking a couch or striking a chair. Patient expression of strong feeling was defined in terms of the amount of time patients cried, laughed, shook, or trembled. In both studies, results indicated that the use of the techniques generated strong feeling expression by patients. It is to be noted that the categories of therapist procedures used in these studies have already been included in the list of therapist verbal behaviors for promoting strong laughter in patients.

Summary and Conclusions: Therapists' Verbal Behaviors Antecedent to Patient Strong Laughter

There are no comprehensive reviews of therapist procedures held as preceding strong laughter in psychotherapy patients. Based upon a review of the research literature, the clinical theoretical literature, and the literature on clinical practice, a provisional set of categories of such therapist verbal behaviors may be posited. These have been organized from an examination of the literature on therapist procedures for promoting strong feeling in patients, as well as the literature on therapist procedures for promoting strong patient laughter.

It is to be noted that these categories refer exclusively to statements by the therapist. Most of these categories take into account the nature and content of immediate patient statements. However, neither the literature on the promotion of patient laughter nor on the promotion of strong feeling yield categories pertaining to the patient-therapist interaction or relationship. Rather, the eight categories refer to the nature and contents of the therapist statements, with varying degrees of taking into account variables pertaining to the patient.

A detailed exposition of these eight categories is given in Appendix A, including a description and discussion of each category, clinical examples and illustrations, and the major sources from the literature. However, a summary description of each of these categories is given below, and constitutes an initial attempt to organize those therapist verbal behaviors which are taken from the literature as promoting strong laughter in patients.

It is important to note that these categories have been derived predominantly from an examination of the clinical and clinical theoretical literature. Only two studies (Nichols, 1974; Nichols & Bierenbaum, 1978) bear upon this issue. Indeed, with these two studies in mind, the central research question is that of examining what therapist verbal behaviors occur antecedent to strong laughter in patients.

(1) Directed interpersonal risk-behavior. The therapist directs the patient to carry out a risked interpersonal behavior. The behavior is interpersonal in that it is to be carried out in an interpersonal relationship with some other imagined or fantasied person, generally a significant other individual. The behavior is to be carried out immediately in the therapy session, within the context of an imagined or fantasied scene including the other individual. It is a risk-behavior in that the behavior is anxiety-engendering, threatening, impulse-related, and unusual or atypical for the patient.

(2) Defined impulsive behavior by patient or other. The therapist defines (describes in detail) an impulsive behavior, i.e., one which is threatening, ordinarily blocked or defended against by the patient, may be dangerous or outlandish, shocking, or rooted in primitive material. The defined impulsive behavior is regarded as carried out by the patient or a significant other individual. Typically, the therapist's verbal behaviors and tone convey a context of impulse pleasure and acting out.

(3) Ridiculous explanation/description of patient. The therapist offers an explanation or description of the patient or the patient's behaviors in a way which is ridiculous. That is, the explanation or description is extreme,

exaggerated, wild, far fetched, unrealistic, burlesqued. Typically, the context includes a playful confrontation, interpretation, or encounter.

(4) Instruction to carry out affect-laden behavior with heightened intensity. The therapist instructs the patient to carry out affect-laden behaviors, and to do so with increasingly heightened intensity. This may consist of instructions to "say it again, louder", to scream and yell the affect-laden words or phrases, to hit or pound or kick with increasing intensity.

(5) Carrying out the threatening behavior as/for the patient. the therapist carries out or acts out behaviors which are threatening to the patient, and the therapist does so within the role of the patient. That is, the therapist carries out these behaviors as or for the patient. These behaviors are threatening, risky, impulse-ridden, bothersome for the patient.

(6) Risked being of the other person or entity. The therapist instructs the patient to risk being the other person or entity. The risk occurs in the threat of the sheer being of that other person or entity, or in the acting out of some impulse.

(7) Excited reinforcement of risked behavior. The therapist responds with excited pleasure immediately following the patient's expression of a risked behavior. The therapist's response includes expressed excitement, approval, welcoming, and pleasure.

(8) Directed risked behavior toward therapist. The therapist directs the patient to carry out a risked (threatening, impulse-ridden, anxiety-producing, atypical or unusual) behavior toward the therapist himself or herself. For example, the therapist may direct the patient to hit the therapist, yell at

the therapist, hug or push the therapist, be sexual or aggressive toward the therapist.

Research hypothesis. Based upon the relevant literature, the following research hypothesis is warranted:

Antecedent to strong laughter, in patients for whom laughter is not a characteristic style in the therapeutic session, there will occur a given set of therapist verbal behaviors which (a) occur in significantly higher proportion than do other therapist verbal behaviors, (b) occur in significantly higher proportion antecedent to events of strong patient laughter as compared with their proportion of occurrence antecedent to events of patient non-laughter, and patient laughter which is mild or characteristic of the patient in the session, and, (c) include the following categories of therapist verbal behaviors:

1. Directed interpersonal risk-behavior.
2. Defined impulsive behavior by patient or other.
3. Ridiculous explanation/description of patient.
4. Instruction to carry out affect-laden behavior with heightened intensity.
5. Carrying out the threatening behavior as/for the patient.
6. Risked being of other person or entity.
7. Excited reinforcement of risked behavior.
8. Directed risked behavior toward therapist.

Chapter II

METHODOLOGY

The purpose of this chapter is to present a methodology for studying the hypothesis introduced at the close of the previous chapter. The methodology should enable an examination of the therapist verbal behaviors which precede instances of strong laughing by psychotherapy patients. With very few studies to draw upon, the aim will be to discuss alternative research strategies, and then to arrive at the methodology to be followed in the present study. This chapter will conclude with a more carefully framed, investigateable statement of the research hypothesis.

Research Strategies for the Study of In-Therapy Events

Strategies used to study the in-therapy events of psychotherapy may be described as falling into two major groups, analogue and naturalistic. It is the purpose of this section to describe both strategies and to select the one best suited to address the questions of the proposed study.

Analogue procedures. Attempts have been made to duplicate the events of psychotherapy through the use of analogue procedures (e.g., Keet, 1948; Levison, Zax, & Cowen, 1961). Munley (1974) describes two categories of analogue procedures which directly attempt to 'recreate' the events of psychotherapy: the audiovisual analogue and the quasi-counseling interview. The audiovisual analogue involves the presentation of audiotaped or videotaped

statements of confederates who take the role of either therapist or client. The therapist-subject or client-subject is asked to respond to the tape at predetermined times. This procedure might be used to assess, for example, whether or not a training program for therapists results in the use of appropriate responses following predetermined statements by confederate clients (e.g., Russell, 1982). The quasi-counseling procedure involves a simulated interview in which either confederate clients or therapists exhibit pre-arranged behaviors in order to assess the effect on client-subjects or therapist-subjects. This procedure may be used, for example, to assess the consequences of a particular type of intervention such as reflection or self-disclosure.

The question is the degree of appropriateness of this research strategy for examining the hypothesis. There are at least two considerations which tend to draw the choice away from the use of an analogue study. One is that it seems rather difficult to construct an analogue situation which will bring about strong, hearty laughter, especially of the kind which lends itself to study of antecedent therapist statements. The second is that such a format begs the research question itself. We do not know what therapist operations are associated with strong patient laughter.

Although the research hypothesis is taken from a careful and comprehensive review of the related literatures, in fact there is essentially no research knowledge on the therapist verbal behaviors which are antecedent to instances of strong patient laughter. As Gelso states, "The degree to which we can safely depart from the naturalistic setting is proportional to the amount we already know about the phenomena in question" (1980, p. 15). The aim

of this research is to examine those therapist verbal behaviors which prove to precede instances of patient strong laughing, and the research hypothesis is so stated as to examine those therapist verbal behaviors which are proposed by the literature, while allowing for the discovery of perhaps additional categories of therapist verbal behaviors which are antecedent to patient strong laughter. Therefore, for these purposes, and given the state of research knowledge on the question, both considerations point away from the adoption of an analogue strategy.

Naturalistic procedures. The use of naturalistic procedures involves the study of events that occur within the context of actual psychotherapy. This is commonly referred to as psychotherapy process research. One approach to the study of patient events is to train therapists to use procedures held as promoting the event and then to determine whether or not it occurs as a result of the procedures (Nichols, 1974; Nichols & Bierenbaum, 1978). These researchers trained therapists in the use of techniques believed to promote the expression of strong feeling in patients, and determined that in actual psychotherapy sessions the use of the techniques did result in strong feeling expression. However, although techniques designed to promote strong feeling have been well articulated in the clinical literature (see Chapter I), as indicated earlier the therapist verbal behaviors for promoting strong patient laughter lack such articulation, are less systematized, and there are essentially no clinical guidelines for training therapists in their development and use. The status of therapist verbal behaviors antecedent to patient strong laughter is such that specific categories of these behaviors

have yet to be defined. Accordingly, at this time, this kind of naturalistic approach is inappropriate to examine the research hypothesis.

More typically, researchers employ a naturalistic strategy that does not involve an experimental manipulation of what occurs in actual psychotherapy (e.g., Hill, Thames, & Rardin, 1979; Meara, Shannon, & Pepinsky, 1979). These researchers study events as they occur naturally in psychotherapy as opposed to manipulating their occurrence. Kiesler (1973) organizes the procedures used to carry out the study of naturally occurring events of psychotherapy into two broad categories of direct and indirect measures.

Indirect measures involve occurrences outside the therapy proper, for example, whether or not the therapist and/or the patient believe therapy is working, how the therapist views the client, or how the client feels about the therapist (Orlinsky & Howard, 1978). It is a reporting or describing of what occurs in psychotherapy, based primarily on the self-reports of the participants. Usually, the information is collected by questionnaire or by interviews after a session (e.g., Barrett Lennard, 1962; Snyder & Snyder, 1961). In the proposed study, an indirect measure might consist of asking a therapist to recall what intervention was used preceding patient laughter or to describe what interventions routinely seem to be followed by patient laughter. The problem is that indirect measures tap memories or speculations about what has occurred in a session rather than looking at specific behaviors found to be occurring in the session itself. The power of this strategy for examining the research question is regarded as rather low.

A more powerful way of studying therapist antecedents of patient laughter seems to call for the use of procedures Kiesler (1973) refers to as

direct methods. These refer to the systematic analysis of therapist and/or patient behavior as it occurs within the context of an actual session. Typically, these measures consist of the application of a system of content analysis to the verbalizations of therapist and/or patient (e.g., Dollard & Auld, 1959; Hill, 1978; Murray, 1956; Stiles, 1979). An advantage of this method over an indirect method is that the data collected represents what therapist actually do in therapy sessions, rather than recollection or speculation about what occurred. The objective of the present research is to identify what therapists actually do in therapy sessions preceding patient laughter. In general, then, the several considerations point toward the adoption of a naturalistic strategy using direct measures of patient strong laughter and antecedent therapist verbal behaviors in actual psychotherapy sessions.

While this strategy has been selected, it should be acknowledged that it has its own problems. Rather than discussing the problems of this approach in general, the focus may be on the problems of this kind of naturalistic approach in studying psychotherapy events similar to that of strong hearty laughter. Here are some of the problems:

- It is inefficient and time consuming to search through dozens and dozens of recorded sessions to locate a sufficient number of the right kind of event, in this case strong laughter. If the event is common and numerous, this is no problem. Strong laughter is not common.

- The aim is to inquire whether strong laughter is preceded by eight different kinds of antecedent therapist statements. This seriously compounds the problem. Not only does one have to locate a sufficient number of strong

laughter events, one also has to locate a sufficiently large number of each kind of antecedent therapist statement. The likelihood of finding a sufficient number of appropriate tapes is quite small.

- Adding another dimension of difficulty to both of the above two problems is the rarity of pure types, i.e. genuine strong laughter and genuine antecedent therapist statements falling in the eight target categories. It is much more likely that the researcher will locate all sorts of mixtures and partial or incomplete examples of both strong laughter and the eight target categories of therapist statements.

- Along the same lines, another problem has to do with the sampling of a reasonably broad range of therapists and patients. Since the research is examining strong laughter in general, and not in one or two particular kinds of patients or therapists, the researcher must locate a large number of different therapists, kinds of therapists, patients, and kinds of patients. This compounds the difficulty of having to have a large pool from which the strong laughter events are to be selected.

- This kind of naturalistic approach makes it virtually impossible to study runs or series or sequences of therapist statements which are followed by strong patient laughter. While this is not the focus of the main hypothesis, the researcher is essentially forced into soft and indirect impressions about runs or series or sequences of therapist statements which are followed by strong laughter. The intervening patient statements are so variable and so uncontrolled that one is thereby restricted to careful examination of immediately preceding therapist statements.

Accordingly, this form of naturalistic strategy is preferable on balance, but it certainly is not free of its own problems in studying events such as strong laughter and the therapist statements which precede instances of strong laughter.

This approach carries with it various research considerations, including the selection of: (a) a system of content analysis for therapist verbal behavior; (b) a means of identifying patient strong laughter; (c) the psychotherapy sessions to be examined; (d) the use of whole sessions versus segments; (e) the unit of study; (f) the data form; (g) judges; (h) procedures for rating; and, (i) statistical methods of analysis. Each of these research considerations will be addressed in the following sections.

Selecting a System of Content Analysis for Therapist Verbal Behavior

Within the field of psychotherapy process research, a common means of investigating therapist and patient behaviors in actual psychotherapy sessions is by means of a system of content analysis. Many content systems are available and have been reviewed elsewhere (e.g., Auld & Murray, 1955; Dittes, 1959; Kiesler, 1973; Marsden, 1965, 1971; Meltzoff & Kornreich, 1970; Russell & Stiles, 1979).

For purposes of the present study a system of content analysis for therapist verbal behaviors should meet the following prerequisites:

(a) The categories should include those therapist verbal behaviors indicated in the clinical, theoretical, and research literature as occurring antecedent to patient strong laughter.

(b) The categories should be appropriate to therapy sessions in general rather than, for example, being appropriate predominantly for special therapeutic conditions such as initial interviews, intake interviews, vocational counseling, or short-term sessions.

(c) Since there is no indication that the promotion of patient laughter is confined to any one psychotherapeutic approach, and since the present research is not confined to investigating therapist techniques within any prescribed single therapeutic approach, the therapist categories should be appropriate across approaches rather than being designed for use within a given approach to psychotherapy.

(d) The number of categories should be sufficiently large so as to enable an examination of therapist verbal behaviors which may prove to be antecedent to patient laughter. Accordingly, systems restricted to, for example, accurate empathy, are thereby excluded.

The above desiderata provide a basis by which to evaluate existing category systems and to determine those which are appropriate for the proposed research. Among the more prominent systems used in psychotherapy research to classify therapist behaviors are: The Depth of Interpretation Scale (Harway, Dittman, Rausch, Bordin, & Rigler, 1955), An Empirical Scale of Therapist Verbal Activity in the Initial Psychiatric Interview (Howe & Pope, 1961), An Empirical Scale for the Measurement of Therapist Specificity in the Initial Psychiatric Interview (Siegman & Pope, 1962), A Multidimensional System for Analyzing Psychotherapeutic Communications (Strupp, 1957, 1960, 1966), Scales for Therapist Accurate Empathy, Nonpossessive Warmth, and Genuineness (Truax, 1962), and the Hill Counselor Verbal Response Category System (Hill, 1978).

Two of these systems are derived from psychoanalytic theory, and thereby fail to meet the considerations cited above (Harway et al., 1955; Strupp, 1957). The scale designed by Truax (1962) likewise fails to meet the criteria since it is derived from client-centered theory. Two of these category systems were designed to measure therapist techniques in initial interviews (Howe & Pope, 1961; Siegman & Pope, 1962). Most importantly, no major category system includes the categories of therapist verbal behavior described in the clinical, theoretical, and research literature as occurring antecedent to patient strong laughter. Accordingly, no existing category system is especially appropriate for the present research.

In view of these considerations, and in order to address the hypothesis, the system of content analysis will consist of the eight target categories described in Chapter I, and an additional 'other' category. These categories are as follows:

(1) Excited Reinforcement of Risked Behavior: The therapist responds with excited pleasure immediately following the patient's expression of a risked behavior. The therapist's response includes expressed excitement, approval, welcoming pleasure.

(2) Instruction to Carry Out Affect-Laden Behavior With Heightened Intensity: The therapist instructs the patient to carry out affect-laden behaviors with increasingly heightened intensity. This may consist of instructions to "say it again louder", to scream and yell affect-laden phrases or words, to hit or pound or kick with increasing intensity.

(3) Directed Interpersonal Risk Behavior: The therapist directs the patient to carry out a risked interpersonal behavior. The behavior is

interpersonal in that it is to be carried out in an interpersonal relationship with some other imagined or fantasied person, generally a significant other individual. The behavior is to be carried out immediately in the therapy session, within the context of an imagined or fantasied scene including the other individual. It is a risk-behavior in that the behavior is anxiety-engendering, threatening, impulse-related, and unusual or atypical for the patient.

(4) Directed Risked Behavior Toward Therapist: The therapist directs the patient to carry out a risked (threatening, impulse-ridden, anxiety-producing, atypical or unusual) behavior toward the therapist himself or herself. For example, the therapist may direct the patient to hit the therapist, hug or push the therapist, be sexual or aggressive toward the therapist.

(5) Risked Being of Other Person or Entity: The therapist instructs the patient to risk being the other person or entity. The risk occurs in the threat of sheer being of that other person or entity, or in the acting out of some impulse.

(6) Ridiculous Explanation/Description of Patient: The therapist offers an explanation or description of the patient or the patient's behaviors in a way which is ridiculous. That is, the explanation is far-fetched, unrealistic, burlesqued. Typically, the context includes a playful interpretation or encounter.

(7) Defined Impulsive Behavior by Patient or Other: The therapist defines (describes in detail) an impulsive behavior, i.e., one which is threatening, ordinarily blocked or defended against by the patient, may be dangerous or outlandish, shocking, or rooted in primitive material. The

defined impulsive behavior is regarded as carried out by the patient or a significant other individual. Typically, the therapist's verbal behaviors and tone convey a context of impulse pleasure and acting out.

(8) Carrying Out Threatening Behavior as/for the Patient: The therapist carries out or acts out behaviors which are threatening to the patient, and the therapist does so within the role of the patient. That is, the therapist carries out these behaviors as/for the patient. These behaviors are threatening, risky, impulse-ridden, bothersome for the patient.

(9) Other: Therapist statements that do not fit into any other category.

While the target categories with an 'other' category will be used to investigate the hypothesis, there are additional considerations which call for the 'back-up' use of a standard category system. Of primary importance is the treatment of the 'other' category. That is, there should be some means to describe therapist statements preceding patient strong laughter which fall within the 'other' category. Furthermore, given the provisional nature of the target categories, it will be useful for the purposes of discussion to describe the target categories in comparison with a more standardized system. Thus, while the target categories will form the central system by which therapist statements will be judged and the hypothesis addressed, it is both useful and practical to select a more standardized system to provide 'back-up'.

In regard to the major category systems described above, the most appropriate to the present research is the Hill Counselor Verbal Response Category System (1978). While this system does not specifically include the target categories, it holds the advantage of meeting the remaining desiderata

and, in comparison with virtually all other direct systems, seems best suited to the 'back-up' needs of the proposed investigation.

The Hill system consists of 14 nominal, mutually exclusive categories for judging therapist verbal behavior. These categories include minimal encourager, approval-reassurance, information, direct guidance, closed question, open question, restatement, reflection, nonverbal referent, interpretation, confrontation, self-disclosure, silence, and other.

The advantages of the Hill system for the present study are: (a) It can be used to categorize the techniques of therapists of differing approaches. The categories were explicitly derived from 11 other category systems from various approaches, as well as from the study of therapy transcripts and comments of expert psychologists (Hill, 1978). (b) The therapist categories were developed to be appropriate for therapy sessions in general. (c) The number of categories is sufficiently large to enable an examination of therapist verbal behaviors antecedent to patient laughter. (d) The system is explicitly designed to refer to actual therapist methods and techniques. Furthermore, its efficacy has been demonstrated in its use in research investigation (e.g., Edwards, Boulet, Mahrer, Chagnon, & Mook, 1982; Hill, 1978; Hill et al., 1979).

Thus, the target categories described in Chapter I (plus an 'other' category), will constitute the system of content analysis by which the hypothesis is addressed, and the Hill system will be used as a 'back up'. A thorough description of the target categories and the Hill Counselor Verbal Response Category System is presented in Appendix A.

Identification of Patient Strong Laughter, Non-Laughter, and Other-Laughter

It is the purpose of this section to develop a procedure for identifying patient strong laughter, non-laughter, and other laughter. Procedures used in previous investigations which report the occurrence of patient laughter will be discussed, and a selected procedure will be presented.

Previous research procedures. There are two investigations in which patient laughter has been studied within the context of psychotherapy (Nichols, 1974; Nichols & Bierenbaum, 1978).

Nichols (1974) and Nichols and Bierenbaum (1978) were able to identify cathartic events, including hard laughter. A similar procedure was used in both studies for the identification of cathartic events. Two clinically unsophisticated judges were trained, in a five-hour session, to identify patient expression of intense feeling. Inter-judge agreement was high (r. 96). Although the precise training procedure was not specified in either article, it appears that the identification of cathartic events, including laughter, was based on the subjective judgement of the judges.

Other options for identifying patient laughter include the use of psychophysiological recording (e.g., Scheff, 1979) or a category system of patient verbal behaviors including patient laughter. In regard to psychophysiological recording, it seems the complexity, cost, and implications for the collection of actual psychotherapy sessions which will serve as data make it an impractical choice and so it will not be considered. In regard to the use of a category system, there is only one which includes specific directions for the use of a laughter category (Dollard & Auld, 1959). These

authors state: "Our position is that laughter is detectable by intelligent people with ordinary social training. Thus we rely on those who transcribe our records to be able to tell a laugh when they hear one" (from Kiesler, 1973, p. 400).

Based upon these procedures, it seems that a useful and appropriate way of identifying patient strong laughter is to use raters or judges who rely on subjective judgement complemented by careful description and examples of patient strong laughter. The specific procedure is given below:

Procedure for identifying patient strong laughter. One judge, a Ph.D. student in clinical psychology, will be given audio taped examples and a written description of laughter that is of strong intensity (see Appendix B). The judge will do an initial screening of audiotaped psychotherapy sessions which will serve as data in the present research. (These sessions will be described in the following section.) The task of the judge will be to identify all moments of patient strong laughter that occur on the audiotapes.

In order to set the criteria for excluding sessions in which patient laughter is a characteristic style of the patient, and since there is no accepted precedent in the literature by which to define the actual amount of laughter that might be regarded as a characteristic style of the patient, the case studies, published transcripts, clinical descriptions, and clinical vignettes described in Chapter I were examined. Based on this examination, it seems that a minimum of 12 instances of laughter, distributed over a 50-minute session, may be taken as constituting a characteristic style for the patient in that session. Sessions in which patient laughter occurs 12 or more times will not be considered in the selection of strong patient laughter excerpts.

Thus, the judge will identify strong patient laughter by noting each instance where the laughter occurs in the session, excluding those sessions in which patient laughter is a general characteristic of the patient.

Two additional judges, having listened to the taped examples of strong laughter, and having read the description, will listen to all laughter events collected by the first judge. Also included will be an equal number of laughter events not meeting the intensity criterion. Strong laughter events will consist of those selected by both judges.

Procedure for identifying patient non-laughter and other-laughter. The research hypothesis also requires selection of two types of comparison patient events; statements which include no patient laughter and those which include mild or characteristic patient laughter.

In the first case, that of patient non-laughter, one judge will be given the audiotapes of sessions in which the three judges have agreed patient strong laughter occurs. The task of the judge will be to randomly select non-laughter patient statements from those audiotapes.

In the second case, that of patient other-laughter, a procedure similar to that described for the selection of strong laughter events will be followed. The judge who does the initial screening of audiotapes will identify all instances of mild or characteristic patient laughter. Since the definition of characteristic patient laughter is based on the occurrence of laughter 12 or more times in a single session, no re-judging of characteristic patient laughter is deemed necessary. In the case of mild laughter, however, once the initial judge has collected the available instances in the data pool, two additional judges will listen to the instances. Also included will be an equal

number of strong laughter events. Patient other-laughter events will consist of those selected by both judges.

The Audiotaped Psychotherapy Sessions: Derivation, Description and Characteristics

It is the purpose of this section to describe the source and nature of the audiotaped psychotherapy sessions to be used as data in the present research, and to discuss some of the characteristics of the therapists and patients in that sample.

The sessions are included in the Psychotherapy Tape Library of the School of Psychology, University of Ottawa. The library currently contains approximately 280 hours of individual, adult psychotherapy. It was developed under the auspices of the School of Psychology for the purpose of providing data for psychotherapy research projects.

There are fifteen therapists currently included in the library. Each is an experienced psychotherapist in part-time or full-time private practice. Some of the therapists are exemplars of given approaches (e.g., Robert Pierce, Ph.D., feeling-expressive therapy; Harold Greenwald, Ph.D., direct decision therapy; Neil Friedman, Ph.D., experiential-focusing therapy). The fifteen therapists represent various therapeutic approaches, including psychoanalytic, experiential, and cognitive therapy. According to the therapists, the sessions illustrate their regular, ongoing work with actual patients, rather than being taken from or constituting demonstration sessions with audiences.

There are approximately 75 patients included in the taped sessions. There is no diagnotic information or designated problem identification for any patient. However, all of the patients are non-hospitalized adults, private patients of the therapists described above, with approximately equal distribution of females and males.

Some of the sessions are initial interviews, while others are taken from the first, second, or third year of therapy. Unfortunately, the majority of the sessions are not identified as to where they occur in a sequence of sessions for an individual patient.

In general, then, the data will be taken from a total pool of 280 hours of individual adult psychotherapy conducted by 15 psychotherapists with 75 patients. It is recognized that such a large resource of actual audiotaped sessions is unusual and especially fitting for purposes of the study. A specific breakdown of therapists, patients, and sessions containing strong laughter will be presented subsequently.

The Use of Whole Sessions Versus Segments of Sessions

This section will address the use of whole sessions versus segments of sessions. Typically, the former procedure has been used to compare therapists using different approaches or to describe in detail the techniques of a single therapist (e.g., Brunink & Schroeder, 1979; Edwards et al., 1982; Hill et al., 1979; Mahrer, Fellers, Durak, Gervaize, & Brown, 1981; Stooten & Goos, 1974). The advantage of this procedure is that every technique used throughout a single interview can be classified, and this is important in a comprehensive

examination of a therapist's behavior throughout a session, or in studies which compare and contrast methods used by various therapists. Usually, the number of sessions used in such studies is relatively small.

Although appropriate for many research questions, the use of entire interviews is less appropriate for the present investigation for several reasons: (a) The research question asks whether there are common categories of therapist statements which immediately precede patient laughter, with a secondary emphasis on the second and third therapist statements antecedent to strong laughter. Examining an entire session would shed little light on the hypothesis. (b) In order to maximize both the number of patients and therapists, the choice leans toward selected segments from a larger number of sessions. (c) In order to maximize the number of instances of strong laughter, the choice likewise is toward the use of segments. In addition, Kiesler (1973) in his review of the methodological issues of process reearch, asserts that it is probably "irrelevant" to score every minute of an entire session if the research question focuses on a specific aspect of therapy (p. 27). Thus, the present investigation will categorize therapist statements as they occur in segments of sessions rather than across entire interviews.

Segment characteristics. The hypothesis of the present investigation is designed to address the therapist verbal statements occurring immediately antecedent to patient strong laughter. Thus, a segment might consist solely of single therapist statements which occur prior to strong laughter events and, for the purposes of comparison, single therapist statements which precede other-laughter and non-laughter patient events. While this type of segment would be adequate in relation to the primary research question, this

investigation is secondarily concerned with broadening the 'window' of therapist statements in order to generate some soft impressions concerning the broader range of therapist verbal behaviors which may occur antecedent to patient strong laughter.

The decision to broaden the window of therapist statements carries with it some further considerations: what will constitute a segment? How large will the segment be? May segments occur in sequence? Are they to be separated by time? By a selected number of intervening statements?

The most common type of psychotherapy segment is the length of time sample (Kiesler, 1973). The primary concern in time-sampled segments has been that the segment accurately reflect the ongoing process of the session. Since the purpose of the present investigation is to study therapist verbal behaviors prior to a specific event, the problem becomes one of determining what constitutes antecedent behavior rather than that of insuring the segments reflect the ongoing process of therapy. Accordingly, the choice is that of a segment which ends with the patient's strong laughing, and including a number of antecedent therapist verbal behaviors or statements. The next issue concerns the size of the window, i.e., the number of antecedent therapist statements in each segment. This can be determined on the basis of sheer number of antecedent therapist statements (e.g., two or five), or by time (e.g., 15 seconds or one minute prior to the patient's strong laughter).

In order to arrive at the size of the segment, a procedure was followed consisting of the application of 'windows' of various dimensions (four minutes, two minutes, 90 seconds, ten interchanges, five interchanges, three interchanges, and one interchange preceding patient laughter) to available

published transcripts which include moments of patient laughter (e.g., Fagan, 1973; Shorr, 1972) and two sample audiotapes of sessions which included four and eight incidents of patient strong laughter respectively. The problem with the use of time in determining segment size was that of rather extreme variability in the number of antecedent therapist statements. For example, a four-minute window preceding patient laughter proved to include two to 19 antecedent therapist statements. A 90 second segment included four to only a fraction of a single statement. Consequently, number of interchanges was deemed a more appropriate determinant of window size. Of the possible combinations, the use of three interchanges preceding patient laughter appeared to be broad enough to encompass techniques therapists might use preceding patient laughter, on the basis of the above sample. The use of a three-therapist-statement window is in accord with descriptions in the literature of moments when patients laugh which generally indicate it is the immediately preceding therapist statement which is critical. The selection of the segment size of three-therapist-statements is a 'best guess' based on the available clinical literature, testing out various segment sizes on two sample audiotaped sessions, and testing out segment sizes on published transcripts which include moments of patient laughter (e.g., Fagan, 1973; Shorr, 1972). It should be underscored that the research hypothesis focuses solely on the immediately antecedent therapist statements. The study of statements occurring two before and three before is simply to generate some soft impressions concerning the broader range of therapist verbal behaviors which may occur antecedent to strong patient laughter.

Based on the segment size, the following decisions have been reached in regard to which particular segments will be used as strong laughter data. As stated earlier, no segments will be taken from sessions in which patients laugh with at least moderate intensity more than 12 times in a 50-minute session. Furthermore, if the patient laughs during the first three therapist-patient interchanges of a session, that segment will also be excluded since the therapist typically has had little opportunity to promote the laughter. Thus, strong laughter segments will be taken from points in a session, following the first three therapist-patient interchanges, in which a patient laughs no more than 12 times in a 50-minute session.

In regard to the distance or separation between segments, the 'demarcation' event of the segment will consist of patient strong laughter which has been preceded by three therapist-patient interchanges which include no patient laughter. That is, if the patient has strong laughter in P14 and strong laughter in P15, the demarcation event will be P14 as long as it is preceded by three therapist-patient interchanges that do not include patient laughter. A minimum of three therapist-patient interchanges (i.e., six statements) must occur between one patient laughter and another for both to be considered as demarcation events for selecting segments.

The research hypothesis also requires selection of two types of comparison segments: those which include no patient laughter and those which include mild or characteristic patient laughter, so that the therapist statements which precede these events may be compared. In the first case, that of no patient laughter, the segments will consist of three therapist-patient interchanges preceding a randomly selected patient statement, with no laughter

occurring at any point. These non-laughter segments will be drawn from the same sessions in which laughter segments have been located. In the second case, that of mild or characteristic patient laughter, segments will be selected from sessions in which this type of laughter occurs. By definition of what will constitute a strong laughter segment, mild or characteristic laughter segments can not be drawn from the same sessions in which strong laughter segments have been located.

Unit of Study Within Segments

Within the segment, a variety of scoring units may be used. These include: the entire segment, the clause, the sentence, the idea, and the interaction exchange. Of these, the "statement" is most widely used in process research (Kiesler, 1973). Kiesler defines this common scoring unit as "an uninterrupted sequence of sentences uttered by either the patient or therapist; everything said between two therapist responses (for patient) and everything said between two patient responses (for therapist) ..." (1973, p. 42).

The present investigation is concerned with classifying therapist statements which precede patient strong laughter. Thus, an appropriate scoring unit in which to study this problem is the therapist "statement". The unit to be categorized in the present study will be each complete therapist statement occurring within the segment described earlier.

The Hill Counselor Verbal Response Category System, described earlier, has been selected for back-up use in the present investigation. Although the

Hill system uses a single clause as its scoring unit, following the unitizing procedure of Auld and White (1956), there does not appear to be any special problem in using each therapist statement (Kiesler, 1973) rather than all of the clauses or sentences in each therapist statement. In bringing this possibility to the attention of Dr. Clara Hill, the present investigator received approval of the author on the understanding that it is noted in this research that such a modification of the unitizing method used by Hill was made (Hill, personal communication, 1982). Parenthetically, this necessitates deletion of the Hill category of "Silence".

Data Form: Videotape, Audiotape, Transcript

The medium of data presentation in psychotherapy process research is usually one of three types: audiovisual recordings (i.e., films and videotapes), audio recordings, and, most commonly, verbatim transcrips (Bergin & Garfield, 1971; Garfield & Bergin, 1978; Kiesler, 1966, 1973). The source of data for the present research consists exclusively of audiotapes, and a choice must be made concerning how the data will be presented (i.e., audiotapes only, verbatim transcripts only, or a combination of both).

The Hill Counselor Verbal Response Category System which has been selected for 'back up' use in the present investigation has typically been applied by judges to verbatim transcripts following exposure to the films or audiotapes from which the transcripts were derived (Hill, 1978; Hill et al., 1979). Judges have simultaneously listened to audiotapes as they rated transcripts (Hill, 1978) and viewed films prior to rating verbatim-transcripts

of the films (Hill et al., 1979). In another study which has employed the Hill system, judges had no exposure to any data form other than verbatim transcripts (Edwards et al., 1982). Use of the Hill system does not require any data but verbatim transcripts and neither Hill (1978) nor Hill and her co-workers (1979) mention what effect, if any, exposure to either audiotapes or films had in judges' ratings. Furthermore, according to Kiesler (1973), the advantage of using audiotapes is that judges can use such behavioral aspects as pitch, tempo, and volume change (p. 46), (extralinguistic) variables which are not addressed in the present research or in the Hill system itself.

Thus, audiotapes could be used in conjunction with verbatim transcripts in the present investigation, but it is unclear what advantage this procedure would hold. In addition, there are some practical disadvantages to the use of audiotapes. The procedure for rating described later in this chapter requires judges to make independent ratings. Judges would either have to be given cassette recorders and audiotapes for their own use, a procedure that would require making multiple copies of all segments and obtaining recorders for all judges, or judges would be required to do their independent ratings in a group, listening to audiotapes, a procedure which might add confounding group process factors. Thus, the problems in using audiotapes seem to outweigh the likely gains. Accordingly, the data form of the present investigation will consist of verbatim transcripts.

One person will type all of the selected segments. In keeping with the procedure established by Hill (1978), transcription will include statements of both therapist and patient, although only the therapist statements will be rated. Whereas presentation of patient statements might seem to contaminate or

influence judgements of therapist statements, Schoeninger, Klein, and Mathieu (1967) and Bordin, Cutler, Dittman, Harway, Raush, and Rigler (1954) have demonstrated that ratings of either therapist or patient statements remain stable whether or not the statements of the 'non-rated' participant are present. The transcription will also include 'stage directions', e.g., whether the patient cried, interrupted the therapist, yelled or whispered, whether there were pauses, or whether the therapist and patient spoke at the same time. Only the notation that patient laughter has occurred will be excluded. 'Stage directions' are usually included in verbatim transcripts, and have been discussed by Bordin and his co-workers (1959) and Gottschalk, Winget, and Gleser (1969). The typed statements will be checked against the audiotaped segments to insure accuracy of transcription.

Number of Segments: Distribution Across Therapists and Patients

One practical consideration concerns the relative infrequency of instances of patient strong laughing. While it would be helpful to be able to choose from a large number of sessions containing instances of strong laughter, in actuality there is a practical ceiling on the number of available sessions. In seeking to obtain instances of patients' frank expressed antagonism toward therapists, Gillespie (1953) reported that instances of this event occurred only ten times in 218 hours of therapy. The target event of the present investigation likewise tends to occur somewhat infrequently. If the data pool is to consist of approximately 280 hours of individual therapy in the Psychotherapy Tape Library of the University of Ottawa, that may place

a somewhat low ceiling on the actual number of available instances of useable patient strong laughter.

The number of segments may be approached by an examination of the research hypothesis and the methodology as described thus far. Accordingly, of nine categories (i.e., eight target categories plus an 'other') of therapist statements, the research hypothesis suggests that eight of these would tend to occur with significantly higher frequencies preceding patient strong laughter. Anticipating that the nature of the data would lend itself to Chi-square analysis, with a minimum of 5 per cell or category, it would appear that the minimum number of strong laughter segments would be 40, and that perhaps 50 to 80 strong laughter segments would more likely provide the data necessary for an examination of the hypothesis.

It is to be noted that for each segment culminating in patient strong laughter, the window shall include the first, second, and third antecedent therapist statement.

Given an essential minimum of 40 strong laughter segments or excerpts, a provisional assessment can be made of the actual number of strong laughter segments available from the data pool. Excluding those instances which occur within the first three therapist-patient interchanges, and excluding sessions in which laughter is a characteristic style of the patient, a provisional assessment indicates a total of 69 available strong laughter segments. These are taken from 31 patients seen by 10 therapists over 39 sessions. Given an essential minimum of 40 instances of strong patient laughter, it appears that the available total of 69 instances should be appropriate for examination of the research hypothesis.

It is noted that the number of excerpts from the 10 therapists range from two (Therapist J, Table 1) to 16, with a rather even progression in contribution between these two extremes. While it would be preferred that each of the 10 therapists would have contributed an equal proportion of the total excerpts, the overall distribution seems to be appropriate for the hypothesis. In examining the findings, it is posible to assess the influence of the heavier contributors to the total number of strong laughter excerpts.

Judges

The majority of process research studies with classification of verbatim transcripts has generally used only two to four judges (e.g., Edwards et al., 1982; Hill, 1978; Hill et al., 1979; Stiles & Sultan, 1974; Strupp, 1957). The clinical expertise of the judges has ranged from undergraduate students with no training in psychotherapy to experienced clinicians. More specifically, the Hill Counselor Verbal Response Category System has typically been used by three judges with clinical expertise ranging from undergraduate students to experienced clinicians (Hill, 1978; Hill et al., 1979; Edwards et al., 1982).

In keeping with the procedure established by Hill, the present investigation will use two 'teams' of three judges including two Ph.D. psychologists who are experienced clinicians, two post-internship doctoral students in clinical psychology, one counselor from the University of Ottawa Counselling Centre, and one 4th year Psychology honors student with nearly a year of experience as a judge in psychotherapy process research.

Therapist	Number of Laughter Segments	Number of Patients	Number of Sessions
A	16	9	12
B	15	6	7
C	9	4	7
D	8	3	4
E	5	2	2
F	5	2	2
G	4	2	2
H	2	1	1
I	2	1	1
J	2	1	1
Total: 10	68	31	39

Table 1. Provisional Distribution of Strong Laughter Excerpts Across Therapists, Patients and Sessions

Procedure for Categorizing Therapist Statements

Commonly, judges either rate all segments in one sitting or divide the work over a period of time. The former approach may offer such advantages as reducing the effects of time, the need for recalibration (i.e., reacquainting judges with the rules of the scoring system), and perhaps decreasing the likelihood of judges discussing ratings with one another. However, there are problems in that procedure, especially when there is a large number of categorizations to be completed. It is difficult to maintain interest over six to eight hours of continuous work. Fatigue is a factor. Group process factors tend to intrude. From a practical and logistic perspective, the sheer size of the task of categorization in the present study does not lend itself to a single sitting. Dividing the task into, for example, weekly assignments holds several advantages: interest in the task may be better maintained, effects of 'set' responding may be minimized, and special problems encountered in the use of the category system itself may be discerned. Of these two options, given the large number of categorizations, the selected option is to use weekly assignments. Each team of judges will meet on a regular weekly basis until all ratings are completed.

The first meeting will be to train the judges. A training procedure similar to that of Hill (1978) will be employed. One 'team' of judges will be trained in the use of the target categories while the second will be trained in the use of the Hill system. The instructions and descriptions of the target system and the Hill system will be handed out and discussed with the appropriate team of judges. Each team will be given sample segments

(approximately 15 therapist-patient interchanges) and will be asked to rate independently the therapist statements over the following week. At the second weekly meeting, the discrepancies among the judges and problems with using the respective category systems will be discussed within each group. This procedure will continue until each team of judges reaches an agreement level of .83 per cent on 'practice' segments. Hill (1978) estimates that training to this level of agreement requires a total of ten hours for both group meetings and independent homework ratings.

At each weekly meeting following the training period, each team of judges will be given approximately five segments and asked to categorize the therapist statements independently over the course of the next week. Non-laughter, strong laughter and other-laughter segments will be randomly presented. That is, in the course of a week each team of judges will be rating approximately 15 therapist statements from both types of segments (i.e., a combination of 30 statements per week from both teams). At each weekly meeting, in addition to the distribution to each team of judges of the next five segments, the categorizations of the previous week will be collected. While there will be no references to any specific therapist statements, a few minutes will be devoted to general problems in the use of the category system. The advantage of this procedure is that it may maintain interest in the task, and also encourage each judge to remain cognisant of the use and criteria for the categories of the system.

After all segments have been rated, those statements which do not meet the criterion of agreement (to be discussed in the following section) will be given to judges to rate a second time. These statements will be interspersed

with rated statements which have already met the criterion of agreement in order to provide one means of checking reliability.

If the combined total of approximately 150 laughter, non-laughter and other-laughter segments is to be categorized, it is estimated the procedure may require about four months to complete. If the judges seem to be able to handle a few more segments each week, the homework assignments will be appropriately increased in order to reduce the overall period of categorization.

The Research Hypothesis

The above methodology allows for a more formal, testable statement of the research hypothesis.

In general, the question is whether identifiable kinds of therapist statements tend to precede patient strong laughter. A review of the clinical, theoretical, and research literature suggests that several categories of therapist statements should precede instances of strong patient laughter, although no research has focused upon this issue.

In order to examine this question, a research strategy has been adopted using a methodology with the following conditions:

(a) Given a data pool of approximately 280 hours of audiotaped individual psychotherapy and approximately 15 therapists representing varying therapeutic approaches, and 75 patients;

(b) Given that those initial segments are excluded in which strong patient laughter occurs within the first three patient statements;

(c) Given approximately 70 verbatim excerpts of strong laughter, approximately 35 verbatim excerpts of non-laughter taken from the same sessions, and approximately 35 excerpts of other-laughter (i.e., laughter which is mild or characteristic or both);

(d) Given a group of judges who place the immediately antecedent therapist statements into a nine-fold category system comprised of the 8 categories taken from the literature as preceding strong laughter in patients, and an 'other' category.

It is hypothesized that a significantly higher proportion of therapist statements falling under the eight expected categories will occur immediately antecedent to strong laughter, as compared with the proportion occurring antecedent to non-laughter and the proportion occurring antecedent to other-laughter.

While the main intent is to explore this hypothesis in regard to the immediately antecedent therapist statements, the design will also allow for examination of the antecedent second therapist statements and the antecedent third therapist statements.

While the main intent is to explore this hypothesis in regard to the eight expected categories, the design will also include categorization of the antecedent therapist statements in terms of the Hill Counselor Verbal Response Category System.

Statistical Methods

The following section will address these questions: How will interjudge reliability be evaluated? What are the criteria for considering therapist statements as classified? How will the results be statistically presented and analyzed?

Inter-judge reliability. Inter-judge reliability will be determined by computation of Kappas (Cohen, 1960; Tinsley & Weiss, 1975). According to Hill (1978), the Kappa is the most appropriate statistic for determining agreement levels on a nominal system for all possible combinations of two judges. The Kappa is the proportion of agreement between two judges after the possibility of chance agreement has been removed.

In the present investigation, Kappas will be computed and reported for each possible combination of judges within each team. Reliability will also be assessed by means of a second procedure. As described earlier, those therapist statements which fail to meet criterion of agreement are to be rejudged. When those statements are presented to the judges, they will be intermixed with a number of randomly selected therapist statements which reached criterion of agreement at the first judging. The second rating of those statements already having met criterion will provide an additional measure of reliability.

Criteria for classification of therapist statements. A therapist statement will be considered as classified when two out of three (67%) judges place it within a single category. It should be noted that Hill (1978) and Hill and her co-workers (1979) used as a criterion of classification the agreement of two out of three judges when the Hill system was employed. The

classification criterion of the present study is in keeping with that suggested by Hill (1978).

Rescoring. For those statements which did not meet the criterion level of 67% after the first scoring attempt, a second attempt will ensue. This will take place after all therapist statements in strong laughing, non-laughing, and other laughing segments have been categorized. If the statement doe not meet criterion at this second attempt, it will be considered 'unscoreable' and dropped from the data analysis. This differs somewhat from Hill's (1978) procedure in which statements which did not meet criterion were discussed by judges to determine the most appropriate category. The advantage of independent rescoring as opposed to discussion and group decision is that it seems to provide added stringency while reducing the likelihood of one judge or a sub-group of judges influencing the selection of a specific category.

Statistical description of the data. The classification of therapist statements into discrete categories constitutes nominal data. Since the present research focuses on the various frequencies of these classifications, the data will be presented in descriptive form and Chi-square values will be obtained.

The descriptive presentation of data will be in terms of percentages, an approach most common in research of this nature (e.g., Hill et al., 1979; Stiles, 1979). Furthermore, anticipating the nature of the data will lend itself to Chi-square analysis, this procedure will also be carried out. Specifically, in regard to the hypothesis, the percentage of times therapists use the eight target categories immediately antecedent to patient strong laughter, other-laughter, and non-laughter will be reported and Chi-square

analysis will be used to determine whether the eight target categories as a group more frequently precede strong laughter than they do other-laughter and non-laughter.

The design of the present study also permits examination of the second and third antecedent therapist statements occurring before patient strong laughter, other-laughter, and non-laughter. Although a study of these statements is not a direct test of the main hypothesis, the data will be presented in the same fashion described above. The purpose of this secondary analysis is to generate some soft impressions concerning the somewhat broader issue of therapist statements antecedent to patient strong laughter.

While the present investigation is focused on eight target categories hypothesized as preceding strong patient laughter, the Hill system will be used as a 'back-up'. Again, data will be described in terms of frequency with which the various Hill categories are used antecedent to patient strong laughter, other-laughter, and non-laughter, and Chi-square values will be obtained.

Chapter III

RESULTS

The major purpose of the chapter is to report the findings bearing upon the main hypothesis. However, this will be preceded by data on interrater agreement, and followed by the findings relative to the other, secondary questions and issues.

Interrater Agreement

Identification of Strong Laughter and Other Laughter

Three judges were used in this task. The first judge made the initial selection of excerpts as containing strong laughter or other laughter from the total pool of excerpts. This judge noted which were identified as falling in the two groups. On this basis, 64 excerpts were classed as containing strong laughter and 30 as containing instances of other laughter.

Two additional judges then independently classed the 94 excerpts as falling in either the strong laughter or the other laughter category. Of the 64 excerpts selected by the first judge as containing strong laughter, the two additional judges agreed with each other and with the initial judge in 60 instances (93.8%). Accordingly, the 4 excerpts failing to gain agreement were deleted from further study. Of the 30 excerpts selected by the initial judge as other laughter, and randomly intermixed in the total pool, both judges

agreed with one another and with the initial judge on each of the 30 excerpts. In all, of the total pool of 94 excerpts, there was agreement among all three judges on 90 (95.7%).

Distribution of strong laughter excerpts across therapists. Of the 64 strong laughter excerpts, four were deleted from further study. In the original pool of strong laughter excerpts, there was an uneven distribution of excerpts, with a few therapists contributing a larger proportion of the excerpts. The actual distribution of strong laughter excerpts is given in Table 2.

With 60 excerpts and 10 therapists, a uniform distribution would have 6 excerpts from each of the therapists. Inspection indicates that therapists A and B contributed more than their share. A Chi-square of 21.28 ($df = 9$, $p < .02 > .01$) confirms the unevenness of the distribution, and suggests that therapists A and B contribute a somewhat excessive proportion of strong laughter excerpts. While one option was to reduce the number of excerpts contributed by these two therapists, the decision was taken to leave the total number at 60.

Classification into the Eight Target Categories and the Other Category

In order to test the main hypothesis, three judges placed 120 therapist statements (60 preceding strong laughter, 30 preceding non-laughter, and 30 preceding other-laughter) in two classifications. One consisted of the eight 'target' categories as a group, and the second consisted of an 'other' category. Of the 120 therapist statements, 112 (93.3%) reached or exceeded the

criterion level of agreement among at least two of the three judges at the first scoring attempt. The eight statements which failed to reach criterion were randomly intermixed with eight statements which had reached criterion on the initial judgement, and all 16 reached or exceeded criterion. In other words, all 120 therapist statements reached criterion. Furthermore, 48 were judged as falling into the eight target categories as a group, and 72 were judged as falling into the 'other' classification.

For the additional secondary issues and questions, it was necessary to categorize the statements as falling into one or another of the eight target categories. Of the 48 therapist statements, 37 reached the criterion level of agreement among at least two of the three judges in being placed into a given one of the eight 'target' categories. In other words, at the first scoring attempt, 37 (77.1%) of the 48 therapist statements reached criterion of agreement when judges placed the statements in one of the eight 'target' categories. The 11 statements which failed to reach criterion were judged a second time, together with 11 which had met criterion. Of these 11, 9 met criterion on rejudgement, and all of the other 11 statements were rejudged as they were the first time. However, the remaining two statements were not deleted from further study because the judges indicated that in both attempts at categorization, they could not decide between category 1 (Directed Interpersonal Risk Behavior) and category 2 (Defined Impulsive Behavior by Patient or Other). Accordingly, it was decided to place one in category 1 and to place the other in category 2. Excepting these two specialty cases, 46 of the 48 statements (95.8%) met criterion and were placed in one of the eight target categories.

Interrater reliability was also computed using the Kappa formula (Cohen, 1960; Tinsley & Weiss, 1975). This formula gives the proportion of agreement between two judges after the effects of chance agreement have been removed. For the two-fold division into 'target' and 'other' categories, interrater reliabilities for the pairs of judges ranged from .76 - .79; for the eight-fold division into the target categories, interrater reliabilities ranged from .70 - .75. On the basis of these results, interrater reliability was deemed adequate for the therapist categories.

Of secondary interest was the categorization of therapist statements occurring two and three statements prior to the occurrence of strong laughter, non-laughter, and other laughter. On the initial categorization, of the total of 240 therapist statements (120 occurring two before, and 120 occurring three before), 192 (80%) met or exceeded criterion. On rejudgement, all but 8 met criterion. However, it should be noted that all of the 8 remaining statements were again those which the judges indicated were either in categories 1 or 2. Accordingly, these 8 were proportionately assigned to one or the other of these two categories. Excepting these 8 statements, 232 of the 240 statements (96.6%) met or exceeded criterion.

Classification into the Hill Category System

Three judges categorized the 120 therapist statements immediately preceding the occurrence of strong laughter, non-laughter or other laughter. As indicated in Table 2, the Hill system includes 14 categories. On the initial judgement, 91 (75.8%) met or exceeded criterion. The remaining 29

Therapist	Number of Excerpts
A	12
B	11
C	9
D	8
E	5
F	5
G	4
H	2
I	2
J	2
Total: 10	60

Table 2. Distribution of 60 Strong Laughter Excerpts Over 10 Therapists

statements were rejudged together with a randomly intermixed group of 29 statements which had not met criterion on the initial judgement. Of these, all but 12 met criterion on the second judgement. However, of these 12, 9 were indicated by the judges as being either interpretation or reflection, and 3 were indicated by the judges as being either closed question or open question. Therefore it was decided to assign these to one of the pairs of categories on a proportional basis. Excepting these 12 statements, 108 of the 120 statements (90%) met or exceeded criterion.

Calculated in terms of the Kappa formula, interrater reliabilities for the pairs of judges ranged from .67 - .72, and were deemed adequate for the therapist categories.

The Main Hypothesis

In general, the question is whether identifiable kinds of therapist statements tend to precede patient strong laughter. Will these statements fall under a group of eight predicted categories suggested within the clinical, theoretical, and research literature as preceding patient strong laughter? Will these statements occur prior to strong laughter but not prior to 'other' laughter, or non-laughter patient events? It should be noted that the main hypothesis is designed to consider the eight predicted categories as a group. The particular frequency with which the eight categories occur independently will be discussed at a later point in this chapter.

It is hypothesized that a significantly higher number of the therapist statements falling under the eight expected categories will occur immediately antecedent to strong laughter, as compared with those which occur immediately antecedent to patient non-laughter and patient other-laughter.

As indicated in Table 3, of the 60 strong laughter events, 44 (73.3%) fell within the predicted eight categories as a group. Of the 30 non-laughter events only 1 (3.3%) fell in the predicted eight categories, and of the 30 other-laughter events only 3 (10%) fell in the predicted eight categories.

These data lend themselves to Chi-square analysis. A comparison of the frequencies of therapist statements falling in the group of eight predicted categories immediately preceding patient strong laughter, as compared with the frequency of therapist statements immediately preceding the non-laughter and other laughter events, yields a Chi-square of 55.6 ($df = 1$, $p < .001$). It seems a significnatly higher proportion (73.3%) of the therapist statements falling under the group of eight predicted categories occurred immediately antecedent to patient strong laughter, as compared with the proportion which occurred immediately antecedent to patient non-laughter (3.3%) and patient other-laughter (10%). The main hypothesis seems to be supported when therapist statements immediately antecedent to patient strong laughter are compared with those statements immediately antecedent to a pooled group of non-laughter and other-laughter patient events. Is the hypothesis similarly supported when the distribution of therapist statements immediately antecedent to patient strong laughter, is compared with that immediately antecedent to non-laughter, and also antecedent to other laughter, when non-laughter events and other-laughter events are considered separately?

When the strong laughter and non-laughter distributions are compared, the main hypothesis is likewise confirmed. A comparison of the frequency of therapist statements falling in the group of eight predicted categories immediately preceding strong laughter, as compared with the frequency of

therapist statements falling in the eight predicted categories immediately preceding non-laughter yields a Chi-square of 39.18 ($df = 1$, $p < .001$).

Finally, when the strong laughter and other-laughter distributions are compared, the main hypothesis is also confirmed. A comparison of the frequency of therapist statements falling in the eight predicted categories immediately preceding strong laughter, as compared with the frequency of therapist statements falling in the eight predicted categories immediately preceding other-laughter yields a Chi-square of 32.31 ($df = 1$, $p < .001$).

In general, the findings indicate that the main hypothesis is supported. The findings suggest that a significantly larger proportion of therapist statements in the eight predicted categories occurred antecedent to strong laughter as compared with those antecedent to non-laughter and other laughter. In this regard, instances of strong patient laughter seem to be somewhat singular events with respect to what therapists do immediately antecedent to their occurrence.

Additional Findings

While the main hypothesis seems to be supported, the findings provide additional data on related secondary issues.

A Closer Inspection of the Eight Predicted Categories Immediately Preceding Strong Laughter

Of the 44 instances of therapist statements falling in the eight predicted categories, there was an uneven distribution over the eight categories. Whereas an even distribution would yield 12.5% in each of the eight categories, a rank ordering of the eight categories, together with their proportion of the total of the 44 instances (Table 3) yields the following:

2. Defined Impulsive Behavior by Patient or Other (18.2%)
5. Carrying Out Risk Behavior As/For the Patient (18.2%)
7. Excited Reinforcement of Risk Behavior (18.2%)
3. Ridiculous Explanation-Description of Patient (15.9%)
8. Directed Risk Behavior Toward Therapist (15.9%)
1. Directed Interpersonal Risk Behavior (6.8%)
4. Instruction to Carry Out Affect-Laden Behavior with Heightened Intensity (6.8%)
6. Risked Being of Other Person or Entity (0.0%)

The first five categories above include 38 of the 44 therapist statements falling in the predicted categories. Categories 1 and 4 account for the remaining six statements.

The frequency of therapist statements falling in the first five categories may be compared against the frequency which may be expected on the basis of an even distribution of the 44 therapist statements across the eight categories. These data yield a Chi-square value of 10.68 ($df = 1$, $p < .01$). The expectation was that each of the eight categories would carry a fairly

Categories of Immediately Preceding Therapist Statements	Patient Event						
	Strong Laughter N = 60		Non Laughter N = 30		Other Laughter N = 30		Total N = 120
	f	%	f	%	f	%	f
1. Directed Interpersonal Risk Behavior	3	5	0	0	0	0	3
2. Defined Impulsive Behavior by Patient or Other.	8	13	1	3	1	3	10
3. Ridiculous Explanation-Description of Patient.	7	12	0	0	0	0	7
4. Instruction to Carry Out Affect Laden Behavior with Heightened Intensity.	3	5	0	0	0	0	3
5. Carrying Out Risk Behavior As/For Patient.	8	13	0	0	1	3	9
6. Risked Being of Other Person or Entity	0	0	0	0	0	0	0
7. Excited Reinforcement of Risked Behavior	8	13	0	0	1	3	9
8. Directed Risked Behavior Toward Therapist	7	12	0	0	0	0	7
9. All Other	16	27	29	97	27	90	72
Predicted Categories (sum of 1 to 8)	44	73	1	3	3	10	48
Total (sum of 9 to 10)	60	100	30	100	30	100	120

Table 3. Distribution of Therapist Statements Immediately Preceding Patient Strong Laughter, Non-Laughter, and Other-Laughter.

Note: f = raw frequency

even load of therapist statements immediately preceding patient strong laughter as opposed to non-laughter ans other-laughter. The findings indicate that five of the eight categories occurred more frequently than did the remaining three. However, categories 1 and 4, when they did occur, provided similar support for the main hypothesis in that they preceded strong laughter, but not non-laughter or other- laughter.

Therapist Statements Immediately Preceding Patient Strong Laughter, Non-Laughter, and Other-Laughter on the Basis of the Hill Category System

The main hypothesis was investigated in terms of the predicted eight categories. Setting these aside, and looking at the findings in terms of the Hill Category System, do the findings provide some indications of any of the Hill categories which seem to precede strong laughter as compared with non-laughter and other-laughter?

The data are given in Table 4. In terms of a Chi-square analysis of the findings, two of the Hill categories seem to occur with significantly higher frequency preceding strong laughter as compared with non-laughter and other-laughter. One of these is Hill's Other category for which the Chi-square value is 13.32 ($df = 1$, $p < .01$), and the second is Hill's Direct Guidance, for which the Chi-square value is 11.64 ($df=1$, $p < .02 > .01$). These are the only Hill categories which occur more frequently preceding strong laughter as compared with non-laughter and other-laughter.

While these two categories account for 55% of therapist statements occurring immediately antecedent to patient strong laughter, it should be noted that 33% of those statements fell within Hill's Other category. The Other category does not describe specific therapist behavior but instead

is used to 'catch' statements not accounted for by the other, more descriptive categories. While the categories of Other and Direct Guidance did occur more frequently immediately antecedent to strong laughter compared with non-laughter and other-laughter, only Direct Guidance is a category of actual therapist behavior.

Categories of Hill System	Patient Event						
	Strong Laughter N = 60		Non Laughter N = 30		Other Laughter N = 30		Total N = 120
	f	%	f	%	f	%	f
1. Minimal Encourager	3	5	1	3	1	3	5
2. Approval-Reassurance	10	17	1	3	3	10	14
3. Information	0	0	1	3	1	3	2
4. Direct Guidance	13	22	1	3	0	0	14
5. Closed Question	1	1	5	18	3	10	9
6. Open Question	0	0	1	3	2	7	3
7. Restatement	1	2	1	3	1	3	3
8. Reflection	1	2	3	10	3	10	7
9. Nonverbal Referent	0	0	0	0	0	0	0
10. Interpretation	10	17	11	37	11	37	32
11. Confrontation	1	1	2	7	4	14	7
12. Self-Disclosure	0	0	0	0	0	0	0
13. Other	20	33	3	10	1	3	24
Total	60	100	30	100	30	100	120

Table 4. Distribution of Therapist Statements Immediately Preceding Patient Strong Laughter, Non-Laughter, and Other-Laughter in the Hill Category System.

Note: f = raw frequency

Using the Hill Category System to provide a closer inspection of the therapist statements immediately preceding strong laughter and falling outside the eight predicted categories. Of the 60 therapist statements preceding strong laughter, 44 fell within the eight predicted categories and 16 fell outside these eight categories. Does the Hill System offer any cues to further description of these 16 therapist statements?

The findings are given in Table 5. With such low numbers distributed over 13 categories, the observed data do not lend themselves to statistical analysis. However, inspection suggests that the Hill System does not provide a particular category, or number of categories, which account for therapist statements falling outside the predicted categories. Four of the 16 statements fell within the 'other' category and thus were not described in terms of therapist verbal techniques by the Hill System. Given the extremely low numbers, and their respective distribution across the categories, it is possible to speculate the Hill categories of minimal encourager, interpretation, and approval-reassurance (accounting for 8 statements in total) may lean in the direction of describing some of the statements not identified by the target categories. However, given the low frequencies, such speculation remains quite equivocal.

Therapist Statements Occurring Two Before Instances of Strong Laughter, Non-Laughter, and Other Laughter

While the main hypothesis focused upon therapist statements immediately antecedent to instances of strong laughter, non-laughter, and other-laughter,

Categories of Hill System	Therapist Statements Immediately Antecedent to Strong Patient Laughter Falling Outside the Predicted Categories	
	f	%
1. Minimal Encourager	3	19
2. Approval-Reassurance	2	13
3. Information	0	0
4. Direct Guidance	0	0
5. Closed Question	1	6
6. Open Question	0	0
7. Restatement	1	6
8. Reflection	1	6
9. Nonverbal Referent	0	0
10. Interpretation	3	19
11. Confrontation	1	6
12. Self-Disclosure	0	0
13. Other	4	25
Total	16	100

Table 5. Distribution of Therapist Statements Immediately Antecedent to Strong Patient Laughter, Not Accounted for by the Target Categories, As Judged Within the Hill System

Note: f = raw frequency

the data allow some inspection of the role of therapist statements two before the target events. Inspection of these findings must acknowledge the stringent restriction that these therapist statements are not independent events. The design focused upon the immediately antecedent therapist statements only. There was no design control of earlier therapist statements, and there is no basis for sound conclusions about the role of earlier therapist statements. Nevertheless, some clues may be obtained about possible patternings and configurations of a series of therapist statements preceding strong laughter. These clues may be taken only as hints for more careful study.

The findings are given in Table 6. Of the 60 therapist statements occurring two statements before strong laughter, 22 fell in the predicted eight categories. Of the 30 therapist statements occurring two before non-laughter, none fell in the predicted categories, and of the 30 therapist statements occurring two statements before other-laughter, only 1 fell in the predicted eight categories. These findings yield a Chi-square value of 23.72 ($df = 1$, $p < .001$). It appears that even two statements before strong laughter, as compared with their occurrence two statements before non-laughter and other-laughter, the eight categories still occur with greater frequency.

Therapist Statements Occurring Three Before Instances of Strong Laughter, Non-Laughter, and Other-Laughter

While holding to the same limitations and restrictions described in the preceding section, the findings allow an inspection of therapist statements

Categories of Second Therapist Statement Antecedent to Patient Event	Patient Event						
	Strong Laughter N = 60		Non Laughter N = 30		Other Laughter N = 30		Total N = 120
	f	%	f	%	f	%	f
1. Directed Interpersonal Risk Behavior	2	3	0	0	0	0	2
2. Defined Impulsive Behavior by Patient or Other.	3	5	0	0	1	2	4
3. Ridiculous Explanation-Description of Patient.	2	3	0	0	0	0	2
4. Instruction to Carry Out Affect Laden Behavior with Heightened Intensity.	3	5	0	0	0	0	3
5. Carrying Out Risk Behavior As/For Patient.	6	10	0	0	0	0	6
6. Risked Being of Other Person or Entity	1	2	0	0	0	0	1
7. Excited Reinforcement of Risked Behavior	3	5	0	0	0	0	3
8. Directed Risked Behavior Toward Therapist	2	3	0	0	0	0	2
9. All Other	38	63	30	100	29	98	97
Predicted Categories (sum of 1 to 8)	22	37	0	0	1	2	23
Total (sum of 9 and 10)	60	100	30	100	30	100	120

Table 6. Distribution of Therapist Statements Occurring Two Statements Before Patient Strong Laughter, Non-Laughter and Other-Laughter.

Note: f = raw frequency

occurring three before instances of strong laughter, non-laughter, and other-laughter.

The data are given in Table 7, and are quite similar to those for therapist statements occurring two statements before the patient events.

Of the 60 therapist statements occurring three statements before strong laughter, 23 fell into the predicted eight categories. Of the 30 therapist statements occurring three statements before non-laughter, only one fell within the predicted eight categories, and of the 30 therapist statements occurring three statements before other-laughter, none fell in the predicted eight categories. These findings yield a Chi-square value of 25.2 ($df = 1$, $p < .001$). Even three statements before, the predicted categories appear to be potent; that is, the proportion of therapist statements falling in the eight predicted categories is significantly higher preceding instances of strong laughter as compared with instances of non-laughter and other-laughter.

Therapist Statements Occurring One, Two, and Three Statements Before Instances of Strong Patient Laughter

The question is whether there are significant differences in the frequency of therapist statements falling in the eight predicted categories one, two, and three statements before the 60 instances of patient strong laughter. The data are given in Tables 3, 6, and 7. One statement before strong laughter, 44 therapist statements fell within the eight predicted categories, and 16 fell in the all other category; two statements before, 22 therapist statements fell in the eight predicted categories and 38 fell in the

Categories of Third Therapist Statement Antecedent to Patient Event	Patient Event: Strong Laughter N = 60		Non Laughter N = 30		Other Laughter N = 30		Total N = 120
	f	%	f	%	f	%	f
1. Directed Interpersonal Risk Behavior	3	5	0	0	0	0	3
2. Defined Impulsive Behavior by Patient or Other.	2	3	0	0	0	0	2
3. Ridiculous Explanation-Description of Patient.	5	8	0	0	0	0	5
4. Instruction to Carry Out Affect Laden Behavior with Heightened Intensity	6	10	0	0	0	0	6
5. Carrying Out Risk Behavior As/For Patient.	2	3	1	3	0	0	3
6. Risked Being of Other Person or Entity	1	2	0	0	0	0	1
7. Excited Reinforcement of Risked Behavior	1	2	0	0	0	0	1
8. Directed Risked Behavior Toward Therapist	3	5	0	0	0	0	3
9. All Other	37	62	29	97	30	100	96
Predicted Categories (sum of 1 to 8)	23	38	1	3	0	0	24
Total (sum of 9 and 10)	60	100	30	100	30	100	120

Table 7. Distribution of Therapist Statements Occurring Three Statements Before Patient Strong Laughter, Non-Laughter and Other-Laughter.

Note: f = raw frequency

all other category; three statements before, 23 therapist statements fell in the eight predicted categories and 37 in the all other category. These data yield a Chi-square value of 20.55 ($df = 1$, $p < .001$). It seems warranted to speculate that, while the eight categories are 'potent' one, two, and three statements before strong patient laughter as compared with statements occurring prior to non-laughter and other-laughter, there are significant differences between these distributions prior to strong laughter. Speculatively, use of the eight predicted categories is more "potent" immediately antecedent to the strong laughter as compared with two and three statements before.

Therapist Statements Preceding Strong Patient Laughter: The Eight Predicted Categories as a Group, Singly, and Sequentially

Findings in regard to the main hypothesis indicate a significantly higher proportion of therapist statements falling under the eight predicted categories occurred immediately antecedent to strong patient laughter, as compared with the proportion occurring immediately antecedent to patient non-laughter and patient other-laughter. With regard to therapist statements preceding strong patient laughter, it appears the eight predicted categories as a group may precede this kind of laughter. In addition, under the stringent restrictions and limitations given earlier, the findings provide a basis for speculations which may be followed as hypotheses in further research. The data are summarized in Table 8.

Categories of Therapist Statements	Statements Antecedent to Patient Strong Laughter						
	One Before N = 60		Two Before N = 60		Three Before N = 60		Total N = 180
	f	%	f	%	f	%	f
1. Directed Interpersonal Risk Behavior	3	5	2	3	3	5	8
2. Defined Impulsive Behavior by Patient or Other	8	13	3	5	2	3	13
3. Ridiculous Explanation-Description of Patient	7	12	2	3	5	8	14
4. Instruction to Carry Out Affect Laden Behavior with Heughtened Intensity	3	5	3	5	6	10	12
5. Carrying Out Risk Behavior As/For Patient	8	13	6	10	2	3	16
6. Risked Being of Other Person or Entity	0	0	1	2	1	2	2
7. Excited Reinforcement of Risked Behavior	8	13	3	5	1	2	12
8. Directed Risked Behavior Toward Therapist	7	12	2	3	3	5	12
9. All Other	16	27	38	63	37	62	91
Predicted Categories (sum of 1 to 8)	44	73	22	37	23	38	89
Total (sum of 9 and 10)	60	100	60	100	60	100	180

Table 8. Distribution of the Eight Target Categories Occurring One, Two, and Three Statements Before Patient Strong Laughter

Note: f = raw frequency

A closer inspection of each of the eight predicted categories suggests that five carry the higher load in terms of immediately preceding strong laughter. These categories are 2, 3, 5, 7, and 8 (Table 8).

In regard to two statements before the strong laughter, it appears that only category 5 (Carrying Out Risk-Behavior As/For Patient) seems to be followed (two statements later) by the strong laughter. A comparison of the frequency of therapist statements falling in this category and those falling in the other seven of the predicted eight categories yields a Chi-square value of 4.39 ($df = 1$, $p < .05 > .01$).

In regard to three statements before the strong laughter, it appears that category 4 (Instruction to Carry-Out Affect Laden Behavior with Heightened Intensity) and Category 3 (Ridiculous Explanation-Description of Patient) seem to be followed (three statements later) by strong laughter. A comparison of the frequency of therapist statements falling in category 4 and those falling in the other seven of the predicted eight categories yields a Chi-square value of 3.84 ($df = 1$, $p < .05$). However, a comparison of the frequency of therapist statements falling in category 3 and those falling in the other seven of the predicted eight categories yields a Chi-square value of only 1.80 ($df = 1$, $p < .20 > .10$).

While for immediately antecedent therapist statements, 44 of the 60 instances of strong laughter fell in the eight predicted categories, only 22 occurred two statements earlier and only 23 occurred three statements earlier. In terms of the therapist statements which precede strong laughter, the findings suggest that immediately before the strong laughing the predominance of therapist statements fell into the predicted eight categories. On the other

hand, the findings suggest that for two and three statements before the strong laughter, many of the therapist statements fall outside the eight predicted categories.

Chapter IV

DISCUSSION AND CONCLUSIONS

The purpose of the present chapter is to discuss a number of topics in the light of the findings reported in the previous chapter, and to culminate in a series of conclusions. Most of these topics have been raised in earlier chapters. The remaining may be understood as further implications in the light of the findings and the research itself.

The Therapeutic Facilitation of Strong Patient Laughter

Perhaps the central thrust of the research was to examine categories of therapist statements which precede strong laughter. From the perspective of the working psychotherapist, the larger issue is that of facilitating the occurrence of strong laughter. There are a number of discussion points which relate to this linkage between therapeutic operations and strong patient laughter.

Some examples of therapist statements preceding strong laughter. It appears that strong hearty laughter is preceded by categories of therapist statements which are distinctive to this kind of laughter. That is, a distinctive set of categories of therapist statements seems to be linked to the subsequent occurrence of strong laughter. These categories of therapist statements seem to occur significantly less often preceding either non-laughter or other than strong, hearty, laughter.

Some examples are in order to provide concrete illustrations of therapist statements preceding these instances. Organized under each of the categories which were supported by the findings, the verbatim dialogue was taken from the actual data. However, it must be noted that changes were taken to insure confidentiality of both patient and therapist, as well as any other referred-to individual in the original tapes.

Category 1. Directed Interpersonal Risk Behavior.

P: We all played the game very well. We all made our own adjustments around this phenomenal father figure.

T: It's your fault, all of you. You played into it.

P: And I loved my daddy!

T: But not for what you've been describing.

P: No, I couldn't see that at all. And I was scared, scared of him. I had to, I had to please him. He was important.

T: Okay, okay. Now I want you to do one more thing. You're afraid that he's right, that you really are unimportant, and that he has a real basis for not being interested in you. That you are bad and that you should know better and that you're really not important and you really are foolish. Look at him and this time don't fight it. Tell him he's right. Tell him you are absolutely unimportant and nothing you say has any import. Tell him your ideas are stupid!

strong patient laughter

Category 2. Defined Impulsive Behavior by Patient or Other.

P: Um, we've gotten really close over her illness. We've had some really good sharing and uh, it's better. You know, I was able to, I was forced out of my routine, you know, paying attention to my job. I really had to. So we really had some good times.

T: So she was able to use that to get a little attention from the old man?

P: Yeah.

T: Good thinking on her part. It's probably the only thing that would have done it.

P: You're right.

T: She probably knew a mere ulcer wouldn't do it, but an ovarian tumor might!

strong patient laughter

P: I felt closed in on when you hugged me.

T: You felt closed in on?

P: Yeah. I, I was more aware of being uncomfortable than pissed. I mean I didn't have any kind of violent fantasy, ah, angry stuff. It was more like, gee, I'm uncomfortable, I'm not ready for this and it seemed, it felt ritualistic to me. That's how ... it felt that way to me. Ritualistic is not a feeling word. It felt closed in and I'm not, I guess, threatening, and I don't know. I didn't like it. I'd like to be able to do some touching. But touching doesn't feel like a problem. Um, and I don't want to lose some caution about that. I don't want to lose some caution about that.

T: You don't want to go around hugging people just helter skelter.

P: No. I don't. I don't.

T: Would that happen if we loosened up your asshole!!! You'd just go around hugging people all through the day!

P: (strong laughter) You can never be too careful.

Category 3. Ridiculous Explanation/Description of Patient.

P: Yeah. There are a few good things about me. I'm handy around the house. I can fix things and, uh, my kids enjoy me.

T: And you help people out. (teasing) Why just last week you were binding cookbooks for charity.

P: Yeah. I smoke meat for charity too. I'm doing that tomorrow.

T: You're smoking meat?!!!

P: (very quietly) Yeah.

T: (jocular, playful) So you're a kind, helpful, reverent, loving, sweet good person?

P: Cheerful, thrifty, obedient, reverent, shit! (strong laughing) A scout!

P: I want more, but I don't even know what I want. (mild crying, long pause).

T: Your feeling level is flat. No real feelings. Just a little bit of crying and then you stop. Well, about the only thing you're good at is silence.

P: (softly) Yeah. I'm good at silence.

T: And stopping your feelings from coming.

P: Yeah. I'm good at stopping.

T: Stopping is the best thing you do! It's as if you hold yourself in tight rein. (playful, teasing) When you grow up, you know what you're gonna be? A corset! An old, ugly cream colored corset!

strong patient laughter

P: (barely audible) It doesn't hurt as much (long pause) I want to (long pause, clears throat)

T: What's your thought? Say more.

P: About going to Boston. (pause) I'd rather stay here (softly) and spend some time with her...

T: (softly) Which is there now ... her or Boston?

P: Boston. Feels like ... In some ways Boston, in some ways not. (pause) I hope I, I guess I'm afraid, worried, worried about me making too big a thing of what's going on with her. My own loneliness, just finding someone and latching on. You know what I mean?

T: I know what you mean. I haven't seen you having alot of problems with that before. You know that? I haven't said (exaggerated) "Here's a guy who goes around hanging onto people in absurd, ridiculous ways, makes a fool of himself, hanging on long past the time they've stopped caring for him!" I never noticed you doing that!!

strong patient laughter

Category 4. Instruction to Carry Out Affect Laden Behavior with Heightened Intensity.

P: You know, it really makes me mad. Day in and day out, it's always the same boring routine. I get up, I make breakfast, I eat breakfast, I buy the paper. I go to work. God! Is it ever dull.

T: Okay. I want you to hit this pillow and say, 'God. I hate this. It's so boring!

P: What?

T: Go ahead. Hit the pillow and say over and over, "God. I hate this. It's so boring!"

P: I hate this. I really hate this. It is so boring. I really hate it. It's boring!

T: Good. Now hit harder and really yell loud.

P: (yelling) I goddamn hate this! I'm bored!!!

strong patient laughter

Category 5. Carrying Out Risk Behavior As/For Patient.

P: (hesitantly) What would I make him do? Well, ah ... he can eat my cooking and like it and he can take those disgusting posters off his door. I don't care what he does inside his

room but he's not gonna show those posters on the outside of the door. And he can come home from school and he can make himself useful and he can do his homework and go to his room like any normal teenager ... And uh, he can stay out of my living room! (pause) (mildly sad) I could never say that to him.

T: (exaggerated, expansive tone) I mean that's going a little too far!

P: Yeah. It was. I'd go hide in my room ... because he was in the living room watching T.V. That's it!

T: That's what?

P: It's my T.V. He can ah, uh ...

T: (yells as patient) Look out you 16 year old turkey! It's my T.V. and it's my living room and you're driving me crazy! Out! Now!

strong patient laughter

P: Well gee, I guess you'd only know if I'd met that goal if I told you.

T: What would you tell me? You'd come in here one day and say ...

P: Uh, Meg. Guess what? ... I'm not real clear on this. It, it goes down to sexual stuff. I mean I'm a better lover than I am loved in, in making love to.

T: So what would you say?

P: I could say, uh ... (pause)

T: (as patient) Uh Meg. I'm an inadequate little turd, compared to this person I'm with!!!

strong patient laughter

Category 7. Excited Reinforcement of Risked Behavior.

P: I didn't get any good shots off, no, Monday was, was over the shooting off. We both talked very sanely about things. But ah, he was sick last weekend, like Saturday, I got up

and I, breakfast in bed. I worked my tail off. He didn't do a thing all day. He laid in bed all day and got up, went to a movie, came back, and went back to bed and uh, I worked the whole time, fed the kids, finished working on a project, cleaned the basement. I went to bed, the kids woke up at 6 a.m. I was going to get up with them, I just delayed it for an extra minute. I just closed my eyes and then he got up. I woke up at 9:30. He's yelling and screaming at the kids. Oh, they were crying and everything. I went downstairs, what's the matter? He said, well you give me one day off and then you make me get up and work again. (pause) I'd just climbed out of bed!

T: So you wake up. He's screaming and yelling at the kids.

P: Oh I got it all out. 'Cause I screamed.

T: (delighted, astonished) Right then and there???

P: Right then and there

T: Well good for you!!! What did you say?

P: I said I just got up. (raises voice) I just got myself out of bed! What are you ... tell me what happened! Don't yell at me! Then he said I had bad breath. For Chris' sakes, I'd just gotten out of bed! So I went over to him and went hah! (makes huge exhaling, blowing sound and laughs heartily).

P: So now I'm trying to bring being separated into perspective, trying to make new friends, a new city, a new house, trying to think single. I'm, boy. I get up in the morning and I hurt all over and I say gotta hit it, gotta go do it. So I'm pushing myself to do things.

T: Now, as I remember you told me last week you had some suicidal thoughts. Where are you with that?

P: Na, that wouldn't happen now ...

T: Feel better now?

P: Yeah. Killing myself for him would be ridiculous. (pause) Killing him may not be ridiculous.

T: A step to mental health!! Homicidal thoughts but not suicidal thoughts!

strong patient laughter

P: Yeah and then we had the fight.

T: Yeah. Now in that fight did you really, was it a real fight?

P: Oh really. We were both screaming and did he ... he must have hit me first. Yeah, he did. And that's what got me really furious. That he hit me.

T: Now if we were going to watch you in that fight, how close did you come to becoming violent, physical, doing something?

P: Uh, oh ... well, I hit him hard. Yes.

T: (absolutely delighted) Oh God! You sound really happy.

strong patient laughter

Category 8. Directed Risked Behavior Towards Therapist.

P: Look, yes, no, whatever you say. Maybe it was a big sweat, maybe it was a little sweat.

T: Is there something you need to say to me?

P: What?

T: I don't know. Do you have something you need to say to me? I'm feel, this is feeling like you're sitting there with your arms crossed answering my questions as though it's my therapy instead of your therapy. So you're looking like you want, maybe have some angry feelings towards me or some kind of unfinished business with me.

P: No, I wasn't even thinking of you. I was thinking (pause) ...

T: Tell me, 'I wasn't even thinking you, how pissed off I am at you'.

strong patient laughter

P: Maybe so. You're saying I should just enjoy it a bit, just keep going, well ...

T: I didn't say anything of the sort! I don't have any special knowledge about that. What I hear you do is evaluate, evaluate, evaluate and everything's coming up short. Your job, Vivian, your last lecture. You're evaluating yourself and you're coming up short.

P: I don't feel people any other way.

T: Than to evaluate them?

P: Yeah. But I never ...

T: (firmly) Evaluate me right now!

strong patient laughter

P: Do you want me to verbalize while I'm hitting the pillow?

T: Doesn't matter. If you want to just hit, that's fine. What sometimes is useful is to hit and let out a sound that isn't a word. Just 'ugh' or something.

P: That's also hard for me to do.

T: Give it a try.

P: I feel silly. Sure. I guess I'm not the only person who's ever said that. (begins hitting) You know what I do do though? Off with your head. That's David and that's Rick, and that's my father and sometimes it's even Ray, even though I love Ray ... (T is holding pillow which patient is hitting) (pause) ... I'm gonna hurt you.

T: (matter of fact tone) Naa. Aim right at my balls. It won't hurt.

strong patient laughter

A provisional common theme and some implications for the facilitation of strong laughter. Given a closer look at some examples of the kinds of statements which seemed to precede strong laughter, it is inviting to examine the several categories of therapist statements which tend to precede this kind of patient laughter. If these categories are studied for themes and

commonalities, one way of organizing the findings may be framed as follows: Strong hearty laughter may occur when therapists carry forward patients' tendencies to engage in behavior which is risky: tabooed, exciting impulsive, threat-filled, wicked, unusual, acted-out, ordinarily blocked or defended against. Therapists carry forward this behavior by such means as carrying it out as or for the patient, defining it as being carried out by the patient or a significant other, directing-instructing-encouraging the patient to carry it out.

Given this provisional commonality of risky behavior, a somewhat more careful set of prescriptions may be framed for how therapists may facilitate the occurrence of strong laughter. On the basis of the categories revealed by the findings, and taking into account the common supposed theme of risky behavior, it is proposed that strong laughter is facilitated when therapists:

- Are cordial toward picturing (seeing, allowing the possibility of, framing, defining, imagining) concrete behaviors which are risky (tabooed, exciting, wicked, impulsive, threat-filled, unusual, acted-out). This seems to go well beyond that of mere acceptance, and to include a more active cognitive-imaginal component.

- Bring the client closer to the risky behaviors by such means as defining them in concrete specificity, or carrying them out in the therapy session either as model-exemplar or in interaction between client and therapist.

- Accompany their statements and operations with feelings of enjoyment, playfulness, buoyancy, lightness, and spontaneity.

In view of this provisional common theme, some sense may be made of the three categories of therapist statements which were less supported by the findings. One was "directed interpersonal risk behavior" (e.g., Downing & Marmorstein, 1973; Shorr, 1972) in which the therapist directs (tells, instructs) the patient to carry out a risky behavior. This one fell somewhat short of significance in the main findings. A second was "risked being of other person or entity" (e.g., Jackins, 1965; Malamud, 1976; Perls, 1970) in which the therapist, in Gestalt fashion, directs the patient to "be" (speak as, function from within the role of) another person or entity. This one rather clearly was excluded from the main findings, and did not appear with any substantive frequency under inspection of two or three statements prior to the strong laughter. The third was "instruction to carry out affect-laden behavior with heightened intensity" in which the therapist typically tells the patient to repeat the behavior, action, or statement, and to do so with heightened feeling, energy, and affect (e.g., Bugental, 1979; Downing & Marmorstein, 1973; Jackins, 1965; Polster & Polster, 1976). While this category was not included among those which immediately preceded strong laughter, further inspection suggested that it seemed to be used substantially three statements before the strong laughter.

It may be that these three categories do immediately precede patient strong laughter, but simply were not part of the verbal techniques used by the therapists in the present investigation. An alternative possibility is that these three categories, as compared with those categories which were confirmed in the main findings, all seem to lack the risk-behavior component. That is, in none of these is the client engaging in or carrying forward some risky

behavior. In one, the client is directed to carry out an interpersonal risk behavior, but there is little or no here-and-now immediacy. The Gestalt being of another person or entity does not typically include the engaging in or carrying out of an explicit risk behavior. Instruction to carry out an affect-laden behavior with heightened intensity likewise emphasizes a feelinged-behavior rather than one which is risky. On balance, there seems to be some provisional basis for understanding that these three categories may fall outside those which preceded strong laughter, in the light of the main findings at least.

The issue of configurational patterns of antecedent statements. In addition to the issue of common themes across the categories of therapist statements immediately preceding strong laughter, there is the perhaps larger issue of configurational patterns. Are there patterns and configurations of therapist (and patient) statements which are effectively linked to the occurrence of strong hearty laughter? The present research seems to indicate that therapist statements may be linked to the occurrence of strong laughter when the focus is on two and three therapist statements before the strong laughter. However, the design shed little light on patterns or configurations of therapist statements, nor was there any inclusion of antecedent patient statements. It seems quite likely that a number of patterns, perhaps starting two or three or more statements before the strong laughter, may be linked with the occurrence of the strong laughter. While the findings themselves are only lightly suggestive, the issue of configurational patterns seems to be raised as a most interesting likelihood. This shall be discussed in more detail later in the present chapter.

Implications for practice of cordial therapeutic approaches. Whether or not the critical components lie in specific therapeutic operations or configurational patternings, the findings suggest that several categories of therapist operations are linked to the occurrence of strong laughter. However, it is recognized that not all therapeutic approaches regard this event as welcomed and desirable, and therefore the findings have little or no implications for their actual practice. Nevertheless, as indicated in the opening chapter, a wide variety of therapeutic approaches hold the occurrence of strong hearty laughter as a welcomed and desirable event. Accordingly, the findings provide some basis for complementing or supplementing their ordinary therapeutic methods to include those identified in the present study as linked to the subsequent occurrence of this event. Pertinent here are at least the following approaches: direct decision therapy, Gestalt therapy, provocative therapy, Adlerian therapy, interpersonal therapy, natural high therapy, personal construct therapy, logotherapy, feeling-expressive therapy, Daseins therapy, Daseinsanalysis, existential therapy, existential analysis, humanistic therapy, intense feeling therapy, holistic therapy, psycho-imagination therapy, encounter therapy, bioenergetics therapy, cathartic therapy, crisis mobilization therapy, phenomenological therapy, emotional flooding therapy, client-centered therapy, implosive therapy, primal therapy, focusing-experiential therapy, re-evaluation counselling, and some schools of psychoanalytic therapy.

Therapeutic conditions under which the designated therapist categories may be used. Regardless of which, or how many, therapeutic approaches use the designated categories for bringing about strong laughter, the pragmatic

question arises: Under what therapeutic conditions may the designated categories be used effectively? Although it seems clear that the categories would not be used haphazardly or without consideration, the present study did not address this question. For the practical psychotherapist, the present study designated the possible use of certain categories while providing no clues as to the therapeutic conditions under which they may be used. However, a few soft hints may be gathered from the findings.

By far the major hint is that the patient is in the vicinity of material which is risky. That is, the immediate therapeutic material would seem to be characterized by anxiety and threat, by wickedness and devilishness, by unusualness and outlandishness, by impulsiveness and excitement.

The second hint is that the material lend itself to what may be termed "behavioralizing". That is, what is risky includes the possibility of carrying out some actual behavior as opposed, for example, to material which is largely cognitive, conceptual, intellectual. Combining these two hints, the proposition is that strong laughter may be facilitated especially under therapeutic conditions when the patient is in the near vicinity of material which is risky and which lends itself to occurrence as concrete behaviors.

The role of humor. The findings do not seem to lend much support to the proposition that strong laughter occurs as a consequence of such humorous techniques as joke-telling, witty remarks, set stories, funny homilies, or clever one-liners (cf., Ansell et al., 1981; Ellis, 1981; Farrelly & Brandsma, 1974; Harman, 1981; Narboe, 1981). In short, the therapist does not seem to be a sheer comedian. Of the 60 instances of strong laughter, 44 seemed to fall into therapist categories other than those of humorous or comical techniques,

nor is there any evidence that the remaining 16 therapist statement were of this nature. On the other hand, the study was not designed explicitly to investigate such techniques, and therefore the weak role of such techniques must be considered as more of an impression than a conclusion.

Nevertheless, both the findings themselves and the soft impressions of the investigator (in listening to the audiotapes of the strong laughter excerpts) seem to corroborate the presence of what may be termed a generally humorous life outlook, a kind of light spontaneity, an appreciation of the absurd, the comic, the ridiculous (Ansell et al., 1981; Farrelly & Brandsma, 1974; Greenwald, 1975, 1976; Mindess, 1971, 1976). Indeed, these qualities seem to be components of the definitions of most of the predicted eight categories, and although perhaps not in the usual meaning of humor, may be taken as a characteristic theme in the therapist categories preceding strong laughter. This point will be further discussed elsewhere in this chapter.

The Nature of Therapeutically Valued Strong Laughter

A rather large number of therapeutic approaches hold that strong laughter is to be regarded as therapeutically valued, as a welcomed and desirable event. Yet the nature of this event is essentially unknown in terms of research investigation within the context of psychotherapy. Do the findings of the present study shed any impressionistic light on the nature of this event?

Strong laughter and risk-behavior: a provisional hypothesis. It is rather singular that a patient is proceeding along without any laughter

whatsoever, and then starts to engage in strong hearty laughter. One way of seeking to understand this event is to obtain cues from the nature and content of the therapist statements which seem to precede the strong laughter.

Inspection of the categories which appeared to antecede the strong laughter suggests at least one common theme across these categories. Whether the therapist defines it, directs the patient to do it, responds and reacts to it, or carries it out his or her self, one common theme is actual, concrete, immediate, idiosyncratic behavior which is risky: tabooed, impulsive, threat-filled, wicked, unusual, acted-out, ordinarily blocked or defended against. It is as if the patient is essentially carrying out or participating in such risky behavior. The findings lend some support to an interpretation of strong laughter as a reaction to or concomitant of the essential carrying out of risky behavior.

This hypothesis may be in accord with the conceptualization of strong laughter as a shift in the client's self-perspective. Clinical theorists hold that the strong laughter may be an index of a therapeutically desirable shift in the patient's self perspective (e.g., Greenwald, 1975; Kris, 1940; Mindess, 1976; O'Connell, 1981; Poland, 1971; Reik, 1964; Shaw, 1960; Sullivan, 1954; Viney, 1981). They speak of the shift being in the patient's way of perceiving, thinking about, relating to their selves, attitudes toward life, symptoms and problems, interpersonal relations, personal constructs, and so on. Psychoanalytic theorists go a step further in suggesting that the shift in the self perspective is predominantly in regard to the patient's perhaps deeper acceptance of the nature of an interpretation which is presumed to

precede the hearty laughter (Freud, 1960; Grotjahn, 1966, 1970; Poland, 1971; Rose, 1969).

If strong laughter is understood as an index of a therapeutically desirable shift in the patient's self-perspective, the "risky behavior" hypothesis may provide some basis for illuminating the nature of this presumed change. To begin with, the findings seemed to provide little support for the place of interpretations, at least with regard to interpretations in general, and in terms of the immediately antecedent therapist statement. However, the findings do allow some speculation that a shift in self-perspective may be occurring in the patient's relationship with behaviors which are risky (wicked, impulsive, unusual, acted-out). It is as if the patient is closer to the possibility of engaging or participating in these behaviors. This shifted perspective in regard to these behaviors may be accompanied with undisclosed kinds of feelings. While not necessarily signifying a shift toward acceptance, it is likely that the patient is closer to the sheer possibility of engaging in the risk-behavior.

According to another group of clinical theorists, the therapeutic value of the strong laughter lies in the presumption that the patient is in some kind of state of heightened feeling-expression or experiencing (e.g., Harman, 1981; Jackins, 1965; Mahrer, 1978, 1983; Nichols & Zax, 1977; Olsen, 1976; Perls, 1970). Does a risk-behavior hypothesis help to account for this welcomed and desirable therapeutic change-state? There are no direct and straightforward bases for inferences. However, some soft and indirect hints may be taken from the nature of the therapist statements which the findings indicate precede the strong laughter. On that basis it may be speculated that

in the concomitant vicinity of the strong laughter the patients indeed may be undergoing a change in which they are engaging or participating in risk-behavior (unusual, tabooed, threatening, wicked, not ordinarily considered or acted out). In this sense, patients are not only undergoing heightened feeling-expression or experiencing, but may be undergoing a therapeutically welcomed and desirable state of engaging or participating in risky behaviors. All in all, the risk-behavior hypothesis seems to have some merit in helping to understand the nature of strong laughter as a therapeutically valued event.

Risk-behavior and the deeper nature of strong laughter as a positive in-therapy event. Some clinical theorists regard strong laughter as therapeutically inert or confounding, perhaps even dangerous (e.g., Levine, 1976; Noyes & Kolb, 1963). Of the remainder, some regard strong laughter as significant mainly on the basis of the supposed consequences later in therapy or outside of therapy, and some hold to the view that therapeutic value lies in the event itself, as an event exemplifying therapeutic change, as a welcomed and desirable outcome of therapeutic process in and of itself (e.g., Ansell et al., 1981; Bugental, 1979; Greenwald, 1975; Grotjahn, 1966; Harman, 1981; Levine, 1976; Nichols, 1974; O'Connell, 1981; Olsen, 1976; Perls, 1970; Polster & Polster, 1976; Yassky, 1976).

The bulk of the theorizing about what makes this event so welcomed and desirable in and of itself, rather than by pointing to subsequent events, may be summarized as follows. (a) It constitutes a shift in self-concept and self-perspective. (b) It represents the expression of strong feeling and strong experiencing which, at least in part, is held as constituting both a

welcomed and desired change-event and an index of positive functioning, of good adjustment, of a valued goal-state. But these are rather large classes of characteristics, and disclose little of the deeper nature of the strong laughter itself. On the basis of the findings of the present study, and guided by the aforementioned hypothesis about the theme of risk-behavior, it is possible to entertain some further inferences or speculations about the deeper nature of such strong laughter in psychotherapy. It should be noted that these inferences or speculations may be considered extensions of the current theorizing about the issue of what makes strong laughter welcomed and desirable.

First, there does seem to be a shift in self-concept or self-perspective. It is speculated that the nature of this shift is into a state of welcoming, accepting, and having good feelings toward one's own tendencies (proclivities, readinesses) for the risk behavior. The picture seems to be one of having a much better relationship toward behaviors which ordinarily are avoided, blocked off, run from, sealed off, seen as dangerous and threatening. Momentarily at least, during the strong laughter event, it is speculated that the state has shifted toward that of acceptance and welcoming of behaviors which take on a relationship in which they are no longer pushed away, defended against, avoided. For the moment, at least, they are related to as risky but wicked, devilish, exciting, titillating. In other words, they are momentarily welcomed and accepted. The proposition is that this is the more specific and deeper nature of what has been described as a shift in self-concept or self-perspective.

Second, not only is the client welcoming and accepting of these risky behaviors, but the client is virtually engaging in their actual expression. More than merely expressing strong feeling, it is speculated that the client is virtually engaging in the actual behaviors which are risky, tabooed, sealed off. In essence, the client is engaging in actual new behaviors which, for the moment of strong laughter at least, are welcomed and accepted by the client.

It would seem to be the therapist operations which bring the client into the state of engaging in this special class of risk behaviors. Each of the designated categories has its own way of engaging the client in the risk behavior. The most direct, perhaps, is when the therapist responds to the client's actual expression of the risk behavior with excited reinforcement; it is likely that the nature of this therapist response also adds to the defining of the antecedent client behavior as risky and worthy of such excited praise. Also, the therapist seems to be deftly skilled in defining risk-behavior as if it were being carried out by the client. The client and the risk-behavior are brought together by the therapist's imagination and verbal description of the concrete risk-behavior. In addition, the therapist carries out the risk-behavior, but this is done as if the therapist were being the client in carrying out the behavior. In directing the client to carry out the risk behavior here and now toward the therapist, there is both a defined specificity and an experiential immediacy to the client's engagement in the risk-behavior. Finally, in the ridiculous explanation-description of the client, the therapist is surrounding the client with two engagements in risk-behavior. In one, the therapist is defining (seeing, describing,

regarding) the client as a burlesqued, caricatured individual for whom such risk-behaviors are part and parcel of the image. In another, in so defining the client in this way, the therapist is carrying out a risk-behavior of describing (accusing, challenging) another person in a way which is wild, far-fetched, outlandish.

All in all, the speculated proposition is that the above two features provide further understanding of the deeper nature of strong laughter for those theories which regard strong laughter as itself a valuable therapeutic change-event.

Strong laughter vs. other langhter. The findings lend support to a sharp and substantive distinction between laughter which occurs as a discrete event, which is strong and hearty and, on the other hand, laughter which may occur as other laughter, including laughter which is more or less characteristic of the client, and which may be milder. This latter kind of laughter is regarded by some clinical theorists as pathognomonic of psychological disturbance (DSM-III, 1980; Levine, 1976; Noyes & Kolb, 1963), and, accordingly, is less regarded as a welcomed and desirable therapeutic event (Ansell, Mindess, Stern, & Stern, 1981; Kubie, 1971; Levine, 1976; Paul, 1978; Polster & Polster, 1976). In this connection, it is perhaps interesting that virtually none of the eight predicted categories occurred antecedent to this latter kind of other laughter.

Some Programmatic Lines of Research Inquiry

The present study was not an isolated or discrete investigation. It was, in large measure, conceived within the context of both psychotherapy research teams of the School of Psychology at the University of Ottawa, and it is the investigator's intention to continue research on psychotherapy. Accordingly, it is quite germane to the investigator's research interests to discuss some programmatic lines of reserach inquiry.

Extension and verification. The two studies relating to therapist operations and patient strong laughter (Nichols, 1974; Nichols & Bierenbaum, 1978) used therapists employing techniques from Jackins' (1965) reevaluation counselling. Two of the major methods used by these therapists were instruction to repeat affect-laden behavior with heightened intensity, and risked being of the other person or entity. Interestingly, these two methods were not among those which emerged as significant in the main findings. Yet the present findings stand virtually alone in terms of providing data on the methods which seem to precede strong laughter. It is not the present investigator's intention to extend and to verify the findings of the study, largely because the present study used up the resources of the research library or data bank of strong laughing excerpts available at the School of Psychology of the University of Ottawa, and also because it is of greater interest to pursue other lines of research inquiry to be discussed in the present section. However, it seems important to extend and to verify these findings on a larger sample, and perhaps on a sample of additional therapists and clients representing other approaches and characteristics.

In extending and verifying the findings, it would seem possible but difficult to use an analogue format in examining the extent to which

particular categories of therapist statements were followed by strong laughter. This might seem to be one next step in research on what facilitates the strong laughter. The hypothesis might then be that when the 'therapist' uses one or more of the categories which proved significant, the consequence would be the heightened likelihood of the occurrence of strong laughter. However, as discussed in the early part of the chapter on methodology, the analogue procedure would appear to be inopportune and inappropriate for these questions.

It would appear more fruitful to study the consequences of the categories which were found significant in the present study. That is, the question may well be as follows: when these categories are used, what are the patient consequences, and to what extent is strong laughter among the consequences? It is possible that further research and refinement may well reveal a number of patient consequences to the effective use of these categories. The working therapist would then be able to assess the extent to which these consequences are generally or differentially useful, welcomed, and desired. If, for example, such research indicates that a few consequences are likely, and all of these qualify as therapeutically welcomed and desired, then the therapist may use these whether or not strong laughter is the prominent consequence or only one of a few consequences all of which are welcomed and desired. Overall, these considerations point away from the efficacy of using an analogue format to examine the extent to which the categories found in the present study prove to be effective in facilitating the subsequent occurrence of strong patient laughter.

In-depth study of the characteristics of patient strong laughter as a positive therapeutic event. A more inviting line of inquiry, in terms of the theoretical and research interests of the present investigator, is the in-depth study of the strong laughter event itself. As mentioned earlier in in-depth study of the strong laughter event itself. As mentioned earlier in this chapter, a fair proportion of clinical theorists who regard strong laughing as a therapeutically welcomed and desirable in-therapy event value the event itself rather than the consequences of the event. That is, rather than seeing the strong laughter as therapeutically welcomed and desirable because it may lead to such consequences as a more positive self-concept or a more accepting therapist relationship, these clinical theorists hold that it is the total laughter event itself which is welcomed and desirable. These clinical theorists assert that when the patient is laughing heartily he or she is expressing a valuable therapeutic state. It is as if the event is a window into a welcomed and desirable therapeutic outcome or state. For these theorists it would be valuable to examine what patients are doing, how they are being, in the concomitant vicinity of the hearty laughter, especially in contrast to prior ways of being and behaving. The present study offers some cues to this question, although there was no attempt to examine what patients are doing and how they are being in the concomitant vicinity of the strong laughter.

These considerations point toward the importance of studying how patients are being and behaving within the target window of the strong laughter itself rather than subsequent to the strong laughter. There is a sharp distinction between a research strategy which seeks therapeutic changes

subsequent to the strong laughter as compared with a research strategy which examines the patient's state during the event punctuated by the strong laughter. The clinical theorists who attest to the value of strong laughter, as well as the suggestive hints offered by the findings themselves, invite careful study of the perhaps distinctive ways in which patients are being and behaving during the strong laughter epoch.

Therapist operations linked to strong laughter as a positive therapeutic event. The above line of inquiry presumes that some instances of strong patient laughter may be more therapeutically positive than others. The two studies by Nichols (1974) and by Nichols and Bierenbaum (1978) both shared a presumption that any kind of strong feeling-expression was therapeutically significant in terms of leading to the more traditional meanings of positive therapeutic outcome. However, the present study opens up a next line of investigation of the characteristics and parameters of the strong laughter event itself. With further investigation of these instances, it is likely that some instances of strong laughter may well be construed as more therapeutically positive than others. This would enable investigation of therapeutic operations which may be more closely linked to those instances whihc are more therapeutically positive, instances in which, for example, the strong laughter event is regarded as an instance of positive, in-therapy change, consequence, or outcome.

Strong laughter as a process event: the study of outcomes. Turning from strong laughter as a positive in-therapy change-event or outcome, in and of itself, the strong laughter is also open to conceptualization as a significant process event. According to this conceptualization, it may well be followed by

more standard meanings of positive therapeutic outcome. Included among these are two which have been cited in the literature, both of which involve consequences which are open to assessment within the therapy situation itself. One of these is a positive shift in the patient's self-concept or self-perspective, and the other is the heightened development of a patient-therapist relationship marked by warmth and acceptance, intimacy, and a reduction in emotional distance.

These two consequences have been cited in the literature as linked to strong laughter itself. In addition, there is a large category of more or less standard therapeutic outcomes which may be investigated. If strong laughter is a meaningful process event, it may be expected to be linked with the subsequent occurrence of indices of such standard outcomes as reduced psychopathology, improved social and personal adjustment, reduction of symptoms and initial complaints, and so on. This line of investigation, with regard to strong laughter, has been initiated by Nichols (1974) and Nichols and Bierenbaum (1978). The present study provides further justification for pursuing this line of investigation.

As was discussed in an earlier chapter, the researcher is open to a choice between pursuing the subsequent consequences and outcomes to strong laughter and, on the other hand, concentrating upon the strong laughter itself and the therapist operations which may help to bring it about. While these are not mutually exclusive choices, the researcher is justified in following interests which may lean toward one or the other line of investigation. Since the present investigator has confronted these choices in the present study, and since these choices are still relevant for next steps in the study of

strong laughter, it appears meaningful to consider these choices in somewhat more depth.

It is the contention of the present investigator that the choice is at least in part a function of the researcher's theory of psychotherapy and saliently meaningful interests in specific issues of clinical practice. With one theory of psychotherapy and one set of interests in particular issues of therapeutic practice, it is understandable that the researcher will be drawn toward conceptualizing strong laughter as a process event, and the researcher may well be inclined toward studying the relationships between this process event and standard indices of therapeutic outcome. However, with another theory of psychotherapy and other interests in issues of therapeutic practice, it is also understandable that the researcher will be drawn toward conceptualizing strong laughter as a significant therapeutic change and in-therapy outcome, and the researcher may then be inclined toward more intensive study of this event and the therapeutic operations linked to its occurrence.

Some researchers and clinical theorists accept a proposition that meaningful and significant in-therapy events (such as strong patient laughter) gain their meaningfulness and significance by demonstration of close linkages with the standard meanings of therapeutic outcome. For researchers and clinical theorists for whom this proposition is paramount, it makes good sense to pursue this line of study.

However, it may also be acknowledged that the linkage between strong patient laughter and standard outcome measures is less than paramount for those researchers and clinical theorists who hold that the actual event of

strong laughter constitutes a welcomed and desirable event in and of itself. A review of these theories of psychotherapy was included in the initial chapter. For these researchers and clinical theorists it may be equally or even more important to inquire further into the nature of this in-therapy event than to look to the relationship between this event and whatever is held (largely from the perspectives of other theories of psychotherapy) as indications of positive therapeutic change and outcome.

Furthermore, it may be acknowledged that some researchers and clinical theorists represent theories of psychotherapy which emphasize the importance of discovering the ways in which working therapists can help to facilitate the occurrence of strong patient laughter either as a meaningful process event, a meaningful in-therapy outcome event, or both. For these researchers and clinical theorists, it may be understandable that the research pursuit of these issues holds more significance than the pursuit of linkages between strong laughter and standard outcome measures.

On balance, it appears that the next line of investigation of the linkages between strong laughter and standard measures of therapeutic outcome is more or less a function, at least in part, of the researcher's explicit or implicit theory of psychotherapy and saliently meaningful interests in specific issues of actual psychotherapeutic practice.

Opening the window of relevant research variables related to strong laughter. The general thrust of the present study was that of looking for what therapists do which is related to strong laughter in patients. However, it is acknowledged that the research variables were quite limited. It would seem

justified to open the window somewhat and to include further research variables. Four classes of additional research variables may be described.

One additional class includes patient variables. While the present research has indicated some categories of therapeutic operations which may be related to the subsequent occurrence of strong patient laughter, a more careful question may be explored: With patients of defined characteristics, what therapeutic operations are effectively linked with the occurrence of strong laughter? For example, this line of research may explore such patient variables as degree and kind of psychopathology or problems, personality dimensions such as ego strength, emotional expressiveness and aggressivity.

A second additional class includes therapist variables. For example, there is much more to therapeutic operations than the transcript of the spoken words. Yet the data of the present study were confined to the actual spoken words. Promising as the findings may be, it seems reasonable to suppose that further light on what therapists do to help facilitate strong laughter would come from careful study of therapists' voice quality, pitch and tone, and related verbal and speech characteristics, as well as the whole domain of therapist (and therapist-patient) nonverbal behaviors such as posture, body movement, eye contact, physical touching.

Third, in the present study no efforts were made to examine such variables as the relationships between strong laughter and the nature of the therapeutic approach (e.g., experiential, behavioral, client-centered, psychoanalytic), the phase of therapy, distribution of strong laughter over sessions, and so on. Nor do the findings of the present study shed any light on these issues. However, a few soft impressions are cordial to further

inquiry along these lines. One is that in the course of looking for instances of strong laughter, the investigator listened to a large number of audiotaped sessions conducted by a large number of therapists. It is the impression of the investigator that while the clients of client-centered therapists may have expressed a variety of emotions and feelings, there was essentially little or no strong hearty laughter throughout a rather large number of such taped sessions. A second impression is that the therapists in the present study whose clients engaged in strong hearty laughter seemed to be following approaches which emphasized the direct promotion of strong feeling and emotion, i.e., the experiential therapies. However these are little more than impressions which may be more carefully investigated as a part of a more general inquiry into the role of the therapeutic approach in relation to both therapeutic operations and the occurrence of strong laughter.

Finally, the window may be opened to include therapist-patient interactional variables. In addition to both simple and complex kinds of therapist variables and patient variables, it would seem quite appropriate to investigate the role of interactional variables occurring between therapist and patient. These were beyond the scope of the present study. However, the softer inquiry into therapist statements two and three therapist statements prior to the strong laughter brings into question the role of the interaction between therapist and patient. It seems reasonable that the therapist-patient interaction occurring one or two or three statements prior to the strong laughter may well play a role in the occurrence of the strong laughter.

Further lines of research inquiry explicitly directed towards the practicing psychotherapist. For the working psychotherapist, the major

question is this: When the therapist is ready to move toward the promotion of strong patient laughter, what operations can be used to facilitate its occurrence? Throughout this thesis, care has been taken to speak about therapist statements which precede the strong patient laughter. However, this question from the working psychotherapist calls for an inquiry into what the practical therapist does which will be followed by strong patient laughter.

At this working practical level of study at least the following questions are entitled to be asked:

(a) What are the proper (appropriate, effective) therapeutic conditions under which the therapeutic process is carried forward by means of patient strong laughter? In other words, when does the psychotherapist want to bring about the strong laughter? Although this question is open to research inquiry, a large part of the working answer may well come from the particular theory of practice. Many theories have a lot to say on the issue of the proper conditions for bringing about strong laughter. However, the present study, as indicated earlier in this chapter, provides some basis for speculating that the proper therapeutic conditions are those in which the client is in the immediate vicinity of material which is risky and which lends itself to translation into concrete behaviors. In other words, the client is quite close to the carrying out of risky behaviors.

(b) What patternings of therapist (and therapist-patient) operations are effective in being followed by strong patient laughter? The present study lent some support to the likelihood that patterns may be more effective than single therapeutic operations. But there needs to be careful study of just what

patterns and sequences are genuinely effective in the occurrence of strong laughter.

(c) To what extent will given therapist statements (and/or patterns and sequences of statements) be followed by strong laughter? The present study looked at some predicted categories of therapist statements which preceded strong laughter (as compared with instances of non-laughter and other laughter). This is one reason why the findings cannot tell us what happens when the therapist carries out these operations. Study is required to see the extent to which strong laughter occurs following certain kinds of therapist statements and perhaps patternings of statements. One way in which this may be accomplished is by means of a dialectic between further research on what precedes strong laughter and research on the consequences of these therapist statements and patterns of statements. Then we may have an increasingly better idea of what to do to facilitate the occurrence of strong laughter.

(d) In addition to the sheer content of therapist statements (and perhaps their patterning), what other factors in and around the therapist statements seem to play a part in the facilitation of strong patient laughter? From the clinical literature, and also from soft impressions of the present investigator in listening to the audiotapes of the excerpts, there is at least one added ingredient. It consists of a communicated sense of openness, spontaneity, a wholesale welcoming of new and risky ways of being, a kind of playfulness and whimsicalness, a buoyant lightness. This may play an important role in the overall effectiveness of therapist statements which prove effective in facilitating the occurrence of strong laughter.

It is suggested that at least these four lines of investigation are meaningful and useful for the particing psychotherapist for whom strong patient laughter may be a welcomed and desirable event.

Some Learnings From this Kind of Psychotherapy Process Research

Psychotherapy process research has not yet produced an overwhelming volume of studies. It is a singular and distinctive research area with its own advantages and disadvantages. As a prospective researcher in the field of psychotherapy process, it seems appropriate to identify a set of learnings which occurred in the course of this research. These learnings will probably have an impact on my own research career, and they are entitled to identification for others who may be considering similar lines of research study. What follows are some considered learnings generated in the course of this research:

The value of a psychotherapy research tape library. It seems to be essential to have access to a psychotherapy research library or data bank. Without such an available psychotherapy library, the sheer assembling of the necessary tapes took approximately three years. Psychotherapy process research would seem to require a rich resource of psychotherapy tapes: audiotapes and videotapes.

Integrative reviews of clinical, theoretical, and research literatures. One of the intellectual excitements in this research venture was the integrative organization and summarizing of the literature on therapeutic operations related to strong patient laughter. As psychotherapy process

research bears closer to the issues and questions of actual psychotherapists, it is likely that additional efforts will be called for in order to organize and summarize the literature bearing on these issues and questions. This was an exciting and pleasing step in the research.

The excitement in studying actual psychotherapeutic data. The research data consisted of actual excerpts from tapes of actual psychotherapy sessions. Such direct involvement in this kind of data lent a sense of realness and relevance to the research. For the clinician-researcher or researcher-clinician, this kind of data excitingly blends clinical work and research.

The value of a collaborative, long-term research team. Not only the sheer collection of the categorizations, but also the identifying and resolving of many of the associated problems, required the close working relationships of a group of students-colleagues-researchers. What is more, the nature of the design called for a considerable amount of work over many months. It would seem that a large proportion of psychotherapy process research calls for an effective team of researchers. It is certainly neither solo research nor research which collects the data quickly. Based on the present research experience, it seems that the success of such research requires a good working research team which operates over extended periods of time.

In addition, there were at least three considerations from the method and design used in the present study. Each of these may be regarded as weak spots or flaws or problems which should be worked out in order to pursue study of therapist statements preceding significant patient events in therapy.

Two category systems vs. one. It seemed excessively time-consuming and somewhat inappropriate to use two separate category systems, one consisting of the eight predicted categories and an 'other' category; the other consisting of the Hill Category System. As indicated earlier, the present study would have benefitted (and it is proposed that similar future studies would likewise benefit) from a single category system. For example, beginning with the categories of the Hill system or a similar system, such research would call for extension either outward or downward to include added categories at the concrete operational level exemplified by the eight predicted categories. Were such a category system available, it would seem that the design of the present study would have been improved and data-collection made more efficient.

Some characteristics of a useful category system. The eight predicted categories essentially disappeared when the data were looked at through the Hill Category System. Using the eight predicted categories and a large 'other' category, five of the eight predicted categories proved significant in the main findings. Using the Hill Category System, the only two significant categories were Direct Guidance and Other. There is a somewhat conspicuous difference between the nature and content of the eight predicted categories and the categories of the Hill system. Mainly, the eight predicted categories were much more concrete, specific, detailed. They are perhaps subcategories under appropriate categories of the Hill system.

There are advantages and disadvantages when one uses either a grosser system with fewer categories or a finer system with either many categories or with subcategories. Nevertheless, it seems clear that the present findings would essentially be undetected by the grosser categories of the Hill system.

It may be proposed that when the research question or hypothesis is at the level of specific and concrete clinical events, the more useful category systems are those whose categories are likewise at the level of specific and concrete clinical events.

The study of complexes, configurations, and patternings of therapist-patient operations related to significant therapeutic events. The design of the present study was restricted to careful examination of only the immediately preceding therapist statement. This was a rather sad compromise for the investigator. Ideally, the preference would be to include rigorous examination of the complex of the two or three or even four therapist and patient statements antecedent to the strong patient laughter. Rather than a flaw, it seems to be more of a restriction to use a design which sheds some rigorous light on only the immediately antecedent therapist statement. In this study, and for future studies along similar lines, it would be better to expand both the hypothesis and the design to include careful examination of the whole complex (patterning, organization) of the several therapist and patient statements antecedent to the strong laughter.

A fruitful relationship between clinical and traditional research and theory. In large measure, the present study confirmed that the predicted categories of therapist statements indeed seemed to precede strong patient laughter. It is interesting to note that the predicted categories came essentially from clinical study of actual psychotherapeutic material by clinicians and psychotherapists rather than from traditional or standard research, and rather than from the ordinary meanings of "theory". Indeed, both traditional meanings of research and theory had little to offer on questions

of therapeutic operations which preceded patient strong laughter. The present study may be interpreted as some testimony to the richness and the meaningfulness of careful clinical theorizing and careful clinical study.

With regard to traditional methods of research, one implication of the present study is that a fruitful use of traditional research methods is to provide more careful examination of the hypotheses, theoretical speculations, data-based inferences, and tentative conclusions provided by rigorous clinical study. In other words, traditional research methods may fruitfully be used to complement clinical research methods.

With regard to the traditional meanings of theory, it is interesting that perhaps the most fruitful theorizing was of an inductive nature from clinical observation rather than deductive theorizing from such bodies of thought as theories of personality, social psychological theories, and the ordinary meanings of bodies of theoretical thought in psychology and psychiatry. With regard to such issues as the therapeutic operations preceding strong patient laughter, the argument may be proposed that a fruitful and rich body of thought is that which may be termed theories of psychotherapeutic practice, and that the data base for such theories of psychotherapeutic practice largely includes the careful clinical study of psychotherapy itself.

Conclusions

In the light of the findings and the above discussion, a number of conclusions may be put forward:

1. Within the limitations and restrictions of the data and the design, the findings seem to support an hypothesis that a significantly higher proportion of therapist statements falling under eight predicted categories occurred immediately antecedent to strong patient laughter, as compared with the proportion which occurred immediately antecedent to patient non-laughter and to patient other-laughter.

These eight predicted categories included the following:

a. Defined Impulsive Behavior by Patient or Other.

b. Carrying Our Risk Behavior As/For Patient.

c. Excited Reinforcement of Risk Behavior.

d. Ridiculous Explanation-Description of Patient.

e. Directed Risk Behavior Toward Therapist.

f. Directed Interpersonal Risk Behavior.

g. Instruction to Carry Out Affect-Laden Behavior With Heightened Intensity.

h. Risked Being of Other Person or Entity.

In addition to the main conclusion, other conclusions seem to be warranted:

2. Of the eight predicted categories, five (a-e) seem to be more significantly related to the occurrence of strong laughter, and three (f-h) seem to be less significantly related to the occurrence of strong laughter.

3. When therapist statements were categorized using the Hill Counselor Verbal Response Category System, the findings indicated that a significantly higher proportion of therapist statements falling under 'Direct Guidance' and

'Other' occurred immediately antecedent to strong patient laughter, as compared with the proportion which occurred immediately antecedent to patient non-laughter and to patient other-laughter.

4. With regard to therapist statements occurring two and three statements antecedent to strong laughter, the findings provide soft indications of the 'potency' of the eight predicted categories as a group, as compared with their occurrence antecedent to non-laughter and to patient other-laughter. Nevertheless, while the predicted eight categories as a group may be speculated as 'potent' immediately antecedent, two, and even three statements prior to the strong laughter, the soft indications are that the highest 'potency' occurs immediately antecedent to the strong laughter.

5. The findings provide some soft suggestings that various combinations and sequential configurations of therapist statements precede the occurrence of strong patient laughter. Beginning with therapist statements three statements and two statements before strong laughter, the soft suggestion is that some of the eight predicted categories, in configuration with unspecified other categories, and culminating in many of the eight predicted categories, seem to be potent in the occurrence of the strong patient laughter.

Implications in the Light of the Findings and Conclusions

In the light of the findings and the above conclusions, four implications were drawn and discussed in the present chapter. In summary, these included the following:

1. Implications for the therapeutic facilitation of strong patient laughter. A common theme across the more significant categories involved what may be termed risk-behavior. On this provisional inference, implications were drawn relative to proposals for therapist statements which may be used to help facilitate strong laughter.

Using both the designated therapist categories and possibly configurations of categories, implications were drawn for the specific therapies which value the occurrence of strong patient laughter, and for the therapeutic conditions under which these categories and configurations may be used. In addition, implications were discussed relative to the role of humor in the occurrence of strong laughter in patients.

2. Implications for the nature of therapeutically valued strong laughter. With regard to the further conceptual understanding and description of the nature of strong laughter as a positive therapeutic event, a risk-behavior hypothesis was applied to the further understanding and description of this event. On this basis, the strong laughter event was provisionally conceptualized in terms of a more accepting relationship toward risk-behavior, and in terms of increased engagement in risk-behavior. In addition, implications were drawn relative to the comparison of strong laughter and 'other' laughter events in psychotherapy.

3. Implications for some programmatic lines of research inquiry. With regard to a research program dedicated to the further study of lines opened up by the present investigation, implications were drawn relative to extension and verification of the present findings, including the appropriateness of analogue formats, relative to in-depth study of the characteristics of patient

strong laughter as a positive therapeutic event, and relative to therapist operations linked to strong laughter as a positive therapeutic event.

If strong laughter is conceptualized as a process event, then it is appropriate that subsequent study focus on the relationships between this process event and standard outcome measures. Considerations leading toward or away from this line of research were discussed.

If the window is to be opened to studying the relationships between strong laughter and further sets of research variables, then four such sets were discussed: patient variables, therapist variables, therapeutic approach variables, and therapist-patient interaction variables.

In addition, consideration was extended to some further lines of research inquiry explicitly directed toward the practicing psychotherapist.

4. Implications for some learnings from this kind of psychotherapy process research. Largely from the personal experiences in and around this study, and with regard to the present investigator's own interests in this kind of psychotherapy process research, some personal learnings were discussed. For others who may be considering a career in psychotherapy process research, such personal learnings may be meaningful in defining the nature of the research inquiry as well as the methods of pursuing this line of study.

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APPENDIX A

Category Systems for Therapist Statements

The following are the category systems which will be used by judges to rate therapist statements in the proposed investigation. Included are instructions to judges which will precede the Hill System and the 'target' category system, the Hill Counselor Verbal Response Category System, and the 'target' category system. The detailed descriptions and clinical illustrations for all Hill system categories are those provided by Dr. Clara Hill. Also included are the description and discussion of each target category, together with clinical examples and illustrations.

Instructions for Categorizing Therapist Statements

1. Study the preceding patient statement(s).

Generally all that is required is to study the immediately preceding patient statement. If that statement is very short, or equivocal, or makes sense only by knowing the statements of the therapist and patient earlier, then study those too.

Pt. 1:	I admire his forthrightness.
T1:	Um-hmm.
Pt. 2:	Well, usually.
T2:	So in general anyhow, you admire his forthrightness.

In order to categorize T2, it is difficult to limit your study to Pt. 2 alone. But T2 makes sense when you look both at Pt. 2 and Pt. 1.

2. Use only a single category for each therapist statement.

Typically there is only one category which is appropriate for the therapist statement. If the statement seems to be comprised of parts, look mainly at the last part to categorize.

Some therapist statements may have one category for the first part and a second category for the second part. It seems that the therapist does two different operations, one at a time. In that circumstance, use the following guidelines:

a. Use your judgement to select which one seems more important. Almost always, one of the two seems to be more important than the other. It carries more weight, affects the patient more, etc.

b. If both seem equally appropriate, give preference to the one which occurred second. In most instances, this will be the one which will have the somewhat greater effect upon the subsequent patient statement.

3. A therapist statement includes everything spoken by the therapist, preceded and followed by patient statements. A therapist statement may consist of a single word (or a behavioral movement such as slapping the chair; or a noise such as a sigh or a grunt). It may consist of a long paragraph or so, with many sentences, ideas, and thought units.

The Hill Counselor Verbal Response Category System

1. Minimal Encourager: A short phrase which indicates simple agreement, acknowledgement, or understanding. It encourages but does not request the client to continue talking; does not imply approval or disaproval. May be a repetition of key word(s); does not include responses to questions (see Information).

Examples:

Pt.: "There's so much I need to do right now and I don't know where to begin."
T.: "MmHmm."

Pt.: "About a year ago I decided to change my major from microbiology to physical education."
T.: "Go on."

Pt.: "I began to understand what was bothering her."
T: "I see."

Pt.: "I've been thinking about how tough the semester has been."
T.: "Yeah."

2. Approval/Reassurance: This provides emotional support, approval, or reinforcement. It may imply sympathy or tend to alleviate anxiety by minimizing client's problems.

Examples:

Pt.: "I can't help but feel that everything will be piled up on me like this for the rest of my life."
T.: "It'll get better."

Pt.: "I'm sorry I'm late."
T.: "Don't worry about it."

Pt.: "I get so uptight before exams."
T.: "Everyone feels that way from time to time."

Pt.: "I didn't know if I should come here."
T.: "I think you did the right thing.

3. Information: This supplies information in the form of data, facts, resources, theory, etc. It may be information specifically related to the counseling process, counselor's behavior or arrangement (time, place, fee, etc.). It may answer direct questions but does not include directions for what the client should do (see Direct Guidance).

Examples:

Pt.: "I just don't know who I am right now."
T.: "According to Erikson's theory, most adolescents go through an identity crisis in their late teens."

Pt.: "What were the results of the test?"
T.: "The SCII indicates that your interest is in forestry."

Pt.: "How about Horney? Did she agree with that theory?"
T.: "I don't know the answer to your question."

Pt.: "Will I be meeting with you regularly?"
T.: "No, this is an intake interview."

4. Direct Guidance: This consists of directions or advice that the counselor suggests for the client, or for the client and counselor together, either within or outside the counseling session. It is not aimed at soliciting verbal material from the client (see Closed or Open Question).

Examples:

Pt.: "What do you think? Should I take the test tomorrow or make it up next week?"
T.: "Take it tomorrow."

Pt.: "Do you have a solution for my tension right now?"
T.: "Practice this relaxation exercise 15 minutes a night."

Pt.: "Last night the president was in my dream."
T.: "Play the part of the man in your dream."

Pt.: "I feel tense talking to you."
T.: "Try and relax."

5. Closed Question: This is a data-gathering inquiry that requests a one- or two-word answer, a yes or no, or a confirmation of the counselor's previous statement. The possible client responses to this type of inquiry are typically limited and specific. If statements are phrased in the form of a closed question but meet the criteria of another category, they should be put in the other category.

Examples:

Pt.: "I went away for the weekend."
T.: "Did you like it?"

Pt.: "I'm still procrastinating."
T.: "Did you read the book I suggested?"

Pt.: "I've been married for 10 years."
T.: "How old are you?"

Pt.: "My husband thinks I'm too fat."
T.: "How much do you weigh?"

6. Open Question: A probe requests a clarification of feelings or an exploration of the situation without purposely limiting the nature of the response to a yes or no or a one- or two-word response. If statements are phrased in the form of an open question but meet the criteria of another category, they should be put in the other category.

Examples:

Pt.: "Everything is really awful right now."
T.: "What kind of hassles do you have?"

Pt.: "My sister got all the attention in the family."
T.: "How do you feel about that?"

Pt.: "I've had a backache for days."
T.: "What's making you tense?"

Pt.: "I got really depressed over Christmas."
T.: "What were you thinking then?"

7. Restatement: This is a simple repeating or rephrasing of the client's statement(s) (not necessarily just the immediately preceding statements). It typically contains fewer but similar words and is more concrete and clear then the client's message. It may be phrased either tentatively or as a statement.

Examples:

Pt.: "My father thinks I should earn my own money since I graduated from college."
T.: "You're saying your father doesn't want to support you anymore."

Pt.: "Since I got into trouble, no one will talk to me or do anything with me."
T.: "So it seems that everyone is ignoring you."

Pt.: "I'm on probation and just got 2 Fs on tests."
T.: "You say you're flunking out of school this semester."

Pt.: "I think I'm finally getting my life in order. I've been feeling good and self-confident most of the time. My job is getting easier and I've been more productive. I think I'll be ready to stop counselling soon."
T.: "Things are going well for you now."

8. Reflection: This is a repeating or rephrasing of the client's statement(s) (not necessarily just the immediately preceding statements). It must contain reference to stated or implied feelings. It may be based on previous statements, nonverbal behavior, or knowledge of the total situation. It may be phrased either tentatively or as a statement.

Examples:

Pt.: "I did better than I've ever done before."
T.: "You're pleased and satisfied with your performance on the exam."

Pt.: "My best friend went out with the guy I had been dating and wouldn't even tell me."
T.: "You feel hurt."

Pt.: "I didn't get to say what I wanted when she called on me in class and I got very anxious."
T.: "It seems that made you uncomfortable."

Pt.: "I don't know if I could handle this problem by myself. It feels like it's too much for me right now."
T.: "You feel uncertain of yourself and overwhelmed by this problem."

9. Nonverbal Referent: This points out or inquires about aspects of the client's nonverbal behavior, for example, body posture, voice tone or level, facial expressions, gestures, and so on. It does not interpret the meaning of these behaviors.

Examples:

Pt.: "I don't know what's wrong. I should be happy."
T.: "You have tears in your eyes."

Pt.: "I'm really happy right now."
T.: "You're smiling."

Pt.: "I don't feel much of anything."
T.: "You're fidgeting a lot with your hands."

Pt.: "I guess you're right about that."
T.: "Your voice was very soft right then."

10. Interpretation: This goes beyond what the client has overtly recognized. It might take one of several forms: It might establish connections between seemingly isolated events or statements; it interprets defenses, feelings,

resistance, or transference (the interpersonal relationship between client and counselor): it might indicate themes, patterns, or causal relationships in the client's behavior or personality. It usually gives alternative meanings for old behavior or issues. If a statement also meets the criteria for a confrontation, it should be put in Confrontation.

Examples:

Pt.: "I really wish you wouldn't bring that up because it makes me extremely mad."
T.: "You may be hostile because I remind you of your mother."

Pt.: "Nothing seems to be going well. School is really rough. And to top that off, my husband and I have been arguing constantly."
T.: "Maybe your difficulties in school are related to your difficulties with your husband."

Pt.: "I'm really angry because lately everyone is ignoring me. People never seem to hear a word I say."
T.: "When you say that nobody listens to you, I wonder if you're asking if I'll listen to you."

Pt.: "Everyone else always does such a good job in speech class. I can hardly get my mouth open. I have these fantasies of everyone laughing at me."
T.: "Since being in front of a class seems to elicit your inferiority conflicts, my guess is that you had some traumatic experience in grade school giving talks."

11. Confrontation: This contains two parts: The first part may be implied rather than stated and refers to some aspect of the client's message or behavior; the second part usually begins with a "but" and presents a discrepancy. This contradiction or discrepancy may be between words and behavior, between two things the client has stated, between behavior and action, between real and ideal self, between verbal and nonverbal behavior,

between fantasy and reality, or between the client's and the counselor's perceptions.

Examples:

Pt.: "Susan asked me how I felt about it, but I knew she didn't really care what I said. Nobody really listens to me. They're too concerned with themselves."
T.: "You said nobody ever listens to you, but you didn't say anything to Susan when she asked how you were feeling."

Pt.: "I'm just feeling great today."
T.: "You say you're happy but you look sad."

Pt.: Silence
T.: "You come here every week, but then you don't talk."

Pt.: "I really want to move out of here but I don't have any money to do it. My mother is still asking me for money every week. She's not working and I am. What else can I do?"
T.: "I would be angry at that, but you say it's okay."

12. Self-disclose: This usually begins with an "I"; the counselor shares his or her own personal experiences and feelings with the client. Note that not all statements that begin with "I" are self-disclosure; it must have a quality of sharing or disclosing.

Examples:

Pt.: "I have to make a decision about which job to take. I have 2 offers which are really good and I could use both to bargain for more money. But I'll be leaving to go to school anyway and I thnk bargaining might be unfair."
T.: "Right now I feel distant from you."

Pt.: "I have so much confusion because I don't want to go through the pain and embarrassment of an abortion. But being fair to myself, I know there's no way I could have a kid right now."

T.: "I can identify with you because I also had an abortion."

Pt.: "I want to socialize but when I get to a party I get so uptight I can't have a prolonged conversation with anyone. Everyone else always seems to be having a good time."

T.: "I also feel anxious in a party-type situation."

Pt.: "I'd like to have you as my father."

T.: "I'd like you for a daughter."

13. Other: These include statements that are unrelated to client's problems, such as small talk or salutations, comments about the weather or events; disapproval or criticism of the client; or statements that do not fit into any other category or are unclassifiable due to difficulties in transcription, comprehensibility or incompleteness.

Examples:

Pt.: "See you next week."

T.: "Bye now."

Pt.: "I don't need to use contraceptives. I haven't gotten pregnant yet and I've always been lucky."

T.: "I don't believe you said something that naive."

Pt.: "I haven't been able to get over the breakup. I'll never meet anyone again. She was the only person I could ever love."

T.: "That's a stupid thing to say."

Pt.: "I spent yesterday watching football."

T.: "The Redskins game was terrific, wasn't it?"

'Target' Category System

1. Directed Interpersonal Risk-Behavior: The therapist directs the patient to carry out a risked interpersonal behavior. The behavior is interpersonal in that it is to be carried out in an interpersonal relationship with some other imagined or fantasied person, generally a significant other individual. The behavior is to be carried out immediately in the therapy session, within the context of an imagined or fantasied scene including the other individual. It is a risk-behavior in that the behavior is anxiety-engendering, threatening, impulse related, and unusual or atypical for the patient.

Examples:

T.: "Line all those old boyfriends up and put a red X on the ones you think are real animals."

T.: "Say those words to Steve."

T.: "Just walk over to her and flex your biceps, damnit!"

T.: "See him! Tell him you are irritated. Let yourself be honest with him."

T.: "Now, tell your husband what you feel. Tell it straight to him!"

Pt.: "Well, I'm mad. My father's sitting there and he won't say anything. I'm mad! I'm really mad at him."

T.: "Say it to him. Tell him that."

2. Defined Impulsive Behavior by Patient or Other: The therapist defines (describes in detail) an impulsive behavior, i.e., one which is threatening, ordinarily blocked or defended against by the patient, may be dangerous or outlandish, shocking, or rooted in primitive material. The defined impulsive

behavior is regarded as carried out by the patient or a significant other individual. Typically, the therapist's verbal behaviors and tone convey a context of impulse pleasure and acting out.

Examples:

T.: "Wouldn't it be fun to throw him down the stairs?"

T.: "Can you see yourself when you're 103 years old, never going on vacation, always working... You tell everyone, 'Later. Later. We'll go on vacation when I'm settled. Then we'll go ... maybe.'"

T.: "Well, I could really make you shiver by unplugging the heater. We'd be in here in our coats and you could tell me how you're going to report me to the APA for patient abuse."

T.: "Your brother would probably tell that guy that your father is a salesman --- better than telling that he's the oldest drug pusher in the state of Michigan!"

T.: "There we are, your mommy and I, both stark naked, sitting in your apartment with nothing to do but give all our attention to little old you."

3. Ridiculous Explanation/Description of Patient: The therapist offers an explanation or description of the patient or the patient's behaviors in a way which is ridiculous. That is, the explanation is far-fetched, unrealistic, burlesqued. Typically, the context includes a playful interpretation or encounter.

Examples:

T.: "Well, you're really kind of foolish, right? David knows, everyone knows what a foolish dunce you really are!"

T.: "Obviously you are the sexiest guy in Ottawa, maybe in Ontario, maybe in all of eastern Canada!"

T.: "I'm going to say something saintly about you, and then you say something saintly about you."
Pt.: "Yeah."
T.: "You are a good person who goes to church."
Pt.: "Yeah. I go sometimes."
T.: "And you are kind to little animals and you eat your brussel sprouts."

T.: "Listen! It's a voice inside you, talking about you and what you're really like. 'He's a con artist. And very good! He'll rip you off and you'll never know.'"

4. Instruction to Carry Out Affect-Laden Behavior with Heightened Intensity: The therapist instructs the patient to carry out affect-laden behaviors with increasingly heightened intensity. This may consist of instructions to "say it again, louder", to scream and yell affect-laden phrases or words, to hit or pound or kick with increasing intensity.

Examples:

T.: "Let yourself be angry. Go ahead and yell!"

T.: "Bellow. More ... Do it more!"

Pt.: "I love my mother." (Starting to cry.)
T.: "Say, 'I love my mother' ... Again ...Again."

T.: "Lay flat on the floor, pull your knees up, then kick, hard."

T.: "Hit hard, have a tantrum. Try smashing."

5. Carrying Out Risk Behavior as/for the Patient: The therapist carries out or acts out behaviors which are threatening to the patient, and the therapist does so within the role of the patient. That is, the therapist carries out these behaviors as/for the patient. These behaviors are threatening, risky, impulse-ridden, bothersome for the patient.

Examples:

Pt.: "Mostly family at the reception ... They were mostly older ... or quiet ... or uninteresting..."
T.: "Or crazy!"

Pt.: "Well, if my wife was there I'd feel better with my mom and dad. She'd take responsibility..."
T.: "For telling them to shut up!"

Pt.: "I told my brother I appreciated what he did for our father, but I guess I didn't like the fact that he had to do it, and uh ..."
T.: "And that Father should damn well stop acting like a helpless baby and do it himself!"

Pt.: "Well, sometimes I get annoyed at their implying things all the time."
T.: "I hate those damned implications!"

Pt.: "Every time I get alone with my supervisor, I feel nervous. He's loud and aggressive (Her voice is getting louder)..."
T.: "And I'd like to drop kick him to Montreal!"

6. Risked Being of Other Person or Entity: The therapist instructs the patient to risk being the other person or entity. The risk occurs in the threat of sheer being of that other person or entity, or in the acting out of some impulse.

Examples:

T.: "Be a raging elephant!"

T.: "Be your seven year old self! Put the grown up you in the chair and tell her how you feel about what she's doing."

T.: "Now, be the policeman. Say words as the policeman. Just be him. Talk from him."

T.: "Be your stomach. Say the words your stomach might say. Talk from you stomach."

7. Excited Reinforcement of Risked Behavior: The therapist responds with excited pleasure immediately following the patient's expression of a risked

behavior. The therapist's response includes expressed excitement, approval, welcoming, pleasure.

Examples:

Pt.: "I think I broke a bottle over his head once."
T.: (Pleased and animated.) "What? You did what?!"

T.: "What's his name again?"
Pt.: "Andy. Andy Toad head."
T.: "Andy Toad head??!!"

T.: "Tell me the name of a close friend."
Pt.: "No."
T.: "Oh!" (Laughs heartily.)

T.: "I like to work with patients who want some real changes and real reconstruction."
Pt.: "Yeah, a major overhaul."
T.: "Right! Yeah! A major overhaul!"

Pt.: "And, Dr. Thorpe, I'd love for you to say, 'John, you can't stay there anymore. I don't know how you're gonna take it.'"
T.: "John, you can't stay there anymore. I don't know how you're gonna take it."

T.: "You loved it! You loved telling him off like that!" (Laughing.)

T.: "Jesus, you sould like it was great fun beating him up!"

8. Directed Risked Behavior Toward Therapist: The therapist directs the patient to carry out a risked (threatening, impulse-ridden, anxiety-producing, atypical or unusual) behavior toward the therapist himself or herself. For example, the therapist may direct the patient to hit the therapist, hug or push the therapist, be sexual or aggressive toward the therapist.

Examples:

T.: "Tell me, 'Joe, you have so much to teach me.'"

T.: "Reach out and touch my hand."

T.: "Tell me you know he's gonna be proud of you."

T.: "Say, 'How can I help you?'"
Pt.: "How can I help you? I really want to help you. How can I help you Dr. Thorpe?"
T.: "Now ask me what do I want from you."
Pt.: "What do you want from me? What would you like? What do you need?"
T.: "I need for you to be yourself."

T.: (Coyly and in a fun loving way.) "I sure hope you can say that special thing to me. That would be so great and I'd feel so happy."

T.: "Look me in the eyes, grit your teeth, and say, 'Leave me alone.'"

Pt.: "If I swing, I'm gonna hit you."
T.: "Good. Hit me. I'll take off my glasses."

9. Other: This refers to therapist statements which do not fit into any other category.

Examples:

Pt.: "I could ask him, but he might say no. He might be busy or have some other excuse."
T.: "It sounds like if he doesn't go with you it means there is something really wrong with you."

T.: "So your grandmother really controlled the entire family."

T.: "There's alot of rage in you that never gets expressed."

Pt.: "No, Sally is my older sister, not my younger."
T.: "Oh sorry, I was wrong."

T.: "Our time is up now."

T.: "Uh huh, I see."

T.: "And how did you feel when you left?"

T.: "Tell me when the headaches first started."

APPENDIX B

Instructions for the Identificaiton of Strong Patient Laughter

The following is the written description for the three judges who will be identifying instances of strong patient laughter. A cassette tape with examples of strong patient laughter as well as examples of mild and 'nervous' patient laughter will accompany this description.

Your task is to identify all instances of patient strong laughter. By strong patient laughter, we mean laughter of the intensity you have just heard on Part I of the cassette. It is hard, loud, raucous, and characterized by heightened intensity. It is not giggles, chuckles, or nervous tittering that you have just heard examples of in Part II of the cassette. It is strong, clearly identifiable laughter. This is the type of laughter you are being asked to identify. Include all instances of laughter similar in intensity to that you heard in Part I of the cassette. If you have any questions about the intensity level, go back and listen to the examples again. It does not matter whether the patient is having pleasant or unpleasant feelings while laughing, whether the patient is also crying or yelling or mad or bothered or happy. It is the intensity which is the important thing. If the laughter is a mixture of strong and not strong, include it as strong laughter.

Instructions for judge 1:

Listen to each session. Each time you identify strong laughter, note the session number and the number on the tape counter where the laughter occurs.

If strong laughter occurs continuously throughout a number of interchanges, note the counter numbers which correspond. If, in a single session, a patient laughs more than 12 times, write down the session number and the word 'exclude'.

Similarly, when you identify moments of mild, low intensity laughter, note the session number and the number on the tape counter where the mild laughter occurs.

Instructions for judges 2 and 3:

Listen to all the instances of patient laughter. If you believe an instance meets the definition of strong patient laughter, mark down the word 'yes' after the corresponding number on the list you have been given. If you believe an instance does not meet the definition, mark down the word 'no'.