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Can Humor Heal?
An Evaluation of Humor in the Medical Setting

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Humor and humor therapy are currently being explored as possible treatments for depression - a disorder with a growing and largely unmet need in modern medicine. According to the Center for Disease Control and Prevention (CDC), "Eleven percent of Americans aged 12 years and over take antidepressant medication" (Pratt). With such prevalence and reliance on antidepressants, it is no surprise that alternative treatments are being explored. But what is the relationship between humor and medicine? Is it possible for the lightness of humor to exist within the highly professional health sphere? If so, what are the effects of humor and can those effects be applied as alternative or supplemental treatments for depression? The first part of this discussion will examine the role of the physician and medical community, as well as the functional benefits humor provides to medical interactions. Then, multiple perspectives regarding humor and humor therapy will be evaluated to consider its application for depression therapy.

Humor in Context

The application of humor is not a new idea, and a few institutions have even formally implemented humor practices. For example, the Clown Care Institute was established in 1989 for the Babies and Children's Hospital at the Columbia-Presbyterian Medical Center (CPMC). This institute introduces clowns to children fighting acute cancer and heart failure to alleviate stress and need for sedation (Balick 2). However, humor therapy does not have to be formal in application. It can exist within the health care system in a variety of ways. Humor therapy, according to the Association of Applied and Therapeutic Humor (AATH), is:

> *Any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life's situations. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual. (Franzini 2)*

Observational studies confirm the presence of humorous dialogue and exchanges in everyday patient-physician interaction. These exchanges can take several different forms. From a simple pun or an exaggeration of fact - nearly anything out of the norm in a hospital environment or therapy session can trigger a humorous response from the patient. Humor can ease anxiety over a diagnosis, or make an intrusive treatment less painful or embarrassing. (DuPre 89). Physicians deal with health, a very personal and very vulnerable part of our existence, and the less anxiety surrounding this interaction, the better and often more effective the treatment. Humor's relationship with health, both formally and informally, is crucial and very much present.

Case Study and Functionality

A closer look at one of these informal humorous interactions reveals the nuance humor adds to the medical setting. "She Laughed", an excerpt from Patients and Doctors - Life Changing Stories from Primary Care, is a physician's perspective about delivering a baby and the effects humor has on the delivery. The exchange begins a few weeks before the pregnancy when the expectant mother voices her fears about incorporating traditional Chinese medicines during the pregnancy. She fears her doctor will disapprove of her family's traditional practices, which among others includes taking a swig of Korean Ginseng just before delivery - or worse yet will not understand the significance of these traditions from her family's perspective.

> *"She wants to bring me all kinds of Chinese medicines, but I know I cannot take those," Sue said sadly.*
>
> *"Do you want to take them?" I asked. Shyly, she nodded.*
>
> *"Then why not?". (Borkan 107)*

This initial exchange, marked by the doctor's casual almost nonchalant response, is the opposite of what is expected in a typical medical setting. Her offhand reply functions in two ways. The first gives power back to the patient by being receptive to the role of tradition and the individual's needs. The doctor ul-

timately knows what will and will not interfere with pregnancy, but instead of belittling the patient with technical jargon, the doctor listens and responds in a manner that is respectful and assures the patient that their perspective is valid. This and other forms of lighthearted or humorous encouragement ensures the patient plays a more informed and responsible role in maintaining their health. (DuPre 129). The second function of this interaction uses humor to successfully react to a patients non-verbal cues. A study of patient-doctor interactions found that "… physicians who are sensitive to subtle non-verbal cues may be better able to detect and satisfy the social and emotional needs of the patient" (Freidman 55). This exchange appears to confirm this analysis. Aware of sadness in the patient's speech and her shy, tentative mannerisms, the physician skillfully responds in a way that is reassuring and comforting, rather than confrontational. Patient-doctor interactions often have an unspoken hierarchy (Diogenes 51). The doctor is more knowledgeable and therefore in a greater position of power. By interjecting humor in the form of unexpected and relaxed dialogue, a medical professional can dismantle this hierarchy and communicate with the patient on a personal level.

A few weeks later in the pregnancy, humor is again implemented during a critical moment of delivery. The baby's head had been crowing for over ten minutes, putting strain on the mother's perineum. The obstetricians debate among themselves deciding whether to cut an episiotomy to prevent tears. An episiotomy is a procedure that is not usually recommended unless critical for delivery as it can cause infection, incontinence, and other forms of irreversible damage to the mother ("Episiotomy" 1). This is a decision with serious medical consequences and action must be taken in a timely manner. During the delivery, the doctors humorous banter provides stark contrast to this tense situation and produces an environment which aids in the delivery of the child.

"Tch! You will never get [the baby] out without a tear," Maria Elana stated emphatically while making a sound West Indians use to express disbelief. "Is that a bet?" I asked. "You're on," said Maria-Elana. . . . My patient thought this whole interchange was funny; she started to giggle. Her husband whispered something in her ear . She started to laugh out loud. Somehow that laughter produces the right combination of pressure and relaxation. The baby's brow began to slip over the edge of the perineum. "Quick take your Ginseng," I said, "and keep laughing." This must have sounded really silly; both the patient and her husband burst into laughter. Soon we were all laughing and giggling helplessly, while the baby's head slipped gently over the perineum as I guided and slowed it. This child was born as every person in the room was laughing. (Borkan 108)

Most apparent in this situation is humor's ability to relax the muscles necessary to deliver the baby. Humor often encourages laughter and other physiological responses (analyzed later in the discussion) that can have a significant impact on the body. But beyond the induced physical effects, there are larger emotional and psychological implications of this exchange. Adopting a lighthearted dialogue under such conditions eases the tension in the room and frames a critical moment of delivery as a routine medical procedure. In fact, this change in tone and situational framing has been recognized as one of the key sociological functions of humor. Even in tense situations and dialogues, the addition of humor can transform the tone of a transaction into one that is more relaxed and conversational (DuPre 97). The doctor is aware of the unique environment dialogue has created and the mention of ginseng in the delivery room only heightens the absurdity. The physicians take their job seriously. However, by exchanging these brief quips they introduce levity and renew confidence in their abilities while simultaneously assuring the patient of her safety and the safety of her unborn child.

Humor is a proven method of "breaking the ice and establishing intimacy" necessary for patient-doctor relations (DuPre97). Childbirth, one of the most intimate medical interactions between a patient and physician, makes the incorporation of humor seem a natural extension of health procedure. What is unique about this interaction is that it involves both the patient and the practitioner engaging in a dance of humorous exchanges. When the tension rose, the doctors reacted gracefully with assuring dialogue and the patient in return laughed and responded positively to the way they handled the delivery. It is not just humor, but the shared experience and reciprocity of humor that makes it such a powerful tool in the medical setting.

But does this intimacy translate to a mental illness like depression? Is humor a power to be harnessed and controlled? Or must it only exist spontaneously

in the ebb and flow of natural conversation to be effective? The implications of its physical and social environmental factors make humor a good candidate for combating depression - a mental illness characterized by both its physical symptoms and its ability to be influenced by social and environmental factors. But to "beli[eve] in the effects of humor is not the same as understanding it" (DuPre 7). And before the relationship between them is analyzed, both humor and depression must be understood in greater detail.

Overview of Depression, Current Treatments, and Challenges

Depression is a chronic condition that affects a large cross section of society, but many cannot afford the cost of treatment throughout their lifetime. A study from the CDC found that, "…more than 60% of Americans taking antidepressant medication have taken it for 2 years or longer, with 14% having taken the medication for 10 years or more" (Pratt). The chronic nature of depression can be an economic burden for the individual, but also contributes to high national health care costs. Annually, the U.S. spends over $43 billion dollars on anxiety disorders alone to develop and administer pharmacological treatments (Reinecke 22).

Alternative treatments may be valuable from more than an economic standpoint. This is especially true when alternative therapies have the potential to limit drug dependency, which can be an ongoing struggle for a patient and can cause both emotional and financial distress. In addition to drug dependency there are also severe psychological implications of long term antidepressant use. High rates of insomnia, agitation, anxiety, nervousness and suicidal thoughts and actions have been associated with depressed individuals taking medications in high dosages over prolonged periods of time (Kresser). These debilitating side-effects can often exacerbate the symptoms of depression instead of alleviating them.

In addition, there are significant challenges associated with both the treatment of depression and the implementation of humor therapy. While much research has been dedicated to managing and treating the effects of depression, there is no definitive cure or pathology for the disorder. The origins of depression are thought to be genetic (chemical imbalances within the brain) or to rise from a combination of "psycho-social" environmental factors that contribute to symptoms of depressed mood or loss of interest in normal activities. Depression is also associated with loss of appetite, weight gain or loss, abnormalities in sleep, or suicidal behavior. (Reinecke 22). This wide variety of manifestations makes depression notoriously hard to treat and relapses in the disorder are common, even among those who initially achieved successful remission through drug treatments.

Previous research has supported the superiority of drug therapy treatments but new research has reshaped this perception. In fact, Reinecke in *Comparative Treatment Series - Depression: A Practitioner's Guide to Comparative Treatment* argues that current research supports "a combination of treatments may be superior to [drug] therapy alone," and "psychotherapy can achieve results comparable to medication" (38). A possible rationale behind this is that pharmacological therapies do not address the underlying environmental and behavior factors associated with depression. While this opens the door to alternative treatments, it questions whether humor therapy alone can properly address the complexities of depression. On one hand humor is "culturally and situationally reflexive" and can be used in a wide variety of settings among a diverse population (DuPre 192). On the other hand, humor's wide variety of applications makes it difficult to narrow down a specific treatment that would best meet the needs of patients. However, humor therapy may still be the best means to address the deficits of pharmacological treatments.

Although humor's versatility makes it difficult to assess treatment options, its specific biological effects have been well documented and well tested. Humor has been linked in multiple studies as a factor that raises pain tolerance for cancer patients and aids in the rehabilitation of heart attack survivors. Significant data from studies include the measurement of increased immune cell activity and production of chemicals in the brain known to counteract the negative effects of stress. (Balick 3). Many of humor's observed healing phenomena function in the same way as traditional drug therapies, by producing or altering chemical responses in the brain. It is this key physiological response to humor, induced by laughter or a rush of endorphins, that therapists argue should be incorpo-

rated within existing psychotherapies for depression.

Opposing Viewpoints in Context

The push for humor's application in the health care setting is not universal. For example, in regards to formal applications, psychologist L.R. Franzini states that the immediate implementation of humor training for physicians can be accomplished through seminars, workshops, lectures, and the cost of training would be far less than other common seminars (2). Franzini identifies a crucial but contestable point. Therapists frequently spend money to incorporate emerging therapies into their practice to gain a competitive edge and stay current with treatment, so why not humor? At seemingly low risk and low cost, why is there resistance to humor therapy?

It may be a question of reputation. Medical professionals spend years in schooling and are responsible for the health of their patients. They rightly regard and take the duties of the profession very seriously. While many therapists are open to the possibility of humor and humor therapy, "…the real fear stems from how a therapist who uses humor will be seen through the eyes of his colleagues. A person who laughs with someone is sharing, and a therapist who does this is giving away some of his power, putting him more or less on an equal level [with patients]" (Franzini 2). Hospitals and treatment centers must be highly efficient, professional environments. There is no room for error, or for human interaction that can be considered as wasteful or needlessly time-consuming, especially when there are so many to treat. However, this desire to maintain the semblance of professionalism may have negative results for patients. As seen in the delivery room of She Laughs it is this "leveling" that breaks down the barrier between patients and caregivers. The caregiver is no longer viewed as an authority figure and the patient becomes more receptive to treatment and less intimidated to ask questions. In a study, it was found overwhelmingly that patients "valued interpersonal over technical skills" among caregivers (DuPre 11). In fact, DuPre asserts that "humor is actually a sophisticated means of organizing and influencing social transaction" and if "humor is inconstant with professionalism; we may want to change our ideas about professionalism" (193). Humor and informal interactions between patient and caregiver are invaluable and maximize the effectiveness of treatment. At times this may require putting the needs of the patient before the doctor's reputation and usual protocols of the typical health care setting.

Others who oppose humor therapy in application to depression contend that the qualitative nature and experimental design of current studies are flawed. The argument is that it is hard to quantify humor when it is so varied among individuals, and hard to measure results on a large scale. Therefore, very few reflective experiments have been conducted and further research must be done. Often depression studies are subjective to those administering the test, and if subjects self-report their own altered mental state it results in "social desirability contamination" (Bennet 189). This describes that a patient's desire for a treatment to work leads to a treatment working, and this manifestation of the placebo effect often leads to error and bias. Another issue with humor therapy is the potential to cause harm to the patient. Kubie published a paper in 1971 that vehemently maintained that the use of humor in psychotherapy is destructive for the patient and there was very little room for humor in psychotherapy. (Franzini 2). Humor in severe cases of depression may have belittling effects on the patient, undermine trust or even victimize the patient. Physicians must be wary of the appropriate time to use humor because what often "…makes humor useful [in the medical setting]….leaves little recourse to the person pierced by a humorous barb" (DuPre 187). Also, Bennet deems the positive effects of humor are minimal compared to the possible risk of negative side effects (189). Very few experts completely deny the positive effects of humor, but many caution the public's overeagerness to incorporate a largely untested, unquantifiable therapy.

Important Conclusions and Future Applications

Humor has a complex but undeniable relationship with health that continues to evolve. Humor therapy as a means of mitigating or treating depression, while still in its early stages, shows promise. These therapies have proven to stimulate the brain in a similar and, in some cases, superior manner than traditional medication, with minimal costs and side-effects. With more research, humor therapy and training may eventually have the backing of the scientific community and the

potential to become part of common health practice.

However, even amid these promising results, there are some experts who consider the preliminary results of alternative treatments as insignificant or misrepresented by false data. But however stringent the dissenting ideas about humor therapy, the use of humor as a health communication tool is difficult to refute. Reinecke reasons that the strongest agents of change in psychotherapy are based on the strength of patient-therapist relationships (41). Additionally, if the therapist feels emotionally invested in the patient's well-being and the patient reciprocates that level of investment through the exchange of humor, this fosters a relationship of mutual aid instead of reliance.

Humor functions as "social footwork" that allows a foundation of trust to be built and thus is crucial to proper diagnosis and patient efficacy (DuPre 83). It can be used as a form of social leveling allowing doctors to communicate with patients from a position of equal power or as subtle recognition of a patient's non-verbal cues. It can also be used for situational framing to produce levity and establish intimacy when necessary. When used effectively, humor's diverse functionality can profoundly influence the outcome of critical health procedures and create environments that promote healing and communication. To neglect the establishment of humor as a communication tool or to dismiss it as child's play would be erroneous as "dissatisfying communication is not only bad medicine, it's bad science, and it's bad business...and if [proper communication is used] patients - as well as caregivers - stand to gain" (DuPre 11).

Current professional and scientific positions argue either to reject humor therapy as pseudoscience or use it as a complete replacement for side-effect causing antidepressants. More moderate opinions suggest that a combination of humor therapy and antidepressants may maximize patient benefits. But even these combinations seem impractical or unrealistic to introduce formally. With the immense need for alternative treatments, and humor's longstanding but understated presence in the health field, the healing power of humor must be officially recognized - but perhaps in a different way than previously proposed by health care professionals.

I propose instead for the shift in attitudes towards the use of humor in the health care environment. This method would allow humor to exist without implementing formal procedure. It does not take up time or additional cost as it calls for a change in mindset not procedure. However, it also allows the positive physiological and environmental effects of humor to permeate into the health sphere and, with luck, patients' lives as well.

Humor alone does not have the chemical-altering capabilities to counteract severe cases of depression. Formal humor therapy is forced, inorganic and is not as effective as impromptu humor found naturally in many patient-doctor exchanges. Health care providers must instead focus on fostering an environment where humor is celebrated rather than discouraged. An environment where humor is considered necessary, welcome, and not as ineffective or unprofessional. If humor's functions and applications can be recognized and valued, it can positively impact the lives of those most affected by depression.

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