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Laugh and the World Laughs with You: An Attachment Perspective on the Meaning of Laughter in Psychotherapy

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Abstract From infancy laughter is a right-brain-to-right-brain attachment behavior mutually aroused and regulated within the caregiver–infant partnership. Laughter continues to be attachment behavior throughout life with potential for enhancing attachment bonds or for defending against them. Laughter in psychotherapy has primarily been viewed as a discharge phenomena with typical interpretations focused on the humor that elicits the laughter rather than the meaning of the behavior itself. Viewing laughter as attachment behavior in psychotherapy provides the clinician with valuable insight about its meaning and management within the therapeutic relationship.

Keywords Laughter · Attachment · Psychotherapy · Infants · Adults

Introduction

Laughter is known to be a right-brain-to-right-brain attachment behavior (Sander and Scheich 2005) with strong social bonding potential for the parent/infant dyad (Bowlby 1969; Schore 2003). Smiling and laughter signal the caregiver that the infant is positively aroused (Cassidy 1999), and serve as an enticement to the caregiver to prolong positive interactions (Bowlby 1969). When laughter occurs in the context of the therapeutic relationship, it is primarily viewed as the expression of conscious or unconscious affect, a discharge phenomenon. Laughter may also be analyzed from the standpoint of verbal content, focusing on the humorous words or jokes that evoked the laughter, or be seen as representing a countertransference enactment (Buckman 1994; Freud 1983; Fry and Salameh 1987; Kubie 1971). These primarily left-brain, one-person, verbal approaches to laughter in the clinical relationship, while interesting and sometimes relevant, overlook what we now know to be the core of human connection—the implicit, relational, expressive, non-verbal, right-brain-to-right-brain links between interconnected subjectivities (Schore 2003; Stern 1998). Viewing laughter as an attachment behavior that represents all aspects of the dyadic attachment/caregiving relationship, from affect arousal and attunement to regulation, provides the clinician with a way of understanding not just the meaning of the laughter itself, but also the light it sheds on the state of the patient's current affect-regulating styles and abilities, attachment history, and the therapeutic attachment/caregiving relationship.

Historical Overview of Laughter

Laughter as Discharge

Both Darwin and Freud refer to Spencer's (1860) essay on laughter. Freud (1905/1983) summarizes Spencer and writes: "... laughter is a phenomenon of the discharge of mental excitation and a proof that the psychical employment of this excitation has suddenly come up against an obstacle" (p. 146). Darwin (1872/1965) quotes Spencer directly: "The excess must discharge itself in some other direction, and there results an efflux through the motor nerves to various classes of the muscles, producing the half-convulsive actions we term laughter" (p. 198). In other words, pleasurable affect builds up as a quantity of

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intrapsychic energy, which at some point must be discharged in the muscular-skeletal, respiratory, vocalized physical expression of laughter.

Freud (1905/1983) also discusses the unconscious motivation behind jokes, linking it to "individual components of a person's sexual constitution," or, in the case of aggressive jokes, sexuality with a "powerful sadistic component" (p. 143). While Freud focuses brilliantly on the analysis of jokes, he explicitly avoids trying to make sense of laughter itself, quoting Dugas (1902) who points out that laughter is a behavior that has attracted a great deal of excitement and curiosity in everyone from ordinary people to philosophers and yet there is no behavior "that remains more unexplained" (as cited in Freud 1983, p. 146). Similar sentiments have been expressed in volume after volume by authors in multiple fields who have attempted this task.

The Interpersonal View of Laughter

Not a few of the students of laughter, Freud included, have, however, noted the social component of laughter. "No one can be content with having made a joke for himself alone. An urge to tell the joke to someone is inextricably bound up with the joke-work" (Freud 1983, p. 143).

Provine (2000) is a behavioral neuroscientist who studied laughter, first in the laboratory and later in natural settings. After decades of study, he concluded that laughter has little to do with humor. Instead, he found it to be "an instinctual survival tool for social animals, not an intellectual response to wit. It's not about getting the joke. It's about getting along" (Tierney 2007).

Panksepp, a neuroscientist and psychologist who has studied laughter in rats, suggests that laughter has several evolutionary functions: to encourage young animals to learn to play with each other, and to reassure other animals that they are playing and not hostile. He says that in humans as well, being able to express playfulness through laughter promotes "social bonding and the development of social skills" (Panksepp and Burgdorf 2003, p. 534).

Although laughter and smiling are frequently seen as one behavior on a continuum of intensity (Darwin 1965), a number of researchers and others have noted that they are distinct and unique phenomena. Lockard et al. (1977), for example, distinguish between the silent, bared-teeth, "submissive grimace of primates" and "the facial expression accompanying laughter evolved from the relaxed open-mouth display of play" (p. 183). Nwokah et al. (1994) argue that although laughter and smiling both indicate positive affect and "often converge, the interactive and communicative features of laughter in dyadic interaction may be more clearly determined by studying laughter separately as a unique phenomenon" (p. 24).

The Development of Laughter in Infancy and its Role in Attachment Formation

Laughter in human infants consistently begins at about 4 months of age (Sroufe and Wunsch 1972; Sroufe and Waters 1976; Sroufe 1995). This is a robust finding that nonetheless sometimes differs according to ethnic group or social class, perhaps based on the amount of holding, carrying and social contact in the early weeks of the infant's life (Anisfeld 1982).

Neurobiologically, the anterior cingulate cortex, an area of the brain involved in play and separation behaviors and in laughing and crying vocalizations matures during the third and fourth quarters of the first year. This development is important for establishing the link between cortical and limbic activity—for processing the external world and the internal responses or affect aroused by it. So when a mother makes a silly face or sound, the baby sees the mother change and is able to appraise it as playful and laughs (Sroufe and Waters 1976). Schore refers to the anterior cingulate as the area responsible "for vocalizations that 'maintain maternal–offspring contact," (p. 158) or in other words, the attachment behaviors of crying and laughter.

In discussing the neurobiological role of positive affective exchanges between mother and infant, Schore (2003) notes that the right cortex is known to be "specifically impacted by early social experiences, to be activated in intense states of elation, and to contribute to the development of reciprocal interactions within the mother–infant regulatory system" (p. 9). Positive affect in the mother's face has been shown to elicit high levels of endogenous opiates in the child's growing brain and these endorphins are biochemically linked to the pleasurable qualities of social interaction, social affect, and attachment (Schore 2003). The positive affective state, which is a combination of joy and interest, "motivates attachment bond formation" (Schore 2003, p. 10). Multiple, complex "biochemical events" help to explain the principle that "stable attachment bonds that transmit high levels of positive affect are vitally important for the infant's continuing neurobiological development" (Schore 2003, p. 10).

Laughter is a behavior that only occurs when caregiver and infant are engaged in face-to-face contact. Unlike crying, which is triggered by separation from the caregiver, infant laughter takes place only in the caregiver's presence (Bowlby 1969; Nelson 2005). As has been demonstrated by showing infants a video of a laughing or crying actress (Davidson and Fox 1982), the infant brain will show a corresponding pattern of positive or negative affect based

on the expressions they are viewing. The perception of emotion in one partner creates a resonant emotional state in the other (Beebe 2003, p. 30).

Laughter represents advances in the child's neurological development and also promotes these advances. The caregiver plays a dual role in arousing the infant to heightened positive affect through face-to-face contact and laugh-eliciting maneuvers, and in helping to down-regulate nonoptimal high levels of stimulation, paying attention to the infant's cues such as losing interest, turning away or averting gaze. As Schore (2003) describes it, "By promoting a symbiotic entrainment between the mother's mature and the infant's immature nervous systems, the child is stimulated in a similar state of heightened sympathetic activity and resultant positive affect" (p. 10). When a mother wiggles her finger toward the baby's stomach, nuzzles his neck and says "coochy, coochy, coo," and the baby laughs, an entire neural network is engaged in both of them with immeasurable benefits for the development of attachment and affect-regulation.

Research on the Development of Laughter in Infants

One study analyzed laughter patterns between mothers and infants from 4 weeks to 104 weeks of age, during 5–10 min play segments videotaped in a laboratory (Nwokah et al. 1994). Of the laughs recorded across 13 subjects during the infant's first year, there were 198 instances of the infant laughing first, 45 where the mother laughed first, and 3 simultaneous laughs. During the second year there were fewer instances of the infant laughing first (176), more where the mother laughed first (73) and an increase in simultaneous onset laughs (17). Even when the mothers were not laughing, they attuned to the infant laughter by smiling or vocalizing. This "analysis of dyadic, reciprocal laughter" suggested that after about 17 weeks, "there is a bidirectionality of laughter responses" (Nwokah et al. 1994, pp. 32–33). Within the first year, laughter is coordinated and becomes a shared experience between mother and baby.

As Beebe (2003) and others have observed, mothers and infants do not exactly match facial expression or level of affective engagement. Instead, they match "the direction of affective change" (p. 29) and do so within one-half second or less. What has been called "maternal facial contingency" (p. 30), the sequences of matching, mis-matching and repairing face-to-face interactions during the first year, has been shown to predict infant attachment security.

In their study of laughter in mothers and infants, Nwokah et al. (1994) noted that in the first year, the mother's goal is to "see and achieve high positive affect, but the infant is not trying to elicit such behavior in the mother. Rather the infant is watching, testing and reacting to mother's social behavior and events occurring in the environment. By the second year, the difference between partner's onsets and offsets of coactive laughter is significantly reduced, showing a greater sensitivity and attunement between mother and infant" (p. 33). Older infants were also observed trying to elicit maternal laughter, clowning with toys or teasing. If the infant's behavior evoked parental disapproval, the mothers would look serious rather than laughing.

Another study of infant laughter looked at 70 babies ages 4 through 12 months in the home to see which of 24 test items would get the babies to laugh (Sroufe and Wunsch 1972). All of the items were "in a sense social, since they involve the agent (the infant's mother) doing something in the baby's presence" (p. 1328). The items ranged from the auditory (noise-making) to tactile (blowing hair, kissing stomach, "coochy coo"), social (cloth in mother's mouth, "gonna get you") and visual (silly movements, disappearing objects). There was an increase in the amount of laughter responses to the test items with age: from 10% in the 4–6 month age group, to 37% at 7–9 months, and 73% at 10–12 months.

Response to various categories of items changed over time, however, with the social item being most effective in eliciting laughter in the youngest group, specifically the auditory/tactile/visual "gonna'-get-you" game. It was the peak item for the 4-month-olds just beginning to laugh, but it succeeded in eliciting laughter at all ages tested. Older infants responded more to the visual/social items such as peek-a-boo and silly movements or disappearing objects. Younger babies would laugh after the stimulus, older babies in anticipation of it. Providing additional evidence of the increasingly interactive aspects of laughter, older babies would often try to reproduce the laughter situations and participate with the mother by taking her hand, leaning in, or putting a cloth back in her mouth. A significant though not surprising observation was that crying infants consistently pull back and turn away from a stimulus, whereas laughing babies stay oriented toward the mother and reach for the object.

Laughter and "Now Moments"

Pleasurable face-to-face encounters between infant and caregiver are the prototype for what have been called "moments of meeting, " or "now moments" (Stern 1998). Such moments occur when things are "moving along" and then something unexpected happens, such as "a funny expression or an unexpected vocal and facial synchronization, and all of a sudden" infant and caregiver are "laughing together… The interaction has been kicked up to

a new and higher level of activation and joy" (Stern 1998, p. 305). As Stern (1998) and others (Lyons-Ruth 1998; Tronick 1998) have noted, such "now moments" also occur in the psychotherapeutic relationship when "each partner contributes something unique and authentic" and a moment is "therapeutically seized and mutually recognized" (Stern 1998 p. 305).

Stern (1998) points out that these psychotherapeutic moments go beyond technique and theory, upending the intersubjective context and creating an enactment that, when it is mutually "recognized and ratified," will bring a "new intersubjective state," into being (p. 305). Certain instances of shared laughter in the psychotherapeutic relationship beautifully represent such moments. They contain an element of surprise, unpredictability and represent "a nonlinear jump" (p. 304)—all qualities that have been used to describe laughter.

Carlberg (1997) reports on interviews with child therapists about what he called "turning points" in the therapeutic process. One respondent told him about an experience with a 10-year-old girl when a moment of intense mutual laughter over some candy with a funny name (which would fit the elements of "surprise, unpredictability and a 'nonlinear jump'") resulted in a "now moment," a "turning point" eight months after the start of therapy. Confirming its transformative impact, the girl afterward drew a picture of two people holding hands and walking toward an open door. The therapist said, "It was like the laughter opened the door." Carlberg concluded that at a turning point, there is a moment of "meeting with a great emotional impact" after which "the change becomes visible" (p. 342)—literally in the little girl's picture representing the therapeutic attachment bond (holding hands) and the establishment of security represented by going through the open door.

Corbett (2004) describes a series of "now moments" involving laughter that occurred early in the treatment of Mr. B. The first occurred when Corbett dropped his pen and it rolled under the couch. He tried to discreetly retrieve it with his foot, but when the patient noticed, he told him what had happened and then "crawled partway under the couch" to get it back. The patient, a quiet, despairing, man with flat affect and energy started to laugh heartily. There followed in subsequent sessions a series of slapstick-like "missteps"—tripping on the carpet, bumping into the couch, spilling tea—all "non-linear" and "surprising" and comedic—that eventually opened up the "relational space" that enabled analyst and patient to connect.

In keeping with the definition of "now moments" as unpredictable, surprising and nonlinear, it is worth noting that naturalistic research on laughter reveals that most laughter is "not a consequence of structured attempts at humor such as joke-or story-telling" (Provine 1993, p. 295). Rather, laughter proceeds from comments that to outside observers seem subjective and arbitrary. What is important is the "playful dynamic of the social setting that includes a multitude of non-verbal and postural cues" (p. 295), which are more important for eliciting laughter than particular verbal messages with particular humorous content. Typical laughter-eliciting comments noted by Provine (1993, p. 294), for example, were often such mundane phrases as "I'll see you guys later," or "Can I join you?" The relative unimportance of content argues for the primacy of the right-brain-to-right-brain connection in positive affect arousal. As many of the clinical examples make clear, in order to get the humor behind the laughter, "you had to be there."

Laughter in Psychotherapy

Two books (Buckman 1994; Fry and Salameh 1987) explore the uses of humor in psychotherapy with children, couples, groups, individuals, the elderly and cancer patients; and from varying theoretical viewpoints, including behavioral, systems, Adlerian, strategic, short-term and rational-emotive. The editors of the *Handbook of Humor and Psychotherapy* define therapeutic humor as "constructive, empathic humor, which is totally unrelated to sarcasm, racist or sexist humor, deformations, put-downs and other abuses of humor" (Fry and Salameh 1987, p. xix). In articles throughout the book, the role of humor in psychotherapy is discussed from a primarily left brain viewpoint, with laughter usually presented as an indicator or a by-product of a humorous verbal exchange.

In spite of these largely positive views, there is a lingering negativity, wariness about, or reluctance to explore the role of laughter in psychotherapy. Kubie (1971) is the most frequently cited psychoanalytic spokesperson for what he has called "the destructive potential of humor in psychotherapy." He pointed out that even a therapist who defends the use of humor appears to feel secret guilt about it because "he almost never reports his own humor in his accounts of therapeutic sessions. He forgets it, hides it, and reports seriously what he actually presented to the patient with humor" (p. 865).

All of the potentially destructive aspects of humor in psychotherapy that Kubie outlines are indeed causes for concern. He points to the risk that humor may mask hostility, divert or foreclose the patient's true thoughts and feelings, hurt or offend the patient, intensify resistance, seduce the patient sexually or emotionally, entice the patient into compliance, or confuse the patient about the therapist's intent. He also points to the likelihood of countertransference enactments being played out in the guise of humor, perhaps masking the anxiety, anger, or

judgment of the therapist. Humor in psychotherapy, in his view, is a form of self-disclosure that violates neutrality to the detriment of the patient and the therapeutic relationship.

Corbett (2004) took Kubie's cautions seriously by looking deeply at his own internal process, including aggression toward the patient. On the other side, however, Corbett noted how the comedy and laughter between Mr. B and himself expanded his empathy and "growing affection" for his patient. In the end, Corbett concluded that with his patient, humor and laughter "served to construct relational space" during the opening phase of treatment with a man who was suffering from alienation and despair. Mr. B, whose parental caregivers had been neglectful, craved a close, caring, non-sexualized maternal relationship with the analyst. He commented about how little he had heretofore laughed in his life.

Siebold (2006) describes a case in which she and a female patient "shared the experience of knowledge about female sexuality by laughing together as she talked about what really felt good to her" (p. 12). Siebold, too, wrestled with possible negative consequences of their laughter. Knowing that the patient's attachment history involved a mother who would "question her sexual morality or accuse her of being a slut," Siebold followed her "countertransference pull to become the accepting, rather than critical or competing, maternal object who could allow her to be sexual" (p. 12). In response to the patient's sexual exploratory behavior, Siebold became the secure base, encouraging the young woman to express and be herself. Shared laughter provided the encouragement and the support.

Laughter as Attachment Behavior in Psychotherapy

Two things seem clear about laughter in psychotherapy: it occurs; and it can have positive or negative effects on the therapeutic relationship and the therapeutic process. Even Kubie (1971) noted that humor can at times be "a safe and effective tool" and, further, that an overly "dour approach" (p. 866) can also have its dangers, especially when working with patients with overly serious, depressive or neglectful parental caregivers. Instead of focusing on the content of the humor, laughter can be viewed as an attachment behavior that may deliver multiple attachment messages and serve to strengthen or weaken the therapeutic attachment bond, or as a means of regulating affect. Looking at laughter as attachment behavior gives the therapist a way of understanding when and why laughter is appropriate and relationship enhancing and when it can interfere.

From a clinical perspective, laughter may be seen to represent connection or detachment. It can invite closeness or it can be a barrier. Some laughter may represent the delight in the mutual recognition of transformation, whereas at other times it serves as a defensive resistance to growth and change. It can be a form of caregiving and affect regulation, or it may represent compulsive caregiving used to entertain and up-regulate depressive affect in others. On the other hand, laughter can be a sign of overstimulation in a person who is in need of down-regulation. The absence of laughter can represent a safe holding environment for some patients, while offering an unattuned caregiver to others.

Looking beyond attachment, laughter may also be seen to occur in other behavioral systems. In the caregiving system it is a way of regulating affect, one's own and another's, and may mask anxiety or hostility. In the affiliative system it says, "I am friendly, you can approach me." In the conflict/appeasement system it indicates, "I am making light of this so I am not a threat" or deliver the message, "I am no longer angry." Flirtatious, seductive laughter conveying sexual energy is part of the mating/sexual system of behaviors, while laughter in delight at the discovery of a new object or idea belongs to the exploration/curiosity system. There is considerable overlap between the above behavioral systems and the attachment system, which helps to explain some of the contradictory views and experiences with laughter in psychotherapy. It often helps to look for the attachment themes underlying laughter even when it appears to be associated with these other behavioral systems. For example, conflict/appeasement laughter may also signal, "I am ready to reconnect after our angry rupture."

Research on Laughter in Psychotherapy

Bedi et al. (2005) interviewed 40 clients who were currently in therapy or had been in the previous year (short-term or long-term, in a variety of settings including clinics and private practice) to identify the variables they considered important for establishing and maintaining a positive therapeutic alliance. One of the categories of behavior described by some respondents was humor. The anecdotal references in this category were to jokes initiated by the therapist. Two took place in the beginning phase of treatment: one client said the therapist joked about exercise in reference to his/her (the therapist's) extra weight; another said the therapist made intelligent jokes to "break the ice" (p. 319).

Humor, jokes and laughter at the beginning of the relationship would function more as affiliative behaviors designed to put the patient at ease and minimize anxiety. However, successful affiliation sets the stage for the later development of the therapeutic attachment bond, or the therapeutic alliance as defined in this study.

A response from another participant referred to the therapist's use of humor for affect regulation: "The counselor made nice, innocent jokes when I cried or was very tense" (p. 319). When the attachment bond is seen as "the mutual regulation of affect," it is clear that this intervention did indeed contribute to the "therapeutic alliance" or attachment. In looking at the mutuality of affect regulation, we might speculate that the patient's tension and tearfulness were negatively arousing to the therapist and hence the lightening of affect succeeded in regulating affect for both partners. Again, it is important to monitor countertransference responses that may foreclose the grief reaction in order to increase the therapist's comfort level.

Marci et al. (2004) videotaped 10 sessions of psychodynamic psychotherapy while simultaneously measuring skin conductivity of both patients and therapists in order to determine the physiologic evidence for the interpersonal role of laughter in psychotherapy. They identified an overall total of 167 laugh responses (approximately 2 every 5 minutes!). Of the 119 laughs by the patient, 76% were initiated *by* the patient, compared with 23.4% when the patient laughed in response to the therapist. There were far fewer total therapist laughs—only 48—and 90.3% of these occurred when the therapist was responding to the patient. The researchers speculate that the significantly fewer laughs initiated by therapists may point to "the natural reserve of trained therapists during a psychotherapy session" (Marci et al. 2004, p. 693).

The physiologic analysis indicated that the skin conductance levels increased in all conditions for both parties, regardless of whether they initiated the laughter or responded to it, evidence that laughter in these sessions (as in mother/infant laughter research) represents mutual arousal. The skin conductance scores for patients increased more when the therapist laughed with the patient than when the patient laughed alone, providing additional support to the impact of mutual arousal when laughter is shared.

Laughter in Psychotherapy: A Suggested Classification Based on Attachment Theory

Laughter as Connection

Laughter at its best in the therapeutic relationship is a right-brain-to-right-brain bonding experience. It says, "we are together, we are of one mind, we both get this and appreciate it viscerally—we don't have to put it into words, we just know and find it delightful."

> Mr. T, a young musician in his early 20s, has often related stories about his father's harsh criticisms. On a recent occasion, Mr. T wrote and recorded a composition and played it for his father. He prepared himself for the usual onslaught of abuse, but at the end, his father gushed: "That is absolutely wonderful! You nailed it! You are ready for Carnegie Hall!" As soon as Mr. T delivered the "punch line," so to speak, of this narrative, we both burst out laughing and continued for a minute or more. From time to time, we still refer back to his father's incongruent and unexpected reaction, chuckle, say "Carnegie Hall" and shake our heads.

I am hard pressed to say precisely what was so funny about that story. Was it disbelief at the positive attunement from his father "out of the blue"? Was it the realization that his father does indeed respect and admire him may be criticizing and admonishing him out of parental pride and responsibility? Was it the surprise, the incongruence or irony that we found humorous? None of those interpretations quite touch the moment when Mr. T finished the story, looked across at me and we both instantaneously started laughing. Somehow, it was more about some unarticulated mutual knowledge tied up in our bond that was represented in our hearty laughter. It both underscored our mutual connection and helped to intensify it. His reaction and my reaction became one in that moment of understanding and insight. It felt, in other words, like a right brain to right brain connection manifest in mutual laughter.

Laughter as Disconnection

Josie and Janet had been in couple's therapy for a year. They had recently been through a frightening medical crisis during which time during which it had appeared that Janet might permanently lose the use of her hand. In a session during the aftermath of the crisis when it was clear that the treatment would be successful, the following episode occurred:

> Janet said that the previous night, Joise had asked her to bathe their son because "I did it last night and the night before and the night before and forever." Janet was upset because Josie's request seemed to be discounting all the stress she had just been through (stress about the threatened loss, visits to many specialists, diagnosis of her condition and now the impact of the treatment). At this point, Josie, smiling brightly and looking impish and winsome said, "Well, it was, after all, your left hand." Janet smiled slightly (I was not tempted to smile but did find myself drawn in by Josie's elfish charm), but Janet said, "That might have been funny the first time or two you said it, but after a while it isn't funny! And

even though it is supposed to be a joke, I think there is truth in it, too." A discussion ensued, with me asking Josie questions about her constant smiling, jokes and humor no matter the situation. When awkward or negative feelings are expressed, her eyes brighten; she says something "cute" and chuckles to herself even if nobody else does (i.e. Janet or me). I suggested that she was using the "left hand" joke in a misguided attempt to regulate Janet's negative affect (here directed at Josie), distract her and defend herself. I reminded her that she had been very worried about Janet's condition too and had spent one session crying with her about their worries for her health. At that point, she became serious, looked at Janet and said that she knew she had been through a lot and that it still impacted her energy and mood, which immediately enabled them to reconnect.

Josie's attachment history involves growing up in a family where there was palpable anxiety in both parents that was displaced in their authoritarian control of their children. Josie's brother rebelled against it. Josie's learned to deflect it by being cute and therefore not adding any additional stress to her overburdened parents. In other words, her smiling, jokes and laughter represent a form of compulsive caregiving in her family of origin, which is often ineffective and counterproductive in her relationship with Janet. In addition, it would seem that the constant use of humor goes hand-in-glove with her avoidant attachment style. It serves to deflect her own and other's negative arousal and the activation of attachment distress.

Laughter as Caregiving and Affect Regulation

A depressed young mother was recounting an experience from the previous weekend when she got up early thinking she would have some time to herself. She described sitting quietly staring at the garden, drinking her coffee, when suddenly a lamp came crashing down (the puppy knocked it over). She jumped up and in that moment saw that the dog had just "pooped" on the carpet and her son was coming inside lugging a leaky sprinkling can. I started to chuckle as I envisioned this scene and she joined in laughing with me. Then she said, "I was so upset and irritated at the time that I couldn't see the humor in it."

My laughter was spontaneous and unplanned. I felt her mood and in a split second took off in a different direction, attempting to regulate and lighten the depressive affect. Fortunately, I read the situation correctly and she was able to lighten up as well. I checked in with myself about a possible enactment in terms of my own unwillingness or inability to tolerate her depressive affect, and I also recalled that her husband's complaints about her depressive affect were the reason she had sought therapy. He said he was tired of always bolstering her sprits when she got down, so that a focus of our work has been to help her learn to self-regulate. In this instance, I used the laughter not only to lighten her mood but also to help her use her left brain to get some much-needed perspective at moments like the one she described. Her comment that she hadn't been able to see the humor at the time indicated that she "got" the "interpretation" intended in my laughter: that there was more than one way to see the situation.

In terms of looking at her early attachment relationships, it is crucial to understand that as one of three children in a high-achieving family (parents and grandparents), the primary way she learned to quell anxiety and insecurity was by accomplishing more and doing it quicker and smarter in a way that would be noticed. It was an unending process in that no matter how hard she tried, she never achieved the recognition, security, and connection that she craved. She also only learned one means of affect regulation: distraction in keeping busy. In words, and here by example, I had been helping her to diversify her ability to regulate affect and supporting her in her efforts to gain security in her relationship with her husband through more connected means than doing tasks or depending on him to "read" her anxiety and reach out to soothe her.

Laughter and Establishing the Therapeutic Attachment Bond

It is difficult to know when laughter is an invitation to the establishment of the therapeutic attachment bond and when it can be a barrier. The same is also true about the absence of laughter—that, too, can be either an invitation to greater closeness or a way of foreclosing it. Clues about attachment style, patterns of affect regulation, attachment history, wounds and losses can be invaluable for helping the clinician to determine laughter's potential role.

An extremely funny former co-worker once shared with me that she was looking for a therapist. She was having a hard time, she said, because "I have to find someone who won't laugh at my jokes." I felt for the poor therapist who would be tested in this way—presented with an extremely funny person without knowing that she needed a straight-faced response. I have, however, held it in my consciousness all these years to remind me that an invitation to laugh may not be what it appears.

On the other hand, an extremely funny San Francisco Chronicle columnist, "Ms. Gonick," who makes no secret of her neurotic struggles, writes of her attempt to engage in therapy when she was feeling suicidal. "And since my shrink saw no need for anti-depressants, we tried to reshape

my psyche through 'talking,' which, for me, meant trying to make her laugh while she in turn had to stifle her laughter in order to keep looking properly shrinkish. Then, since all that talking made me no saner and quite a bit poorer, I quit." (Gonick 2004, p. E-20).

In the case of my coworker I can only assume, without knowing her personal history, that entertaining or "enlivening" an early caregiver was behind her humor—that it, like for the patient Josie mentioned above, represented a form of compulsive caregiving. She needed a therapeutic relationship with someone who was strong enough to act as her caregiver in order to heal from her early attachment wounds. On the other hand, Ms. Gonick, who needed a laugh in response from her therapist, used humor and laughter as a form of self-regulation aimed at enlivening herself and avoiding the pull of suicide. For her it was not about up-regulating a depressed caregiver, but rather about up-regulating her own depressed and threatened self. Her desperate attempts to make other people laugh were lost on the therapist who played the therapeutic "role" rather than being able to support Ms. Gonick's admittedly limited and symptomatic attempts to save her own life. By rejecting the humor, by not being able to "start where her client" was, she rejected Ms. Gonick's existence with the result that Ms. Gonick left the therapy.

In these two accounts, the therapist has just two clues: the conscious awareness of both these women about what they needed, and the countertransference "read" of the situation. A new patient may be able to "communicate" his/her need to a properly receptive therapist through giving her attachment history, through body language, or perhaps even through directly coaching the therapist. It would appear that Ms. Gonick's therapist understood in her right brain that laughter was the proper response. However, she tried ineffectively to "stifle" her laughter and remain "properly shrinkish," which threatened Ms. Gonick's fragile efforts to stay alive.

Conclusion

Laughter is at its core an attachment behavior that serves throughout life to enhance attachment/caregiving and affiliative bonds. However, it can also be many other things—hostile, distancing, defensive and seductive–to name a few that may enter into the therapeutic relationship. The attachment messages implicit in all of these other possibilities, however, also make it possible to increase the consciousness of the therapist about how to assess laughter, when (and why) to use it, and when (and why) it is in the best interests of the patient to keep a straight face.

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