What's So Funny: Humor's Impact on Third Party Evaluation of Clinicians

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What's So Funny: Humor's Impact on Third Party Evaluation of Clinicians?

Humor and its use have many positive benefits in a variety of areas. Humor is a cognitive process that usually includes positive displays of affect such as laughter or smiling. More specifically, humor has been defined as "a perception of an inconsistency that causes no harm to the *perceiver*, frames the message *non-critically* and elicits an *emotional response* of amusement that can include smiling or laughing" (Baisley & Grunberg, 2019, p. 1). These authors go on to clarify how the way the perceiver experiences the attempt at humor is crucial to their judgment of whether the attempt is successful. The perceiver must have no negative reaction to the attempt at humor, and the attempt at humor must elicit a response consistent with humor; or at minimum an appreciation for the joke that was made.

This concept may seem simple, but with the extreme subjectivity of humor it becomes difficult to effectively measure humor due to differences between receivers of humor. Various subtypes of humor have been described (Baisley & Grunberg, 2019). For example, sarcasm, also known as disparagement humor, could come across as mean-spirited to some, but intensely humorous to others. Positive humor includes anecdotes (comical personal stories), jokes (pre-packaged anecdotes that people memorize and pass on to others), puns (humorists' use of a word that evokes a second meaning), witticisms (humorous sayings or expressions that are routinely or recurrently used in conversation), irony (statements in which the literal meaning is different from the intended meaning), hyperbolic statements (comic presentation marked by extravagant exaggeration and outsized characterization), and self-enhancing humor (having a humorous outlook on life that is utilized to maintain self-esteem and cope with stress) (Baisley & Grunberg, 2019).

However, humor is not always positive. Gladding and Wallace (2016) described four different types of negative humor, including satire (aggressive humor that pokes fun at social institutions or policies), dark humor (dealing with misfortune or death with a pessimistic outlook), teasing (humorous remarks directed at the listener's personal appearance or shortcomings) and risqué humor (unsubtle humor often marked by coarse jokes and sexual situations). It is surmised within the therapy context, these negative attempts at humor could lead to disastrous outcomes. Some studies reported that humor could cause individuals to develop unhealthy prejudices as well as be utilized against other people in insulting or hurtful ways. Humor is especially damaging when used to humiliate an individual or target someone's self-esteem or intelligence. This has a high possibility of ruining any chance of humor's positive impact in essentially every context in which humor can be utilized (Amici, 2019).

Despite these potential negative effects, humor's positive impacts are greater in number and significance. Humor has more uses than simply making people laugh; with extant research documenting how humor is used as a tool to promote well-being in a variety of settings such as workplaces, elder care facilities and even individual therapy (Lehmann-Willenbrock & Allen, 2014).

Humor has been described as the "handmaiden of wellness," as it has strong positive benefits both mentally and physically (Gladding & Wallace, 2016). Humor can be used to enhance communication, focus, and team cohesion, as well as in a clinical setting such as therapy. Humor can be helpful when focusing on the task at hand and has been shown to be an effective icebreaker in difficult social situations (Dziegielewski et al., 2003). However, in excessive amounts, humor can have the opposite impact by becoming a distractor from tasks. It can also display a sense of "aloofness" in the individual making an attempt at humor, as it can be

perceived as condescending or disrespectful to the receiver. Therefore, for humor to be an effective tool, a balance must be maintained.

Researchers have described how humor can be used in an intentional manner to improve workplace settings (Dziegielewski et al., 2003). Effective use of humor in the workplace can be conducive to a more positive working environment. Research shows that humor leads to improvements in productivity within team-based groups, increases in identifying novel solutions, and enhanced communication (Lehmann-Willenbrock & Allen, 2014). When employed effectively, humor can also elevate one's interpersonal status and social standing within the workplace (Hoption et al., 2013; Bitterly et al., 2016).

The positive benefits of humor extend into the arena of mental health as research has documented increased individual emotional well-being, decreases in perceived stress, and reductions in depression and anxiety when humor is employed (Crawford & Caltabiano, 2011). Humor also has strong, positive applications when utilized to enhance overall health and wellness. Its implementation has strong positive returns on helping those experiencing negative emotions (Scott et al., 2014), as well as the elderly (Wilson & Richman, 1995).

Employing humor within a psychotherapy context has the potential to be very impactful, and has been described as a positive interaction that enhances physical and/or emotional well-being (van der Wal & Kok, 2019). More specifically, humor has been shown to have marked positive returns when utilized within the context of clinical therapy leading to strengthened rapport and greater progress in treatment (Sultanoff, 2003; Gladding & Wallace, 2016).

The most obvious application of humor in therapy is promotion of the therapeutic relationship. While the essential nature of building rapport within a therapy setting is well documented (Dziegielewski et al., 2003), it is also one of the more difficult things to achieve.

When implemented appropriately, humor showcases the therapist's humanity, and displays they are paying attention to and understand the client at a personal level.

Direct influences on individuals' biochemistry as a product of humor have also been reported. An array of associated benefits are usually coupled with an increase in serotonin (Yoshikawa et al., 2018). Individuals who laugh have reduced levels of stress-related hormones, as well as increased concentrations of antibodies. The biological benefits do not end there, however. During the physical activity of laughing several systems of the body are exercised such as the cardiovascular system and the muscular system (Sultanoff, 2013). The physical act of laughter can also lower blood pressure and heart rate, as well as reducing self-reports of perceived bodily pain. The benefits of laughter impact mood in addition to the biochemistry of the body.

Humor can also be utilized as a cognitive tool to improve client's moods (Dziegielewski et al., 2003). Another way therapeutic humor enhances well-being is by stimulating creative thinking. For example, clients can utilize humor to reframe terrible situations in a different perspective, which is something that can be challenging for clients battling mood disorders such as depression. Thinking through a more humor-oriented lens helps clients think in a novel and more positive manner that is in direct contrast to more maladaptive thinking patterns commonly found in therapy clients (Dziegielewski et al., 2003).

Humor may have its most direct influence on emotions. Sultanoff (2013) described how humor can reduce the impact of stressful events as well as reduce anxiety and negative mood. This author also noted how anger itself cannot be maintained if laughter or humor is occurring. A third point emphasized by Sultanoff was that humor can help depressed clients learn the sensation of being depressed can in fact fade, due to them enjoying humor in the moment.

Laughter-inducing therapies have been shown to increase therapy effectiveness, with indications of being more cost-efficient compared to more intensive and sombre therapeutic approaches (van der Wal & Kok, 2019).

Despite the positive indications of humor's potential as a therapeutic tool, causality has not been established due to a paucity of randomized control trials and reliance on anecdotal results from various authors (Wal & Kok, 2019). In addition to the rather shallow pool of research findings, previous authors have not promoted humor as a "cure-all", but rather as an adjunctive component that could be integrated into other established therapy approaches. Also, the potential utility of integrating humor into a balanced therapeutic approach that includes serious discussions of sensitive topics and conveys respect for the client has not been adequately explored.

The existing literature regarding the use of humor in clinical settings concurs in regards to certain limitations that should be kept in mind. Therapists run the risk of having clients respond in a manner indicating the attempt at humor was irrelevant to their own counselling experience. If inappropriately timed or overemployed, humor could serve to create distance or avoidance of important therapeutic issues. The largest concern is the client viewing the attempt at humor as a put down or an attack (Sultanoff, 2013).

Balancing and using humor effectively in therapy may be quite challenging and many therapists may not possess the inclination or confidence in their ability to employ it in an effective way. For clinicians to effectively utilize humor to its true potential, they would need to receive explicit training, with authors suggesting humor can be viewed as another tool within the "clinician's toolbox"—a therapeutic skill that could be taught, developed, and mastered (Franzini, 2001).

The largest caveat regarding whether humor has a positive or negative impact is the perception of the recipient. The individual initiating the attempt at humor could think what they say is hilarious, yet the receiver is insulted, disgusted or just plain apathetic towards the attempt (Bennett, 1996). This perception is highlighted even more when it comes to a therapeutic context. Rapport is one of the largest predictors of successful therapy but is inherently reciprocal and not up to the therapist to determine absent endorsement from the client. Ultimately, it is the client's perception of the therapist that defines strong rapport. If the client dislikes their therapist, therapeutic progress is unlikely. But, if the client perceives their relationship with the therapist as strong and positive, rapport is strengthened and treatment outcomes are enhanced (Fortems et al., 2022).

In summary review of the scholarly literature cited, client's perceptions of the quality of the service being provided by their therapist is a crucial component in determining therapy outcomes. Client's perceptions of a therapist's personal qualities are critical in judgments of the quality of the service provided. When employing humor in therapy, a therapist assumes some predictable risks. Initially, the attempt at humor could be lost on the client. Worse yet, it could be misconstrued to be viewed as insensitive, disrespectful, or even offensive, thereby alienating the client and damaging rapport. Ultimately, it is the client's perception of and reactions to attempts at humor by a therapist that determines whether humor served to build rapport, or damaged the therapeutic alliance.

While the effective and appropriate use of humor in therapy may be difficult to master, successful attempts at humor in the clinical setting have the potential to facilitate therapy and improve client satisfaction through enhancing clients' perception of their therapist. Therefore,

the focus of the current study is to utilize an analog approach to assess reactions to therapist's attempts at humor within a clinical setting.

The broadly stated hypothesis is that differential ratings of important therapist qualities will be elicited when study participant's witness attempts at humor that elicit a positive, neutral or negative reaction from a client. More specifically, global ratings of the therapist, along with ratings of the therapist's expertness, attractiveness and trustworthiness, will be statistically significantly higher when the client provides a positive reaction compared to when the client reaction is neutral or negative. Secondarily, it is hypothesized that therapist ratings on all four dependent measures will be significantly less favorable when the client's reaction is negative compared to a neutral reaction.

Standpoint

Humor has always been a large part of my life. I enjoy comedy movies and making people laugh and often use humor in difficult situations to both defuse these situations and refocus the conversation. As someone who enjoys both using humor and comedy itself, I am strongly aware of the positives that come from making people laugh. I aim to combine both my personal experience with humor's usefulness with the previous research on humor and its application in a clinical setting to formulate a greater understanding of the positive, and possibly negative, impacts of humor, when applied in a clinical setting—more specifically, humor's impact on ratings of perceived quality of therapists.

Method

Participants

Participants were recruited from Amazon's Mechanical Turk crowdsourcing survey program. A power analysis was utilized to determine an ideal sample size of 149 participants. An

initial sample of 184 participants was collected, with 20 being excluded from the statistical analyses due to leaving portions of the survey blank or incomplete. The eventual sample included an N = 164 participants, with 65.24% self-identifying as White and 35% as Female. Participants' ages ranged between 18-66 (*M*age = 35.5, *SD* = 10.4). Research participants were reimbursed at a rate of $3.64 as compensation for their participation.

Materials

Demographics Form. Questions solicited participants' self-reported age, gender identity and race. (See Appendix A for a copy of the Demographics Form).

Video Vignettes. Three videos were created, with each depicting a brief therapy session. The main content of each video was identical, with the therapist and client statements matching exactly during a description and discussion of therapeutic tools or techniques commonly employed in Cognitive Behavioral Therapy (e.g.; S->T->E->P->B Chart and a description of the "Levels of Thoughts"). At a critical juncture in the therapy session, the therapist enacts one of three interventions that differentiate the three vignettes. In the "positive humor" condition, the therapist pauses and smiles and offers a light-hearted comment which is followed by the client smiling and chuckling. In the "neutral" condition, the therapist carries on with the discussion with no discernible reaction from the client. In the "negative humor" condition, the therapist makes a comment that is somewhat sarcastic followed by the client shifting uncomfortably in their chair with a facial expression of disappointment or disgust. (See Appendix B for a transcript of the three videos).

Counselor Rating Form-Short Version. To measure client perceptions of therapist quality, the Counselor Rating Form- Short Version (CRF-S; Corrigan & Schmidt, 1983) was used. More specifically, the CRF-S was created to improve the usability of the previously

established, but lengthier, Counselor Rating Form (Barak & LaCrosse, 1975). The CRF-S examines three subscales of a therapist's quality—attractiveness, expertness, and trustworthiness. Despite reducing the CRF to 4 items per subscale, the CRF-S does not sacrifice the strong psychometrics previously reported for the original CRF measure. The format of the questionnaire is as follows: 12 items are given that the participant rates on a 7-point semantic differential scale of how much the therapist in question meets a specific quality. Therefore, total scale scores can range from 12 to 84, with higher scores indicating more favorable ratings. Scores for each of the three subscales can range from 4 to 28, again with higher scores indicating the therapist being viewed as more Attractive, Expert, or Trustworthy. The first four items are summed to produce the Attractive subscale; items 5 through 8 are summed to compute Expertness; with the last four items summed to compute the Trustworthy subscale score. Example items from the CRS-F include characteristics such as "Friendly" (which loads on the Attractive subscale), "Experienced" (which loads on the Expert subscale), and "Honest" (which loads on Trustworthy subscale). Strong reliability and validity have been established for all three subscales for the CRF-S including Attractiveness (r_{xx} = .93, R^2 = .245), Expertness (r_{xx}= .91, R^2 = .303) and Trustworthiness (r_{xx} = .82, R^2 = .251). The authors of the CRS have interpreted these statistics to mean the measure will return roughly the same scores over time as well as effectively measure the intended constructs (Corrigan & Schmidt, 1983). (See Appendix C for a copy of the CRF-S).

Design

This study employed an experimental design with the three conditions of "positive", "neutral" and "negative" client response as depicted in the three videos serving as the levels of the independent variable, and participants ratings of the therapists depicted in the videos using the CRS-F as the dependent variables.

This procedure produces a between-subjects design because participants in the study viewed and provided ratings for only one of the three videos. Potential confounding variables controlled for include qualities of the therapist (gender, physical stature, clothing, voice tone and rate) and the session itself (language level used, content covered in session). These variables were controlled by using the same actor to portray the therapist, as well as the same actor to portray the client, in all three videos; and using the exact same script of what the therapist and client say across the three videos, except during the brief period when the independent variable is enacted.

Procedures

Participants were recruited through announcements posted within Amazon's Mechanical Turk Online Survey Software. Participants first read and completed informed consent forms (See Appendix D) online before any other facet of the procedure was administered. After completing the Demographics Form, participants were randomly assigned to one of three conditions and instructed to view the video connected to that condition. After viewing the assigned video, they were asked to rate the therapist in the video using the CRF-S. Participation concluded with being shown the Debriefing Form (See Appendix E).

Results

The first proposed hypothesis for this study was that the participants in the "positive humor" condition would provide statistically significantly higher ratings on the total scale score, as well as all three subscales, on the CRF-S compared to ratings provided by participants assigned to the "neutral" and "negative humor" conditions. The second hypothesis was that participants in the "negative humor" condition would provide ratings on the CRF-S that were

statistically significantly lower than those provided in the neutral condition for all four dependent measures.

A Multiple Analysis of Variance (MANOVA) was utilized along with Roy's largest root to identify statistically significant differences between groups on each of the three CRF-S dimensions, F (3, 160) = 3.88, p = 0.01, η_p^2 = 136.07). Follow-up post-hoc tests using Bonferroni correction were then ran, specifically One-Way Analyses of Variance (One-Way ANOVAs). One-Way ANOVAs determined the negative condition (N = 55, M = 20.31, SD = 4.53) provided significantly lower Expertness scores F (2, 161) = 5.021, p = .008) compared to the positive (N = 56, M = 22.73, SD = 4.37) condition. The negative condition (N = 55, M = 63.49, SD = 10.705) also provided significantly lower Total Therapist scores F (2, 161) = 3.405, p = .036) compared to the positive (N = 56, M = 68.52, SD = 12.163) condition. Because the MANOVAs conducted on the other two dependent measures failed to reach the established $p < .05$ standard, follow-up one-way ANOVAs were not conducted. More specifically, Attractiveness approached significance F (2, 163) = 2.58, p = .079), but Trustworthiness was not significant F (2, 163) = 1.28, p = .282).

The first hypothesis was partially supported with the ratings on Expertness and Total Therapist shown to be statistically significantly higher for the positive condition compared to the negative condition. However, this hypothesis was not supported on these two CRS-F dimensions in the comparison between the positive and neutral conditions. The second hypothesis was also partially supported as the negative group produced statistically significantly lower scores compared to the neutral condition on Expertness and Total Therapist. Neither the first or second hypotheses were supported on comparisons across conditions focused on the ratings of Attractiveness or Trustworthiness.

Discussion

The current study could serve as the foundation for future research that seeks to identify the utility of humor as a tool within clinical practice. Humor has been shown to enhance well-being in settings ranging from healthcare to other workplaces. Findings from the current study support previous suggestions that humor could also enhance outcomes in clinical therapy settings. Prior to the experimental design employed in the current study, support for the idea of using humor as a tool to build rapport, a potentially valuable step in the therapeutic process, has been anecdotal at best. Therefore, the current study serves as an initial attempt to fill the glaringly vacant void of empirical research on this topic and can serve as a foundation upon which future research can evolve. The goal of this study was to apply an experimental research design to hone the focus on humor and its use in a clinical setting, specifically a 1-on-1 therapist-to-client individual therapy setting, and attempt to clarify how humor impacts client's perceptions of the therapist.

Results of this study showcase that therapists who successfully make clients laugh or show no reaction to comments that are thought humorous are viewed as being more expert and better therapists overall compared to humor that elicits a negative client response. Conversely, the current results also highlight that therapists who attempt humor that results in clients being visually insulted or hurt are at risk of damaging the therapeutic alliance by reducing their perceived expertness and overall rating. This relationship alludes that humor is risky and that attempts are truly a "gamble", possible harming or hurting the relationship with the client.

Limitations for this study lie mainly in the medium of the experiment. Rather than directly experiencing the client role, participants were "once removed" and merely served as "witnesses" to therapist-client interaction. Therefore, whether clients in a position to directly

receive the humor would react similarly is unknown. Future research could be done in an actual clinical setting as opposed to using the video vignettes employed in the current study. The seriousness and sincerity of an analog approach coupled with the potentially emotionally distancing effect of watching a video could be at least partially improved by including focus checks to more strenuously ensure that participants are paying close attention to the videos. Another solid direction for future research lies in the realm of rapport. The three domains measured in this study (Attractiveness, Trustworthiness and Expertness), while not directly mapping onto rapport, they make up valuable pieces of the therapeutic relationship. Rapport was not directly measured however, and could be measured directly in the future to solidify this relationship.

This experiment examining the relationship between humor and client reactions is one of the first steps in establishing humor as a therapeutic tool beyond the anecdotal support it currently holds. Future research can be designed to evaluate whether certain comments tailored to specific clients can have differential effects. Creation of a scale to measure which variety of humor a client is attuned to would be helpful moving forward as well. Overall, more research can be, and needs to be, done in order to solidify humor as a tool in the therapist's repertoire. This deeper research could prove to be invaluable for rapport building and treatment efficacy.

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Appendix A

Demographics Form

1. **What is your age in years (e.g., “18”)?**

2. **What is your gender identity? Please check one.**

   □ Male □ Female

   □ Genderqueer/Androgynous, Intersex, Transgender, Transsexual or another gender identity not listed here

3. **What is your race/ethnicity? Please check one.**

   □ Caucasian □ African American, Latino/Hispanic, Asian

   □ Native Hawaiian/Pacific Islander, American Indian/Alaskan Native or another race/ethnicity not listed here

4. **What is your class year? Please check one.**

   □ First Year/Freshman □ Sophomore □ Junior □ Senior

   □ Graduate Student □ Not a student

Appendix B

Scripts of Vignettes

Therapist: Good morning [CLIENT], how are you doing today?

Client: Oh, it's okay, it's just been a rough week.

Therapist: It's been a rough week for you. Tell me more about that.

Client: Well, I was super sad because I didn't get invited to watch the basketball game with my friends.

Therapist: I can hear the disappointment in your voice, let's talk about that today. Tell me more about that situation.

C: Well, I **HATE** basketball and I don't like any sports, but I do like food and being with my friends. So, it hurt my feelings that they didn't want to be around me.

T: **So, next time just beer and wings and skip the basketball game?**

Those sound like something we call "Automatic Thoughts" which are thoughts that just happen outside of our control and may or may not be helpful. I would like to look at these closer with a tool we call the STE(P)B chart.

C: [**Client Scoffs/is insulted OR Neutral/no response OR Laughs/smiles depending on condition**] Okay

T: *Draws outline of STE(P)B* So this is the STE(P)B chart, together we will fill this out. The first letter, S, stands for "Situation" which is the who, what, when and where of the event we are focusing on. Next is the "T" or Thoughts. These are the thoughts you have within that situation. Next is "E" or Emotions- what you were feeling at the time of the situation, for example sad, mad, upset, embarrassed. "P" is Physiological, or what physical sensations you are feeling, like sweating, hot face, or other sensations. And finally, "B" or Behaviors. These

are the actions you engaged in that situation. Notice these arrows between each letter, this is a chain reaction, one letter leads to the next in order. Let's go through this chart together. Let's start with "S" or the situation. What would you put here?

C: I was not invited to watch the basketball game.

T: Okay, what is the who, what, when and where of that?

C: I was sitting in my room by myself, waiting for the phone to ring.

T: *Writes "I was sitting in my room by myself, waiting for the phone to ring" on board* Alright. So now, we will move on to "T" or Thoughts. What was going through your head following not being invited to watch the basketball game?

C: They hate me. They never want to hang out with me. I'm boring.

T: *Writes all of these thoughts* What other thoughts did you have?

C: Nobody likes me and everybody hates me.

T: **You're the least liked person on the planet? I can think of at least 5 worse than you.** These are all good examples of what automatic thoughts look like. Let's move onto the Emotions block. What emotions were you feeling during this situation?

C: [**Client Scoffs/is insulted OR Neutral/no response OR Laughs/smiles depending on condition**] I was sad. I was feeling down. Unloved. Unwanted. Hurt. I think that's it.

T: Okay, and what about the physiological block? What sensations did you experience? Remember, this is what is happening in your body.

C: My face got really red and hot. After that, I just got really cold.

T: So, there you are in the room, you're feeling unloved and down on yourself, what did you actually do?

C: I cried. I also got into bed and I just sat there in my dark room with my covers on me. Just staring.

T: Alright, now that all of this is written out let's move onto this bottom block. This block focuses on altering your view of the situation, leading to a more positive behavior as a result. As you see, the situation remains the same. "It was 7:30, Friday night you know your friends are at the game" so it stays in the box. For the Thoughts box, what could you have thought instead that would be more helpful or beneficial?

C: They know I hate basketball, so they would have known I would have said no anyway so they were looking out for my feelings.

T: **My, my…those are some really thoughtful friends!**

C: [**Client Scoffs/is insulted OR Neutral/no response OR Laughs/smiles depending on condition**] They did text me so that means they do care.

T: Your friends do care, what else?

C: There was a movie I wanted to watch at home.

T: **Your friends could never top a night with Captain America and Iron Man!**

You got some quality time by yourself to watch that movie. Alright, now let's go onto the next box: Emotions. As a result of these more helpful thoughts what new emotions would you be feeling?

C: [**Client Scoffs/is insulted OR Neutral/no response OR Laughs/smiles depending on condition**] I probably feel calm. Not super happy but probably glad.

T: Okay, what else?

C: I would be feeling relieved that my friends care about me.

T: You feel relieved about the situation, what else?

C: I think that's it.

T: Alright. Now let's move onto the next box: P for physiological sensations. Things that you actually physically feel on or inside your body. Ideas for anything that fits here?

C: Probably nothing. I wouldn't be crying and I wouldn't be hot.

T: **Yeah, 'cause nothing kills the party atmosphere we got going here like crying.**

So, we can put NOT crying, NOT being hot.

C: [**Client Scoffs/is insulted OR Neutral/no response OR Laughs/smiles depending on condition**] Yeah

T: Alright let's move onto the final box: Behaviors. So, what we've learned is how important your thoughts are, and how they can actually alter your feelings and behaviors by changing your thoughts. What would you actually do differently in response to the SAME situation, but a more positive slant on your thoughts, emotions and physiological sensations?

C: I would still be in my room. But I would not be feeling negative.

T: You're feeling more positive than you were. Alright, what else?

C: I would schedule another activity with them.

T: Great, you would do something else with them! Anything else?

C: No. That's it!

T: Alright, see how you had a completely different behavior, come from the exact same situation?

C: Yes, I got a different behavior because I changed the "Steps"

T: Yes! What are some other "takeaways" you got from working through this STEPB, maybe even thoughts about the whole process?

C: I should not jump to conclusions because that will lead to negative thoughts.

T: **Conclusions are probably in the top 5 things NOT to jump into**

[**Client Scoffs/is insulted OR Neutral/no response OR Laughs/smiles depending on condition**]

Yes! Very good. This is a valuable tool that you can utilize at almost any time of day with a variety of situations that you encounter, especially recurring situations.

Appendix C

Counselor Rating Form- Short Version

On the following pages, each characteristic is followed by a seven-point scale that ranges from “not very” to “very”. Please select the point on the scale that best represents how you viewed the therapist. For example:

FUNNY

Not very _X_ : ___ : ___ : ___ : ___ : ___ : ___ Very

WELL DRESSED

Not very ___ : ___ : ___ : ___ : ___ : _X_ : ___ Very

These ratings might show that the therapist did not joke around much, but was dressed well. Through all of the following characteristics we ask you to rate are desirable, therapists may differ in their strengths. We are interested in knowing if you view these differences.

Friendly

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Likeable

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Sociable

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Warm

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Experienced

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Expert

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Prepared

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Skillful

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Honest

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Reliable

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Sincere

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Trustworthy

Not very ___ : ___ : ___ : ___ : ___ : ___ : ___ Very

Appendix D

Informed Consent Form

Study Title: What's So Funny: Humor's Impact on Third Party Evaluation of Clinicians

The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate you are free to withdraw at any time, without penalty.

Purpose: The purpose of this project is to examine the impact of clinician's efficacy based on their attempts at humor within a clinical setting.

Participation: You will first view one brief video containing a small portion of a fictional therapy session. You will then evaluate the clinician's performance based on the videos you watched. Participation is expected to take approximately 30 minutes.

Benefits and rights: You may learn about the psychological research process through your participation and may gain insight into your own attitudes and beliefs. You will earn participation credit towards your PY100 Psychological Research Activities requirement. This study counts as an in-person study and you will receive ## points of course credit for your full participation.

Expected risks: No risks are anticipated. However, if any materials arouse strong emotions, you may choose to not respond to items or to stop participating at any time without explanation or penalty.

Extent of confidentiality: Your responses will be anonymous. At no time will your personal data be accessible. Your name and identity will not be associated in any way with the research findings. Once your responses are entered into a secure statistical program, data will be examined in aggregate, such that no individual's responses will be traceable from the products of this work, such as journal articles and presentations.

Alternatives: Alternative options to earn points towards your PY100 Psychological Research Activities requirement are available, including participation in other studies or completion of a written assignment. Please see your PY100 syllabus for details.

Do not hesitate to ask any questions about the study at any time. Additionally, please feel free to contact the principal researcher at jameson.brehm@washburn.edu with any questions or concerns regarding any aspect of this research Thank you for your participation!

Sincerely,

Jameson Brehm, Principal Investigator

Terms of participation: I understand this project is research and that my participation is solicited but completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits to which I may otherwise be entitled. I also understand that I will receive 0 points of credit towards my PY100 Psychological Research Activities requirement in exchange for participation. By writing my name below, I verify that I have read and understand this consent form, and willingly agree to participate in this study under the terms described.

Appendix E

Debriefing Script

Thank you for your participation in this research project. The goal of this study was to examine whether client reactions impact perception of therapists based on successful and unsuccessful attempts at humor. We believe that the therapists whose clients react in a positive way will be rated better compared to the therapist whose client reacts in a negative way. Your participation is not only greatly appreciated by the researchers involved, but the data collected will potentially aid in the continuation of this study to continue to explore humor and its best use in a therapeutic format. Thank you for participating in this study. If you have any questions about this study, please feel free to email using the contact information below:

Jameson Brehm (jameson.brehm@washburn.edu)