The “Conspirative Method”: Applying Humoristic Inversion in Psychotherapy

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THEORETICAL PERSPECTIVE

When I began my professional career as a clinical psychologist, I was especially interested in paradoxical interventions. Such interventions seemed to be particularly effective for unravelling the puzzling behaviors of some of' my patients. My first effort was to compile everything in the literature that fell under the category "paradoxical". I found that Alfred Adler, as early as 1914, had used paradoxical strategies to treat patients. Two early students of Adler, Rudolf Dreikurs and Erwin Wexberg, further developed these techniques into a systematic therapeutic method called *antisuggestion* (Dreikurs, 1944; Wexberg, 1929).

My research also led to my discovery that Viktor E. Frankl, a well-known exponent of modern psychotherapy, was one of Adler's close associates in the 1920's. In one of my early publications, I compared the specific rationales of the Adlerian *antisuggestion,* Frankl's *paradoxical intention,* and the innovative contributions of the Palo Alto group (Titze, 1977). 1 began to particularly appreciate Frankl's work, and now see him as the original mentor of humoristic psychotherapy.

At that time, unfortunately, I did not accept the connections between paradoxical methods and the realm of humor. My daily work in psychiatric hospitals constantly involved people suffering from severe psychological disturbances. They were passive, depressive, self-destructive, and humorless. Classical therapeutic methods, derived from behavior therapy and psychoanalysis, seemed ineffective, so I began to use paradoxical methods. Despite some consultants' comments that such methods might have dangerous and uncontrollable effects, I found that even severely disturbed patients were not nearly as traumatized by these interventions as expected, even when such paradoxical interventions were explicitly meant to be shocking and provocative.

Once in a group therapy session a young woman wept away intensively without any restraint. (In this respect, Adler used to speak of "water power"). All group participants were evidently deeply impressed and struck with this expression of weakness and helplessness. I instinctively realized at that moment that the compassion of the other patients and nurses at hand was not very helpful for the patient. Thus, I said to one of the nurses: "Go and get an tin bucket, so that she can fill it up with her eye-wee!" Everyone was shocked at my use of such strong language, particularly the patient in question. Completely scandalized, with her eyes wide open, she stared at me. The flood of tears dried up. Feeling completely assured of the consent of her comrades, she had a go at me and screamed: "What a mean guy you are! How dare you insult an ill woman like me!" My reaction was "hyperbolic": "You are right. I am the meanest ass in the world. Now I have the deepest guilt. I think I am just going to cry. So let's fill the bucket together with our precious liquid!"

The entire group, including the patient, laughed uproariously, which showed me the important connection between aggression and the self-liberating power of laughter. Years later, I commented on the aggressive roots of many humor genres in a monograph concerning the special importance of laughter in therapy (Titze, 1985a). The reasons why I no longer apply such a provocative form of humorous intervention, however, will be explained later.

THE PRECONDITIONS FOR BEING MENTALLY INSANE

Especially stimulated by the works of Adler and Freud, I finally realized the power of humor for invalidating the inhibitions and constraints that dominate the emotions of psychologically disturbed people. These self-defeating inhibitions can be traced to certain cultural ideals of education that promote rigid conformity to what Freud called the "reality principle," and what I call the "normality principle". This implies forced efforts by adult educators to make children obey those who set the rules concerning good behavior. Failure to conform elicits negative responses from those adults with whom the children interact.

Thus, most children are regularly confronted with both open and hidden forms of aggressiveness perpetrated by adults who have power over them. Subsequently, children have difficulty learning to appropriately express their aggressive potential.

Ethologists like Eibl-Eibesfeldt (1970) and Lorenz (1966) have clearly pointed out the importance of aggressiveness as a precondition of assertive conduct for every creature, including man. Alfred Adler also made the "striving for power" a central theme of his theory of personality. Innate aggressiveness that is inhibited through socialization may lead to misguided forms of aggressive behavior. When such behavior is directed against the environment and consists of antisocial tendencies, it is often labeled as "psychopathic". Psychopaths are irresponsible and unstable in their attitudes toward life. They are predominantly hedonistic and show no concern for those against whom they may direct aggressive and often destructive behavior.

Neurotics, on the other hand, are restrained in their assertive attitudes against their social environment and tend to direct aggression against themselves in a self-defeating manner. I am convinced that those who are forced to give special consideration to implicit moral standards in the course of their socialization process, within the context of strict educational measures, end up taking things especially seriously in their later life. A characteristic fear of negative consequences (punishment) constitutes one of the most important motives of their regressive actions. In his theory of the "superego", Freud assumed that the "censor," emanating from the internalized normality principle, is a particularly inflexible force that intensifies the individual's feelings of guilt. Obsessional neurosis represents a clear instance of how strictly and scrupulously conscience sets its demands. No wonder neurotic individuals display a typically serious and humorless self-expression. They quite literally have nothing to laugh about! Further theoretical considerations on this topic have been presented elsewhere (Titze, 1979c; 1984).

COMING TO UNDERSTAND THE IMPORTANCE OF AGGRESSION

From this theoretical substructure I formulated my specific therapeutic intentions. Because neurotics have difficulty coping with their own aggressiveness, the therapist would not be advised to confront them directly with aggression. This difficulty stems from having repeatedly faced counter-aggression during their early development. The therapist should therefore avoid being identified with persons who have exercised power and superiority over the patient by not bringing aggression into the therapeutic relationship. If the therapist tries to provoke the patient in order to modify his or her behavior with regard to certain normative expectations (cf. Farrelly & Matthews, 1981), the result could be a struggle for power between patient and therapist, and these well-known phenomena of resistance and negative transference may evoke detrimental forms of aggression in the patient. Consequently, I have tried to find ways of promoting my patients' assertiveness without expecting them to be adjusted to certain normative expectations.

MULTIPLE THERAPY

Dreikurs's (1950) innovative technique of *multiple therapy* has been particularly helpful. It involves two therapists, which allows the patient to experience different roles (role casting). One therapist becomes the patient's opponent *(advocatus diaboli),* while the other takes the role of a good and caring ally. The extraordinary possibilities provided by this form of therapy have been most effective (Titze, 1979a).

Once a psychiatrist on a psychiatric ward asked for consultation in the case of an extremely negativistic patient. This man had decided to reject all food offered to him by the nurses. So I informed the psychiatrist about multiple therapy and eventually convinced him to join me in applying this method. We both met the patient, who was extremely emaciated, in the psychiatrists office. He did not take any notice of us and sat down with his face turned toward the wall. I previously instructed the psychiatrist not to take heed of the patient but to inform me in his presence about the negative sides of his conduct. The psychiatrist then told me in a low voice (people usually listen more carefully if one is talking about them in a low voice, for this is perceived as a kind of threatening conspiracy against themselves) that the patient had refused to take any food for a long time and that he had beaten the nurses when they tried to feed him. Furthermore, he reported other negative aspects of the patient's conduct.

After he had spoken in this way for about ten minutes, I interrupted him harshly: "Shut up", I shouted, "I can't stand listening to you gossip about this pleasant and brave man! You insolent guy, how dare you violate the dignity of this man in such an impertinent manner! Do you know what I would have done if I were in his place? In addition to what he did in his bold fight for his human rights, I would have puked in my bed."

Suddenly the patient, who had not paid any attention to us yet, looked at me and said: "That's exactly what I did long ago!" I then turned my back to my co-therapist to address the patient. Now it was my turn to speak very softly, making suggestions to him about how to tyrannize the nurses and the doctors in the future. I believe that this session represented my first implementation of the "conspirative method".

THE CONSPIRATIVE ALLIANCE

Unlike my previous directive form of therapeutic confrontation (cf. p. 2), in the session above my attitude towards the patient was not provocative. Instead, I orchestrated an aggressive atmosphere for the patient by instructing the psychiatrist to criticize and blame him. This inevitably evoked counter-aggression by the patient. However, his behavioral repertoire did not include suitable patterns that would allow him to act aggressively in a constructive and overt way. We can assume that the patient's inability to act assertively is somehow connected to his premorbid development, that is, the interactional patterns in his early socialization. In fact, there was evidence that during his childhood the patient had been prevented from counteracting properly to the aggressive behavior of others, which probably explains his pattern of self-defeating aggression. His acute refusal of food reflected this pattern and seemed to provide the most vital expression of his negative attitude towards life. The attending staff had treated the patient's refusal of food as merely maladjusted behavior, which led to a combative relationship with him. This little spark of active assertiveness should have been nurtured, not extinguished, in order to restore the lost *élan vital.*

When I role-played the patient's position, I became his substitute in assertiveness by attacking the psychiatrist as the most powerful representative of the repressive ward. Note that I used strong language in my intervention-expressions that are usually connected with strict taboos. Effective jokes use such expressions in order to generate the liberating power of laughter in the audience. Real laughter arises, as pointed out by Hobbes (1968), Koestler (1964), and Paul (1963), when a person who seems to be threatening to another is brought down. This "inversion of grandiosity" is one of the most important stimulants for laughter.

By vicariously showing the kind of aggression the patient had been unable to activate on his own, I decisively facilitated my conspirative alliance with him. However, I was not yet aware that many years

earlier Jackson (1963) had treated paranoid patients in a very similar way! When the patient remarked that he had vomited in his bed before, he was beginning to interact with me, and I was able to conspire with him. The stage was set for us to start chatting about all those marvellous wicked things he had not yet dared to talk about. It was rather unimportant that I was the one to verbalize his aggressive thoughts, because the patient was emotionally engaged. I had noticed him smiling faintly, which signalled to me that he felt fully understood and accepted by another person.

THE CONSPIRATIVE METHOD

Following this experience, I was ready to gradually and systematically work out the preconditions for the conspirative alliance method. It no longer seemed particularly useful or necessary to use a multiple therapy setting. The second therapist, in his or her function as the "*advocatus societatis*", has a disturbing effect. Because the second therapist symbolizes the internalized censure of the super-ego, the patient may have difficulty acting freely. It became increasingly evident that the conspirative alliance could only unfold efficiently through confidential dialogue. Thus, I practice accepting my patients' needs as much as possible: I try to accept their "unknown goals" (Adler, 1927), "their hidden reasons" (Dreikurs, 1971), and their lifestyle. Because I fully identify with the patient's genuine problems, I can mirror them through concrete actions and verbalizations, thereby showing patients how to accept themselves.

I consistently try to strengthen those components of the patient's self that constitute the "young child within" (Adler, 1927). It is this realm of one's basic personality where Freud's "pleasure principle" dominates and where the so-called "primary processes" originate. These motivational processes generate exactly those rule-less, irrational, irresponsible, egoistic, or affect-logical (Ciompi, 1982) tendencies that predominate not only in the thoughts and actions of infants and lunatics, but also in the creative dynamics of humor and jokes. I try to promote those processes that produce the liberating humoristic reaction which occurs when a rebellion against reality constraints (Freud, 1905/1960) takes place. By keeping the censures and self-reproaches of conscience away from the patient's basic personality, the "young child within" can come forth. The following example clearly demonstrates this point:

Once a patient complained that he possessed certain weaknesses of character which "with the best will in the world" he simply could not overcome. He confessed, rather shamefully, that he masturbated, drank, smoked, and talked about other people behind their backs. In a seemingly unaffected voice, I asked him what was wrong with these behaviors, to which the patient replied: "Of course, you can't imagine things like that! You as a doctor just don't have problems like that!" Whereupon I countered: "What do you mean, problems? I do it several times a day and gain tremendous relief and liberation from it. Then I thoroughly enjoy smoking cigarettes. And when I get to my favorite bar in the evening, I regularly say nasty things about my associates!"

My response had broken several social taboos in one stroke, inevitably challenging the patient's rigid conscience yet also triggering a liberating effect on the young child within him.

First, of course, he expressed his incredulity by being amazed and indignant: "I absolutely can't believe that you would do things like that. You are simply kidding me!" Now it was my turn to put myself in his place in order to help him accept himself and have the courage to be imperfect: "Are you trying to suggest to me that it isn't good? *I* get a lot of fun out of it and *I* don't mind admitting it. But please, do not inform anyone about that, you know. It's simply my private business and has absolutely nothing to do with therapy. What I'm telling you, I wouldn't, by any means, have told all those feeble-minded dummies having no fun in their lives! *Make sure, therefore, not to talk to anyone else about this.* That's really confidential, you know!"

The application of the conspirative formula, as figured out above for the first time, made the invalidation of the pretended augustness of my professional status credible for the patient. If I had not applied this formula,

the patient might have thought that I was merely pulling his leg. Despite my, "superior" professional position, I voiced fears of social criticism similar to his, and thus became a kind of fellow-sufferer.

THE THERAPEUTIC RELEVANCE OF EQUALITY

Over-respect for the superiority and augustness of authorities stems from fear of negative sanctions for one's own assertiveness. It represents one of the most important components of the feelings of inferiority as described by Adler. Every form of psychopathological disorder is, I am convinced, based more or less on those feelings of over-respect for authority. Such an attitude supplants the liberating element of disrespect that, according to Freud (1928, 1905/1960), is the precondition for humoristic phenomena and healthy self-assertiveness. It is one of the central paradoxes of psychotherapy that the therapist must not be a "therapist" in order to efficiently apply then type of interventions mentioned above. The ability to transcend the therapist role is not related to the therapist's *function* as a helping person, but only to his or her professional role assessment! An effective therapist inevitably gives up the superior position derived from professional status ("expert," "guru," "master").

This social equality, as advocated by Rudolf Dreikurs (1971), allows the patient to identify with the therapist as a model for self-accepting assertiveness only when he or she can view the therapist as an *imperfect* person--someone who has certain weaknesses yet can still have fun in life. Occasionally, it may even be useful for the therapist to "humiliate" himself or herself regarding his or her professional role. That is more regularly the case if the therapist is dealing with severely disturbed patients suffering from acute depressions or psychotic disorders.

A depressive patient who could not get up in the morning did not appear for the first interview at my office at the appointed time. When he came late to the next session, he excused himself by saying that he was "always half there" in the morning.

I did not take any notice of this (obviously hitherto efficacious) excuse but declared: "Well, you couldn't have done anything better than show me what a little nobody I am! Normally I sit here fat and complacent behind my desk and I'm used to people trotting in here punctually to the second. This morning as I was foolishly sitting around here, after a long time I really did feel like a twit. And yet I can't really be angry with you. I find it very plucky of you not to fall in with all the shitty conventions of society. I think I have learned something from you!"

After a long silent lapse during which the patient was looking at me with unbelieving astonishment, I continued, "I implore you not to tell anyone about my emotional lapse which you have experienced right now!" The patient was now smiling.

Because of this conspirative intervention, many things happened. In the patient's view, I had forgotten my role as a therapist, and by doing this I demonstrated to him that I was as imperfect as he was. Furthermore, I also introduced the subject of aggression without involving any of the counter-aggressions that the patient had learned to fear so much. By using the conspirative formula, the patient's anticipation of counter-aggression was invalidated.

The patient was at first unprepared to enter into this alliance; obviously, he was still too distrustful. After a long period of silence, he finally asked if I was angry with him. I answered: "Angry, I should be angry with you? But that is totally illogical! I'm doing okay. I make a pile of money without making a special effort; everyday I watch people humiliate themselves in front of me and generally I have the feeling of being a great guy. And then look at you: persecuted by bad luck, tormented and looked down on by mean and vulgar people! So why should I be angry with you? Quite the opposite: How on earth do you work it that things are bad for you and good for me and other slobs? Today you really brought it home to me that you are not such a poor wretch after all but that you possess something like human dignity. Because I was the one who

waited for you today, I suddenly realized who was dependent on whom! But, for heaven's sake, don't tell anybody about what just happened between us!"

In the follow-up, and still in line with the conspirative alliance, 1 declared that if I were he, I would deal with the "other slobs" in the same way. In other words, I would fail to keep appointments at the employment office, would not turn up for invitations, and so on. I thus vicariously lived out for the patient that forbidden assertiveness he only dared to activate under the guise of his pathology. In this instance, I was making use of the technique of sarcasm, such, as revelling in the idea of how fine it was to make fools of other people. Finally, I used strong language that, once again, proved to be very appropriate for bringing up aggression-related issues.

TECHNIQUE

I developed the conspirative method to help manage manifold problems that occurred during therapeutic work. Therapists trained in analytical or depth psychology procedures face various difficulties in addressing relationship problems occurring in therapeutic interactions. On the other hand, the conspirative method takes advantage of the genuine possibilities that arise from adopting a humoristic approach towards life and the world. This approach often generates an inversion of normative constraints, in many respects similar to creating a good joke (Koestler, 1964). Accordingly, the therapist can get acquainted with the young child within the patient, which constitutes the specific field of work for analytic psychotherapy.

Direct confrontation with the unconscious core of personality is a great challenge to the therapist, because the phenomena of transference and counter-transference may be involved. Because humoristic inversion usually includes those aggressive or disrespectful tendencies that are-crucial to living assertively, the central theme of aggression inevitably arises during the analytical therapeutic relationship. Confrontive and provocative techniques must be critically and carefully handled to avoid reinforcing a patient's sense of powerlessness and inferiority. In my experience aggression can be productively dealt with only when social equality, as facilitated by the conspirative setting, has been achieved.

TRAINING IN DEPTH PSYCHOLOGY

The conspirative alliance method demands subtle intuition and a level of skill that comes from comprehensive analytical training, and it should be reserved for individual rather than group psychotherapy. In my own work, I favor the teleoanalytical approach of Adlerian psychology (Titze, 1979c), enriched by the findings of Frankl's logotherapy. I am convinced that many unconscious causes and motives of human behavior stem from the super-ego, where internalized censure is at work with its inhibiting and self-defeating effects, especially for the neurotic.

PERTINENT USES

The process of humoristic inversion, as facilitated by the conspirative method, can release the patient from those unwholesome normative constraints that he or she believes language would reinforce this image of the normal adult, so humoristic therapy uses exactly the kind of concrete language and figurative expressions that children and humorists use. The conspirative therapist does not aim at personifying a stance of therapeutic abstinence as demanded particularly by orthodox psychoanalysis. He or she would not merely pontificate on the causes of the patient's problems in an emotionally detached manner. Rather, by being sincerely attuned to the patients frame of reference, the therapist constantly tries to promote the patient's ability to gain distance from his or her unpleasant and painful feelings. Frankl (1978) has demonstrated that this self-liberating attitude can be best achieved by means of a paradoxical intervention. In this method, the "awful distress" that patients usually suffer is not merely analyzed in the framework of a conspirative alliance but can eventually be seen from a humorous angle. The patient and therapist thereby unite in "tragic optimism" that marks the attitude of the real humorist (Frankl, 1967). When the conspirative method is

handled with true empathic care and skill, it can be used with many neurotic and psychotic patients and is especially helpful for paranoids. The conspirative method might be contraindicated in working with antisocial personalities (psychopathic disorders). Because these individuals are primarily motivated by the pleasure-principle, that is, the needs of the young child within them, a method constructed for invalidating restraints might be counterproductive. The following example, nonetheless, illustrates the effectiveness of the conspirative method even for a patient experiencing behavioral dyscontrol problems.

I was once attacked by a hyper-aggressive dissocial woman who was treated in a closed psychiatric ward. She had punched her fist into my face, so that my glasses fell to the floor. (I admit that it was not easy for me to keep my self-control and remain relaxed). Yet it was clear to me that this woman, who had suffered so much from other people's aggression, would have been reinforced anew in her antisocial attitude if I had grown furious. Moreover, expression of fear and insecurity on my side would have been just as disadvantageous, as this might have reinforced the patient's destructive aggressive patterns.

For these reasons I turned away from her to ask a nurse to take the patient to my office. Violently punching and slapping several ward members, she was eventually forced to go there. This had caused so much sensation within the ward that, in a short period of time, a crowd of people gathered in front of my office door.

After having tugged the patient into my office, I dismissed the nurses and locked the door. Furiously spitting, the woman got ready to start another attack. Now was the time to initiate my conspirative maneuver. So I turned to her whispering: "For God's sake, I need your help badly! Before I entirely lose face in this ward and become the laughing stock of everyone here, I must do something to regain respect. Otherwise, I can pack up my bags! That's why I ask you to scream for help as loudly as you can. At the same time we should both clap our hands to make people think I'm beating you up. But this absolutely has to remain our secret!"

Puzzled, but signaling fun, the patient spontaneously agreed to take part in this mad show. This marked the beginning of a mutually positive relationship and later allowed us to have numerous rather constructive talks.

CLINICAL PRESENTATION

Years ago, a suicidal patient came to see me unannounced. I had treated this man a few years earlier in a psychiatric hospital. He was presently suffering from severe depressions and had decided to kill himself that very day. Work, family, leisure time--in short, his whole life--seemed senseless and unbearable to him. He stood there in front of me, speaking very softly. He stressed that all therapists, including me, had completely failed in helping him. Consequently, he had come to my office not to seek treatment but simply to say goodbye.

In his bag he had a rope for hanging himself. He also brought along his Last Will and Testament. Bursting into tears, he read his last message to his wife and children. For his wife, should she decide to marry again, he wished a better and, especially, a more courageous man than he had been. Further, he urgently admonished his children not to allow a competitive society to dispirit them. When he started to read the last part, where he begged his family not to entirely forget him, he completely broke down.

I waited for a couple of minutes, and then responded, "You've totally convinced me that your life isn't acceptable for you anymore. As a therapist I actually shouldn’t tell you this because it is certainly illegal and, furthermore, somehow a surrender in the face of your tremendous difficulties. That's why I ask you urgently not to tell anybody, especially your wife, what I'm just going to tell you now: You should do what you decided to do! Firstly, you will overcome all the miseries of your life. Secondly, you will demonstrate to everyone the tragedy of your existence, and, last but not least, think of the guilt of those people who did you

wrong. Anyway, it will be too late for them! But I object to one point: If you kill yourself right away, people will think of you as a dead loss, unable to cope and compete with others in society. Your children will feel pity for you and will say that their father was too weak and too good a man to get along in life! Your enemies and competitors will say, 'We always knew he was a weakling. Now he backed out of life!' So let me make you a proposal: Give yourself one more month in order to square away the accounts you still have with other people. Do everything you didn't dare to do up to now because of fear and for other reasons. Having only one more month to live, you can, without further problems, afford to be ruthless and severe. In your final four weeks of life you can treat all the loony bastards you can't stand in quite a brutal way. When you take your final step after one month, people will remember you as a strong and tough person. If you agree, and I'm convinced you will, come back after exactly one month from now. Then it will be me with whom you will have your last chat. There will be a bottle of brandy on this desk, so we can have a drink together. It will be an honor for me, after all, to fulfill that task for you which is normally due to a priest!"

Shortly after I had started talking to him, the patient had raised his head and stopped crying. He seemed to be puzzled, yet listened very carefully to me. When I eventually presented my hand to him in order to seal the contract, he did not take it. I accepted this and accompanied him to the door. Finally I said, "All I told you now is strictly confidential and has to remain a secret! Don't tell anything to anyone, especially not to your wife. Nevertheless, I want to see her tomorrow. I will then find out if you kept the secret."

The patient's wife came in the next day with a bouquet of flowers. She was quite enthusiastic, smiling happily as she reported that her husband had come home the day before in a completely different mood than his usual one. She told me that he had grinned and even laughed like he had not done for many years. Furthermore, she said that her husband had gone to work voluntarily that morning. He had been so frolicsome the day before that he had stayed up with her long after midnight to talk while drinking a bottle of wine.

I did not comment on her report but asked her sternly, "'Did your husband inform you about the conversation we had yesterday?" - "No, not directly", she answered. - "That means he did!" - "No", she replied, "not really, but please tell me what happened yesterday".

Seriously and decisively, I said, "I am not permitted to give away a secret. I can only say as much as this: Imagine that you are the wife of a sailor bound f or a very long voyage in exactly one month minus one day. What would a sailor's wife do in such a short period of time? Think about this very thoroughly and try to act appropriately to this very situation! But I can't tell you more". After this short conversation, I asked her to return in exactly one month and then dismissed her.

This intervention clearly illustrates the conspirative method. The patient had come in with a problem he considered too grave to bear. So everyone normally would think that the therapist ought to act "very therapeutically". Yet, simultaneously, the patient had clearly indicated that in his case a "therapeutic" approach would be unsuccessful. (Recall that the patient had accused all therapists who had ever treated him of having failed totally.) lf I had acted "therapeutically," I would have been working in total opposition to the patient. What else, but "It is not as bad as you think," or, "You should think it over once more," and so on, could I, from a conventional standpoint, have told him? However, when I pretended to have surrendered in that very field where 1 was supposed to be the expert, he could then experience an unexpected victory.

In this way I used the patient's "private logic" (Adler, 1927) so that I would be able to "walk in his own shoes" (Titze, 1985a). Obviously, the patient had low self-esteem resulting from defeats in his life tasks (work, family, and communal activities). Consequently, my goal was to restore his self-reliance and anchor a recognition of his own worth. My procedures countered his feelings of powerlessness by encouraging him to prove to posterity what a strong and courageous person he was. By doing so, the patient trusted me to be on his side and not in opposition to him. Furthermore, the way that I expressed my surrender as a therapist offered him an opportunity to regain prestige and superiority.

Although my procedure was not therapeutic in a conventional sense, it surely followed the unusual and perplexing strategy of humoristic inversion as it operated within our conspirative alliance. Now the patient was no longer an outsider with respect to his suicidal intentions. On the contrary, he had gained an enthusiastic supporter who not only wanted to make a contract with him but even hoped to get the chance of acting as a priest. The patient must have recognized that all this was very peculiar as his wife told him that she, too, had received secret and unusual information during her session with me.

One month later the whole affair came to an interesting resolution. On the appointed date the patient came in, bringing along his diary entries concerning the last month. (These entries were printed in full length in Titze [1979b].) He reported on the recent developments in his life. Above all, he told me that he had succeeded at following his own way. He had simply told others, disrespectfully, what he thought of situations he did not enjoy or appreciate. He had also avoided trouble and self-defeating forms of anger by doing things completely on his own, whereas he had previously always insisted on the help and assistance of others. "Consequently, I couldn't get annoyed", he reported to me. Altogether, he had decided to carry on with life. We agreed upon an appointment for a joint therapy session for himself and his wife in I more month. Yet, instead of coming in, his wife called and informed me that there was no need for a session as far as she and her husband were concerned. She reported that they were getting along quite well. I agreed, and she ended the conversation with the comment, "Nevertheless, it must be nice for you if people can do without your help!"

SYNTHESIS

Psychotherapy has made far too little use of the theoretical and methodological implications connected with the phenomenon of humor. Consequently, a main objective of this chapter has been to examine some therapeutic applications of humor.

The humorous therapist--who may appear paradoxical or even crazy (Jackson, 1963)--can have rapid and direct access to the sphere of unconscious and irrational events within the psyche, designated as "primary processes" (Freud, 1905/1960), or, as I prefer to say, the "young child within the patient". The therapist then, quite logically, becomes the expert in a particular type of *weltanschauung*, which produces its own logic and its own symbolic codification (Ciompi, 1982; Titze, 1985c). Inevitably, such a therapist will gradually begin to think and to speak differently from the normal, everyday person. He or she will learn to see the world through the eyes of the young child that the patient once was: and will decipher it from this perspective. He or she will also use a corresponding "parabolic" (figurative, concrete) language, which is even stronger than normal colloquial speech, thereby inevitably reaching the young child within the patient and becoming an ally. To facilitate this process, the therapist must provide the following conditions:

1. Create an atmosphere of empathy.
2. Focus on experiences related to the here and now.
3. Identify unconditionally with the patient's needs and expectations,
4. Become a model for assertive acceptance of exactly those needs and expectations.
5. Reflect to the patient in a conspirative way how he or she can be assertively self-accepting.
6. Finally, stimulate the patient to gain a life attitude that may be correlated to "the wisdom of the fools", which takes nothing seriously (Titze, 1985a).

We are undoubtedly just beginning our exploration of the highly promising therapeutic possibilities offered by humor, and numerous perspectives in this therapeutic arena may be considered (Salameh, 1983). Any therapist taking into account the fascinating realm of humor cannot help becoming a true humanist (0'Connell, 1976) and will therefore stop treating patients as objects and join hands with them under the auspices of real equality.

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