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REVIEW

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The use of banter in psychotherapy: A systematic literature review

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Abstract

There has been a large body of literature and commentary on the use of humour in therapy. The goal of this paper was to systematically review the literature to find out whether one type of humour, banter, is reported as being used in psychotherapy. Aims included investigating the measures taken, banter's relevance to psychotherapy and the extent to which the existing literature addressed the outcome of therapy. Additionally, a deductive content analysis was carried out to extract banter-related examples reported in clinical practice. Results showed that few studies explicitly referred to banter, and no study investigated banter as the main independent variable in the context of therapy. Results also revealed that there was only one paper that related banter to the outcome of therapy. Several conceptual nuances of banter-related humour were highlighted, and theory-driven constructs regarding the use of banter in therapy were identified. Context and attunement to a client's banter palate were highlighted as particularly important factors concerning the reception of banter in the therapeutic relationship. Finally, initial results indicate that one kind of psychodynamic-oriented psychotherapy, the mentalisation-based treatment, seems to be very well suited for the use of banter when challenging clients.

KEYWORDS

banter, humour, mentalisation-based therapy, psychotherapy

1 | INTRODUCTION

The idea that humour can be used in psychotherapy for healing experiences has gained wider acknowledgement in the psychotherapeutic literature over recent decades. Norcross and Lambert (2018), in particular, have identified therapeutic humour as a promising interpersonal construct for psychotherapy.

Martin and Ford (2018) reported on the different approaches that have been taken to use humour in psychotherapy and broadly identified three areas: humour as therapy, specific therapeutic approaches and humour as a communication skill. Firstly, two therapies rely on both exaggeration and sarcasm to challenge patients. Rational-emotive therapy (Ellis & Grieger, 1986) aims to replace false beliefs, and the goal of provocative therapy (Farrelly & Lynch, 1987) is to provoke emotional responses that lead to changes in perceptions and actions.

Secondly, with regard to specific therapeutic approaches, humour has been used successfully to replace progressive muscle relaxation in systematic desensitisation (Smith, 1973; Ventis, 1973). Although humour has been used as a basis to paradoxically and playfully exaggerate symptoms (Frankl, 1960; Witztum et al., 1999), one author reported that this effect is dependent on clients having low humour scores (Newton & Dowd, 1990).

Humour as a therapist skill is the third area identified by Martin and Ford (2018). This might involve humour's impact on strengthening the therapeutic relationship or overall effectiveness of therapy (Franzini, 2001; Saper, 1987; Teyber, 1988). Empathic humour to support common goals—such as establishing positive rapport, gaining an understanding of the client's thoughts, feelings and behaviour patterns, as well as reducing levels of emotional stress—across different therapeutic approaches has been suggested by several authors (Gelkopf & Kreitler, 1996; Kuhlman, 1984; Pierce, 1994; Saper, 1987).

Finally, empirical research regarding the use of humour in psychotherapy does not reveal quite the same picture as in other areas; several studies in fact indicate that either nonhumorous interventions were rated as more effective (Rosenheim & Golan, 1986; Rosenheim et al., 1989) or that no significant differences could be found between nonhumorous and humorous statements/conditions (Foster & Reid, 1983; Killinger, 1987). Other findings suggested an increased liking towards therapists when humour was perceived as funny by both client and therapist (Megdell, 1984) as well as negatively targeted humour towards other group members accounting for the majority of humour within groups (Peterson & Pollio, 1982).

Furthermore, several authors have expressed concerns about the risks involved in using humour in therapy. Most notably, Kubie (1970) argued that humour might cause clients to trivialise the severity of their problems, but others also criticise inappropriate redirections of attention (Kuhlman, 1984; Pierce, 1994). In addition, Marcus (1990) warned of particular clients who might venture into a pathological form of humour in which their problems and the therapy itself become an object of ridicule. Perhaps as a result of such safety issues, Salameh (1987) developed a five-point rating scale for classifying to what extent humour is helpful or harmful in therapy.

Now that a general introduction to humour in therapy has been given, existing theories of humour will be explored in the following paragraphs. There are five central theories of humour: psychoanalytic, dominance and aggression, psycho-physiological (cathartic), incongruity and reversal (Martin & Ford, 2018). Following these early theories, researchers began to investigate interpersonal functions of humour, including among other topics such as social/group cohesion (Martin & Ford, 2018). In psychoanalytic theory, jokes or wit distracts the superego long enough to allow unconscious sexual and aggressive impulses to come up from the id (Freud, 1960 [1905]). The inhibitory energy that would otherwise be required to repress those impulses is thus no longer necessary and instead released in the form of laughter (Martin & Ford, 2018).

The psycho-physiological or cathartic experience of humour is based on the innate potential and fulfilment of an adaptive homeostatic function (Titze & Eschenröder, 2011). In this view, laughing contributes to the homeostatic balance of the body by stabilising blood pressure, stimulating circulation and generally helping the body to relax. Dominance and aggression theories, on the other hand, emphasise aggressive tendencies that surface during humorous exchanges or outbursts. These tendencies can be traced back to Aristoteles' degradation theory, which postulated that the mere observation of defects, deformations or ugliness incited people to laugh (Martin & Ford, 2018). One of the foremost advocates for this theory argues that there is always a winner and a loser with respect to the contest which jokes inevitably unleash (Gruner, 2017).

Where dominance and aggression theories stress hostile aspects, interpersonal functions draw attention to social connections affected by humour (Martin & Ford, 2018). Humorous events can add to the formation of ingroups and their maintenance while at the same time strengthening cohesion with respect to outsiders and different values (Terrion & Ashforth, 2002). Particular group values or characteristics may be strengthened by a positive collective experience of mirth—the distinctive emotion elicited by the perception of humour (Martin & Ford, 2018). This in turn can lead to a reduction of social distances between members and a common sense of identity (Fine, 1977).

A key component of incongruence theories of humour is paradox (Eysenck, 1942). Generally, normal healthy thinking happens within some consistent predictable frame. In contrast, humour goes beyond that scope by consequently, yet unsystematically, jumping to another frame of reference where other logical principles apply. Such incongruity can lead to surprise, puzzlement, laughter and mirth (Suls, 1983). In contrast to the question of linear predictability and incongruence, reversal theory suggests that people switch back and forth between two states of mind: seeing things playfully versus a more serious goal-directed frame of mind (Apter, 2001).

Now that some of the main humour theories have been summarised, it is evident that bantering is not explicitly mentioned. Its placement among those theories, however, can be ascertained from its constituent definitions to some extent. Taking teasing as an example, Martin and Ford (2018) report on one regrettable incident of merciless teasing in childhood in the context of the superiority/aggression theory. They go on to explain how even today puns are still used as a way of getting the better of others in social situations, prompting oftentimes a barely audible groan as an admission of defeat. In addition, bantering is well suited to interpersonal functions; indeed, our initial literature review on banter found articles, specifically, in reference to interactions in therapy groups (Aledort & Dluhy, 2014; Grover, 2010).

De Silva Joyce (2016) has analysed conversation exchanges in work, education, medical and museum contexts. From a linguistic point of view, she argues that people are not actively conscious about the effect that their language might have in a conversation most of the time. Effects that remain unconscious to the speaker add another level of ambiguity to banter; not only is the perceived message highly individual (e.g., a child playfully rhyming somebody's surname with a negative or rude word may affect people in entirely different ways), but also the banterer may not be aware of the potential danger of offending somebody. In conclusion, banter can be explained on different levels by several theories of humour, each providing useful insights to its potential function.

Banter is one style of aggressive humour that is not explicitly defined in the psychotherapeutic literature. Roncoli (1974) took the

TABLE 1 Search strategy

Search row	Search query	Results
1	(jest* or teas* or banter* or mock* or jok* or laugh* or sarcas* or cynic* or funny or (wit or witt*))	53361
2	(humor* or humour*)	83309
3	psych*	3054704
4	(mental* or therap* or online forum* or self help group* or focus group*) &	5666688
5	1 and 2 and 3 and 4	566

Webster dictionary definition in her perspective on bantering in psychiatric care: "to ridicule lightly and good-naturedly" (p. 172). In the Oxford English dictionary, it is defined as "the playful and friendly exchange of teasing remarks" (Oxford, n.d.-a). Teasing is defined as "intending to provoke or make fun of someone in a playful way" (Oxford, n.d.-d). However, to make fun of someone is defined as "to joke about them in a mocking or unkind way" (Oxford, n.d.-b). This slightly contradictory chain of definitions is perhaps why people clarify the playfulness element by saying "good-natured banter". In other words, the content of the joke may be unkind or provocative, but it is well-meaning in some way because of the speaker's bantering intention, for example to encourage somebody to see another perspective or reflect since "many a true word is spoken in jest" (Oxford, n.d.-c).

The phrase "it was said in jest" is sometimes used by a banterer in retrospect to clarify banter in a conversational exchange (Merriam-Webster, n.d.). Likewise, with "tease" or "joking" when somebody says that "they were only joking/teasing" (Macmillan, n.d.)—the context here implies that something might have been taken personally that was only meant as banter. On the same note, it is important to mention that pathological labels that might be used to direct a therapeutic process can cause gaslighting and therefore harm to the client (Tormoen, 2019).

Within the definition of banter, the historical changes in its meaning described by Martin and Ford (2018), in particular, the modern umbrella usage, are taken into account. Thus, the definition of banter used in the current research includes both witty repartee and the coarser type of ridicule in the context of the definitions given above. It is unclear whether bantering can be used in psychotherapy beyond obsessional patients as described by Roncoli (1974).

One pointer can be found in mentalisation-based therapy (MBT), in which banter could play a role in challenging. That means helping patients to recognise feelings, understand what those feelings cause to happen within themselves and relate this emotional flow to accompanying mental states (Bateman & Fonagy, 2016). When challenging automatic responses, Bateman and Fonagy (2013) argued that a patient's failure to mentalise could serve as a direct marker for a sensitive attachment system. Loss of mentalisation was found to be related to a worse performance on processing affective and cognitive aspects of humour (Uekermann et al., 2008); thus if banter failed to provoke mentalisation, that might reflect a fragile attachment system.

The interpersonal level of banter in therapy is the focus of research in this paper. Initial positioning in the research has shown that there is considerable literature regarding the negative offensive effects of banter: sexual abuse (Costa et al., 2015), derisive banter (Roark, 2013), inappropriate professional behaviour (Gross et al., 2012) and homophobic humour (Espelage & Swearer, 2008). Likewise, its importance with respect to positive interactions in therapy (Aledort & Dluhy, 2014; Grover, 2010), online forums (Gaysynsky et al., 2015), fitting into groups (Jayakumar & Vedage, 2014), social skills (Sutherland, 2011) and building social work identities (Gregory, 2009) are well covered. However, whether banter occurs in therapy and, if so, to what extent, as well as the forms it might take, has been somewhat neglected in research to date. Therefore, the goal of this systematic review is to find and analyse the position of banter in psychotherapy and then examine it further by means of an explorative deductive content analysis.

1.1 | Aims and objectives

The present paper systematically reviews studies published in past few decades on the use of banter-related humour in the context of adult psychotherapy. Its use may be triggered by either the client or the therapist, be positive or negative and affect pleasant emotions such as mirth/cheerfulness or any others.

The main focus points of this paper are (a) to discover any evidence for the use of banter in the psychotherapeutic literature irrespective of variables such as intention or session/therapy outcome and (b) develop a theoretical category system for bantering through a content analysis on literature meeting the eligibility requirements of the systematic review.

2 | METHOD

2.1 | Design

A systematic literature review of quantitative and qualitative research was carried out in the summer and autumn of 2019 using the PRISMA methodology as a guide. The following search engines were used: PsychINFO, MEDLINE, and ERIC, with search dates encompassing their launch dates to 3 May 2019.

2.2 | Search strategy

How the databases were searched is depicted in Table 1. Each search row was limited to abstracts. For the purposes of narrowing down the results to banter-related articles, individual terms were checked to find the ones which leveraged the most results (reflected in the first row of Table 1). Psych* was used to gather everything related to psychology broadly, and the final line narrowed down results further to include articles not only related to therapy, but also mental health, online forums, self-help groups and focus groups to increase the sensitivity of the search. Searching only for banter and therap* alone produced just 11 results, and from those results, the ones which seemed most relevant included the psych* term. Exclusion criteria are listed in Figure 1.

2.3 | Data analysis

Twenty studies resulted from the eligibility review (see Figure 1). Some exclusion criteria were repeated from the screening stage as it was not always clear from the title/abstract alone. The first literature search for only the term "banter" found merely a few articles, most of them unrelated to psychotherapy. For this reason, the design was expanded so that the search method was more sensitive and less specific, and additionally, some articles were kept in based on the inclusion criterion: related to some important function of humour. However, it quickly became apparent that there were enough articles for the review without the need for this additional inclusion criterion. No studies were excluded due to quality concerns regarding their design or measures. A second member of the research group repeated the screening process with the same records (566) and exclusion criteria. An inter-rater reliability score of 96% was obtained.

For those twenty studies (Figures 2 and 3depict study origins and designs respectively), Excel tables were created to collect data. That included the following: design, setting, participants/events, result and discussion, particularly for banter-related humour in therapy (see Tables 3 and 4). The data were first collected into a mind map and then populated into the tables for the synthesis of results in the quantitative part of the systematic review.

Following the mapping and synthesis, theoretically based categories were defined for a narrative review to extract clinical examples of banter or banter-related humour in therapy using a deductive content analysis. It was performed to gain more qualitative insight into the function and context of reported examples using a controlled assignment of categories to text. The categories were extrapolated from relevant theoretical considerations regarding the use of banter in psychotherapy.

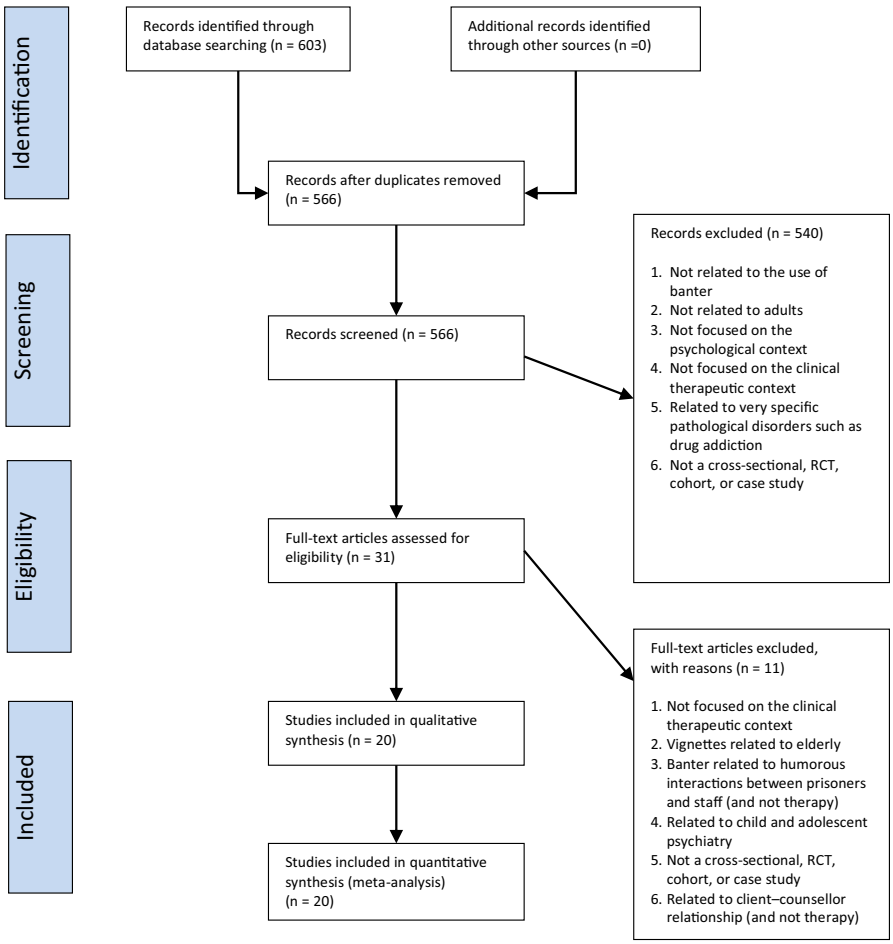

FIGURE 1 PRISMA flow diagram

The text material for the deductive content analysis was the 20 articles on banter/humour in therapy selected by screening all sections in the papers. The level of abstraction was concrete examples and their immediate context (i.e., remark only, remark and response(s), or immediate exchange relating to and including remark). The examples needed to fit well into one or more of the category definitions given. Finally, the coding unit was phrases, sentences or paragraphs with clear reference to the research question.

3 | RESULTS

3.1 | Countries and designs used in studies

Most studies originated from the United States, followed by Israel (see Figure 2). Only two studies were RCTs and by far the most common design was case studies/materials (12 in total). Four cross-sectional studies were included (see Figure 3).

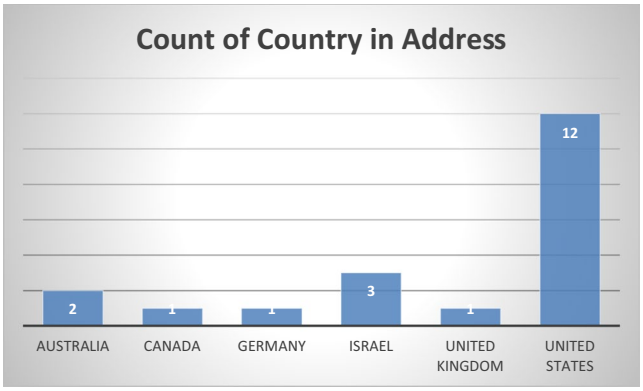

FIGURE 2 Study origins

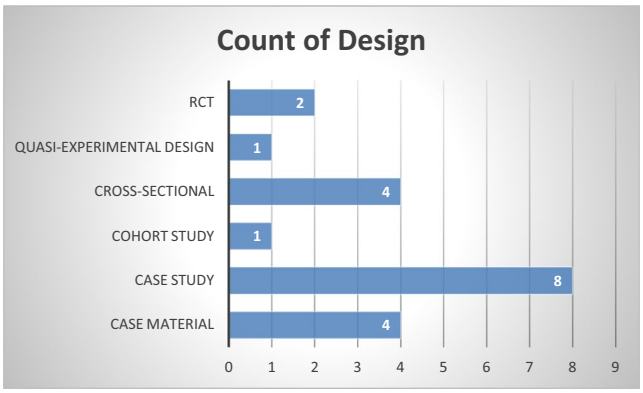

FIGURE 3 Study designs

3.2 | Banter definitions and banter-related concepts used in studies

Five articles used the term "banter" explicitly in their text (Bader, 1993; Haig, 1986; Kissane et al., 2004; Rutchick, 2013; Yonkovitz, 1998). Bader (1993) did not define banter or include it as a category of humour; however, it was illustrated concisely with examples such as the one below. As a result of the bantering in this example, John gradually becomes more self-reflective over time. This noticeably slower application of banter contrasts with the results for the more provocative and pointed nuances of banter outlined at the end of this section:

> One instance of banter was when John, as he was wont to do, was imperiously and coolly instructing me in exactly how a comment of mine had been worded poorly and had implied that he was bad; it could have been worded differently so as to make him feel appreciated. He ended it all with the question, "Are you able to follow this?" I responded, "Wait… could you speak more slowly?" He replied that he was trying his best but that I was a poor student. I sensed that he was now "playing" with me more than before, and I responded: "But I thought this was just a Sunday drive!" This allusion to his account of the pressure-filled Sunday drives with his mother made him laugh, and he then began to talk about how one of his clients had been "picky" about some remodeling that he had done for her. He realized that this kind of criticism could spoil his whole day, but imagined that *I* might think of this as an overreaction. […] These interchanges became common and were usually brief. I understood them as reflecting a gradual deepening of John's ability to be self-reflective in my presence and to begin to collaborate.
>
> (p. 32)

A slight overlap between Rutchick's (2013) and Yonatan-Leus et al.'s (2018) studies was the inclusion of a similar code—namely, the aggressive humour style. Yonatan-Leus et al. (2018) measured it using The Humor Style Questionnaire. The questionnaire is designed to find out how people use humour in their life, and in their study, it was one of the therapist measures. This category fits well with banter because of the teasing aspect of bantering and the context (friendly therapeutic environment). While it is not possible to ascertain directly from their results whether the aggressive humour style was harmful to patients, they do state and make a case for it not being too painful, highlighting the need to be pointed sometimes to make progress, and to be continually mindful regarding the client's capacity to bear any strain. In the event that remarks are too pointed and painful, this may trigger the patient's defence mechanisms.

Rutchick (2013) had two codes, "Dark Humor" and "Aggressive Humor", that were both applied to language that made fun of someone else in a bantering sense in the examples presented. In contrast,

TABLE 2 List of banter nuances with frequencies

Bantering nuance	Frequency	Authors
Mocking, irony with positive intentions	1	Fabian (2011)
Emotional/humorous confrontation	3	Golan et al. (1988), Rosenheim and Golan (1986) and Yonatan-Leus et al. (2018)
Pointed interpretations, sharp wit that is not particularly kind	1	Schimel (1978)
Self-deprecating humour, black humour [made fun of situations ranging from difficult/challenging to terrifying/life-threatening]	1	Rutchick (2013)
Denying sympathy/empathy using humour	1	Kennedy (1991)
Aggressive humour style [If I don't like someone, I often use humour or teasing to put them down]	2	Rutchick (2013) and Yonatan-Leus et al. (2018)
Teasing therapists to increase their perceived humanness and reduce fear towards them or therapy itself	1	Wright (2000)
Ridiculous descriptions of the client	2	Falk and Hill (1992) and Gervaize et al. (1985)

Haig (1986) outlined constructive uses of humour and one category "As a form of communication" explicitly commented on the possible requirement for a therapist who can reciprocate and participate in "banter" if it occurs. This constructive use of banter bores marginal similarities to the constructive notion of "authentic harmony" in Kissane et al. (2004). In particular, it was enabling; in the former for communication and in the latter for an environment where creative energy could be expressed as "banter". Also, Yonkovitz (1998) stressed the importance of bantering in initial interactions for tactical humour (also a category in the study) in which immediate therapist responses were given.

To sum up from the five articles that referred directly to the term "banter", three of them (Haig, 1986; Rutchick, 2013; Yonkovitz, 1998) had categories which included banter as part of their definition or explanation (dark/aggressive humour, communication, initial interactions/tactical humour) and the other two (Bader, 1993; Kissane et al., 2004) reported banter initiated by both therapist and client to enhance communication, be an outlet for creative energy, as well as providing opportunities for self-reflection and collaboration.

Secondary findings showed that several strands of nuances were compatible with components of banter. There are essentially two components in our working definition (Oxford, n.d.-a): (1) teasing remarks, (2) playful, where (1) consists of the subelements (1a) provocation/making fun of (1b) someone else or oneself. The nuances of banter collected in Table 4 (list of banter nuances with frequencies) were identified in the results.

It is not these banter-related results per se that will be interpreted later, but the strains of banter evident in them. The dualities of playful and pointed are wrapped up in banter and can be extrapolated from some, if not all the points above. For example, pointed interpretations are both playful/teasing and provocative.

3.3 | Measures and therapy outcome

The key finding was that only one very recent study (Yonatan-Leus et al., 2018) related the use of humour/banter in therapy to the outcome of therapy. They used the OQ-45 (Outcome Questionnaire; subscales of Symptom Distress, Interpersonal Problems, Social Role) to measure the outcome of therapy and predicted better therapy outcomes. Clients were asked to complete the OQ-45 at five different points in time: intake, as well as after sessions 5, 15, 28 and 32. Four humour styles were measured by the Humor Style Questionnaire, including an "aggressive" humour style (AHS) defined as follows: "If I don't like someone, I often use humor or teasing to put them down." Therapist questionnaires were sent out five years after the end of the study and hierarchical linear modelling was used to analyse variance and predictor variables. Clients of therapists with a high AHS had better therapy outcomes ($p < .05$).

Eleven studies (Bader, 1993; Bloomfield, 1980; Fabian, 2011; Grotjahn, 1971; Haig, 1986; Kennedy, 1991; Lusterman, 1992; Marcus, 1990; Poland, 1971; Schimel, 1978; Wright, 2000) were

TABLE 3 Summary of cohort, RCT, quasi-experimental and cross-sectional studies included in the systematic review

Authors, year	Design and method	Setting	Participants, events	Humour/banter-related result(s)	Discussion points
Yonatan-Leus et al. (2018)	Cohort study, self-report questionnaires, 5 years later	Jerusalem–Haifa study, dynamic psychotherapy for 1 year	29 therapists and 70 clients	Therapists with a higher aggressive humour score were considerably more effective than those with a higher honesty score Questions the "kind" therapist approach that might be perceived as uncompromising and inflexible, even rendering the therapist unable to explore the patient's feelings (if that required an unauthentic therapist self-directing his or her own emotional responses)	Observing the client's therapeutic zone of proximal development (TZPD), pushing boundaries yet not mobilising the client's defence mechanisms For future studies: which types of interventions do AHS therapists employ? No therapist was extremely aggressive in his or her humour/honesty style
Kissane et al. (2004)	Randomised control trial	Melbourne-based for women with advanced breast cancer	Not specified	Humour is one piece of evidence for noticeable maturity in a supportive-expressive group therapy Authentic harmony between therapists	Creative energy may emerge as, among other things, banter if therapists are able to express ambivalences and facilitate an atmosphere of mutual respect, in which the therapists' valuing of each other's contribution can stimulate group members to benefit more from the rich diversity of the group
Ventis et al. (2001)	Randomised control trial	24-item behavioural approach test with an American tarantula	40 students highly fearful of spiders	No differences were seen between the traditional desensitisation approach and humour in systematic desensitisation	Self-efficacy may be enhanced when experiencing a feared stimulus in a humorous context Humour in therapy took the form of humorous statements about spiders and coming up with funny nicknames for spiders alone or with others
Yonkovitz (1998)	Quasi-experimental design	Workshop and therapy	21 therapists and 61 clients	Low-to-medium use of provocative bantering was reported in therapy Clinicians who attended the workshop seemed to use the humorous interventions presented in the workshop (e.g., sharing humorous stories or making the client aware of the absurdities and ironies of life) more often than controls	It may not be the therapist's general style of humour that can predict positive humorous interventions, but rather subtleties such as their comfort with emotional arousal and affective interaction Projective assessment may predict better which therapists will be funny or which clients may benefit from humorous interventions
Falk and Hill (1992)	Cross-sectional	Brief psychotherapy	236 events from 8 cases	Client laughter greater when preceded by humorous remarks as compared to risk interventions Out of the risk interventions, ridiculous description of the client provoked the most laughter	Particularly stress-reducing interventions related to client laughter Humour effect moderated by therapeutic alliance, facilitative nonverbal behaviours and individual appreciation of humour

(Continues)

TABLE 3 (Continued)

Authors, year	Design and method	Setting	Participants, events	Humour/banter-related result(s)	Discussion points
Gervaize et al. (1985)	Cross-sectional	Therapy	15 professional therapists with 75 adult patients	Defined categories of therapist statements were found to occur before strong laughter	Authors identify patterns leading up to the strong laughter, usually starting with some risky behaviour, followed by sharing and/or imagined concrete steps, exaggeration and then a welcomed occurrence in the therapeutic relationship
Rosenheim and Golan (1986)	Cross-sectional	Tape-recorded therapist interventions	Hysterical, obsessive and depressive patients; 36 adult patients	A restricted set of patients, particularly obsessive personalities, stood out for their rejection of humorous interventions	Differences for the type of humour or rather the therapeutic aim (e.g., bypass defences, emotional confrontation) were not reported
Golan et al. (1988)	Cross-sectional	Tape-recorded therapist interventions	60 female patients, of three personality types: obsessive, hysterical and depressive	Asked to rate three types of therapist intervention (anxiety reduction, perspective building and emotional confrontation), patients consistently preferred nonhumorous ones	The size of the effect depends on the personality type; generally, they suggest that there is no single variable can explain whether humour will be successful in therapy The dynamic properties of the therapeutic relationship are an unknown variable

case studies or case material that did not include either outcome of therapy measures nor any other measures.

Eight studies (Falk & Hill, 1992; Gervaize et al., 1985; Golan et al., 1988; Kissane et al., 2004; Rosenheim & Golan, 1986; Rutchick, 2013; Ventis et al., 2001; Yonkovitz, 1998) used various measures including ratings for humorous interventions, humour questionnaires (Situational Humor Response Questionnaire—SHRQ; Martin & Lefcourt, 1984); the Revised Questionnaire on the Sense of Humor—RQSH (Svebak, 1974), codings for verbal expressions of humour (Rutchick, 2013), humour ratings of hierarchy items (Ventis et al., 2001), behavioural approach task (BAT) scores (Ventis et al., 2001), fear arousal self-reports (Walk, 1956), perceived self-efficacy (Bandura & Adams, 1977), The Anxiety Differential (Nietzel et al., 1988), Spider Cognitive Dimension Rating (adapted from Bandura & Adams, 1977), Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960), Coping Humor Scale (Lefcourt & Martin, 1986), humorous hierarchy scene ratings (Ventis et al., 2001) as well as group and meeting notes (Kissane et al., 2004).

3.4 | Deductive content analysis of clinical examples of banter

Alongside the banter definitions and categories described at the beginning of the results section, a multitude of issues connected in part to the nuances of banter already mentioned was discovered. The content analysis in this section is pivotal to gaining a deeper qualitative understanding concerning how and when bantering reportedly manifests itself in psychotherapy according to the existing literature. We analysed which concrete examples of banter or banter-related humour in therapy were mentioned in any of the articles, including both remarks and responses.

This section is organised by the theoretically based categories that were created based on the literature to carry out a deductive content analysis on the 20 articles selected for eligibility in the systematic review (Bader, 1993; Bloomfield, 1980; Fabian, 2011; Falk & Hill, 1992; Gervaize et al., 1985; Golan et al., 1988; Grotjahn, 1971; Haig, 1986; Kennedy, 1991; Kissane et al., 2004; Lusterman, 1992; Marcus, 1990; Poland, 1971; Rosenheim & Golan, 1986; Rutchick, 2013; Schimel, 1978; Ventis et al., 2001; Wright, 2000; Yonatan-Leus et al., 2018; Yonkovitz, 1998).

3.4.1 | C1: Challenging

Theoretically driven category definition: One study highlighted the very fine line between the feeling of a positive humorous intervention and other emotional states at odds with experiencing something as funny (Marcus, 1990). The study explained how analysing an individual's humorous quirks is connected with the determination of automatic thoughts. Marcus (1990) highlighted three types that were of special relevance: irresponsibility/unaccountability,

incongruity and inconsequentiality. Those thought patterns could have resulted from some external life situation and may be related to intrapsychic antithetical ideation and there is a chance to alter non-adaptive/dysfunctional thinking through a person's unique humour, possibly black humour. This is done by making the person conscious of what they seem to be emoting and the perceived significance of that emoting for others "to understand why others sometimes see them differently than they see themselves" (Marcus, 1990, p. 424).

Anchor example(s) and coding rules:

Theoretical-based category—C1: Challenging

Definition—helping patients to recognise feelings, understand what those feelings cause to happen within themselves and relate this emotional flow to accompanying mental states

Banter-related examples—He said "I feel very warm and affectionate towards her". But these words were accompanied by clenched fists and teeth. When we asked him "What are your fists doing Bill?", he said with glee "Bashing her". This helped him to recognise the ambivalence which was still present within him

Coding rules—initiated by the therapist; if not all aspects of the definition, point to C4 or C5, emphasis in this category on processing of emotions

3.4.2 | C2: Promoting/facilitating therapy

Theoretically driven category definition: The most exhaustive overview of functional aspects of humour was given in Haig (1986); the "as a form of communication" category especially captured the need for therapists to reciprocate and participate in humour in order to facilitate communication.

Anchor example(s) and coding rules:

Theoretical-based category—C2: Promoting/facilitating therapy

Definition—banter used in communication to help start a reciprocal and participative process or in a relativising manner

Banter-related examples—John responded, "Sunday was supposed to be a day of rest-but I don't even get that." After a pause, he demanded, "O.K., so now what?!" I replied that he didn't want me to get lulled into the delusion that we were actually working together!

Coding rules—initiated by the therapist or client; more general sense than C1, C4 or C5 with the focus on enabling clients so that ultimately they will be able to work with painful or uncomfortable feelings

3.4.3 | C3: Authentic harmony between therapists

Theoretically driven category definition: The theoretical consideration for this category stems from Kissane et al. (2004), namely, to create an enabling environment that allows creative energy to be expressed. In this category, the technique of emphasising harmonious things that take place in the group is central, in contrast to relativising in C2, new perspectives through confrontation in C4, less threatening perspectives through confrontation in C5 or challenging related to emotional flow in C1.

Anchor example(s) and coding rules:

Theoretical-based category—C3: Authentic harmony between therapists

Definition—banter expressed in this environment allows creative energy to be expressed

Banter-related examples—No matter how the group responded or what we said, suggested, interpreted, or advised, nothing helped, and the bitter fighting went on. Finally the group therapist said: "Do you know that on Noah's Ark sexual intercourse was forbidden? When the couples filed out of the Ark after the Flood, Noah watched them leave. Finally the tomcat and she-cat left, followed by a number of very young kittens. Noah raised his eyebrows questioningly, and the tomcat said to him: 'You thought we were fighting?'" After that, the group cut short the woman's description of the marital fighting, implying that, if that was the way she wanted to live and love, then she should do so and not complain

Coding rules—Banter between therapists or group members that emphasises processing things which take place in a group, perhaps with reference to therapist interventions

3.4.4 | C4: Risky yet essential interventions

Theoretically driven category definition: In the spirit of mocking or teasing the client, Falk and Hill (1992) and Gervaize et al. (1985) report one category of therapist statement entitled "ridiculous description of the patient." Although there are slight differences in the examples given, in both cases, the client is essentially teased through exaggeration. The closing line at the end of Bloomfield (1980) can perhaps elaborate these risky yet essential interventions: "challenges preconceived and sacred notions, puts things into perspective, highlights contradictions within us, and makes it possible to see things from a new angle, with new eyes." (p. 141).

Anchor example(s) and coding rules:

Theoretical-based category—C4: Risky yet essential interventions

Definition—challenges preconceived and sacred notions, puts things into perspective, highlights contradictions within us and makes it possible to see things from a new angle, with new eyes

Banter-related examples—"The next time you negotiate with her, try floating this proposal: that she clean your apartment while you watch sports and then the two of you can talk during the commercials!" Fred roared with laughter at this comic articulation and caricature of his phallic narcissistic desire

Coding rules—initiated by the therapist; all aspects of challenging/provocation without the relation to emotional flow; otherwise C1: challenging

3.4.5 | C5: State transformation through confrontation

Theoretically driven category definition: The notion of transforming a patient's state into another state that better serves the client, for example, thoughtful introspection, was a common catalyst in several articles (Kennedy, 1991; Lusterman, 1992; Schimel, 1978). The starting state in such transformations was often guilt, strong uncomfortable feelings or even agony.

TABLE 4 Summary of case material and case studies included in the systematic review

Authors, year	Design and method	Setting	Participants, events	Humour/banter-related result(s)	Discussion points
Bader (1993)	Case study	Psychoanalysis	Clinical vignettes	Suggests that the use of humour can be a means towards disinhibiting clients so that they feel able work on painful affects	Banter should not be forced, but shaped to the therapist's style of humour as it may be initiated as a result of (and reflect) internal work triggered within the therapist A "flat" stance towards clients may reinforce traumatic childhood symptoms
Wright (2000)	Case studies	Group therapy	Vignettes	Even the best planned and well-meant interventions may go wrong, one advantage of group therapy is that it often emphasises processing the things that take place within the group Being clear on the task with the group and risking more subjective involvement (e.g., playfulness, humour, teasing) can help the therapist to look at his or her boundary violations reflectively and/or reformatory if they seem out of touch with the group	Effectiveness of teasing when it involves the therapist, particularly benevolent teasing of the therapist, can increase the compassion and understanding felt towards the therapist, including less fear and less defensive idealisation Group humour to defuse anger, embarrassment as well as facilitating the sense of belonging, trust and tolerance
Rutchick (2013)	Case studies	Community counselling sessions/ videotaped therapy	5 client participants	Client verbal expressions of humour (VEH) were often a mixture of dark, aggressive and/or self-deprecating humour. The most frequent contexts in which humour was used were serious, difficult or traumatic topics Participants laughed twice as much in comparison with their VEHs	Humour was most likely to be expressed as subtle wordplay, sarcasm and anecdotes rather than more overt expressions such as one-liners, jokes or puns Oftentimes, the therapist's laughter was found to be inappropriate, not in response to any client remark or relating to something humorous
Fabian (2011)	Case studies	Therapy of patients with borderline conditions	Several clinical vignettes	Joking not only has a relativising outcome, but it also influences the treatment of concrete thinking, aggression, compulsion, depression and ambivalence One clear example is the use of humour to express aggression in a concealed or disguised manner in order to ease his or her burden That is the burden or dilemma of suffering under built-up aggression and at the same time the feeling of disempowerment due to the lurking and lumbering fear of losing the therapist given the safe boundary requirements of therapy (in which the patient may have to do without patterns of behaviour that had helped previously)	Humanising mocking of the therapist can often provide a short respite from the intensive transference between therapist and patient Especially for borderline patents, who may idealise and devalue in quick succession, such a loosening up can lead to deeper personal insights which in turn may develop a more realistic patient–therapist relationship Humour may be a defence against not only aggression, but also related emotions such as rivalry or jealously. In addition, emotions like shame, fear and grief can disguise themselves behind the facade
Lusterman (1992)	Case study examples	Therapy	Young adults	An appropriate joke, connected to the client's metaphoric bind, might act as a catalyst to introduce change Humour and metaphor both have disarming qualities that can traverse boundaries whereas comparing things often causes a "yes – but" thinking	For jokes to work, the therapist has to enjoy telling them and make sure it is about the therapeutic situation and not his or her need for attention If a joke has to be explained, then it is not funny. Thus, if a client does not respond to a joke, the therapist should not try to push it further and risk triggering the very resistance he or she is trying to disarm

(Continues)

TABLE 4 (Continued)

Authors, year	Design and method	Setting	Participants, events	Humour/banter-related result(s)	Discussion points
Kennedy (1991)	Case study	Psychoanalysis	3 examples	Banter can be understood as projecting a negative self-attribute onto somebody else One effect of general laughter is that it allows people to think and behave more freely, particularly in groups Playing to artificial emotions can be undercut with a bit of irony The gravity of strong feelings, which may bring out divisive effects or even run the risk of engulfment, can be lessened or transformed into a more powerful expression that better serves the client's needs by a well-timed witticism	If a therapist feels that a patient cannot express something, humour can help to broach the subject in a way that is not too intimidating Elements of a patient's presentation or history that have been buried by aridity and humourlessness are harder to process than when a patient uses humour as a defence Even though humour may detract or deny empathy and sympathy for one another, it can still be useful for the victim and joke teller due to the inherent respect shown towards the patient's resilience which can then allow room for the good practice of autonomy
Marcus (1990)	Case studies	Therapy	Two vignettes	Demonstration of a cognitive structural approach to correct dysfunctional thoughts based on humorous aspects of a patient's presentation	Tempering anxiety (nervous laughter), covering up hostility (turning it into sarcasm or a form of teasing), attenuating depression (laughing through one's tears) and trivialising the seriousness of material which comes to mind during therapy
Bloomfield (1980)	Case studies	Psychotherapy and analysis	Various patient examples	Not all uses of humour are constructive A vital balance must be struck between risk and intervention outcome	Awareness that humour can disguise hostility and jokes can let out (directed and undirected) aggression
Schimel (1978)	Case material	Psychoanalysis	Patient examples	Some humorous remarks that could be seen as demeaning or belittling out of context, nonetheless, have the power to change what might be an agonising discourse full of guilt and despair to one of thoughtful inspection The selective and compassionate use of humour can help to promote or further interpretative functions	The issue remains that some patients will consider wit and/or humour as hostile or demeaning Though not particularly kind, wit highlights congruities in the patient's ongoing function and may be used to express both mindful or unconscious meta-messages which stepwise analysis can work with to process the issues reflected in the witty remark(s)
Haig (1986)	Case material	Psychotherapy	Clinical examples from a case	Constructive aspects of humour: forming the therapeutic alliance, breaking through resistance, modulating anxiety, as an affect releaser, fostering self-observation, acceptable outlet for feelings of hostility, assisting diagnosis, counter-transference indication, building ego strength, a form of communication, promoting use of a transitional area, free association and lateral thinking, iconoclastic function, improving the palatability of interpretations and to help the therapist cope Destructive aspects of humour: denial, regression, suppression, ingratiation, hostile therapist, narcissistic therapist and undermining confidence in therapy	Paranoid patients may perceive even the slightest smile as a hostile attack Patients who like banter and communicate with it may need a therapist to reciprocate banter initially to promote the therapeutic process

(Continues)

TABLE 4 (Continued)

Authors, year	Design and method	Setting	Participants, events	Humour/banter-related result(s)	Discussion points
Poland (1971)	Case studies	Psychotherapy	2 brief case reports	Humour may indicate the state of the therapeutic alliance and observing ego as well as provide a useful mode for interventions	Evaluate the strength of the therapeutic alliance before using humour Laughing may prompt an ego split which could allow the patient to join the therapist in observing the process
Grotjahn (1971)	Case material	Psychotherapy	Examples from group members	Raging with/at patients or crying with them is not appropriate; nevertheless, it should be acceptable to laugh with them; group therapy without laughter is very wrong A wisecrack can bypass resistance quickly and feel acceptable; furthermore, the patient is given the opportunity to understand the message himself or herself	Negative rumination that leans towards excessive complaining about a situation, which the patient actually seems to enjoy and want, can be cut short by a pointed interpretation and facilitatory group efforts

Anchor example(s) and coding rules:

Theoretical-based category—C5: State transformation through confrontation
Definition—does not challenge any preconceived or sacred notions, but causes a transformation in the client's processing towards a more positive and less threatening perspective by confronting or defusing their statements in some way
Banter-related examples—"Did they teach you in school to make interpretations that your patients can't understand or use?!" I would respond, "Do you think I went to school to learn how to do this?" Or else I might retort, "Yes-it was in the same course where they taught me to blame the patient for my mistakes!"
Coding rules—initiated by the therapist; when humour can be identified as a catalyst for positive change, it does not run the risk of C4 or hold the emotional reflective component of C1

3.4.6 | C6: Humanising the therapist

Theoretically driven category definition: Several studies refer to the concept of making the therapist appear more human and therefore less formidable (Fabian, 2011; Kennedy, 1991; Wright, 2000) by teasing the therapist in a benevolent manner.

Anchor example(s) and coding rules:

Theoretical-based category—C6: Humanising the therapist
Definition—banter/teasing used in communication to help make the therapist appear less formidable
Banter-related examples—He ended it all with the question, "Are you able to follow this?" I responded, "Wait… could you speak more slowly?"
Coding rules—initiated by the therapist or client; the therapist is the butt of the joke or target of the banter

3.4.7 | C7: Negative banter or banter-related humour

Theoretically driven category definition: Indeed, an aversion for humorous interventions was reported in some studies (Golan et al., 1988; Rosenheim & Golan, 1986). Even so, these studies related to the psychopathological context where responses to humour may be more sensitive than in general psychotherapy. A further study which investigated pathological aspects of humour also noted the possible hostile or demeaning effects of humour taken the wrong way (Schimel, 1978).

Anchor example(s) and coding rules:

Theoretical-based category—C7: Negative banter or banter-related humour
Definition—banter/teasing used in communication which leads to or itself can be considered to contain destructive aspects such as hostility, suppression, trivialisation of serious material, demeaning, humiliating and assaulting
Banter-related examples—he would accuse me of trying to blame or "one-up" him, "pulling rank" to protect my embattled authority
Coding rules—initiated by the therapist, but can only be coded based on the client's response(s)

Most banter-related examples were classified as C2, C4 and C5. All other categories had just a few examples placed in them, notably C1 (challenging) and C7 (negative banter-related humour) (Table 5).

4 | DISCUSSION

Results showed that few studies explicitly referred to banter (Bader, 1993; Haig, 1986; Kissane et al., 2004; Rutchick, 2013; Yonkovitz, 1998), and no study investigated banter as the main independent variable in the context of therapy. However, when banter was split down into its main components, many instances of overlapping humour (even when it was not referred to as banter-related) were found in the literature (Fabian, 2011; Falk & Hill, 1992; Gervaize et al., 1985; Kennedy, 1991; Rosenheim & Golan, 1986; Schimel, 1978; Wright, 2000; Yonatan-Leus et al., 2018). Many functions of this type of banter-related humour were highlighted. They included facilitating slow reflective processes (Bader, 1993), enabling communication and harmony (Haig, 1986; Kissane et al., 2004), making the therapist more approachable (Fabian, 2011; Kennedy, 1991; Wright, 2000), transformative perspective shifts (Fabian, 2011), as well as providing a protective space in which clients' behaviour can be safely challenged (Yonatan-Leus et al., 2018). One study related the use of banter-related humour in psychotherapy to therapy outcome (Yonatan-Leus et al., 2018). The aggressive humour style that therapists were reported to have used in that study, which through its examples matched well with banter, predicted positive therapy outcomes.

Studies originating mostly from the United States may reflect either more research done on humour in the United States (Pinna et al., 2018) or the relatively narrow selection of articles in the screening process, in particular with the focus on banter-related literature and empirical studies (Kissane et al., 2004; Ventis et al., 2001; Yonatan-Leus et al., 2018). Although most studies were case studies in design, a new strand of literature beginning in the mid-1980s (Gervaize et al., 1985; Golan et al., 1988; Rosenheim & Golan, 1986) and going through to more recent work (Kissane et al., 2004; Ventis et al., 2001; Yonatan-Leus et al., 2018; Yonkovitz, 1998) seems to have focussed on more empirical designs to investigate humour in therapy.

Studies mentioning banter explicitly were few; nonetheless, this can perhaps be accounted for given the general scarcity of work on humour in therapy (Bloomfield, 1980). Almost 40 years on from Bloomfield's comments, Martin and Ford (2018) write, "Although empirical work in these areas is quite limited, our review of the relevant research literature suggests a gap between many of the enthusiastic claims of practitioners and the evidence of science" (pp. 369–370). Banter's arguably innocuous characteristics and wide-ranging functions in everyday life make it difficult to pin down. The finding that banter often leads to reflection occurring slowly after a mutually agreeable build-up of banter suggests potential benefits of its inclusion in therapy.

Bantering clearly has aggressive aspects to it and these elements were found in the results, which referred to aggressive or dark humour. Furthermore, that banter can enable communication and that banter frequently implies authentic harmony fits well with social cohesive theories of humour (Haig, 1986; Kissane et al., 2004).

However, for the hallmark of banter in therapy above, context is very important (Bateman & Fonagy, 2019). It makes a difference if a therapist is making such statements as compared to a narcissistic employer/parent/bully. Writing in metaphorical terms, it can be argued that the good-natured part of banter is an oath to do no harm, protect those who are vulnerable and be respectful. This argument makes sense in the psychotherapeutic context due to the nature of and professionalism connected to this health-giving environment.

That only one study (Yonatan-Leus et al., 2018) related humour to therapy outcome would seemingly reflect the difficulty in analysing and gathering the necessary material due to the sensitive topics involved in therapy and its respective need for confidence. Nevertheless, the key finding that the aggressive humour style category was most successful in predicting the positive outcome of therapy (i.e., symptoms got better) is an evidence-based result. Given the similarities between AHS and banter mentioned earlier, this supports the idea that banter-related humour is used in therapy. Schimel (1978) pointed out the need for care in its application as follows: "It is suggested that, if the psychoanalyst can become skilful in the selective and compassionate use of humor to subserve interpretative functions, he will have added a powerful tool to his psychotherapeutic armamentarium" (p. 378). Further studies are needed to analyse banter in therapy in more detail (investigating subtypes and contexts) and replicate the therapy outcome finding.

The weight of case studies in this review and their dates of publication explain to some extent why no measures were included in the majority of those selected here. Besides, many of the studies contained in this review were psychoanalytic. Although no analysis was performed regarding which banter-related examples occurred in which type of therapy, the low frequency of challenging banter-related examples found overall in the articles might reflect the primary usage of challenging in MBT.

The wide range of banter-related humour found in the deductive content analysis demonstrates to some extent that it is already quite a pervasive element of therapy. Examples have shown that the form varies much and can be anything from direct sarcasm to telling funny stories, and often a mixture of confrontation and bantering repartee.

TABLE 5 List of deductive categories with frequencies

Category name	Frequency
C1: Challenging	2
C2: Promoting/facilitating therapy	17
C3: Authentic harmony between therapists	2
C4: Risky yet essential interventions	14
C5: State transformation through confrontation	13
C6: Humanising the therapist	1
C7: Negative banter or banter-related humour	3

It suggests that the guise of everyday bantering often allowed for progress in therapy. Furthermore, banter is used in a way that mixes types of communication exchange (e.g., confrontation, storytelling and emphasis on the human condition) and types of joking, for example irony, self-deprecation, exaggeration, word play (cf. King, 2016; Rutchick, 2013). The result of this combination produces its telltale defining characteristic in therapy of playfulness and pointedness.

Two other banter-related types of humour were ridiculous descriptions and teasing the therapist, both of which were well received in many examples in the deductive content analysis. Another result was the aversion to humour in some cases. Indeed, this was and remains a contentious issue to date. A prominently cited author who warned against the use of humour in therapy, and particularly for therapists at the beginning of their career, is Lawrence Kubie (Haig, 1986, p. 546). Schimel (1978) also cites Lawrence Kubie as having "condemned all use of humor in psychotherapy as inevitably destructive" (Schimel, 1978, p. 373). Bader (1993) separated modern analytic thinking, which rather embraces the use of emotional responses in the analyst, from the older school of abstinence with its well-founded concerns regarding analysts who inadvertently or intentionally project their own conflicts onto the patient (p. 24). The small number of examples of negative banter in the deductive content analysis could point towards in-built safety mechanisms (e.g., professional guidelines for good practice). However, a publication bias (Begg, 1994) towards positive outcomes in therapy cannot be ruled out.

Although many studies did not have outcome measures, other variables were measured using various humour scales and behavioural scores (fear, anxiety, coping). This seems to reflect the general-purpose effects of humour in tempering anxiety (Golan et al., 1988; Haig, 1986; Marcus, 1990) and empowerment (Crawford & Caltabiano, 2011)—gaining a positive sense of mastery (social connectedness) or narcissistic power (aggression or dominance related theory). Freud's seminal works also included the assertion that humour can reduce stress, anxiety and negatives responses towards a situation (as cited in Meyer, 2007, p. 20).

The case for banter-related humour in therapy is also supported by several results found in this systematic review: humorous quirks offering a starting point for analysis (Marcus, 1990) and the transformative power of banter-related humour (Kennedy, 1991), in addition to cutting through resistance (Grotjahn, 1971; Haig, 1986; Lusterman, 1992), or just providing more space to breathe and explore when transference becomes particularly intense. The findings of Yonatan-Leus et al. (2018) suggest that a strict policy of kindness and honesty are not always enough for successful therapy outcomes. That is because such noble and rigid expectations may struggle to hold the multifaceted roles and responses that are sometimes required for a therapist to engage with the client and make progress.

Banter seems to be a good practice for therapy generally (Bader, 1993; Roncoli, 1974; Yonatan-Leus et al., 2018; Yonkovitz, 1998). Indeed, it already inherently has something good-natured in its definition (broader contemporary usage and not the harsher historical witty elitism culture). Nevertheless, given the concerns outlined above, the choice of bantering terminology used in communication with patients should arguably be geared to their "banter palate". In particular, for banter to be effective and positive, the therapist and client need to get to know each other. That would seem to be a precondition for attunement to the intricacies of their banter palates.

The challenging category was explicitly created with MBT (Bateman & Fonagy, 2019) in mind. When a client begins to mentalise excessively (e.g., when conversation focuses on symptoms and starts to sound like it is literally from a textbook), he or she may have entered the so-called pretend mode, in which there is little or no connection to reality and a state of disconnection with the client. A challenge to exit this pretend mode is recommended by Bateman and Fonagy (2019).

> "When I ask you something, to me you seem to veer off the topic and not answer. Am I right, do you think, or am I being too sensitive?" [therapist asking][…] it is marked as the clinician's mental state, asks the patient to consider the process of the moment, can be said humorously with some self-deprecation, and places the clinician into the interaction
>
> (Bateman & Fonagy, 2019, p. 114).

The results of the current review might have been different if a less contemporary definition of banter was taken. Another limitation of the study is that banter remarks and responses to them were all bundled together in the analysis. Further studies are also needed to investigate which factors may influence responses other than the banterer's intentions, perceived message and psychopathological considerations, for example, whether LaMothe's theory of emotional habits (LaMothe, 2012) could characterise patterns of responses.

Finally, another result was the use of humour to bypass defences or resistance through emotional or humorous confrontation (Golan et al., 1988; Grotjahn, 1971; Rosenheim & Golan, 1986). If not bypassed, sometimes just an easing of the often very intensive transference was enough to allow for a change or new perspective (Fabian, 2011). This theme was initially formulated as a category. However, there were insufficient examples to determine anchor examples for its coding rule.

In conclusion, the results suggest that banter and banter-related humour may be more or less appropriate for different psychotherapies. Where spontaneity, playfulness and pointed confrontation are allowed and encouraged, banter is likely to flourish. That is assuming that it happens under the right circumstances (e.g., attunement to the client's humour palate, to serve some form of progress for the client). The technique of challenging in MBT (Bateman & Fonagy, 2016) would seem to provide a platform in which a high usage of banter might be a predictor for successful therapy outcomes. However, further research is necessary to strengthen these results. Avenues to this end could include the following: (a) collecting empirical data on the types of bantering interventions that therapists use in real psychotherapy sessions (fine-tuning and extending the existing

category system), (b) investigating whether any such empirical session data unearth harmful clinical examples of banter, (c) replicating the key finding from Yonatan-Leus et al. (2018) that the usage of aggressive banter-related humour correlates with an improved symptomology outcome, and (d) looking more closely at any interaction between therapeutic alliance and bantering. Presumably, there would not be a main effect of bantering without a main effect of therapeutic alliance; however, there could be a main effect of therapeutic alliance without a main effect of bantering. It would be interesting to examine whether bantering and the therapeutic alliance show interactions with different bantering categories, for example, between rather conspiratorial techniques, authentic harmony and challenging.

Limitations of the methodology include that only English and German studies were taken into consideration. Furthermore, interpretations are based on the inclusion criteria (e.g., relating to adults), many studies were excluded, for example, anything relating to childhood, special pathological disorders like drug addiction or the elderly. The sufficiently high inter-reliability score indicates a reliable systematic analysis.

CONFLICT OF INTEREST

The authors report no conflict of interest.

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QUESTIONNAIRE
C6(26) Part 1 of 2
The use of banter in psychotherapy: A systematic literature review

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- There is only ONE correct answer per question.

Introduction

Question 1: According to *Martin and Ford* (2018), which three broad areas describe the different approaches that have been taken to use humour in psychotherapy?

- **A:** Humour as a defense mechanism, specific cognitive approaches and humour as a linguistic tool
- **B:** Humour as therapy, specific therapeutic approaches and humour as a communication skill
- **C:** Humour as a diagnostic tool, behavioural activation approaches and humour as a coping skill
- **D:** Humour as an ice-breaker, psychodynamic approaches and humour as a social skill

Question 2: Which theory of humour emphasizes aggressive tendencies and can be traced back to Aristotle's degradation theory?

- **A:** Incongruity theory
- **B:** Psychoanalytic theory
- **C:** Reversal theory
- **D:** Dominance and aggression theory

Question 3: What is identified as a key component of incongruence theories of humour?

- **A:** Paradox
- **B:** Superiority
- **C:** Catharsis
- **D:** Homeostasis

Question 4: How is the term "teasing" defined in the Oxford dictionary?

- **A:** To ridicule lightly and good-naturedly
- **B:** Intending to provoke or make fun of someone in a playful way
- **C:** To joke about someone in a mocking or unkind way
- **D:** The playful and friendly exchange of remarks

Methods

Question 5: TRUE or **FALSE**: When performing the deductive content analysis, the level of abstraction was limited to abstract theoretical concepts rather than concrete examples.

- **A:** TRUE
- **B:** FALSE

Results

Question 6*: In Bader's* (1993) study, what was the reported effect of the "slower application of banter" on the patient named John?

- **A:** It caused John to drop out of therapy immediately
- **B:** John gradually became more self-reflective over time
- **C:** It triggered John's defence mechanisms and increased aggression
- **D:** John felt the therapist was mocking his mother

Question 7: Which humour style from the Humor Style Questionnaire, used by *Yonatan-Leus et al.* (2018), fits well with banter because of its teasing aspect?

- **A:** Self-defeating humour style
- **B:** Affiliative humour style
- **C:** Aggressive humour style
- **D:** Self-enhancing humour style

Question 8: What did the study by *Yonatan-Leus et al*. (2018) reveal regarding therapists with a high aggressive humour style (AHS)?

- **A:** Clients of these therapists had better therapy outcomes
- **B:** Clients of these therapists consistently reported feeling bullied
- **C:** These therapists were unable to establish a therapeutic alliance
- **D:** There was no significant difference in outcomes compared to other therapists

Question 9: *Marcus* (1990) suggests that the use of humour to challenge a client, by analising their humorous quirks, is connected to determining what?

- **A:** Their childhood trauma
- **B:** Their level of intelligence
- **C:** Automatic thoughts
- **D:** Their sense of social cohesion

Question 10: According to *Haig* (1986), what is the function of banter when used for promoting or facilitating therapy regarding communication?

- **A:** It allows the therapist to dominate the conversation
- **B:** It requires the therapist to reciprocate and participate in humour to facilitate communication
- **C:** It is used to define boundaries between therapist and client
- **D:** It serves as a distraction technique to avoid painful topics

THE END

QUESTIONNAIRE
C6(26) Part 2 of 2
The use of banter in psychotherapy: A systematic literature review

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- There is only ONE correct answer per question.

Question 1: Based on *Kissane et al*. (2004), what is the central technique when banter is used to establish authentic harmony in a group therapy setting?

A: Exposing the client's defense mechanisms
B: Emphasising harmonious things that take place in the group
C: Relativising the client's problems through storytelling
D: None of the above

Question 2: Regarding the use of risky yet essential interventions, what does Bloomfield (1980) suggest these humorous interventions do to "preconceived and sacred notions"?

A: Reinforce them
B: Ignore them
C: Validate them
D: Challenge them

Question 3: When using banter for state transformation through confrontation, what was often the client's starting state before the transformation occurred?

A: Boredom or disinterest
B: Joy or excessive happiness
C: Guilt, strong uncomfortable feelings or even agony
D: Confusion or memory loss

Question 4: Is it **TRUE** that several studies refer to the concept of making the therapist appear more human and therefore less formidable?

A: YES
B: NO

Question 5: What concern did *Kubie* (1970) raise about the use of humour in therapy in the context of negative banter?

A: It might cause clients to trivialise the severity of their problems
B: In short-term therapy there is no place for it
C: It is only effective with a minority of clients
D: It prevents the therapist from maintaining professional distance

Discussion

Question 6: What do *Martin and Ford* (2018) suggest about the relationship between practitioner claims and scientific evidence regarding humour in therapy?

A: Scientific evidence has validated all practitioner claims
B: Practitioners have underestimated the scientific validity of humour
C: There is a gap between enthusiastic claims of practitioners and the evidence of science
D: Practitioners rarely make claims about humour

Question 7: In the context of the review's content analysis, what is identified as the telltale defining characteristic of banter in therapy, resulting from the combination of different communication and joking types?

A: Aggression and hostility
B: Adherence to professional boundaries
C: Absence of any personal feelings
D: Playfulness and pointedness

Question 8: In Mentalisation-Based Treatment (MBT), what mode is a client said to have entered when they mentalise excessively with little connection to reality?

A: The pretend mode
B: The depressive mode
C: The manic mode
D: The avoidant mode

Question 9: What does the author suggest might have led to different results in this review?

A: If the review had focused only on group therapy
B: If a less contemporary definition of banter was taken
C: If the review included studies on children
D: If the review had excluded case studies

Question 10: TRUE or **FALSE**: A key finding identified for future replication is that the use of aggressive banter-related humour correlates with an improved symptomology outcome.

A: TRUE
B: FALSE

THE END

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ANSWER SHEET

C5(26)

The use of banter in psychotherapy: A systematic literature review

***Time spent on activity** **hour** **min**

You can complete any one, or all the parts of this activity.

	PART 1												PART 2										
	A	B	C	D	E		A	B	C	D	E		A	B	C	D	E		A	B	C	D	E
1						6						1						6					
2						4						2						7					
3						5						3						8					
4						9						4						9					
5						10						5						10					

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