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Paradox and Play:

A Study of Therapeutic Humour and Psychosis

Felicity Adams

Submitted in fulfilment of the requirements for the degree of:

Doctor of Psychology

Department of Psychology

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I would like to thank my friends and family who have been through the journey with me. You are the best cheerleaders I could have asked for.

Finally, I would like to dedicate this thesis to the clients I have worked with through the years who have experienced psychosis. You have taught me about courage and strength and I am indebted to you for all you have shared with me.

Declaration of Powers of Discretion

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Section A

Preface

Out beyond ideas of wrong-doing and right-doing,
there is a field. I'll meet you there

Rumi, 13th century

Preface

When I started my professional training, the one thing I was certain about was my fascination with the clinical area of psychosis. I imagined that with the doctoral training, new areas of interest would supersede this passion. Indeed, there have been many new areas I have become fascinated by, but never as much as the research and clinical practice of working with psychosis. It is possibly no coincidence, then, that my research naturally fell within this area.

However, whilst this research is focused around psychosis, the thread that runs through this portfolio is really my development as a counselling psychologist. The skill of a counselling psychologist, to me, is to work using evidence-based practice with a reflexive stance. The foundation beneath this is the humanistic philosophy that underpins our practice and it is my development of this philosophy (both personally and professionally) that is charted through this portfolio. In essence, the question for me has become, *how do I meet my clients more fully*? Part of the answer lies in connecting with clients through involvement and interaction, on a human, as well as a professional, level. Therefore, each piece in this portfolio explores what it means to bring oneself therapeutically to the work. Furthermore, this portfolio examines how counselling psychologists can make an empathic connection by taking a risk to experiment and play with a particular presentation where it has historically been considered inappropriate to do so.

This thesis is a collection of works that all approach the subject of psychosis from a different angle and thus show the range of skills I have honed in my training to become a counselling psychologist. The first piece is an extended client study, from my second year of training, detailing my work with a client experiencing psychosis. Despite writing various client studies and process reports, the one I have submitted as part of this thesis was the one I kept coming back to as a piece that reflects my working style most clearly. It describes my learning curve in using CBT for psychosis, along with the frustration that CBT was not sufficient and thus how to integrate some Acceptance and Commitment Therapy (ACT) techniques into my practice to help the client.

The second piece of work in this portfolio is an original piece of research: 'How is Humour Experienced by Therapists Working with Clients Experiencing Psychosis: A Grounded Theory.' This research explored what it was like for therapists to use humour when working with clients experiencing psychosis, exploring clinical examples from their practice in a semi-structured interview. Many interesting findings came out of this research and they have implications for clinical practice both inside and outside of the therapy room.

In the final section, I have written a journal article ready for submission to *Schizophrenia Bulletin*. It offers a summary of the research along with a reflection on a portion of the results and their implications for clinical practice. This final piece demonstrates my ability to condense work ready for publication to the wider academic community.

This thesis charts my interest in humour through the years from its inception and the chance discovery of Lemma's (2000) book that gave me hope that I was not alone in that nagging thought that there had to be room for something more in therapy. Why did no one else ever talk about using humour in the therapy room? This book was a breath of fresh air, and from there I began to search for more literature on humour and hypothesise what its therapeutic benefits might be. Still feeling this topic was rather foolish and not academic enough, I shared my idea with my research supervisor and was surprised to find my humorous hypothesis was taken seriously. I have since reflected on how I have internalised the idea that humour is not 'the done' thing in therapy. This thesis is thus an exploration on what place humour might have in therapy, specifically with regard to psychosis.

Throughout my training, I have had the benefit of learning and practising multiple models, including CBT, person-centred approach, psychodynamic, systemic and integrative theories. Each modality has added a different perspective to how I formulate clients' presenting problems and how I see the world. As a result, this thesis is an amalgamation of the different ways of conceptualising experiences of psychosis. There are multiple perspectives or interpretations, some harmonious and some conflicting. I think this is the beauty of the counselling psychology profession, to be able to hold multiple opinions that might conflict, in order that we may view something in as full a manner as possible.

Despite this range of approaches, one thing remains clear in my mind. One cannot remain neutral in therapy; indeed, the idea of abstinence or objectivity is a myth (Stolorow & Atwood, 1997). The way we are with our clients will have an impact on how they respond; the interaction is reciprocal. Our clients are not diagnoses; they are people first and foremost.

How can we *not* be involved with them? Therefore, our involvement with our clients must be considered carefully and this thesis is an attempt to do just that. What happens when we, the therapist, bring ourselves to the therapy room and connect with our clients through the use of humour?

References

Lemma, A. (2000). *Humour on the couch*. London: Whurr Publishers.

Stolorow, R. D, & Atwood, G.E. (1997). Deconstructing the myth of the neutral analyst: An alternative from intersubjective systems theory. *Psychoanalytic Quarterly, 66,* 431-449.

Section B

Using CBT With A Client Experiencing Psychosis: An Extended Client Study

'Now tell me, Matilda,' Miss Honey said. 'Try and tell me exactly what goes on inside your head...'

Roald Dahl

My Reasons for Choosing the Work

I have chosen to write up this client as a case study as I believe it demonstrates a case where I have been able to work effectively using Cognitive-Behavioural Therapy for psychosis (CBTp) to promote positive change and recovery. The client presented with a number of complex and challenging issues for me to work with and I believe this case shows how I was able to tailor the therapeutic work to the individual. This case also took some imaginative thinking, spontaneity and a little risk-taking in our sessions.

I have learnt a lot about the links between theory and practice from this client. In my experience, clients who present with psychosis never present with psychosis alone. There is usually understandable anxiety at the bizarre experiences they have, as well as social anxiety and varying degrees of depression associated with psychic decompensation and the loss of self (Michail & Birchwood, 2009). This means being able to work with a number of issues in one session and work sensitively to negotiate what coming to terms with psychosis means for the client. I also believe this was a case where I was able to work more integratively, combining traditional CBT techniques with third-wave CBT approaches, as well as using the counselling psychologist core skills of identifying process and transference to inform the work.

Summary of Theoretical Orientation

CBT is based on the theory that our thoughts, emotions, physiological sensations and behaviours are all interlinked with each other (Beck, 1995). These four factors are all influenced by the environment around us (Padesky & Greenberger, 1995). According to the model of CBT, individuals make sense of the world around them by forming cognitions, including surface level, negative automatic thoughts (NATs) and deeper level cognitions such as core beliefs. Core beliefs are ones that the individual holds about the world, themselves and others and they tend to be more strongly held.

The *way* in which we think is also important to the theory of CBT, as we all employ certain thinking styles or cognitive biases to our thoughts such as 'jumping to conclusions' or 'catastrophising'. In some people, thinking can become heavily distorted by these cognitive

biases, leading to distortions in the way the people view themselves, others and the world around them. CBTp works to help individuals who experience unusual perceptual experiences and thoughts to find less distressing ways to make sense of them.

The primary task of CBTp is to facilitate engagement with the client by fostering a relationship of collaborative empiricism (Chadwick, Birchwood & Trower, 1996). The client is then guided towards identifying and modifying their distressing beliefs and experiences by using a Socratic dialogue rather than directly confronting or colluding with them (Turkington & McKenna, 2003). Work with the client starts by gaining an understanding of the nature of these beliefs and understanding what distresses the client, as well as giving immediate coping strategies to offer some relief to these experiences.

Work then proceeds on an individual case formulation so that an understanding of core beliefs and assumptions held about the world, self and others are identified. These beliefs, evaluations or assumptions can become unhelpful, they can then be explored by setting up experiments in session and by giving homework, allowing clients to make sense of their experiences and learn how various strategies, such as avoidance and safety behaviours, serve to maintain their distressing experiences (Chadwick et al., 1996).

Two models by Garety, Kuipers, Fowler, Freeman and Bebbington (2001) and Morrison (2001) offer a framework within which psychosis can be understood. Garety et al. propose a deficit-based model where a dysfunction in cognitions leads to anomalous experiences. Morrison, on the other hand, conceptualises psychotic phenomena as 'intrusions into awareness' and it is the interpretation of these intrusions that causes the associated distress in an individual (please see Figure 1). This model is derived from work on anxiety, based on the idea that distress is caused by a misinterpretation of internal or external events. Morrison highlights the similarity between this model and anxiety; for example, if a person with hypochondria has a lump on their hand they might interpret this as cancer, but someone with psychosis might interpret this as a tracking device planted by an agent. Either might be right or wrong; the key difference is that people would be more likely to accept the first interpretation as culturally acceptable rather than the second.

I chose Morrison's model to formulate this case as I felt it would be the most simple to use with the client. I find Garety et al.'s model can be quite overwhelming to share with clients. Even when the model has been broken down bit by bit, it can be quite hard for a client to digest. I also found Morrison's model the most normalising and easy to share with my client:

it does not make any suggestions about deficits but merely points out that the interpretation one makes of an event is culturally unacceptable and might be based, in part, on faulty self and social knowledge. This model is optimistic as the faulty knowledge it describes is amenable to change and I think this provides much needed hope to a sufferer of psychosis.

This model works well to normalise the experience of psychosis as it suggests it is possible for anyone to make an erroneous interpretation of an event. It also explains how individuals are more likely to make culturally unacceptable interpretations based on their life experiences and beliefs about themselves and others. For example, one can understand that having a mistrust of authority due to previous discrimination might make an individual hypervigilant and use a cognitive bias of 'jumping to conclusions' when they find a lump on their hand and thus make a misinterpretation that *'I'm being tracked by the Police'*. This misinterpretation is then reinforced by emotions, bodily sensations, avoidance and safety behaviours (Morrison, 2001).

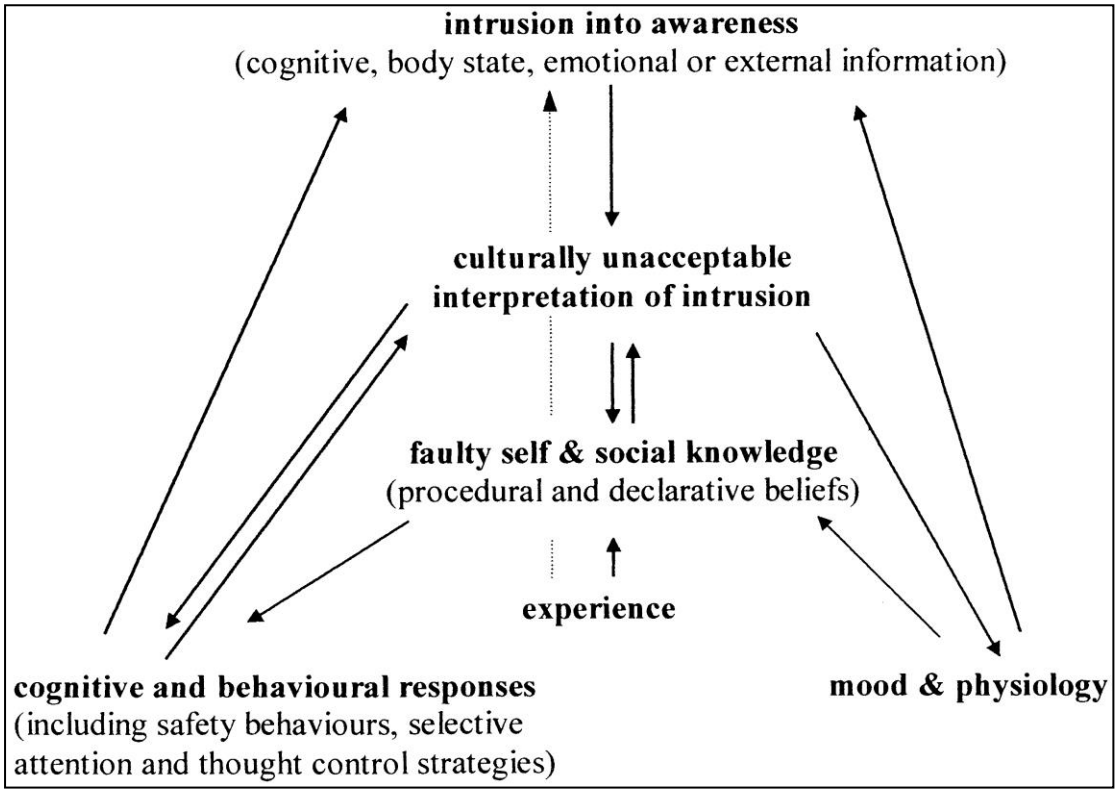


Figure.1. A Cognitive Model of Psychosis (Morrison, 2001)

Evidence has shown that CBT produces good results in the treatment of psychosis; however, the effect sizes are modest, not all results are significant and there are severe problems with

the evaluation of these trials (Turkington & McKenna, 2003). It is difficult to evaluate psychological trials in the same way one can with drug trials (UKCP, 2011). Firstly, it is impossible for the therapist or participant to be blind to the intervention; these are not anonymised drugs that are being administered but psychological interventions which one cannot be screened from. Trials are further complicated by factors such as the Hawthorne effect (Jones, 1992). This is a sort of placebo effect where results are distorted due to the special attention research participants receive from researchers (Turkington & McKenna, 2003). This is not forgetting the allegiance the researcher might have to the model or intervention they are testing, possible quite unconsciously, the very thing they are testing is likely to be an intervention they have some hope or belief in and this too can distort results (Luborsky et al. 1999). There is still a great need to keep developing and critiquing the model of CBTp and not accept the results of these trials at face value. The therapist must remain flexible, adapting CBTp based on individual needs as clients with psychosis are a heterogeneous group; thus, CBTp is not a one-size-fits-all solution. Third-wave approaches such as Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl & Wilson, 1999) has also been suggested as a possible way to alleviate distress in psychosis.

ACT uses mindfulness-based interventions alongside behavioural activation to promote change in individuals. Rather than trying to control or avoid experiences, ACT encourages clients to compassionately confront unworkable strategies that lead to a restricted life (Hayes, 2004). Clients are taught strategies that promote cognitive defusion through mindfulness, experiential tasks and metaphors. Thus, symptoms are indirectly targeted by altering the context within which they occur rather than striving to eliminate them. Research looking at whether ACT can be used to help individuals with psychosis has produced encouraging results in terms of reducing relapse rates (Bach & Hayes, 2002; Gaudiano & Herbert, 2006). Bach and Hayes demonstrated that after four sessions of ACT, patients' rehospitalisation rates were reduced by 50% over a six-month period. There are methodological issues with this research though, 20% of participants who were approached for this study declined to take part. There may also be a selection bias operating here, participants who agreed to take part might have been more motivated to overcome their symptoms of psychosis and were thus more likely to respond to ACT than those who declined to take part. Secondly, intention-to-treat analysis was not completed on the data. Analysis was completed on the outcome data of the 35 participants in each treatment group rather than the 40 that started in each group which means that results may be overly positive. Thus, this group may not be a representative

sample of people experiencing psychosis. Gaudiano and Herbert (2006) have since found encouraging results in an ACT treatment group versus enhanced treatment-as-usual using psychiatric inpatients (although not statistically significant) and White et al. showed that ACT significantly reduced depressive symptoms following a psychotic episode (White et al., 2011).

The Use of Language

The terms *symptoms, paranoia* and *delusions* are commonly used within the field of mental health and are becoming increasingly associated with medical terminology. The term *psychosis* was originally quite a radical term that critics of the term *schizophrenia* used, but it has now become increasingly adopted for medical usage. Coming from a critical realistic perspective rather than a one of medical naturalism, using terms such as *psychosis* or *delusions* can be problematic as they do not fit with my epistemological stance.

The term *psychosis* used to be more radical but it is more medicalised now because *schizophrenia* is a troubled term and so many of the discourses associated with *schizophrenia* have now passed to the word *psychosis*. It now comes to be seen as if it is describing something that naturalistically exists. This is an objectivist or naturalistic view, one that assumes mental abnormality exists and it is out there readily to be simply observed and verified by expert observers (Pilgrim, 2008). It also assumes that these experiences or utterances are indicative of an inherent pathology. This is in contrast to my own epistemological position; I do not believe that mental disorders simply exist ready for our verification. On the contrary, I believe that the physical world exists but how we perceive phenomena will be based on our interactions with them. However, I believe we have to be careful not to come from such a deconstructionist position that the very real discursive positions and material realities are negated. Thus I have decided to use the term in parentheses to show it is a problematic term but also to recognise that the way it is taken to mean something solid is worthy of continuous note.

Our interactions with the world around us are not objective scientific investigations. We come to any phenomena or experience saturated with our own interests and values (Pilgrim, 2008). Critical realism emphasises how cognitive, social and political factors as well as our interests and values will shape our perception of the world around us. What does this mean for clinical work? In my work it means that I question the terms used so frequently in clinical practice. Terms such as *schizophrenia, psychosis, delusions, paranoia* or *hallucinations*

which are concepts applied to a wide range of behaviours and utterances. Although it is useful to give a name to a phenomena so there is a shared language to describe it, using the term *delusion,* for example, means subscribing to a narrow operational definition that presupposes that there is normal thinking and delusional thinking (Harper, 2004). Accepting the word *delusion* implies some moral judgement about whether a person's thinking is good or bad, or right or wrong because logically there must fall a point where thinking is either delusional or not. Using any term means there is a risk of reifying it so that it becomes a thing, an object and an accepted fact. Psychosis is not an object, it is not something that freely exists, nor is it an innate pathological state to be observed. It is a complex interaction of social, cultural and individual factors and using medical language can obscure our understanding of these vital processes (Pilgrim, 2007).

A delusion is not an object, it is a socially constructed phenomena. It is a belief in something that, despite evidence to the contrary is held with some certainty. There are numerous examples of people without a diagnosis of psychosis who have beliefs that are not supported by any concrete evidence and are not seen as unusual or problematic (religion, or professing one's football team to be the best despite concrete evidence to the contrary). In the case of delusions though, it is because the belief is culturally unacceptable that is becomes problematic. It is with this in mind that I worked using Morrison's formulation of psychosis (Morrison, 2001) as it situates an individual's experiences within a social context rather than making assumptions about *basic cognitive dysfunctions* and *anomalous feelings* i.e. problems located within the individual as the Garety et al. formulation does (Garety et al. 2001).

Within this case study I shall use the term *psychosis* critically, that is to say, I do not accept it as a fact but I use it as a heuristic to describe a wide range of unusual experiences and / or utterances that a person can experience that they may or may not find distressing. I also think it is important to use the language that David used to describe his experiences. What could be perceived as *paranoid thinking* was described by David as his *anxious thoughts*. What could be described as *auditory hallucinations* were described by David as *hearing voices* and anything generally regarding *symptoms* was known as his *unusual or distressing experiences*. It was important to work within David's frame of reference, to allow these to be his own experiences rather than being colonised by me using professional jargon (Dillon & May, 2002).

The Referral and Context of Work

'David'* was referred to me by his care-coordinator within the Early Intervention (EI) team that I worked in, after he expressed concerns that he was relapsing. David had been under the care of the EI team for two years. He previously had 20 sessions of CBT with a clinical psychologist two years ago, but had started to hear voices more frequently and he was feeling paranoid.

* *Please note that identities have been changed to preserve anonymity.*

The Presenting Problem

David reported that his paranoia and anxiety had returned; specifically, he felt he was under surveillance from a group of three friends with whom he had fallen out because he owed them some money. He felt that there was a conspiracy against him, although he was unsure what that was. David believed that these three men were able to 'push' unpleasant thoughts into his head and their reason for doing this was to confuse and frighten him. David believed they were pushing thoughts such as: *'we are watching you'* or commands such as: '*drink your life away'*, which he found hard to resist because he feared something bad would happen if he did not follow the orders. David also became very concerned that other people could hear these thoughts and people would judge him for having 'horrible' and 'dangerous' thoughts. Along with having thoughts pushed into his head, David described a return of two voices talking loudly to him; he could not understand what they were saying to him and he was unsure who they were. David recognised these unusual experiences as early warning signs from the relapse prevention plan he had created with his previous psychologist and requested psychological help from his care coordinator.

Summary of Biographical Details of Client

David was a 28-year-old male living at home in a small flat with his parents. David was attending college and was working as a retail assistant in a local shop. David first became unwell in February 2007 when he heard voices, had ideas of reference that everything going on around him was in some way about him; for example, songs on the radio or people in the street were part of some larger conspiracy against him. This led David, understandably, to feel paranoid, so he stopped going to work, and when he became increasingly unwell, he was admitted to hospital. David was discharged a couple of weeks later and he moved back home where he was taken under the care of the EI team in April 2008. In June 2008, David was

arrested and charged for threatening and abusive behaviour. Since then, David had done well to return to work and college, managing his voices and paranoia.

His mother had suffered from depression and was off work due to poor physical health. His father was also unable to work due to severe physical health problems and he was a heavy drinker. David described living with his parents as stressful, as his mother often became upset that David had been unwell and she feared he would not *'make anything of his life'* and would end up being an alcoholic like his father. David would tell me how his mother would check he had taken his medication each day and he described feeling pressurised to get back to work or college by his mother. I hypothesised that there might be a high level of Expressed Emotion in the household (Barrowclough, Tarrier & Johnston, 1996).

David was taking an antipsychotic, 7mg Risperidone nocte, which he was happy to take; he told me it quelled the voices and helped him to sleep at night. David's only qualm about taking the medication was the weight gain he experienced, which was significant. I could see how much he struggled with the weight gain, but he went to the gym frequently and I admired his commitment. He said on balance that he felt that it was worth taking his tablets for the respite it gave him from the voices.

Initial Assessment and Formulation of the Problem

David presented as a well-kempt young man who made good eye contact and a rapport was easily established. I explored the different dimensions of David's voices and beliefs, such as the distress he experienced, the controllability of his unusual experiences and the relationship he had with his voices. These were based around the Psychotic Symptom Rating Scale (PSYRATS) (Haddock, McCarron, Tarrier & Faragher, 1999) and Beliefs About Voices Questionnaire (BAVQ-R) (Chadwick, Lees & Birchwood, 2000).

The return of David's unusual experiences seemed to have been triggered by a period of accumulating stress from work (feeling pressured to take on more shifts than he wanted to do), college (completing coursework and studying for exams) and home life (his mother's constant worrying over his health and a lack of financial independence to move out) within a context of increasing alcohol use (approximately two bottles of whisky a week). David's residual unusual experiences were maintained by his threat belief of being under surveillance at all times, leading to a hypervigilance of his environment with thoughts that '*other people are trying to trap me into a plot*' and *'I will be suspected of being a terrorist'*. When David experienced an intrusive thought, he misinterpreted it as being 'pushed' into his head by his

enemies. This misinterpretation was reinforced by his belief that he had been 'bad' in the past. David had a history of selling drugs, being in fights with gangs and he had lost his last job when he became unwell the first time. Thus, it was logical to him that others would want to play with his mind to punish him for his past misdemeanours.

David also sensed an 'atmosphere' where he felt people were plotting against him. This sense of atmosphere interested me. David could not quite put his finger on how or why this occurred, but he would get the feeling that something sinister was going on, like a gut feeling, and that everything around him seemed very important. I held a hypothesis that this might be something akin to Kapur's salience hypothesis where an aberrant salience is applied to everything around a person. This makes someone feel that everything has importance and relevance to them (Kapur, 2003).

Both the sensation of having thoughts pushed into his head and sensing an atmosphere led David to avoid going out, which served to maintain his anxiety, decrease his confidence and increase his threat belief as he was never able to challenge and disconfirm it. David also increased his alcohol intake, causing his mood to drop and increasing the likelihood that he engaged in ruminative thinking (please see Appendix 1 for a formulation).

Negotiating a Contract and Therapeutic Aims

David and I agreed to work for approximately 20 sessions as per the placement protocol (NICE recommends 16 or more sessions; NICE, 2009). The number of sessions was kept flexible to allow David more sessions if needed. Confidentiality, use of supervision, length, frequency and duration of sessions were discussed and agreed upon. David stated his goals of therapy to be:

- To feel less paranoid so that he could go out without feeling there was a plot against him;
- To feel less distressed by his voices; and
- To understand how people were 'pushing' thoughts into his head and how it was that other people were able to hear these thoughts.

The Pattern of Therapy, Therapeutic Plan and Main Techniques Used

Once the goals for therapy were agreed upon, psycho-education around the Stress-Vulnerability model was given (Zubin & Spring, 1977). I find this model a valuable heuristic to use with clients as it describes how certain early life events, mixed with stressors, conspire

against a person and increase their likelihood of developing psychosis. It is not a direct cause-and-effect model, but it does help to make sense of people's experience in a straight-forward manner which can be very reassuring.

This model helped David to become aware of how the different elements of his life had conspired against him: a busy workload, heavy alcohol use and early life experiences (e.g. being bullied at school, being in trouble with the Police) might have contributed to making him more vulnerable to developing unusual and distressing experiences. One early life event that also seemed important was that David felt a strong sense of protecting others who were vulnerable. When someone was being picked on at school, David would always step in to help them out. This led David to have a heightened sense that people were out to harm others and an increased sense of hypervigilence.

The humorously titled paper *Beck Never Lived in Birmingham* (Moloney & Kelly, 2004) also helped me in my formulation as it encouraged me to think how the environment was contributing to David's psychosis. David's psychosis could be formulated around his erroneous thinking, but it had to be taken into account that David was surrounded by gangs, violence, drug-dealing and financial insecurity on a daily basis. Putting his psychosis down to faulty thinking would not only be unhelpful, but it would be faulty thinking in its own right.

Once David understood this rationale, we identified ways to reduce this stress (reduce working hours and avoid friends who like causing trouble) and promote his coping skills (using self-soothing strategies). I also recommended David to read *Think You Are Crazy? Think Again* (Morrison, Renton, French & Bentall, 2008), a CBTp self-help guide for individuals with psychosis to supplement our work. David said he found this book helpful as it reassured him to see that the things he experienced had been written about by others and made him feel less alone in his unusual experiences.

David's goals were then ranked in the order he wanted to work through them:

1) Hearing voices
2) People 'pushing' thoughts into his head that others could hear
3) Feeling paranoid

These goals were worked upon across a number of sessions; thus, they will be discussed below by in term by each unusual experience, rather than in chronological order.

1. I gave David a list of coping strategies to manage hearing voices to offer some immediate relief (please see Appendix 2). David was willing to try these out and he experimented with different ones with varying success. Some strategies made the voices worse, such as focusing on the voices. David's distress did reduce as he continued to experiment with the different coping strategies and I encouraged David to develop and modify techniques he already used but did not identify as a strategy. For example, by listening to music through his headphones rather than speakers, David was able to reduce the volume and frequency of the voices and his distress reduced from 70% to 15% (please see Appendix 3 for full outcome data). On further exploration, David had not realised that his voices reduced when he was engaged in physical activity at the gym. We were able to reframe the gym not only as a place he had to go to lose weight, which felt like an imperative he must follow, but also as a space which offered a relief from his voices. This made going to the gym far more attractive to David and helped to serve multiple functions.

Once David had a sense of mastery over the voices, we started to challenge his beliefs about the voices (please see Appendix 4). David believed they were '*powerful*' and *'if I don't do what they tell me to do, they get stronger'.* I asked David to find evidence that supported or challenged these beliefs. I appealed to David's entrepreneurial side by explaining to him that if we were going to invest in a business opportunity, we would want to know how solid the business was before we put all our money into it. David really bought into the analogy of checking whether the foundations of his beliefs were solid, and with this, he began to realise he had no evidence that the voices were powerful. Instead, he developed alternative beliefs about his voices supported by concrete evidence. David took a big risk and he talked back to the voices and he learnt they could not harm him. This led to the new belief: *'When I don't act on these thoughts nothing happens.'* David started to realise that his voices increased when he was stressed: 'M*y voices are a reaction to my thoughts and emotions at a certain point in time'*; thus, they were reframed as something he could control.

I continued to build on this idea that David could develop a different relationship with his voices, rather than striving to eliminate them. This was achieved by using an ACT-based technique of visualisation, based on work by Steven Hayes (for his work on psychosis, see Bach & Hayes, 2002). So far, we had taken a very logical and scientific approach to David's beliefs about his voices, but I wondered if there was more that could be done to help promote this change.

It led me to speculate about the private experiences David might have when he heard the voices. David could describe the characteristics of the voices, and I wondered whether he might also have built up some image of them in his mind. I asked David if the voices were to take on physical characteristics, what they would be. I also asked David if he was willing to close his eyes and visualise the voices. He described them initially as brown, sticky and long'. I asked David to stay with this image and he continued, describing how the voices were turning into a daddy long-legs. David was able to hold this image clearly in his mind; I asked David what he would like to do with this image. David imagined rolling up a newspaper and swatting the daddy long-legs with it.

We repeated this exercise over a number of sessions. David found this exercise powerful and he laughed and smiled whilst doing it. David reported that he felt much more in control of his voices and less threatened by them. David's relationship to his voices changed; instead of them having a 'one-up' position they were transformed into something rather small and insignificant. This helped to decouple the negative affection associated with the voices. From then on, David was able to use this visualisation technique if the voices started to get louder and this became one of his main coping strategies.

2 and 3. David believed that his enemies were 'pushing' thoughts into his head and that other people could hear them, leading him to feel paranoid. I conceptualised this as David experiencing intrusive thoughts and misinterpreting their source as external rather than internal. I gave psycho-education around intrusive thoughts based on the work by Rachman and De Silva (1978) to help normalise his experiences. I explained how people experience many thousands of thoughts on a daily basis and how they can be ego-dystonic (e.g. having a thought to jump out of a window without wanting to do so).

We challenged David's metacognitions of '*if I think something, it must be true'* based on Well's work (2003) and we generated alternative metacognitions such as '*a thought is only a thought*' and *'a thought is not always accurate'.* Over time, David started to realise that the thoughts being 'pushed' into his head were actually his own anxious worries, and although they felt odd and alien at times, David had come to understand that they were his; this in turn reduced David's paranoia. We developed the metaphor from ACT (Harris, 2009) of thoughts being like leaves floating down a stream. This was a defusion technique where David and I sat with our eyes closed and imagined our thoughts were leaves floating down a stream. The thoughts floated by and David learnt to watch them with openness and curiosity before

deciding whether it was worth reacting to them or judging them (Harris, 2009 p. 112). Each time we tried this, we always debriefed afterwards so I could check in to see how David found it. Initially, it was quite hard for him to visualise, so we played around with different ideas, such as words on a TV screen or clouds floating in the sky. It seemed to help David, as he was able to gain some distance from his thoughts, allowing them to be there without trying to push them away.

David believed people could hear these thoughts, so we devised an in-session experiment to see if I was able to hear them. I asked David to write down on a piece of paper a thought that came into his head without me seeing what he had written, and then to concentrate on saying it loudly in his head. We repeated the experiment a number of times with different thoughts, but I could not hear any of them and his belief dropped from 95% to 0% pre to post-experiment (please see Appendix 6 for details of the experiment).

The Therapeutic Process

David talked openly about his difficulties, and with his keen sense of humour we were able to develop a collaborative alliance. However, I was aware of the cultural differences between us and how this may affect our rapport. David was a young black male from a deprived background, involved in gangs and criminal activities. I am a white middle-class female of a similar age with no direct experience of gangs or the language (slang) that he would use. However, I felt my curiosity to understand his situation served to bridge this gap, and I felt David appreciated that I was working hard to understand his world. We also had a similar taste in music, so we were able to build a rapport based on this and David would play music he had created in his studio at the end of our sessions.

David clearly held our sessions in high regard and when his care coordinator would visit his home, his mother would ask after me, referring to me as the 'miracle worker'. Although I was pleased to be having a positive effect on David's life and distressing experiences, I certainly felt the pressure not to let David and his mother down. I saw this was a parallel process to the demands David must have felt from his mother to not let her down, and this helped me to empathise with David further.

Difficulties in the Work

Initially, I found it difficult to understand David's description of events and the intricacies of his unusual experiences. David would often use idiosyncratic language such as '*politicking*' that I was not familiar with (a word he used to describe his battle to suppress his intrusive

thoughts). I worked with this by asking David to explain his personal meaning; this helped to strengthen our relationship as it demonstrated my wish to learn from him.

The main difficulty I faced was challenging David's belief that people were in a plot against him, as I felt at risk of decreasing his self-esteem. David's belief that he was involved in some conspiracy placed him at the centre of the plot, giving him a raison d'être that elevated him above the hum-drum of everyday life. When David walked into a shopping centre, he felt everyone knew who he was – he described feeling partly scared but partly important. David spent a lot of time watching American reality TV series on E! News of celebrities, and David would talk frequently about wanting to be rich and famous. I worked around this by not only helping him to generate alternative explanations of what was happening but also to build up his self-esteem by discussing his positive attributes, coping skills and talents, of which he had many. David was a gifted musician and rapper; friends and acquaintances would often ask to attend his studio for his help in producing their music. David was a very bright and genial guy whom I felt genuine positive regard towards. This was something I shared with David and it happened in spontaneous moments; for example, after he showed me his latest sample of music on YouTube I expressed my delight in his music and his clear talent.

Making Use of Supervision

Supervision was extremely helpful as, initially, I struggled to make sense of the complex information David presented with; there was such a whirlwind of information in the first few sessions that I found it hard to keep on top of the all the different experiences David was having. We were also able to reflect on this transference; I came out of sessions feeling almost dizzy and confused and it enabled to me to gain an insight into what it might be like for David. On a practical level, we also discussed Morrison's formulation and applied it to David's experiences to help conceptualise his unusual experiences. This helped me to separate out the information into its various components and start to make sense of it. We also discussed how to share this formulation with David in a way that felt collaborative and digestible.

Supervision also helped me when it came to designing an experiment in-session to help test David's beliefs that his thoughts were being broadcast. We had spent time previously in supervision thinking about how to devise experiments in-session when the opportunity arose, and I learnt the importance of anticipating all possible outcomes. For example, if I said I did

not hear any thoughts that David was trying to make me hear, would David believe me? What would the different outcomes mean to David and how to work through each one?

Changes in the Formulation and the Therapeutic Plan

David's formulation changed based on new information and so I reformulated with time. David and I had spent the majority of our time focusing on reducing the voices and stresses at work and college. However, at around session 12, it became clear that David's psychosis was affected by his family, particularly his mother's belief he would not recover or *'make anything of himself'*. His mother had told him during a fight that *'you will end up no good, just like your father'*. This was a very entrenched belief, which had built up over a number of years, and so we worked carefully to challenge the veracity of this. David offered evidence that went against this and he described all the ways in which he had achieved, such as going on to college when most of his friends had not, writing, performing and producing music, and setting up a studio that other people came to use. We also discussed his hopes and plans for the future: David hoped to be a producer or to be a technician as he was skilled at fixing broken musical equipment. David was able to reframe these comments over time as something that a worried mother might say but was not necessarily an accurate prediction of his future. This became a useful tool to apply generally with David's stressors, to be able to observe, then, more objectively before reacting to them emotionally.

Changes in the Therapeutic Process Over Time

Towards the end of our work, David stopped hearing voices and was able to see that the thoughts that were being 'pushed' into his head were actually his only anxious thoughts. David described how this shift in thinking left him with a lot less to do each day. He no longer needed to 'politick' or fight the voices: both battles had been dropped. I noticed with this came a shift in our relationship. David came to sessions and he was flat and withdrawn from me. He did not say much and sat staring away from me.

I reflected this change back to David, and on exploration, it became clear that without these unusual experiences, David felt life was quieter; in fact, life had become empty. David said he felt frustrated coming to talk to me about things from the past and I wondered if he also felt angry at me for being a catalyst for this change. This took some time to work through, and over a number of sessions David and I were able to process coming to terms with the loss of his voices. Although his persecutors, they had filled up David's life and had not left much space for him to think about anything else. Now David had time to reflect on some of his

missed dreams and opportunities and this was deeply painful for him. In time, David and I started looking towards the future and setting goals (going back to college and recording in the studio) and this helped him to feel there was a future ahead of him again.

Evaluation of the Work to Date and Therapeutic Ending

David and I have now finished working together. The positives of the work are that David does not hear voices and he now understands thoughts being pushed into his head are his own anxious worries. We were able to look ahead to living without voices, supporting him towards his goals and updating his relapse prevention plan (please see Appendix 3 for full outcome data).

David and I developed a good rapport and I knew that finishing our sessions would be hard for him. I started to work on the ending quite early, initially by just gently reminding him each time what session number we were at. Our work could have easily been filled at the end with completing relapse prevention plans and questionnaires, but I decided to leave an open space for David and me to reflect on our time together and what it would be like not to come to sessions anymore. David said he was worried it would feel like another hole in his life, just like the hole the voices had left. I felt it was important to stay with these feelings as well as share my own sense of sadness of our ending. David was aware that should he need further booster sessions, he was able to re-refer himself through his care-coordinator.

Liaison with Other Professionals

Liaising with David's care-coordinator helped as it informed her about our work and how she could reinforce coping strategies David was trialling out. I would have liked to have liaised with the psychologist that David worked with previously; however, she had left her post some months previously. There was a file available with her notes, such as his relapse prevention plan and letters to his GP, which were informative.

What You Learnt about Psychotherapeutic Practice and Theory

I have learnt how important it is to spend time building a rapport, particularly with this client group who feel particularly paranoid and distrustful of others, and not to rush and jump straight into 'treating' the client. Given the pressures many practitioners in the NHS face with scarce resources and waiting lists, this can be hard to balance. However, when working with someone who is suspicious of the world and others around them, it is important to build trust by being supportive and congruent. Without David's trust in me, the experiment where we tested whether I could hear his thoughts would not have worked.

I also learnt the importance of remaining flexible and curious as to what the client brings to the session and what happens in the session, rather than sticking to a fixed agenda. For example, when David disclosed his belief that I could hear his thoughts, which came as a surprise to me, we were able to use this in-session as an experiment. By being flexible, I was able to think on my feet and design a way of testing this belief, which proved a valuable step forward in our work.

Finally, I learnt the key to working with complex presentations is to keep the formulation as a 'work in progress' as it constantly evolves. It took many sessions for a full picture to emerge, much beyond the standard two to three sessions of an assessment we might usually assume. There were many different factors holding David in position and I believe it took time for David to feel comfortable enough to share the full picture with me. For example, when working with David's delusional beliefs, I began to reformulate on the understanding that they were there to protect his low self-esteem which had not initially been apparent. It reminded me of advice that Irvin Yalom gives: to be careful of what defences we pull away from our clients 'unless one has something better to offer in its stead' (1989, p. 90). I knew by challenging David's delusional beliefs, I was leaving him in grave danger of deflating him completely unless I offered something in its place. Reformulating in this way helped to inform my treatment plan as I was aware how challenging these beliefs could affect him.

Critical Reflections

In spite of my reflexivity before and during therapy with David, it is now that I look back on the work that I believe a greater awareness and familiarity with the literature surrounding social inequality and paranoia would have enhanced my practice. As I reflect on David's formulation and the differences between him and me, I can see that I could have drawn more on the social and political environment that David sits within. Research shows that social inequality (including factors such as race, culture and class) may directly affect the experience of paranoia (Harper, 2011). Mental distress is negatively impacted by social inequality and specifically it seems that the gap between richer and poorer people seems to have a dose-response relationship to the level of mental distress in developed countries, i.e. the bigger the gap, the higher the rates of mental distress (Pickett & Wilkinson, 2010). Although the CBT model does ask us to consider the environment in relation to our clients difficulties, I did not reflect fully on how much factors such as social inequality and adversity contributed to David's mental distress. There is also a specific effect to living in a city like

London, due to our fixation with CCTV (according to The Standard there are now 10,524 CCTV cameras in 32 London boroughs).

There is also research that suggests that the plausibility of a person's beliefs can be affected by their social context and the *way* they tell their accounts. If accounts seem intelligible, well formed, in temporal sequence and with a valued endpoint they are more likely to be seen as plausible (Harper, 2011). All this research points to the idea that the evaluation of a belief as a psychotic symptom, or not, is influenced by the race and gender of the client *and* by the plausibility of the experiences of paranoia (Harper, 2011). This means we have to be careful when we apply terms such as *paranoia* that we are not doing away with these important issues and sweeping them under the carpet.

Campaigners such as The Hearing Voices Movement also known as Intervoice (2011) and Tamasin Knight (2006) works in opposition to the view that beliefs must be rational, plausible or modified to become so to fit into societal norms. These campaigners state that society needs to allow people to have differing ways of perceiving the world. What is crucial to a quality of life is *how* people relate to their beliefs and to the world around them and not the ability to think normally or rationally. Rather than striving to abolish these experiences and training our clients to think rationally we need to be able to offer them a space to reflect on them and to support them to live a meaningful life. This perspective is in alignment with ACT which is not striving to abolish symptoms but is working to increase psychological flexible and live an active and meaningful life in a value-driven direction.

This is the way my therapeutic practice is evolving, away from the traditional forms of CBT where we encourage people to think rationally, towards this more value-based work. Through exploring the literature on social contexts as the cause of *paranoia*, I will be better placed to avoid this as a therapeutic blind spot and will endeavour to make these factors more explicit in the work.

In the future, I will also reflect on the gender, racial, ethnic and cultural scripts to create pre-session hypotheses about the differences in the room as suggested in Coordinated Management of Meaning (CMM) (Pearce and Cronen, 1980). For example, how might our different identities have impacted on what was going on in the room? Locating myself as a white woman with certain power inequalities could have been useful, it could have freed up some dysfunctional beliefs that were not stated because the differences between us were unspoken e.g. David's possible daily experiences of racism that I have not experienced as a

white woman. Sharing our feelings of injustice towards power inequalities we faced (in different ways) could have helped to make sure David's subjugation was not reinforced in therapy and was explicitly addressed.

There is also the wider history of slavery and the history of power inequalities for black people that David's formulation sits within. I may not talk about these explicitly each session but having an inner ear to these unspoken processes is useful so that they could be taken up and discussed as they present themselves. This internal supervisor is in place to question these scripts which then allows the CBT work to continue within a context of these scripts, so that the client is situated within the appropriate, social, historical and political context (Smail, 2005).

Learning from the Case about Yourself as a Therapist

I learnt that despite the complexity of David's difficulties, I was able to stay with his anxiety and distress. By forming a collaborative alliance with David, I was able to stay with him, rather than falling into the trap of acting as a professional who would fix his problems. This is a skill that has developed since I started my training as I have gained more confidence. I believe that before I would have been anxious to show my competency and needed to prove my worth as a trainee psychologist. As my confidence continues to grow, I am becoming more comfortable to admit my 'not knowing'. With this freedom, I feel I am much more able to relax and to be present with the client, thus freeing up space to think more creatively and imaginatively in-session.

References

Bach, P., & Hayes, S. (2002). The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *70*(5), 1129-1139.

Barrowclough, C., Tarrier, N., & Johnston, M. (1996). Distress, expressed emotion, and attributions in relatives of schizophrenia patients. *Schizophrenia Bulletin*. *22,* 691-702.

Beck, A. (1995). *Cognitive therapy: Basics and beyond*. New York: Guildford Press.

Chadwick, P., Birchwood, M., & Trower, P. (1996). *Cognitive therapy for delusions, voices and paranoia.* Chichester: Wiley.

Chadwick, P., Lees, S., & Birchwood, M (2000). The Revised Beliefs About Voices Questionnaire (BAVQ-R). *British Journal of Psychiatry*. *177,* 229-32.

Dillon, J. & May, R. (2002). Reclaiming Experience, *Clinical Psychology, 17*, 25 -77.

Garety, P., E. Kuipers, E., Fowler, D., Freeman, D., & Bebbington, P. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine*. *31,* 189-195.

Gaudiano, B., & Herbert, J. D. (2006). Acute treatment of inpatients with psychotic symptoms using acceptance and commitment therapy: Pilots results. *Behaviour Research and Therapy*, *44*, 415-437.

Guy, A., Thomas, R., Stephenson, S., & Loewenthal, D. (2011). NICE under scrutiny – the impact of the National Institute for Health and Clinical Excellence guidelines on the provision of psychotherapy in the UK. UK Council for Psychotherapy.

Haddock, G., Mccarron, J., Tarrier, N., & Faragher, E. (1999). Scales to measure dimensions of hallucinations and delusions: The Psychotic Symptom Rating Scales (PSYRATS). *Psychological Medicine, 29,* 879-889.

Harper, D (2004). Delusions and discourse: moving beyond the constraints of the modernist paradigm. *Philosophy, Psychiatry and Psychology*, *11*, 55-64.

Harper, D. (2011). Social inequality and the diagnosis of paranoia. *Health Sociology Review, 20(4),* 423-436.

Harris, R (2009). *ACT made simple.* Oakland, CA: New Harbinger Publications.

Hayes, S (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioural and cognitive therapies. *Behaviour Therapy, 35,* 639-665.

Hayes, S., Strosahl, K., & Wilson, K. (1999). *Acceptance and commitment therapy: An experiential approach to behaviour change.* New York: The Guildford Press.

Intervoice. (2012). About us. Retrieved 28th October 2013 from, http://www.intervoiceonline.org/about-intervoice

Jones, S. (1992). Was there a Hawthorne effect? *American Journal of Sociology*, *98,* 451–468.

Kapur, S. (2003). Psychosis as a state of aberrant salience: A framework linking biology, phenomenology, and pharmacology in schizophrenia. *American Journal Of Psychiatry, 160,* 13-23.

Knight, T. (2006). *Beyond Belief: Alternative ways of working with delusions, obsessions and unusual experiences.* Available online as free download from www.peter-lehmann-publishing.com/beyond-belieft.htm

Luborsky, L., Diguer, L., Seligman, D. A., Rosenthal, R., Krause, E. D., Johnson, S., Halperin, G., Bishop, M., Berman, J. S. & Schweizer, E. (1999). The researcher's own therapy allegiances: a "wild card" in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice, 6,* 95–106.

Michail, M., & Birchwood, M. (2009). Social anxiety disorder in first-episode psychosis: Incidence phenomenology and relationship with paranoia. *British Journal of Psychiatry, 195,* 234-241.

Moloney, P., & Kelly, P. (2004). Beck never lived in Birmingham: Why CBT may be a less useful treatment for psychological distress than is often supposed. *Clinical Psychology, 34,* 4-10.

Morrison, A. (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy, 29*, 257-276.

Morrison, A., Renton, J., French, P., & Bentall, R. (2008). *Think you are crazy? Think again: A resource book for cognitive therapy for psychosis*. Hove: Routledge.

National Institute For Health Care and Excellence (NICE) (2009) Schizophrenia (update): NICE guidelines. http://www.nice.org.uk/nicemedia/live/11786/43608/43608.pdf

Smail, D (2005). *Power, interest and psychology: elements of a social materialist understanding of distress*. Ross-on-Wye: PCCS Books.

Padesky, C., & Greenberger, D. (1995). *Clinician's guide to mind over mood.* New York: Guildford Press.

Pearce, W., & Cronen, V (1980). *Communication, action, and meaning: The creation of social realities*. New York: Praeger.

Pickett, K., & Wilkinson, R. (2010). Inequality: An underacknowledged source of mental illness and distress. *British Journal of Psychiatry, 197*, 426-428.

Pilgrim, D. (2007). The surivival of psychiatric diagnosis. *Social Science and Medicine, 65*, 536-547.

Pilgrim, D. (2008). Abnormal psychology: unresolved ontological and epistemological contestation. *History and Philosophy of Psychology*, *10(2)*, 11-21.

Rachman, S., & De Silva, P. (1978). Abnormal and normal obsessions. *Behaviour Research and Therapy*, *16*, 233-238.

Turkington, D., & Mckenna, P. (2003). Is Cognitive-Behavioural Therapy a worthwhile treatment for psychosis? *British Journal Of Psychiatry, 182*, 477-479.

Wells, A. (2003). A comparison of metacognitions in patients with hallucinations, delusions, panic disorder, and non-patient controls. *Behaviour Research and Therapy*, *41*(2), 251-256.

White, R., Gumley, A., McTaggart, J., Rattrie., McConville, D., Cleare, S., & Mitchell, G. (2011). A feasibility study of Acceptance and Commitment Therapy for emotional dysfunction following psychosis. *Behaviour Research and Therapy. 49*, 901-907.

Yalom, I. (1989). *Love's executioner and other tales of psychotherapy*. London: Penguin.

Zubin, J., & Spring, B. (1977) Vulnerability: A new view on schizophrenia. *Journal of Abnormal Psychology, 86,* 103-126.

Appendices

1. **A Formulation of David's Psychosis**
2. **Coping Strategies for Voices**
3. **Outcome Data**
4. **Beliefs about Voices**
5. **New Beliefs about Voices**
6. **Experiment to Challenge David's Beliefs**

Appendix 1: **A Formulation of David's Psychosis**

Appendix 2: Coping Strategies for Voices

Here is a list of strategies that have helped other people cope with voices:

- Listening to music from my iPod
- Listening to books on tape
- Wearing ear plugs
- Humming
- Reading aloud
- Relaxation: deep breathing or relaxation tapes
- Meditation
- Massage
- Praying
- Singing
- Talking back to the voices
- Setting aside time to listen to the voices – e.g. tell them that you are busy and to come back later
- Focusing on the voice and what it is saying
- Generating the voice and removing it by thinking of something else
- Ignoring the voices
- Counting under your breath
- Distraction: watching TV, listening to music, reading
- Being physically active e.g. playing sport, going for a walk
- Visiting places: getting out and about
- Keeping occupied: household chores, shopping
- Taking medication
- Chewing gum
- Soothing yourself:
    - Have a bath
    - Pamper yourself, do your hair, make-up, nails, etc.
    - Use products that smell nice, aromatherapy
    - Eat or drink something that tastes nice
- Being alone
- Going somewhere quiet
- Question whether what the voices say is true
- Having a chat with someone about anything but the voices
- Having a chat with someone about the voices
- Avoiding street drugs
- Avoiding things that stress you out
- Keeping a diary about what the voices say
- Imagine squashing the voices in a vice
- Saying positive things to yourself (e.g. I'm not going to let the voices control my life)

Appendix 3: Outcome Data

David was asked to rate his general mood at the start of each session, how loud and frequent the voices were and how much they distressed him. He also rated how distressed he felt about the belief that people could hear his thoughts. Below shows a chart of how these percentages changed over the course of therapy.

What Was Being Measured?	**1st session**	**10th Session**	**20th Session**
General Mood (0% being the worst you've ever felt, 100% the happiest you've ever felt)	40%	50%	80%
How loud are the voices? (0% being inaudible, 100% being the loudest they have ever been)	70%	75%	0%
How often do you hear the voices?	All day, every day	At least 3-5 times a day	Maybe once if I'm really stress but not really anymore
Distress associated with the voices (0% being no distress at all, 100% being the most distressed you have ever been)	70%	15%	0%
Belief that thoughts can be pushed into my head (others can hear) (0%-100% conviction)	95%	0%	0%
Distress associated with this belief	80%	0%	0%

Appendix 4: Beliefs about my Voices

Strong and Powerful

- These voices are strong
- I believe should listen to the voices and monitor them closely
- If I get mad at the voice, they start to panic, which can distract me more
- The voices push me to act in a certain way

All-Knowing

- They sound like someone I know, but I don't know who
- The voices make me feel paranoid
- The voices seem to know what I am about to do next and what I'm thinking

Demanding my Attention

- If I don't do what they tell me to do, they get stronger
- They make me question myself
- They distract me with their confusion
- I am left feeling that I need to know something
- The voices are pushing me to think stuff of people (not always good things)

The Voices are Trapping Me

- The voices can cause me to get caught up in a trap
- They set traps for me

Appendix 5: New Beliefs about my Voices

<u>Not Powerful or Strong</u>

- The voices can be strong sometimes (e.g. I get strong voices two mornings a week), but although they can be really serious, I don't have to act on them.

- Even though I had voices telling me to kill myself, I didn't act on them because this is what they want me to feel. When I don't act on these voices, nothing happens.

- Even when some of the weirdest thoughts or voices are being pushed into my head, I don't act on them because it doesn't bother me.

- My brain is working faster than usual, which makes me hear voices of people that I know.

- My voices are a reaction to my thoughts and emotions at a certain point in time (e.g. I see a girl that I like and my emotions and thoughts trigger the voices to make me take action).

- The voices can work in positive ways to boost my confidence or motivate me, but it's not about the positive voices to boost my confidence and motivate me, I need to feel this way within myself.

- The voices demand my attention like children, but it doesn't mean I have to pay attention to them.

- When I have a good day, the voices can't get my attention to try and bring me down.

Appendix 6: Evidence for and against Beliefs

Belief to be examined: People can hear the thoughts that are 'pushed' into my head

Associated mood: Paranoia

Belief rating: 95%

Experiment: Write down a thought on a piece of paper and do not let Felicity see it. Then when we are ready, say it as loudly in my head as I can, over and over again. Ask Felicity to write down what she can hear.

Possible Outcomes:

A) If Felicity writes down what I was thinking, this is COULD be evidence that my thoughts are being broadcasted. BUT, it could be coincidence. If this happens, then we will repeat the exercise 10 times again. If she gets it right 10 times, then my thoughts are being broadcast; otherwise, I am happy any correct guess she makes is due to chance because I trust her to tell me the truth.
B) Felicity says she cannot hear what my thoughts are - I trust that she will not be lying to me.

Evidence for Belief	**Evidence against Belief**
People look at me when I have thoughts 'pushed' in my head. This must mean they can hear the thoughts	I thought something in my head and Felicity could not hear it
I get a 'feeling' that people can read my thoughts	Even though I think that people can hear my thoughts I have not asked them
	I may be 'jumping to conclusions'

Belief rating (re-rated): 0%

Alternative belief: People cannot hear my thoughts, or the thoughts that get 'pushed' into my head by my enemies. It is only due to my anxiety that I think this can happen.

Associated mood: Relaxed, calm.

Section C

Doctoral Research Study

How is Humour Experienced by Therapists Working with Clients Experiencing Psychosis? A Grounded Theory

Abstract

This qualitative research is a study of how humour affects the therapeutic relationship and work with psychosis. Eight participants were interviewed using in-depth semi-structured interviews to gain an insight into the lived experience of using humour in therapy with clients experiencing psychosis. Not only did the interviews give clinical examples of humour with clients experiencing psychosis, but they also provided an opportunity to explore how therapists explained their use of humour with reference to the theoretical framework they worked within. In addition, they allowed for the acquisition of valuable data on the participants' lived experience of sharing these insights and clinical examples with me.

The interviews were transcribed and the data was analysed in accordance with Charmaz's Social Constructivist Ground Theory principles (Charmaz, 2006) . Nine main themes emerged from these interviews as being dimensions of using humour in therapy with clients experiencing psychosis. The use of humour with clients experiencing psychosis produced a range of effects, from the positive, such as allowing clients to play with ideas and feel connected to the therapist, to the negative, such as masking or avoiding pain or humour being misinterpreted.

I have attempted to weave my reflexivity throughout this research to show how my own experiences and knowledge have affected the data that emerged from the interviews. Recommendations are made for future areas of research in light of these findings.

For me, insanity is super sanity. The normal is psychotic. Normal means lack of imagination, lack of creativity

Jean Dubuffet

1. Introduction

In this chapter, I shall introduce the concept of using humour within therapy generally and then separately address the different ways of conceptualising psychosis by critiquing the various models and discourses we use to understand them. I shall then consider the overlap that exists between the two areas, therapeutic humour and psychosis. With this overlap in mind, I shall then be able to hypothesise how using humour with psychosis might be therapeutically beneficial. Let us start by considering the place humour has within therapy.

1.1. Humour in Therapy

Humour has its place in life. Let us keep it there by acknowledging that one place where it has a very limited role, if any, is in psychotherapy

(Kubie, 1971)

Unlike Kubie, people have, for a long time, seen the value in using humour in therapy, including many eminent therapists from a range of modalities such as Whitaker, Rogers, Ellis and Erickson, to name but a few (Gelkopf, 2011). There has also been some more formal attempts to incorporate humour into therapy, such as Provocative Therapy (Farrelly & Lynch, 1987), the Conspirative Method (Titze, 1987) or Victor Frankl's Paradoxical Intention (Frankl, 1967). Indeed, Freud referenced humour in two major works (S. Freud, 1905, 1927), with *Jokes and its Relation to the Unconscious* being the most in-depth. As the title suggests, Freud believed humour, just as dreams, was a fruitful road to unconscious material (S. Freud, 1905). To Freud, humour represented a link between the unconscious and the ego and he believed people employed humour as a safe or socially acceptable way to express their impulses and drives, such as aggression, sexuality or anything socially taboo (Felices, 2005).

These impulses cause us anxiety and so the super-ego is employed to turn the ego away from expressing them. In the case of humour they are given some airtime. The super-ego has a moment of benevolence and allows the ego some narcissistic pleasure; this is seen as a triumph of the pleasure principle (Lemma, 2000). The pleasure allows a temporary reprieve from the pain of reality; something we once found to be frightening is now seen to be comical

and benign (Whitaker, 1975). As we laugh, we start to feel better; humour gives the feeling of liberation and catharsis (Dziegielewski, Jacinto, Laudadio & Legg-Rodriguez, 2004) and it also gives us a sense of mastery over something we once feared (Richman, 1996).

In Freud's view, humour is a defence mechanism: the most adaptive and mature defence in our armoury against anxiety. It is present in someone with a fully-functioning psyche where they can laugh at their own misfortunes or shortcomings (Dziegielewski et al., 2004; Vaillant, 2000). Freud described it as a well-functioning safety valve: 'Wit is the best safety valve modern man has evolved; the more civilization, the more repression, the more need there is for wit' (Freud, 1905).

How do humour and jokes work? They are often about the conversion to the opposite. With a joke, we are normally presented with a serious or normal take on the world and then in the second take we are asked to see something entirely opposite; it is the surprise that follows that brings us mirth. A good example of this is the sublime New Yorker cartoon of Lassie. In the first frame, a swimmer in peril shouts 'Lassie get help!' and in the second frame, we find Lassie lying back on a shrink's couch in therapy, getting her own kind of help. Not what we anticipated! It is the incongruity between the expectation and the final result; a competing of ideas that brings a release of tension and causes laughter.

Figure 2. 'Lassie! Get Help!' Cartoon, Danny Shanahan for *The New Yorker*, 1989

This is a lay description of humour, but what do we mean when we talk about humour specifically in therapy? The American Association of Therapeutic Humour (AATH), an

organisation that promotes the healing qualities of humour, describes therapeutic humour on their website as: 'any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life's situation' (AATH, 2013). It is a good start, but in this research, I shall use Lemma's more comprehensive definition of humour in her excellent review *Humour on the Couch*:

> *Humour will be used to refer to any verbal utterance or non-verbal behaviour that is experienced subjectively as amusing even if it does not necessarily produce the response of laughter or a smile. A sense of humour will be broadly used to denote humour production and appreciation; a sense of playfulness or whimsy; a personal recognition of humour; the capacity to laugh at oneself and problems; and the capacity to master difficult situations through the use of humour*
>
> **(Lemma, 2000, p. 10)**

It is best to define humour in this way, rather than simply by whether one laughs or not as laughter can also be a response to fear (Lemma, 2000). What is important in Lemma's definition is that it shows that there are many different forms of humour; it is much more than just 'cracking a joke' with a client. More often, it is pointing out illogical reasoning, taking issues to the point of absurdity, making a pun or simply repeating a sentence back to a client to allow them to see the humorous content of what they have just said (Franzini, 2001). This is how I conceptualised humour when interviewing my participants. I am not interested only in the laugh-out-loud, joking moments but the other, more subtle forms of humour that can be used in therapy too (and in my view are often more likely to be found). Now humour in therapy has been defined I shall critique the literature of using humour in therapy generally and then with psychosis and outline the empirical research supporting it.

1.2. Therapeutic Benefits of Humour

The literature surrounding the use of humour in therapy has long been characterised by a colourful debate between its advocates and opponents. Grotjahn was one of the first supporters to write about the therapeutic benefits of humour back in 1949 (Grotjahn, 1949). Advocates of humour cite a range of benefits, from improving physical health, including combating illnesses such as hypertension, strokes and cancer (Apel, 2002; McGhee, 1979), to psychological well-being such as moderating stress (Martin & Lefcourt, 1983) and relieving

the physical arousal associated with aggression and apprehension (Koestler, 1964). Humour has been shown to be effective in treating depression and anxiety (Dimmer, Carroll, & Wyatt, 1990).

Advocates for humour in therapy describe multiple positive outcomes, one of which is how powerful humour is as a social facilitator (Gelkopf, Sigal, & Kramer, 2001). We can laugh and joke by ourselves, but more often than not it is in the presence of others, leading Morreall to describe it as a social lubricant (Morreall, 1991). Humour in therapy allows the client and therapist to relax, drawing them together to form an alliance and feel connected to each other (Dziegielewski et al., 2004). It can also increase the mutual enjoyment between the client and the therapist, and when humour is there and jointly appreciated, we feel safe and understood, rekindling the 'we' feeling that Stern wrote about between the infant and mother (1985). Research shows that humour can enhance rather than hinder or damage the therapeutic alliance and the process of therapy. Humour used appropriately can serve as a potent catalyst for change (Kuhlman, 1984). By integrating humour into therapy, it can be used as a method to enhance catharsis, allowing clients to share their innermost thoughts and feelings in a way that feels less threatening, helping clients to gain more control over their situation (Solomon, 1996). It can help clients discuss issues that are regarded as 'taboo', expressing them in a more socially acceptable way. Sand explains that humour in therapy is a way of allowing the person to grapple with these drives and impulses (Sands, 1984), whilst Lemma describes some humour as subversive: it allows us to express what is base in us (Lemma, 2000).

Kierkegaard, a staunch existentialist, saw life as intrinsically comical. He argued that life is full of contradictions, and where there are contradictions the comical emerges (Lemma, 2000). Humour allows us to bring together these contradictions, elaborate upon them and expand upon them in our imagination. Once we find a resolution to these contradictions, a pleasant cognitive shift occurs and allows a release of tension (Morreall, 1987). Being able to see the incongruity of life and laugh about it would seem a valuable skill: taking a humorous stance can help to change our perceptions, attitudes and beliefs (Dziegielewski et al., 2004). This broadening of attitudes allows a stepping back, giving a different perspective and thus an opportunity for change.

Humour is also a form of play. Play is not just for fun; Winnicott believed it was an important developmental achievement that created a bridge between the unconscious phantasy and external reality (Felices, 2005). Winnicott described play in 1971 as the 'third area' (Colman,

2007) where, between our boundaries, there is a space where there can be an acting out or a sublimating area of mastery. In that symbolic area, we play with children and teach them about feelings, thoughts and actions. With adults, we can use interpretation and play with words and ideas. It is in that relational area where we can also use mature humour.

As we can see, humour has many therapeutic qualities: at one level it fosters stress reduction, creativity and mastery; however, at a deeper level, humour can have a self-reflective and interpretive function. Richman summarises the benefits of therapeutic humour well by suggesting the areas of congruence between humour and therapy are as wide as: creating a positive atmosphere, positive acceptance, problem recognition, listening with empathy, allowing multiple meanings, communicating forbidden ideas, presenting different perspectives, facilitating insight, anxiety reduction and facilitating cohesion (Richman, 1996). The question remains, though: what do the dissenters say are the caveats to therapeutic humour?

1.3. Caveats to Humour

Even the most ardent supporters of humour in therapy note the need to exercise caution for its appropriate use. The suggested detrimental effects that humour in therapy might cause are best described by Saper (1987), who suggested that the improper use of humour is any that 'humiliates, deprecates, or undermines the self-esteem, intelligence, or well-being of the client'. Thus, we must be sceptical of humour that is used for our own gains and gratification or that works in a way that alienates the client. Kubie's writings in 1971 in *The Destructive Potential of Humour in Psychotherapy* adds further fuel to the opposition of humour in therapy, stating:

> *No matter how consciously well intended the therapist's humour may be, the patient usually perceives it as heartless, cruel, and unfeeling…the technical devices of analytic therapy…have as one of their central goals the protection of the patient from the frailties of the therapist…We can leave their protection only with many precautions. Yet humour is a subtle way of circumventing their protective restrictions… I have seen humour tried countless times. Yet I cannot point to a single patient in whose treatment humour proved to be a safe, valuable, and necessary aid'*

(Kubie, 1971)

Although no one would deny that humour has it limits in therapy, Franzini does make the valid point that clinicians' reticence to use humour may be due to the incongruence of humour with the 'sober and grim nature of the profession' (Franzini, 2001). Arguably, such a solemn enterprise as psychotherapy should not have time for jokes. According to Carl Rogers, the father of client-centred therapy, 'therapy is hard work'; as such, having a laugh in therapy does not sit well with many professionals and it is seen as having no therapeutic import. Lemma rightly points out the perceived unsaid rule that if we have not cried, the therapy has not been hard enough, and if we have laughed, the work has not been serious enough (Lemma, 2000).

It cannot be denied that there are some serious pitfalls to using humour in therapy. Returning to Kubie, he maintained that humour was merely an amusement for the therapist and it masked aggressive and hostile feelings towards the client. He argued that humour allows for the expression of destructive impulses in the well-worn phrase 'it was only a joke', allowing an outlet for mockery and derision. However, although Kubie's own derision for therapists is clear, he fails to take into account how therapists can weigh up the pros and cons of using humour. Just as we can make an ill-timed interpretation, so too can we make an ill-timed humorous remark. Every intervention comes with a risk, but this is the skill of a mature and experienced therapist to evaluate it (Sultanoff, 2003).

There are pitfalls for client-initiated humour too. Humour might be used as a way to create armoury and block contact with the therapist by using self-deprecating or frivolous humour to avoid difficult material. Winnicott's true-self / false-self dichotomy is relevant here (Winnicott, 1945) in that where psychic pain occurs, the true-self is eclipsed in part by the false-self that comes into being to provide protection. It is possible that this false-self might come in the form of being the 'joker' and act as a shield to prevent real contact with the therapist.

Grotjahn (1949), a supporter of therapeutic humour, has noted an interesting developmental take on humour; that it is a way of gaining mastery and control over the other. In the oral phase, a baby learns to smile and when someone smiles back, the baby has learnt control over the other person. Thus, humour can also be interconnected with superiority as we are making

someone respond in the way we want them to. There is a power dynamic in humour: for every wit there is a butt of the joke and this must not be forgotten.

If we take this as our starting point for considering humour in therapy, using humour when working with psychosis should raise even louder alarm bells. Indeed, clinicians have voiced their concerns that humour should not be used where such grave mental health disorders are concerned. Researchers have suggested that individuals with psychosis lack a sense of humour due to the deficits of the Theory of Mind that have been demonstrated in some sufferers (Corcoran, Cahill, & Frith, 1997), allegedly rendering them unable to understand another's mental state and thus 'share a joke'. However, research has also emerged that counteracts this suggestion. Tsoi et al. (2008) conducted a study and rated individuals with psychosis versus controls in their ability to appreciate and rate humorous video clips and found there was no significant difference between the two groups. Other research has shown that humour can be successfully used with individuals who experience voices using one-to-one psychotherapy (Kirivanta, 1998), psychiatric settings (Gelkopf et al., 2001) and within a therapeutic community (Felices, 2005). It is not clear whether having unusual experiences could interfere in some way with an individual's ability to appreciate humour (e.g. by being distracted by a voice or a distressing thought). One's sense of humour might also be affected by other forms of mental distress such as feeling low and / or anxious in relation to having unusual and distressing experiences, or it may have been that the experimental setting is too contrived for humour to be enjoyed.

Despite this longstanding battle for and against therapists' use of humour in therapy, humour has, nonetheless, found its way into the practice of many psychoanalysts and psychotherapists. Even Kubie conceded in his 1971 paper that you could not rule out using humour altogether. My sense is that humour will inevitably occur within therapy and given this is the case, its use in therapeutic practice should not be overlooked.

Let us change tack for a moment and consider what psychosis is. I shall then explain how humour, therapy and psychosis are linked. There are a number of approaches and models that have informed the construction of psychosis. I shall outline the ones most relevant and pertinent to the study and critique them, with particular focus on what these models would suggest the points of correspondence between humour and psychosis are.

'Doubt is to certainty as neurosis is to psychosis. The neurotic is in doubt and has fears about persons and things; the psychotic has convictions and makes claims about them. In short, the neurotic has problems, the psychotic has solutions'

Thomas Szasz

1.4. Medical Model of Psychosis

Psychosis is an umbrella term that encompasses a range of disorders from schizophrenia, schizophreniform disorder, schizoaffective disorder and bipolar affective disorder. It is defined as a cluster of symptoms that include experiencing unusual perceptual sensations in any sensory modality (e.g. hearing voices and experiencing visual hallucinations). Individuals may also hold unusual or delusional beliefs that appear divorced from reality, leading them to feel paranoid and they may experience disorganised speech (APA, 2000). These symptoms must be seen to cause distress to the individual and despite the person's ability to reality test, beliefs are still held with some conviction.

DSM-IV states that two or more symptoms of delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour, or negative symptoms must be present for a significant portion of time during a one-month period. If, however, the delusions are bizarre enough or hallucinations consist of a voice giving a running commentary or two voices conversing with each other than one symptom alone is enough to diagnose schizophrenia. Emphasis is placed on the duration of symptoms that must persist for six months and the social dysfunction it causes (to work, relationships and self-care).These experiences are labelled diagnostically as 'schizophrenia'(APA, 2000), although the British Psychological Society (BPS) recommends using the less pejorative term of psychosis to describe this range of experiences, which I shall be doing throughout this study (BPS, 2000).

Historically, psychosis started out as 'dementia praecox', which was coined by Kraeplin in 1896 to describe what he thought was early onset dementia in young people, as distinct to manic depression. This was then later relabelled by Bleuler as 'schizophrenia' and it was Karl Jaspers who famously dismissed psychotic speech and delusions as 'un-understandable' (Jaspers, 1963). In 1985, Andreasen categorised psychotic symptoms into two measures: positive symptoms (hallucinations, delusions and thought disorder) owing to the fact that they

are seen to occur in addition to a person's 'normal' behaviour, and negative symptoms (poverty of speech, anhedonia, apathy, avolition) (Andreasen, 1985).

There are faults with this medical model as the classification of symptoms is riddled with flaws. Not only is the distinction of positive and negative out of date, it is overly simplistic. Negative symptoms implies a 'taking away' of a person's abilities or character, yet this is often not the case and it tells the clinician nothing of their internal state (Bentall, 1990). In his book *What is Madness?* Leader persuasively argues that, outwardly, clients might appear immobile and passive; but, inwardly, this might be a coping mechanism to defend against highly aroused states of fear and anger. Even Bleuler recognised there must be a stormy emotional scene behind the passive façade (Leader, 2011).

Whilst it can be useful to have a diagnostic system to reference people's symptoms and therefore classify them, this diagnosis has limited reliability (consistency of diagnosis between psychiatrists), construct and predictive validity (meaningfulness and usefulness of the diagnosis). What is problematic with this diagnostic system is that there is no key symptom present in all cases of schizophrenia; this means that two people with a diagnosis could have no two symptoms the same. Bentall likens the DSM-IV diagnostic criteria to a Chinese takeaway menu. Almost anything has been cited as a cause for schizophrenia, and every area of the brain has been implicated (Bentall, 2003). Research has focused on a neurobiological approach to psychosis, despite a lack of concrete evidence that any such deficits exist (Boyle, 2002).

This brief romp through psychiatric history clearly marks one thing, regardless of the nosology: the diagnoses are distinctly pessimistic. The absence of hope for recovery, let alone hope of being able to converse intelligibly with others, or live a meaningful life, is palpable. Dementia praecox implies there is a decomposition of the mind, an inventible decline that is infused with gloom and despair. Laing directs us to Berg's idea that the terminology related to the symptoms is a veritable 'vocabulary of denigration' (Berg in Laing, 1969, p. 27). Schizophrenia is only conceptualised in what is lost and deficient: a *lack* of insight, a *mal*-adaption and what resides is something to be got rid of.

Cynics of the psychiatric classification of schizophrenia argue that the medical diagnosis often does more to stigmatise than it does to help, and it was Szasz, in the anti-psychiatry movement, who argued that the medicalisation of madness is a form of social control,

dismissing mental illness altogether as an 'empty vessel' (Szasz, 1987). The fundamental problem with the medical model is that the very term schizophrenia is flawed, and even Bleuler in the end said that his definition was wrong (Leader, 2011) . Van Os argued, 'The traditional concept of schizophrenia as a homogeneous disease entity has become outdated and is in need of a more valid and clinically useful successor' (van Os, 2003, p. 586). He, along with many other psychologists, argued for a symptom-based approach, rather than a categorical one. This can be found within the CBT approach described below.

1.5. CBT/ Normalising Approach

Cognitive Behavioural Therapy (CBT) provides more hope for individuals who experience psychosis as it sees their unusual experiences as understandable and is based on the premise that there is no division between healthy and unwell but that experiences lie on a continuum. CBT involves examining our thoughts and beliefs connected to our moods, our behaviours, physical experiences and events in our lives. A central idea in CBT is that our perception of an event or experience affects our emotional, behavioural and physiological response (Padesky & Greenberger, 1995).

CBT for psychosis (CBTp) is a specific branch of CBT and cognitive models have developed to conceptualise psychotic experiences, including that of Garety, Kuipers, Fowler, Freeman and Bebbington (2001), which proposes a deficit model where basic cognitive dysfunctions cause anomalous experiences, and that of Morrison (2011), which proposes that there are intrusions into awareness that are only problematic because of their cultural unacceptability. The focus in CBTp is on normalising these experiences, helping individuals to reassess the appraisals they have made and generate alternative explanations (Morrison et al., 2004).

CBTp is recommended by the National Institute of Health and Care Excellence (NICE, 2009), but the efficacy of CBTp is far from bulletproof; CBTp has consistently produced moderate effect sizes and there are some rather large discrepancies in the positive effect sizes between studies due to hidden biases of varying methodologies (Tarrier & Wykes, 2004). Although CBTp has been shown to be effective, its success seems less impressive when it is compared to non-specific-supportive interventions such as befriending (Sensky et al., 2000; Wykes, Steel, Everitt, & Tarrier, 2008) and treatment as usual (Farhall, Freeman, Shawyer, & Trauer, 2009). Most striking of all was its inability to change a sense of hopeless (Wykes et al., 2008). In fact, Lynch, Laws and McKenna (2010) conducted a meta-meta-analysis and

found that CBT was no better than non-specific control interventions in the treatment of schizophrenia and it did not reduce relapse rates.

Whether one conceptualises psychosis as intrusions into awareness or as anomalous experiences, it still does not provide us with categorical evidence that we are dealing with clinical psychosis. 'Normal' people have psychotic symptoms too. Romme, Honig, Noorthoorn, and Escher (1992) put an advert out on TV asking people who had auditory hallucinations to take part in a survey. He found that only 76 of 173 respondents were in psychiatric care. Posey and Losch (1983) interviewed students and found 71% had experienced some brief visual hallucination during wakefulness, whilst 39% reported hearing their thoughts being spoken out loud. We know hallucinations are quite common after bereavement, extreme fatigue and stress (Honig et al., 1998; Rees, 1971). When it comes to delusions, we only have to go as far as the 'paranormal' to see that in a survey of 60,000 British adults, Cox and Cowling (1989) found that 50% of people expressed a belief in thought transference between people, 25% believed in ghosts and 25% in reincarnation. The divide between madness and sanity is not so clear-cut, adding support to the argument for psychotic and non-psychotic symptoms to lie on a continuum (McGovern & Turkington, 2001; van Os, 2003).

Acceptance and Commitment Therapy (ACT), a third-wave of cognitive therapy, is also important in the conceptualisation of psychotic experiences. ACT is a mindfulness-based behaviour therapy, which, as the name implies, involves mindfulness skills and experimental exercises to challenge some of the rigid rules we place upon ourselves and our thoughts. ACT is derived from the theory of human language and cognition, Relational Frame Theory (Hayes, Barnes-Holmes, & Roche, 2001). Simply put, humans learn to respond relationally to various stimuli and can learn relationships between stimuli, thus patterns build in our mind through language. From an early age, we learn that verbal relations are fundamental and dominant. ACT sees that 'most suffering is due to the mind' and it is verbal activity that runs our lives and supersedes any other form of activity (Hayes, Strosahl, & Wilson, 1999, p. 49).

There are six key components to ACT: Contact with the Present Moment, Self-as-Context, Defusion, Acceptance, Values and Committed Action. The components are interrelated and are worked with experientially with the use of metaphors and paradox running throughout to increase psychological flexibility. Bach and Hayes' (2002) study demonstrated that after using only four sessions of ACT, rehospitalisation rates of patients with psychosis were

reduced by 50% over six months which is an encouraging result. However, 20% of participants declined participation so it is possible a selection bias was at work, where those more motivated to engage in therapy and therefore more likely to respond to an intervention were the ones who agreed to take part. Secondly, intention-to-treat analysis was not completed on the data. Analysis was completed on the outcome data of the 35 participants that completed each treatment group rather than the 40 that started in each group which means that results may be overly positive. Gaudiano and Herbert (Gaudiano & Herbert, 2006) found encouraging results in an ACT treatment group versus enhanced treatment-as-usual using psychiatric inpatients (although not statistically significant) and White et al. showed that ACT significantly reduced depressive symptoms following a psychotic episode (White et al., 2011). This finally brings some hope to the otherwise gloomy picture of what it is like to experience psychosis. Before we proceed any further, it is worth considering the language used within theses discourses to describe experiences of psychosis.

1.5.1. A Note on the Use of Language

It is worth noting the use of medical language within the discourses so far with psychosis, although it does not only pertain to exclusively to psychiatric and psychological accounts of psychosis but lay discourses too. Historically medical language has been employed to talk about mental distress, terms such as *schizophrenia, psychosis, delusions* or *hallucinations* are frequently used and often with little consideration. However, these terms are problematic. Inherent within the medical language is the idea of illness and disease, an approach that fits with a medical naturalism but one that does not fit with my epistemological stance of critical realism.

Medical language sits within medical naturalism, meaning that the terms are seen as facts that mental illness is out there, ready to be observed and verified by impartial observers (Pilgrim, 2008). It assumes the terms are non-problematic and spoken about in such a way to make the phenomena the primary concern and the sufferer secondary (Pilgrim, 2007). The sufferer becomes minimised and the context within which the experiences are occurring are not highlighted. Discussing *psychosis* rather than *a person having some unusual experiences* turns psychosis into an object that becomes reified. This medical language obscures our understanding of the social causes of madness (Pilgrim, 2007).

This medical language is saturated with social, political and economic interests. Whether a belief is delusional or not is entirely down to the observer who themselves is embedded in a complex social and political web. There is no norm for our beliefs, so when a belief if judged

as delusional it is not a fact but an interaction between the client and the person assessing it. There is a lot invested by professionals, policy makers and pharmaceutical companies to keep this language and this discourse alive. Simply put, a diagnosis with symptoms needs treating, treating people gives jobs and treatable disorders need drugs to treat them.

It becomes more absurd when we think that the medical language that is used to describe bodily functions is applied to the psychology of the mind and of human behaviour which involves emotions and thoughts (Boyle, 2007). It is only when we step back and starts to consider the control inherent in this language that we should become more critical of it.

In this thesis, I shall refer to individual's experiences of psychosis to denote a set of behaviours or utterances. At times it becomes grammatically hard to do so and so occasionally the term *psychosis* is employed. This is not meant as a diagnostic category, and I assign the same caution to using the term *psychosis* as I do to *hallucinations* or *delusions*. Let us continue to consider further movements and discourses around the experiences of psychosis, namely the Survivor Movement.

1.6. The Survivor Movement

The Survivor Movement takes a different perspective of mental distress. Rather than seeing unusual experiences or utterances that fall under the umbrella term of psychosis as problematic and a sign of illness, it takes a very difficult and empowering stance to having these experiences. It uses first-hand accounts of service users to celebrate the madness, difference and the creativity in lunacy. The campaign organisation 'Mad Pride' started in the early 1990s and has spread globally, and their well-known UK activists include Pete Shaughnessy and Rufus May, who have campaigned for the rights of service users and the abolishment of the negative perceptions of mental illness (Curtis, Leslie, & Watson, 2000). There are events such as 'Bonkers Fest', an annual arts and music festival celebrating madness, creativity and individuality. One only needs to look at some of the advertising on the Mad Pride website to see how humour is incorporated into their advertising and campaigning, with events such as 'The Paranoid Olympics – You'd Better Run!' to get a flavour of the humour and irreverence applied to mental health, services and the politics that surrounds it.

Service users' views have slowly penetrated into mainstream psychology, CBTp takes its coping mechanisms from the Survivor Movement and health care settings now work on the premise of the Recovery Model. The Survivor Movement brings the humanity back into the

picture, reminding us these are not just statistics but individuals. It gives a voice to survivors, detailing the often harrowing and painful journey they have had. It is also inherently optimistic, showing that one can survive mental distress and live a full, creative and meaningful life, bringing a much needed sense of agency to its sufferers. In Kay Redfield Jamison's exquisite autobiography *An Unquiet Mind* (1996), she wrestles with the uneasy question of what life would be like if we were able to screen out psychosis from the world. She reminds us that manic depression actually confers many advantages in artistic temperament, energy and vigour, whilst more subtle effects, such as small personality traits and thinking styles, would be lost.

The Survivor Movement also shows that humour can be used intentionally, as a political and campaigning tool. Demonstrations with people waving placards saying 'Hugs Not Pills!' show how humour can been used as a tool to add verve to a message. Mad Pride have organised Bed Pushes with pretend patients shackled to the four corners of a psychiatric bed, with others around holding giant syringes pushing these beds the length of the country. It gets people to pay attention to the campaign against the subjugation of those suffering with mental distress. There is little literature on service users' views on therapeutic humour; however, videos and written accounts of people's experiences of psychosis are punctuated with humour. In Mark Roberts' autobiographical chapter 'The Last 69 Bus to Chingford' in *Mad Pride: A Celebration of Mad Culture* (Curtis et al., 2000), humour is clearly present in his writing but it is not overtly referenced. Elyn Saks's YouTube video (Saks, 2012) of her experiences of chronic psychosis is undoubtedly funny at points. The wit and irony makes you engage with their stories, which are compelling, tragic and humorous to read. I believe the humour that is inherent in these accounts and within the Survivor Movement campaign is indicative of the way service users might like therapy to be.

Psychosis is too often about an illness, of what is lost and what is wrong in the person rather than the creativity that is there. Leader builds on Szasz's writings and argues that this obsession with mental health and mental hygiene is ludicrous as the concepts are misnomers. Mental hygiene does not exist and perpetuating the myth of clean minds free from pain is akin to violence; it is a form of social control telling people how they should think (Leader, 2011; Szasz, 1987). In this thesis, when I refer to psychosis, I define it is as a state of mental distress or suffering rather than an 'illness', as fuelled by the medical discourse. Rufus May aptly points out that today's medical language otherwise focuses on psychosis being a

‘degenerative process’ and it colonises an individual’s experiences and beliefs, leaving clients feeling objectified and a passive victim of a ‘disease’ (May, 2006).

1.7. Psychodynamic Perspectives

A psychodynamic approach to psychosis argues that a weak ego is overwhelmed by irruptions from the unconscious, the id and super-ego, and breaks down so that the person can no longer distinguish reality. Freud described how in psychosis, due to anxiety and intra-psychic conflict, defence mechanisms from earlier development stages are employed, such as delusional projection, denial of external reality and a distortion of the outer reality to fit with one’s inner needs (Bateman & Holmes, 1995; Hingley, 1997).

An emphasis is placed on the early infantile relationship, and the fragmentation or breakdown of this early relationship is seen as setting the scene for defences to be employed against anxiety. Klein argued that in the face of extreme anxiety about one’s own annihilation, we use the defence of splitting things into good and bad. The paranoid position can be the early template for symptoms of schizophrenia (Klein, 1946). Our fear of death is projected into the mother and, thus, the baby develops a fear of persecution. However, it has been argued that a greater emphasis should be placed on the caring environment. Winnicott believed that psychosis originated from problems in early infancy where there is a failure by the caregiver to hold, contain or mirror, leaving the baby traumatised (Winnicott, 1960). Thus, one could argue that the infant’s anger or sense of ‘badness’ for being inadequately held and contained is projected into the caregiver (Hingley, 1997).

The psychodynamic model is not too far away from CBTp either. Hingley notes that the models of CBTp that have emerged are closely linked to psychodynamic theory where delusions may be acting as a defence mechanism warding against low self-esteem (Hingley, 1997). What is interesting to note is that there has been a lack of any recent advances in psychodynamic theory. Most literature on psychosis focuses on the efficacy of psychodynamic psychotherapy, but there is very little recent literature to be found on the theoretical advances with the field of psychosis post-Freud until Lacan, which I shall come to next.

One thing for certain is that there is quite some pessimism associated with psychodynamic treatment of psychosis, due mainly to the poor treatment results found. Mueser and Berenbaum (1990) conducted a review in this area and concluded that there should be a moratorium on the use of psychodynamic treatment, and that it should be relegated ‘to the

dustbin of history' (Mueser & Berenbaum, 1990, p. 260) However, Freud did have some optimism with psychosis with his idea of the restitution mechanism: that, given time, the mind finds its way to balance itself and that, in fact, psychosis is not madness per se but a response to madness, i.e. it is an attempt at self-cure. A delusion is actually an attempt at a solution, e.g. if someone is staring at you, the belief you are being followed is an effort to make sense of the situation. However, with the use of medication, it is not possible to observe the restitution mechanism, as antipsychotics tend to blunt cognitive processes and affect. Hingley echoes Freud's humanity when she argues for an understanding of symptoms as 'potentially common human experiences' to help reduce the fear and distress experienced (Hingley, 1997, p. 308). Indeed, it was Freud who remarked that 'every normal person, in fact, is only normal on the average. His ego approximates to that of the psychotic in some part or other and to a greater or lesser extent' (S. Freud, 1924). If we turn to Lacan's view on psychosis, there is more optimism to be found, which helps us to conceive how humour might be a useful component of therapy.

1.8. Lacanian Perspective

Lacan persuasively wrote about the distinction between psychosis and neurosis by noting the radically different way defences work to keep away unbearable knowledge from the ego (Fink, 1997). In neurosis, the main defence used is repression, but Lacan argued that in psychosis, the mechanism is foreclosure, where knowledge is radically expelled and almost cut off from oneself. It is seen only to exist in the other with an absoluteness that makes it impossible for the person to recognise it comes from within. Hallucinations are therefore experienced as a return from the real (Fink, 1997).

Lacan theorised the psychotic's relationship to language as a whole is entirely different to other structures. The anchoring point that ties language (a signifier) and meaning (the signified) together is not present in psychosis, thus language literally falls apart for the psychotic (Leader, 2011). The button that binds these threads together is something known as the 'paternal metaphor'. The father is not so much of a real figure but a *function*; the authority that is seen to come between mother and child and facilitate the necessary stage of separation, introducing the child to culture, law and language and giving a meaning to the relationship. This metaphor binds together the Symbolic world with the Imaginary (our bodily image) or the Real (our libidinal life, arousal and excitation). Therefore, if this paternal metaphor is absent, the Symbolic world is foreclosed and it never becomes tied to the Imaginary or Real.

Lacan argued that the paternal function is either present or not; there are no possible states in-between and in a psychotic structure the paternal metaphor is absent. This means, using Fink's words: 'once a psychotic, always a psychotic' (Fink, 1997). A psychotic structure cannot be changed and therapy can only help the traits recede. As pessimistic as this initially sounds, it is indeed quite hopeful. It reminds us that we all have structures of one kind of another and that no one has a clean and perfect mind. Indeed, if we are to think of the many artists who have suffered from psychosis, this is a very creative structure.

What is important in Lacan's thesis is that the psychotic's relation to language as a whole is different to neurotics. One might think that using humour, which often consists of playing with language and words, could become problematic, but Lacan argued that psychotics do get language. Rather than feeling inhabited or possessed by language, a psychotic feels as if it is coming from outside of them (Fink, 1997). Playing with language might actually be very helpful. We can think of the psychotic who comes up with neologisms where the words become a fixation, as though it is an anchor for them, something to stitch themselves to. Leader argues that it is important to understand that language problems only exist sporadically for the psychotic; they will only be affected at certain moments in time (Leader, 2011). Individuals suffering from psychosis are described as being concrete rather than abstract in thinking, but Leader provides numerous examples in his book where this is not the case, demonstrating that this binary distinction is unhelpful. Whether we are being concrete or metaphorical is entirely context- and speaker-dependent. What is important is that if psychotics can play with language, they might be able to start to find their place amongst it.

In my view, playing with words to create neologisms is like joking, as it is also about playing on words and concepts. One of Jung's patients described neologisms as 'power words' (Leader, 2011). This suggests that playing with words and creating new ones gives a naming function to experiences that cannot be named; a smart move, really, when we consider this is precisely what scientists do. Naming something helps to temper it and stop the 'sliding of meaning' (Leader, 2011, p. 71).

Apart from the Survivor Movement, one might notice the lack optimism, but, also, on the whole, the lack of humour in any of these conceptualisations of psychosis. These accounts explain what deficits and malfunctions there are in the conceptualisation of psychosis, although very few theories take into account the creativity that can be found. Not only is there very little research into these more positive and creative aspects of psychosis, such as

how people with psychosis can laugh and can enjoy humour, there is a vacuum in the research addressing whether humour as a therapeutic tool can be effective when working with individuals who experience psychosis. Let us see how and where there may be a natural overlap between humour and psychosis and explore what this means for the therapeutic encounter.

1.9. Humour, Therapy and Psychosis

We only need to look at the stock image of the 'madman' laughing psychotically (think of Jack Nicholson's chilling laughter in the film *The Shining)* to understand why humour and laughter have not had an easy relationship with psychosis. Where there is such a departure from reality, how can there be space for humour? How could one possibly conceive of using humour when symptoms are no laughing matter? Let us think more broadly for a moment. Maybe it is not such a huge leap to consider why humour and therapy may be a natural partnership. We only have to think about what people quote as the first thing they look for in a potential partner when dating – the proverbial GSOH (good sense of humour) seems a prerequisite. Whilst we are not out to date our therapists, we are entering into a unique relationship; should it not be that a therapist should have this too, to some degree?

The treatment of psychosis is difficult and no treatment method alone (psychotherapy, medication and family therapy) has high success rates. Despite the advances in treatments, clients can still feel hopeless about their symptoms and relapse is sadly common. Gelkopf argues that humour can provide an adjunct to conventional treatments, not only helping with symptoms but helping clients more broadly with other changes experienced with psychosis such as social, emotional and cognitive effects (Gelkopf, 2011). Indeed, literature focusing on service users' perspectives of the very word 'recovery' shows the different meanings 'recovery' has for clients. Researchers interviewed clients with psychosis and found recovery meant less about eliminating symptoms and more about rebuilding a sense of self and rebuilding their life (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006; Wood, Price, Morrison, & Haddock, 2010). This demonstrates that therapy needs to take into account a broader definition of recovery, one that is holistic and introduces more humanity to therapy.

Research shows that the major effect in therapy is due to the personality of the therapist and their ability to form a warm and supportive relationship (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985); indeed, when clients (inpatients and outpatients, many with a diagnosis of schizophrenia) were asked, they felt the therapeutic relationship was the most

important part of their treatment (Johansson & Eklund, 2003). If there was a therapeutic tool that enhanced both the alliance between the therapist and clinician and improved therapeutic outcomes, then why not use it, especially when the tool in question is free and easy-to-use. It could give some temporary reprieve from the daily distress experienced by individuals with psychosis or, indeed, any other major mental health disorder (Gelkopf, 2011). Why humour and not another characteristic or 'tool'?

There is one thing that links humour, therapy and psychosis and that is the use of paradox. Betrando and Gilli (2008) argue that paradox exists between humour and therapy and it is my belief that it exists in the third, psychosis. Humour works by virtue of paradox, it is about bringing together incongruous and competing ideas where the first sets up an expectation of something and the second is different and unexpected. It is about bringing the opposite into focus. Therapy itself is paradoxical: for change to occur *in* therapy, it actually has to happen *outside* the therapy. It involves play, but of the most serious topics. It is an intimate relationship, yet one that is also formal (Bertrando & Gilli, 2008). There is also paradox in the relationships we choose to use humour in: Lemma (2000) says laughter is a natural by-product of a close relationship and it enlivens it; however, often when we joke with someone we are making some antagonist remark that could be seen as hostile. Thus, there is a paradox here, as joking is something that might be offensive, yet it is done with those we feel closest to.

In psychosis, there are often paradoxes and incongruity at play too if we consider the delusions our clients experience: patients believing they are being followed by others for their money when they are destitute. Psychosis is about seeing and hearing things that do not fit in with others' expectations and also about behaving in ways that are incongruous. Applying Morrison's interpretation on psychosis, we can see that both humour and psychosis involve things that are culturally unacceptable. Jokes are often talking about the taboo thing that should not be said. Indeed, with psychosis, it is the cultural unacceptability of the intrusion that causes the problem. It is not deemed as normal and that is when the experience becomes a problem. Thus, being able to create a space that is different and allows for paradox might be useful.

Lothane talks specifically about how humour has its place in understanding paranoid delusions – both contain elements of the absurd and are a parody of reality (Lothane, 2008). Neither psychotic delusions nor jokes have to be based in reality. We can joke about things that could never conceivably take place and delusions might be described this way too.

Felices aptly writes that one is: ‘facilitating the client simultaneously to live in two worlds through the use of humour. Humour permits the harmony between reality and illusion’ (Felices, 2005).

Delusions are no laughing matter, but Lothane argues humour might help the client to laugh at their own delusions. He noticed that even in work as early as Schreber’s case (an eminent German judge who developed psychosis in 1884), over time he was able to find irony in his delusions and described the oxymorons that lay within them. This is why humour might be so vital when working with psychosis: it allows for illogical and inconsistent ideas to be expressed. It opens up a creative or transitional space (Winnicott, 1960). Christie noted how: ‘genuine humour plays a part in facilitating progression in our analytic work in a way that parallels the importance of the playful engagement in infant development’ (Christie, 1994, p. 481).

If therapy is about bringing clients into contact with their unconscious material and jokes and humour are seen as a route to the unconscious, perhaps humour could also be incorporated into therapy (as are slips of the tongue and dreams). The reticence of therapists in using humour in psychosis might come from the model they use to conceptualise psychosis. If the view is that delusions and hallucinations have no meaning and are about a deficit, then humour would not have any value. If, however, we can think less about the pathology and more about the individuality of the person in distress, then humour might have a place in therapy. Using humour with psychosis might help clients to express their experiences in a way they have not been able to do before. It might also help to open up different and multiple perspectives on a problem.

1.10. Identifying a Gap

As humour will inevitably occur within a therapeutic context, with psychosis being no different, there is a need to understand what the possible benefits and pitfalls are of therapeutic humour in these circumstances. Working, as many professionals do, in a national health service where the dominant discourse is the medical one, there can be an unspoken gloomy outlook on psychosis and its treatment from the outset. However, when clients were asked what model they used to help them understand their distress, McEvoy, Aland, Wilson, Guy, and Hawkins, (1981) found that only 13% of the sample used the medical model to understand their experiences. Romme and Escher (1993) found that clients draw on a broad range of models and reasoning to make sense of their psychosis, including mystical,

parapsychological and dynamic factors. Recovery from a client's perspective is more often to do with taking control of one's life and developing a positive self-identity, as well as having hope, regardless of symptom change (Davidson et al., 2006; Wood et al., 2010).

So, if therapists keep practising within the medical model, then we are faced with a situation where we are talking in two different languages. We are using a framework that could be quite limiting; we are yet again perpetuating the violence of hopelessness. Worse still, it leaves little place for the sources of comfort so desperately needed in those dark moments of despair: humanity, warmth, an ability to see a light and even the lighter side of life when the client cannot. If therapists can work more relationally with their clients and bring in a wider framework, where there is a space to help individuals think more broadly about their situation, this might be helpful and have some therapeutic merit. Thus, the question is this:

How is humour experienced by therapists working with clients experiencing psychosis?

More specifically:

1. Does humour help to foster a therapeutic alliance?
2. Does humour help to facilitate change in the client?
3. Does humour hinder the work; is its use inappropriate?

Let us now move to the methodology section where I shall explain my research design, my choice in methodology and how this fits with my epistemological stance.

2. Methodology

In this chapter, I shall explain my research question and why I chose the methodology of Grounded Theory. I shall explain the epistemological basis behind Grounded Theory as well as describe my own epistemological stance. I shall then explain how Grounded Theory is employed and how my own reflexivity is interwoven into this process, providing examples along the way using 'reflective spaces'.

2.1. Development of Research Question

In this research, I wanted to explore how humour could be used in therapy with clients who experienced psychosis. I was curious to know what therapists' lived experience of this was and their understanding of it, and what theoretical framework they used, if any, as a rationale for using humour. I believe that humour is not a phenomenon that exists of its own accord; it is a socially constructed phenomenon, created by someone and, although we can laugh at ourselves, more often than not, it is observed and reacted to by another person as humorous (or not). If we do laugh or joke by ourselves, our interactions with friends, colleagues and countless others will have shaped our thoughts along the way. Therapeutic work does not occur in a vacuum either; there is another person present in the room, meaning that the relationship, the work and its content are co-created and co-constructed. It is my view that humour is a socially constructed phenomena, and the essence of it can be captured using a qualitative method that subscribes to the social constructivist viewpoint, namely Grounded Theory (Charmaz, 2006).

With this in mind, the research aims were to understand:

- Does humour help to foster a therapeutic alliance?
- Does humour help to facilitate change in the client?
- Does humour hinder the work; is its use inappropriate?

2.2. Rationale for Qualitative Methodology

The decision to use a qualitative research method rather than a quantitative one came as a consequence of the research questions established above. The literature to date shows there is a dearth of research explicating *how* humour works within therapy and particularly within psychosis. Using a qualitative method was the most appropriate choice as it allowed me to explore the process of how humour worked in therapy with clients experiencing psychosis. A quantitative methodology would have elucidated the number of humorous interventions used or the number of therapists who used it, but this would have only served to give numerical

data. We know anecdotally that some therapists do use humour, so it would be more useful clinically to gain a qualitative sense of the experience. For example, what was the intervention? How was it delivered and what was its effect? Using a qualitative method allowed me to explore how humour worked and how it was experienced by therapists when working with clients experiencing psychosis.

2.3. Epistemological Stance

There are a number of epistemological standpoints which come under the umbrella of scientific research. Briefly, there is the 'hypo-deductive', 'positivist' or 'naive' position, which subscribes to the idea that phenomena are out there in existence, and given the correct methodology, they can be discovered. Their discovery is then said to confirm or disconfirm an *a priori* hypothesis regardless of the perceptions or beliefs held in relation to the event or phenomena (Henwood & Pidgeon, 1992). This objectivist approach implies that knowledge is out there to be found and if the researcher adheres to the methodology, data can be collected with neutrality and objectivity (Charmaz, 2006). Specifically with mental distress, this epistemological stance assumes that mental abnormalities exist, almost as an object, waiting to be unearthed and then verified by expert, objective observers (Pilgrim, 2008).

An opposing view is a 'contextual' or 'interpretative' stance which proposes that phenomena do not exist without our construction, or at least our involvement and interpretation of them. Henwood and Pidgeon (1992) argue that our identification and classification of a phenomena is influenced by our perception and understanding of it. Indeed, facts and values are intertwined with one another, so Charmaz and Henwood (2008) argue that taking an objective stance is impossible. They argue that a researcher must take an interpretative stance where we can only ever gain an abstract understanding of a phenomenon, rather than being able to deduce facts or make predictions.

I take a constructivist stance towards research, and in particular, a critical realist stance, as suggested by Pilgrim and Rogers (1997), which acknowledges the physical existence of objects but recognises that as humans our perceptions are subjective. This goes against the stance of naïve medicalism as it does not assume that phenomena simply exist (e.g. mental disorder) as an innate pathological state ready to be discovered and verified. Instead, it means that one approaches knowledge critically, being fully aware of our values and our socio-political position (Pilgrim, 2008). What does this stance mean for this research topic?

It means that we can perceive real objects that exist in the world, but our investigation of them will be saturated with our own ideas, interests and values. In turn these interests and values will have been affected by the wider context of our social and political environment (Pilgrim, 2008). So for example, two individuals could sit together discussing their views on therapeutic humour. This is a conversation where the two people physically exist in the room but their perception of one another is entirely open to their own interpretation. The conversation that follows is then one that is saturated with each person's own experiences, beliefs and values, all of which are couched within the wider context of socio-political factors. For example, our views around the use of therapeutic humour will be saturated with our ideas of mental *illness* versus *distress*, with our ideas of therapy and this will all sit within agendas and government policies about psychological therapies. Added to this is whatever is said by one person is then interpreted by the other and vice versa so any conversation becomes one person's interpretation (the researcher) of the other person's interpretation (the participant) of an event (therapy in humour with an individual experiencing psychosis) which is in itself another co-constructed event.

I am concerned with how participants construct meanings of a particular event or phenomenon and I aim to get as close to the experience as possible to understand it, whilst acknowledging that I can never really know, I can only make an interpretation of it (Charmaz, 2006). I believe that the research will be shaped by my experiences, assumptions and beliefs about the world. I do not believe it is possible to stand as a separate entity from psychological research as we are not impartial and objective but embedded in the world around us. As Clarke (2006) persuasively argues, it is unlikely that any researcher can approach a research question without considerable background knowledge or reading, and so claiming a naïve stance to the work is unrealistic.

Instead of trying to bracket this interaction, a constructivist stance embraces it by introducing as much reflexivity as possible. A social constructivist stance recognises that each researcher comes to the research with experiences that will shape their interpretations and thus recognises that due to this subjectivity, the results are situated in a particular context, time and culture (Charmaz, 2006).

2.4. Grounded Theory

Grounded Theory was first described by Glaser and Strauss (Glaser & Strauss, 1967) as a reaction within the field of sociology to the more traditional quantitative research methods

that were being used. Its development came about as a way of capturing narratives that gave a sense of a person's lived experience of a phenomenon under investigation (Madill, Jordan, & Shirely, 2000). The analyses of these narratives proceeded using a number of techniques that ensured that codes, and then theory, that were created were firmly rooted in the data.

Initially, the approach took a naïve positivist approach, with the view being that phenomena were out there to be discovered by the researcher. Since then, Grounded Theory has developed and grown and there are a number of divergent strands as it has been interpreted differently by researchers. Glaser and Strauss parted ways and this led to two different schools of thought – Strauss and Corbin (1990), who took on a more manualised and thus prescriptive approach, and Glaser (1992), who disagreed with this development as he felt that this level of prescription interfered with the process of discovery (Willig, 2008). Charmaz has subsequently developed a more social constructivist approach, which is used in this study (Charmaz, 2006).

2.4.1. Social Constructivist Grounded Theory

A Social Constructivist view of Grounded Theory acknowledges the role the researcher has in the entire research process. They researcher will shape every step of the research: from the way they approach the research question, the questions they ask their participants and the analysis, each step will affect the data that emerges (Willig, 2008). Rather than trying to eradicate the researcher from the study, a social constructivist view encourages the analysis to be grounded in reflexivity, relativity and positionality (Charmaz & Henwood, 2008). Pidgeon and Henwood's (1992) idea of a researcher generating a theory from the data rather than discovering it seems more apposite. This means that the theory that is discovered is only one of many available which is open to interpretation and, to some degree, is really a metaphor (Madill et al., 2000).

2.4.2. Rationale for Social Constructivist Grounded Theory

I chose a social constructivist approach to Grounded Theory because it allows theory to emerge from the data without holding any *a priori* hypothesis. Although the researcher comes to the topic with beliefs, values and previous reading about the topic (which need to be clarified before they conduct the research), they should bracket any assumptions or ideas about what the data will hold (Charmaz, 2006). Bracketing these assumptions means the researcher is aware of them so they do not fuse with what is discussed in the interviews and when analysing the data. The researcher needs to remain reflexive throughout the whole

research process. Questioning what is the investment in the research area and asking questions such as: ‘do I hope to draw certain conclusions and if so, why?’

An alternative approach would be the objectivist stance where the researcher claims neutrality and tests a hypothesis without imposing themselves on the data. Charmaz argues the downfall to claiming such neutrality is that tacit assumptions can be erroneously given a higher status than they deserve, and this becomes amplified when there is only a small sample size (Charmaz, 2006). Social constructivist Grounded Theory stresses that these implicit statements, taken-for-granted sayings and assumptions should be problematised from both the researcher’s and participants’ viewpoint so that we can learn what lies beneath them (Charmaz & Henwood, 2008).

The methodology requires the researcher to move back and forwards between the data by analysing it, forming tentative hypotheses about the data in the form of codes, and moving back to the field to gather, check and refine the categories (Charmaz & Henwood, 2008) . This makes a robust methodology that stays true to the data, rather than guessing or interpreting what might have been (Glaser, 1992).

Within the Grounded Theory methodology, there are a wide range of methods available to gather data. This allowed me to be creative with my data collection (i.e. through interviews, emails or diaries, or a combination of each), enabling me to gather rich data from a number of sources. This flexibility towards the data collection and analysis suited my epistemological and reflexive stance compared to an objective stance such as Strauss and Corbin’s. I worried that applying a strict methodology to the data would not allow for the theory to emerge spontaneously from the data (Charmaz & Henwood, 2008).

Grounded Theory goes beyond the descriptive of other methodologies, such as Interpretative Phenomenological Approach (IPA). The model that is created under Grounded Theory is one that is very much based in the data, and thus truly represents what the participants said, as compared to some other approaches which take a more interpretative stance to the data analysis.

2.4.3. Traditional vs. Abbreviated Grounded Theory

There are two forms of Grounded Theory: the traditional full form and the abbreviated form. The first one, as the name implies, involves using the Grounded Theory to create a fully cyclical interpretative enquiry where data collection and analysis continues until theoretical

saturation has occurred (Willig, 2008). This is seen as the preferable method as it ensures that rich data has been sought. The abbreviated form of Grounded Theory means that the researcher is primarily concerned with data analysis where a Grounded Theory-inspired methodology is employed to analyse a set number of transcripts to create a systematic representation of their lived experiences (Willig, 2008). This means that a cut-off point for data analysis is artificially imposed.

In this research study, the abbreviated form of Grounded Theory was employed. This was not an ideal position to take; the full form would have been preferable. However, due to time and resource constraints, it was not possible to continue interviewing participants beyond the eight participants recruited. However, Willig (2008) argues that employing the abbreviated form has become more common and it can still produce insightful and rich data.

2.5. Reflexivity

It was important to consider how my own stance to this research topic would affect the questions that I asked and the interpretations that I made about the data. In the following sections I have reflected on my relationship to the research topic within a professional capacity, i.e. what my assumptions and experiences of mental distress are. Secondly, I reflect on what my relationship is towards humour in my personal life and how this may affect my how I approach the research. I then reflect on my professional relationship to humour, considering how my experiences might affect my views about using humour in the clinic room. Finally I reflect on my evolving relationship to CBT.

2.5.1. Professional Relationship To The Research Topic

I have had a keen interest in psychosis since my undergraduate degree, having being taught by psychologists such as Prof. Richard Bentall and Dr. Tony Morrison, who inspired me to challenge the conventions and norms, such as what it meant to be ‘schizophrenic’ and to challenge the medical model of mental illness. From this I went on to work in research projects looking at the early detection of schizophrenia, where I became increasingly concerned with the diagnostic validity of the term *schizophrenia*. I went on to take a number of graduate roles in psychological services and a medium-secure unit working mainly with service users suffering from psychosis. From there, as a trainee counselling psychologist, I chose my main placement in an Early Intervention (EI) service in central London, which cemented my interest in working in the area. I started to think about what interventions the EI

team provided clients with and I became curious to know if there were other ways to engage clients more fully with services and in psychological therapies specifically.

Having developed close links with this EI team as well as others in London, I have been afforded the opportunity to be part of Multi-Disciplinary Team (MDT) discussions, peer supervision and training that has prompted me to think about how to further and broaden my clinical work in this area. With his as my starting point, as well as my own experiences of humour in therapy, I developed an interest in humour in therapy with clients experiencing psychosis.

2.5.2. Personal and Professional Relationship to Humour

I have continued reflecting on my own experiences of humour and my assumptions about humour in therapy with clients experiencing psychosis throughout this research process, in personal therapy, in supervision and more informally amongst colleagues. I think on the whole, I have a positive of view towards using humour in life. Life can be hard, and although we do not want to laugh every time something terrible happens, I do believe that being able to laugh when things are difficult can offer a tremendous relief. Friends would probably describe me as an optimist, I tend to look on the bright side of life and this is reflected in my enjoyment of humour. Apart from being having an optimistic outlook on life, I can see from my own personal experiences how profoundly connected we can feel to other people when we share a joke or a humorous moment together. My early experience of humour within my family was one of bonding – sitting down to watch topical panel shows such as 'Have I got News For You' or sitcoms such as 'Frasier' were programmes that brought us together, they provided a commonality and a shared joke. However, I do also believe that humour can be used to avoid contact with people; it can be a way to keep things light and cover up awkwardness in social situations.

I enjoy watching stand-up comedy and other comedy programmes and films. I like the way comedy often allows a person to express a view that is off limits and it can open up our eyes to seeing a situation from another perspective. I enjoy watching comedians such as Daniel Kitson, Steven K Amos, Dylan Moran and Gina Yashere, they use humour which tends to be quite self-deprecating whilst pointing out various absurdities around us that we might fail to see. It is important to acknowledge my interest in humour as it has been a driving force for this research. I am interested to see if there are potentials points of overlap with humour and therapy, where it may be beneficial for clients experiencing psychosis.

Although I am positive about humour generally within life, I am undecided as to what part I think it has to play in therapy (and with clients experiencing psychosis specifically). I think there might be some benefits although I do not know what these are. I am also aware that there are likely to be pitfalls and during the interview process I remained curious and open to exploring what the experiences of using humour with clients experiencing psychosis were.

I am not neutral when it comes to conducting this doctoral research. I work within mental health services where psychological therapies for individuals experiencing psychosis are still a relatively recent advancement. Before the 1980's psychosis was the *forgotten child* of behaviour therapy (Bellack, 1984). This was coupled with a crushing sense that recovery was impossible for individuals experiencing psychosis. This leaves me in a complicated position as I work in services with this historical background yet I do not believe in this pessimism. This research is therefore an attempt to deconstruct our understanding of psychosis and demonstrate how one can work with clients experiencing psychosis in a positive and empowering manner that does not reinforce subjugation and pessimism.

Having used humour in my own practice made me mindful that I might risk making assumptions about the reasons why other therapists use humour. I have included a reflective space below where I describe a clinical experience of using humour in a session with a client experiencing psychosis, and how humour was used to help him when he was hearing voices. I decided it was important to be as explicit as possible about my experience of humour so the reader is clear about my relationship to the research topic, i.e. one of curiosity to the topic with some limited positive experience of using humour. I shall be using reflective spaces throughout this chapter as an opportunity to consider how my own personal experiences and relationship to this topic affects the data collected as well as stating my assumptions about the research in the following section - 2.7. Assumptions about the Research Question.

Reflective Space

I was working with a young client suffering from psychosis, and we started to talk about the voices he heard. He described them as 'all-seeing' and 'all-knowing'. As therapy developed and our rapport strengthened, we started to do some imagery work with the voices. My client was able to visualise the voices as 'annoying daddy-long legs' that buzzed around his head and irritated him. Over time, we explored what he could do with the voices. He imagined rolling up a newspaper and 'squashing them'. My client found this exercise powerful and he laughed and smiled whilst imagining this scenario. As a result, over time, the client reported feeling much less controlled by his voices and started to view them as rather 'small' and 'insignificant'. This humorous visualisation became one of my client's main coping techniques.

2.5.3 My relationship to CBT

I also felt it was important to reflect on my beliefs and assumptions relating to the primary model I work in when working with clients experiencing psychosis and how this might affect my relationship to the research question. I use CBT predominately when working with clients experiencing psychosis. CBT was the first model I was trained within and it is one that offers some comfort to a nervous trainee with its manualised treatments and outcome measures to help ascertain how therapy is progressing (or not).

CBT historically was built upon the idea of modern scientific psychology with collaborative empiricism and behavioural modification. There is a commitment to collecting objective evidence which I believe can come in the way of subjective accounts more likely to be found in psychodynamic or person-centred work (Safran and Segal, 1990). How does this approach work with clients experiencing psychosis? There is a danger, in adopting more traditional CBT methods we dehumanise and decontextualise our clients' distress. Working to collect data and challenge thoughts can come at the expense of exploring what it feels like to be possessed by voices and under constant surveillance; we may not capture the lived experience.

During my training I have become increasingly critical of some of the therapies that fall under the CBT umbrella and this is reflected in my move through placements from purely CBT to short-term and long-term psychodynamic placements to finally reaching an integrative placement which I felt reflected my practice the best. I believe CBT can be

extremely useful for clients but it needs to occur with the context of a person-centred approach. Research shows time and time again that it is the therapeutic relationship that is the most significant factor is positive outcomes of therapy (Lambert & Barley, 2001).

The criticism cast upon CBT of being too scientific and empirical seems outdated to me. I may have been fortunate with my pick of colleagues but I do not know any therapist who simplifies therapy entirely into thought records, behavioural experiments or cognitive biases. Conventional treatment manuals for working with individuals experiencing psychosis emphasise the importance of a long engagement process before beginning therapy and state that no colonising practices should take place e.g. persuasion to alternative views, discrediting a person's beliefs (Chadwick, Birchwood & Trower, 1996). My practice has developed from the technique-based approach to an interest in understanding the lived experience of a phenomenon for an individual. CBT at its best, in my opinion, comes in the *third wave* approaches with therapies like Dialectic Behaviour Therapy (DBT; Linehan, 1993) and Acceptance and Commitment Therapy (ACT; Hayes, 2000). These approaches place a greater emphasis on the context of the client's world, their early life experiences and take into account the socio-existential complexities of people's lives. Madness or misery (rather than psychosis or depression) are normal reactions to adverse and stressful conditions such as economic disparity and a lack of opportunities.

The move in these approaches is to focus on the relationship an individual has to an experience rather than abolishing that experience and this is where I would place my current practice. I think within this third wave there would be a more accepted place for humour to sit. Humour is rarely written about within CBT literature, but as a counselling psychologist it is consonant with my approach. In my development as a counselling psychologist, I have felt a pull towards including a more humanistic side, ranging from being warm and empathic, to showing my vulnerability and taking risks to use humour with a client. Research suggests that the therapeutic relationship is one of the key factors in successful therapy (Lambert & Barley, 2001) and I believe that using humour in therapy can help to build a strong therapeutic relationship.

2.6. Emic vs. Etic Position

The terms 'emic' and 'etic' refer to anthropological viewpoints that the researcher can take within their data collection and observation work. The terms refer to whether the researcher is seen as being within the field of enquiry or outside it. A researcher that is seen as naïve to the

phenomenon under observation would describe themselves as 'etic'. A researcher who viewed themselves as within the culture would described themselves at 'emic'. Relating this back to Grounded Theory, I suspect that being in the etic position would be favourable for a Strauss and Corbin approach to Grounded Theory as it presupposes that the researcher is naïve to the social processes and phenomena being explored and can therefore approach the data collection without preconceived ideas or prejudices.

I acknowledge that within this research I have taken both etic and emic positions. This is because I identified as being emic, working as a trainee psychologist who has worked within the field of psychosis and has at times employed the use of humour within my therapeutic work. However, I also identify as being etic, as I am not a qualified psychologist and I am not currently working in the field of psychosis. I have limited experiences of using humour in therapy all together, and specifically within psychosis, and I am therefore curious to understand the phenomena under investigation beyond my limited exposure to the topic.

2.7. Assumptions about the Research Question

Acknowledging the importance of a researcher's reflexivity within the process of Ground Theory, I have reflected on what beliefs and assumptions I have bought to this study prior to data collection.

- Acknowledging my assumption that there might be something (as yet unknown) beneficial about using humour in therapy with clients experiencing psychosis
- Most therapists will have had some experience of a humorous situation within a therapeutic context. This might range from client-initiated humour to clinician-initiated humour or, indeed, something that is humorous in the external environment.
- Therapists being interviewed will have thought at some point about what function humour could serve in therapy generally and have reflected on the impact of using humour with clients with psychosis specifically.
- Therapists that are being interviewed will be open to the idea of discussing what it is like to use humour in therapy with clients with psychosis.
- Some therapists will be advocates of using humour in therapy with psychosis, but some might feel this is inappropriate.
- Therapists' disclosure of using humour in therapy with psychosis will be affected by the stance that they perceive the researcher to have on the topic.

- Therapists who agree to take part in the interview might struggle to recall examples of humour in therapy with psychosis instantly, but having a diary where they have written down case examples could help them in the interview.

2.8. Contribution to Counselling Psychology

As it has been previously stated, there is a dearth of literature that addresses how humour may be useful therapeutically, and even less is available in relation to psychosis. In a profession that is becoming increasingly concerned with manualised treatments, protocols and guidelines, research that addresses and explores how a phenomenon such as humour could be beneficial in therapy is needed to redress this balance.

Through this research, I hope to gain an understanding of how humour is constructed in therapy with clients experiencing psychosis and the function(s) it may serve. With an understanding of therapists' lived experience of this phenomenon, I hope to open up a dialogue within the professional community about how to use a wider range of therapeutic techniques, where appropriate, in therapy with psychosis. This research will help to open up a discussion about how we, as therapists, can bring ourselves more fully to the therapeutic relationship, including using humour, and by doing so challenge the dominant discourse that using humour might be seen as 'unprofessional'. I hope not only to understand how humour might be useful in therapy with psychosis but to also understand the drawbacks and pitfalls of using humour with psychosis in order that a balanced discussion of its timely and appropriate use can begin.

2.9. Recruitment

Recruitment took place by contacting professionals that were known through placements, neighbouring Early Intervention teams, training courses or contacts my research supervisor knew in the field of severe mental illness and were thus likely to come into contact with individuals who experienced psychosis. I emailed these contacts and asked them if they would be interested in taking part in the research, giving them an outline of the study and what participation would entail and I attached a participant information sheet (see Appendix A). Every contact replied saying they would be willing to take part in the study. One person's email inbox was full and therefore the message bounced back. I did not pursue this contact as a sufficient number of people had responded by this point, reaching my desired sample size of eight.

I kept my inclusion criteria very broad to allow for a diverse range of therapists to be included in this study, thus giving a true reflection of therapists' views on the subject. My inclusion criteria for this study were:

- Clinicians from a variety of theoretical backgrounds, e.g. CBT, psychodynamic, person-centred, narrative, social constructivist, Acceptance and Commitment Therapy (ACT).
- Have experience of working with clients with psychosis (defined as a minimum of 2 years post-qualified experience). This was to ensure that I recruited therapists who felt they had substantial experience.
- Working in a range of settings e.g. NHS (including Early Intervention [EI] teams, community mental health teams [CMHTs], psychotherapy departments within the NHS), as well as private practices.
- A good command of English as well as practising in English.

No exclusion criteria were applied so as not to reduce the generalisability of the findings. Below is a description of the participants recruited to this study.

2.10. Demographics

Only a small amount of demographic information was collected from participants, on a need-to-know basis, in keeping with my own ethical stance. Participants' modality was established as was ascertaining that all participants were two years post-qualification. I did not ask for the number of years a therapist had been working for as I felt this would not be meaningful. I pondered whether the number of years of working in the field of psychosis would make someone's experiences of humour with psychosis any more or less valid. In recruiting clinicians with a minimum of two years post-qualification I aimed to attract mature clinicians who felt comfortable working with psychosis. Killinger argues that maturity rather than clinical experience is the likely variable that leads to facilitative, therapeutic humour (Killinger, 1987).

The sample comprised a total of eight therapists: one family therapist, two psychotherapists and five clinical or counselling psychologists. There were three female and five male therapists of which: three identified themselves as CBT (although subscribing to integrative approaches e.g. drawing on systemic and existential approaches), one ACT, two systemic,

one psychodynamic psychotherapist and one Lacanian psychoanalyst (please see Table 1 for the demographic details).

Participant Pseudonym	Gender	Approach
Sophie	*F*	*Family therapist*
James	*M*	*CBT/ Existential*
Chris	*M*	*CBT*
Mark	*M*	*Systemic*
Richard	*M*	*Systemic*
Philip	*M*	*ACT*
Angela	*F*	*Psychodynamic*
Katie	*F*	*Lacanian Psychoanalyst*

Table 1. Relevant Demographic Details of Participants

2.11. Pilot Study

Pilot studies are an essential component of conducting research as they allow for the testing of research questions and tools before 'real' data collection begins. The pilot study allowed me to see whether the methodology was sufficient to collect in-depth, meaningful data that is essential for a robust and ethical research project.

I also believed that completing a pilot interview would be beneficial as I could test out my semi-structured interview and develop my skills in interviewing participants. It was important for me to become comfortable with the process of interviewing participants about this topic; given that I was interviewing therapists who were more senior than me, there was a certain anxiety I felt towards not 'looking stupid' in front of my more experienced peers. This pilot study allowed me to adjust the questions I had pre-prepared in a way that encouraged participants to speak openly about the topic. Some initial questions invited more 'yes' or 'no' answers, but by devising questions that were thought-provoking and more open-ended, I encouraged a more substantial discussion on the topic. For example, my opening question became 'What were your initial thoughts about this topic when you first received my email?' In my experience, this was the most useful opening question as it allowed participants to start

with what they felt was important and gave them an open platform to speak. From there I had a number of pre-prepared questions that helped to penetrate the topic further.

Not only did the pilot study allow me to learn how well my questions worked to elicit information from the participants, I also learnt that certain concepts would have to be explained. For example, in this study I was interested to learn how humour could be useful when working with psychosis at a 'formulation level' and less about the off-the-cuff humorous remarks that are made, for example, at the beginning of the session to reduce some initial anxiety. (However, these too might prove to be useful examples of how humour is used in therapy). The idea of using humour at a formulation level seemed to intuitively make sense to me, but from the first interview I learnt this was something that needed to be explained.

The pilot study consisted of interviewing one former colleague of mine who worked within an Early Intervention service and who met the inclusion criteria. On meeting the participant I explained the purpose of the interview, the nature of confidentiality, the procedure for the interview and obtained signed consent, giving the participant a copy and a printed copy of the information sheet (that had already been sent electronically via email) for their own records. I then set up the two dictaphones – one main one and one back-up – and started the interview.

The pilot study allowed me to gain feedback about the interview in terms of how the participant found the whole experience. Did they feel sufficiently settled in? Did they understand my questions? Did they feel too probed or led in a certain direction? This helped me to gain useful insights into my questioning style and allowed me to hone my questions further to help stay on the topic.

I also learnt what was useful about the tools I needed in the interview. For example, having a printout of potential questions reduced my anxiety as I knew I had prompts when a line of questioning came to a natural end. In addition, I learnt that having a blank notebook with this printout of questions sitting within it was helpful. This meant I had space to write down observations or thoughts that came into mind in a free-form way. Early on in the interview, I noticed that a rush of questions and ideas would come into my head. Initially, I relied on being able to hold these in my head, but at one point, my mind went blank. From this experience, I learnt to write down one simple 'key word' to keep me on track and remind me what my next question would be, thus allowing me to listen fully to the participant.

2.12. Data Collection

Once a participant agreed to take part in the study, I asked them to keep a 'humour diary' in the preceding weeks to help them recall and retain examples of times when they had an experience of using humour with clients experiencing psychosis. I predicted this would help participants as instant recall of historical events in an interview can be difficult. Interviews were arranged in a quiet space, in a consulting room within the practice where the participants worked. Interviews took between 60-75 minutes.

Semi-structured interviews were chosen as the preferred method of data collection, rather than using focus groups or listening to recordings of therapy sessions to analyse instances of humour. This decision was taken for a number of reasons. Firstly, I felt that listening to recorded sessions of therapists with their clients would not give me a full understanding of how humour worked in therapy with psychosis. By listening to examples of humorous interactions, I would have to make assumptions as to why the intervention worked and I would not have an insight into the therapist's own views on humour. I would have to infer the rapport between the therapist and client, and I would not be able to tell what impact the humour had on the client without listening to all subsequent sessions that took place. Using this method would also prevent me from exploring with the participant *how* they constructed the phenomenon of humour and how they described their lived experience of it.

Secondly, there was the option to set up focus groups whereby a number of therapists could have been invited to discuss their views on using humour in therapy with psychosis. I felt that this was not the most beneficial way to gain an in-depth understanding of the phenomena. Due to the lack of literature on the topic, coupled with a discourse that 'humour is not something that therapists do', I hypothesised that therapists might feel a pressure of social conformity and may not speak freely about their experiences or beliefs around using humour in therapy with psychosis.

Interviewing participants individually using a semi-structured interview felt the most appropriate method. It allowed for an open and in-depth discussion around the topic where participants felt comfortable enough to share some clinical examples of their work. It also allowed richer narratives to develop as participants had the space to think about how humour worked in therapy and how their use of humour related to their own views of the world, their personal histories and therapeutic modality.

In addition, I felt using semi-structured interviews was a natural method of data collection as it drew on similar skills that were required as a (trainee) counselling psychologist. As a trainee psychologist, I felt well placed to conduct interviews by drawing on skills such as making others feel at ease, exhibiting genuineness, unconditional positive regard, congruence and demonstrating a respect for differing opinions. Secondly, I have skills that assisted the interview process, such as active listening, reflecting, processing information, summarising statements and formulating questions from the answers to previous questions. Non-verbal cues were also used to foster an environment where participants felt encouraged to speak freely about their experiences, such as nodding, smiling and sitting in an open and relaxed posture.

2.13. The Interview Process

Before the interview, participants were asked to keep a 'humour diary'. Following the guidelines of Willig (2008), as little guidance as possible was given to participants about how to complete their diary. Enforcing guidelines as to how to do this would lose the essence of what details the participant felt were important. By enforcing fewer parameters on participants, I hoped to decrease attrition in the study as participants might be put off by the prospect of keeping a diary. The format of the diary was left up to the participants (e.g. a journal or on a MP3 player) and I explained to participants that it was an aide-memoire that they might choose to use for the interview. I also sent a courtesy email, one to two weeks before the planned interview date, to gently prompt participants to keep their diary before the interview. Every participant followed these guidelines and wrote down some examples of humorous interventions in their work; in addition, some participants also wrote down their thoughts, which they also brought into the interview.

At the start of the interview I was careful to explain to participants that this was not a 'standard' interview comprising a series of set questions, but it was a free-form discussion. The purpose of this was to allow participants to speak freely about the topic of humour in therapy with psychosis to gather rich data about their thoughts and experiences, rather than for the discussion to be steered by my preconceived beliefs.

I considered Willig's (2008) guidelines towards conducting a semi-structured interview. Willig suggests planning an 'agenda' of questions to help prepare the researcher and keep them 'on track' in the interview. However, Willig cautions the use of having too many topic headings to prevent questions becoming too specific and directive (Willig, 2008). A more

effective route of questioning was to formulate questions off the back of the interviewees' last statement. This allowed me to check my understanding of the last comment and to continue in the same direction, creating continuity (please see Appendix C). It is important to note that not every question was used in every interview; however, all potential questions are given in the appendix as an example of what could have been used. Questions were also formulated after each interview in line with Strauss Corbin (Strauss & Corbin, 1990), who suggested that questions should be generated as new themes emerge from each interview.

Once each interview was completed, I spent time writing down descriptive details of the interview process. I went back over notes that I had jotted down during the interview and expanded on them so that they would be legible when reviewing them with the transcript for coding. I also then noted down any further details about the interview process, such as memos, including observations about the participant's body language during the interview, any emotions that came up during the interview and at which points these occurred. In addition, I observed when a participant struggled to discuss certain topics or when there were times the tempo changed and they seemed more passionate about a topic. These non-verbal observations helped to add to the richness of the data. Please see Figure 3 for an example of a memo.

Memo after Interview 4

I noticed that during the beginning of the interview I felt quite nervous as I started to explain the interview topic. I wondered what the participant might be making of this interview topic. This reminds me to be aware that if I am feeling a little nervous, then how might the participant be feeling at the prospect of sharing sensitive information about their clinical practice? Will they feel scrutinised? It is going to be a really important part of my interview process: fostering an environment that feels open and relaxed so they know that I am curious to understand rather than judgemental.

Figure 3. An Example of a Post-Interview Memo

2.14. Transcription

Verbatim transcriptions of audio-files began after each interview, with the next interview beginning after transcribing and coding of the previous interview had been completed. Transcription is a lengthy task; however, it did allow me to gain an intimate connection with

the data. After transcribing, I listened to each tape twice more whilst reading the printed transcripts, allowing me to become well acquainted with the material and check for any typing errors (please see Figure 4 for an example of transcription).

Interviewer: *Interesting. So it's suggesting something to me about changing a power imbalance that's often present within the therapist-client relationship? Would you suggest it has some sort of mechanism like that?*

Richard: *It definitely has that. When I use it, as a way of making fun of myself, as a way of being, being very human, and making very explicit my humanness. It's definitely something… you know, it's saying, away from 'I'm this expert' sitting there, you know, with I don't know, writing lots of notes and being serious.*

Figure 4. Example of a Transcript (Richard: Page 15 Lines 6-12)

2.15. Coding of Interviews

Glaser (1978) suggests coding line-by-line to allow for in-depth coding rather than taking general themes from the data. However, since each participant speaks differently, it is important to consider what counts as a unit of data that requires a code, and whether the size of the unit should be the same between participants. For example, some participants' accounts were convoluted and comprised many pauses or half-completed sentences within one line, whereas some participants' accounts were concise with one line containing a number of potential codes within it. I therefore decided to code on a case-by-case basis, with a minimum of one code per line of transcript, with two codes per line where necessary.

I also considered the importance of coding my own statements within the interview. Although this is not explicitly stated in any literature on Grounded Theory, taking a social constructivist view, I felt that it was important to code and analyse these sentences. The interview was a dialogue, thus the language of both people should be analysed as one person's comment affects the other person's response and so on.

2.15.1. Initial Coding

Initial coding is the first stage of coding that the researcher completes post transcription. Its purpose is to start making sense of the data and examine it for potential theoretical

importance (Charmaz & Henwood, 2008). This involves the researcher examining what is going on in the data and *describing* the action that is conveyed in each sentence by using gerunds, creating 'active coding' (Charmaz, 2006). Coding in this way prevents the researcher from making loose codes that do not fairly represent the themes (please see Figure 5 for an example of line-by-line coding and Appendix D for a longer example). Making these initial codes means the data can be looked at with a level of objectivity, freeing the researcher from their own opinions and whether they agree or not (Charmaz, 2006).

During this stage of coding, particular attention was paid to how individuals used language. As Charmaz argues, Social Constructivist Grounded Theorists should not take anything for granted. This means that any in-vivo codes (any taken-for-granted meanings, turns of phrases or idioms) should be problematised so that no assumptions are made about them (Charmaz, 2006).

Participant's Quote	**Initial Coding**
1.'Just one function is that it manages intensity	*managing intensity*
2. But one of the ways it manages it	*having multiple functions*
3. It allows a stepping back	*stepping back*
4. It allows the playful to be pulled back into the content	*bringing playful in*
5. But it does something else which is shift attention	*Humour shifting attention*
6. It shifts attention or distorts something'	*Distorting content*

Figure 5. Initial Line by Line Coding of Richard's interview (Page 6 Lines 12-15)

2.15.2. Focused Coding

The most frequently occurring initial codes were picked out and labelled as 'focused codes'(Charmaz, 2006). These focused codes become a means to sort through and compare large amounts of data within the transcripts. These focused codes are compared against the data, against other codes and analysed in conjunction with written memos and diary entries (see Figure 7 for a diagram of the stages of analysis in Ground Theory (Pandit, 1996)).

2.15.3 Memo-writing

Memo-writing pertains to the notes which are kept in relation to the data collection and analysis and is separate from the humour diary. Its primary purpose was to record notes about the codes and explaining the hypothetical links between these codes to form high-level codes. In essence, it is a way of logging one's 'working out' so that the steps in the data analysis can be understood by others. Memo-writing helped me to remember the steps in my thinking, as well as identify any changes in analytic thinking or emerging concepts (Willig, 2008) (please see Figure 6 for an example of a memo).

> *Whilst I am coding I can see there are some links between some initial codes. There is something linking 'absurdity', and 'finding irony in things' and 'being flexible'. Maybe it's having 'lightness towards experiences' like Philip has described. I think Richard and Chris talk about this too. I need to go back to their interviews and compare and contrast what their descriptions are of lightness or levity.*

Figure 6. An Example of a Memo

2.15.4. Constant Comparative Analysis and Negative Case Sampling

After some tentative categories have been created, theoretical sampling is employed. Firstly, constant comparative analysis is used to help the researcher understand where there might be gaps in a category or to understand where some delineation is required to create sub-categories (Willig, 2008). This is done so that no presumptions are made about emerging categories and the theory that starts to emerge in the analysis is firmly grounded in the data. Secondly, negative case examples are sought to find instances where data does not fit the code to encourage the redefining or improved accuracy of codes so that they reflect the data.

2.15.5. Theoretical Saturation

Data collection is meant to continue until no new codes can be found in the data. This means that any further data that is collected beyond the point of saturation does not add to the coding in any way but to confirm what has already been coded. This is a theoretical ideal and in practice it can never be achieved as there will always be more data that can add to an emerging code or theme. Although this is a helpful idea to strive towards, I prefer Dey's (1999) term of 'theoretical sufficiency'. In this research, the abbreviated form of Grounded

Theory was used, thus theoretical sufficiency was imposed after eight interviews due to time and resource constraints.

2.15.6. Axial Coding

Strauss and Corbin (1990) recommend using axial coding, where codes are grouped together using prescribed concepts, as a way to create a framework to bring the data back together after it has been separated into its various codes. Not only was it meant as a way to make sense of the data but it was also to sensitise them to the data by encouraging them to look at the data in a different way. However, this can lead to the use of prescriptive coding and ties the researcher to preconceived notions about the data. I therefore decided not to use axial coding and allow high-level codes to emerge *from* the data.

2.15.7. Theoretical Coding

When theoretical sampling is complete, the researcher is left with a number of categories that have been checked against the data and no new categories emerge. At this point, one must then work to weave the categories together and integrate them into a framework that produces a theory or model of the phenomenon under investigation (Charmaz & Henwood, 2008) (see Appendix E for a full worked example of initial coding to theoretical coding of a transcript).

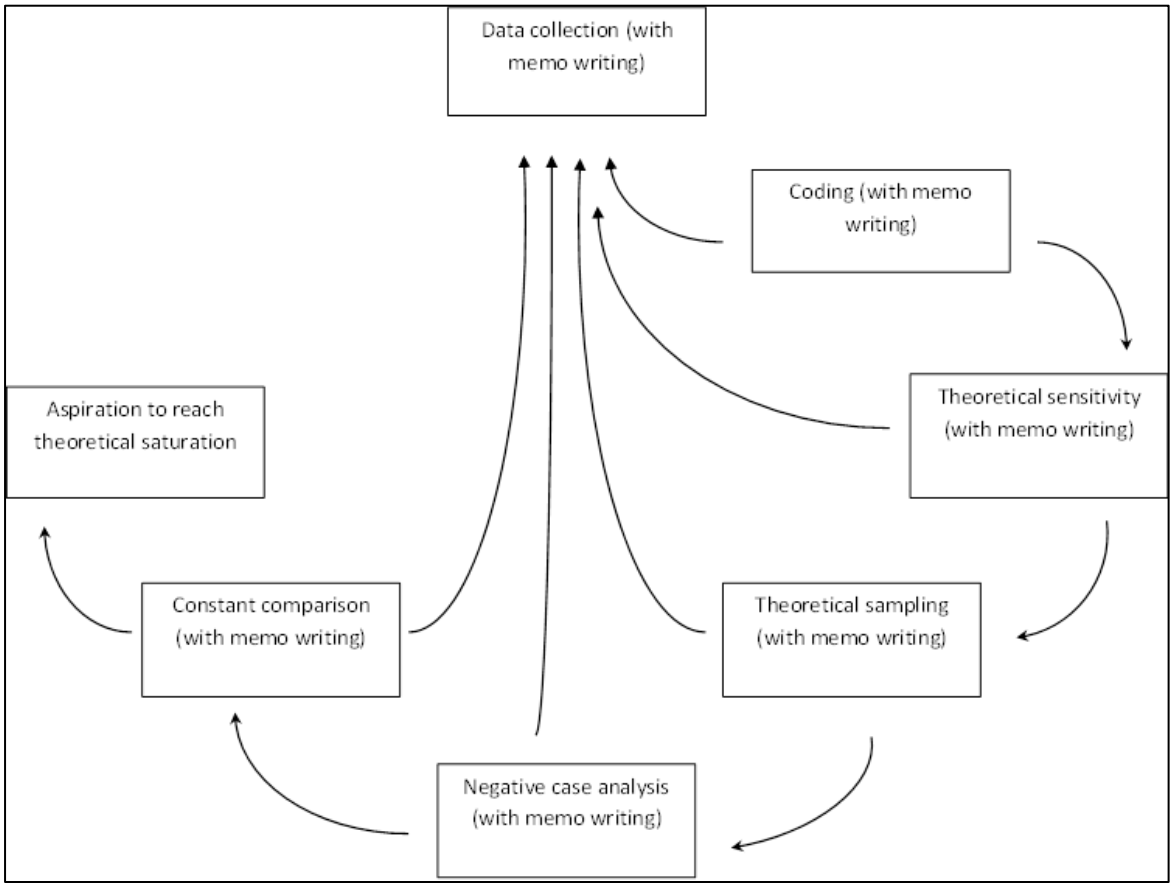


Figure 7. The Stages of Grounded Theory

2.16. Ethics Approval

Many ethical considerations were made before commencing the study. Firstly, ethics approval was given by City University Ethics Committee; the board reviewed the research proposal and the study was approved. The study was supervised by a chartered psychologist with an interest in this area, providing an appropriate space to discuss any ethical dilemmas. My conduct was guided and stayed in line with the BPS 'Code of Ethics and Conduct' (BPS, 2006), 'The Health Professional Council Standard Of Conduct and Ethics' (HPC, 2008) and 'The BPS Guidelines for Minimum Standards of Ethical Approval in Psychological Research' (BPS, 2004).

As I have worked within the field of psychosis as a trainee, I excluded any clinicians that I am currently working under as participants on ethical grounds (for example, a placement supervisor). I felt that any personal disclosures made within the interview might affect the supervisory relationship.

I also considered the possibility of any harm that could occur to participants. This interview offered a very low chance of participants being detrimentally affected by the questions; however, all participants were offered the opportunity to debrief afterwards if they felt that any difficult material had been raised during the interview. All participants were given time to reflect on the process of being interviewed on this topic and 'de-role'. Alternatively, they were given the opportunity to debrief with my research supervisor, if this was felt to be necessary. If further psychological support had been needed, the appropriate provision of care would have been provided, e.g. through the Samaritans. However, no further support was necessary after the interview (either by my supervisor or external services) and there have been no subsequent reports of distress made to me or my research supervisor.

2.16.1. Informed Consent and Confidentiality

Informed consent was gained from all participants. Participants were sent an electronic copy of the information sheet via email when they were first approached outlining the aim of the study, detailing how long it would take, what would occur, what support was available after the interview should it be needed, and how I would maintain confidentiality regarding information that was collected from the participant during the interview.

2.16.2. Data Storage

The information sheet also detailed what would happen with the data once it had been collected, including how it would be stored: audio files were securely stored on a computer

with a password to access the data files; transcripts made of the audiotapes were kept in a locked filing cabinet. Information on what would happen to the data once it was no longer needed was also supplied: data will be kept for up to two years and after this time it will be deleted from the computer and transcripts will be shredded. However, a deadline was given to withdraw their consent (set as the date by which the data analysis was completed of March 2012). This ensured that any withdrawal at a later stage would not affect the write-up of the findings. Participants will also be informed of any publications that occur out of the acquired data. Finally, confidentially was preserved by removing names and any identifiable details of participants from the transcripts.

2.16.3. Safety

Personal safety for both the researcher and the participants was sought at all times. Participants were interviewed without exception at their place of work, either in their office or a consulting room within the service. The safety of the location was assessed to see if there were any risks involved prior to attending and I let my whereabouts be known to others (e.g. the time and location of the interview) so that safety was ensured.

2.17. Documenting my Reflexive Stance

The concept of a reflective stance in this study means that, as a researcher, I am aware of how my pre-existing thoughts and ideas about the research topic affect the data collection. During this whole process, I kept a diary outlining my own thoughts about using humour in therapy. Alongside this were discussions with peers, colleagues and my research supervisor, which were noted down in the journal. This has been helpful as it has allowed me to map and see the changes in my thoughts in relation to the topic and to be aware of how this shaped the data collection and theory generation (please see Figure 8 for an example of a diary entry).

8th December 2011

Walking along the road this morning I had a humorous encounter with a stranger. A rather self-assured guy on rollerblades whizzed past us both and attempted a rather flamboyant turn which ended in him tripping over a loose paving stone and coming to a rather unglamorous halt. Luckily he wasn't hurt but maybe his pride was! This stranger and I both looked at each other and smiled, trying to supress our laughter. It was a shared source of amusement and I felt a connection with this person. I wonder if this is a similar process to what happens when humour occurs in therapy, there is a moment of meeting between two strangers. A sense of 'connectedness'?

Figure 8. A Diary Entry

2.17. Assessing the 'Suitability' Of Grounded Theory

2.17.1. Validity and Reliability

Both validity and reliability are well-known terms commonly used to assess the rigour of scientific research. However, within Grounded Theory these concepts do not fit so readily. In the case of validity it would mean to ask the question 'did what was being measured really get measured?'(Prince, Stewart, Ford, & Hotopf, 2003); however, I was not measuring a phenomena, but rather I was exploring its construction through participants' accounts. Instead, it is important to assess if the interpretations made about these accounts are valid (Woods, 1998).

Similarly, the concept of reliability – that what has been measured was stable so that under the same conditions another researcher would have found the same thing (Prince et al., 2003) – is not consistent with a social constructivist view. Between two researchers there will be differences in the data collected and theory generated as each will bring their own lens to the data. Indeed, Madill et al. remind us that one tiny change in a question can lead to a huge difference in the response and therefore the direction of the interview (Madill et al., 2000). It is for these reasons that the researcher has a responsibility to make their own relationship to the material explicit and explore how this will have interacted with theory generated from the data. If these concepts do not help us assess how rigorous the data collection and theory generation has been, then alternative concepts must be used instead.

Reflective Space

I have reflected on how my epistemological stance has changed over time. Having completed a research MSc within quantitative research methods in mental health, I was aware that I approached the topic of qualitative research methodology with a somewhat sceptical manner. I struggled to understand how qualitative methodologies would be 'robust' and whether I would be producing research that felt scientific enough. I think this concern has been based on the education, not only in my MSc, but more generally my education has been situated within a Western society where there is a premium on scientific enquiry, evidence-based research and statistical analyses. It felt daunting departing from what I knew; there is a certain safety in statistics. There were no questionnaires or number crunching to hide behind, just my interviews and my reading of the data.

Research supervision was incredibly valuable to me. Being able to discuss my anxieties of departing from the known with someone who understood was very containing. It also made me start to question how I have internalised messages throughout my education of the superiority of quantitative research leading to an internalised 'quali-phobia' as my supervisor called it! The use of humour here has not escaped me. Giving a humorous name to the process helped me to externalise it and create some distance, allowing me to question it rather than run back to the familiar in a moment of anxiety.

Once I understood that Grounded Theory was coming from a different philosophical base and thus would be evaluated via different means, I allowed my scepticism to drop. I enjoyed learning about qualitative methods and the acknowledgement of the role of the researcher within the data analysis is something I felt had been lacking in previous methodologies. By taking a leap, I actually found a methodology that resonated with my own personal reflexive style. It is probably no coincidence thought that I chose a qualitative method that requires the least amount of interpretation as Ground Theory requires the theory to emerge from the data. The danger is of course that this gave me some false confidence about the results being less biased and thus in some way more 'scientific'. There have certainly been challenges along the way with this but I have enjoyed learning to incorporate my reflexivity into the research and realise the blind spots in my research.

A number of alternative criteria for evaluating the quality of all qualitative methodologies have been suggested by Henwood and Pidgeon (Henwood & Pidgeon, 1992), which are:

1. The researcher should ‘keep close to the data’ so that the theory is a ‘good fit’

2. Theory should be ‘integrated at diverse levels of abstraction’ so that theory should be based on rich and dense data

3. The ‘reflexivity of the researcher’ must be explored

4. 'Theoretical sampling and negative case analysis' is suggested to measure the quality of the results

5. There is a 'sensitivity to negotiated realities', which means being aware of how truly the codes fit what participants said

6. There is ‘transferability’; this refers to whether the data is applicable beyond its specific context

I will revisit these criteria in the discussion to evaluate how well I have adhered to these guidelines. In the next section I shall present the findings which reflect how therapists experienced humour in therapy with clients experiencing psychosis.

3. Findings

In this section, I shall give an overview of the data and subsequent theory that emerged from the participants' interviews. I shall describe the nine main categories that emerged from the analysis. Whilst several dimensions of using humour in therapy with clients experiencing psychosis rose from the interviews, one core underlying category titled 'Building Blocks' emerged that was necessary as a prerequisite to using humour in therapy with psychosis. Each of the remaining eight emergent themes will be discussed in turn, using referenced quotes from individual transcripts to illustrate each point. One long worked example of a coded transcript can be found in Appendix D. [1]

The aim of this section is to weave the fragmented codes together into a narrative that tells how therapists experienced humour in psychosis. In this way I hope to capture the dimensions and qualities of their lived experience of the phenomenon, as well as the lived experience of telling me about this. No theme stands in isolation in this study; within quotes there are references to multiple codes. This suggests there is an interplay between the themes of how humour works, and potentially an additive effect between them. What I have endeavoured to do is cross reference these themes, showing the interconnection of concepts to add depth to the analysis (please see Figure 9 for a diagrammatic representation of the nine main themes that emerged as dimensions of using humour in therapy with psychosis).

[1] Direct quotes are given from participants' interviews which are written in italics and are demarcated by a pseudonym. Pauses in speech are indicated by the use of three dots (…) and any omission in data is denoted by square brackets []. An inclusion of information for clarification purposes is given in square brackets, an 'x' has been used in the place of clients' names or any identifying details to preserve anonymity. Each quote will be referenced by the pseudonym first letter, page number and line to maximise transparency e.g. (S8:2-4) represents Sophie, Page 8, lines 2-4.

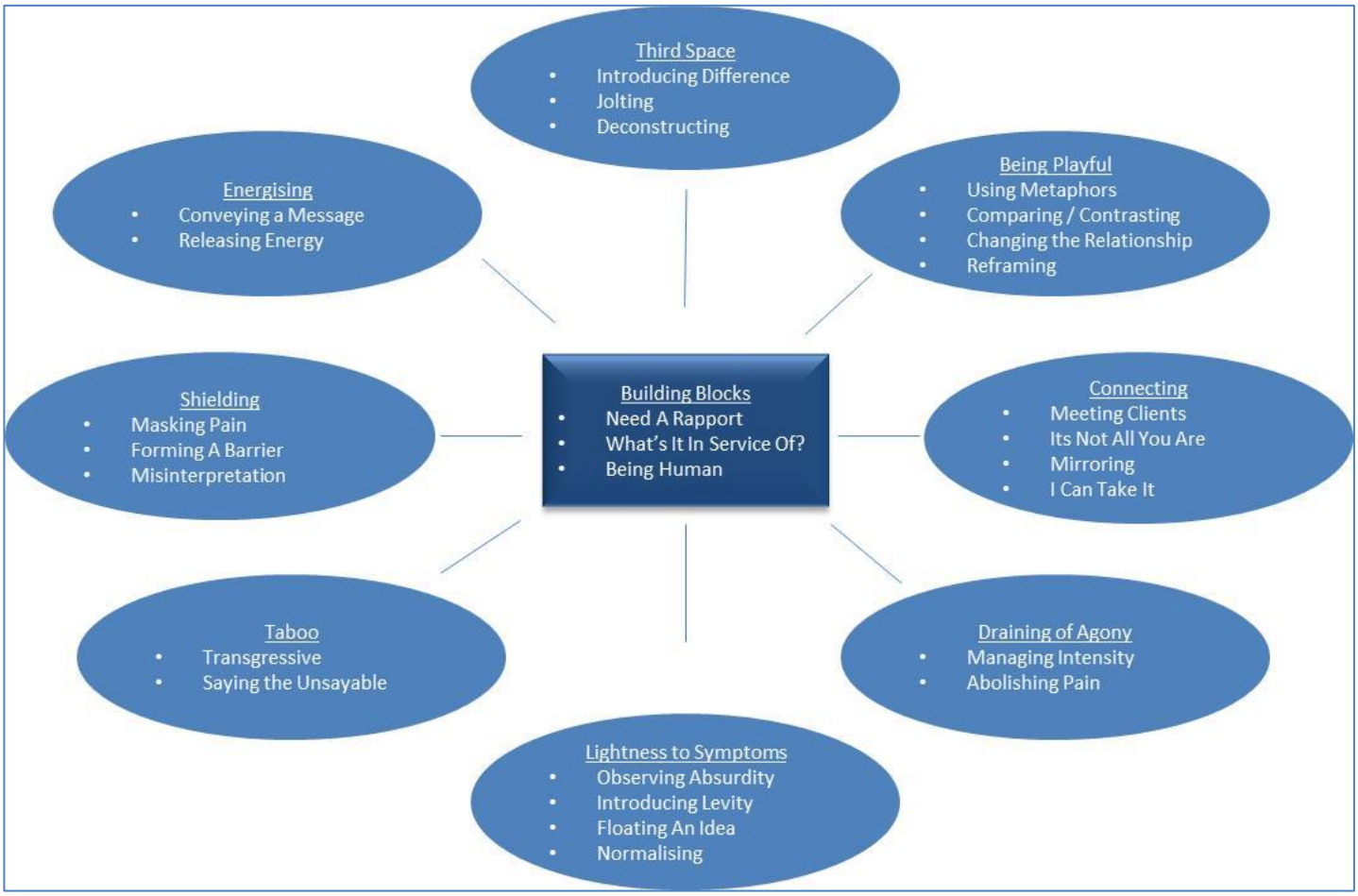
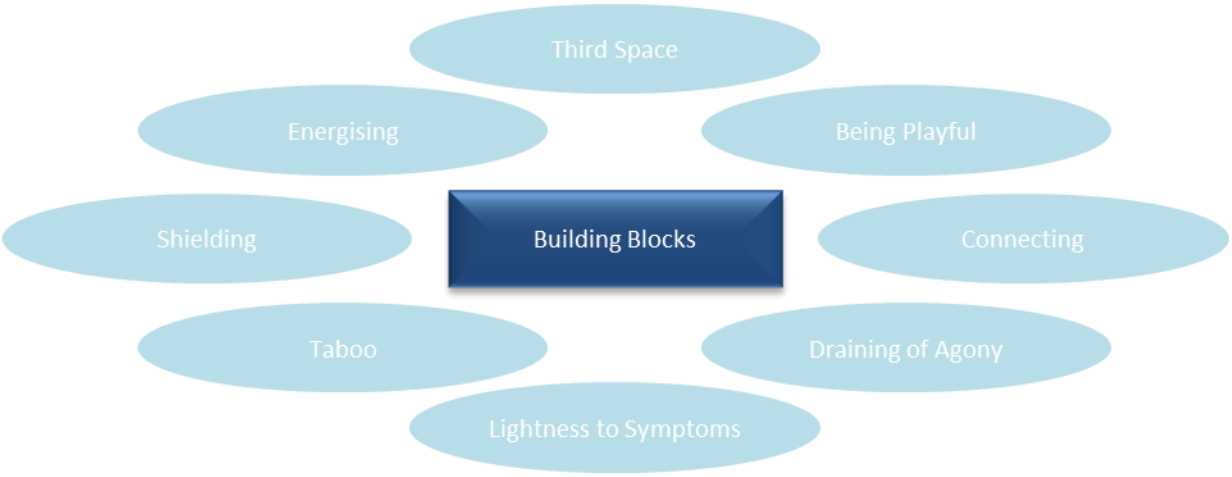


Figure 9. Overview of Final Theoretical Codes



3.1. Building Blocks

Three fundamental conditions were highlighted by all participants as key to using humour in therapy with clients experiencing psychosis. It emerged that an awareness or presence of these factors was necessary for humour to be considered as potentially useful in therapy with psychosis.

- **Need a Rapport**
- **What's it in service of?**
- **Being Human**

3.1.1. Needing Rapport

All participants stated that a rapport had to be formed, to some degree, before humour could be used in therapy with psychosis. Participants felt that without a sufficient therapeutic rapport with clients, using humour in therapy with psychosis could be a high-risk approach due to the opportunities for humour to be misconstrued or misinterpreted by clients with psychosis. Sophie said:

> *Yeah, I say that if you don't really know your client or user very well it could be misinterpreted, it could be seen as 'this person doesn't know what I'm going through and he's taking it in a very light-hearted way'. So I think, my view, you need to have a good relationship with that person*
>
> **(S2:12-15)**

James described what might happen if you used humour in therapy before a therapeutic rapport has been established:

> *I: It's coming back to that idea again of using it once you have a rapport, using it once you know someone and not going in blind straight away with it?*
>
> *J: Yes, partly because I think you've got to have that for them to let you in, you've got to be sure how it fits together formulation-wise and got to have the key aspects of 'what's supporting this belief?' um because otherwise it's like you are trying to untangle a ball of string and your just pulling it tighter and tighter*

(J11:3-6)

James argued that it was not only rapport that was necessary but the knowledge of the client's background history assembled in a formulation. The therapist needs to know how the humour fits with the client, knowing how the voices or symptoms are affecting them; without this, there is a risk of causing damage.

3.1.2. What's it in service of?

Each participant, in their various ways, described having a cautious and circumspect approach to using humour in therapy with clients experiencing psychosis and they said that it needed to be carefully considered. Therapists all individually raised the question: 'What would the purpose of using humour in therapy be?' If humour was used in therapy with clients with psychosis, it was felt that the therapist must have a clear rationale of why they were using it, along with an understanding of how the client might experience it. Participants described this in a number of ways, including 'knowing why you use it', 'assessing its use', 'reflecting on its use' and 'checking in with the client'. Sophie expressed it as:

> *I think that's a danger that you have to self-monitor yourself to 'am I doing this, a witticism, to get me out of that because I feel uncomfortable?' I think you need to be self-reflexive and think 'why am I doing that?'*

(S19:12-14)

Therapists described needing self-awareness of why humour was being deployed, such as having an understanding of whether they were using it for their own gains to reduce anxiety or avoid a difficult topic. If it was not for those reasons and it is was 'in service of the client', then participants still felt the use of humour needed to be evaluated by checking to see if

humour progressed therapy or not. Participants also noted that as a therapist, there was a responsibility attached to using humour and the therapist needed to take accountability for using humour and not tie the client in with the consequences. Philip articulated this:

> *It's about being self-aware of what is the purpose of my sense of humour and again, my absurdist take on the world is not everyone's take and it's not about convincing someone to take an absurdist point of view*

(P21:3-5)

In essence, there had to be a good trusting relationship with the client, where humour was coming from a position of integrity; not to be making fun of the client or to ease the therapist's anxiety. It needed to be delicately handled and not done in a patronising or humiliating manner. Interlinked with this theme was the idea of 'Being Human'.

3.1.3. Being Human

Participants spoke about bringing humanity to therapy, and in particular, described the benefit of bringing one's personality to therapy. For example, self-deprecating humour was helpful in the initial stages of rapport-building in therapy. In showing their fallibility, therapists could deconstruct the idea of being 'a professional with all the answers' and take themselves out of the hero/rescuer role, or, indeed, make themselves less of a persecutory figure. Chris described it as:

> *There's something about humour being an aspect of being a human being in a room with somebody that I think would be, that should go across modalities*
>
> *I: yes*
>
> *Chris: to my mind, I can see it fits very well with Rogerian viewpoint to it….the thing is if you're not doing that then you're not engaging, then you wouldn't be able to work with people with psychosis and I think humour is part of the humanity of being with somebody in the room*

(C3:23-26)

Humour was described as a 'leveller', as Chris pointed out above, but it is also takes courage to use humour and Richard felt that taking risks in therapy was important as this is precisely what we ask clients to do. If done appropriately, using humour when working with psychosis can bring humanity and compassion to the therapeutic relationship. Although there may not

be a right way to incorporate humour, themes of how humour was used emerged, including 'being kind', 'being compassionate', 'being sensitive', 'empathising not undermining', but 'not ridiculing clients' and 'not using humour as another way to stigmatise clients'.

Participants also said they felt that using humour in therapy was about having a personal style and it should be used in a way that is natural, not forced or technique-driven, as Richard said:

> *But it is also drawing on what comes up naturally which happens the longer you do this. You find the way you resonate*

(R9:8-9)

Sophie:

> *Yeah it comes naturally, I don't think: 'hmm I'm going to use humour now!'*

(S6:15)

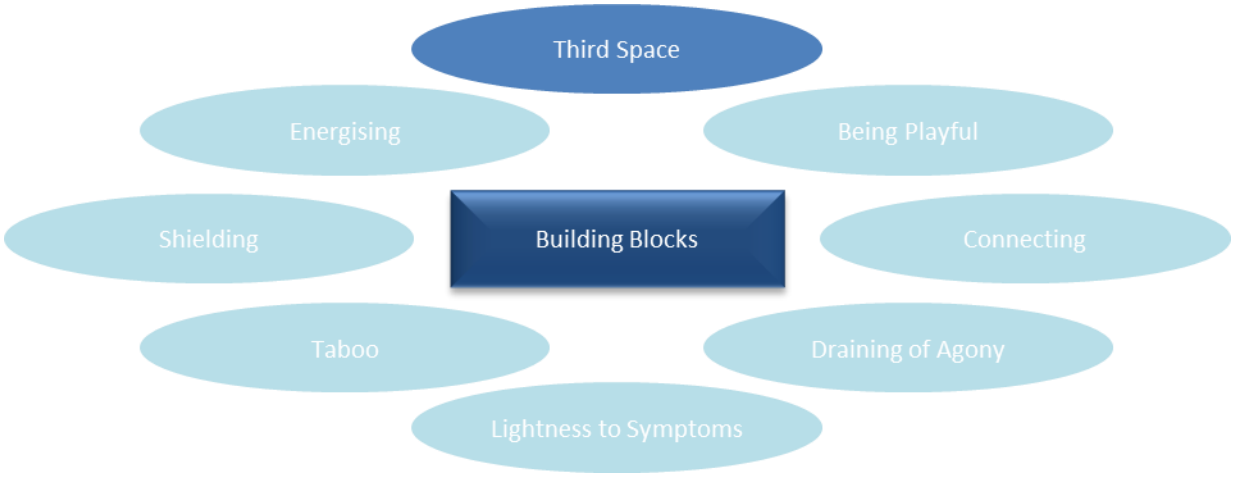
James:

> *It's not something you can just take off the shelf: 'hey we'll use humour at this time'*

(J11:23-24)

Philip summarised this well, noting how as humans we find fantastic ways to get ourselves stuck in a mess and this needs to be accepted with humanity from one human to another with warmth and empathy, rather than from a lofty perspective as a professional.

An additional concern raised by Mark was that today's health services are unintentionally squeezing humanity out of the contact with clients, and bringing in humour can reinstate an element of 'Being Human' back into the system. With a consideration of these key building blocks, I shall now describe the eight themes that emerged from the data as distinct yet interrelated codes that chart participants' experiences of using humour with psychosis.



3.2. Third Space

Participants often described how humour had helped to create a 'Third Space' within therapy. Humour was described as creating an environment that was not just 'more of the same', enabling clients to see themselves in a different light. Participants also described using humour to open up conversations that might have previously felt off-limits and thus help to deconstruct some of the fears and myths they held about psychosis or even the process of therapy. 'Third space' emerged from the analysis in a variety of ways as described below.

3.2.1. Introducing Difference

Participants spoke of the need to introduce difference into the sessions, in a way that defined the therapeutic space as unlike what has gone before in the clients' world. Therapists described working with clients with psychosis who had seen multiple health professionals and who had told their story many times before and had little hope that anything could be done to change things. Therefore, participants said humour was a way to create a space that was new and unusual, as Richard described:

> *[I 'm] constantly having to think in what way do I respond that will allow difference that might in turn allow the person to experience themselves in a slightly different way. I can't control that but I can control how I am with them*
>
> **(R7:17-19)**

Katie described it as:

You have to remember it's not a normal dinner party conversation and so if your responses are a bit strange sometimes... that's... good... too

(K8:1-2)

Creating difference was beneficial to participants as it allowed for possibilities and for clients to find new ways to think. From the accounts given, it emerged that being different also often gave a 'jolt' to the client.

3.2.2. Jolting

Participants described how they often used humour to say things that were provocative, paradoxical or irreverent with their clients. The humour could be quite shocking and therapists knowingly used this quality, saying things that were unexpected to turn a situation on its head. This idea of jolting the client could be used for many different reasons and Richard's excerpt below explains how he used humour to demonstrate a disregard for the way things 'should be done' in therapy:

You will deliberately use paradox, you will deliberately sometimes provoke and challenge but you will at the same time be very irreverent about yourself. You're not doing because you are an expert or… you are using yourself, sort of therapeutic use-of-self sort of way. So, when I do that, I'm not making a laugh because I'm anxious, I'm making a joke because I am trying to do something. I am trying to shift it

(R9: 3-8)

Richard goes on to give an example of how he used irreverent humour with a client who felt she should bring only serious topics to therapy:

She used to come and always talk about these things and she just feels like today she just wants to talk about everyday stuff and you know it was just, she was beating herself up because she should be using… and I said to her something along the lines of: 'Oh so we should be talking about really deep shit or something?!'

I: (Laughter)

Richard: And it was just so… the looking at her and see the jolt of… This is a woman that, who completely cut her arm open trying to kill herself the year

before and I think it was just, taking the piss out of us. Out of this idea that this is all serious and heavy and erm… you know, that somehow there is this unspoken obligation of 'you've got to bring heavy stuff' you know

(R18:22-19:7)

What emerged from these accounts was that humour could be used in therapy with psychosis to create an imbalance. This jolt could be shocking and could be the nudge needed to allow for a loosening up of ideas and thinking about things in a new way. This jolting could also be a way to deconstruct beliefs, psychotic or otherwise, as described below.

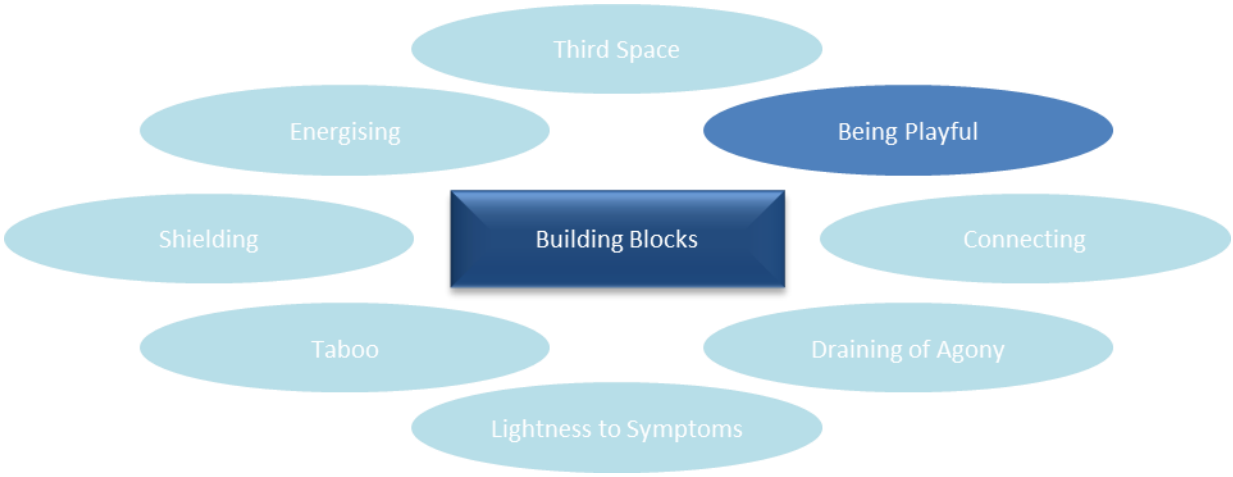
3.2.3. Deconstructing

Participants believed humour worked with psychosis to deconstruct beliefs clients held about themselves or others, or to disrupt ideas held about their symptoms or therapy more generally. Participants had experiences where humour had been an effective way to break down the idea of normalcy. In fact, humour seemed to be able to deconstruct the very idea of therapy and the obsession with sense-making in therapy, as Katie said:

If there's also the idea that the world kind of absurd and impossible and paradoxical and full of things that don't add up then yeah… it might be a kinder way to work

(K13:19-21)

Katie's description echoed what emerged from other accounts, where humour seemed to lampoon ideas around 'mental hygiene' and this misnomer that individuals can have tidy minds which are free from pain. She talked about emphasising the 'absurdity of life', a theme I shall return to later. With this third space comes the ability to think about one's predicament in a new way and potentially be playful with it, as described below.



3.3. Being Playful

Many of the clinical examples that participants retold were indeed humorous, but another defining feature of them was the way they introduced play into the therapy. Rather than using side-splitting humour, therapists described a more subtle form of humour that involved playing with ideas and language; using metaphors; playing with material by exaggerating it and comparing and contrasting. Therapists described distorting material and highlighting the element of the ridiculous; by doing so, therapists opened up a less rigid and more creative space showing old material in a new light. Chris described it:

> *Within therapy its play is the creative space, a creative place to be in, rather than being stuck and stuck in a problem. I think humour may be a pathway to facilitating that more playful mode of possibility and non-fixedness whatever the opposite would be*
>
> **(C17:21-24)**

Three subthemes emerged as ways in which play could be introduced into therapy with clients experiencing psychosis; the first of which was through the use of metaphors.

3.3.1. Using Metaphors

Participants frequently described using humorous metaphors in their work to help clients describe a certain situation, symptom or emotion they were experiencing. Therapists described using metaphors that clients brought to help enter their world. By extending and expanding these metaphors with humour, therapists described being able explore and talk about things in a way that clients were not able to do before by staying within their realm of experience.

Philip described a moment where a client used the metaphor of being stuck, as though in quicksand, and how she wanted to be rescued by a Tarzan-like figure. Philip was able to elaborate on this metaphor, asking her to imagine him in a Tarzan outfit to enable a light conversation about what therapy might entail. By doing so, Philip was able to understand some of the expectations the client had about therapy. A secondary function was that it introduced self-deprecating humour, thereby helping to build a rapport as previously mentioned in the sub-theme 'Being Human'. Alongside playing with metaphors was the idea of playing with material by comparing and contrasting, as the next section explains.

3.3.2. Comparing and Contrasting

Another way that play was characterised by participants was how it could loosen the conviction behind a delusion by helping the client to compare and contrast their delusion with what the reality might be. Please see Figure 10 for an extended quote where James explains how he compared and contrasted a delusional belief to help reduce a client's certainty he was being stalked in a 'Bourne Identity' style operation:

An Extended Extract…

[There] was a guy on a secure ward, he was locked up and very agoraphobic, very scared about going out. A diagnosis of paranoid schizophrenia as well, so part of my work was trying to see if he could go out more… and one of the main obstacles was that with him, he was convinced that there was a van parked around the corner from the unit that was full with people from the past from when he used to take a lot of crack and they were after him because they knew he had a lot of money…He didn't have a lot of money but we put that to one side. So we spent a bit of time thinking about how this would be organised because he liked things like the 'Bourne Identity' and stuff like that.

'How do you expect these people to be?'

'What would they have to do?'

'What sort of equipment would they use in the van?'

'How do you they change over and keep an eye on you?'

Pointing out all of their qualities and then sort of saying to him: 'Who are these people?'

Client: 'Well all the people I used to hang around with when I was a crack head'.

'So what were their qualities? What were your qualities when you were a crack head?' And then just compared and contrasted. It was very funny because obviously you don't expect complete crack heads to be manning a Bourne Identity type security operation.

I: when you think about it, you think probably not!

James: It really didn't work and this guy could see that and we were both really laughing about it. Waking up, scrabbling around the flat for a piece of gauze that might have a piece of crack on it to desperately get into your system and you haven't washed or used the bathroom and all sorts and then you're supposed to be…

I: A Matt Damon lookalike.

James: in the van ready for him to come out of the unit to be abducted and it made us both laugh because it was so stupid and he said 'well actually it's not really real is it? I'm being daft.' So I said 'well let's go and see' and so we did and went round the corner and there was no van there at all

I: So I guess he was still a bit cautious there was something out there

James: you could see it in his mind but we thought strike while the iron is hot, you know - let's go! And see what happens and so we built up to going out more and more each day. But it was quite a powerful event because it got him out and about, out of the unit quite regularly after that

Later James continues:

How would you go about reducing a belief that seems pretty delusional? I mean why would they want to abduct a guy on benefits from a MSU really? So if you think well there's no logic behind this, how are you going to start unpicking this? If you don't unpick it, he's not going out. Because he was genuinely scared so it was only through going through the clear items and details of what would be needed and then contrasting it. I think it's the contrast again; I guess this is how people say jokes work, don't they? They build up a particular thing and then pull the rug out…

(In unison) from under your feet!

(J8:18-10:13)

Figure 10. An Extended Extract of 'Comparing And Contrasting'

This example worked by broadening the difference between the belief and reality; the contrast became so surreal it made the client's delusion fall down. This in turn seemed to be the energising force which spurred this client to go outside of the unit and challenge his fear, a theme that I shall elaborate on later. The way this humour worked was to create some change and this was a theme that emerged elsewhere in the interviews.

3.3.3. Changing the Relationship

Participants' accounts were full of examples where humour worked with clients with psychosis to help address the power imbalance often found with voices. Clients frequently describe hearing voices that are omnipotent, ruling over their life, commenting on whatever they say or do and often being abusive in their content. This can lead to clients having a subjugated relationship to their voices. Participants repeatedly described how using humour helped to reduce their power by personifying them as weak, without ever directly challenging the content or validity of the voices. When experiencing the voice in a different way, through humour, participants felt it opened up the possibility to have a less subjugated role and increase their sense of agency and control. Therapists encouraged clients to play with the quality of their voices, changing the pitch and tone of them to help clients experience their voices in a different way, as Philip described:

> *So we might do an exercise where we might say out loud what the voice is saying and then we might say out loud what the voice is saying in another voice [ ] like a Mickey Mouse voice, or in… this when it becomes a bit Python-esque. I had someone say the voices in a way that sounded exactly like Terry Jones, a bit lispy! [ ] So I'm sitting there appreciating this sort of: 'Oh no you're not!' (In a high pitched voice)*
>
> *I: Sounds slightly pantomime?*
>
> *Philip: Yeah! 'He's just a very silly boy!' You know, it had that sort of quality to it [ ] but it worked because the voice was telling him to cut himself. To harm himself and you know, a fair amount of time he resisted the voice but he would resist and the voice would, he would say the voice out loud in this very dark tone and then we would just do it in this way 'Cut yourself! Cut yourself!' (In a high pitched voice)*
>
> *I: Hard to take it seriously*

Philip: I know! And I'm checking in with him about what it's like because it sounds funny but is it actually funny.

I: That's a good point

Philip: and the client was finding it funny and it seemed like through finding it funny and doing this, that there was a bit of a shift in, it transformed it

(P14:11-15:13)

Philip played around carefully with the voices, distorting and exaggerating their qualities humorously. This transformed the relationship the client had with the voice and helped to disempower it, over time rendering it impotent. In another example, James described characterising the voices in a slightly different, yet still humorous way:

Religious ones [voices] can be quite powerful. So recently, we were able to reframe somebody's ones who she thought were angels or God as annoying Jehovah Witnesses who knock on the door and want to come and berate you about issues of the Bible and guilt and that!

I: They are quite persistent. It's quite a good analogy

James: There's a lot of them around x tube! And they do the rounds knocking around here um so that's obviously again something we had in common. How do you resist them? How do you say no to them? What works to get them to go away? What doesn't?

I: Does that work quite well?

James: Yeah, because again, it helps people to see things slightly differently. And in that situation it very much does change the power balance

(J15:11-21)

As James suggested, humour helped to lampoon the voices and change their quality, so rather than being a terrifying religious apparition they became characterised as nagging and bothersome. An alternative yet connected approach is to help reframe a client's experience as outlined below.

3.3.4. Reframing

Reframing refers to using humour to allow clients to step back and view their situation or their symptoms from a different angle. Participants described this in a number of different ways, including 'reframing', 'de-literalising', 'decentring', 'shifting focus', 'diffusing' and 'externalising'. What emerged was a collection of sub-themes that were all connected by the fact that humour allowed clients to observe the activity of their mind.

Gaining distance from symptoms allowed clients to spectate upon their symptoms, rather than being pulled in by them. Sophie gave an example of reframing when she joked with her client that her voices had stopped because they were on holiday:

> *It [humour] is a way of kind of offering a different frame to the experience. So it's a frame that you can control. So I choose to frame this in a different way, in a humorous way, I am controlling and wrapping the experience*

(S2:16-3:2)

Humour appeared to be a good way to reframe clients' voices as less powerful as even they needed a holiday and were not invincible. Indeed, the mechanism of reframing becomes quite obvious when we think that the very way humour works is to offer an alternative perspective on life, as James explains:

> *It [humour] is also a big aid to de-centring. What you're wanting your clients to do in CBT is to de-centre, to step outside their own processes and their own world and observe it. Obviously, a lot of humour relies on that. It relies on us seeing ourselves from another angle and catching something funny in that*

(J2:20-22)

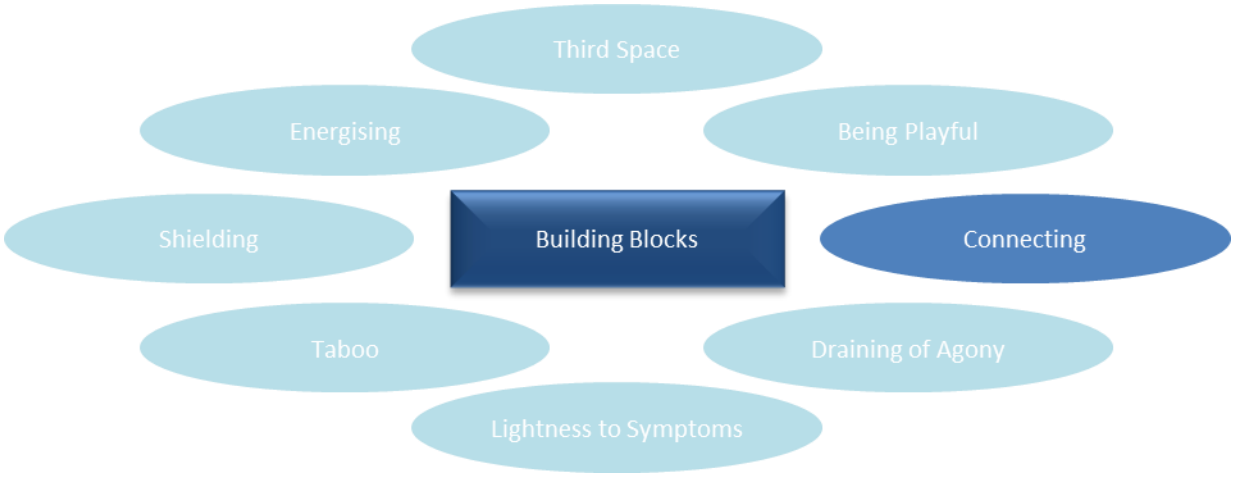
Others described humour as working in a slightly different way, by making the problem lie outside of the person. This appeared to work by externalising the issue, allowing the client to gain some distance from their experiences. Again, coming back to metaphors, Chris developed a metaphor with his client of Cinderella's ugly sisters for the shame and self-criticism associated with psychosis. Chris postulated its use as:

> *I think it's a bit of a defusion process, a bit of ACT. You are externalising something um and you're defusing power from it, power of control over the person and just …and just the kind of visceral connection that person has to those negative thoughts. First the process of externalising is useful you know,*

broadening the difference between that and the person but then externalising it away which kind of puts the self-critical part up for taking some power away through humour

(C5:9-15)

This seems to be a similar mechanism to how James's example of Jehovah's witnesses worked. In both examples, humour wrapped the experience up in a different way, taking the edge of anxiety and confusion away for long enough so that the client could look at it with a different lens. Whilst humour was described as being able to lambast symptoms and pull things apart, in other instances, it was also experienced as a connecting force bringing the therapist and client together.



3.4. Connecting

Just as it was mentioned earlier that a good rapport was needed before humour was used in therapy with psychosis, therapists said that humour could also further rapport. Humour was described as a 'connecting force' that brought relationships closer together because it provided a commonality between therapist and client; laughing together about something was felt to be collaborative and cohesive. Mark described humour as:

> *I think it [humour] can be a bridge but it can also be a sign that there is a bridge already*

(M3:16-20)

Later on Mark continues:

> *There's something about humour which is saying 'I like you enough, I know that we share this element of humour enough that we will both find this funny' so that's quite a nice thing, it's not just funny but it's also saying something about your relationship with that person*

(M12:20-13:2)

Laughing together, as Mark described, allowed clients to feel understood and connected. Humour provided an emotional experience for the client, which was vital as it provided an experience above and beyond just working at an intellectual or cognitive level. Angela described it as:

> *I think that therapy is all about human connection and I think that's the most important element of the work is the human connection*

I: Without doubt, I guess there will be very little therapeutic change that will occur if we haven't created those core…

Angela: Yes and if it's too intellectual, people switch off. They're not very interested they think 'I don't want to listen, I don't want to you know, think too much' because that takes people away from their feelings and humour is a very direct, it has direct access to feelings

(A23:15 - 23)

Angela's account demonstrates how humour might be used to allow for a 'moment of meeting' where the work moves away from being intellectual to being relational. There were a number of different forms of connecting that participants described that I shall elaborate on in the following sections.

3.4.1 Meeting Clients

Participants described a different way in which humour allowed a connection with clients, by being able 'to join them in their madness', providing a way in which we can meet our clients more fully. Richard described this meeting whilst having a particularly off-the-wall conversation with a client and how this helped forge a connection:

Almost placing yourself in that world. [] and a permission to be mad, not in a mental health way but permission not to be all 'duh' [Pulls a face of looking very serious]. I think what humour does is, it allows… more flexibility about what it means to be illogical and inconsistence and chronological. And so if I can be a bit sort of free-associative, sometimes in a humorous way and sometimes not that makes it also okay. I can meet you there. It's that Rumi poem: 'Out there beyond ideas of right doing and wrong doing there's a field. I'll meet you there.' And it's sort of sometimes for me humour allows you to meet at that place. Beyond client and therapist, beyond healthy and not

(R21:21-22:11)

In the process of meeting the client through humour, Richard was also able to deconstruct what it meant to have a mental illness, linking to the focused code of 'Deconstructing'. Richard described having a moment of meeting with a client and there was something curative about laughing together. This idea of meeting clients more fully was echoed throughout the interviews and it emerged that doing so helped to build a rapport with clients.

Participants not only spoke about meeting clients and the rapport this formed but also how humour could demonstrate to clients that therapists were reaching out to their different sides, seeing them as more than just 'unwell'.

3.4.2. 'It's Not All You Are'

Participants stated that just as we bring ourselves fully to the session, so too should we attend to the 'wholeness' of a client. Several participants spoke about working with the 'unwell aspects' of the client but, at the same time, appreciating that there are many other sides to them that should be reached out to as well. Philip described needing to work with the whole client and the full range of emotions they have:

> *I work with whole human beings and what's interesting is well, human beings, yes they get very sad about things, they also find things funny. Many of them. And so, err; yeah shouldn't it be that if I am working with a whole human being that if it's appropriate then finding things funny is one of the things we do?*

(P19:5-9)

This idea of working with the whole person is elaborated on by Richard, who gave an example of how and why he joked to a client with psychosis about their self-harming:

> *I hope that what she experienced is that, yes this [self-harm] is serious, but it's not necessarily hopeless. This isn't the whole world, it doesn't mean it's not important but it's not all there is to you and all there is to what's going on*

(R7:10-12)

What emerged from these examples was that by opening up the range of emotions within a session, the client might experience themselves differently, for example, being more than a client who self-harms. Just as participants described being able to deepen their connection through humour with their clients, so too could it provide an opportunity to mirror their clients.

3.4.3. Mirroring

Participants spoke about the function that humour served in terms of mirroring their clients. They described how sharing a joke or laughing with their client was important as it demonstrated attunement to the client's emotional state and an ability to stay alongside their

mood. Participants described this mirroring as creating intimacy and containment. Angela explained why she felt responding to a client's humour was important:

> *To respond to his humour felt quite important in terms of concrete mirroring of how he was relating to me. Um… I very much felt there was something about, in the transference relationship, that he had this great need to be understood and held by me and he would bring me things that he had done in the past last drawings, its… he was very artistic at drawings. He had written a lot of poetry and it felt really important that I take this very seriously but at times he would tell anecdotes and I kind of sensed, I wasn't sure if they were jokes or anecdotes… how humorous were they meant to be so I felt that I needed to be very attuned to whatever he was presenting in his feelings*

(A1:22 -2:8)

This mirroring was deemed vital to working with psychosis because:

> *Mirroring provides a type of reparation, it's almost as if you're bringing them back to something very very basic and human about being held and contained by another human-being. So if you are able to stay with the mood of the patient and contain the mood of the patient you are providing the kind of early containment that should have been provided or was probably, partially provided between mother and infant*

(A8:1-5)

Angela's extracts suggested that humour worked as it provided an experience of mirroring and early containment for clients with psychosis who may have had unsettled and fragmented relationships with their primary care-giver. Angela also said that this process of mirroring was quite instinctive, it was a fundamental way of connecting to another person, and without it, therapy could be quite an uncomfortable place. This containment is needed to help make exploration in therapy possible and is linked to the next theme of 'I Can Take It'.

3.4.4. 'I Can Take It'

Participants spoke about demonstrating their ability to contain their clients' emotions to make them feel safe enough in therapy. Humour was a way to show clients the therapist could bear their symptoms. Participants described using humour to show they were not overwhelmed by their symptoms. Richard described it as:

There's something about demonstrating your strength, which isn't about demonstrating your expertise or your power. It's illustrating 'I can hold it; I'm not going to be flooded and overwhelmed by this'

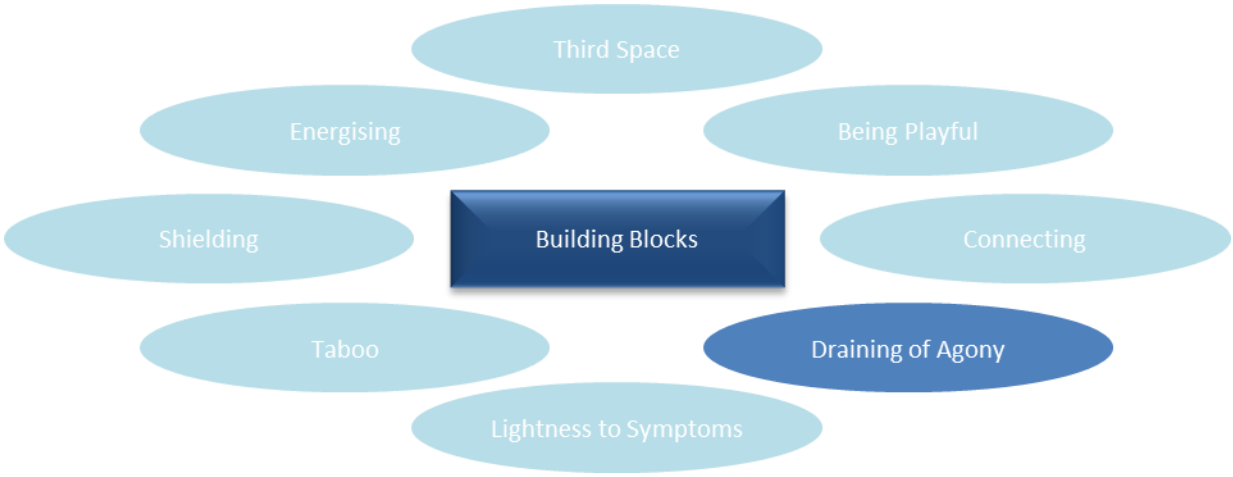
(R17:5-8)

Mark explored the same theme:

A lot of people who work in this area are not afraid by unusual experiences. Quite a lot of people who end up working in the area of psychosis have either had unusual experiences themselves and had friends and relatives who do, umm, or maybe have a high tolerance for novel experiences and also see the humour in them

(M5:7-11)

Using humour demonstrated an ability to bear the client's story and show they were not frightened by their unusual experiences. Participants described how a rapport developed and how this encouraged clients to discuss their symptoms more freely. This theme has a close connection to 'What's It's In Service Of?' as participants described treading a fine line between using humour to show a high tolerance to unusual experiences and being 'misinterpreted' and 'forming a barrier', which I shall come to later.



3.5. Draining of Agony

Participants spoke about the various ways in which humour served to manage or change clients' emotions. Humour was considered a way to gain distance from fears, thereby reducing the emotional intensity felt in sessions. Participants described how humour could be soothing, allowing for the processing of information with less anxiety. Telling a funny story about something painful was described evocatively by Katie as: 'draining it of its agony'. There were two ways that humour could drain agony, as described below.

3.5.1. Managing Intensity

Different therapists talked about the need to 'manage emotional intensity' during their sessions with clients experiencing psychosis. They described using humour as a way of dialling down intensity within sessions, as Richard describes:

> *One of the particular specific ways I use humour at times, is to, what I call, a reduction to manage intensity so I think as therapist, my role is to manage intensity. That means, across the therapeutic process and also within the session… So I have the responsibility towards managing intensity, that doesn't mean I'm reducing intensity, anxiety and intensity is essential for change. But, too much can be overwhelming, and I don't necessarily want to end the session on a high level of intensity*

(R5:20-6:4)

Far from using humour to manage participants' own anxieties (a common perception of using humour in therapy), humour helped to moderate the emotional intensity and make therapy

bearable for the client. As well as moderating emotions, therapists described how humour could help to untie negative emotions from symptoms.

3.5.2. Abolishing Pain

Humour was described poetically as the 'anaesthetic to therapy' because it worked to decouple emotions that became associated with psychotic symptoms. It allowed for the processing of information to occur in a different way: a way that did not include anxiety or shame. Although symptoms did not disappear, participants described how their clients could start to form quite a different relationship with them when humour was involved. Katie described how humour helped a client who had hallucinations of people jumping out of the TV at her:

> *The symptoms can seem so sort of unbearable and you're so kind of persecuted by it and it's such a terrible thing but sometimes people get on quite, sort of, the symptoms don't go away in therapy but they become more jovial about the place that the symptoms has for them and a bit more able to laugh about the symptoms. And it might still be there, very much, but not as something so upsetting… I think with that woman it was definitely that she'd go 'oh that is so silly; it's silly and I don't have to be worried about that now kind of thing'*

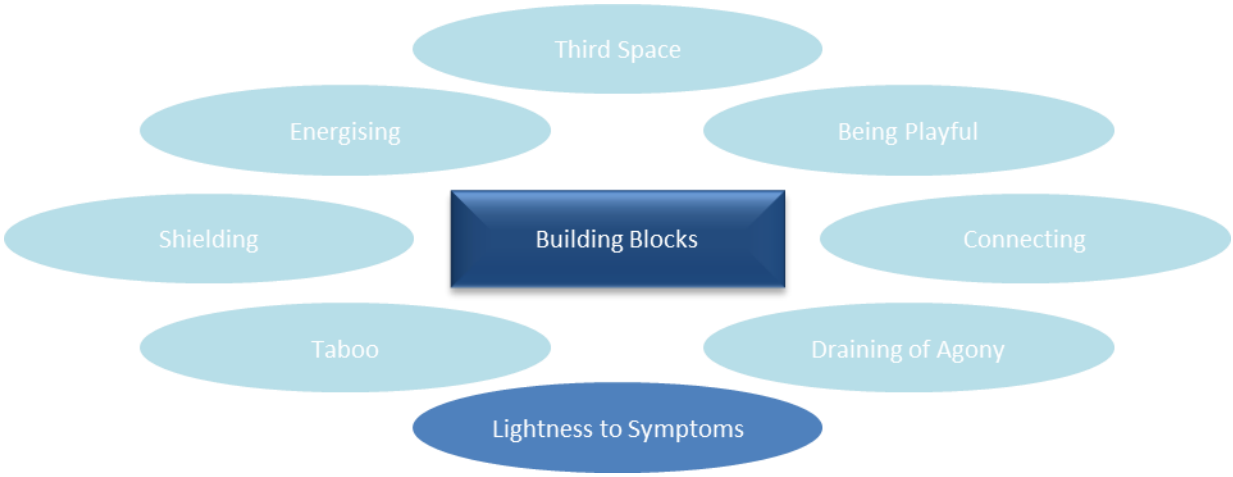
(K19:10-17)

Katie reflected on why reducing some of the anxiety with psychosis was important (compared to working with neurotic clients who use different defence mechanisms), to help to pace sessions and prevent too much terrifying information coming out at once:

> *With psychotic people it's more that stuff might come out in a rush and then we have to stop it being frightening or you have to almost guide them away from it and say "well, everyone's got that!"*

(K5:1-4)

Participants frequently spoke about using humour to reduce the terror clients experienced in relation to their symptoms. Humour helped to reduce the anguish clients felt by changing the relationship they had to the symptoms, linking back to the theme 'Changing the Relationship'. Another way that humour worked, in a similar vein, was by providing an element of lightness to experiences.



3.6. Lightness to Symptoms

Participants described the types of humour they used when working with psychosis with some forms of humour being off-limits, such as mocking or belittling clients, or using any humour that reinforced a power dynamic to stigmatise clients. There were certain types of humour that repeatedly emerged that would be used, such as using humour in a way that modelled some lightness towards symptoms and life more generally. For example, therapists described using self-deprecating humour about themselves, such as Philip in his Tarzan metaphor, to model a position of lightness and not taking himself too seriously. Below are specific types of lightness that emerged from the data.

3.6.1. Observing Absurdity

Another style of humour that emerged was observing absurdity, just as we have seen before in Katie's quote in 'Deconstructing'. Some participants stated the importance of taking an absurdist stance in their work with psychosis as it encouraged clients to see the silliness and ridiculousness in things, in the most compassionate way. It helped clients to feel less stuck as they could start to play with the absurdity of life. Philip described it like this:

> *It [humour] can throw up absurdities but the person may or may not appreciate them so the interesting thing is whether someone starts to appreciate the absurdities and it's not about again ridiculing them as much as, the move is to put it out here and it's something we are playing with so if humour is about being playful with things that you are not supposed to be playful with or... then that could again be freeing…err…liberating. I talk about it, like it's very strategic but a lot of it is just me drawing upon my own experience and trying to create that*

environment where someone might be more free, and humour might be one way to do it

(P17:6-13)

Angela described the function of absurdity in psychosis as thus:

I: And by pointing out the absurdity, how would that help someone with psychosis?

Angela: It would enable them I think to, sort of differentiate? To what was absurd and what wasn't, I suppose if you could point that out in a meaningful way then I think it would perhaps enable people to gain more insight into the onset of illness and their symptoms… to see it more from an absurd point of view rather than an ill or pathological point of view

(A18:13-17)

Katie described why absurdity and nonsense was important in therapy with psychosis, interlinking with deconstructing beliefs clients might have about coming to therapy to get cured:

I wonder if there's something about not having to understand things because that sort of model of therapy: the person is going to get insight and they're going to know, they going to go through their history, they're going to get it and that's it! Their whole life is going to be explained to them and then their symptoms will be explained and then they go off and live correctly...That mental hygiene kind of thing, awful! And so the bringing in stuff that's ludicrous just sort of throws that off because that's never going to happen…So I suppose that nonsense thing, keeping it there is a really tangible aspect of the work it's really helpful

(K11:19-12:4)

These quotes suggest there is something inevitable about life being absurd and full of weird and wonderful paradoxes. This is an essential part of being human, and the loss of laughter and play is often part of psychological distress, so bringing it back through being absurd could be helpful. Also, keeping nonsense in the work and not needing to understand everything parallels psychotic experiences which are hard to understand. If you can model a more fluid way of relating and reducing the terrible anxiety of understanding symptoms, it

could stop things getting so stuck. Participants felt that humour could give a place for the symptom to exist and this might give more alleviation than getting caught in a battle trying to dismantle it or get rid of it.

3.6.2. Introducing Levity

Participants described their experiences of using humour in psychosis as having the quality of 'levity'. Using humour in sessions allowed participants to introduce a different tone by bringing in lightness to the work. Participants stressed that this levity was not used in a way to keep material light and breezy to avoid difficult topics or emotions. However, they felt that bringing levity to sessions allowed for a flexibility or lightness to the topic that might not have been felt before, as Philip described:

> *Maybe [it is] helping them find levity where it can be, for me. Because I just think, that that might open doors or at least that provides more of a spectrum of experience than when you work with people and they come and they talk with you and they present this spectrum of their experience which is pretty narrow… but if they have a skill at humour, then it might be about drawing upon that skill and maybe even suggesting 'you know, you could approach even maybe some of your problems in a way that involves your sense of humour'*

(P21:5-13)

This might allow for a freedom in thinking towards an experience or an emotion, encouraging a sense of choice in how to be and help clients to develop a flexible relationship to a situation. Katie pointed out that a painful experience will often have humour in it and finding that humour might bring some lightness or relief:

> *You do sometimes see those things where somebody is really really upset and then they'll find something incredibly funny in the thing that they're upset about and that is really alleviating and I mean it's weird the way the two things just definitely can have a place together and it's not that you know that if there's too much humour then you can't be serious*

(K16:9-13)

Participants felt that finding the pathos in the situation, almost a gallows humour, could be soothing to clients. It introduced a different tone: of being absurd, weird or illogical, which,

in turn, might make it possible for a range of emotions to be expressed. Just as humour allows us to feel differently, maybe it can allow us to talk differently too.

3.6.3. Floating an Idea

A further way that participants thought humour worked with clients experiencing psychosis was that it was a way of floating an idea out to a client or planting a seed of a new idea. This overlaps with the code described later of 'Saying the Unsayable'; 'Floating an Idea' pertains to the way a therapist can say something that cannot be said, the latter code referring to the client. Richard describes an example of this:

> *Sometimes with humour it's a very powerful way of sowing the seeds. Sometimes it's saying it and immediately changing the topic and talking about something else but it's been… it's there*
>
> **(R14:16-17)**

This idea of sowing a seed is echoed throughout the interviews, suggesting humour was often used as an effective way of introducing an alternative idea to the client. Humour often made the interventions enigmatic, with its meaning being not entirely clear, forcing the client to think about what it was or what it meant. Humour has scope to open things up rather than shut them down and is not constrained to producing a defined meaning to something.

3.6.4. Normalising

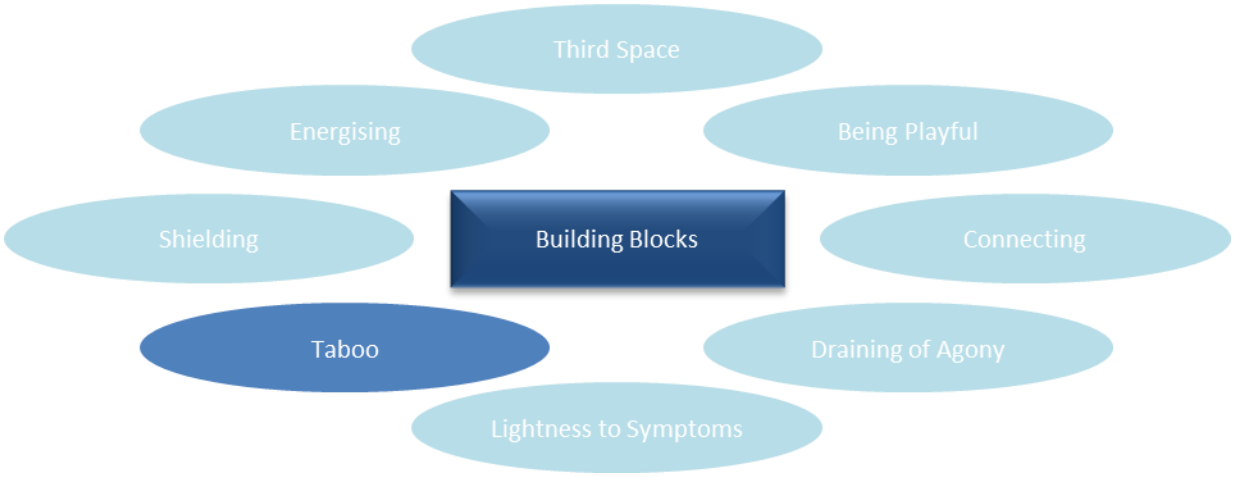
Just as humour was described as a 'leveller' between client and therapist, it was also seen as a way to normalise the difficulties that clients with psychosis were facing without invalidating them. Richard described how normalising in therapy is integral to his work with psychosis, showing again how this interlinks with the focused code of 'Deconstructing'. In this example, Richard's client:

> *It [humour] is also normalising… the family members were sitting there. Part of her experience was that she always felt the odd out in this family. So the family, really to me, don't look crazy - mental health crazy. They had a very peculiar ways of doing things. Which is lovely, that's them. Hearing all these stories I remember saying something along the lines of 'I understand now why you are so mad, because with this family it's surprising you're still here!' (Laughter)*
>
> *I: And how did that go down?*

R: They laughed well… the family laughed. It was still an acknowledgement that 'we are a bit strange perhaps!' But I'm not saying : 'you are mad, mentally ill' but 'yeah you are different'. But that doesn't mean there is something wrong with you

(R15:15-16:12)

In contrast to this experience of lightness that humour bought to sessions, participants also described quite an opposite experience. They described what a dark and subversive streak humour had, as described in the following section.



3.7. Taboo

Participants' experiences of using humour in psychosis included the feeling that what they were doing was taboo. They felt that it was something that was not discussed amongst colleagues, not focused on in training and, thus, there felt something 'underground' about it, as though it was something they should not be doing in therapy. Participants also commented that often the system they worked in discouraged humour, with risk management and protocols driving out creativity, creating a defensive practice agenda, and this led to an increased perception that humour had no place in therapy.

3.7.1. Transgressive

Within this theme of taboo, certain different forms of it were experienced. Some participants described using humour in psychosis as transgressive; that in some way it went beyond the boundaries of what is usually considered the 'done thing' in therapy. Philip described it like this:

> *You don't get trained to use humour in therapy, so there's something maybe err… that might be a bit transgressive about doing it. It's interesting you're doing this research study because it's like, how much do mental health professionals or people who work psychotherapeutically talk about using humour? I can imagine that people will think, well humour is just a defence mechanism, it's all about lightness and you can't really go there with anything and that may well be the case. Um, it's completely context dependent*

(P18:13-19)

Philip voiced the views of many participants that because humour was not discussed or incorporated into training, it has the quality of being 'off-limits' and it felt subversive. However, on further exploration, this was not deemed to be an entirely unhelpful attribute of humour when working with psychosis. Indeed, Mark suggested there was an important relationship between the two:

> *That's what makes psychotic experiences kind of crazy, scary, because they're that taboo breaking thing. And you could say that's sort of what humour does; humour is quite often about breaching cultural taboos and pointing out social rules, pointing to how situations that look normal are actually a bit crazy and erm, and also pointing to the kind of craziness of everyday life. So I think broader from it being a technique, to there being something quite interesting between the relationship between humour and psychosis*

(M11:16-22)

This suggests humour serves an important function when working with psychosis because it taps into, and elaborates on, a creative and imaginative process that is already at play in psychosis. Humour could be a way to mirror a process at work, and by using it, help to open doors to topics through humour.

3.7.2. Saying the Unsayable

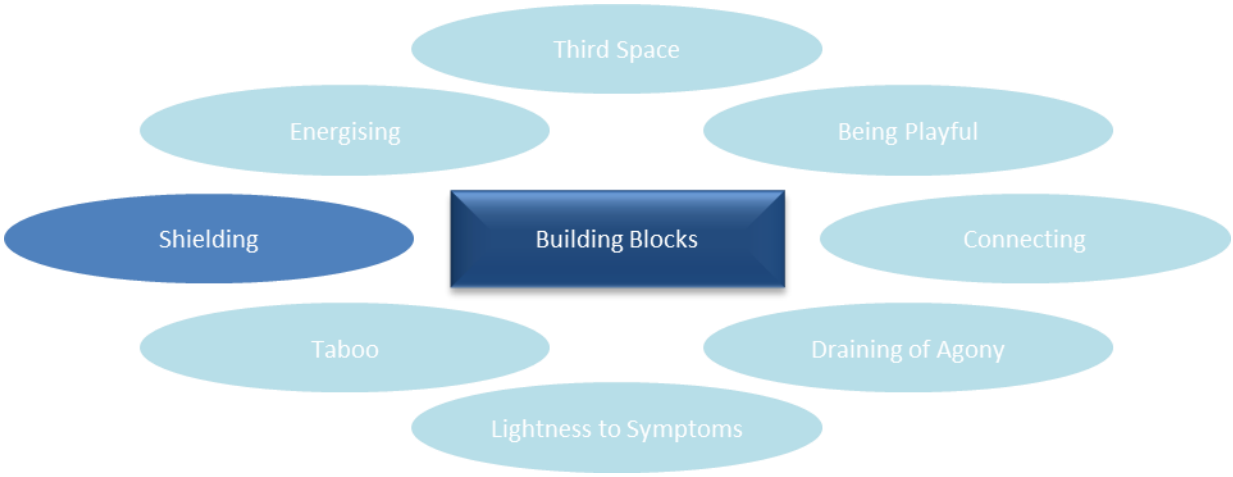
Participants hypothesised how using humour in psychosis might have worked from the client's perspective. A common theme throughout was the idea of 'Saying the Unsayable', such as indirectly communicating one's needs or approaching difficult topics; in essence, to mention the unmentionable. For example, in Angela's women's group, it allowed for the discussion of very raw topics and traumatic incidents. Sophie described how using humour in psychosis might be a helpful way to communicate to others:

> *I'm wondering if it could help also people to share their experience with other people. Some people find it so difficult to talk about distressing experiences to parents, friends, whether it might be helpful for people to talk about their experience in a way that it doesn't undermine the distress of the traumatic experience but its skirting around and using a witticism to make it more approachable. 'This is what is happening to me but hey I'm controlling this'*

(S3:8-13)

Sophie suggested that humour transformed material to make it more manageable for the client, allowing an expression of their anxiety. Clients often do not want to talk to people about their bizarre experiences and this is a way for them to exert more control over how they feel, so it is less threatening to themselves and to others.

Angela described humour as a sophisticated way to communicate to others; it was an 'offering' that made material more approachable for other people. Philip noted that his client's humorous question 'are you going to be like Tarzan and swing in and rescue me?' was a way of checking if he cared or not. Making something humorous helps people to connect with others; it invites them to listen and to gain empathy. However, participants did also voice concerns over how humour could work in quite an opposite way to this, by shielding clients from the help they need.



3.8. Shielding

Participants all acknowledged the significant drawbacks to using humour with clients experiencing psychosis, discussing myriad reasons why it might be unwise and inappropriate. Participants wondered whether clients' use of humour was a way of avoiding painful material. Conversely, participants felt their own use of humour might make the tone of sessions too light and chatty and would prevent clients from bringing difficult topics; there needed to be a place for difficult feelings to be discussed. Participants said therapy was not about always about being serious, but using humour needed to be carefully considered as too much of it might indicate that something was being avoided or left unsaid. Angela said she would be unlikely to instigate humour in therapy but if a client brought it in then, if appropriate she would consider laughing along with them. However, she felt that were it was important to interpret instances of humour and Chris said he would check to see how it felt to laugh together.

It was also considered that humour might be misconstrued as laughing at or mocking clients. In a client group that is known to have high levels of bullying and social anxiety, participants stated adamantly that humour should not be used to further stigmatise clients or undermine their terrifying experiences as Mark persuasively argued:

> *No - I quite like taking the mickey out of other people but they either need to be the same power or with more power. I don't really find it funny taking the mickey out of people with less power than me, that's just another instrument of power isn't it?*

(M14:12-15)

Therapists described different ways in which humour could impede therapy that I shall explore below.

3.8.1. Masking Pain

Within the theme of 'Shielding' it became apparent from the interviews that there were a number of different ways that humour could block or hinder therapy. Firstly, participants reflected on why a client might be using humour in therapy and some said it might be a defence mechanism used to diminish the severity of feelings and mask their pain. Chris explained what he would do if a client used humour quite defensively:

> *So if I felt it was a rapid quick-fire delivery I might wonder. If that was from the start I might be thinking, well: 'I've noticed that when we're meeting we, you know, there's lots of laughter in the room' and I'd probably try to process that and wonder with the person about what maybe isn't getting talked about*

(C10:5-8)

Not only could humour be used to mask pain, it could also prevent clients getting the help they need, as Sophie argued (although, interestingly, contradicting her earlier point that it could aid clients in getting help, thus showing the vacillation of therapists' opinions and experiences):

> *If you use humour all the time, it maybe because you are too scared of being accepted and the only way that people talk about their experiences is by making other people laugh. But that might deny them the support and other people might think 'well he's not that distressed or she's not that distressed because he is laughing about it'. But it might be a mask as well so I think if you are using humour all the time then it might be masking what is going on underneath, and how traumatic the experience, the psychotic experience is*

(S4:17-5:3)

Although many described humour as a natural defence, Sophie highlighted the point of not letting humour become an avoidance technique where it can be used to mask the terror and trauma of experiencing psychosis. In both examples, it seemed that humour could be a way to avoid contact with the therapist and used to laugh things off. Angela emphasised looking behind the laughter, behind the defence, as the function of humour might not be helping the

client. They may only be ridiculing themselves or protecting other people, rather than actually getting the help and support they desperately need. Participants also spoke about how their own use of humour could form a barrier and how this could be detrimental to therapy.

3.8.2. Forming a Barrier

Some participants felt that rather than furthering therapy, humour could actually become a significant barrier in the work by alienating the client. Working with clients with high levels of paranoia meant there was the risk that clients could to take the humour in the wrong way (as we saw right back in the first quote of the findings from Sophie). Angela succinctly states how humour could go wrong:

> *The risk of the therapist bringing humour is that people can feel humiliated; you know laughter has that side of laughing at somebody*

(A8:19 -20)

Sarcasm, and humour of that ilk, was described as a high-risk strategy as it was easy to offend or alienate the client. The humour could be misconstrued as the therapist taking the client's symptoms in a light-hearted way or worse: mocking them. Even laughing inadvertently to a client's joke can have repercussions, as Katie described:

> *I once laughed at someone's self-deprecating joke and they were so upset - it was properly witty of them you, but they just didn't want to be laughed at*

(K10:16-17)

Laughing or joking with a client in this way could make them feel more paranoid or insecure. Therefore, what emerged was the importance of knowing when humour would be inappropriate, such as when clients are very disturbed or behaving in a way that is funny to other people but there is not a shared reality. Joking in this way would only serve to reinforce the power dynamic between client and therapist that Mark said was crucial not to amplify. Related to this theme was the emerging theme of 'Misinterpretation'.

3.8.3. Misinterpretation

There was a theme of being circumspect about using humour as participants frequently described it as being a 'play on words' and that this could become problematic. Jokes are often about play with the meaning of words, double-entendres and taking advantage of the complexity of the English language. Participants worried that not only might clients be

feeling paranoid, but their thought processes could be quite muddled; therefore, humour could be misinterpreted and become an obstacle in the work. Angela said it was difficult to know how humour would be received and Mark and Philip both said that clients could take things literally as clients sometimes have quite concrete thought processes.

Indeed, it is not only that thinking can become concrete, but a client's whole relationship to language could change. Mark explained why playing with language might be difficult with psychosis, using the example of the musician Sid Barrett of Pink Floyd fame:

> *He [Sid] was out of it in terms of psychosis, and he, there's some kind of thing that he keeps on saying: 'what makes a joke funny?' And it's quite striking, because it's just the kind of thing that somebody might say when they are psychotic. You know, when you've lost, when you're really really out of it and you've lost the connection between words and meaning and so that's again why humour might be a tricky thing because somebody might not get why something is funny anymore*

(M29:1-7)

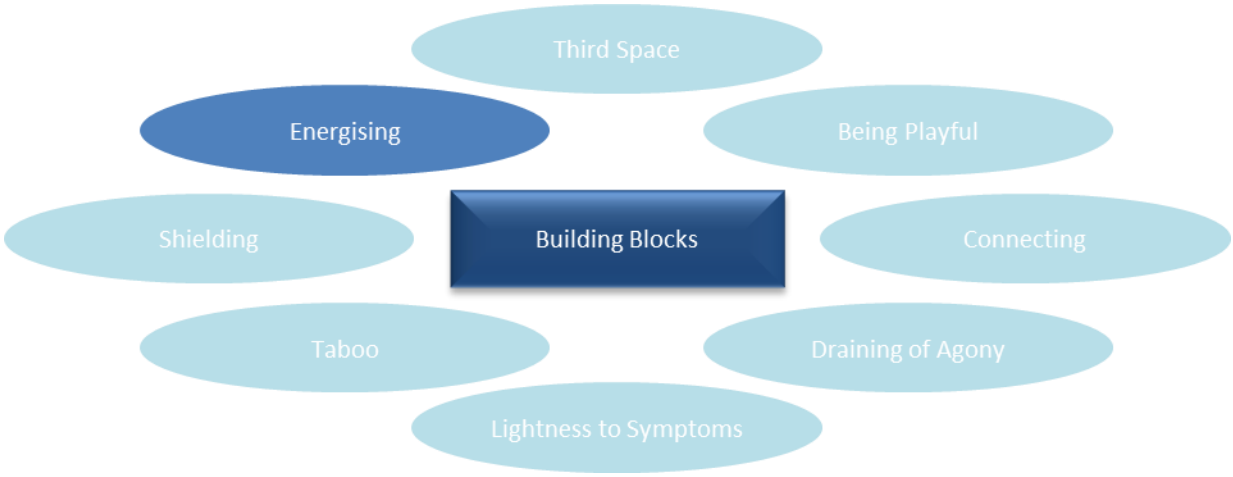
On a related note, what emerged from the data was that types of humour were seen as being culturally loaded and this was another reason that humour was open to being misinterpreted, as Mark explained:

> *I guess also, you could be thinking about London context as well, particularly there's such a lot of cultural diversity as well and I guess it's also getting to know different kinds of humour within different cultural groups and also ensuring you're humour isn't particularly culturally loaded that somebodies going to get it really*

(M22:6-9)

Where there is a range of cultural diversity, it is important to know one's humour is not culturally loaded and that the client is going to understand it. For example, in some cultures, humour is quite banterous, meaning that it is witty but with an undertone of ribbing the other person, or as Sophie described, in her culture things are taken in a more light-hearted way, but this is not the case in other cultures. Therefore, some types of humour might be misconstrued by somebody from a different culture.

In essence, what emerged within the realms of ‘Shielding’ was the concern that humour could be misunderstood by clients experiencing psychosis and that the worst outcome would be the client feeling they are being mocked or laughed at. The fear was that this could then lead to irreparable damage and this would just replicate a well-trodden path of the client feeling marginalised and cut off from others. Interestingly, apart from Katie’s example, none of the participants could remember any examples of humorous moments not working in therapy or being badly received. This may have been a selective recall bias at play, but it could show how humour more often than not has a beneficial effect. It might also be down to the judgement of the participants, i.e. they only used humour in appropriate circumstances when key ‘Building Blocks’ had been considered. One final theme that emerged was ‘Energising’, as described below.



3.9. Energising

Participants described how their experiences of using humour had the quality of adding vitality to sessions, helping to convey a message and add energy to often quite heavy material. Humour helped to energise therapy and, in some cases, to effect change; as with James' example, humour galvanised his client caught up in the Bourne Identity operation to get out of the unit to test his delusion. There were a number of ways that energy appeared to have a role within humour and psychosis, as outlined below.

3.9.1. Conveying a Message

Participants described using humour to help make the work with the client more accessible and engaging. Humour was used deliberately to make the work lighter and funnier so that new ideas become more memorable. Philip described how he used humour to help engage his clients experiencing psychosis within group work:

> *In our groups, they have they have a spirit of, what we think is fun, we will have little cartoons and present things in a fairly light way, um and the idea there is to make it accessible to people um and that maybe that if there is a sense of humour involved it is more memorable as well. The idea of it, is not necessarily for our group sessions to be completely light and breezy and not to feel anything but it's just that's a way to maybe, yeah making the more material something that people might start to approach*
>
> **(P6:7-13)**

Chris described how he thought humour could be used to help make specific instances more memorable:

> *I think humour is almost like a cognitive marker, a flashbulb experience. So we are in a room and we are sharing a metaphor which is for me, the ones that work, are unforgettable and then I think that humour would be the same thing*

(C5:23-6:2)

Attaching a humorous image to an event made it more charged and alive. Humour could make the work more evocative and, at times, provocative, which helped to engage clients.

Humour was also described as a way in which clients could develop new ways of seeing and relating to themselves. Clients who developed quite rigid and narrow views of themselves could be encouraged to develop alternative, more empowering, views. The success of these views was dramatically improved if humour was one component, as Mark said:

> *Yeah, and you're trying to get a richer, more layered story, and a more interesting story is one that has different perspectives in, different layers in it. So a monologue is less interesting that a dialogue. So, I guess, humour can be one of those other things, you know, where you're finding an alternative, funny perspective*

(M27:4-7)

This suggests humour can mean tapping into a new story, rather than the story that has been told many times before about being a 'schizophrenic'. If the alternative views created by the client become richer and more compelling, they are more likely to become the dominant and memorable story. What also emerged from interviews was how humour could be used with a broader import to convey a message outside of the therapy room, when campaigning about mental health at a societal level. Conveying a message charismatically can be an effective way to get people to engage both inside and outside of therapy.

3.9.2. Releasing Energy

In contrast to the above descriptions of giving energy to sessions, participants also described how they felt there was a 'release of tension' and a sense of relief that came about through humour. Katie described how joking allowed for the 'communication of the unsayable', as discussed previously, but how it also released energy:

Because you know in Freud's theory of jokes there's this thing of the unconscious umm being give an outlet in a very nice codified way so a joke is a bit like a dream – that it comes out in this other form and so its bearable and palatable but it's still given some sort of air time that you think it's an unacceptable idea and that's why it's so satisfying and nice you laugh because it's a relief

(K3:25-4:1)

Humour was described as being like a pressure valve release and this links to an observation Angela made about the physical release of serotonin that comes with laughter. This release of energy relates back to the theme 'Observing Absurdity'; if you are able to approach life's difficulties with some humour, there can be something freeing about it. Just as humour became a way to expel energy, it also became apparent that humour could be used as a way to build up a barrier, as discussed in 'Shielding'.

Aside from the themes that emerged from the interviews, there was the equally important aspect of the process that occurred. By this I mean all the parts of the interview that are not about *what* was said, but pertains to *how* things were said, the physical reactions and tone of the response. How might this play a role in the understanding of humour in psychosis?

3.10. Using Process in Interviews

Re-reading the interviews and in-vivo memos, I noticed when participants appeared a little uncomfortable they often used humour and this usually occurred when they were giving a clinical example. It seemed they were using humour to cover their anxiety and this struck me as a parallel process to what occurs in relation to humour in therapy outside of the interview, i.e. that using humour with psychosis is seen as taboo and off-limits and thus telling me felt subversive too.

I grappled with what to do with this data. I felt participants were laughing because they had just said something taboo, and I could sense it was a defensive, uneasy laugh, but I wondered whether these codes were sufficiently robust as they were my own interpretation and thus not grounded in the data. However, I have sufficient evidence to base these codes in the analysis as these are events that occurred in the interview that were independently observed to keep them as categories. My reading of this process is the only one I have and so to dismiss it as irrelevant would mean relegating valuable data to the dustbin. It is important to amalgamate these into the categories as they were a vital communication that signalled something was

occurring in the interview that could not be articulated. It is the very fact that something cannot be said that is important. What does that tell us about what it is like to use humour with psychosis? One answer is that it is complicated and fraught with a dance between risk-taking (using humour) and anxiety (justifying its uses).

Throughout the interviews, I was aware of a dance not only between themes but between varying views of using humour in psychosis. I noticed that participants often moved from sharing experiences to justifying them quickly. This might demonstrate the conflict that is felt outside of these interviews for clinicians; they felt that there is something off-limits about sharing these experiences amongst professionals and that it must be justified. Below is an extract of Sophie's interview where she has just described joking with her client that her voices have gone on holiday. I have underlined her justifications:

> *Sophie: We met she was in good spirits and we met at the coffee shop and um I was asking her about her symptoms and about her voices and she said 'well I haven't had voices for a few days now' and I said 'oh that good'. She said 'I wonder what's happening' and I said 'well maybe because we have been talking about people going on annual leave' and I said 'maybe they have gone on holidays'…and um it was just a sentence but we did both laugh at that. And she said 'I hope they take two weeks leave' and I said 'well yeah I hope they do'. And she said 'they'll come back' and I said 'well maybe they will come back a little bit more rested!'*
>
> *I: Ok*
>
> *Sophie: So that was it. I have, I guess I said that to her because I have, I've know this young woman for two years now and I have a very good relationship with her. And she knows that I know how distressing the voices are so she knows that I am not undermining how traumatic and difficult living with the voices are because it effects all aspects of her life really.*

(S1:18-2:8)

The subtext to Sophie's words imply that she only used humour because she knew the client well and knew she was psychologically robust enough to receive it. This gives an interesting commentary on the subversive label attached to humour with psychosis.

Separate to the process of taboo, I observed that there was a process of 'Synchronicity' in the interviews which occurred specifically around the time of sharing a joke with a participant. I wondered again whether this was a parallel process linking back to the code of 'Connecting'. I observed moments in interviews where I felt very much on the same page and really connected through moments of laughter. When Philip talked about using humour, at one point there was a run of conversation where we finished each other's sentences and we really chuckled together. I felt we shared the same understanding of the event and it gave me a valuable experience of how humour worked to forge a connection between two people. I wondered if there was also an overlap between this synchronicity and 'energising'; sharing a joke was energising and added a certain 'frisson of energy' that Angela described, but it gave a sense of release as one experienced a shared understanding or appreciation of a phenomena. Conversely, it is interesting to remember how different I felt when Richard told a joke about custard and I did not get it. I remember feeling left out and foolish for 'not getting the joke'. Humour clearly has the ability to create quite opposite emotional experiences.

With these emergent themes and process in mind, a diagrammatical presentation has been made that aims to represent the interplay between these themes (please see Figure 11). This hypothetical schematic model proposes two phases to using humour in psychosis. Firstly, there is an awareness of the *building blocks* that therapists must either have, or at least consider, before using humour in therapy with psychosis. Secondly, there are the eight themes of: *Third Space*, *Being Playful*, *Connecting*, *Draining of Agony*, *Lightness to Symptoms*, *Taboo*, *Shielding* and *Energising* that show how therapists experienced using humour in psychosis.

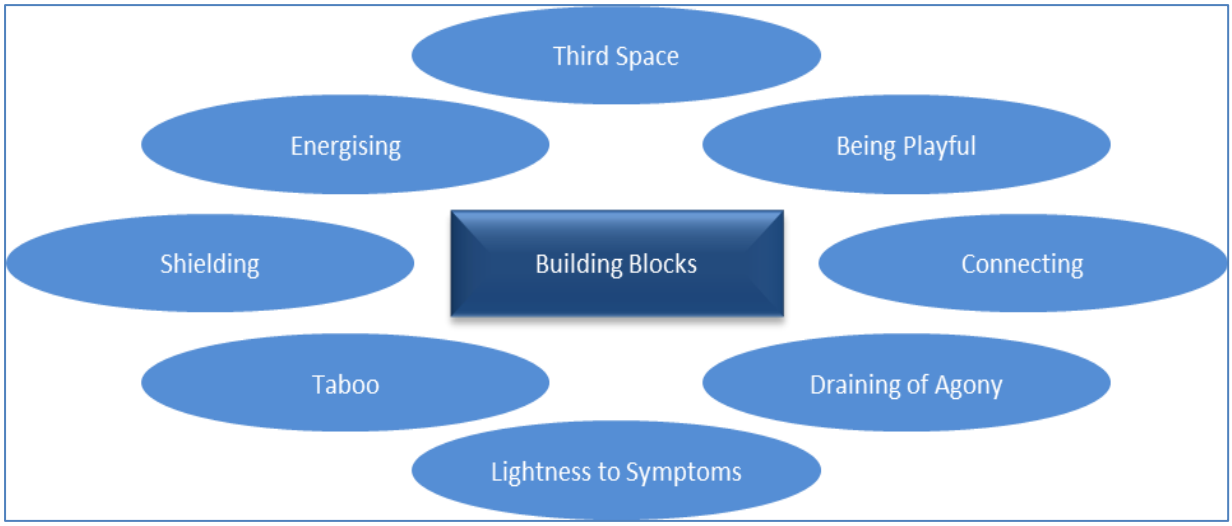


Figure 11. Proposed Schematic Model of How Therapists Experienced Humour With Psychosis

I shall now change the focus, to discuss what these results mean in relation to the literature review in the following discussion. What do these results mean in light of the literature surrounding psychosis and particularly with humour and psychosis? How can these positive experiences of humour with psychosis make sense with some of the pessimistic views of psychosis?

4. Discussion

If you want to tell people the truth, you'd better make them laugh, or they'll kill you

George Bernard Shaw

4.1. Introduction

This study was designed to shed light on how therapists experienced humour when working with psychosis. From reviewing the current literature, I concluded that there was a dearth of research about how humour was experienced with psychosis and, therefore, this study was developed to generate new knowledge. Grounded Theory was selected as the best method to produce an account to describe how humour was experienced with psychosis and I felt its additional focus on what it was like for participants to explain their use of humour to me was also valuable. Eight interviews were conducted and from the qualitative analysis nine main theoretical categories emerged as key dimensions of how humour was experienced with psychosis. A core connecting category of 'Building Blocks' was also identified and was a fundamental pre-requisite to be considered and adhered to before humour could be considered as therapeutically useful with psychosis.

4.2. Overview of the Results

In this discussion, I shall describe how the nine theoretical codes link back to existing theories discussed in the introduction, whilst highlighting new relevant literature in light of the findings. Next, I shall discuss the strengths and limitations of this study, and demonstrate how this study meets the appropriate standards of rigour and credibility that were outlined in the methodology. I shall also offer some final points of reflexivity before considering the implications of this study for the practice of counselling psychology and suggest ideas for future research in this area. Rather than going in turn through each theme and linking it back to the literature, I have organised this discussion around the four finer questions stated in the introduction in relation to the main research question: how is humour experienced by therapists working with psychosis? These were:

- Does humour help to foster a therapeutic alliance?
- Does humour help to facilitate change in the client?
- Does humour hinder the work; is its use inappropriate?

Let us start to consider how these findings answer the first question before answering each of the following questions in turn.

4.3. Does Humour Help to Foster a Therapeutic Alliance?

4.3.1. Building Blocks

Participants felt that using humour helped to build a rapport (supported by both the focused codes of 'Being Human', 'Meeting Clients' and 'It's Not All You Are'). What emerged from the interviews was that humour helped to build a rapport by demonstrating the therapist's humanity and empathy. This way of relating to clients follows the core principles espoused by Carl Rogers of person-centred therapy. He proposed three necessary and sufficient core conditions for therapy: being genuine, offering unconditional positive regard and having a deep empathic understanding. He argued that these core conditions were integral to building a therapeutic relationship of relational depth (Rogers, 1967). Relational depth is described as:

> *a state of profound contact and engagement between two people in which each person is fully real with the other, and able to understand and value the other's experiences at a high level*
>
> **(Mearns & Thorne, 2007, p. 64)**

Humour emerged from the interviews as one way of demonstrating these core conditions. By using humour, therapists demonstrated their genuineness; for example, when using self-deprecating humour, therapists could demonstrate a deep empathic understanding by being able to laugh together with the client in a way that showed they understood their client's predicament. In essence, humour demonstrated the therapist's ability and desire to be real and human. Demonstrating these core conditions also helped the therapist to connect with the real or existential self of the client, rather than the presentational aspects of self (Mearns & Thorne, 2007). Working together with the existential self means having a good rapport, but it is also about relating at a much deeper level and working in relational depth. Mearns and Cooper (Mearns & Cooper, 2005) specifically reference the benefit of therapeutic humour with relational depth:

> *It is amazing how much humour can be involved in work with clients at relational depth. When people cannot lie to each other they can openly acknowledge their*

inadequacies in relation to each other – what better way to mark such a powerful encounter but with humour

(Mearns & Cooper, 2005, p. 95)

As this quote shows, humour has the ability to help individuals relate differently to one another at a deeper level (Lemma, 2000). Relating differently to one another, for example, through the use of humour, creates a qualitatively different type of interaction. It is this difference in interaction that Lemma identifies as being therapeutically useful. She explains that not all psychic changes come about through talking alone, but rather by the way one talks and *how* one talks. Therefore, it is the interaction between the therapist and client, rather than words alone, that can lead to a procedural change. The way we experience 'being-with-others' can start to alter old patterns of being and relating with others are challenged (Lemma, 2003).

Stern et al. wrote a brilliant and illuminating paper about the 'Something More Than Interpretation' in therapy which is apposite here (Stern et al., 1998). Not all knowledge is explicit and declarative; much of our knowledge is implicit (not only how we know how to ride a bike, for instance, but more importantly here, how we know how to be with others). Stern at al. (1998) talk about the importance of the interactional inter-subjective process that occurs between client and therapist in therapy. They describe moments of authentic person-to-person connections which alter the relationship and therefore how the client sees themselves. These moments could come in the form of a well-timed interpretation, or a well-timed humorous remark: 'When a bout of free play evolves into an explosion of mutual laughter' (Stern et al., 1998, p. 907). Humour is a point of 'mutual fittedness' where both parties understand what is going on right here and now. Stern et al. argue that it is these types of interactions in therapy that cause lasting change, rather than a sterile interpretation that, although accurate, will not take root (Stern et al., 1998). Another way we can demonstrate our mutual fittedness is through mirroring.

4.3.2. Mirroring

Participants described the importance of mirroring the client to help them feel contained and understood. For example, if a client used humour, participants felt it was important to respond with humour, rather than remaining neutral or serious. Laughing with a client demonstrates attunement and this is akin to parent-infant interactions (Stern et al., 1998).

Linking back to the literature stated earlier in the introduction, we saw how psychodynamic theories hypothesised that psychosis was due in part to a failure in the caring environment, and, potentially, this was accounted for by a lack of mirroring. Kohut and Wolf (1978) developed this theory by suggesting that psychosis is partly due to biological factors and partly due to a 'total failure' in positive mirroring and optimal frustration. For whatever reasons, there can be a failure in intimacy with mother and child at infancy, which can affect the ability for positive mirroring to take place. Mirroring is one way that intimacy can develop; in intimate moments between mother and baby we see the cooing and smiling that takes place, and it is in this early intimacy of the mother and child playing together where humour is learnt (Lemma, 2000). Thus, mirroring in therapy might become an opportunity to experience what has been absent. There is also neuroimaging data that helps us to understand how humour and mirroring are processed by the brain and the effect they have on the client.

Schore (2010) describes how the attachment mechanism is a right-hemisphere-to-right-hemisphere affective transaction that starts developing as early as 2 years old. This right-brain-to-right-brain connectivity is activated in high affective states, suggesting that the right brain is more involved than the left during emotional situations of implicit information processing, whilst the left hemisphere is more involved in explicit and conscious information processing (Schore, 2010). Often with clients there have been varying levels of misattunement in early infant development, as Kohut and Wolf (1978) allude to, and, thus, therapy can be an opportunity to reattune clients and help build secure attachments. This explains how being attuned to someone's emotional state and reflecting this by mirroring a client (e.g. by laughing with them) might 'hit the mark' more than accessing their left brain through an explicit conscious process of giving an interpretation.

Schore continues this idea by explaining that although the left brain mediates most linguistic behaviours, it is the right brain that deals with the wider aspects of communication, such as cadence, gestures and facial expressions (Schore, 2010). Therefore, if we keep working at a purely cognitive and linguistic level, when we know that sixty per cent of human communication is non-verbal, therapists are missing an entire spectrum of valuable communication channels. Mirroring also provides a sense of containment and this is something I shall discuss further within the research connected to the code 'I Can Take It'.

4.3.3. Normalising

It became apparent from the data that first and foremost, humour was a useful way to 'normalise' clients' experiences and help them to deconstruct the myth of 'mental health'. Gelkopf (2011) talks about the wider benefits of humour in therapy, about how treatment should be less about symptom reduction and more about social integration, quality of life and empowerment. Thus, humour can not only be a therapeutic tool to challenge beliefs, but it can also work more broadly to help clients feel less isolated by allowing them to see that they are not alone in their experiences. This ties back with the earlier literature, which advocates for psychosis to be seen as a continuum (McGovern & Turkington, 2001; van Os, 2003).

4.3.4. Connecting

Another way that humour helped to foster a therapeutic relationship was through the theoretical code of 'Connecting'. It emerged through the focused code of 'It's Not All You Are' that clients could relate differently to others by allowing different sides of themselves to come forward. Returning to the theory of the person-centred approach, the concept of configurations is relevant here. We develop configurations, which are a set of feelings, thoughts and behaviours that pertain to a certain dimension of ourselves (Mearns & Thorne, 2007). A person can have multiple dimensions and different dimensions are in dialogue with one another. I would theorise that someone with psychosis or severe mental distress might feel certain dimensions, such as the 'well and functioning' self, have been diminished whilst the 'ill patient' configuration has taken precedence. Using humour might be one of many ways to help engage the healthy self again. Joking with a therapist, or playing with words and ideas, could help to increase self-esteem by appealing to the part of the self that is mentally agile and engaged with the world rather than just being the sufferer, the passive recipient of therapy.

Kay Redfield Jamison, an eminent psychologist who suffers from bipolar disorder, described in her memoirs *An Unquiet Mind* (1996), how lithium slowly shut these different configurations down until she felt only a shadow of her former self:

> *Each time I had to give up a sport, I had to give up not only the fun of that sport but also that part of myself that I had known as an athlete*
>
> **(Redfield Jamison, 1995, p. 103)**

Appealing to these different configurations is absolutely vital in therapeutic work; it demonstrates a belief for clients' growth and recovery. If these configurations are recognised and nurtured in a supportive environment (humour being one way to foster a warm and empathic environment), then it will encourage what is known as the actualising tendency. The actualising tendency posits that given a nurturing environment, people tend towards a state of growth and the best possible fulfilment of their potential (Mearns & Thorne, 2007).

These findings links back to the Survivor Movement literature, which emphasise the importance of hopeful stories of recovery (Geekie, Randal, Lampshire, & Read, 2012). In my literature review, I could only find a handful of books, such as *Mad Pride: A Celebration of Mad Culture (Curtis et al., 2000),* that give hopeful stories so there is more that could be done to instil hope to clients about recovering from psychosis. Finally, one further theme helps us to answer the question of how humour helps to further the therapeutic relationship and that is through 'Draining of Agony'.

4.3.5. Draining of Agony

Humour emerged as an effective way to manage or temper the therapeutic relationship by 'Managing Intensity', helping to maintain a good therapeutic relationship and therefore making therapy bearable for the client. Moderating the emotional intensity of therapy was important as it kept the session feeling safe enough for the client to be able to stay in therapy and reap the benefits. If emotional intensity is too high, the client might not be able to process information in-session. This links back to Lacan's position that the status of knowledge is far greater in the psychotic structure, thus the power of knowing can become too much and this would be too overwhelming for the client (Fink, 1997).

Gelkopf and Kreitler (1996) advocated humour as a method for reducing 'excessive anxiety' by allowing an emotional outlet and catharsis. Humour is a good mind-relaxing tool to help clients settle into session more and allow them to access more cognitions or emotions that might otherwise remain inaccessible by being neurotically defended (Gelkopf & Kreitler, 1996).

Humour was also an effective way of reducing anguish, emerging from the data in the focused code of 'Abolishing Pain'. Corey (1986, in Saper, 1987) reminds us that 'humour and tragedy are closely linked and that after allowing ourselves to feel some experiences that are painfully tragic, we can also genuinely laugh at how seriously we have taken our

situation' (Saper, 1987, p. 361). This links with the vast tragicomedy literature, showing that there is a place for the serious and tragic to blend with humour. What is evident so far is that humour can help increase the therapeutic rapport between the client and therapist and this is likely to help facilitate change. Let us now consider in what way can humour help to facilitate change in the client.

4.3.6. 'I Can Take It'

As mentioned earlier in answer to the first question, normalising was an effective way of releasing tension and helping to forge a relationship. Another way of demonstrating to clients that their experiences were manageable was through the code 'I Can Take It'. This relates to Bion's concept of a therapist being like a 'container' (Bion, 1962) and Winnicott's idea of 'holding' difficult emotional experiences (Winnicott, 1945). Humour was an effective way of helping clients to see that their experiences were not overwhelming as the participants could hold the pain like a mother holds emotions for a baby. The mother receives, contains and transforms the child's communications and therapy is no different (Lemma, 2003). This holding allows for the unfolding of the client's story, knowing it can be held within safe parameters and then be sensitively dealt with (Lemma, 2003).

4.4. Does Humour Help to Facilitate Change in the Client?

4.4.1. Third Space

One of the theoretical codes that answers this question is 'Third Space' (which included the sub-themes of 'Introducing Difference', 'Jolting' and 'Deconstructing'). Within this theme was the idea of marking out the therapeutic space as different. If therapeutic work becomes a 'social exchange' and too chatty, then we run the risk of the client feeling obliged and unable to discuss what is really on their mind (McCormick, 2000). In all these focused codes, it emerged that humour created a shock and enabled clients to see themselves differently. The central way that this jolt seemed to work was through creating a space to think differently.

Firstly, this relates back to Winnicott's idea of the 'third space', a transitional space that we can mentally play within. Fonagy holds a slightly different interpretation of what 'third space' means; he describes it is as more of a reflective space, where one can think about the activity of the mind and of others' mental activity (Colman, 2007). In both cases, this space is one of imagination. Conscious and unconscious material converges and can be played with, allowing for the emergence of new ideas (Colman, 2007). Interestingly, Colman argues that

this imaginal space, which is an area of the mind lying between subjective fantasy and external reality, only comes into existence through the interaction *between* people. Going back to early infant research, the baby's development is aided by the mother, who can help to make representations of their experience. Often this is done with humorous and loving mirroring, such as exaggerated facial expressions (Colman, 2007). In therapeutic terms, it means that this imaginal and reflective space only comes into being with another, and, presumably, with the right conditions in place. Stern et al. (1998) build upon this idea by suggesting that it is in moments-of-meeting that an 'open space' is created and therapeutic change is possible. Due to a change in the intersubjective environment, the old has been disjointed and shaken up, leaving space for new ideas to emerge.

Why might this idea of space be so important in psychosis, though? Watts argues that space, or the lack of, is the primary problem in psychosis (Watts, 2012). Watts reasons that in some cases, space is not produced in a developing child by the mother, known as the 'Maternal Function'. This function is where the mother allows for a dialogue and for her presence and absence to be registered. In psychosis, the registering of the mother and baby as separate beings is not registered, but is foreclosed. Since the mother is not seen as an Other, there is no alienation or separation. Signifiers can then become entangled and there is no 'chink of space' (Watts, 2012, p. 50).

The jolting code in 'Third Space' was described as being provocative, paradoxical and irreverent; this ties in with the work of Burnham in his family therapy where he describes using paradoxical interventions. These are interventions that are used when thinking has become fixed and rigid. Introducing a paradoxical intervention, one that is humorous or opposite to what was expected, helps to unlock the entrenched beliefs, rather than trying to directly challenge them (Burnham, 1986).

This is similar to Titze's idea of 'humouristic inversion' (Titze, 1987). By this, Titze means using humorous or unexpected interventions in therapy, for example, unexpectedly surrendering to not knowing how to solve a client's problem. This counters the client's own feeling of powerlessness and he described how this allowed a return of the client's own self-reliance, allowing the client an unexpected victory (Titze, 1987). This encourages a sense of personal freedom and a change to show courage and superiority (Richman, 1996).

This seems a similar theoretical position to that of Ellis, the founder of Rational Emotive Therapy, who, in his 'Fun as Psychotherapy' paper, describes using humour in a jolting fashion: 'What better vehicle for doing some ideological uprooting than humour and fun?'(Ellis, 1977, p. 11). This beautifully describes the purpose of this type of intervention, to 'puncture asinine ideas' and help the client find more effective views instead (Ellis, 1977). This punctuation is similar to Lacan's idea of scansion. Lacan talks about interrupting clients and redirecting them to material that seems more important. This prevents the client from superficial talk, such as giving a running account of their week. 'Scanding', i.e. punctuating the work with something surprising or humorous, helps to direct our clients to where the work might go. In this way, it opens up the work to being different to the dinner party that Katie warned against in 'Introducing Difference', stopping therapy from becoming predictable and creating an imbalance that can produce unconscious manifestations (Fink, 1997).

4.4.2. Metaphors

ACT advocates the use of play in a variety of ways to promote psychological flexibility and therefore therapeutic change. One way in particular is through the use of metaphors to help explore a client's situation. Humorous metaphors have a particular link with psychosis, as I have stated earlier. Neither humorous metaphors nor delusions are real, but they serve a purpose in that they both communicate something. Using humorous metaphors in therapy creates a 'sidestep from reality', allowing the therapist and client to explore the client's experience (Viney, 1985, p. 236). With psychosis in particular, I believe it is a useful way to explore a client's experience because it develops the 'as-if' quality of the experience without ever having to directly challenge the veracity of it. Humour allows the client to transcend reality and develop a flexible perspective that allows the client the possibility of change (Viney, 1985).

Metaphors paint a verbal picture in our mind, and when they are humorous, they are even more likely to stick. In humour, ambiguity builds tensions until there is a relief with the punch line; if the resolution is linked with a verbal image painted in our minds, it will become imprinted. Killinger argues that the '…coupling of humour with insight around particular issues under discussion establish a positive link in the mind' (Killinger, 1987). When Philip's

client feels stuck, an image of Philip swinging on a vine like Tarzan will no doubt come to mind and induce mirth and a smile.

Metaphors are at the heart of ACT practice, helping to avoid didactic teaching and encourage a discussion. One of the six components that metaphors target is 'cognitive fusion' as they work well to destabilise situations (working in a similar mechanism to jolting) and create de-fusion by separating the distance between the client and the problem (Hayes, Strosahl, & Wilson, 1999). Once there is distance, the client can then see alternative ways of looking at situations. Luoma et al. (2007) argue that metaphors can bring new meanings to light on a situation in a rapid manner without the need for excessive descriptions. They go on to described how a metaphor 'catalyses diffusion and one brief analogy can get across many qualities of diffusion without the need for an exact description' (Luoma, Hayes, & Walser, 2007, p. 80).

4.4.3. Changing the Relationship and Reframing

Playing with metaphors helps to change the relationship clients have with their symptoms. Frankl said humour allows humans to create perspective, putting a distance between himself and whatever may confront him (Frankl, 1967). This 'Reframing' of a situation emerged from the data in words such as decentring, externalising or diffusing, which relate to acceptance-based cognitive therapy (Teasdale, 1997). Indeed, it was the father of CBT, Aaron Beck, who described distancing as the process of regarding thoughts objectively (Beck, 1976, in Gelkopf & Kreitler, 1996). In ACT terms, this process is known as deliteralisation or cognitive defusion (Hayes, Strosahl, & Wilson, 1999). All these terms describe the ability to step out of one's own thought processes and gain a different perspective and allow for a novel reinterpretation of events. Within ACT, it is seen as observing oneself as 'self as context', rather than 'self as content' (Luoma et al., 2007).

Bach and Hayes showed that by using four sessions of ACT with psychosis, it reduced hospitalisation rates by 50% over a four-month period (Bach & Hayes, 2002). Although a significant proportion of participants declined to take part in the study, the authors did show some promising results that ACT works to change the relationship the client has with the voices, by encouraging acceptance of the voices over suppression and avoidance of them. Rather than treating thoughts as fearsome, or as literally true or false, their content can be observed more objectively. This seems to reduce the believability without it ever being directly challenged (Bach & Hayes, 2002).

Burnham describes using reframing in family therapy, where the meaning attached to a certain behaviour or interaction is altered so that it is amenable to behavioural and emotional change (Burnham, 1986). Redefinitions help to normalise a problem and place a solution within the grasp of the client, especially as the emphasis is on reframing the positive aspects of the problem. Reframing is described as re-punctuating a client's reality, not by minimising their difficulties, but by offering a different frame on their experience, 'enabling them to survive a crisis' (Burnham, 1986, p. 147). Consequently, this leaves clients open to choice; with an increased distance from the problem comes the ability to choose how to deal with the problem. This, in turn, gives the client a kind of power and control (Viney, 1985). A client who can joke about their voices is moving towards deciding whether they are worth paying attention to and obeying them, or not.

4.4.4. Comparing and Contrasting

CBT literature is also relevant with the focused code of 'Comparing and Contrasting'. CBT asks clients to look at a situation in detail that upsets them to understand the core belief underlying it (Padesky & Greenberger, 1995). Comparing and contrasting has parallels with the downward arrow technique, which is designed to deconstruct a belief, allowing it to be pulled apart to its bare bones and exposing the cognitive bias at play. Comparing and contrasting also seems to work through a similar mechanism of exposing the erroneous thinking, but this time by exaggeration of the differences between beliefs and reality. This has links to the previous idea of paradox, where the therapist promotes the worsening of the problem, rather than apparently working to dissolve it (Burnham, 1986). Ellis, who employed humorous exaggeration to deliberately help change clients false beliefs, described exaggerating the significance of a client's belief with humorous counter-exaggeration as a way to deconstruct the belief (Saper, 1987).

4.4.5. Lightness to Symptoms

Another way that humour encouraged therapeutic change was through encouraging a 'Lightness to Symptoms'; within this was the focused code of 'Observing Absurdity'. This links with the existential work of Kierkegaard and Sartre, who said that life is inherently absurd; appreciating this can help to free up flexibility in thinking about life. In Whitaker's paper 'Psychotherapy of the Absurd', he argues that therapy is a microcosm of our living, so bringing in absurdity to the work is a way of demonstrating to the client how to 'zig zag with

the absurdity of life' outside of the therapy room (Whitaker, 1975, p. 11), helping clients to gain objective distance and tolerate anxiety and stress. Whitaker was talking about working with aggression, but his points map equally well to any other form of distress. He also talks about how absurdity breaks old patterns and ways of thinking: '…cutting diagonally across the affect through the use of tongue-in-check humour or a non-rational extension of the situation' (Whitaker, 1975).

Whitaker also notes how humour has a variety of uses, one of which is being able to create a 'creative craziness' in therapy, where the work becomes less stuck and amenable to change. Whitaker gives examples, such as saying outrageous things to clients in a bid to add a 'roguish touch' to the work, helping the client to break the old patterns of thought and behaviour. Whitaker describes using absurdity with the metaphor of the Leaning Tower of Pisa:

> *When it [a belief] is such it resembles the leaning tower of Pisa. The patient comes in offering absurdity, and the therapist accepts the absurdity, builds upon it, escalates it until the tower has become so high and tilted that it crashes to the ground*
>
> **(Whitaker, 1975, p. 12)**

This explanation could work equally well to explain the function of 'Comparing and Contrasting', where a belief is built upon until it falls down, yet without directly ever challenging the client. What stands out here is the client's and therapist's ability to play and have fun with the symptoms, providing a refreshing take on the situation (Richman, 1996). As we shall see, this links to how 'Introducing Levity' can also help to promote therapeutic change.

4.4.6. Introducing Levity

Albert Ellis argued that emotional disturbance largely consists of taking life too seriously and, thus, a return to humour and play was a sign of emotional adjustment (Ellis, 1977). Humour comes from incongruity and being able to generate multiple interpretations of an event. Viney argues that being able to produce numerous takes on an event can transcend self-imposed limitations of naïve realism (Viney, 1985). Ellis advocated that we stop taking life too seriously and Kelly (1967) argued that we should break free from limited internal worlds and build alternative interpretations. If you can create change with the immediate

environment in therapy, this can stimulate creativity and give a flexible perspective that leaves the client open to change outside of the room. So, we can see how humour can help to build a rapport and it can also encourage therapeutic change, but can it help to open up topics of discussion?

4.4.7. Floating an Idea and Conveying a Message

Humour also helped to encourage therapeutic change by allowing the therapist to sow a seed. Lemma gives a wonderful description of how humour can help to do this: the Zen moment when a joke hits, our defences are down and it is at that moment when a new idea can best be implanted (Lemma, 2000). As Greenwald (1987) argues, if we can attach humour to an interpretation, the client is much more likely to take it up, rather than reject it, and so too are they more likely to remember it. It seems that humour helps to float an idea because it creates an ambiance of freedom and openness (Greenwald, 1987). This ambiance is highly constructive, and given that humour works by being spontaneous, it gives licence for the client and therapist to freely share their ideas of deepest concerns (Richman, 1996).

Humour not only helped to float an idea, but it also helped to convey a message by adding vitality and energy to it. Ellis argued that using humour helped to make therapeutic content vivid and memorable, in contrast to the monotony and seriousness of many repetitive and didactic points (Ellis, 1977). Ellis suggested using provocative and humorous terms within therapy to help underscore a point he was trying to make. For example, Ellis would use unusual words such as ‘wormhood’ or ‘slobhood’ to point out the self-defeating adjectives clients describe themselves with. These terms highlighted how clients put themselves down and it helped them to re-indoctrinate themselves with new healthier terms (Ellis, 1977).

Both ACT and CBT frameworks promote the idea of creating a cognitive marker in the therapeutic work. Flashbulb moments are described when emotional arousal is high and these lead to greater recall of the event afterwards (Conway, 1995) . Retaining new insights in therapy is key if it is to have any long-lasting change and effect (Killinger, 1987).

I believe the theories of Family Therapy also apply to these findings. Family therapy advocates introducing a new script and story to someone’s life to help them see themselves in a new dimension. If a new script is made that is elaborated upon and is rich and humorous, it is more likely to be taken up. Creating humorous, irreverent and playful counter-stories of survival in adversity are helpful to the client (Dillon & May, 2002).

4.4.8. Saying the Unsayable

Many psychologists have written how humour allows hostility and aggression a sublimated expression so that the things that we otherwise cannot say can be said. Greenwald (1987) specifically talks about using humour with clients experiencing psychosis: firstly, with a client suffering from distressing paranoid thoughts, humour was able to dissolve their suspicions through laughter; and, secondly, with a woman experiencing psychosis by joining in her schizophrenese, helping to engage and communicate in the 'decipherable poetic way that schizophrenics frequently use' (Greenwald, 1987). This also corroborates the focused code of 'Meeting Clients', where Richard described joining in the madness with his clients and speaking in an illogical or consistent way to forge a connection. Greenwald describes his rationale as:

> *Not being frightened by the symptoms, no matter how extreme, not being frightened by the hallucinations, but entering them in a kind of humorous way, frequently allows us to help the patient make the very difficult transition from acting in this manner to acting more realistically. They may begin to realised that they can deal with reality better if they are not as grim about it*
>
> (Greenwald, 1987, p. 50)

Thus, humour allows for the safe expression of ideas, but it also allows us to express several layers of functioning at once, by accessing unconscious and conscious layers altogether (Greenwald, 1987).

4.5. Does Humour Hinder the Work; is its use Inappropriate?

4.5.1. Shielding

There was indeed significant consideration given to the negative and harmful effects that humour may have when working with clients experiencing psychosis. These included the ideas that it could shield, thereby 'Masking Pain' and 'Forming a Barrier' between the client and therapist. There was also the concern that humour was open to 'Misinterpretation', leaving the client feeling mocked and unsupported. This fits with Kubie's view that humour can be a way for the therapist to mask hostility towards the client. Aggression can become veiled by a façade of camaraderie (Kubie, 1971). If humour is masking hostility in the therapist then Kubie points out the client is somewhat forced to accept the humour without expressing justifiable resentment at being played with for their suffering (Kubie, 1971).

This idea of shielding relates back to the initial literature of Winnicott's concept of the false-self as humour could be providing a mask for clients or therapists to hide behind, preventing clients from accessing the help and support that they need. I do believe that this is indeed a possibility, but it might be an overly simplistic view as not all humour serves to prop up a false-self. Humour might do this at times certainly, but Anna Freud believed that humour was a mature defence on a par with sublimation or altruism. Humour and other mature defences are a way of dealing with conflicting anxieties or thoughts whilst still remaining socially integrated beings (A. Freud, 1966). Thus, it is possible to use humour and still be presenting a true self.

Humour can serve many functions and what this research shows is that some functions can be very negative, as it can be felt as a hostile attack on the client (Richman, 1996). This is a sobering reminder that humour is not always useful in therapy with clients experiencing psychosis. Another finding was how humour could mask pain that the client was experiencing. Humour can stand in the way of expressing genuine pain. They may be trying to laugh off the importance of their symptoms (Kubie, 1971) and this can lead to evading the help that they need.

4.6. Taboo

I have written up the findings about taboo in a new section not related to the three questions asked above. This is because I felt that taboo was not necessarily something that furthered the therapy or not. It was more that I felt it was an interesting process that occurred within interviews and was spoken about as a potential factor in therapy. Humour is transgressive, just as psychotic experiences can be, and this might be why humour works in these instances. They are both crossing cultural boundaries of what is acceptable; by introducing humour, the therapist is giving permission to discuss other topics that are taboo.

The taboo that was identified in the process of the interviews signals what it might be like to use humour within a multidisciplinary team. What emerged was a sense that 'you have to be in it to get it'. Philip described working in mental health teams as like being in the trenches together; if you are outside, you might judge the gallows humour used. Humour serves an important function in the face of stress, though, as it allows us a way to manage our predicament, transcending our misfortune and finding optimism within it (Shatzky, 1988). Cade talks specifically about the creative function humour can serve with therapeutic teams,

describing numerous examples where constructive interventions were created out of a bout of joking around. Cade also says that from the outside, the humour might be deemed inappropriate, but it serves to break free of the usual mental furrows we get stuck in and allows a creative freedom through free-associating in a joking way (Cade, 1982). It seems that humour allows us to free ourselves up in some way and become more creative in our thinking, but it can also help us to speak the words that feel so dangerous.

4.6.1. Taboo in the Process

A number of participants reflected on what it was like to articulate their use of therapeutic humour. Philip said: 'I'm noticing that I'm trying to explain my sense of humour' and James, who said: 'I don't suppose it's something I've discussed widely with people.' This implied that although Philip and James used humour regularly in therapy and with psychosis, it was not something they often articulated. My sense is that within teams, there is quite a colonising effect with the language we use. We might use medical language depending on which professionals we are working with, and humour might not fit with this discourse. Rufus May talks about the colonising effect of medical language with psychosis and how this can work to alienate the client from their own experiences, objectifying them and making them feel passive victims of their symptoms and treatment. This language, compounded by anxiety and powerlessness, undermines the subjective experience of psychosis (May, 2006). It is my belief that bringing in everyday language and 'normal' interactions of laughter, play and irreverence brings the power back to the client, allowing them the space to construct their own narrative of their experiences, free from medical jargon. This thesis is an attempt to decolonise the therapist from the idea that therapy must be a sober and serious affair with psychosis.

4.7. Limitations of this Research

As I have acknowledged above, the theory generated from these interviews is situated within a specific time, place and context. The theory cannot be said to be representative of all therapists but more a snapshot of a group of experiences. The data was analysed by one researcher, meaning that the perspective gained will only be one of many other interpretations that could have been formed. As Grounded Theory is couched in positivist language there is a risk of forgetting the role of the researcher in the data analysis. Thus, I have built reflexivity into the data analysis and acknowledged that I am viewing this data from a certain perspective and that a phenomenon can never be captured in its entirety (Willig, 2008).

Grounded Theory cannot give answers to how well these findings can be generalised or predict trends in other populations (Willig, 2008). However, what Grounded Theory, in this instance, does offer, is a window into a phenomenon that is, at present, misunderstood and under-researched. Rather than thinking of the generalisability of the results, the important quality of this research is its usefulness in its ability to provide a tool for thinking and expanding our vision.

There may have been a selection bias operating in this study, whereby those who advocated the use of humour in therapy agreed to take part in the study (and were recommended to me, so it was likely they were going to have an interest in the topic) and thus this research may not have identified therapists who were sceptical about the use of humour. In response to this limitation, it must be noted that not all participants were in favour of the use of humour. To take into account this bias, quotes from the transcripts are available in the appendices so that the reader is able to see clearly for themselves what the emergent themes were and draw their own conclusions from the data. However, everyone who received my email agreed to take part, which is unusual for research and reflects the fact that this is an interesting topic that people are curious to discuss and explore. This perhaps also hints that it is taboo and thus it is not spoken about enough.

Finally, there are limitations to the model of Grounded Theory generally in that there are things that this model cannot do. Firstly, it is not able to give a 'cause-and-effect-style answer' to the phenomena. However, in the case of this research, what Grounded Theory can do is to answer the question of *how* humour might work in therapy with clients experiencing psychosis. It can elucidate the meaning behind social processes; it can give an insight into how people construct meaning around using humour; and it can give a snapshot of the 'lived experience' of using humour with psychosis.

Indeed, there are also limitations with my own interviewing style. Rather than laughing with participants when they joked, it might have been more useful to ask them what they were laughing about and trying to get at the anxiety beneath their humour. On reflection, I could have tried to disrupt more of the taken-for-granted meanings that came up in interviews; problematising them rather than going along with the implied meaning would have given some more useful data. For example, when Philip described himself as a 'slob' just like everyone else, what did he mean? However, there is a balance to be struck between being humourless and probing, and being warm and empathic to help keep the interview moving.

4.8. Evaluation of the Study

A number of alternative criteria for evaluating the quality of all qualitative methodologies have been suggested by Henwood and Pidgeon (Henwood & Pidgeon, 1992).

The researcher should *'keep close to the data'* so that the theory is a *'good fit'*. Grounded Theory ensures there is a good fit as its main tenant is to stay close to the actions described in the data and not to depart from the data with ungrounded interpretations. In addition, the language of the participants was used in the initial codes to ensure that high-level codes were rooted in the data.

Theory should be *'integrated at diverse levels of abstraction'*, and that theory should be based on rich and dense data. The method of triangulation was employed where multiple sources were used to garner as much information as possible. For example, therapists from a range of modalities were interviewed and different methods of data collection were used, including transcribing the interviews verbatim and using participants' humour diaries as a source of information. The aim within a social constructivist approach is not to use triangulation as a way to gain convergence of data, i.e. to see if eventually everyone says the same thing after a while, but to gain a 'completeness' where a diversity of ideas is maintained (Madill et al., 2000).

The *'reflexivity of the researcher'* must be explored. A bias in how data is interpreted would, in certain approaches, have been seen as a downfall of the research; however, within a social constructivist approach, it is seen as inevitable that the coding and theory generation will be effected by the researcher's own experiences, knowledge and training (Madill et al., 2000). My own stance to the topic has been explored and I am aware of how this will affect the data I collected and the theory that I generated. It was also recommended that documentation should be thorough; this was achieved by logging how I arrived at high-level codes in memo-writing and by reflecting on discussions and thoughts in my diary.

'Theoretical sampling and negative case analysis' is suggested as another criterion to measure the quality of the results. This was achieved by going through the data and searching for cases that did not fit with a code that had been created. The purpose of this process was to make sure that positive data searching did not occur where only examples that are consistent with the code or theory are sought. Instead, I looked for the anomalies, which encouraged me to re-define the code or to create subcategories codes, thus making the coding finely tuned.

There is a *'sensitivity to negotiated realities',* which means being aware of how truly the codes fit what the participants said. This was negotiated by giving the coded transcripts to my research supervisor to gain their views on the appropriateness of the coding.

There is *'transferability';* this refers to whether the data is applicable beyond its specific context. Grounded Theory data collection is meant to continue until there is theoretical saturation, although in practice this was difficult to do. Even if this occurred, the results are arguably not generalisable as the data gathered is of a particular time, place and context. These interviews are situated in 2011 where the Survivor Movement and its influence has saturated clinical practice and so the responses today will differ greatly to the early nineties when the movement had not got underway. I also believe that the clinicians I interviewed are at the cutting edge of the field of psychosis as they are all involved in research and working in large teaching hospitals, which might make them more confident about using humour with psychosis than other therapists.

4.9. Implications for Practice

Research to date has taken a pessimistic view on whether clients with psychosis can appreciate humour, citing difficulties ranging from cognitive, attentional and Theory of Mind deficits. What this research shows is that participants had multiple and varied experiences of humorous moments with clients. Participants repeatedly demonstrated through their clinical examples how clients with a range of symptoms (including delusions, paranoia, voices, co-morbid depression, anxiety, trauma etc., on medication and without, in private practice and in NHS settings) could comprehend and appreciate humorous instances. These clinical examples proved that clients were also more than able to initiate instances of humour.

Above and beyond being able to appreciate instances of humour, accounts of humour with psychosis appeared to be *vital* in therapy. Humour helped the client and therapist to connect with each other, to energise the sessions, to reframe problems, to allow for an expression of unsayable things and, in turn, to allow new ideas to be suggested and taken up. Humour, most importantly, modelled a different stance that one can take in the world, one that involves a degree of lightness and an appreciation of absurdity and nonsense.

4.9.1. Humour as a Coping Mechanism

It is this last point that I feel could be most helpful for clients. Teaching clients that they can

approach some of their symptoms or life troubles with some appreciation of irony or absurdity is indeed a useful coping mechanism. It is possible that laughter and humour will only be thought of as a defence mechanism, but it is one of the most mature ones that we have in our armoury and, arguably, the most adaptive one we can employ (A. Freud, 1996). Clients with psychosis who present to services tend to use maladaptive coping strategies such as avoidance and less active coping strategies than healthy controls (or compared to individuals in the community who do not present and therefore arguably have good coping strategies) (Philips, Francey, Edwards, & McMurray, 2009), thus alternative coping strategies are needed to help clients to survive the otherwise rather bleak outlook. Indeed, it was Freud who described humour as a useful coping strategy.

Killinger also argues that using humour successfully models going about life in a way where we take a creative and humorous approach to the world. Humour encourages us to take a more expansive and exploratory cognitive style and if clients experience this in therapy, they may seek to do this in the future (Killinger, 1987). Humour also helps with systematic desensitisation (Gelkopf, 2011). Ventis, Higbee and Murdock (2001) showed how humour worked in systematic desensitisation to reduce fear, in the case of spiders, and I believe humour could work to reduce the fear in relation to psychotic symptoms. Ventis asked his participants to generate humorous statements about spiders, which worked equally as well as traditional desensitisation to reduce his participants' fear. This finding could have some application with psychosis: humour could be introduced in relation to clients' symptoms, which could help to reduce the fear they experience.

Humour is about being paradoxical and contradictory, and sometimes acknowledging the humour in symptoms and finding irony in situations allows a way of opening up some space to try things out in a novel way. In this way, symptoms can be looked at, even if only for a moment, and cognitive defusion might be said to occur in this instance. In CBT terms, pointing out absurdity allows a way to de-centre, so the symptom is not all the person is. My belief is this ties in closely with the person-centred approach; it is about bringing our humanity as therapists by pointing out that we struggle with life and its meaning, or lack of, as much as clients do.

4.9.2. Therapeutic Use of Self

Using humour does not necessarily mean that one must be telling jokes to clients. I believe there are many more ways to use humour in therapy with psychosis. Killinger researched

whether humour in therapy was a facilitative skill or not, and in doing so, she identified many more subtle and creative forms of humour than just jokes. This included using exaggeration or simplification, incongruity, unexpected surprises, figures of speech, and clever or unusual phrasing that allowed for a play of words (Killinger, 1987). So, in fact, when we are using humour with psychosis, it is unlikely to be just about telling jokes; it is more likely that we mean playing with words, repeating something back to a client or even just saying something a little odd. Whatever it might be, humour is a way to demarcate the conversation and the therapeutic space as different and that is what I believe to have therapeutic import. This links to Katie's quote that therapy is not a dinner party; it should not be about creating more of the same, but creating a third space that allows for play, reverie and reflection.

I do not think that humour is something that can be used as a specific technique in therapy, like one would use the 'downward arrow technique' to challenge unhelpful thinking. Nor is it my intention to encourage humour with psychosis in a way that others might call 'laughter therapy' that is, prescribing laughter as medicine. Laughter therapy is a set of techniques and ideas, itself a formal therapeutic intervention that is used to elicit laughter in patients suffering with medical conditions. Bertrando and Gilli argue that, rather than being a tool, humour should be seen as a feature of the therapeutic dialogue. This alludes to the idea that the therapist can take a certain position within the work, the way they choose to frame the therapy and the style within which they work (Bertrando & Gilli, 2008).

My argument falls in line with Greenwald and Lemma; one must not be afraid to bring in to therapy one's sense of humour, although I appreciate that this is no small thing to do. As Greenwald says, this means suspending the serious, ponderous attitude and, where appropriate, bringing in humour if it helps to free things up for the client (Greenwald, 1987). So often humour is left out of therapy as it is seen as unprofessional, uncaring or too 'New Age' (Gelkopf, 2011). What I call for is humour to be used intentionally in therapy with psychosis, if the therapist has considered those fundamental 'Building Blocks' (having a good rapport and an understanding of the caveats and pitfalls). This is not to say that everyone must use it, but for people who feel it is naturally within them to be humorous or witty, then why not capitalise on this attribute with clients.

This sort of spontaneity and creativity is described well in Ringstrom's (2001) work where he talks about cultivating the improvisational in therapy. Rather than working in a prescriptive and set way, Ringstrom advocates imaginative and authentic intersubjective

engagement. I believe that using humour with psychosis, when done sensitively and with great care, can convey a deep involvement with the client. It helps the therapist to engage in a client's disparate and disconnected parts of themselves. Humour, mirth and laughter are all part of the natural range of human emotions that we experience and so should we shy away from bringing them into therapy with psychosis.

4.9.3. Developing Healthier Core Beliefs

I believe that by not using humour, we may be reinforcing our clients' self-view of being fragile and weak, that they cannot handle humour. Using humour with psychosis shows that the therapist can see a client's various configurations as humour appeals to the functioning part of them. Too often, therapy is about focusing on the deficits and fragility of the client and thus inadvertently reinforcing the weakness of the client (Farrelly & Lynch, 1987). Humour lies in harmony with my view of psychosis as a functioning way of being in the world that is different, but not worse or better than other ways of being.

This is not to say I wish to encourage clients to minimise their distress or de-emphasise the hardship they face, or to cajole clients to just 'get on with it', but instead to encourage them to have a different relationship with their symptoms. By this I mean a relationship where clients do not feel subjugated by their voices, where the humour has drained some of the agony and clients can feel lighter towards their symptoms. Humour creates a space where clients can talk about their experience and make sense of their taboo and painful experiences, which can be liberating (Dillon & May, 2002).

4.9.4. Implications for its Wider Use: A Campaigning Weapon

Campaigning for the understanding and education of mental health disorders has come a long way in the last decade. There is still some way to go in creating public awareness and public education to reduce the stigma that is attached to mental distress generally and psychosis specifically. The discourses around psychosis, spurred on by media portrayals, is that having psychosis means you are 'a psycho', 'a raving loony' or you have a 'split personality' who will cause you harm, despite the fact that individuals with psychosis are much more likely to be the victims of crime (Walsh et al., 2003). So how does one change the public and media perception of psychosis? Well, one way of catching the imagination of the public and the media is through attaching some humour to the message we wish to convey. Looking at the recent film *Silver Linings* is one great example. Here is a sensitive, charming and humorous portrayal by Bradley Cooper of what it is like to live with bipolar disorder. This portrayal has

helped to breathe life and humanity into what is otherwise characterised as a very bleak and hopeless disorder.

Humour can work as a campaigning tool to get people to hear your message. Mark talked about humour being a 'campaigning weapon' that gives vigour and verve to an argument and helps to underscore a point (Ellis, 1977). When the Survivor Movement campaigned against benefit cuts for service users, an image of David Cameron dribbling in a straightjacket on their website (http://madpride.org.uk/index.php) sticks firmly in the mind and this is the power of humour; it becomes a flashbulb moment outside of the therapy room too. I think that this use of humour within a campaigning domain suggests the power relations at play too. It says an awful lot about who is allowed to mock who through humour as it is the service users who are allowed to mock the more powerful, but it is obviously not acceptable the other way round. This suggests that humour can be used as an instrument of power and it serves as a salutary reminder of the effect it can have on those on the receiving end.

There are also benefits to using humour which are outside the therapy room in therapeutic-related processes. Participants also spoke about how humour helped to build team camaraderie. Working with clients presenting with high levels of distress, drug misuse and suicide is highly demanding. Humour within team settings can help to prevent burnout (Gelkopf, 2011) and it can act as the very coping mechanism we should teach our clients.

4.9.5. Spreading the Word

I asked fellow counselling psychologists and trainees about their use of humour with psychosis. Most felt that it was something that they would not try and were curious to know what my experiences were of using humour with psychosis. This straw poll, although not formal quantitative research, did give me an impression of how some therapists might shy away from using humour. This highlights the importance of this research in spreading the word and helping to inform therapists of its uses and potential benefits with psychosis and perhaps more broadly with other forms of distress. I think this is especially important, given the pressures therapists are under in the current economic climate. Working in the NHS with the current pressure to produce short-term therapy, where therapeutic outcomes are microscopically evaluated, has put enormous pressure on therapists, and this can cause humanity to be squeezed out of the therapy room.

I also believe that humour has an extremely valuable place within the supervisory space. I think it is important that supervisors incorporate it, where appropriate, with their supervisees to help shape their learning and help them to see that humour is extremely valuable. Sadly, I feel a risk culture has developed within services where anything novel or labelled as being personal is deemed unprofessional.

4.10. Final Points of Reflexivity

I have offered my reflections along the way with this research so I will not repeat myself, but instead offer final reflections on the overall process of conducting this research. My journey through this whole research process has been a daunting, wonderfully exhilarating and creative process. Immersing myself in Grounded Theory, and qualitative research generally, for the first time was a huge task and academically very challenging. I am, however, immeasurably glad that I have done this as it is only through conducting the research that I can see the value that social constructivist Grounded Theory holds and the knowledge it is capable of generating.

I see now how I approached this research with such naivety and without a full comprehension of the task at hand. There were moments in the data analysis stage where I felt utterly overwhelmed with the task of sifting through the data and trying to bring the fragmented codes together into a coherent form. I think this disarray came because I believed that the process would be a linear one. I can now say that this research has been cyclic, and that returning time and time again to the interview recordings and their transcripts was the most valuable step I learnt to do.

I think my own training as a counselling psychologist has shaped the research and the resulting theory that has emerged from the interviews. Having been trained in a number of theoretical perspectives (Psychodynamic, CBT, Systemic, Person-Centred and Integrative models), this research has been viewed through multiple lenses. I hope this has given the benefit of drawing from multiple theories to explain the results, but at the same time, this might give multiple and conflicting accounts of how humour with psychosis was experienced. I believe this is the strength of psychology, to be able to hold multiple and, at times, conflicting accounts, of a phenomenon. There can be multiple truths and perspectives on a situation.

I feel deeply honoured to have spent time with each of my participants and for their frankness in describing their personal accounts of using humour with psychosis. Through listening to their clinical examples, as well as their rationale of why they have used humour, it has been a deeply liberating experience and I hope this comes across when other therapists and trainees read this research.

I am aware that I have not experienced psychosis and that critics might therefore question how I could know how it would feel, as a client with psychosis, to have humour in the therapeutic work. However, I can draw upon my own experiences of humour in my personal therapy. In moments of utter despair, humour has, at times, served as a wonderful beacon of light amongst the dark. For me, it did not undermine the depths of my misery, but instead it helped me to tilt my head just enough to see the light again. I cannot account for other people's experiences of humour in therapy; no doubt there have been times when its use has been utterly deplorable and inappropriate. However, I hope that these instances, like any other blunders in therapy, are the exception rather than the rule and that we can consider the benefits of humour with psychosis as a way of getting out of the prison of everyday life (Bertrando & Gilli, 2008).

I am also aware that I came to the research with some assumptions and beliefs about humour. Having always been fond of humour within my personal life it was no great leap for me to be curious as to its use within therapy with clients experiencing psychosis. I think at times this passion has been useful; spurring me to read around the topic with great enthusiasm and develop the research questions and having genuine curiosity in the interviews with fellow psychologists. During the research I reflected on my tendency to focus on the positive aspects of the findings but I have been mindful of this and made sure I have spent due time and attention on the negative aspects of humour in therapy with clients experiencing psychosis too. Supervision was again a useful space to reflect on my relationship to this topic and consider my motivations to conducting this research.

4.11. Future Research

Having completed this research, I feel I have started to answer the question of how humour works with psychosis, but as always with new areas of research, as you start to find answers more questions are generated and there are areas of research that I would like to follow up. To start, I think it would be valuable to continue interviewing therapists about their experiences of humour with psychosis; increasing the sample size would expand the theory

generated so far and I could continue collecting data until I reached theoretical saturation. I would also like to interview clients with psychosis about their experiences of using humour. There is too little literature, as in most domains, about service users' experiences of therapy. I would like to see if there is any cause-and-effect with humour in therapy with psychosis. For example, I would like to develop a quantitative study looking at the changes in symptoms, such as a rating of believability of symptoms and distress over time. This is based on the Bach and Hayes study (2002) where they tested how effective ACT was over a four-month period.

Finally, I think it would be important to take into consideration the cultural differences of using humour in therapy. I would be interested to see whether it is beneficial to match therapists and clients in the types of humour they use (Franzini, 2001). What happens when people with different types of humour meet, and can it still be useful?

5. Conclusion

I sincerely hope that this research goes some way to opening up the way that therapists view their role and the work they can accomplish with clients experiencing psychosis. I hope that, practically speaking, this allows therapists to take more risks to be creative, be more involved and as Watts rightly says, be 'more willing to screw up' (Watts, 2012, p. 48). I cannot claim that the results of this study give a definitive account or theory of how humour works with psychosis; however, I think it is a valuable starting point and one that I shall continue to explore, as outlined in the future research ideas above.

I am not arguing that this is the only way to work with psychosis, but I am suggesting it as one alternative way that may enhance therapy as it stands right now. It seems that if humour is used in therapy generally, and more specifically, with psychosis, it is done accidently. This research provides an important platform for therapists to discuss its application and to validate it as a useful tool. Leader argues that work with psychosis is taken too much at face value these days, and health professionals work to reduce symptoms, rather than thinking how the symptom might actually be an attempt at a solution, something that Bleuler actually originally argued with his idea of primary and secondary symptoms, but these got confused with Schneider's First and Second rank symptoms. Leader says we must be instructed by the psychotic in an open-ended dialogue that offers 'a space free of the dominant values of efficiency and achievement endorsed by contemporary society' (Leader, 2012). Using humour therapeutically allows us to work beyond the idea of right or wrong of reality. We

can create a space for our clients to explore what psychosis means for them and how to live life full of the quirks and absurdities that it holds for all of us.

References

AATH (Producer). (2013). The American Association of Therapeutic Humour. Retrieved from www.aath.org

Andreasen, N. C. (1985). Positive vs. negative schizophrenia: A critical evaluation. *Schizophrenia Bulletin, 11*, 380-389.

APA. (2000). *Diagnostic and Statistical Manual IV - Text Revision*. Washington, DC: APA.

Apel, L. (2002). The healing powers. *Expectant Parent, 32*(11), 28-30.

Bach, P., & Hayes, S. (2002). The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 70*(5), 1129-1139.

Bateman, A., & Holmes, J. (1995). *Psychoanalytic contributions to psychiatry*. London: Routledge.

Bellack, A. (1986). Schizohprenia: behaviour therapy's forgotton child. *Behaviour Therapy, 17*, 199-214.

Bentall, R. (1990). *Reconstructing schizophrenia*. London: Routledge.

Bentall, R. (2003). *Madness explained: Psychosis and human nature*. London: Allen Lane, Penguin Books.

Bertrando, P., & Gilli, G. M. (2008). Collapsing frames: Humour and psychotherapy in a Batesonian perspective. *International Journal of Psychotherapy, 12*(3), 12-22.

Bion, W. R. (1962). *Learning from experience*. London: Heinemann.

Boyle, M. (2002). It's all done with smoke and mirrors: Or, how to create the illusion of a schizophrenic brain disease. *Clinical Psychology* (12), 9-16.

Boyle, M. (2007). The problem with diagnoses. *The Psychologist 20(5)*, 290-292.

BPS. (2000). *Recent advances in understanding mental illness and psychotic experiences*. Leicester: British Psychological Society.

BPS. (2004). *Guidelines for minimum standards of ethical approval in psychological research.* Leicester: British Psychological Society.

BPS. (2006). *Code of ethics and conduct.* Leicester: British Psychological Society.

Burnham, J. (1986). *Family therapy*. Abingdon, Oxon: Routledge.

Cade, B. W. (1982). Humour and creativity. *Journal Of Family Therapy, 4*, 35-42.

Chadwick, P., Birchwood, M., & Trower, P. (1996). *Cognitive therapy for delusions, voices and paranoia.* Chichester: Wiley.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.

Charmaz, K., & Henwood, K. (2008). Grounded theory. In C. Willig & W. Stainton-Rogers (Eds.), *Handbook of qualitative research in psychology* (pp. 240-260). London: Sage.

Christie, G. L. (1994). Some psychoanalytic aspects of humor. *International Journal of Pscyho-analysis, 75*, 479-489.

Clarke, A. E. (2006). Feminism, grounded theory, and situational analysis. In S. Hess-Biber & D. Leckenby (Eds.), *Handbook of feminist research methods* (pp. 345-370). Thousand Oaks, CA: Sage.

Colman, W. (2007). Symbolic conceptions: The idea of the third. *Journal of Analytical Psychology, 52*, 565-583.

Coles, S., Diamond, B., & Keenan, S. Clinical psychology in psychiatric services: the magician's assistant? In Coles, S., Keenan, S., & Diamond, B (Eds.), *Madness contested: power and practice.* (pp. 111-120). Ross-on-Wye: PCCS Books.

Conway, M. (1995). *Flashbulb memories*. Hove: Lawrence Erlbaum Associates.

Corcoran, R., Cahill, C., & Frith, C. D. (1997). The appreciation of visual jokes in people with schizophrenia: A study of 'mentalizing' ability. *Schizophrenia Research, 24*, 319-327.

Cox, D., & Cowling, P. (1989). *Are you normal?* London: Tower Press.

Curtis, E. D. R., Leslie, E., & Watson, B. (2000). *Mad pride: A celebration of mad culture*. London: Spare Change Books.

Davidson, L., O'Connell, M. J., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Pscyhiatric Services, 57*, 640-645.

Dey, I. (1999). *Grounding grounded theory*. San Diego: Academic Press.

Dillon, J., & May, R. (2002). Reclaiming experience. *Clinical Psychology, 17*, 25-28.

Dimmer, S. A., Carroll, J. L., & Wyatt, G. K. (1990). Uses of humor in psychotherapy. *Psychological Reports, 66*, 795-801.

Dziegielewski, S. F., Jacinto, G. A., Laudadio, A., & Legg-Rodriguez, L. (2004). Humor: An essential communication tool in therapy. *International Journal of Mental Health, 32*(3), 74-90.

Ellis, A. (1977). Fun as psychotherapy. *Rational Living, 12*, 2-6.

Farhall, J., Freeman, N., Shawyer, F., & Trauer, T. (2009). An effectiveness trial of cognitive behaviour therapy in a representative sample of outpatients with psychosis. *British Journal of Clinical Psychology, 48*, 47-62.

Farrelly, F., & Lynch, M. (1987). Humor in provocative therapy. In W. F. Fry & W. A. Salameh (Eds.), *Handbook of humor in psychotherapy: Advances in the clinical use of humor* (pp. 81-106). Sarasota, Florida: Professional Resource Exchange.

Felices, A. (2005). Humour as an ingredient of the treatment in a therapeutic community for psychosis. *Therapeutic Communities, 26*(1), 33-40.

Fink, B. (1997). *A clinical introduction to Lacanian psychoanalysis: Theory and technique*. Cambridge: Harvard University Press.

Frankl, V. E. (1967). *The doctor and the soul*. New York: Bantam.

Franzini, L. (2001). Humour in therapy: The case for training therapists in its uses and risks. *The Journal of General Psychology, 128*(2), 170-193.

Freud, A. (1966). *The ego and the mechanisms of defence*. London: Karnac Books.

Freud, S. (1905). *Jokes and their relation to the unconscious*. London: Hogarth Press.

Freud, S. (1924). *Neurosis and psychosis. S. E. IXX*. London: Hogarth Press.

Freud, S. (1927). *Humour, SE 21: 160 166*. London: Hogarth Press.

Garety, P. A., Kuipers, E., Fowler, D., Freeman, D., & Bebbington, P. E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine, 31*, 189-195.

Gaudiano, B., & Herbert, J. D. (2006). Acute treatment of inpatients with psychotic symptoms using acceptance and commitment therapy: Pilots results. *Behaviour Research and Therapy, 44*, 415-437.

Geekie, J., Randal, P., Lampshire, D., & Read, J. (2012). *Experiencing psychosis: Personal and professional perspectives*. Hove: Routledge.

Gelkopf, M. (2011). The use of humor in serious mental ilness: A review. *Evidence-Based Complementary and Alternative Medicine, 2011*, 1-8.

Gelkopf, M., & Kreitler, S. (1996). Is humor only fun, an alternative cure or magic? The cognitive therapeutic potential of humor. *Journal of Cognitive Psychotherapy: An International Quarterly, 10*(4), 235-254.

Gelkopf, M., Sigal, M., & Kramer, R. (2001). Therapeutic use of humor to improve social support in an institutionalized schizophrenic inpatient community. *The Journal of Social Psychology, 134*(2), 175-182.

Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.

Glaser, B. G. (1992). *Emergence vs forcing: Basics of grounded theory analysis*. Mill Valley, CA: The Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Pitcataway, NJ: AldineTransaction.

Greenwald, H. (1987). The humor decision. In W. F. Fry & W. A. Salameh (Eds.), *Handbook Of humor and psychotherapy* (pp. 41-54). Sarasota, Florida: Professional Resource Exchange.

Grotjahn, M. (1949). Laughter in psychoanalysis. *Samiska, 3*, 76-82.

Hayes, S., Barnes-Holmes, D., & Roche, B. (2001). *Relational frame theory: A post Skinnerian account of human language and cognition*. New York: Springer.

Hayes, S., Strosahl, K., & Wilson, K. (1999). *Acceptance and commitment therapy: An experiential approach to behaviour change*. New York: Guilford Press.

Henwood, K., & Pidgeon, N. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology, 83*, 97-111.

Hingley, S. M. (1997). Psychodynamic perspectives on psychosis and psychotherapy I: Theory. *British Journal of Medical Psychology, 70*, 301-312.

Honig, A., Romme, M., Ensink, B., Escher, S., Pennings, M., & Devries, M. (1998). Auditory hallucinations: A comparison between patients and nonpatients. *Journal of Nervous and Mental Disease, 10*(10), 646-651.

HPC. (2008). *Standards of conduct, performance and ethics*. London: Author.

Jaspers, K. (1963). *General psychopathology translated*. Manchester: Manchester University Press.

Johansson, H., & Eklund, M. (2003). Patients' opinion on what constitutes good psychiatric care. *Scandinavian Journal Of Caring Sciences, 17*, 39-346.

Kelly, G. A. (1967). A psychology of the optimal man. In A. H. Mahrer (Ed.), *The goals of psychotherapy*. New York: Appleton-Century-Crofts.

Killinger, B. (1987). Humour in psychotherapy: A shift to a new perspective. In W. F. Fry & W. A. Salameh (Eds.), *Handbook of humor and psychotherapy: Advances in the clinical use of humor* (pp. 21-40). Sarasota, Florida: Professional Resource Exchange Inc.

Kirivanta, P. (1998). Successful psychoanalytically oriented psychotherapy with a middle-aged male schizophrenia patient. *International Forum of Psychoanalysis, 7*, 163-168.

Klein, M. (1946). Notes on some schizoid mechanisms. In J. Mitchell (Ed.), *The selected Melanie Klein*. Harmondsworth: Penguin Books.

Koestler, A. (1964). *The act of creation*. London: Hutchinson.

Kohut, H., & Wolf, E. S. (1978). The disorders of the self and their treatment: An outline. *International Journal of Psychoanalysis, 59*, 413-425.

Kubie, L. (1971). The destructive potential of humour in psychotherapy. *American Journal of Psychiatry, 127*, 861-866.

Kuhlman, T. L. (1984). *Humour and psychotherapy*. Homewood, IL: Dow Jones-Irwin.

Laing, R. (1969). *The divided self*. London: Penguin Books.

Lambert. M., & Barley. D. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 357-361.

Leader, D. (2011). *What is madness?* London: Penguin Books.

Leader, D. (2012). Introduction. *Journal Of The Centre For Freudian Analysis and Research,* (22), 9-13.

Lemma, A. (2000). *Humour on the couch*. London: Whurr Publishers.

Lemma, A. (2003). *Introduction to the practice of psychoanalytic psychotherapy*. Chichester: Wiley.

Linehan, M (1993). *Skills training manual for treating borderline personality disorder*. London: Guildford Press.

Lothane, Z. (2008). The uses of humour in life, neurosis and in psychotherapy: Part 2. *International Forum of Psychoanalysis, 17*, 232-239.

Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien, C. P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry, 42*, 602-611.

Luoma, J. B., Hayes, S., & Walser, R. D. (2007). *Learning ACT: An acceptance and commitment therapy skills-training manual for therapists*. Oakland, CA: New Harbinger Publications.

Lynch, D., Laws, K. R., & McKenna, P. J. (2010). Cognitive behavioural therapy for major psychiatric disorder: Does it really work? A meta-analytical review of well-controlled trials. *Psychological Medicine, 40*(1), 9-24.

Madill, A., Jordan, A., & Shirely, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist, and radical constructivist epistemologies. *British Journal of Psychology, 91*, 1-20.

Martin, R. A., & Lefcourt, H. M. (1983). The sense of humor as a moderator of the relation between stressors and moods. *Journal of Personal and Social Psychology, 45*, 1313-1324.

May, R. (2006). Understanding psychotic experience and working towards recovery. *www.rufusmay.com*. www.rufusmay.com

McCormick, E. (2000). The therapeutic relationship. In E. McCormick & N. Wellings (Eds.), *Transpersonal psychotherapy: Theory and practice* (pp. 20-51). London: Cassell.

McEvoy, J. P., Aland, J., Wilson, W. I., Guy, W., & Hawkins, L. (1981). Measuring chronic schizophrenic patients' attitudestowardstheir illness and treatment. *Hospital and Community Psychiatry, 32*(12), 856-858.

McGhee, P. (1979). *Humor: Its origin and development*. San Francisco: W. H Freeman.

McGovern, J., & Turkington, D. (2001). 'Seeing the wood from the trees': A continuum model of psychopathology advocating cognitive behaviour therapy for schizophrenia. *Clinical Psychology and Psychotherapy, 8*, 149-175.

Mearns, D., & Cooper, M. (2005). *Working at relational depth in counselling and psychotherapy*. London: Sage.

Mearns, D., & Thorne, B. (2007). *Person-centred counselling in action* (3rd edn.). London: Sage.

Morreall, J. (1987). *The philosphy of laughter and humour*. New York: State University Of New York Press.

Morreall, J. (1991). Humor And work. *Humour, 4*(3), 359-373.

Morrison, A. (2011). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy, 29*, 257-276.

Morrison, A., French, P., Walford, L., Lewis, S. W., Kilcommons, A., Green, J., . . . Bentall, R. (2004). Cognitive therapy for the prevention of psychosis in people at ultra-high risk: Randomised controlled trial. *British Journal of Psychiatry, 185*, 291-297.

Mueser, K. T., & Berenbaum, H. (1990). Psychodynamic treatment of schizophrenia: Is there a future? *Psychological Medicine, 20*(253), 262.

NICE. (2009). Schizophrenia (update): NICE Guidelines

http://www.nice.org.uk/nicemedia/live/11786/43608/43608.pdf.

Padesky, C., & Greenberger, D. (1995). *Clinician's guide to mind over mood*. New York: Guildford Press.

Pandit, N. R. (1996). The creation of theory: A recent application of the grounded theory method

Philips, L. J., Francey, S. M., Edwards, J., & McMurray, N. (2009). Strategies used by psychotic individuals to cope with life stress and symptoms of illness: A systematic review. *Anxiety, Stress and Coping, 22*(4), 371-410.

Pilgrim, D. (2007). The survival of psychiatric diagnosis. *Social Science and Medicine, 65,* 536-547.

Pilgrim, D. (2008). Abnormal psychology: unresolved ontological and epistemological contestation. *History and Philosophy of Psychology, 10(2),* 11-21.

Pilgrim, D., & Rogers, A. (1997). Mental health, critical realism and lay knowledge. In J. M. Ussher (Ed.), *Body talk: The material and discursive regulation of sexuality, madness and reproduction*. London: Routledge.

Posey, T. B., & Losch, M. E. (1983). Auditory hallucinations of hearing voices in 375 normal subjects. *Imagination, Cognition and Personality, 3*(99), 113.

Prince, M., Stewart, R., Ford, T., & Hotopf, M. (2003). *Practical psychiatric epidemiology* (1st edn.). Oxford: Oxford Press.

Redfield Jamison, K. (1996). *An unquiet mind: A memoir of moods and madness*. London: Picador.

Rees, W. (1971). The hallucinations of widowhood. *British Medical Journal, 4,* 37-41.

Richman, J. (1996). Points of correspondence between humour and psychotherapy. *Psychotherapy, 33*(4), 560-566.

Ringstrom, P. (2001). Cultivating the improvisational in psychoanalytic treatment. *Psychoanalytic Dialogues, 1*(5), 727-754.

Rogers, C. R. (1967). *On becoming a person*. London: Constable.

Romme, M. A., & Escher, A. D. (1993). *Accepting voices*. London: Mind Publications.

Romme, M. A., Honig, A., Noorthoorn, E. O., & Escher, A. D. (1992). Coping with hearing voices: An emancipatory approach. *British Journal of Psychiatry, 161*, 99-103.

Safran, J. D, & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy*. New York: Basic.

Saks, E. (Producer). (2012). A tale of mental illness: From the inside. Retrieved from http://www.youtube.com/watch?v=f6CILJA110Y

Sands, S. (1984). The use of humour in psychotherapy. *Psychoanalytic Review, 71*(3), 441-460.

Saper, B. (1987). Humor in psychotherapy: Is it good or bad for the client? *Professional Psychology: Research and Practice, 18*(4), 360-367.

Schore, A. (2010). The right brain implicit self: A central mechanism of the psychotherapy change process. In J. Petrucelli (Ed.), *Knowing, not-knowing and sort of knowing: Psychoanalysis and the experience of uncertainty*. London: Karnac Books.

Sensky, T., Turkington, D., Kingdon, D., Scott, J. L., Scott, J., Siddle, R., . . . Barnes, T. (2000). A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication. *Archives of General Psychiatry, 57*, 165-172.

Shatzky, J. (1988). Schlemiels and schlimazels. In V. Janik (Ed.), *Fools and jesters in literature, art and history*. Westport, CT: Greenwood Press. (Reprinted from: NOT IN FILE).

Solomon, J. (1996). Humour and ageing well: A laughing matter or a matter of laughing? *American Behavioural Scientist, 39*(3), 249-271.

Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.

Stern, D. N., Sander, L. W., Nahum, J. P., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., . . . Tronick, E. Z. (1998). Non-interpretative mechanisms in psychoanalytic therapy: The 'something more' than interpretation. *The International Journal of Psychoanalysis, 79*, 903-921.

Strauss, A. L., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques* (2nd edn.). London: Sage.

Sultanoff, S. M. (2003). Intergrating humour into psychotherapy. In C. Schaefer (Eds.), *Play therapy with adults* (pp. 107-143).

Szasz, T. (1987). *Insanity: The idea and its consequences*. New York: Wiley.

Tarrier, N., & Wykes, T. (2004). Is there evidence that cognitive behaviour therapy is an effective treatment for schizophrenia? A cautious or cautionary tale? *Behaviour Research and Therapy, 42*, 1377-1401.

Teasdale, J. D. (1997). The relationship between cognition and emotion: The mind-in-place in mood disorders. In D. M. Clark & C. G. Fairburn (Eds.), *Science and practice of cognitive-behavior therapy* (pp. 67-93). New York: Oxford University Press.

Titze, M. (1987). The conspirative method: Applying humouristic inversion in psychotherapy. In W. F. Fry & W. A. Salameh (Eds.), *Handbook of humor and psychotherapy* (pp. 287-306). Sarasota, FL: Professional Resources Exchange.

Tsoi, D., Lee, K., Gee, K., Holden, K., Parks, R., & Woodruff, P. (2008). Humour experience in schizophrenia: Relationship with executive dysfunction and psychosocial impairment. *Psychological Medicine, 38*(6), 801-810.

Vaillant, G. E. (2000). Adaptive mental mechanisms. *American Psychologist, 55*(1), 89-98.

van Os, J. (2003). Is there a continuum of psychotic experienes in the general population? *Epidemiologia e Psichiatria Sociale, 12*(4), 242-252.

Ventis, W. L., Higbee, G., & Murdock, S. A. (2001). Using humor in systematic desensitization to reduce fear. *The Journal of General Psychology, 128*(2), 241-253.

Viney, L. L. (1985). Humor as a therapeutic tool: Another way to experiment with experience. In F. Epting & A. W. Landfield (Eds.), *Anticipating personal construct psychology* (pp. 233-245). Lincoln: University of Nebraska Press.

Walsh, E., Moran, P., Scott, C., McKenzie, K., Burns, T., Creed, F., . . . Fahy, T. (2003). Prevalence of violent victimisation in severe mental illness. *British Journal of Psychiatry, 183*, 233-238.

Watts, J. (2012). On the maternal fuction of schizophrenia. *Journal Of The Centre For Freudian Analysis and Research 22*, 47-65.

Whitaker, C. A. (1975). Psychotherapy of the absurd: With a special emphasis on the psychotherapy of aggression. *Family Process, 14*(1), 1-16.

White, R., Gumley, A., McTaggart, J., Rattrie, L., McConville, D., Cleare, S., & Mictchell, G. (2011). A feasibility study of acceptance and commitment therapy for emotional dysfunction following psychosis. *Behaviour Research and Therapy, 49*, 901-907.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd edn.). Maidenhead: McGare Hill/ Open University Press.

Winnicott, D. W. (1945). Primitive emotional development. *Through paediatrics to psychanalysis: Collected papers*. London: Tavistock.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *International Journal of Psychoanalysis, 41*, 585-595.

Wood, L., Price, J., Morrison, A., & Haddock, G. (2010). Conceptualisation of recovery from psychosis: A service-user perspective. *The Psychiatrist Online, 34*(465), 470.

Woods, B. (1998). Discussion group report: Issues in the supervision and assessment of doctorate theses using qualitative approaches. *Clinical Psychology Forum, 114*, 28-29.

Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive behaviour therapy for schizophrenia: Effect sizes, clinical models, and methodological rigour. *Schizophrenia Bulletin, 34*, 523-537.

Section D

Publishable Article

Finding A Space To Play With Psychosis:

A Grounded Theory

Finding A Space To Play With Psychosis: A Grounded Theory

Felicity Adams*

*To whom correspondence should be addressed; City University, London. UK;

Email: Felicity.adams.1@city.ac.uk

Keywords: *schizophrenia, treatment, therapeutic relationship, Recovery, Grounded Theory*

Abstract (250 words. Final word count 3791)

The use of humour in therapy has long been a contentious issue, with advocates and dissenters abound. Research shows that using humour in therapy can have multiple benefits: reducing stress, anxiety and hostility. Research has also shown that humour can have benefits with a range of presentations. There is little research, however, to show the therapeutic benefits of using humour when working with clients experiencing psychosis. Indeed, there is some research that suggests clients experiencing psychosis lack humour appreciation skills. In this research, eight therapists were interviewed about their experiences of using humour in therapy with clients experiencing psychosis to understand if therapeutic benefits can be identified. Interviews were transcribed and analysed using Charmaz's social constructivist Grounded Theory. Nine main themes emerged, of which three main themes (Third Space, Connecting and Lightness to Symptoms) shall be explored in this article. These themes tie in with literature in the field of cognitive theory, psychodynamic theory and family therapies. The paper concludes with a reflection of what the implications of these findings are for therapeutic practice.

Introduction

Playing around with psychosis is not something that automatically springs to mind. How can one play with psychosis and why should one? Humour and laughter are frowned upon in psychotherapy, frequently seen as childish and immature[1]. Others have said therapists' reticence to use humour in therapy is because it may seem 'New Age'.[2] Worse still, writers such as Kubie described humour in therapy as heartless and cruel, used for a therapist's own gains[3], whilst Saper pointed out its improper use can humiliate and undermine self-esteem[4]. One would not argue with Saper's idea of improper use, but what about its proper use? It is clearly a subject close to our hearts. Indeed, *The Psychologist* dedicated its entire last issue to

the subject of humour[5]. First, let us define what is meant by humour in therapy. Lemma describes it as:

> *any verbal utterance or non-verbal behaviour that is experienced subjectively as amusing even if it does not necessarily produce the response of laughter or a smile. A sense of humour will be broadly used to denote humour production and appreciation; a sense of playfulness or whimsy; a personal recognition of humour; the capacity to laugh at oneself and problems; and the capacity to master difficult situations through the use of humour.*[6]

The criticism of the term *schizophrenia* is now a familiar argument[7] which shall not be repeated here, but are terms such as *psychosis* any better? The term psychosis refers to the interpretation of a range of behaviours and utterances that are deemed abnormal by society and are equated to madness. Although it can be useful to have a shared language to described phenomena. using the term can be problematic as it transforms psychosis into a reified object leaving the person as an afterthought to the diagnosis.[8] It can cause a preoccupation with heritability and illness and can diminish the importance of factors of society, culture, poverty.

This research takes a critical realist stance, this acknowledges the physical existence of objects but recognises that as humans our perceptions are subjective. This means these medicalised terms are viewed critically; diagnoses do not *exist* of their own accord awaiting verification as naïve medicalism would assume. Instead we must approach all knowledge critically, being aware of the social and political factors that affect these constructs. A bio-psycho-social formulation is favoured to diagnostic categories.[8]

CBT for psychosis (CBTp) is recommended in Nice Guidelines[9]; whilst this can be effective, there is room for improvement. A meta-meta-analysis found that CBTp was no better than non-specific control interventions in the treatment of schizophrenia and it did not reduce relapse rates[10]. As therapists, we need to think about what else we could be doing to increase the efficacy of CBTp. One answer might come in the *way* that we work with our clients when using CBTp. Perhaps therapists could incorporate humour into therapy, although, to be clear, this is different from laughter therapy. Laughter therapy is about prescribing laughter as medicine, a set of techniques and ideas, itself a formal intervention used to elicit laughter in patients. Here, we explore humour as a part of the therapeutic work; as part of a therapeutic repertoire.

Humour has many broad benefits, including: improving physical health, combating illnesses such as hypertension, strokes and cancer to psychological well-being[11] such as moderating stress[12] and relieving the physical arousal associated with aggression and apprehension[13]. Humour has also been shown to work in other mental health disorders: it can help to treat depression, reduce anxiety and offer an emotional catharsis in a range of conditions[14].

Evidence shows that humour in therapy has some merit with mental distress, but how might humour work with clients experiencing psychosis? Humour and psychosis have a particular overlap that means humour could be helpful in therapy: the use of paradox. Betrando and Gilli[15] argue that paradox exists between humour and therapy and it is my belief that it exists in the third, psychosis. Humour works by nature of paradox; it is about bringing together incongruous and competing ideas where the first sets up an expectation of something and the second is different and unexpected. It is about bringing the opposite into focus. Therapy itself is paradoxical: for change to occur in therapy, it actually has to happen outside the therapy. It involves play, but of the most serious topics. It is an intimate relationship, yet one that is also formal[16]. There is also paradox in the relationships we choose to use humour in: joking is normally about making a hostile remark to someone or saying something controversial, yet we normally joke with people we feel closest to,[16] so, again, paradox is at play there.

In psychosis, there are often paradoxes and incongruity too if we consider the unusual experiences and beliefs clients describe: patients believing they are being followed by others for their money when they are destitute. Psychosis is about seeing and hearing things that do not fit in with others' expectations and about behaving in ways that are incongruous. Applying Morrison's psychological interpretation to psychosis[17], we can see that both humour and psychosis involve things that are culturally unacceptable. Jokes are often talking about the taboo thing that should not be said. Indeed, with psychosis, it is the cultural unacceptability of the intrusion that causes the problem. It is not deemed as normal and that is when the experience becomes a problem.

Paranoid or unusual thinking and humour both have many similarities. Both have elements of the absurd and are a parody of reality[17], and neither have to be based in reality. We can joke about things that could never conceivably take place and unusual thinking might be described this way too. As Felices aptly writes, one is: *'facilitating the client simultaneously to live in two worlds through the use of humour. Humour permits the harmony between reality and illusion.*'[18] Lothane[16] argues it might help the client to laugh at their own unusual beliefs. He

noticed that in work as early as Schreber's case, he was able to find irony in his beliefs and described the oxymorons that lay within them. This is why humour might be so vital when working with psychosis: it allows for illogical and inconsistent ideas to be expressed. It opens up a creative or transitional space.[19]

Methods

Study Participants

Recruitment took place by contacting professionals that were known through work, neighbouring teams and contacts in the field of severe mental illness. Eight therapists from a range of modalities were interviewed using semi-structured interviews about their experiences of using humour with psychosis. Recruitment criteria was left as broad as possible to increase the generalisability of the results, but clinicians must have English as a first language and be a minimum of two years post-qualification. Recruitment aimed to get mature clinicians who felt comfortable working with psychosis, as maturity rather than clinical experience is a likely variable that leads to facilitative, therapeutic humour.[20]

The sample comprised a total of eight therapists: one family therapist, two psychotherapists and five clinical or counselling psychologists. There were three female and five male therapists of which: two identified themselves as CBT (although subscribing to integrative approaches, e.g. drawing on systemic and existential approaches), one ACT, one family therapist, one systemic, one psychodynamic psychotherapist and one Lacanian psychoanalyst.

Procedures

Participants were asked to keep a humour diary two weeks prior to the interview, detailing any clinical examples of humour to aid them in the interview. Informed consent was obtained and in-depth semi-structured interviews were conducted by F. A, focusing on clinical examples participants had of humour when working with clients experiencing psychosis. Participants' rationale for using humour based on their theoretical framework they worked within was also explored. Interviews were kept open-ended so that interviewees could elaborate on areas they felt were important.

Analysis

Audiotapes were transcribed and processed using Charmaz's Grounded Theory.[21] Initial coding took place using gerunds to keep the codes short and active. Initial codes were checked with the researcher's supervisor and variance in assignment of codes was resolved.

The most frequent and pertinent initial codes were used to create focused codes. By using negative case sampling and going back to the data in a cyclical process, codes were redefined, leaving nine broad themes, known as theoretical codes, to emerge from the data.

Results

Nine main categories emerged from the data as being constructs of how humour was experienced when working with psychosis. One core theme, *Building Blocks*, emerged from all interviews as being necessary conditions for using humour with psychosis. Three focused codes made up *Building Blocks*; two of which were *Needing a Rapport* and *What's it in Service of?* These two themes described how participants felt they needed a rapport with a client first before using humour and they had to have a rationale for why they were using humour, as well as an understanding of how they felt it would further therapy. Participants were dubious about using humour for their own gains, e.g. to hide their discomfort or mask their anxiety. The final focused code within *Building Blocks* was *Being Human,* which referred to using humour to show one's humanity and personality in therapy. Humour helped to reduce the power relations between the therapist and client and helped deconstruct the idea of being *'a professional with the answers'*. Eight further codes aside from these *Building Blocks* emerged; however, I shall focus on three codes that have given the most interesting results: *Connecting, Third Space* and *Lightness To Symptoms.*

Connecting

Participants described the effect that humour had on increasing the rapport with the client acting as a *'connecting force'*. Participants said*: 'There's something about humour which says "I like you enough, I know that we share this element of humour".'* Participants also reflected that it was a way of creating an emotional experience for the client: *'If it [the work] is too intellectual, people switch off…because it takes people away from their feelings and humour is a very direct, it has direct access to feelings.'*

Third Space

One of the most interesting themes that emerged was *Third Space*, including focused codes of *Introducing Difference, Jolting* and *Deconstructing.* Participants repeatedly referred to this idea of using humour to define the therapeutic space as different. Participants described saying something shocking or provocative, moving the conversation away from everyday conversations: *'I'm constantly having to think in what way do I respond that will allow difference that might in turn allow the person to experience themselves in a slightly different*

way.' One participant describes why they would use paradox: *'You will deliberately use paradox, you will deliberately try and provoke and challenge but you will at the same time be very irreverent about yourself… because I am trying to do something. I am trying to shift it.'*

Lightness to Symptoms

Another way that humour encouraged therapeutic change was through encouraging *Lightness to Symptoms*, by modelling a position of lightness towards life's situations and not taking things too seriously. Within this was the focused code of *Observing Absurdity.*

This included encouraging clients to *'see [life] more from an absurd point of view rather than an ill or pathological point of view'.* One participant elaborated: *'It's not about ridiculing them as much as, the move is to put it out there and it's something we are playing with so if humour is about being playful with things that you are not supposed to be playful with or… then that could be freeing, err… liberating.'* Humour helped clients to look at situations with a different perspective.

There were negative themes that emerged regarding humour too, but these are not the focus here due to the limitations of the word count. Briefly these negative themes were concerning how humour could be '*misinterpreted'*, clients could feel therapists were laughing *at* them not with them and this could *'from a barrier'*. It also emerged that humour could become a way to avoid painful and difficult topics, *'masking clients' pain'*. Therapists voiced their concerns of sessions becoming *'too light'*.

Discussion

Connecting

Laughing with a client demonstrates attunement and this is akin to parent-infant interactions.[22] Often with our clients there have been varying levels of misattunement in early infant development, as Kohut and Wolf[23] allude to, and thus therapy can be an opportunity to reattune clients and help build secure attachments. Schore[24] describes how the attachment mechanism is a right hemisphere-to-right-hemisphere affective transaction. This right-brain-to-right-brain connectivity is activated in highly affective states, suggesting that the right brain is more involved that the left during emotional situations of implicit information processing, whilst the left hemisphere is more involved in explicit and conscious information processing.[24] This explains how being attuned to someone's emotional state and reflecting

this by mirroring a client (e.g. by laughing with them) might 'hit the mark' more than accessing their left brain through explicit conscious process of an interpretation.

Schore[24] continues this idea by explaining that although the left brain mediates most linguistic behaviours, it is the right brain that deals with the wider aspects of communication such as cadence, gestures and facial expressions. Therefore, if we keep working at a purely cognitive and linguistic level, when we know that sixty per cent of human communication is non-verbal, therapists are perhaps missing a spectrum of valuable communication channels.

Humourous moments can be conceptualised as 'moments of meeting'. Stern et al[25] write: *'A moment of meeting can occur in humorous moments in therapy there is a spontaneous, unpredictable and authentic response by the therapist finely fitted to the situation.'* This means that humour is a wonderful way to develop a rapport with clients. In therapeutic work, we must strive to work authentically. We need to carry a personal signature when we speak and moments of spontaneous humour are a good example of this. Indeed, continuing metaphors throughout the work and having some in-jokes can help make the process of therapy deeply personal, whilst still maintaining boundaries.

Third Space

This relates back to Winnicott's[19] idea of 'third space', a transitional space that we can mentally play within. Conscious and unconscious material converges and can be played with, allowing for the emergence of new ideas. Interestingly, Colman[22] argues that this imaginal space, an area of the mind lying between subjective fantasy and external reality, only comes into existence through the interaction *between* people. In therapeutic terms, it means that this reflective space only comes into being with the therapist and, presumably, with the right conditions in place. Relating back to Stern's moments-of-meeting – they suggest they create an 'open space' where therapeutic change is possible.[25] Due to a change in the inter-subjective environment, the old has been disjointed and shaken up, leaving space for new ideas to emerge.

Space, or a lack of, Watts argues, is the primary problem in psychosis.[26] Watts explains that in some cases, space is not produced in a developing child by the mother, known as the maternal function. This function is where the mother allows a dialogue and for her presence and absence to be registered. In psychosis, the registering of the mother and baby as separate beings is not registered, but is foreclosed. Since the mother is not seen as an Other, there is no

alienation or separation. Signifiers can then become entangled and there is no 'chink of space'. [26]

Not only did humour define the space as being different, it emerged that humour created a shock and enabled clients to see themselves differently. This jolted the clients and thus created a nudge to think differently and created a cognitive shift. The jolting was often described as being provocative, paradoxical and irreverent; this ties in with the paradoxical interventions of Burnham's family therapy[27]. Introducing paradoxical interventions that are humorous or opposite to what was expected helped to unlock entrenched beliefs, rather than trying to directly challenge them.

Ellis describes using humour in a jolting fashion: *'...what better vehicle for doing some ideological uprooting than humour and fun?'*[28] This punctuation is similar to Lacan's idea of scansion. Lacan talks about interrupting clients and redirecting them to material that seems more important. This prevents the client from superficial talk such as giving a running account of their week. 'Scanding', i.e. punctuating the work with something surprising or humorous, helps to direct our clients to where the work might go. In this way, it opens up the work to being different to a dinner party conversation, stopping therapy from becoming predictable and creating an imbalance that can produce unconscious manifestations.[29]

Lightness to Symptoms

This links with the existential work of Kierkegaard and Sartre, who said that life is inherently absurd; appreciating this can help to free up flexibility in thinking towards life. In Whitaker's excellent paper 'Psychotherapy of the Absurd', he argues that therapy is a microcosm of our living, so bringing in absurdity to the work is a way of demonstrating to the client how to *'zig zag with the absurdity of life'*,[30] helping clients to gain objective distance and tolerate anxiety and stress. Whitaker was talking about working with aggression, but his points map equally well to any other form of distress. He also talks about how absurdity breaks old patterns and ways of thinking: *'cutting diagonally across the affect through the use of tongue-in-check humour or a non-rational extension of the situation.'*[30] What stands out here is the client's and therapist's ability to play and have fun with the symptoms, providing a refreshing take on the situation.

Ellis argued that emotional disturbance largely consists of taking life too seriously and thus a return to humour and play was a sign of emotional adjustment.[28] Humour comes from incongruity and being able to generate multiple interpretations of an event. Viney argues that being able to produce numerous takes on an event can transcend self-imposed limitations of naïve realism.[31] Ellis advocated we stop taking things too seriously and Kelly argued we break free from limited internal worlds and build alternative interpretations. If you can create change with the immediate environment in therapy, this can stimulate creativity and give a flexible perspective that leaves the client open to change outside of the room.

Conclusion

These results show that humour has a definite role in facilitating therapeutic change with clients experiencing psychosis. Accounts of using humour with psychosis appeared to be *vital* in therapy. Humour helped the client and therapist to connect with each other, to energise the sessions, to reframe problems, to allow for an expression of unsayable thoughts and, in turn, to allow new ideas to be suggested and taken up. Humour, most importantly, modelled a different stance that one can take in the world, one that involves a degree of lightness and an appreciation of absurdity and nonsense.

Teaching clients that they can approach some of their symptoms or life troubles with some appreciation of irony or absurdity is indeed a useful coping mechanism. It is possible that laughter and humour will only be thought of as a defence mechanism, but it is one of the most mature that we have in our armoury and, arguably, the most adaptive one we can employ.[32] Clients experiencing psychosis who present to services tend to use maladaptive coping strategies such as avoidance and less active coping strategies than healthy controls (or compared to individuals in the community who do not present and therefore arguably have good coping strategies).[33] Alternative coping strategies are needed to help clients to survive the otherwise rather bleak outlook. Indeed, it was Freud who described humour as a useful coping strategy.

The argument here is not to use humour the whole time in therapy, but to reserve it so that it maintains some potency when it is used. Therapists must give themselves permission to try out a more playful aspect of their therapeutic work, decolonising them from the idea of only being serious and a ‘blank screen’ and expanding their repertoire to include being playful, using puns, irony and exaggeration, as well as paying attention to how things are said, the cadence speed and rhythm. Humour is not something that can be used as a specific technique

in therapy. Bertrando and Gilli argue that rather than being a tool, humour should be seen as a feature of the therapeutic dialogue. This alludes to the idea that the therapist can take a certain position within the work, the way they choose to frame the therapy and the style within which they work.[15]

By not using humour we are reinforcing our client's self-view of being fragile and weak, that they cannot handle humour. Using humour with clients experiencing psychosis shows that the therapist can see a client's various configurations as humour appeals to the functioning part of them. Too often, therapy is about focusing on the deficits and fragility of the client and thus inadvertently reinforcing the weakness of the client.[34]

This is not to say therapists should minimise the distress of clients or de-emphasise the hardship they face and cajole clients to just 'getting on with it', but instead to encourage them to have a different relationship to their symptoms. This means having a relationship where clients do not feel subjugated by their voices, where the humour has drained some of the agony and clients can feel lighter towards their symptoms. Humour creates a space where clients can talk about their experience and make sense of their taboo and painful experiences, which can be liberating.[34]

References

1. McCormick E. The therapeutic relationship. In: Mccormick E, & Wellings N, eds. Transpersonal psychotherapy: theory and practice. London, England: Cassell; 2000: 20-51.
2. Gelkopf M. The use of humor in serious mental illness: a review. *Ev-Based Comp Alt Med* 2011;1-8.
3. Kubie L. The destructive potential of humour in psychotherapy. *Am J Psychiatry* 1971;127:861-866.
4. Saper B. Humor in psychotherapy: is it good or bad for the client? *Prof Psy Res Prac* 1987;18:360-367.
5. The Psychologist. 2013;26,4.
6. Lemma A. Humour on the couch. London: Whurr Publishers; 2000.
7. Bentall, R. Reconstructing Schizophrenia. London: Routledge; 1990.
8. Pilgrim D. Rhetorical aspects of the contention about cognitive behavioural therapy. *Hist, Phil Psych* 2009:11:37-54.
9. NICE. *Schizophrenia Update*. Nice Guidelines; 2009.
10. Lynch D, Laws KR, & McKenna PJ. Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials. *Psych Med* 2010;40, 9-24.
11. Apel L. The healing power. *Exp Par* 2002;32:28-30.
12. Martin R, & Lefcourt H. The sense of humor as a moderator of the relation between stressors and moods. *J of Personal Soc Psychol* 1983;45:1313-1324.
13. Koestler A. The act of creation. London: Hutchinson; 1964.
14. Dimmer S, Carroll J, Wyatt G. Uses of humor in psychotherapy *Psychol Rep* 1990; 66:795-801.
15. Bertrando P, Gilli G. Collapsing frames: Humour and psychotherapy in a batesonian perspective *Intl J of Psychother* 2008; 12: 12-22.
16. Lothane Z. The uses of humour in life, neurosis and in psychotherapy: part 2. *Inter Forum of Psychoanal* 2008; 17: 232-239.
17. Morrison, A. The interpretation of intrusions in psychosis: an integrative cognitive approach to hallucinations and delusions. *Beh and Cog Psychother* 2002; 29 257-276.
18. Felices, A. Humour as an ingredient of the treatment in a therapeutic community for psychosis. *Ther Comm* 2005; 26:33-40.

19. Winnicott D. The theory of the parent-infant relationship. *Int J of Psychoanal* 1960;41:585-595.
20. Killinger B. Humour in psychotherapy: a shift to a new perspective. In: Fry WF, Salameh A, eds. *Handbook of humor and psychotherapy*: *Advances in the clinical use of humor*. Sarasota, Florida: Professional Resource Exchange Inc; 1987:21-40
21. Charmaz K. *Constructing grounded theory: a practical guide through qualitative analysis*. London: Sage; 2006.
22. Colman W. Symbolic conceptions: the idea of the third. *J of Anal Psychol* 2007; 52:565-583.
23. Kohut H, Wolf E. The disorders of the self and their treatment: an outline. *Int J of Psychoanal* 1978;59:413-425.
24. Schore A. The right brain implicit self: a central mechanism of the psychotherapy change process. In: J. Petrucelli (Ed.), *Knowing, not-knowing and sort of knowing: sychoanalysis and the experience of uncertainty*. London: Karnac Books; 2010:177-202.
25. Stern D, Sander L, Nahum J, Harrison A, Lyons-Ruth K, Morgan A, et al. Non-interpretative mechanisms in psychoanalytic therapy: the 'something more' than interpretation. *Int J of Psychoanal* 1998; 79:903-921.
26. Watts J. On the maternal function of schizophrenia. *J Centre Freud Anal Res* 2012; 22:47-65.
27. Burnham J. *Family Therapy*. Abingdon, Oxon: Routledge; 1986.
28. Ellis A. Fun as psychotherapy. *Rat Liv* 1977;12:2-6.
29. Fink B. *Clinical introduction to lacanian psychoanalysis: theory and technique*. Cambridge: Harvard University Press; 1997.
30. Whitaker C. Psychotherapy of the absurd. With a special emphasis on the psychotherapy of aggression. *Fam Pro* 1975;14:1-16.
31. Viney L. Humour as a therapeutic tool: another way to experiment with experience. In: Epting F, Landfield A, eds. *Anticipating personal construct psychology*. Lincoln, USA: University of Nebraska Press; 1985:225-233.
32. Freud A. The ego and the mechanisms of defence. London: Karnac Books; 1966.
33. Philip, L, Francey S, Edwards J, McMurray N. Strategies used by psychotic individuals to cope with life stress and symptoms of illness: a systematic review. *Anx, Stress Coping* 2009; 22: 371-410.

34. Dillon J & May R. Reclaiming Experience. *Clin Psy* 2002;17:25-28.

Appendices

Appendix A: Participant Information Sheet

Department of Psychology
City University
Northampton Square
London EC1V 0HB
Telephone: +44 (0)20 7040 8500

Fax: +44 (0)20 7040 8580
Email: felicity.adams.1@city.ac.uk

PARTICIPATION INFORMATION SHEET

Study Title: ***How is Humour Experienced by Therapists Working with Psychosis?***

Researcher: Felicity Adams

Research Supervisor: Dr. Jay Watts

What is the purpose of the study?

This study is designed to explore the ways in which humour is used when working with individuals who experience psychosis. There are a number of studies that have looked at how or why humour is used in therapy, but there is very little research that looks at its uses when working with individuals with psychosis.

It is hoped that the information gained from interviewing participants will provide a clinician-based perspective on the use of humour in psychosis, with the expectation that this will inform future clinicians and trainees about its possible benefits and drawbacks.

Thank you for expressing an interest in participating in this research. If you do decide to participate in this study, the following information will inform you of what the process will involve.

What will I be asked to do?

Participating in this research will involve meeting the researcher for a semi-structured interview at a time and place convenient to you. The interview will last for approximately 45 minutes. It will be audiotaped and it will explore your clinical experiences of using humour in therapy when working with clients who experience psychosis.

All information which is collected about you during the course of the research will be kept strictly confidential. You may decline to answer any questions you wish. You may withdraw from the study at any time without giving a reason via the ID number which can be found on your participant consent form. If you decide to withdraw, you have the right to do so up until June 2012, once data analysis has been completed. Audiotapes and transcripts will be securely stored on a P.C. with a password to access the data files. Printed transcripts (for analysis) will be kept in a locked filing cabinet and the key will be kept in a locked drawer away from the filing cabinet.

What are the possible disadvantages and risks of taking part?

There is no evidence to suggest that taking part in an interview of this nature will have any risks; however, if you should become distressed, please tell the researcher, who can provide additional support.

What are the possible benefits of taking part?

The information gathered from this study may help to inform future clinicians and trainees about the benefits or drawbacks of using humour in therapy, specifically with psychosis.

What will happen to the results of the research study?

The results of the research will be submitted for publication to scientific journals and may be presented at conferences when the study is finished. A copy of published results will be available at that time from Felicity Adams. You will not be identifiable in any report or publication.

Who has reviewed this study?

City University ethics committee have reviewed this study and granted ethics approval.

Contact for further information?

If you would like more information now or in the future, please contact:

Felicity Adams

Department of Psychology
City University
Northampton Square
London EC1V 0HB

Work Mobile: 07890 201 358

Or to contact an independent party, please contact Dr. Jay Watts (Research Supervisor) on **0207 040 0143**.

Appendix B: Participant Consent Form

CITY UNIVERSITY LONDON

PARTICIPANT CONSENT FORM

Study: How is Humour Experienced by Therapists Working with Psychosis?

Researchers: Felicity Adams

Research Supervisor: Dr. Jay Watts

Participant ID Number:

Please tick the following boxes:

(1) I confirm that I have read and understood the information sheet for the above study and I have had the opportunity to ask questions ☐

(2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason ☐

3) I agree to take part in the above study ☐

(4) I agree to audio taping of the interview for the purposes of this research project ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix C: Semi-structured Interview Schedule

Thank you for agreeing to be interviewed today. Before we get started I just wanted to tell you about this study and explain a bit about the questions I am going to ask you. I'm going to keep the questions quite open and broad and just see where it takes us.

Just to give you some background, I don't know much about how, when and why people use humour in therapy generally and particularly with psychosis. It is something that has always interested me, but not knowing much about it, I wanted to find out more from clinicians about their own views, good or bad. There are no right or wrong answers. What I am hoping for today is any thoughts you have on using humour in therapy, and if you are willing, to share with me the times when perhaps it has worked well and times when maybe it hasn't!

I asked you to keep a diary in the weeks before we met – have you been able to do this? Great, well, then I would be really interested to hear about that later in our interview to find out about the experiences you have had.

Broad Starter Questions:

1. What was your initial reaction to the research question when you received my email?
2. What are your thoughts about using humour in therapy with psychosis?
3. Tell me about times when you have/have not used humour when working with individuals with psychosis?

Questions regarding the use of humour in psychosis:

1. Can you think of a specific case when it has been important to use humour?
2. Can you think of times when humour has or has not been useful?
3. Why or how did it help the client?
4. Thinking about the modality you work in, is there any theory that would back up your use of humour?
5. Could you tell me about any experiences you have of client-initiated humour?
6. If you had to give advice to a supervisee about using humour with psychosis, what would it be?
7. If you had to summarise your experience, what would you say?

Appendix D: A Section of Transcript with Initial Codes (From Interview 5 Pages 2-4)

Transcript	**Initial Coding**
F: Hmm, so it sounds like when you are doing training you would talk about it then with trainees or fellow professionals. Could you give me a glimpse of what sort of things you would say in the training courses that you do?	Talking about humour in training
P: Um, well, if it is about the use of humour it will be, because this is something I often talk about, it's the different ways in which you can use humour and its different therapeutic uses of humour. But also, in part, in helping people develop their therapeutic repertoire and the therapeutic use of self really. Humour, play, irreverence, (pause) I don't know, is tied together so there is a part of humour which is very functional and used for a very specific reason and part of humour which is to do with the playfulness and irreverence which is also very important. And I think when you are training people it is very important, because we, in psychology, we are trying to become these very competent umm, purveyors of psychological interventions most importantly, CBT. And it's all very, it can lead to self-importance and I think to balance that we need irreverence and playfulness in humour about our self, first. If we can't laugh at ourselves, we can't take our self.... if we can't take the piss out of ourselves basically I don't think we can be good therapists. Because we lose our flexibility and for me the essence of	Using humour in different ways therapeutically Developing a therapeutic repertoire Using therapeutic use of self Being playful Humour being functional Being irreverent Teaching humour in training Balancing self-importance Being able to laugh at ourselves Encouraging flexibility through humour

the therapeutic use of self is a full range of emotional experiences and ways of being with the world, being present in the room, but being with ourselves the way and think and feel about ourselves.	Bringing a full range of emotions Humour as a way of being present
F: I think that's a very interesting point, it's so much more than just being able to use humour in the therapeutic relationship but how we use it for ourselves. And I see what you mean about taking ourselves too seriously and being able to… I like that word, playfulness, to be able to keep things open and being a bit more flexible rather than having quite rigid presentations of ourselves.	Not taking ourselves too seriously Being playful Being open about what a therapist has to be
P: Yep	
F: So you talk about there are different types of humour, could you maybe expand on the different types that there are, particularly when you're working with clients?	
P: umm, well I think one of the things is, when I start to see a new client, when I am forming a relationship. For me, especially in mental health, so working with people with psychosis, because in mental health, with the clients I've been working with, they have been in the system for a very long time so it's more of the same, they have probably seen other psychologists, social workers, psychiatrists… too many… and one aspect of the therapeutic relationship for me is to very quickly define a territory, well define	Humour helps to form a relationship Working with clients who have had multiple contacts with services Using humour to define a territory Showing difference 'This is different'

a domain that is marked as containing difference. This is different in some way. Err, and that relates to many levels but on a very general scale it's about difference, introducing difference, and one way of doing that is a playful, irreverent, sometimes humorous response the first time I see someone, within the first meeting.	Introducing difference Being playful Giving a humorous response early on
F: So really, quite early on?	Using humour early on
P: very early on, because for me it's introducing my willingness to be there, my willingness to take risks, my willingness to be real, to be authentic, whatever that means! Not to get too existential! Well, but my willingness to engage someone and not engage in just their 'illness' part of them. Not engage just the patient part of them but for me to bring humour in relation to the persons, I'm relating to a person, for me that's what it means. So, someone may not like it but that doesn't matter in that sense to me (laughter) because I also have to maintain my own flexibility in terms of the difference so that's the one aspect. I think the other bit for me, for me it's an assessment tool as well.	Showing a willingness to take risks Being authentic Using humour to make a point lightly Being willing to engage with all aspects of a person Relating to the person Humour might not be liked Maintaining a flexibility to using humour Using humour as an assessment tool
F: ok	
P: so when I see a new, I want to bring difference and establish difference as a foundation for therapeutic relationship secondly I want to use it as an assessment tool, means. So very often when I'm assessing someone whose possible for therapeutic work, I want to tap on, as much as I can tap on, rather than just the story that has	Establishing difference as a foundation for the TR Assessing someone for therapy Tapping into a new story

been told a million times err about being a paranoid schizophrenic and being very ill, if you except that diagnosis. Umm, so for me, bringing in humour, in the beginning, is a way of seeing how someone responds to irreverence and for me it is a very important index or indicator of their flexibility within that way of thinking about themselves. So just likes important to me, I want to see to what extent the person can engage with it. Umm, so it ties in again with difference but it's more sort of: 'how do they respond to it?' do they respond and laugh and we can…. We can play and come back. We can step back because for me, humour is also a way, one thing, of stepping back a bit. Or not.	Accessing a different side of the client Seeing how they respond Indexing their flexibility Assessing how they engage with humour Seeing how they respond Seeing if they can play Humour as stepping back
F: so it suggests something about how they themselves or their world. Maybe something about their flexibility?	Assessing flexibility of client
P: It's flexibility is the key thing for me, in terms of humour. So, uum, I can't think of an example now but it will be, very early on, in the assessment, so in the first session. I will see what the person does with the humour.	Assessing early on if clients use humour

Appendix E: An Example of Moving from Initial Coding to Mid-Level Codes for the Focused Code 'Being Human'

Transcript (Participant)	Initial Code	Mid-level Code
'There's something about humour being an aspect of being in a room with somebody'(P3)	Humanity of being with someone	Demonstrating Humanity
It's done with huge compassion and humanity (p6)	Bringing humanity to therapy	Demonstrating Humanity
It can help people to see that you're a human being and not just a professional' (P4)	Showing your humanity	Demonstrating Humanity
'I suppose I'm conveying a sense of… I'm… what am I trying to do sometimes? Sometimes it's self-deprecating' (P6)	Being self-deprecating	Fallibility
'I'm just a slob like everyone else' (P6)	Showing your shortcomings	Fallibility
'you know stop taking yourself so seriously' (P5)	Not taking self seriously	Fallibility
'I am me, I am not a role. I think humour is one way of drawing that distinction' (P5)	Showing I am not a role	Bringing Oneself
'You are using yourself, sort of therapeutic-use-of-self sort of way' (P5)	Using self in therapy	Bringing Oneself
Humour is also a way of saying 'this is who I am', you didn't come to see a psychologist you came to see me' (P5)	Bringing myself not 'therapist'	Bringing Oneself
'Therapeutic use of self is the use… what it means to be human but with a bit more intent, with a bit more deliberateness in a thoughtful way' (P5)	Using oneself deliberately	Bringing Oneself
'It comes naturally, I don't think 'hmm 'I'm going to use humour now!' (P1)	Bringing a natural style	Bringing Oneself
If you're not willing to show the way, in	Showing a vulnerability	Taking a Risk

terms of risks, in terms of being able to be vulnerable…' (P5)		
[contd] 'in terms of being able to fuck up and make mistakes [] if you can't do that it's not fair' (P5)	Showing you're not frightened to mess up	Taking a Risk
'Humour takes courage' (P5)	Having courage	Taking a Risk
'Finding your way, your way of doing it. What works for you' (P5)	Owning your own style	Owning Own Style
'It [humour] has to go with the relationship and with the kind of person you are' (P4)	Humour needing to fit personality	Owning Own Style
If you're showing genuineness and humours part of who you are' (P6)	Showing genuineness	Being Genuine
To my mind I can see how it [humour] fits very well with Rogerian viewpoint'	Being congruent	Being Genuine
There's something important there, that it's about your personality and what you are like a person' (P1)	Being genuine	Being Genuine

Appendix F: Guidelines for Authors, Schizophrenia Bulletin

MANUSCRIPT PREPARATION

All manuscripts are submitted and reviewed via the journal's web-based manuscript submission system accessible at http://mc.manuscriptcentral.com/szbltn. New authors should create an account prior to submitting a manuscript for consideration.

Manuscripts submitted to *Schizophrenia Bulletin* should be prepared following the *American Medical Association Manual of Style*, 10th edition. The manuscript text (including tables) should be prepared using a word processing program and saved as an .rtf or .doc file. Other file formats will not be accepted. Figures must be saved as individual .tif files and should be numbered consecutively (i.e., Figure 1.tif, Figure 2.tif, etc.). The text must be double-spaced throughout and should consist of the sections described below.

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This page should consist of (i) the complete title of the manuscript, (ii) a running title not to exceed 50 characters including spaces, (iii) the full name of each author and the authors' institutional affiliations, (iv) name, complete address, telephone, fax, and e-mail address of the corresponding author, and (v) separate word counts of the abstract and text body.

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Manuscripts should be concisely worded and should not exceed 5,000 words for invited articles for theme issues and reviews, 4,000 words for regular articles, or 2,500 words for invited special features. The word count should include the abstract, text body, figure legends, and acknowledgments and must appear together with the abstract word count on the title page of the manuscript. Supplementary data, including additional methods, results, tables, or figures will be published online.

Abstract
Provide a summary of no more than 250 words describing why and how the study, analysis, or review was done, a summary of the essential results, and what the authors have concluded from the data. The abstract should not contain unexplained abbreviations. Up to six key words that do not appear as part of the title should be provided at the end of the abstract.

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Unsolicited original manuscripts reporting novel experimental findings should be comprised of these sections, in this order: Abstract, Introduction, Methods, Results, Discussion, Acknowledgments, References, and Figure Legends. Review articles must contain an abstract; however, the body of the text can be organized in a less structured format. Authors of review articles are encouraged to use section headers to improve the readability of their manuscript.

Number pages consecutively beginning with the title page. Spelling should conform to that used in *Merriam-Webster's Collegiate Dictionary*, eleventh edition. Clinical laboratory data may be expressed in conventional rather than Système International (SI) units.

Acknowledgments
These should be as brief as possible but include the names of sources of logistical support.

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Authors are encouraged to be circumspect in compiling the reference section of their manuscripts.
Please note: references to other articles appearing in the same issue of the journal must be cited fully in the reference list.

Each reference should be cited in consecutive numerical order using superscript arabic numerals, and reference style should follow the recommendations in the *American Medical Association Manual of Style*, 10th edition, with one exception: in the reference list, the name of all authors should be given unless there are more than 6, in which case the names of the first 3 authors are used, followed by "et al."

- Book: Talairach J, Tournoux P. *Co-planar stereotaxic atlas of the human brain*. New York, NY: Thieme Medical Publishers; 1998.
- Book chapter: Goldberg TE, David A, Gold JM. Neurocognitive deficits in schizophrenia. In: Hirsch SR, Weinberger DR, eds. *Schizophrenia*. Oxford, England: Blackwell Science; 2003:168-184.
- Journal article: Thaker GK, Carpenter WT. Advances in schizophrenia. *Nat Med* 2001;7:667-671.
- Journal article with more than 6 authors: Egan MF, Straub RE, Goldberg TE, et al. Variation in GRM3 affects cognition, prefrontal gluatamate, and risk for schizophrenia. *Proc Natl Acad Sci USA* 2004;101:12604-12609.
- Article published on Advance Access only: Gilad, Y. and Lancet, D. March 5, 2003. Population Differences in the Human Functional Olfactory Repertoire. *Mol Biol Evol* doi:10.1093/molbev/msg013.
- Article first published on Advance Access: Gilad, Y. and Lancet, D. 2003. Population Differences in the Human Functional Olfactory Repertoire *Mol Biol Evol* 2003;20:307-314. First published on March 5, 2003, doi:10.1093/molbev/msg013.

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