How do therapists understand and use humour in their work with obsessive-compulsive clients?: A grounded theory study

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Abstract

This qualitative research study seeks to explore how experienced therapists - the majority of whom are Cognitive Behavioural Therapists - understand humour; and how they use it in the treatment of Obsessive-Compulsive Disorder (OCD). Between two and three per cent of the population have OCD and the World Health Organization ranks it in the top ten most disabling illnesses. However, forty per cent of obsessive-compulsive clients who engage in Cognitive Behavioural Therapy (CBT) for OCD either refuse, do not finish or fail to benefit from treatment. At the same time, research indicates that the therapeutic alliance is the primary driver for client change in therapy; and that humorous interventions help to strengthen this alliance. Data from semi-structured interviews with eight participants were analysed using Willig's abbreviated grounded theory method (2013) and a tentative model was constructed. Humour is presented as an expression of paradox in OCD (it being at once illogical, distressing and dangerous; as well as creative, informative and absurd). Participants continuously assess the type and function of humour used in session. 'Light' and soothing humour promotes constructive outcomes (distancing while closely bonded, playfulness, normalising, reframing); while 'dark' and provocative humour risks negative results (defending, offending, rupturing). When making decisions about humour use, participants have regard to both in-the-moment, and longer term, feedback on the strength of the therapeutic relationship; as well as certain individual differences (religion, class, gender, age, etc. of the client) and intrapsychic variables (the participant's own experience, training and professional reputation). The implications for theory and practice are discussed, with an emphasis on enhancing knowledge in the field of counselling psychology. Recommendations for future research are also made.

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1. Introduction

1.1 Background to this study

There has been growing interest in interdisciplinary humour research over the last few decades (Franzini, 2001; Martin, 2007). Indeed, since 1988, the International Society for Humor Studies has published a journal, *Humor*, dedicated to such research. Within the field of psychology, however, while there is an abundance of anecdotal evidence and 'advocacy literature' in support of therapeutic humour (Saper, 1987, p.363), there has been relatively little empirical research on its direct impact on psychotherapy (Saper, 1987; Franzini, 2001; Gelkopf, 2009; McGraw & Warner, 2012) and even less on its use in the treatment of particular clinical presentations (cf. Adams, 2013; Rutchick, 2013; Chauhan, 2015), specifically, Obsessive-Compulsive Disorder (OCD).

But what is 'therapeutic humour'? How has it been defined? The clinical psychologist, Louis Franzini (2001), an advocate of training therapists in the use of therapeutic humour, defines it as including "both the intentional and spontaneous use of humor techniques by therapists...which can lead to improvements in the self-understanding and behavior of clients" (p.171). The Association for Applied and Therapeutic Humor (an international community of psychotherapists, social workers, counsellors and other professionals who promote the use of humour) defines it 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. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual" (Sultanoff, 2015, p.1). Unsurprisingly, both of these definitions emphasise the positive elements of therapeutic humour.

Historically, however, psychotherapy has had an uncomfortable relationship with therapeutic humour (Kubie, 1971). At one level, humour has not been viewed as the preserve of serious empirical research (McGraw & Warner, 2012; Snow, 2014); and, when it has been researched, it has sparked controversy. While some clinicians have commended the use of humour in therapy (Ellis, 1977a; Kuhlman, 1984; Baker, 1993; Sultanoff, 2002), others have been less than enthusiastic (Freud, 1905/2013; Kubie, 1971; Marcus, 1990) - and perhaps for good reason. Humour was recently identified as one of seven potential 'chronic strategies of disconnection' between therapists and their clients (Cooper & Knox, 2018) and, historically, the potential dangers of its misuse (e.g. distraction, alienation of the client, inappropriate content, bad timing, etc.) have been well documented (Schnarch, 1990; Pierce, 1994; Saper, 1987). At the same time, however, humour has been widely recognised as a positive, therapeutic tool (Ellis, 1977a; Fry & Salemeh, 1987; Saper, 1987; Franzini, 2001; Sultanoff, 2002; Goldin et al., 2006) and has been associated with reduced stress, pain control, positive mood states, lower levels of perceived anxiety and depression, higher levels of self-esteem and a healthy self-concept (Maslow, 1970; Rogers, 1980; Lemma, 2000; Abel, 2002; Kuiper at al., 2004; Savage et al., 2017).

While the use of therapeutic humour continues to invite debate, what is perhaps clear from the research is that humour often does arise within therapy (Bloch & McNab, 1987; Franzini, 2001; Strean, 1993) and I would contend may therefore be of potential interest to practising therapists.

Research indicates that between two and three per cent of the population have OCD (NCCMH, 2006, p. 20; Rachman & De Silva, 2009) with over half suffering from co-morbid depression or anxiety (Leahy, Holland & McGinn, 2012, p. 353). The World Health Organization ranks OCD in the top ten of the most

disabling illnesses (Bobes et al., 2001, cited in NCCMH, 2006, p. 19). However, forty per cent of obsessive-compulsive clients who engage in Cognitive Behavioural Therapy (the treatment of choice within the NHS for OCD (NICE, 2005)) either refuse treatment, do not finish treatment or fail to benefit from it (Abramowitz, 2006). At the same time, research indicates that the therapeutic alliance is the primary driver for client change in psychotherapy (Strupp, 1960; Lambert & Barley, 2001; Watson, 2007) and that humorous interventions help to strengthen this alliance (Gelkopf & Krietler, 1996; Richman, 1996). Thus, further research into alternative therapeutic interventions for those obsessive-compulsive clients who do not respond to treatment may be beneficial to both clients and therapists alike.

1.2 Reflexive Statement (Part 1)

It is important that I acknowledge my long held fascination with humour and its place and function in human relationships: this was my main motivation for conducting this study. Life can be difficult; and while humour can be offensive and divisive, it can also bring a sense of perspective and relief to problems, as well as the potential for an emotional connection with, and better understanding of, others.

One of my earliest memories is feeling the vicarious effect of my grandfather's laughter as we listened to Tony Hancock's 'The Blood Donor'. While the jokes were impenetrable to me at the time, I derived huge pleasure from *his* pleasure; and vice versa. We chuckled a lot. It was a bonding experience; and one grounded in inter-subjectivity. But I have also experienced humour in other different, but equally important, ways. 'Black' humour was the mainstay of both my pregnancies and subsequent bouts of post-natal depression. It provided me with the language to construct a range of painful emotions surrounding my fears that I might

not be a 'good enough' mother, so releasing some of my emotional pain and enabling me to better cope with my anxiety. At work, too, humour has been a way for me to better understand and bond with my peers; to engender a sense of 'togetherness' through both good and bad experiences.

It was perhaps no surprise then that, when I started my training in counselling psychology, I began to draw parallels between humour and therapy and was predisposed to see the potential value of humour within the therapeutic relationship. I also believe that the therapist and the comedian may have more in common than at first appears: they may both seek to alleviate the burden of our 'psychic pain' (Birner, 1994) and they both engage with, and appeal to, the very subjective nature of our 'meaning-making'. As Freud (1905/2013) put it: "Only what I allow to be a joke *is* a joke" (p.105). Both comedian and therapist may find inspiration from the complexities and contradictions, the difference and disconnection, in our lives, seeking to encourage the exploration of, and curiosity about, the often hidden and unrecognised incongruities of our subjective experiences, by questioning and challenging accepted 'truths' and beliefs. Thus, both humour and therapy may enable us to conceptualise "familiar things in unfamiliar ways and unfamiliar things in familiar ways" (Borbely, 1998, cited in Lemma, 2000, p. 3).

In my limited clinical experience, the familiarity of the comedian and therapist with paradox and incongruity is very much in keeping with the experience of many obsessive-compulsive clients for whom OCD can be as creative and humorous as it is distressing and dangerous. I therefore embarked on this research study keen to better understand the potential overlap between humour and therapy; and, specifically, where it may be helpful to therapists in monitoring and managing the therapeutic relationship with obsessive-compulsive clients.

Throughout this research project, I have been very aware of my own preconceptions about, and experiences of, therapeutic humour particularly in my work with obsessive-compulsive clients. While I cannot position myself outside of this research - and any attempt to achieve such a 'God's eye view' (Haraway, 1988) would have been misleading - I have been in a continuous state of reflection on how my views and beliefs have influenced, and been influenced by, the process of this research and its findings.

At the start of this research project, I held certain beliefs and assumptions about the research topic. I believed that there were likely to be far greater benefits than risks – all to be explored – associated with using therapeutic humour in the treatment of obsessive-compulsive clients. (This assumption was heavily challenged and, as a result, I have since revised and moderated my views.) I also assumed that the participants would have experience of therapeutic humour that had worked well, and not so well, in session with their obsessive-compulsive clients; and that they would have some views on whether therapeutic humour might be a help or a hindrance in their treatment.

Before I present the research itself, however, the literature review that follows is intended to provide a framework for this study and to explore the theoretical underpinnings of both humour and OCD.

2. Literature review

In this chapter, the various theoretical frameworks that have been developed to explain humour are briefly reviewed and the controversy surrounding the use of therapeutic humour in session with clients is explored. The existing empirical research on therapeutic humour is then reviewed. Next, the main theoretical approaches to OCD and the principal models used to explain, and treat it, are outlined. Finally, the connections and common ground between humour and OCD are discussed; the 'gap' in the literature, together with its relevance to counselling psychology, identified; and the research questions presented.

2.1 Humour theories

Why are things perceived to be funny; and what are the cognitive and emotional processes involved? Philosophers and theorists have derived three main theories of humour - superiority, incongruity and relief – to answer these questions (Gelkopf, 2009; Martin, 2007).

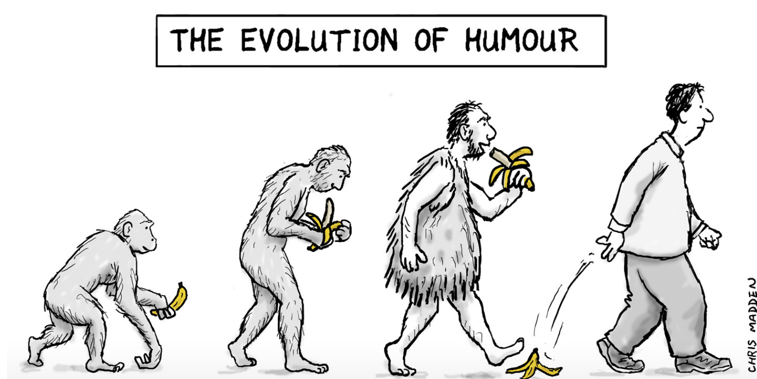

Figure 1. 'The evolution of humour' cartoon. © Chris Madden, 2015

2.1.1 Superiority theory

For some Classical philosophers, humour originated in the defect or deformity of another, which manifested in enjoyable feelings of superiority in the

observer (McKeon, 1941; Koestler, 1949). However, aggression (albeit sometimes unconscious) is portrayed as an 'essential' characteristic of humour which discounts some of its other important facets: benevolent word play or nonsense (Martin, 2007); or humorous, yet benign, incongruity (Munro, 1988).

2.1.2 Incongruity theory

Kierkegaard argued that, wherever life exists, there is contradiction and whenever there is contradiction, comedy arises (Heuscher, 1993). Thus, incongruity, it is suggested, accounts for the underlying structure of all jokes involving a punchline, which we experience as a surprise (Lemma, 2000). Freud (1905/13) noted that jokes comprise two, contrasting trains of thought; one which follows a 'discursive logic' and another (the punchline) based on an opposing 'poetic logic'. For him, the discursive logic is indicative of overt, conscious thoughts while the poetic logic corresponds to covert, unconscious elements. Koestler (1964) described these conscious and unconscious aspects as 'double-mindedness' and viewed the interplay between them as the basis of creativity. Indeed, laughing at an incongruity requires the ability to amalgamate contradictory ideas and so entertain the existence of other viewpoints. Thus, there is a growing awareness of other possibilities, other realities and other interpretations; and so, a 'theory of mind' (Fonagy et al, 2002). However, while incongruity theory may explain the cognitions required to understand a joke, it has less to say about the emotional responses which make the resulting humour so enjoyable (Suls, 1983).

2.1.3 Relief theory

Freud (1905/13) also theorised that laughter releases excess nervous energy, enabling repressed experiences and feelings to be given *indirect* expression. He analysed three 'laughter situations' ('jokes', 'the comic' and 'humour') and proposed a psychological account of why we joke and how it causes us pleasure. In 'jokes', energy – which would otherwise repress 'forbidden' feelings - is released as laughter. In reacting to 'the comic', we laugh to release left over cognitive energy which would have been used to solve an intellectual challenge. In 'humour', we save emotional energy and laugh when a situation is less serious than anticipated. Thus, for Freud, humour is a link between the unconscious and the ego: people laugh as a socially acceptable means of expressing their otherwise unacceptable aggressive or sexual drives (Felices, 2005).

However, not all humour involves laughter and, as Morreall (1982) notes, while there may be a link between *some* laughter and the release of nervous energy, it cannot be claimed that *all* laughter involves such a release. Sometimes there is no build-up of excess nervous energy and so laughter may be equally attributable to the 'surprise' of an unforeseen incongruity. Freud's theory also assumes an 'intra-subjective' conflict within the individual and so discounts the importance of the 'inter-subjective' processes involved in humour (Newirth, 2006).

2.1.4 Humour and play

Developmental theorists have since taken up this mantle and researched the intersubjective nature of children's experience and their cognitive and emotional development via the stimulation and excitement of play (Bowlby, 1988; Stern, 1985; Winnicott, 1971). Humour and laughter occur in the context of play (Martin, 2007).

Indeed, Stern (1985) likened the childhood game of 'peek-a-boo' to the pleasure derived from an unforeseen incongruity, much like the punchline of a joke. Klein (1961), too, stressed the importance of play in a child's ability to abandon perfection in favour of a degree of uncertainty and ambivalence between good and bad; love and hate. The ability to relate to others and play is thus cast as a key developmental achievement (Reddy, 2008).

The broad scope of these theories allows for a rich diversity in the form humour might take; from a playful joke, to an unintentional pun; from extreme exaggeration to self-deprecation. They also allow for a range of emotional responses, from laugher to more subtle reactions; an empathetic smile, for example. So why have some theorists constructed therapeutic humour in such negative terms?

2.2 Therapeutic humour as 'destructive'

Freud was interested in humour and reportedly told jokes to his patients in session (Strean, 1993), but he warned against its use within the therapeutic frame (Freud, 1912). While he argued that humour can provide access to a client's unconscious material (1905/2013), he also felt that engaging in humour with a client may disguise sexual or hostile impulses and so render the resolution of the transference difficult (Freud, 1912).

For Freud, humour is a socially acceptable means for us to gratify our innate aggressive and sexual drives (1905/2013). The triumph of the 'pleasure principle' occurs as the benevolent super-ego indulges the selfish ego in some narcissistic pleasure via its expression of humour (Lemma, 2000). Thus, the pleasure we derive from humour brings a momentary reprieve from the 'pain' of reality as our initial source of anxiety is recast as something funny (Vaillant, 1992). In this way, Freud

viewed humour as the most adaptive and mature defence we use to combat anxiety.

The incompatibility of humour and orthodox psychoanalytic practice has led some clinicians to view the use of humour in therapy with suspicion. Kubie (1971) took up Freud's concerns: "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" (p.866). Certainly, the discourse on therapeutic humour has identified some serious potential pitfalls to using humour in therapy. Many clinicians have argued that the use of ridicule, sarcasm and irony by the therapist may make clients wary and defensive (Kubie, 1971; MacHovec, 1991; Schnarch, 1990). Both Parry (1975) and Thomson (1990) thought that humour could lead to an imbalance within the therapeutic relationship, blocking effective communication. Kubie (1971), too, warned that humour "is perhaps the most seductive form of transference wooing" (p. 864). Grotjahn (1957) reasoned that humour may provide the means for a therapist to gain mastery and control over the client; or vice versa. And, understandably, many clinicians have warned against using humour in circumstances when a client is grieving, or feeling very vulnerable (Rosenheim & Golan, 1986; Kubie, 1971).

Ziv (1984) noted that the client's personality traits, as well as the individual differences between the client and therapist, were also significant in the evaluation of therapeutic humour. Individual experience and knowledge, ethnicity, age, class are all considered to have a strong bearing on an individual's sense, and use, of humour in therapy; thus rendering it an unpredictable, 'context-driven' intervention.

Other critics of therapeutic humour have focused on the dangers of its unpredictable and spontaneous nature (Kubie, 1971; Altman, 2006). As Altman (2006) notes: "An interaction that is experienced by both [analyst and patient] as

humorous depends on an unconscious confluence which is largely spontaneous. Efforts to orchestrate a particular outcome to an intervention that is meant to be humorous may well reveal more than is intended and thus have an unpredictable unconscious resonance" (2006, p.573). As such, it is suggested that the use of therapeutic humour may involve too great a degree of risk.

2.3 Therapeutic humour as 'constructive'

Advocates for the use of therapeutic humour have also provided many anecdotes and vignettes to describe the positive clinical outcomes brought about through humour (Gelkopf, 2009; Franzini, 2001; Bader, 1993; Haig, 1986). Richman (1996) summarised the potential benefits as creating a positive atmosphere; strengthening the therapeutic alliance; encouraging cohesion, positive acceptance, problem recognition and empathetic listening; enabling multiple meanings; communicating taboos; enabling alternative perspectives and a sense of proportion; and, reducing anxiety. Newirth (2006) suggested that therapeutic humour mitigates transference-countertransference fantasy, which he argues both strengthens the intersubjective connection between client and therapist and provides a potential route for transformation. Salameh (1983) provided an historical overview of therapeutic humour noting the techniques which have been reported to bring about positive change: "surprise, exaggeration, absurdity, incongruity, confirmation/affirmation humour, word play, metaphorical mirth, impersonation, the tragicomic twist and bodily humour" (p.78).

Some clinicians have also formally incorporated humour into their modalities (Ellis, 1987; Frankl, 1967; O'Connell, 1981). Ellis (1987), the founder of Rational Emotive Therapy, believed that people cause themselves distress and that humour

could be used to confront their 'irrational' beliefs, to challenge pessimism and to precipitate change. Controversially, Ellis was also renowned for singing 'rational humorous songs'[1] with his patients to ridicule and challenge their beliefs and behaviours (Ellis, 1977b). Frankl, the founder of Logotherapy and a pioneer of existential therapy, employed the technique of 'Paradoxical Intention' (Frankl, 1967). By focusing attention on anxiety-provoking thoughts or behaviours and exaggerating them to the point of absurdity, he encouraged clients to see the humour and irrationality implicit in them (Ameli, 2016). Farrelly and Brandsma (1974), in their book *Provocative Therapy*, also advocated a radical form of therapy in which the therapist plays devil's advocate with, often humorous, interventions intended to induce an ability to laugh at neurotic behaviour and so 'jolt' the client out of their existing mindset.

2.4 Empirical research into therapeutic humour

Most of the 'evidence' presented up to this point has been based on the opinions and anecdotal experience of individual clinicians. This is, in large part, explained by the fact that there is relatively limited empirical research on therapeutic humour. In 1987, Saper, a clinical psychologist, estimated that there were only two dozen studies in total and those that had been conducted "are found wanting in terms of design, methodology and definitive results" (Saper, 1987, p.360). In his view, this is because humour is "formidable, if not impossible, to research" (Saper, 1987, p.366). I would also suggest that the historic emphasis on quantitative

[1] For example, see "Whine, Whine, Whine! (Tune: Yale Whiffenpool Song, by Guy Scull – a Harvard Man!): "I cannot have all of my wishes filled – Whine, whine whine! I cannot have every frustration stilled – Whine, whine, whine! Life really owes me the things that I miss, Fate has to grant me eternal bliss! And since I must settle for less than this – Whine, whine, whine!" (Source: http://trop.troy.edu/kness/ellis-ret%20handouts/rational%20humorous%20addiction%20songs%20by%20ellis.pdf)

methodologies is perhaps less compatible with the complex constructions of humour, making research more difficult.

2.4.1 Quantitative research: inconclusive results

In his analysis, Saper (1987) reviewed six quantitative doctoral research studies, which examine different aspects of humour and therapy but, overall, provide inconclusive results. I tried to obtain copies of these studies but was left frustrated in my attempts: almost all are available only as 'abstracts'.

Labrentz (1973) conducted a research study (at the University of Southern Mississippi) to assess whether a humorous cartoon presented to clients immediately before their initial therapy session had an effect on their subsequent perception of the therapeutic relationship. Clients were asked to complete a 'Relationship Questionnaire' immediately after the session. Results indicated that the scores of those clients who had been presented with the cartoon were 'significantly' higher than those clients in the groups which had been presented with geometric designs, had been kept waiting or had simply received therapy 'as usual' (control). Saper (1987), however, notes that these results were "barely confirmed at the .05 level of significance" (p.362). In addition, this study does not cover the use of therapeutic humour in session, and I would argue that it therefore has less to offer the debate.

Golub (1979) examined whether in-session humour improved the ratings participants gave to the therapist and therapy session. Participants were required to view two scripted, videotaped therapy sessions in which two actresses played the role of therapist (one using humour; the other, none) and one played the client (in both sessions). The humour employed in the 'humorous' session "took the form of gentle confrontation that highlighted what the client was saying and called attention

to the process between therapist and client" (Golub, 1979, cited in Saper, 1987, p.362). However, the results indicated that there was no significant difference between the participants' evaluations of the therapists whether they did – or did not - employ humour.

I would suggest, however, that the very limited scope of Golub's study (only two sessions), which was binary in character (humour used or not), used only one 'type' of humour (a "gentle confrontation") and employed actresses reading from scripts to 're-create' therapy sessions, tells us very little about the authentic use of multiple, and spontaneous, humour in the course of 'real' therapy.

Several other studies, not covered in Saper's (1987) review, used 'simulated' therapy sessions in which pre-recorded humorous and non-humorous therapist 'interventions' were played to participants. In studies by Rosenheim and Golan (1986), Golan, Rosenheim and Jaffe (1988) and Rosenheim, Tecucianu and Dimitrosky (1989), the participants preferred the non-humorous interventions. They viewed them as more helpful, likely to enhance the therapeutic relationship and evidence of greater empathy and understanding. However, such simulations do not take account of the therapeutic relationship between therapist and client, nor the subjective and spontaneous humour that may arise between them. As such, they cannot provide conclusive evidence of clients' preferences for therapeutic humour. Equally, in Rosenheim et al's study (1989), the participants were 'non-chronic schizophrenics' and so the results may have application only to this client population.

Gervaize, Mahrer and Markow (1985) conducted a study into the humorous interventions which evoke therapeutic, client laughter. Their findings highlighted that client laughter was not initiated by jokes, slapstick or comedic one-liners;

instead, it was the spontaneous playfulness of the therapist, an understanding of the comic-tragic and the client's recognition of themselves as silly that mattered most. The study concluded that client laughter induced a cathartic experience and resulted from interventions designed to encourage risk-taking by the client. A replication of this study (Falk and Hill, 1992), however, found that clients did not laugh when they were invited to engage in risky behaviours and that some clients reported greater 'benefits' from humorous interventions than others. However, both studies used 'quantitative' categories of conscious, humorous intervention by the therapist which had been pre-determined by the researchers. This overlooks the more complex and spontaneous interpersonal and intersubjective processes at work; as well as the use of client humour. Moreover, participants were observers of, rather than participants in, the therapy: they simply watched recordings of eight counselling exerts in order to identify and evaluate which therapist interventions resulted in client laughter.

In 2010, Blevins, a doctoral student of Auburn University, Alabama conducted a study to explore the perceived effectiveness of humour as a therapeutic tool based on the 'social influence model' (Strong, 1968); and how the relationship between self-reported sense of humour and ratings of therapist attractiveness, effectiveness and expertness was moderated by expectations of humour in counselling. Participants comprised a non-clinical sample of 227 members (44 males and 183 females) of the general public (aged 19 to 75 years), approximately half of whom were currently or had previously been in therapy. Each participant read two clinical vignettes which contained both humorous and non-humorous interventions. The humorous interventions were created by Blevins from descriptions of humorous therapeutic techniques derived from other sources. The participants also completed four instruments: a measure of expectations about humour in therapy, two

administrations of the Counselor Rating Form-Short Form (Corrigan & Schmidt, 1983) and the Multidimensional Sense of Humor Scale (MSHS) (Thorson & Powell, 1993).

Results indicated that sense of humour was significantly correlated with effectiveness for one of the humorous vignettes. For this same vignette, the expectation of humour in therapy also moderated the relationship for total effectiveness, expertness and trustworthiness scores. Overall, however, there were no significant differences in the ratings for effectiveness of 'humorous' and 'non-humorous' counsellors; and no differences in effectiveness between using facilitative humour and using no humour. Thus, in general terms, the results neither supported nor condemned the use of humour in therapy. However, those participants who expected humour and rated themselves high on sense of humour (indicated by the MSHS) seemed to be a group which may benefit from the use of humour in therapy.

In terms of critique, approximately half of the participants had no personal experience of therapy and so, arguably, had less to offer the debate on therapeutic humour. Equally, the vignettes used in this study were constructed by the researcher and evaluated by the participants. It was therefore not possible to explore or account for the importance of the therapeutic relationship which exists in 'real life' therapy and its impact on the humour used in session. Finally, the nature of the predetermined vignettes again overlooks the more spontaneous expressions of humour that often arise in therapy.

In conclusion, I agree with Saper (1987) that there is still little empirical evidence on the use of therapeutic humour and that, in terms of quantitative studies, what does exist is inconsistent. However, this may be explained by Saper's focus on quantitative methodologies. Humour, I would contend, is subjective and contextual,

the result of a particular relationship at a particular point in time. Within therapy, it is also implicitly dyadic and inter-subjective. To my mind, all this makes it the 'natural' preserve of qualitative research.

2.4.2 Qualitative studies: a focus on the therapeutic relationship

In recent years, there has been an increase in qualitative research into therapeutic humour. In his doctoral thesis, Gregson (2009) carried out a phenomenological investigation to explore both client and therapist humour. The study sought to shed light on: (i) the characteristics of humour, in order to formulate a 'general description' and understanding of humour in therapy; (ii) the dynamics of humour and their clinical relevance; and (iii) humour theory.

Eight female participants (three therapists; five clients, a total of five dyads) were recruited at the Duquesne University Psychology Clinic. Each dyad provided a video or audio recording of one therapy session for analysis and the researcher conducted a semi-structured interview with each participant to review fifty 'humorous instances' (pre-selected by the researcher) from the recordings.

Clinical, conversation and humour theory analyses were conducted on the resulting data. The clinical analysis sought to engage with participants' motivations for using humour, focusing on psychoanalytic defences. The conversation analysis constructed an account of how conversational convention shaped the humour used and limited participants' responses. Finally, humour theory analysis interpreted each 'humour instance' in terms of incongruity, release and superiority theories.

The study found that the humour used by participants varied widely but was almost always signalled by cues (laughter or exaggerated gestures). Moreover, humour was a function of context and a means of communication (rather than a

source of 'pleasure'); and often signalled uncertainty or aggression within the therapeutic relationship. Finally, client-initiated and context-dependent humour occurred more frequently than therapist-initiated or objectively-understandable humour.

In terms of critique, Gregson unilaterally selected the fifty 'humorous instances' for analysis - using laughter as an indication of humour - thus precluding not only the views of participants but also those potential instances of humour in which laughter did not occur. He also notes bias in the research: "I tend to focus on the repressed and taboo…and this preference seems to be reflected by my emphases on the contentious aspects of humor [in this study]" (2009, p. 215). There was also little opportunity (except, peripherally, in the interviews) to assess the impact of humour over the course of treatment. Again, there was no information about the clients' clinical presentations or what session number each recording related to and it was therefore impossible to determine whether these had a bearing on the humour used in session. Finally, since all participants were female, the study provided no insight into the humour of male clients and therapists.

Scott (2009), a doctoral student in counselling psychology and psychotherapy at Middlesex University and Metanoia Institute, conducted a grounded theory study of eight experienced therapists – two men and six women, all practising from an integrative perspective - using semi-structured interviews to explore the effects of humour in individual therapy and, in particular, the intersubjective views of humour as 'heightened affective moments', which have the potential to create transformation. The main research questions were: How can humour enhance the therapeutic process? How can humour hinder the therapeutic process? What are the factors that influence therapists' decisions to use or respond to humour with their

clients? What kinds of humour are appropriate for therapy? Can humour be a route to the unconscious?

The study findings suggested that therapists engage in an assessment process to determine the appropriateness of using or responding to humour and identified various ways in which humour might enhance or hinder the therapeutic process. The appropriateness of using or responding to humour was found to be determined by three sets of variables: characteristics of the relationship (in particular, the duration of therapy); characteristics of the therapist (comprising their personal and professional history); and, characteristics of the client (specifically, how they used or responded to humour, racial and cultural differences, character styles, affect regulation and whether their humour is prejudiced). In terms of enhancing the therapeutic process, findings indicated that, when used appropriately, humour might facilitate trust and bonding; change clients' perspectives; promote self-forgiveness; enable the expression of disavowed thought and feelings; and promote appreciation and joy. By contrast, when used inappropriately, humour might block underlying feelings; promote a sense of shame or ridicule in the client; or lead to a rupture in the therapeutic relationship.

I found this study compelling in terms of its ability to draw from, and build upon, previous anecdotal research and so develop a more rigorous framework to assess the potential benefits and pitfalls of therapeutic humour use. In terms of critique, there was no information about the clients' clinical presentations and it was therefore impossible to determine whether these had a bearing on the humour used in session. Equally, the participants were all integrative therapists and so, as Scott suggests (2009, p.108), any variations in humour use between theoretical orientations may have been lost.

Wolf-Wasylowich (2011), an MA student in Counseling Psychology, conducted a phenomenological exploration of eight therapists' (seven female; one male) experiences of therapeutic humour. Participants were recruited via a 'snowball' email to therapists at two health centres in Alberta, Arizona. They came from a range of professional backgrounds (social work, psychology, occupational therapy and nursing) and had varying levels of experience (between one and fifteen years) to a wide range of clinical presentations. Semi-structured interviews with participants sought to answer a number of questions: How do therapists understand humour in the therapeutic relationship? In what ways is humour perceived as therapeutic or not? How is humour used by the therapist and client within the therapeutic relationship?

The study findings indicated that an "established therapeutic relationship" was vital for humour use (2011, p. 61). Participants reported that humour occurred naturally and spontaneously, enhancing the therapeutic relationship by enabling participants both to appear more 'human' (less like 'experts') and to communicate alternative perspectives to clients. Equally, participants felt that clients' use of humour often signified resilience and hope. Humour was used for 'emotional regulation', enabling clients to manage difficult emotions. On the downside, participants voiced concern that clients would misconstrue humour as mocking their problems. They also noted that sometimes humour was used to avoid uncomfortable emotions. Interestingly, the findings indicated that use of 'cultural humour' by therapists encouraged "a deeper bond and understanding" (2011, p.65) with clients. However, details of the participants' culture and ethnicity were not provided and so it was impossible to contextualise these findings.

Rutchick (2013), a doctoral student in clinical psychology at Pepperdine University, conducted a qualitative content analysis of videotaped therapy sessions involving the trauma discussions of five client-participants from community counselling centres. The coding system created was based on existing literature on humour and psychology and examined verbal expressions of humour and laughter in psychotherapy sessions with trauma survivors. Results indicated that client-participants consciously engaged in, and responded to, humour both verbally and by laughing, most frequently in the context of "serious, difficult or traumatic topics" (p. xvi). Client-participants' 'verbal expressions of humour' (VEH) often consisted of combinations of 'Dark', 'Aggressive' and/or 'Self-Deprecatory' humour, being potentially maladaptive forms of humour (Martin, 2007). Client-participants laughed almost twice as often as they produced a VEH and the therapists joined in that laughter about half the time. Additionally, the therapists were often found to laugh inappropriately and outside the context of any identifiable humour (either VEH or laughter).

The main limitation of this study relates to the fact that all client-participants were trauma survivors and so the results may have application only to this client population. However, Rutchick also notes that the coded data did not always fit perfectly into the coding scheme which may have increased the potential for researcher biases to impact the data coding and analyses. Additionally, the placement of the recorded therapy session (i.e., whether it was the second of ten sessions or the fortieth of forty-five sessions) was unknown for most of the client-participants. Since the nature of the therapeutic relationship and level of client distress may change during therapy, this information may have provided more context regarding the intent or function of the humour used.

Adams (2013), a doctoral student in counselling psychology at City University, London, conducted a social constructivist grounded theory study (Charmaz, 2006) of how humour affects the therapeutic relationship with clients experiencing psychosis. The study aimed to answer the following questions: Does humour help to foster a therapeutic alliance?; Does humour help to facilitate change in the client?; Does humour hinder therapy?

Eight therapists (three female; five male), with at least two years' post qualification experience and from a range of professional backgrounds (family therapy, psychotherapy and clinical/counselling psychology) and theoretical positions (CBT, ACT, psychodynamic and psychoanalytic), were recruited from the researcher's professional network. Each participant kept a 'humour diary' for several weeks to record examples of humour they experienced with their clients. Thereafter, semi-structured interviews were conducted with each participant.

The study identified three 'necessary conditions' to using humour: (i) an existing 'rapport'; (ii) a clear rationale for using humour and an understanding of how the client might experience it; (iii) 'being human' and willing to demonstrate empathy. The findings also identified eight other functions of humour (being playful, connecting, draining of agony, lightening symptoms, communicating taboo, shielding emotion, energising communication and 'third space' or deconstructing meaning and introducing difference).

Participants felt that humour enabled them to foster the therapeutic alliance by managing emotional intensity and enabling them to "relate differently to [clients] at a deeper level" (2013, p. 141). Moreover, 'mirroring' a client's humour made that client feel better understood, more able to cope and, additionally, 'normalised' their experiences. Humour also helped clients connect with different 'configurations'

(thoughts, feelings and behaviours relating to different dimensions of the self (Mearns & Thorne, 2007, cited in Adams, 2013, p.143)) of themselves - for example, the 'well and functioning self' - that may have diminished as a result of psychosis.

In terms of facilitating change, the study found that the 'jolt' of humour in therapy was an effective means to carve out the therapeutic space as different from 'normal' social interaction, enabling clients to discuss what was really on their mind. Humour also enabled clients to reframe their relationship with their symptoms, creating perspective and a reinterpretation of events. By contrast, humour was sometimes reported as hindering therapeutic work. In keeping with Kubie's views (1971), the study found that humour could be used to 'mask pain' and 'form a barrier'.

In terms of critique, Adams herself notes that there may have been "a selection bias operating in this study" (2013, p. 155) since the potential participants were recommended to her precisely because they had an interest in the topic and all eight agreed to take part.

Gibson (2014), in his doctoral thesis in existential psychotherapy and counselling at Middlesex University, conducted an IPA to explore therapists' experience of therapeutic humour. Six participants (three men and three women; all qualified psychotherapists with at least five years post-qualification experience) were recruited by word of mouth. Half the participants were non-native English speakers. The researcher collected data via semi-structured interviews.

The study findings identified three superordinate themes (energy and depth; therapeutic relationship; and, psychological and behavioural shifts) as well as six 'positive', and three 'negative', sub-themes. The majority of participants were positive about humour's use to redress power imbalances with clients, but some felt

that it could establish or reinforce such imbalance. All participants described humour as enabling clients to explore experiences that might otherwise prove too difficult. However, humour was also constructed as a means for clients to mask their true feelings. Again, humour helped to establish and strengthen the therapeutic relationship, and was often used by clients to diffuse aggression and hostility. In one context, humour served as a "bridging device" (2014, p. 129) to shift the focus away from the cultural differences between therapist and client. However, it was noted that humour was also used to enhance seduction and collusion between therapist and client (p.132).

Overall, the findings of this study replicate the existing discourses on the potential benefits and possible pitfalls of therapeutic humour use. However, Gibson himself notes his own bias in favour of therapeutic humour stating that he was "already an advocate of humour in the consulting room" (2014, p. 182). Equally, since half of the participants were non-native English speakers, they may not have fully understood their clients' culturally-nuanced use of humour. As Gibson notes, humour "depends on shared knowledge and because of this much humour is culture-specific" (2014, p. 153).

Most recently, Chauhan (2015), a doctoral student at Roehampton University, conducted a narrative analysis of six therapists' (five counsellors and one clinical psychologist, with largely humanistic theoretical backgrounds) experiences of humour with clients diagnosed with a terminal illness via an exploration of how tragedy and comedy present themselves in the therapeutic space. In keeping with Bruner's relaxed narrative approach (1991, 2004), Chauhan was free to analyse the content and structure of participants' narratives as she saw fit and she therefore chose to pay particular attention to the characters (heroes, villains and victims), plot

(tragedy and comedy; reversal of fortune; struggle between contending forces), temporality (linear timelines; in the moment humour; distortions in chronology between past, present and future) and situatedness (boundaries; awkwardness; taboos). Findings, in the form of participants' narratives, were presented in the form of a play and concluded that participants experienced humour as a 'personal experience', one that is 'risky', often 'black' and which may conflict with an initial sense that participants need to be 'serious' and 'cautious' in session, particularly with this client population. Humour is also presented as a means to 'treat the client like a person, not like a dying person' but only when it is initiated by the client.

In terms of limitations, again, in this study, the participants were all clients diagnosed with a terminal illness and so the results may have application only to this client population. Perhaps more interestingly, Chauhan herself notes, too, that the narrative model may focus too heavily on the subjective creation of a plot, characters, situatedness and temporality and so be too 'directive', limiting the reader's ability to develop their own experience and interpretation of the data. However, I would contend that this is likely to be the case for all qualitative research.

2.5 Obsessive-compulsive disorder

During the European Renaissance, obsessions and compulsions were categorised under the umbrella term 'scrupulosity' (Short History of OCD, 2009; Cefalu, 2009). Later, they were conceived of as symptoms of religious melancholy (Burton, 1621). In 1691, John Moore, the then Bishop of Norwich referred to those "obsessed by naughty and sometimes blasphemous thoughts [which] start in their minds, while they are exercised in the worship of God [despite] all their endeavours

to stifle and suppress them, the more they struggle with them, the more they encrease" (cited in Stanford Medicine, 2019, p.1).

Over time, theories about OCD took on a broader understanding. In nineteenth century France, OCD was characterised as a disease of the emotions and volitions (Stanford Medicine, 2019). By contrast, in Germany at the same time, it was regarded as a disorder of intellect (Stanford Medicine, 2019). By the early twentieth century, the French psychiatrist, Pierre Janet, and Freud dominated debates around the nature of obsessions and compulsions. While Janet conceptualised OCD as a neurosis - rather than a psychosis - and championed its treatment with medication (notably, opium, morphine and arsenic), Freud's views on *Zwangsneurose* (later translated as 'obsession' in England and 'compulsion' in America) were radically different and focused on unconscious conflicts (Freud, 1895/2014; Al-Sharbati et al., 2014). As evidenced in his case of 'The Rat Man', Freud interpreted obsessions and compulsions symbolically and advocated treatment in the form of psychoanalytic analysis (Freud, 1909/2001).

The current diagnostic criteria for OCD are set out in The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) (see Appendix A). In short, OCD is characterised by "the presence of either obsessions or compulsions, but commonly both" (National Collaborating Centre for Mental Health [NCCMH], 2006, p. 15). Obsessions are "recurrent, persistent, thoughts, images or impulses that intrude into consciousness and are experienced as senseless or repugnant" (Rachman & De Silva, 2009, p. 3). They may include fears of contamination by germs, harming oneself or others, or behaving unacceptably. A person will recognise obsessions as their own thoughts but they occur against the person's will and are resisted, causing distress (NCCMH,

2006). Abramovich (2006) identified six domains of dysfunctional beliefs associated with OCD: excessive responsibility, over-importance of thoughts, need to control thoughts, overestimation of threat, perfectionism and intolerance for uncertainty (p.412).

Compulsions are "repetitive, purposeful forms of behaviour" (Rachman & De Silva, 2009, p. 3) which a person feels driven to carry out in order to reduce distress or to prevent a feared event. They may include excessive cleaning or repeated checking. A person may recognise the behaviour as senseless and does not gain pleasure from it (NCCMH, 2006).

Research indicates that between two and three per cent of the population have OCD (NCCMH, 2006, p. 20). OCD appears across many countries and cultures, is experienced equally by gender and occurs across the life span, with typical onset between early adolescence and young adulthood (Leahy, Holland & McGinn, 2012) and stress implicated in both the onset and persistence of OCD (Rachman, 1998; Zator, 2014).

The World Health Organization ranks OCD in the top ten of the most disabling illnesses by decreased income and quality of life (Bobes et al., 2001, cited in NCCMH, 2006, p. 19). Indeed, individuals with OCD experience a sense of "overwhelming personal failure matched against age appropriate life goals" (Murphy & Perera-Delcourt, 2014, p.111). However, forty per cent of OCD clients who engage in CBT, the treatment of choice for OCD, either refuse treatment, do not finish treatment or fail to benefit from it (Abramowitz, 2006). Thus, further research into alternative therapeutic interventions for those who do not respond may be beneficial to both clients and therapists.

2.5.1 Psychoanalytic and psychodynamic perspectives

Psychoanalytic approaches to OCD argue that obsessive-compulsive symptoms symbolise an individual's struggle to control impulses that are unacceptable at the conscious level: the system of repression in such an individual fails and thus unwanted thoughts are allowed to enter consciousness (Steketee, 2012). As Fenichel (1945) puts it, the ego is embroiled in a two-way battle fighting both intolerable impulses and a severe superego.

For Freud, those suffering from OCD fixate at the anal-sadistic psychosexual stage of development (where aggressive and sexual impulses conflict with a rigid superego) and are preoccupied with a desire for control (Kempke & Luyten, 2007). A severe superego is perceived to originate from the internalisation of critical and demanding significant others and is coupled with high levels of aggression as a result of an excessive repression of anger (McWilliams, 1994). In his analysis of the *Rat Man*, Freud (1909/2001), highlighted the conflicting feelings of love and hate towards the father, coupled with a strong repression of this hate born out of love for the father. The ambivalence conflict regarding aggression towards significant others explains the defence of reaction formation; hence the conscientiousness and perfectionism of obsessive-compulsive clients are interpreted as attempts to repress hostile and sexual impulses. However, such impulses often emerge in the form of obsessions (for example, thoughts about harming a significant other). Equally, the overuse of other defence mechanisms serves to maintain the distress of those suffering from OCD: isolation and intellectualisation (unwanted impulses are characterised as alien); and undoing (carrying out compulsions is deemed to cancel out or neutralise offensive impulses) (Salzman, 1980; Steketee, 2012).

More recent psychodynamic theories of OCD centre on object relations (the content and structure of mental representations about the self and others based on a child's interactions with caregivers) and highlight the development of a fragmented or ambivalent self (Levy, Blatt, & Shaver, 1998; Chlebowski & Gregory, 2009). For obsessive-compulsive clients, such representations - which guide thoughts, feelings and behaviours – are, in part, constructed from highly negative aspects of both the self (for example, excessive morality and self-criticism) and other (who are often perceived to be critical and intolerant) and cannot be adequately integrated into a coherent image of self or other (Kempke & Luyten, 2007). The inability to tolerate such ambivalence results in a desire for control and autonomy; and, thus, intellectualisation is preferred and uncontrollable impulses, like emotions, are avoided (Kempke & Luyten, 2007).

Psychoanalytic and psychodynamic treatments of OCD focus on the identification, interpretation and modification of the client's defences (NCCMH, 2006), and prioritise the therapeutic relationship, and transference and counter-transference interpretations (Gabbard, 2001; Cutler et al., 2004). Both Kay (1996) and Chlebowski and Gregory (2009) present persuasive evidence of clinical cases of OCD in which psychodynamic treatment optimised treatment outcomes. Lieb (2001), too, presents a case study detailing the successful integration of psychoanalysis, psychopharmacology and behaviour modification in the treatment of OCD. However, psychodynamic approaches have been widely criticised as lacking an evidence base (Ponniah et al., 2013; Foa, 2010; Van Ornum, 1997). Indeed, within the NHS, the current Clinical Guideline [CG31] for OCD treatment states: "When adults with OCD request forms of psychological therapy other than cognitive and/or behavioural therapies as a specific treatment for OCD (such as

psychoanalysis, hypnosis, marital/couple therapy) they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments" (NICE, 2005, para. 1.5.2.8). This view is echoed by the Royal College of Psychiatrists which lists 'psychoanalytical psychotherapy' among those treatments which it states "do not work for OCD"; although, at the same time, it concedes that "some people with OCD do find it helpful to talk about their childhood and past experiences" (Royal College of Psychiatrists, 2019).

In their defence, I would argue that psychodynamic approaches fall outside the current paradigm for evaluating psychological treatments within the NHS. The requirement for an evidence base and cost-effective treatment, while understandable, has led (perhaps unfairly) to the marginalisation of psychodynamic approaches in the treatment of OCD.

2.5.2 The cognitive-behavioural model

Salkovskis (1985) developed a cognitive-behavioural model for OCD. It conceives of obsessions as 'normal' intrusive thoughts, which an individual misconstrues as an indication both that there is a serious risk of harm to themselves or another, and that they are responsible for such harm.

Those suffering from OCD focus great attention on their intrusive thoughts and may employ a number of behavioural responses, or 'neutralising actions', in an attempt to reduce their sense of responsibility (Salkovskis, 1985). This heightened sense of responsibility results in them falling into a pattern of mental and behavioural exertion "characterised by over-control and preoccupation" (Salkovskis, 2007, p. 229). However, paradoxically, such attempts at over-control result in failure

and thus serve to increase distress. Equally, all attempts to avert harm, and the responsibility for it, simply increase a person's preoccupation with it.

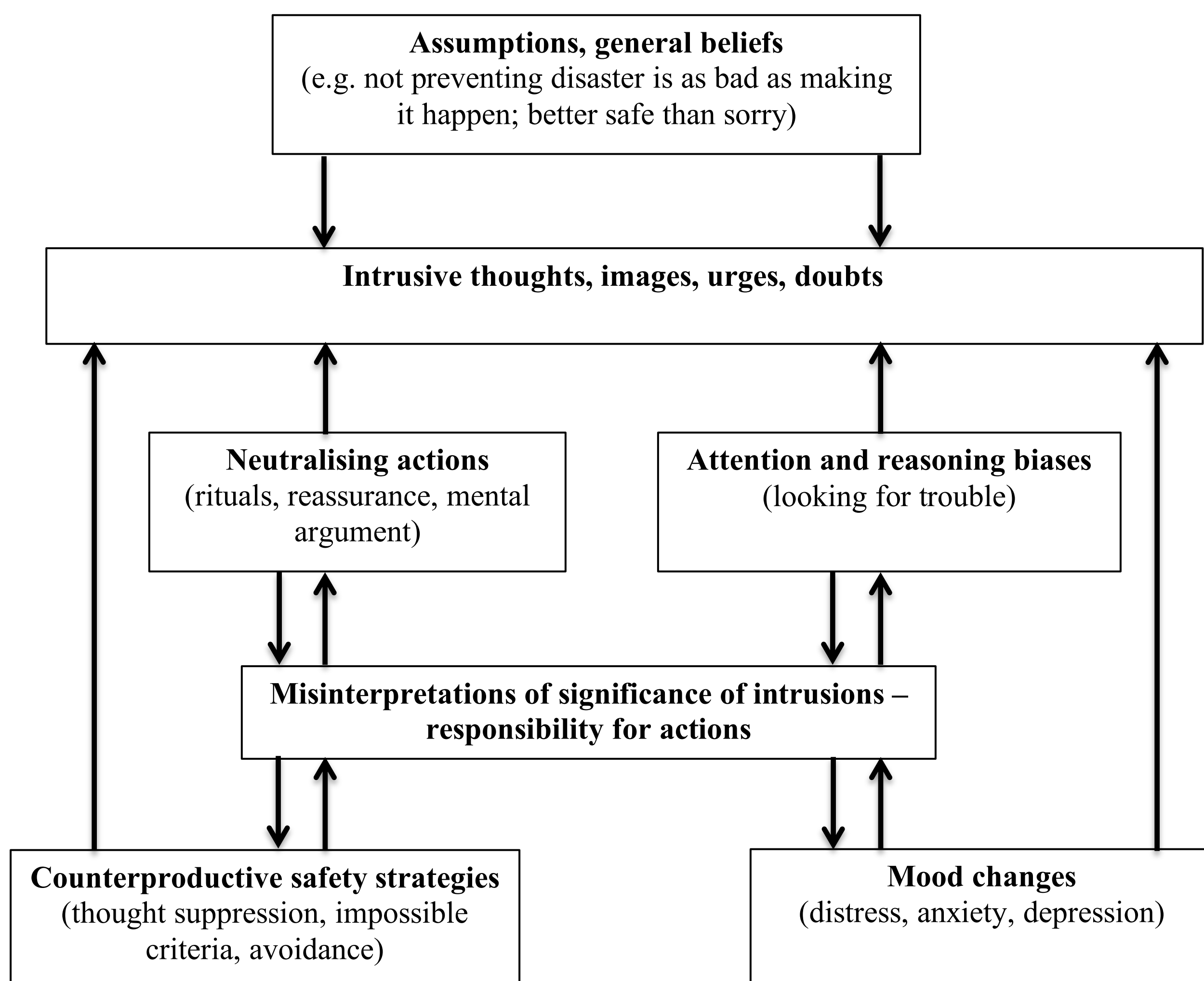

Figure 2. Cognitive-behavioural model of OCD. Salkovskis, 1985.

2.6 The treatment of OCD within the NHS

Within the NHS, OCD is currently treated in both primary and secondary care settings, and often in combination (NICE, 2005). The former offers

pharmacological treatment in the form of serotonin reuptake inhibitors, while the latter primarily provides psychological treatment and antidepressant medication (NCCMH, 2006). Given the diverse needs of those with OCD, such treatments are delivered via a six-phased model of 'stepped care', in which the least invasive interventions (for example, self-help materials) are initially offered, followed by increasingly intensive interventions, as severity or risk require (Haaga, 2000, cited in NCCMH, 2006, p. 40).

In February 2019, NICE announced that it would update its guideline on the treatment of OCD as a result of its surveillance of NICE guideline CG31 (NICE, 2005). Since its initial publication, clinical practice and treatment of OCD has progressed to include a technology-enhanced CBT intervention; transcranial magnetic stimulation and deep brain stimulation technology; new pharmacological interventions and augmentation therapies among treatment-resistant groups; and variation in the 'stepped care' model particularly for specialist care services for children (NICE, 2005).

2.6.1 Cognitive and behavioural interventions

CBT is the most common psychological treatment for OCD within the NHS (Roth & Fonagy, 2004, cited in NCCMH, 2006, p. 27). The treatment protocol (NICE, 2005) encourages flexibility by outlining various treatment stages, including: developing a CBT maintenance cycle of the client's obsessions; identifying their obsessional thoughts and designing strategies to modify their beliefs about responsibility; designing behavioural experiments to challenge the negative assumptions on which a client's sense of responsibility is based (for example, asking them to list all factors in a feared outcome and apportioning their relative

contributions in a pie chart) and to test the processes involved in their obsessional thought patterns (for example, demonstrating that thought suppression may increase the regularity of that thought and challenging incorrect beliefs, like 'If I think it, I must want it to happen'); modifying general assumptions (for example, 'not trying to stop harm is as bad as deliberately making it happen'); and, employing exposure and response prevention strategies (ERP) to demonstrate that 'neutralising actions' simply serve to maintain beliefs and distress, while stopping such behaviours will bring relief (Salkovskis, 2007).

2.6.2 Efficacy and effectiveness of CBT for OCD

Research has demonstrated the efficacy of CBT in the treatment of OCD (Bunmi et al., 2012; McKay et al., 2015). A recent meta-analysis of nineteen studies totalling seven hundred and fifty-two participants (four hundred and thirty-one in the treatment group and three hundred and twenty-one in the control group) indicated that Exposure Response Prevention (ERP), cognitive therapy, and a combination of the two, reduced obsessive-compulsive symptoms (d = 1.08), general anxiety (d = .67) and depression (d = .58) in those with OCD (Rosa-Alcazar, Sanchez-Meca, Gomez-Conesa & Marin-Martinez, 2008, cited in Hunsley, Elliott & Therrien, 2014, p. 16).

In terms of effectiveness, Houghton et al. (2010) found that twelve out of the twenty-eight participants in their study who completed CBT treatment 'recovered' from OCD (cited in Hunsley, Elliott & Therrien, 2014, p. 17). However, there is no mention of how 'recovery' was measured and the question of relapse was not addressed. Equally, evidence for the effectiveness of group cognitive therapy for

OCD is growing (Anderson & Rees, 2007); and, in particular, its impact on reducing shame (Spragg & Cahill, 2015).

Less positively, Franklin et al. (2000) noted that forty per cent of OCD clients who engaged in CBT did not finish treatment (cited in NCCMH, 2006, p. 104). Additionally, even if clients do complete treatment, a "significant proportion" do not respond (Abramowitz, 2006). Thus, further research into alternative therapeutic interventions for those who do not respond may be beneficial to both clients and therapists.

2.6.3 Support groups, activism and humour

Over the last thirty years, the views and experiences of mental health service users have adopted an empowering, collective voice in the form of 'Mad Pride' (Curtis et al., 2000). This movement has grown into a global presence and campaigns for the citizenship rights of "psychiatric survivors, consumers and mad folks" and the abolition of the prejudice and stigma surrounding mental illness (Finkler, 2009, p.2). The irreverent humour and creativity of Mad Pride is evident in the campaigns and events they run, such as the 'Mad Pride Bed Push', the 'Paranoid Olympics – You'd Better Run!' and the recent 'Mad Hatter's Tea Party'. These inherently positive and humorous events bring a political voice and common humanity to the survivors of mental illness, including those with OCD.

Within the UK, there are several charities which provide support to those specifically affected by OCD. OCD UK and OCD Action, for example, offer advice, information and advocacy services and campaign to challenge prejudice and stigma. In 2018, OCD UK launched the 'Little Bit OCD' campaign to challenge the perceptions of OCD as a trivial condition in which people are just a bit tidy or fussy

about their appearance or surroundings. They recruited people with OCD who attended local events giving first-hand accounts to the general public about their experiences of OCD. Most people listened and reported that their perceptions of OCD as a trivial condition had changed as a result (NIHR, 2019).

There is also a growing number of personal accounts of OCD being published. In 'The man who couldn't stop: OCD and the true story of a life lost', Adam (2014) presents a compassionate, humorous and often tragic account of OCD which blends science, history and personal memoir. The wit and irony in his story make it all the more compelling. Similarly, in 'Overcoming OCD: A journey to recovery', Singer (2015) describes the recovery of her son from OCD. For her, while OCD is a potentially devastating disorder with the ability to destroy lives, it also often engenders a sense of humour in those living with it born out of "creative thinking, a quick wit, the ability to laugh at oneself in the face of adversity..and to see the comical, and often absurd, aspects of OCD" (Singer, 2019, p.1).

2.7 Humour, OCD and therapy

2.7.1 The perception of OCD as 'funny'

Over the past few decades, OCD has often been constructed as 'funny' – a source of amusement - by the mainstream media. Indeed, recent cinematic portrayals of OCD have tended to focus on the comedic aspects of the disorder, while downplaying the distress and anxiety that it causes (think of Jack Nicholson's 'ridiculous' determination to avoid stepping on those 'dangerous' cracks in the pavement in '*As Good as it Gets*' or the 'neat-freakish' *Monk* in the comedy- drama detective TV series) (Cefalu, 2009; Hoffner & Cohen, 2018). OCD is also often trivialised on social media (for example, with the use of #OCD) (Pavelko & Myrick,

2015) and research indicates that even the overwhelming majority of those suffering from OCD tend to view their rituals as "rather silly" or "absurd" (Stern & Cobb, 1978, p.236).

Cefalu (2009) argues that the 'incongruity theory' of humour may provide some explanation for this comedic portrayal of OCD: the disparity between the underlying seriousness of purpose of an individual's compulsions or rituals and their apparently trivial and repetitive nature makes them an easy target for comedy. Additionally, as Cefalu (2009) goes on to suggest: "The repetitive rituals displayed by severe obsessive-compulsives often seem reminiscent of the ritualistic activities of small children (recall Freud's account of the *fort-da* game) or even of some instinctual behavioural patterns of animals (a cat chasing its tail, for example)" (p.48). This echoes Freud's (more sinister) description of the 'repetition-compulsion' (in The Uncanny, 1919) in which he describes the instinctive activity of the unconscious mind overruling the 'pleasure-principle'; which, for the observer, makes it uncannily difficult to distinguish between a human being acting out their compulsions and an automaton.

2.7.2 Paradox in humour, OCD and therapy

It could be argued that paradox and incongruity are central to our understanding of both humour and OCD. As we have seen, much of humour is born out of paradox: it brings together apparently absurd or contradictory statements, propositions or behaviours. There is often an initial expectation or a prediction of events, which is quickly replaced by something unexpected and unforeseeable. In OCD, too, distressing and anxiety-provoking obsessions are often paradoxically coupled with apparently trivial or 'absurd' compulsions or rituals.

Bertrando and Gilli (2008) have also highlighted the paradoxical nature of therapy. Therapy is a process which attempts to relieve and heal emotional distress; and while, at times, it can involve light-hearted moments of play, it can also be a difficult and painful process. The therapeutic relationship is framed by formal professional and ethical boundaries but, in order for therapy to be effective, it must also involve intimacy and trust. And, while the focus of therapy is often what occurs 'in session', it is whether - and how - the client chooses to implement change 'outside session' which is significant.

2.7.3 Creativity, spontaneity and humour appreciation in OCD

The link between humour and creativity is well established (Humke & Schaefer, 1996). But, perhaps more interestingly, while OCD has traditionally been associated with a rigid and inflexible cognitive style (Kline, 1971; Pollak, 1979; Binik, Fainsilber & Spevack, 1981) and a lack of spontaneity (Surkis, 1993); some more recent research indicates that it is also positively correlated with creativity (Furnham, Hughes, & Marshall, 2013; cf. Levine & Nadin, 2013) and "excessive imagination" (Paradisis, Aardema & Wu, 2015). In addition, studies suggest that there is no difference in humour recognition or appreciation between obsessive-compulsive patients and age, education and gender-matched 'healthy' controls (Mergl et al., 2003; Bozikas et al., 2011).

Thus, the creative 'jolt' of humour (Farrelly & Brandsma, 1974; Adams, 2013) may provide a therapeutic means to tap into obsessive-compulsive clients' subjective creativity and meaning-making, potentially loosening the grip of their mental rigidity and inflexibility (Killinger, 1987); and the control it has over their lives. As Moreno (1971) suggests, spontaneity is an "energy that propels a person

toward an adequate response to a new situation or a new response to an old situation" (cited in Surkis, 1993, p.123). To my mind, humour may provide just such a combination of creativity, flexibility and spontaneity in the therapeutic context (Coleman, 1971; Ortiz, 2000).

2.7.4 Existing literature on therapeutic humour and OCD

The existing literature on the use of therapeutic humour in the treatment of OCD is very limited in scope but provides some interesting observations.

In their 1988 study, Golan, Rosenhein and Jaffe explored the reactions of sixty, female clients with 'obsessive, hysterical or depressive personality types' (twenty of each type) to humorous and non-humorous therapist interventions. The participants used eight-point scales to rate twelve simulated, tape-recorded interventions (selected by a group of fifteen 'senior psychologists') designed to reduce anxiety, build perspective and confront emotions. Results indicated a clear preference for the non-humorous interventions independent of personality type (although a clear trend ranged from 'neutral' responses to humorous interventions to outright disapproval); and that, characteristically, obsessive clients were more emphatic in their rejection of humour aimed to confront their emotions. However, a content analysis of participants' responses to two open questions about what they liked and disliked about the humorous interventions suggested that humour provoked more positive responses than the quantitative analysis of the closed questions might at first have suggested. A considerable number of participants commended the humorous interventions on their ability to 'relieve tension', enable 'directedness on the part of the therapist' and 'improve self-understanding'.

In her case study of 'Bill', a man with OCD, Ortiz (2000) notes that "using humor with clients who suffer from OCD is common" (p.194) and, when used sensitively and selectively, can help to put a client at ease, to laugh at their fears, to provide them with confidence while constructing exposure scenarios and even during exposure work.

Surkis (1993), too, argues that humour enables the therapist and client to engage in a "channel of affect rather than on an intellectual, reasoned, logical wavelength" (p.133). Via a series of case studies, he explores those humour techniques that he has successfully employed with obsessive-compulsive clients. Specifically, he notes that by mirroring a client's anger by using "not-angry aggressive humour" (p.129) in the form of caricature, the therapist can disarm and bypass obsessive defences and so more readily and quickly access a client's inner conflicts.

In a similar way, Roncoli (1974) highlights the benefits of 'bantering' ("ridicul[ing] lightly and good-naturedly" (Webster, 1960, cited in Roncoli, p.172)) with obsessive-compulsive clients. One assessment of the obsessive-compulsive clients is that they are the victims of outwardly benevolent caregivers who, at the same time, were covertly hostile and aggressive (Sullivan, 1956, cited in Roncoli, 1974). Thus, such clients harbour aggression and ambivalence towards others; and doubt both their own and others' integrity. Bantering serves to highlight this ambivalence and so bring it into the client's awareness: the therapist openly ridicules the client but their use of humorous exaggeration is also indicative of a covert benevolence. Additionally, in the process of bantering, the client's feelings of aggression are momentarily interrupted and freed in the form of laughter.

In his report on the use of Paradoxical Intention in the treatment of phobic and obsessive-compulsive clients, Gerz (1966) notes that out of the six obsessive-compulsive clients he treated, four made a complete recovery and two were sufficiently well improved that they were able to work (p.548). He presents a case study on one of his obsessive-compulsive clients and describes how, in a washing compulsion, one very effective intervention involved telling the client to say: "I love to make my hands as dirty as possible. I'm crazy about germs. Who wants to be clean anyway?" (p.552). However, he also notes that treatment success is dependent on the therapist believing in what they are doing and thoroughly understanding the technique.

Lewis (2016), too, recounts the successful treatment of one client - presenting with obsessive blasphemy - with three, one-hour sessions of PI. The client was asked to endorse the view that God would be able to discern between true blasphemy (driving from the 'inner spirit') and blasphemous thoughts as a result of a mental illness. The client and therapist then devised some "humorously blasphemous and risqué thoughts involving the saints meeting one another for sexual liaisons" (p.177) which the client was encouraged to paradoxically will. The combination of PI and relaxation techniques results in a complete remission of the client's symptoms after just three sessions.

2.8 The 'gap' in the literature

While there has been growing interest in humour research over the last few decades, there is still relatively little empirical research in the area of therapeutic humour (Gelkopf, 2009; McGraw and Warner, 2012). The handful of quantitative studies on therapeutic humour that do exist are inconsistent (Saper, 1987) or

inconclusive (Blevins, 2010) in their findings, while qualitative studies have again tended to focus primarily on the discourses surrounding the potential pros and cons of therapeutic humour use with generic client populations (Gregson, 2009; Scott, 2009; Jeffrey, 2010; Wolf-Wasylowich, 2011; Gibson, 2014).

While there are some recent qualitative research papers on the use of therapeutic humour in the treatment of specific client populations (Adams, 2013; Rutchick, 2013; Chauhan, 2015), there are no qualitative studies on the use of therapeutic humour in the treatment of OCD. Equally, there is only one quantitative research study (Golan, Rosenhein and Jaffe, 1988); and a few clinical vignettes and anecdotes on the positive benefits of therapeutic humour in the treatment of obsessional patients (Roncoli, 1974; Surkis, 1993; Friedman, 1994; Ortiz, 2000; Lewis, 2016).

This gap in the literature has led me to propose a research study to investigate how therapists working with obsessive-compulsive clients understand and experience humour in session.

2.9 Relevance to counselling psychology

A key principle of The NHS Constitution is that "the patient will be at the heart of everything the NHS does" (Department of Health, 2015, p. 3). The humanistic, value-based practice of counselling psychology also highlights individual subjectivity and meaning-making (Woolfe et al., 2010). Indeed, Cooper (2009) notes that counselling psychologists prioritise humanistic principles in their practice which place the individual subjective experience above generalised theoretical models, while also attempting to strike a balance between the two. As such, while this research study does not aim to develop any general 'laws' on

therapists' understanding of humour in their work with obsessive-compulsive clients, given the paucity of research into the effectiveness of different therapeutic orientations (other than CBT) in the treatment of obsessive-compulsive clients, as well as the high drop-out rates associated with CBT treatment, this study attempts to contribute to the discipline of counselling psychology by exploring some of the contexts and processes involved in humour work with this client population.

Counselling psychologists increasingly work with obsessive-compulsive clients in NHS settings. While the therapeutic relationship lies at the heart of counselling psychology (Woolfe et al., 2010), the Practice Guideline for OCD also notes: "Whatever intervention is used, the key principles remain the same. This involves first establishing a good therapeutic alliance based on a working partnership between patient and therapist" (NCCMH, 2006, p. 28). A strong therapeutic alliance is also associated with positive therapeutic outcomes (Hovarth & Greenberg, 1994; Martin, Garske & Davis, 2000) and yet, many clients with OCD are strongly resistant to therapy (American Psychiatric Association, 2007; NCCMH, 2006). The literature suggests, however, that therapeutic humour may help to address such resistance precisely by strengthening the therapeutic relationship (Mosak, 1987; Sultanoff, 2013). By seeking to find out more about the nature of therapeutic humour and its relationship to the therapeutic alliance in the treatment of OCD, the findings may inform counselling psychologists and other health professionals working with this client group.

Finally, Woolfe et al. (2010) note that there are three key features which distinguish counselling psychology from other divisions within the BPS: namely, a growing emphasis on, and awareness of, the role of the therapeutic relationship; a shift away from the traditional 'client-expert' relationship - within the medical model

- towards a more humanistic approach; and the promotion of wellbeing as opposed to a focus on illness and pathology. This study aims precisely to engage with, and explore, each of these features by developing a better understanding of the subjective experience of therapists using humour in their work with obsessive-compulsive clients and the methods they use – or avoid – to promote the wellbeing of those clients.

2.10 Research questions

The proposed research questions are:

How do therapists, from a range of modalities, decide whether, when, and how, to use therapeutic humour in their work with obsessive-compulsive clients?

More specifically:

a. How do therapists understand humour in the context of their work?;

b. How do therapists understand humour in the context of their work with obsessive-compulsive clients?; and

c. What are the issues and processes involved in the emergence, and use, of humour in session with obsessive-compulsive clients?

3. Methodology

This chapter outlines the rationale for adopting a qualitative approach, and for selecting Grounded Theory, for this study. The researcher's epistemological stance, and a more detailed review of Constructivist Grounded Theory, will be presented. The research procedure - specifically, participant recruitment and data collection, management and analysis – will then be summarised. Finally, issues of ethics, reliability and validity, together with the researcher's own reflections on the research process, will be outlined.

3.1 Rationale for qualitative methodology

In the most general terms, qualitative methodologies draw on an 'interpretivist' or 'contextual' philosophy that seeks to better understand both how, and what, we can know (Brown, 2002). Thus, they prioritise the complexity of individual experience, proposing that phenomena cannot exist without our interpretation or construction of them and concluding that an objective stance is not possible (Charmaz & Henwood, 2007). This sits in sharp contrast to quantitative methodologies which prioritise a positivist, 'hypo-deductive' approach, focusing on the testing of hypotheses and manipulation of variables in order to discover a set of pre-existing generalisations or 'universal laws' (Thompson, 1995). Given the subjective, complex and contextual nature of 'humour', a qualitative approach was deemed more appropriate.

A review of the existing empirical studies into therapeutic humour, and the nature of the research questions derived from them, further informed the researcher's decision to select a qualitative methodology. Within the therapeutic context, humour is implicitly dyadic and inter-subjective. Again, this makes it the natural preserve of

qualitative research, which seeks to make sense of the meanings individuals ascribe to social phenomena as they occur in natural settings (Denzin & Lincoln, 2000).

3.1.1 Suitability of grounded theory

Various qualitative methods were considered by the researcher before she settled on Grounded Theory. Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009) would have examined the unique, lived experience of participants and how they make sense of therapeutic humour in the treatment of OCD. However, it would not have allowed for the development of a theory surrounding it. Discourse Analysis was also considered, but rejected since its primary focus is to investigate how linguistic practices shape and reflect social, cultural and political practices rather than to develop a theory to explain a social process (Starks & Trinidad, 2007).

The choice of Grounded Theory arose primarily from the research questions. The study aims to develop a theory on how therapists, from a range of different modalities, conceptualise humour and how, if at all, they use it with obsessive-compulsive clients. By identifying and comparing 'concepts' within the data, Grounded Theory aims to develop inductive, contextualised theories to explain social behaviours and processes (Charmaz & Henwood, 2007) and so is, arguably, best suited to investigate humour within the therapeutic context. Given the small-scale nature of this doctoral research study, an abbreviated grounded theory method (Willig, 2013) was followed.

3.1.2 Epistemological stance

The nature of knowledge – *what* we can know and *how* we can know it - can be conceived within a number of paradigms including positivist, post-positivist,

constructivist-interpretative and critical (Denzin & Lincoln, 2011). This study's research paradigm combines the researcher's ontological realism (the assumption that there is a real, physical world which exists outside of theoretical construction) with her constructivist epistemology.

Given the complex, contextual and highly subjective nature of the research topic and research questions, this study's research paradigm was heavily informed by Charmaz's epistemological stance in her Constructivist Grounded Theory (CGT) (Charmaz, 2006). This acknowledges the key role of the researcher in the entire research process – from the conception of the research questions, to the drafting of the interview schedule and phrasing of the interview questions, as well as the analysis of the data and construction of theory (Willig, 2013). Rather than aspiring to the attain an objective stance, the researcher's role in the process is fully acknowledged and the research process grounded in reflexivity, relativity and positionality (Charmaz & Henwood, 2007). Thus, the researcher is deemed to generate, rather than discover, theory from the data (Henwood & Pidgeon, 2003).

This view stands in stark contrast to Glaser's 'Classical' Grounded Theory (1995) which, although almost silent on its ontological and epistemological stance (Bryant, 2002; Urquart, 2002), has been interpreted by some as adopting a 'soft' positivism since it implicitly assumes "an objective, external reality, a neutral observer who discovers data, reductionist inquiry of manageable research problems, and objectivist rendering of data" (Charmaz, 2000, p.510; Kenny & Fourie, 2015). Indeed, while Glaser (2002) has, in turn, criticised Charmaz's constructivist paradigm, he has not contested her assessment of Classical Grounded Theory as implicitly positivist (Kenny & Fourie, 2015). Such a positivist approach is at odds with the research questions, the underlying tenets of qualitative research and the

researcher's own personal epistemology. Equally, Strauss and Corbin's Grounded Theory (1998), while acknowledging the subjectivity of the researcher and participants, promotes a more manualised, and so prescriptive, approach to research; and one in which the researcher's role is to uncover the 'truth' about the research object. Again, the very complex and subjective nature of humour as a social process does not sit comfortably within this ontological perspective.

While the epistemological position of this research study is informed by CGT (Charmaz, 2014), the research procedure and analytic method was is in keeping with the tradition of grounded theory methodology developed in psychological, rather than sociological, research (Henwood & Pidgeon, 2003; Charmaz & Henwood, 2007; Willig, 2013).

3.2 Procedure

3.2.1 Participants

An open invitation letter (see Appendix B) was posted on the discussion fora and members' areas of the BPS, the UK Council for Psychotherapy (UKCP), the British Association for Counselling and Psychotherapy (BACP) and the British Association for Behavioural and Cognitive Psychotherapies (BABCP) websites. The letter contained background information on the research study, details of the inclusion criteria and brief details of what participation in the study would entail. The inclusion criteria were set to include therapists from any modality (CBT therapists, clinical psychologists, counselling psychologists, counsellors, person-centred or humanistic therapists, integrative psychotherapists, psychoanalytic therapists or psychodynamic therapists) with at least five years' post qualification experience and experience of working with obsessive-compulsive clients (which

included clients with a formal diagnosis of OCD or Obsessive-Compulsive Personality Disorder, or those who simply identify with or seek to work on their obsessions or compulsions). Those who were interested in taking part in the study were asked to contact the researcher by telephone or email to set up a meeting, at a time and venue to be agreed between the researcher and participant.

Due to time and resource constraints, eight participants were recruited, which was considered to be sufficient for this abbreviated grounded theory study (Willig, 2013). In terms of 'theoretical sampling', in order to explore possible similarities and variations between groups and emerging themes in the data (Urquhart, 2013), participants from a variety of modalities were recruited. Of the eight participants who took part in the research, two were Cognitive Behavioural Therapists (CBT Therapists); two were Clinical Psychologists and CBT Therapists; one was a CBT Therapist and Health Psychologist; one was a CBT Therapist and Occupational Therapist; one was a CBT Therapist and Existential Therapist; and one was an Integrative Psychotherapist. The participants' length of post-qualification experience ranged from 8 to 19 years. Four of the participants currently work for the NHS, three in an IAPT service and one in secondary care. A further three participants currently work in private practice and one is a research academic. All participants have considerable experience of working with obsessive-compulsive clients. Six participants identified as female and two, male; and all described their ethnicity as White British. The participants' ages ranged from 45 to 66 years. The order in which the participants took part in the research study, together with key demographics, is set out below in Table 1.

Table 1: Participant demographics

Interview Schedule No. (Appendix Ref.)	**Participant**	**Age**	**Gender**	**Ethnicity**	**Native English speaker?**	**Modality**	**Accrediting Body**	**Year of qualification**	**Current Employer**	**Past experience of working with OCD**
One (Appendix G)	**A**	45	Female	White British	Yes	Clinical Psychologist; CBT Therapist	BABCP; BPS	2010	Private practice	NHS IAPT service; CADAT, Maudsley
Two (Appendix H)	**B**	56	Female	White British	Yes	CBT Therapist; Health Psychologist	HCPC; BPS	2007	Private practice	NHS IAPT service; private practice
Two	**C**	66	Female	White British	Yes	Integrative Psychotherapist	UKCP	2004	Private practice; MIND	Private practice; The Priory; NHS IAPT service
Three (Appendix I)	**D**	45	Female	White British	Yes	CBT Therapist	BABCP	2009	NHS	NHS IAPT service; private practice
Three	**E**	56	Male	White British	Yes	CBT Therapist; Occupational Therapist	BABCP; HCPC	1999	NHS	NHS IAPT service
Four (Appendix J)	**F**	45	Male	White British	Yes	CBT Therapist; Existential Therapist	BABCP	2010	NHS	NHS IAPT service; private practice

Interview Schedule No. (Appendix Ref.)	**Participant**	**Age**	**Gender**	**Ethnicity**	**Native English speaker?**	**Modality**	**Accrediting Body**	**Year of qualification**	**Current Employer**	**Past experience of working with OCD**
Four	**G**	52	Female	White British	Yes	CBT Therapist	BABCP	2006	NHS	NHS secondary care service
Four	**H**	48	Female	White British	Yes	Clinical Psychologist; CBT Therapist	BABCP; BPS	1999	A UK university	NHS; private practice; OCD research trials in UK and Canada

3.2.2 Data collection

The interview appointments with participants were scheduled for approximately one and a half hours. This provided adequate time to respond to any questions that the participants had about the research, to obtain their consent, to conduct the interview and to debrief them. Before the start of the interview, the researcher asked each participant whether they had any questions. In the event, none of the participants asked any questions at this stage. The participants were then asked to complete a consent form (Appendix C) and a demographic questionnaire (Appendix D). The questionnaire contained a request for general demographic information on each participant (including their gender, date of birth, ethnic and racial background, whether they were a native English speaker), as well as information about their theoretical modality, accrediting body(ies), year of qualification, current employer and length of service, as well as details of relevant past experience working with OCD. This assisted the researcher in theoretical sampling by helping to identify potential areas of diversity among the participants which might need further investigation (Willig, 2013).

Once each participant had given their consent, they took part in an audio-recorded, semi-structured interview with the researcher, based on the relevant interview schedule (see Appendices F, G, H and I). The interviews were conducted on an individual basis in order to gain a deeper understanding of the process by which each interviewee determines whether, when and how to use humour in their work with their OCD clients and to identify which factors may have a bearing on this process.

In accordance with regulatory guidelines for best practice (BPS, 2014; LMU, 2014), the researcher had assessed both the sensitivity of the research topic and the

potential vulnerability of the participants as being low on both counts. However, as a precaution, a distress protocol (Appendix F) was prepared and, during the interviews, the researcher watched for signs of a participant becoming distressed and would have stopped the interview if any participant had so requested. In the event, the protocol was not required. On completion of their interview, each participant was given the opportunity to ask further questions about the research and was provided with a debriefing document (Appendix E) detailing their rights to confidentiality and to withdraw from the study, and providing the details of whom to contact should they have any concerns or complaints. The researcher also explained that the audio recordings of participants' interviews would be deleted as soon as the research study had been published but that the anonymised transcripts would be retained in a password-protected file on the researcher's computer. In the event, none of the participants asked any further questions at the end of the interview, neither did any of them withdraw from the study or raise any concern or complaint.

The questions contained in the interview schedules were derived from issues raised both in the current literature on humour in therapy (see Section 2, Literature review) and by the researcher's own reflections on the topic (outlined in Section 1.2, Reflexive statement (part 1)). As the research process progressed, the researcher further refined and amended the interview schedule to take account of any new areas of inquiry and different concepts raised by each subsequent participant. The researcher's aim was to keep the interview questions as open-ended, non-directive and relevant to each participant as possible. To this end, where appropriate, the researcher deviated from the interview schedule, and used relevant prompts, in order to enable participants to better elaborate on their views (Willig, 2013).

The initial interview was a pilot to establish whether the first interview schedule (Appendix G) was adequate for gathering sufficient data. The researcher determined that, as a result of the pilot interview, the interview schedule be amended to include a question on whether humour was touched upon in the participants' therapeutic training, and some additional probe questions to explore the different types of humour that the participants are familiar with. The findings in the first three interviews were then transcribed and coded in keeping with constructivist grounded theory guidelines (Willig, 2013) and an initial model was produced based on the researcher's preliminary set of concepts and ideas.

Before the fourth interview, after an initial round of data analysis, tentative categorisation and model-building (as precedented in abbreviated grounded theory analysis), amendments were made to the interview schedule with a view to discovering additional concepts and building on the existing findings. Specific questions were added relating to the differences in presentation among OCD clients and how, if at all, these may affect the treatment or specific interventions; and how therapeutic humour might affect the therapist's experience of the client and vice versa. Two new participants were then interviewed and their data transcribed, coded and analysed in line with Willig's guidelines (2013). Additional amendments were then made to the model and interview schedule. The latter included adding questions on the function of humour in session and how, if at all, it relates to the therapeutic relationship. Three more participants were interviewed to further explore the validity of the draft model and earlier findings. These interviews were all analysed in keeping with the above guidelines. At this stage, it was determined that, due to time and resource constraints, theoretical saturation was sufficient for the purposes of this

small-scale, research study following an abbreviated version of grounded theory (Willig, 2013).

3.2.3 Data Management

Each of the interviews were digitally recorded and transcribed by the researcher. In accordance with the regulatory guidelines for best practice (BPS, 2014; LMU, 2014) and the Data Protection Act, 1998, the names and contact details of the participants, together with all recordings, transcripts and written findings, were stored (separately from one another, in password-protected files) on the researcher's home computer, to which only the researcher has access. The participants' consent forms and demographic questionnaires were kept in a locked filing cabinet at the researcher's home. It was agreed in advance with each participant how they wanted to manage the incorporation of pseudonyms into the research findings and interview transcripts to ensure that real names and identifying references were omitted.

3.2.4 Data analysis

Data collection and initial data analysis of each transcript were carried out simultaneously in order to guide amendments to the interview schedule and further data collection (Willig, 2013). As recommended by Willig (2013), the researcher also engaged in 'theoretical sampling' by collecting relevant selective data to further refine major concepts and emerging themes to achieve 'adequate' saturation. In keeping with Willig's guidelines (2013), all interview transcripts were 'open coded' line by line to generate initial concepts. This process of open coding aimed to identify initial concepts directly from the data (rather than allocating existing

concepts to the data), and focused on the actions described by the participant in each segment of data. There then followed a process of 'clustering' during which comparable open codes were grouped together, as mid-level and then focused codes, in an attempt to explain larger segments of 'similar' data. The researcher then developed analytical sub-categories - those concepts which could be grouped together to make initial connections between, and theories about, the research phenomena – from each transcript. At the same time, axial coding enabled the researcher to further develop and link concepts into conceptual sub-categories, as well as to identify 'action codes' and so, build up additional sub-categories and, eventually, categories. All participant transcripts and open codes were continuously compared, and focused codes and sub-categories refined and developed. Such constant comparative analysis was repeated throughout the research process (Holton, 2007). For a detailed example of the data analysis process, see the data analysis sample in Appendix M; and the list of categories, sub-categories and focused codes in Appendix N.

In tandem with the coding process, the researcher engaged in a continuous process of memo-writing to record her ongoing, and developing, interpretations of the data. Such memo-writing also encouraged the researcher to reflect upon, draft, build and refine, the developing grounded theory model, which was initially drafted after the first three interviews and was continuously developed and refined after each subsequent participant interview. As Willig (2013) notes, memo writing is an important step to link data collection to the production of drafts as it encourages the researcher to continuously analyse and reflect on their codes, categories and emerging ideas. Throughout the data collection and analysis process, the researcher engaged in 'negative case analysis' to identify, reflect on and further investigate data

that contradicted or compromised the emerging conceptual framework and model. Once the final participant interview was coded and analysed, the final model was further developed and reviewed.

3.3 Ethics, reliability and validity

The researcher sought ethical approval for the research study via London Metropolitan University: approval was granted on by the Chair of the School of Psychology Research Ethics Review Panel on 17 May 2016 (see Appendix K).

Ethical considerations were considered by the researcher at every stage of the research process and, at all times, the researcher's conduct was guided by, and in keeping with, the London Metropolitan University's Code of Good Research Practice (LMU, 2014) and the BPS Code of Ethics and Conduct (BPS, 2009). Participants' rights and interests were considered during the research design phase, during data collection and analysis and in reporting findings. Specifically, in keeping with the British Psychological Society's Code of Human Research Ethics (BPS, 2014), a balance was sought to ensure that participants were able to express their views and experience while being protected from any exploitation, harm or breach of confidentiality.

Access to participants was also regulated by the relevant (divisions of) organisations contacted by the researcher, which could choose not to advertise the research to their members if they did not feel it was appropriate. The researcher was informed by only one such body, the Division of Clinical Psychology (DCP) within the British Psychological Society, that due to the large volume of requests the DCP receives, it is not able to promote student research projects.

Within Constructivist Grounded Theory, the concepts of 'validity' and 'reliability' have slightly different meanings to their use in more traditional forms of scientific research. Validity focuses on whether the researcher's interpretation of participants' accounts of the research phenomena are valid rather than the accurate 'measurement' of research phenomena (Woods, 1998). In terms of reliability, too, the idea that the phenomenon that has been 'measured' is stable so that, under the same conditions, another researcher would obtain identical results (Prince et al., 2003) does not fit with the subjectivity and multiple 'realities' of social constructivist theory. There will inevitably be differences in the data collected and theory generated by different researchers: even the same participants will respond differently to the same questions at different times and even a small deviation from an interview schedule will change the direction of the interview. Thus, the researcher is keen to make her own relationship to the data explicit and to explore how this has influenced the theory generated. Additionally, the researcher has been guided by the following criteria (Henwood & Pidgeon, 1992) for evaluating qualitative methodologies: stay 'close to the data' to ensure that the theory is a good 'fit'; explore the reflexivity of the researcher; use theoretical sampling and 'negative case analysis' to assess the quality of the results; check how well the coding reflects what was actually said by the participants; and ensure that the theory is derived from rich and dense data and so 'integrated at diverse levels of abstraction'.

3.4 Personal reflexivity

As the research process moved from conception and design through to the interview, coding and analysis stages, I became increasingly aware of how important the adoption of a reflexive stance was to the research process. My existing ideas,

bias and preconceptions about the use of humour in therapy, as well as its potential benefits and possible pitfalls in the treatment of OCD, became increasingly apparent and open to challenge as the complexities of the research subject became clearer. I found that keeping a journal to document my thoughts and reflections, as well as drafting memoranda to document the key connections and ideas grounded in the data, assisted me not only in the identification and development of concepts and theory, but also in the exploration of a shift in my own thoughts and preconceptions during the research process.

The next chapter will outline the research findings on how therapists use humour in therapy with obsessive-compulsive clients.

4. Findings

4.1 Introduction

In this chapter, I present an overview of the research findings and the proposed Grounded Theory model. I go on to detail both the categories and the sub-categories which comprise this model. Each of these categories and sub-categories are supported by quotations from the participant interview transcripts. Data from the transcripts have been anonymised and participants have been given pseudonyms to protect their identities. Quotations from the participant transcripts are in italics.

The model took shape gradually over the course of the participant interviews and subsequent coding and data analysis process. The following research questions were explored throughout the analysis:

How do therapists from a range of modalities, decide whether, when, and how, to use therapeutic humour in their work with obsessive-compulsive clients?

More specifically:

a. How do therapists understand humour in the context of their work?;

b. How do therapists understand humour in the context of their work with obsessive-compulsive clients?; and

c. What are the issues and processes involved in the emergence, and use, of humour in session with obsessive-compulsive clients?

4.2 Overview of findings

From the analysis, I have identified nine categories which together comprise, and summarise, the key variables that the participants (as therapists) use to determine whether, when and how to use humour in their work with obsessive-compulsive clients.

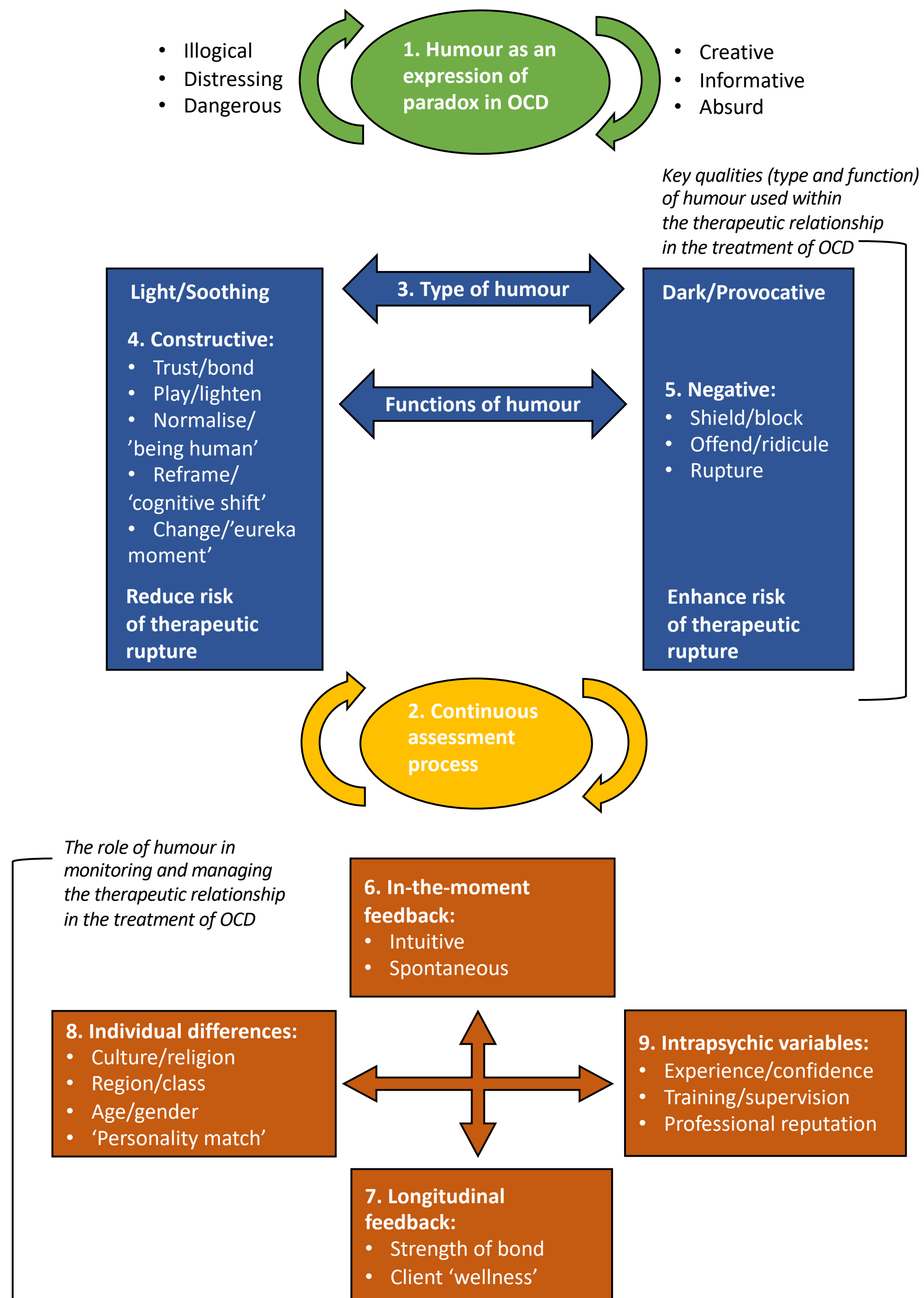

Figure 3. The significance of humour in OCD and its treatment

The Grounded Theory model above, entitled 'The significance of humour in OCD and its treatment', illustrates the overall findings of the research. These

findings indicate (in green at the very top of the model) that the participants interpret humour as an expression of paradox in OCD (it being at once illogical, distressing and dangerous; but at the same time creative, informative and absurd). However, participants were also clear that not all humour is appropriate for use in session with obsessive-compulsive clients and so they described their engagement in a continuous assessment process designed to weigh up the likely risks and benefits of using or responding to humour with their obsessive-compulsive clients. This ongoing assessment process forms a core category and sits in the centre of the model (in yellow).

Participants reported that they continuously assess the key qualities (type and function) of humour used within the therapeutic relationship in the treatment of OCD. Each of these qualities is also a core category in the model (in blue). Participants reported that when a 'light' or soothing type of humour is used or responded to appropriately, it is more likely to bring about constructive results (by engendering trust and a connection between the therapist and client; by lightening the mood and encouraging a more playful and flexible approach to treatment; by normalising the client's experience of OCD; by encouraging the client to reframe and develop a sense of mastery over their OCD; and to enable change and a shift in perspective possible via 'eureka moments' of humorous incongruity) and so reduce the risk of therapeutic rupture.

Conversely, participants indicated that when a 'dark' or provocative type of humour is employed in session, it is more likely to damage the therapeutic process (by enabling the client to shield or block their thoughts and emotions; by causing offence or appearing to ridicule the client's distress in the face of their OCD; and ultimately by increasing the likelihood of rupturing the therapeutic relationship).

Participants' assessment of the role of humour in monitoring and managing the therapeutic relationship in the treatment of OCD is influenced by four other categories which sit at the bottom of the model (in red) as in-the-moment feedback received in session with an obsessive-compulsive client (in particular, participants' intuition as to the appropriateness of humour use, as well as their engagement in spontaneous humour with the client); longitudinal feedback accumulated over the course of therapy (comprising the strength of the therapeutic relationship; and the client's use of, and response to, humour as an indicator of their 'wellness'); individual differences between the therapist and OCD client (being their respective culture and religion; regional identity and class; age and gender; and the 'personality match' between the therapist and client); and intrapsychic variables existing within the mind of the therapist themselves (including their relative experience and confidence; their experience of humour in training and supervision; and their desire to maintain their professional reputation).

The model serves to simplify and explain what is, in reality, a very complex set of psychological assessments over the longer term, as well as in-the-moment decisions made by therapists – some conscious, others more intuitive – on the use of humour in the treatment of OCD. With further research, it could possibly be extended to other similar kinds of clinical presentation.

4.3 The grounded theory model: categories

Nine categories were identified during the analysis of the data and, together, these represent the key areas of the decision-making process by the therapists comprising this study on whether, when and how to use therapeutic humour in their treatment of obsessive-compulsive clients. In the remainder of this chapter, I shall

present each of these categories, together with the related sub-categories comprising them; in each case noting which participants contributed to the data underlying, and supporting, each sub-category.

Category 1: Humour as an expression of paradox in OCD

Category	Sub-category	Participants
1. Humour as an expression of paradox in OCD	1.1 OCD as illogical, distressing, dangerous	A, B, C, D, E, F, G, H
	1.2 OCD as creative, informative, absurd	A, B, C, D, E, F, G, H

1. Humour as an expression of paradox in OCD

All participants highlighted the paradoxical nature of OCD and most drew upon the 'incongruity' theory of humour to explain its more comic overtones. While participants reported that their clients' obsessions are often presented as illogical, distressing and dangerous; their compulsions were constructed as creative, informative and absurd.

"You want clients to connect with the humorous side of the ridiculousness [of OCD], that's it's not that really big and terrifying..you could not get anything more opposite really, could you? Something that is hilariously funny and absurd and yet something that is catastrophically dangerous and terrifying" [Participant D]

This powerful statement speaks to the contradiction at the heart of the OCD experience, its potential link to the absurd and, by definition, the experience of 'dark' and 'light' humour. The mixture of the humorous with the darkly serious can be deeply foxing and perplexing. Other participants noted that there is a 'painful irony' about the extent to which clients concentrate on tasks (which they themselves often perceive as ridiculous) when such compulsions, typically orchestrated to

alleviate their underlying obsessions, simply make clients worse by locking them into ritualistic loops.

"Sometimes there is a painfully ironic element [to OCD]...and I think people see this, you know, that their safety behaviours, a lot of their compulsive behaviours are in themselves, you know, the problem...OCD is paradoxical, isn't it? On the one hand the person does the behaviour [checking a car door handle is locked] to prevent the car being stolen but, on the other hand, the behaviour actually increases the risk of it happening...cos the car door handle broke [laughs]" [Participant E]

1.1 OCD as illogical, distressing, dangerous

While it has been recognised that a person's belief in their ability to exert control over their environment and to produce desired results are important for psychological health and wellbeing (Leotti, Iyengar & Ochsner, 2010), struggles to increase or reduce control are believed to be at the root of all anxiety disorders (Shapiro, Schwatrz & Astin, 1996). The obsessive-compulsive client suffers from a low sense of autonomy and, in their attempt to compensate for this, tries to maintain an impossibly rigid control over thoughts, impulses, actions and emotions (Reuven-Magril, Dar & Liberman, 2008). Thus, obsessive-compulsive symptoms and beliefs have been linked to a *high desire for control* combined with a *low sense of control* over self and environment (Moulding & Kyrios, 2007). Similarly, in this study, all of the participants had experienced the illogical thinking of their obsessive-compulsive clients as stemming from just such an unattainable desire for certainty and control.

"Most clients get that [their thinking] has gone into an illogical place...of course OCD has an initial illogical seed…an overwhelming need for certainty" [Participant A]

Participants also recognised the very debilitating nature of OCD. A client's obsessions can cause them considerable emotional distress while their associated compulsions can dominate their lives to the exclusion of almost all else.

"Having OCD can be very serious, very time consuming and very distressing" [Participant F]

Many participants also identified the sense of fear and shame felt by their obsessive-compulsive clients: the fear and distress that they might be responsible for causing some sort of hurt or harm and the potential shame of being judged harshly by others for having done so.

"Underlying fears that you are going to do some horrendous thing which means that you will be vilified and ostracised...by everyone, forever...that really stays with people...and is highly distressing...it's something about the sense of being 'I'm a bad, I'm a really bad person having these thoughts'" [Participant A]

1.2 OCD as creative, informative, absurd

Participants also noted the existence of the more positive aspects of OCD and pointed out just how creative, as well as informative, their clients' compulsions can be.

"With OCD, it's almost as if there's the anxious brain on creative overdrive...the things the brain has come up with that that person is buying into...can be really creative and fascinating…If people come in with OCD, almost everyone is different...it's very unusual to get three people with contamination fears in a row and, if you do, all of their fears are different...erm...for one person, it might be glitter, for another, it might be chewing gum on the pavement...and for another, it's

animal hair or whatever...it tells you a lot and all of that has a sort of creativity about it" [Participant A]

Many participants also noted that they could laugh with their obsessive-compulsive clients about the absurdity of their obsessions and compulsions. For example, there may be a 'humorous' realisation on the part of the client that their predictions surrounding the likelihood of a particular event occurring are completely absurd or irrational.

"In OCD, in particular, [humour] works with the absurdity and irrationality of it...it's like 'I know this is just completely mad' and…talking about behavioural experiments and what the likelihood is...they might say something like 'oh, I think the likelihood of a plane crashing through this window is something like fifty per cent' and I would be like 'Really? Fifty per cent?' [laughs] [Participant H]

As we have seen, obsessive-compulsive clients have a strong desire for - but a lower sense of - control over both themselves and their environment (Moulding & Kyrios, 2007). Humour and laughter in the above scenario provided a release from the client's anxiety, making their perceived lack of control easier to tolerate. Indeed, this contains echoes of Freud's (1905/13) third 'laughter situation' ('humour') in which an individual saves emotional energy and laughs when a situation turns out to be less serious than anticipated.

Category 2. Continuous assessment process

Category	Sub-category	Participants
2. Continuous assessment process	2.1 Initial assessment	B, C, D, E, F, G
	2.2 Ongoing assessment of humour use	A, B, C, D, E, F, G, H

2.1 Initial assessment

Almost all of the participants expressed the view that a client's response to, and use of, humour could be a useful tool in the initial assessment of OCD in order to gain a more nuanced picture of the client's current state of emotional distress, as well as their historic 'personality'. A client's ability to access humour might be a helpful indication of their ability to engage with different perspectives and, possibly, their potential to change.

For one participant, the assessment of their obsessive-compulsive clients' ability to access and use humour provides an important insight into the degree to which those clients are controlled by their 'desire for control' (Moulding & Kyrios, 2007): it allows the participant to determine just how fixed and rigid their clients' efforts to control their thoughts, actions, impulses and emotions are.

"I think [humour] can be an assessment tool [for OCD] as well...if somebody has gone into a very fixed position...it's a way of assessing 'Did they hear that reference?' or 'Can they access it?' or 'Are they totally fixed?' and they can't actually see anything other than their own interpretation." [Participant C]

Equally, the client's recognition of their ability to relate to, and use humour, before they became unwell – and how they perceive themselves when they are well – can also add another layer of depth to, and understanding of, the client.

"If you are trying to get a sense of how things were before [they became ill with OCD], listening to clients say 'Oh, people used to say I had a really good sense

of humour or that I was really dry', you then know that's there...[and] that there's lots of stuff you can get in touch with...so humour can have a place [in the assessment process]" [Participant G]

2.2 Ongoing assessment of humour use

All participants said that, throughout therapy, they continued to assess their obsessive-compulsive clients' responses to, and use of, humour in order to monitor the 'appropriateness' of humour use in session and how it might be interpreted and experienced by a client.

"I think that [assessing a client's response to, and use of, humour] is a constant part of the monitoring throughout the session to see how a person is...and throughout therapy, you know, any sign of emotional change really can be indicative of something important, whether it is a positive emotion, which we would normally associate with humour, or whether it is a negative one." [Participant E]

This ongoing assessment of the obsessive-compulsive client enables the therapist to be empathetically attuned to them, to better understand their 'tolerances' and boundaries and so adjust their own responses to better match or mirror those of their client (which, in turn, inform, and relate to, Sub-categories 4.1, Trust/bond; 6.1, Intuitive in-the-moment feedback; and 7.1, Strength of bond). Humour is thus presented as one means to test, on an ongoing basis, the intrapsychic, interpersonal and intersubjective processes at work during therapy.

"As you're getting to know your patient, you are sort of testing all the time, you know 'Where are the boundaries? Where are the parameters? What sort of person is this?'...which is a sort of constant assessment and reassessment...and humour is part of that" [Participant F]

Most participants also recognised that their use of humour, and that of the obsessive-compulsive client, may increase during the therapeutic process as the client becomes more relaxed and less self-critical; and so, perhaps, less controlled by their 'need for control'.

"My decision to use more humour with OCD clients is often based on where they are in the process, very much so...I think, you know, too early and it could be quite shaming, and they might feel like an outsider, being laughed at, which would be totally inappropriate but there comes a point where there is a pathway...they may choose a different way of being and realise that they are 'good enough' and then it [humour] can be empowering" [Participant C]

Category 3: Type of humour

Category	**Sub-category**	**Participants**
3. Type of humour	3.1 Provocative/'dark' humour	A, B, C, D, E, F, G, H
	3.2 Soothing/'light' humour	A, B, C, D, E, F, G, H

All of the participants described the paradoxical nature of humour, as well as the different types of humour encountered within the therapeutic relationship in the treatment of OCD. Such humour occupies a broad spectrum encompassing both the 'lighter', more soothing types of humour (for example, gentle teasing, shared jokes, smiling and nodding to communicate engagement and understanding) and the 'darker', more provocative types of humour (for example, sarcasm, sardony, schadenfreude and 'black' humour).

"Humour is on a continuum...you can have anything from a wry smile to outright guffawing...there are different grades of it as well, from the slapstick to the more subtle, darker types of humour, like sardony or sarcasm" [Participant D]

3.1 Provocative/ 'dark' humour

Many participants suggested that 'dark' humour, much like OCD, is built on an uncomfortable foundation of incongruity: a situation that appears absurd and funny can, at once, also be tragic, painful and stressful.

"There is that whole tragic side to comedy isn't there? I do just keep thinking of John Cleese cos of the tragedy of it and then 'Fawlty Towers' is a classic example of just making endless fun out of really stressful situations, where your anxiety and anger are about to bubble over...so humour can have a place in dark times, in difficult times, when you're very anxious" [Participant G]

All of the participants identified certain types of 'dark' humour, which they would avoid in session with obsessive-compulsive clients; most notably, laughing at or mocking a client's distress.

"It would be very dark and disrespectful to laugh at a client's distress" [Participant B]

In addition to assessing the *type* of humour that might be (in)appropriate to use in session (and in keeping with Freud's (1905/2013) assessment that "[o]nly what I allow to be a joke *is* a joke" (p.105)), participants also noted that it was very important to assess the individual client, as well as the therapist's relationship with them at any given time, in order to determine whether humour may be of therapeutic benefit or not (see also Categories 6, In-the-moment feedback; 7, Longitudinal feedback; and 8, Relational variables).

"You would never in any way want a client to think that you were finding their distress amusing or that you were mocking it or not fully getting it" [Participant A]

On occasion the participants' assessment of their obsessive-compulsive clients' tolerance for humour can prove wrong. One participant gave an example of when their own provocative style of humour had backfired and caused the client greater distress.

"At the end [of therapy], I asked for some feedback and he [the client] said 'I found your humour at times to be very difficult, I know you were trying to make light of my rituals but the obsessive part of me...erm...because you were highlighting it, it made me want to obsess about it even more'...his obsession was that he was a paedophile so one of his behavioural experiments was to spend some time on his own with his one year old son and I made a quip, I said 'When you're there, don't listen to the latest songs by Jimmy Saville or Gary Glitter'...he laughed at the time, but..." [Participant F]

3.2 Soothing/ 'light' humour

All of the participants identified certain types of 'light' humour (from a wry smile – a metacommunication to indicate that they are able to view a bad or distressing situation in a slightly amusing, perhaps more detached, way - to some gentle banter) which they use to soothe their obsessive-compulsive clients' distress and, at the same time, help to shift them towards a more accepting and flexible (less critical and fixed) perspective. Participants found that these 'light', but slightly provocative, forms of humour, enabled them to be tuned in but, at the same time, slightly distanced from their clients and thus able to suggest different and alternative

perspectives and interpretations (see also Sub-categories 4.2, Play/lighten; 4.4, Reframe/'cognitive shift'; and 4.5, Change/'eureka moment').

"A therapist can make gentle observations, you know...a smile and some support and enthusiasm can move a client on so that they can be more open to a joke or take some feedback - 'Ha! You messed that up!' - rather than that rigidness they were feeling" [Participant C]

Many participants also reported using gentle teasing as a means to challenge – without appearing critical and judgemental – the critical thoughts or unhelpful behaviours of obsessive-compulsive clients.

"Sometimes even just an inflection in your voice can indicate a lightness, bring a lightness...so I was thinking about saying [to a client] 'So, did that work?' and smiling... slightly teasing, when I know full well that it has not worked" [Participant G]

Most participants indicated that their own circumspect use of humour in session would naturally gravitate towards light, and so much 'safer', humour and so mitigate against inadvertent offence or the rupture of the therapeutic relationship.

"If humour is on a spectrum, I only stick to the very light end...it's very safe" [Participant H]

Category 4: Constructive functions of humour: reframing and lightening, distancing while closely bonded

Category	Sub-category	Participants
4. Constructive functions of humour	4.1 Trust/bond	A, B, C, D, E, F, G, H
	4.2 Play/lighten	B, C, D, E, F, G
	4.3 Normalise/'being human'	A, B, C, D, E, F, G
	4.4 Reframe/'cognitive shift'	A, B, C, D, E, F, G H
	4.5 Change/'eureka moment'	A, B, C, D, E, F, G

4.1 Trust/bond

All of the participants identified the use of soothing or 'light' humour as being likely to enhance the trust and bond between them and their obsessive-compulsive clients. Humour enabled participants to attune to their clients; to demonstrate their attentive awareness of, and responsiveness to, them. In this way, such attunement is similar to the healthy developmental interactions witnessed between a child and its caregiver (Stern, 1985; Fry & Salameh, 1987; Mosak, 1987). Indeed, one participant described CBT for OCD as positively encouraging shared, 'in jokes' between the therapist and obsessive-compulsive client precisely in order to build such a collaborative and trusting bond.

"The Beckian style of CBT [for OCD]...it's a way of eliciting together, like an 'in joke', like 'We know, nudge nudge, wink wink, what this is"...Beckian CBT is a shared, collaborative 'in joke', like 'I get it and when I do that thing, you get it...ha ha'" [Participant D]

Some participants also felt that humour enabled the obsessive-compulsive client and therapist to bond through a mutual expression of relief when the client

discloses something significant – and often scary – for the first time, which was viewed as an important part of 'holding' and containing the client's fear and anxiety.

"The other thing it [humour] can do, I was thinking, was this idea of relief, too, when the client tells you something they are scared of admitting and they are relieved and you often laugh, you know, 'What the bloody hell was all of that about? Why was I so worried?' so there's an anxiety or tension release in laughter which can be bonding, too" [Participant D]

Participants also noted the value and importance of 'joining in' with client-initiated humour - provided that such humour is 'light' and appropriate - again to encourage a mutual understanding and bond.

"If a client initiates humour that is relevant and appropriate and relates to what they're talking about then I think that's great and I would actively encourage it" [Participant A]

Other participants viewed humour as a means for obsessive-compulsive clients to demonstrate their trust in the therapist and to indicate that they are on the same 'team', fighting the OCD together.

"Humour is a way for clients to demonstrate intimacy and trust" [Participant F]

"Humour unites us against the OCD, 'It's you and me against the bully'" [Participant A]

4.2 Play/lighten

For Bateson (1954/2000), play behaviour involves a 'meta-communication'; that is a statement which provides the correct interpretative context for such behaviour. Thus, each play behaviour involves the exchange of signals between the

participants in play which carries the message "This is play"; and, consequently, such behaviour can be correctly interpreted as friendly rather than hostile. Such a message, Bateson contends, results in a paradox – a negative statement containing an implicit negative meta-statement (e.g. "This sentence is false": if it is false, it is false that it is false, and so it also true; and vice versa). Thus, in a play situation, the implicit statement "This is play" can be rephrased as "These actions in which we now engage do not denote what those actions *for which they stand* would denote"" (pp.179-180). Bateson, in turn, suggests that the expression *for which they stand* is synonymous with *which they denote* and so develops the message as follows: "These actions, in which we now engage, do not denote what would be denoted by those actions which these actions denote". The result is that the message "This is play" creates a constructive paradoxical frame as the correct interpretative context for all play behaviours; and so enables the participants in play to experience a beneficial psychological contradiction in their own behaviour. As Bateson contends: "..without these paradoxes the evolution of communication would be at an end. Life would then be an endless interchange of stylized messages, a game with rigid rules, unrelieved by change or humor" (p.193). In these terms, the paradoxical nature of play and humour within the therapeutic frame enables rules to be challenged and alternative perspectives, explanations and communications – and so change - to emerge.

Indeed, while obsessive-compulsive clients do not access therapy to 'have a laugh' with their therapists, all participants described how the lighter, more playful aspects of humour enabled them to put their clients at ease and to reveal a lighter side to the human condition.

"I try to use humour to put clients at their ease, to soothe them...for this client, everything is so serious so I use humour to show...to say there is a lighter side to life" [Participant B]

For one participant, encouraging clients to poke fun at, and so externalise, 'the OCD' has the added benefit of making the condition less terrifying.

"I often say 'If you can poke a bit of fun at this, it will seem less sinister to you'...like 'Oh, yeah, ok, it's you [the OCD] again, thanks very much for your input, but I'm not going to engage with you today'" [Participant A]

Another participant employs playful metaphor, likening himself to a parrot sitting on his obsessive-compulsive clients' shoulders, to introduce a serious therapeutic intervention in a more accessible, and less judgemental, way. This has the effect of softening the experience for the client – as well as making the intervention more memorable.

"People often talk about having me, like a parrot on their shoulder, prompting them...the image itself is humorous but the message is serious so it's a nice, gift-wrapped serious message which makes it more palatable" [Participant E]

Some participants highlighted the importance of 'playfulness' in building a strong, but safe, relationship with the client; one that achieves a 'healthy' distance but with a closeness, much like a 'bridge'. Finding playfulness and humour within the therapeutic relationship may trigger a parallel process in the client's own internal world, too. It may enable the obsessive-compulsive client to develop a different object-relation with their distressing thoughts, feelings and behaviours, one that shifts them away from denial and avoidance and instead enables them to maintain a safer distance from, but remain connected to, such thoughts, feelings and behaviours.

Thus, in the extract below, humour was seen as a means to challenge the 'obstacle of perfectionism' and need for unachievable control in obsessive-compulsive clients**.**

"Playfulness is an interface with the client, it's almost like a bridge...and it integrates the self, you know, it softens things...like 'It doesn't matter, you know..Is that really important?' which...The lights on or off, that compulsion to keep trying doesn't seem so important...It's like it challenges the obstacle of perfection, 'It doesn't matter, it's ok'...I think working with paint, I worked with a client once and we were using ink and it just blobbed onto the page and they were like 'Ahh.', horrified they'd made a huge mistake, but, you know, they could make a tree out it...it wasn't the end of the world, the consequences didn't really matter and so it allowed them to challenge their message 'Oh my god, I've messed up and it's my fault'" [Participant C]

Some participants suggested that their obsessive-compulsive clients' sense of self is enhanced via 'playfulness' and humour which foster the development of important skills by the client; specifically, in terms of acceptance, curiosity, connectedness and empathy.

"Playfulness and humour are inter-related...playfulness is about the soft skills of play and creativity and working with that aspect of people's personality and having fun is part of that play...it allows people to connect and relate...Anyone can access play and it's not about being perfect so there's an acceptance which actually connects with their own issue of 'not being good enough' or 'I didn't get it right the first time' or 'I'll keep on going over and over, I'll get the right t-shirt' or 'I'll find the right thing'...actually, 'good enough' is fine...that first t-shirt is good enough'" [Participant C]

4.3 Normalise/'being human'

Many participants used humour as a means to model and demonstrate their own faults to their obsessive-compulsive clients, thus normalising such behaviours. They pointed out that humour was a helpful and effective means to communicate their 'human' side - and, in particular, their own foibles and fallibility – so challenging the notion that therapists are somehow detached 'experts' who have all of the answers ready at their fingertips in manualised treatment protocols.

"Clients need to know that they are dealing with a human...not a robotic follower of evidence-based, treatment protocols" [Participant E]

The use of self-deprecatory humour was seen to 'normalise' the experience of an obsessive-compulsive client's intrusive thoughts making them seem less threatening, while at the same time enabling the therapist to build a greater rapport with the client; to show their 'human side'.

"Sometimes I will be slightly self-deprecating and that is something I do deliberately as a way of trying to show my human side… I will talk about when I get an intrusive thought and will express some tongue in cheek, self-deprecating thought like 'I know I'm being daft in doing that but...'" [Participant E]

Thus, humour may enable the therapist to challenge, as well as normalise, a client's 'dysfunctional' thoughts in a compassionate and sensitive manner; one which demonstrates empathy and understanding, rather than criticism or judgement.

"Humour is a way of getting the message across in a less challenging way without the client thinking 'This is disproportionate thinking and therefore I am defective'" [Participant E]

Again, one participant noted how, as human beings, we can all experience life as being ridiculous to the point of absurd sometimes; and, for those clients

suffering from OCD, that ludicrousness can be 'lightened' when the therapist shares similar experiences in session.

"There's a ludicrousness about life sometimes...what happens and how you respond and sometimes [humour] can just be a bit light, 'Well, that happens to me, too'" [Participant G]

Indeed, one participant revealed that they had bonded with an obsessive-compulsive client, and normalised the client's contamination fears, by laughing together about the therapist's 'human side'; specifically, the therapist's dream that they had developed an eye infection as a result of the behavioural experiment that they had conducted together with the client.

"When we were doing behavioural experiments, humour was great, when you could joke about some funny story or something…using humour, showing that human side, the funny side, that really helps them connect…I mean an example...it happened in an OCD programme actually, I was working with somebody and she had a fear about her eyes cos she wore contact lenses but she was like really, very extreme in the way she managed her eyes and lenses...and so we had to do an experiment together where I took my contact lenses out and we put them into cases without washing our hands, and then we went outside for a walk, came back and put the lenses back in without washing our hands and I had to check in with her the next morning...but it was really funny cos that night I had a dream that I had developed a huge eye infection and ended up in eye casualty so we really laughed about that [laughs]" [Participant G]

4.4 Reframe/'cognitive shift'

All participants mentioned the use of humour to encourage obsessive-compulsive clients to take a step back and view their symptoms from a different (perhaps, more objective) perspective, describing this experience as 'reframing', 'restructuring', 'shifting focus', 'getting the cognitive shift', 'gaining perspective' and 'gaining mastery over' their OCD. By distancing themselves from their symptoms, obsessive-compulsive clients were better able to observe and challenge their symptoms rather than being controlled by them. The idea that by changing the language you use to describe something affects the way that you think about it is very much in keeping with Whorf's views in his essay *Science and Linguistics* (1940). Thus, in the therapeutic frame, the obsessive-compulsive client's use of humour can be a 'context cue' for a shift in their thinking.

"Humour is a therapeutic tool which I often find gets the cognitive shift I am looking for.. I've got to the point recently, with several people actually, who were very unwell where they've really got to that point of meta-awareness and they're able to almost poke fun at the OCD and say 'Oh, I know what it's doing now...it's bringing out the big guns cos I'm not listening to it anymore' [laughs] and we really laughed at that together…If I help a client get into that sense of being able to view it [OCD] as that 'pesky thing' that's been saying things that aren't helpful or true and that they don't need to engage...it promotes the 'I'm not frightened of you anymore' message and adds to their sense of mastery over things" [Participant A]

One participant, an advocate of Provocative Therapy, described their humorous approach to challenging an obsessive-compulsive client's sense of their own responsibility and culpability by providing a different, extreme explanation and

thus reframing the client's original 'blame structure' as less convincing and powerful than previously thought.

"[Provocative therapy] is all reframing, it's all cognitive restructuring…so you use humour [in the treatment of OCD] to reframe their thought patterns…if someone blames themselves, you could go 'It's not your fault, it's more likely the fault of the Ancient Egyptians' then switch back 'Well, maybe it is your fault'...by switching between wide extremes, there's no way they can't reframe their blaming structure and expand their ways of seeing the problem" [Participant F]

Another participant noted the use of gentle humour in a behavioural experiment to challenge an obsessive-compulsive client's (scary) belief about 'thought-action fusion' and so test their belief that they could cause harm to others via their thoughts alone.

"There was somebody else on the [OCD treatment] programme who was quite scared by his belief that he could, just by thinking something, that something bad would happen to somebody, so his thought was 'I really wish that [therapist name] would have a really bad headache tonight...so the next morning, we got back together to discuss these experiments, and he had wished that [therapist name] had got a bad headache but she came in and said 'I didn't feel that headache you wanted me to have' [laughs] and so we were able to use humour for that" [Participant G]

In this extract, the humour arises from the simple relief felt when the therapist did not experience a headache (again, in keeping with Freud's (1905/13) description of the 'Relief Theory' of humour) but it also provides a playful, yet powerful, metacommunication to the obsessive-compulsive client that his frameworks for interpreting the world – his belief about a 'thought-action fusion' - are illogical and flawed.

4.5 Change/'eureka moment'

The majority of participants described how they often found humour arose in profound moments of change when obsessive-compulsive clients recognised a shift in their relationship with their OCD and their experience of OCD symptoms; and were able to laugh at the absurdity of their predicament. This change was characterised by participants as a 'jolt', a 'nudge', and a 'eureka moment'.

"With OCD, it is that 'eureka moment' when a client gets it and goes 'Duh…stupid old me, I'm such a dick' or something and they might laugh cos it becomes 'I'm a bit of an idiot and not this terrible person who's doing mad stuff and really intense'" [Participant G]

In the next extract, the participant suggests that, at its core, OCD is quite a 'mischievous' illness: like a trickster, it wants to 'catch you out' and may therefore be quite well suited to humorous interventions. Indeed, most participants accessed humour as a means to be provocative or irreverent with obsessive-compulsive clients in order to shift their perspective and initiate a moment of realisation that turns the client's perspective on its head.

"Therapy is about getting people to see things in a different way and steering them in the direction of discovery… In OCD, I think by the nature of the illness, it likes to catch you out so I think if you point that out, you know, that becomes apparent and that can evoke humour cos the client goes 'Oh, yeahh...' and often laughs [laughs]...you know, so all sorts of things like saying 'Tell me what you did...So you wore gloves?...So, how does that fit with what we're been talking about?'...and they'll go 'Oh, yeahh...' and laugh so, you know, there's those kind of realisation moments" [Participant D]

One participant described a moment of shared humour with an obsessive-compulsive client – whilst they were rating the likelihood of their predictions coming true – to signify a breakthrough and significant shift in a client's thinking. Their shared humour marked the client's realisation that their prediction was way off the mark, paving the way to a cognitive 'step-shift' or 'eureka moment'.

"It can be a moment of humour [when rating predictions] when some clients get, almost in their body language, as well as the way they smile when they are saying it, 'Well, it's [their prediction] is just totally out, isn't it? It's just totally wrong' and you might smile and say 'So, is that not 100% again?' [laughs]" [Participant A]

Additionally, clients may recognise the humour and absurdity implicit in their powers of 'magical thinking' and, in particular, in their beliefs surrounding 'thought-action' fusion.

"With mental contamination, you know, how you can 'make bad things happen'...there's quite a lot of humour in that because it's very magical thinking and they [clients] can accept the irrationality of that...and when you say 'Well, how come you can make bad things happen but not good things?' and they'll sort of come out and say 'Oh, yeah, if I could make good things happen and win the lottery…' [laughs]" [Participant H]

The common thread in each of these extracts is that humour can be employed to create, and exploit, an unexpected contradiction or imbalance in an obsessive-compulsive client's thinking sufficient to allow a therapeutic change or shift in their perspective.

Category 5: Negative functions of humour: defending, offending, rupturing

Category	Sub-category	Participants
5. Negative functions of humour	5.1 Shield/block	A, B, C, D, E, F, G, H
	5.2 Offend	A, B, C, D, E, F, G, H
	5.3 Rupture	A, B, C, D, E, F, G, H

5.1 Shield/block

All participants identified that some obsessive-compulsive clients use self-critical humour as a 'defensive' form of avoidance which prevents them from confronting, and dealing with, difficult emotions. Equally, by joining in with or laughing at such client-led 'humour', participants felt they would be colluding with the client in such behaviour. As a result, participants all stated that they would instead seek to unpick and explore with the client the beliefs underlying such humour.

"I would definitely not laugh at [a client's] self-deprecating, self-critical humour...I would say 'Well, that sounds really sad to me or that sounds really difficult" [Participant H]

One participant distinguished between the negative and destructive use of humour by obsessive-compulsive clients to make a mockery of themselves as opposed to a more positive and constructive form of humour by which clients seek to make a mockery of their OCD.

"You've got to make sure that they [clients] are not sort of making a mockery of themselves...I like the idea of making a mockery of the OCD but not themselves within that and not being used as an avoidance...if a client used black humour, I probably would have shared laughter but then I would say 'In all seriousness though, what does this…I'm interested in these thoughts that you are having about yourself cos they don't sound...well, whatever, I would explore it" [Participant D]

One participant also noted that a client's use of humour to avoid anxiety during exposure work in the treatment of OCD was unhelpful and might reduce the efficacy of treatment.

"Humour can get in the way of the exposure effect, which is integral to all anxiety disorder work, so if someone is avoiding those feelings by using humour then that is an avoidance-safety behaviour which we would then be saying 'Well, maybe you need to cut that out a bit'" [Participant E]

5.2 Offending the client

All of the participants noted that they were cautious and circumspect in their approach to using humour in session with clients with OCD. They identified the use of provocative or dark humour - which shamed or ridiculed the client - as wholly inappropriate and damaging both to the client and to the integrity of the therapeutic relationship. All participants agreed that it should therefore be avoided.

"I would consciously avoid any sort of provocative humour which might cause any offence, particularly with clients who are incredibly unwell...it may be a personal fear and I may be wrong but I don't think it would be appropriate to use humour when you're getting people to do scary things [exposure and behavioural experiments] and they're nervous and scared" [Participant A]

Participants also noted that they undertake a continuous assessment of the appropriateness of humour in session and whether it might cause offence to the client. None of the participants would employ humour with a client who was visibly upset.

"When weighing up whether humour is appropriate, you think about whether it might cause offence...I would never use humour with a client who was upset or crying" [Participant B]

Additionally, the majority of participants felt that sarcastic humour was potentially most damaging to the therapeutic relationship with obsessive-compulsive clients and should be avoided at all costs.

"I don't use sarcasm with [obsessive-compulsive] clients...It can be so damaging…I don't like sarcasm anyway; it's supposed to be the lowest form of wit" [Participant B]

"I think you can do real harm...damage with sarcasm...by using humour inappropriately… I would never use sarcasm towards an [obsessive-compulsive] client; I don't like sarcasm, I don't find it funny, ever" [Participant H]

5.3 Rupturing the therapeutic bond

While all participants reported that they would never intentionally cause a therapeutic rupture, many noted that they have sometimes felt that their use of humour, however well intentioned, might be taken the wrong way by an obsessive-compulsive client and might therefore lead to a rupture. Repairing a rupture was viewed to be more likely when the therapeutic relationship was stronger and more established.

"You have to be very sensitive with laughter especially…I laughed in an assessment today and had to apologise...'I'm not laughing at you' [laughs] and the client said 'No, it's fine'" [Participant D]

Other participants noted that when they have inadvertently used 'clumsy' humour, it was important for them to notice the client's discomfort and to apologise.

"I think if you do say something clumsy, how the client responds is equally important and it's okay to get it wrong sometimes because, if you have a good rapport…the client will tell you and you can then say sorry" [Participant C]

One participant gave an example of when their own 'sarcastic' use of humour led to a significant therapeutic rupture and the client leaving therapy. Again, the participant had assumed a greater degree of connection, and attunement, with the client than actually existed.

"I actually think I lost a patient once when I used humour...it was a very sarcastic use of humour but we'd been working together for a while and I knew it wasn't true and I thought she'd know that I was jesting...it was something to do with her landlord telling her that she had to move out and I said something like 'Was it all the wild parties?' but she did not find it funny at all...I think I said it as a way of connecting and thinking that we had more of a connection than we actually did" [Participant D]

Category 6: Humour as in-the-moment feedback

Category	Sub-category	Participants
6. In-the-moment feedback	6.1 Intuitive	A, B, C, D, E, F, G, H
	6.2 Spontaneous	A, B, C, D, E, G, H

6.1 Intuitive

The majority of participants described their intuitive use of humour arising from in-the-moment feedback from obsessive-compulsive clients in session. They suggested that there are times when using humour with such clients simply 'feels right'; in moments of emotional attunement with their clients.

"It's almost...being part of it [sharing humour with client] just feels right, you know.." [Participant C]

One participant described this intuitive and unconscious process as 'clinical reasoning'. Such reasoning, which taps into an intersubjective 'felt sense of shared experience', enables the participant to gauge when, and whether, humour use is appropriate.

"I prefer the term 'clinical reasoning' but people sometimes talk about gut feelings and instinct, which I regard with slight caution but, yeah...you are going with the felt sense of shared experience in the room, aren't you?" [Participant E]

Another participant described it in terms of the countertransference – their own emotional engagement with the client - that they have not yet fully formulated or understood.

"You know whether to use humour or not…it's the hairs on the back of your neck…that gut reaction which is an unconscious process and the countertransference you haven't formulated fully" [Participant C]

Another participant identified the in-the-moment use of humour as the result of their 'hunch' about an obsessive-compulsive client which arises from paying close attention to, and noticing, that client's unique, and often very subtle, engagement in humour in session. Again, attending to the possibility of humour while, at the same time, being deeply attuned to the client appears to contain and hold their inner world while enabling moments of deep connectedness between the therapist and the client.

"I get a hunch about people...If you really pay attention, you just notice that this person has a sense of humour or they might say something slight and you just respond and smile and say 'Oh, that was funny'...Once you know that is there, you

can bring humour in but never on a conscious level – it's not on the agenda" [Participant G]

Some participants have also noticed a feeling of guilt or disconnection in the moment during session providing immediate feedback that their use of humour may have been inappropriate.

"There are times when I'll feel a wave of guilt in session and think, 'God, I said that; I should not have said that or that was inappropriate" [Participant F]

"I've had a feeling in session before ..and it just feels like it's all fallen off, you know, not been very successful...like, maybe they [the client] did not get it [the humour] and I have thought 'Oh, was that insensitive?'" [Participant D]

6.2 Spontaneous

Almost all participants reported that some of the humour arising in session between them and their obsessive-compulsive clients was spontaneous and could provide a useful and immediate outlet for pent up emotion.

"When an [OCD] client laughs, why wouldn't you laugh with them when they are laughing at the ridiculousness of it [their compulsions]…the laughter is like a pressure valve…they come out with something that just hits the situation on the head and it is a release from the stress" [Participant C]

Another participant likened the spontaneous humour that arises between them and their obsessive-compulsive clients to a sense of mutual relief, akin to Freud's (1905/13) description of the 'Relief Theory' of humour, that laughter releases nervous energy, enabling repressed experiences and feelings to be given *indirect* expression.

"I was thinking of [humour with obsessive-compulsive clients] as this idea of relief…when you are relieved, you often just laugh...'What the bloody hell was all of that about?' so there's a release of anxiety or tension between you" [Participant D]

Similarly, sometimes the spontaneous nature of humour in session can provide useful in the moment feedback, to bring the therapist back into check, when such humour has landed flat or not worked out as planned.

"When you catch yourself thinking 'I shouldn't have used humour then', you've said it almost before you've thought about it but you don't say it again" [Participant B]

Category 7: Longitudinal feedback gained over the course of therapy

Category	Sub-category	Participants
7. Longitudinal feedback	7.1 Strength of bond	A, B, C, D, E, F, G, H
	7.2 Client 'wellness'	A, B, C, E, F, G

Participants reported that they assessed the use of humour in session with obsessive-compulsive clients to provide 'longitudinal' - or longer-term feedback gained over the course of therapy - on both the strength of the therapeutic relationship and the relative 'wellness' of clients over the course of therapy. Additionally, these categories informed participants in their assessment of the appropriateness of humour use in session.

7.1 Strength of bond

All participants noted assessing the strength of the therapeutic bond in determining their use of humour in session with their obsessive-compulsive clients. Indeed, many reported that some degree of rapport has to be established before

humour is used. However, once a rapport is established, the therapist's use of humour with obsessive-compulsive clients is often a factor in determining the strength of the therapeutic bond - and the likely level of client engagement in treatment. This was reported as particularly important in the treatment of OCD since client drop-out rates are particularly high.

"Humour is all about relationships...it is just part of forming any relationship...the biggest risk in treatment success [for OCD] is people not coming back so trust is the biggest thing and you need to use humour to build that trust…We work as a team...hopefully, we'll get on and we increasingly use humour as a connection between us to help make unpalatable tasks a bit easier and to help you trust me" [Participant H]

A client's humour may also change during the course of therapy if the therapeutic bond grows stronger and more trusting. One participant noted the shift in a client's humour from self-critical and isolating to shared and inclusive as their rapport grew.

"We're now twenty, twenty-five weeks into therapy and, you know, now she [the client] trusts me, she uses humour in a different way...so, instead of being so derogatory about herself and trying to make light about feeling very isolated from others, it's much more of a sort of shared humour and she is an amusing lady, a very likeable lady…I think part of the recovery is that they [clients] would get humour...it is part of what they need from you within that [therapeutic] relationship because they have spent so long being the oddball or the geek or whatever...where they weren't understanding the 'in jokes' within a group and just that feeling of sort of 'I don't fit in', 'I can't relate'.."

[Participant C]

One participant even highlighted the risk to the therapeutic relationship of being too uptight and not using humour in session with obsessive-compulsive clients.

"I think the risk of being too uptight is that that can be misperceived as being condescending... erm...you know, that there is the risk of this overly-sincere therapist who takes everything so seriously and never smiles and I don't think that inspires confidence in most people [with OCD]..If they can see you with a bit of normal life experience...with a degree of humour used in sessions, I think that helps people to feel comfortable" [Participant E]

7.2 Client 'wellness'

Many participants viewed their obsessive-compulsive clients' use of humour as an indicator of their relative 'wellness' over the course of therapy. When clients are feeling emotionally unwell at the start of therapy, their capacity for - and use of - humour is diminished. However, as they start to heal and feel less emotionally fragile, they are better able to be more spontaneous, flexible and humorous. Additionally, while 'mockery' as a form of humour may, in some contexts, been viewed as negative and destructive (see Sub-category 5.1, Shield/block), in the following extract the 'mocking of negative thoughts' by the client is presented as a positive and constructive form of humour; one that is indicative of client 'wellness'.

"It [humour] really is about them [obsessive-compulsive clients] becoming better and about wellness and that's when I feel I can use humour and clients respond to it...and that's a good thing. I have a belief that it [a client's use of humour] shows they are getting better…Certainly, when you have conversations

with people who get better and start to poke fun at their self-critical thoughts or negative thoughts, I would definitely see their use of humour and mocking of their own negative thoughts as a sign of wellness" [Participant A]

In a similar way, another participant characterised the obsessive-compulsive client's use of humour in session as a return of the 'healthy self'.

"As the patient feels more relaxed and in a better place, they are able to use humour: it's the 'healthy self' returning isn't it? It's a great insight actually because people just forget to laugh almost...they just get consumed by their problems" [Participant G]

Several participants noted the importance of monitoring a client's use of, and response to, humour to gauge a shift in the client's psyche from being rigid and fixed in their thoughts (and feeling alienated or isolated from others) to being softer, and more flexible (and so feeling more joined up with others).

"If you look at mental health and well-being being on a continuum to mental ill health, if you look at wellbeing, it's about being spontaneous, being able to adapt and being free-flowing...erm...to the opposite, fixed side, where it's being rigid and feeling alienated…so, I think humour is, you know, what human beings are able to connect with and relate to others so if they [obsessive-compulsive clients] can learn [in therapy] to be flexible, it can help them relate to both themselves and others…There's something about the fixed, the rigid, the lack of humour, the isolation, the illness at one end [of the spectrum] and then moving towards something that is more flexible, that's more connected, more creative, more relaxed.." [Participant C]

However, not all participants were convinced that there is a connection between an obsessive-compulsive client's 'wellness' and their use of humour. One

participant viewed humour use more as a personality trait which might reveal itself in the client as the therapeutic relationship strengthened.

"I don't see that there were many people who were humourless at the beginning and, as they get better, they start to be able to use humour...I think it's more a personality characteristic that might show itself as they built up that therapeutic relationship but I don't think it's an indicator of wellness" [Participant H]

Category 8: Individual differences which affect the participant's assessment and use of humour in session with OCD clients[2]

Category	Sub-category	Participants
8. Individual differences	8.1 Culture/religion	B, C, D, F, G, H
	8.2 Region/class	B, C, D, F
	8.3 Age/gender	C, D, G, H
	8.4 'Personality match'	A, B, C, D, E, F, H

The majority of participants reported that there were four types of individual differences which affected their assessment of the appropriateness, and use, of humour in session with obsessive-compulsive clients. These were the respective culture and religion; regional identity and class; age and gender; and the 'personality match' between the therapist and obsessive-compulsive client.

[2] The less that a participant perceives that they have in common with - or can relate to - their obsessive-compulsive client's cultural, religious, regional and class backgrounds and their age, gender, and 'personality', the more cautious that participant is in using humour in session with that client for fear of causing offence.

8.1 Culture/religion

Many participants noted that differences in the cultural or religious backgrounds of the obsessive-compulsive client and the therapist resulted in their using humour more cautiously with clients for fear of causing offence.

"Cultural factors is another big one...I might not connect in the same way with someone who was very obviously from a different cultural, spiritual or religious background from mine cos you don't want to put your foot in it, do you?" [Participant D]

There may also be a greater risk that the therapist's humour might not be shared with a client from a different culture.

"I think if somebody is from a different culture...then I think it can be harder to find that common ground to ensure that humour is shared" [Participant H]

8.2 Region/class

Several participants reported that humour may vary from region to region and that they were sensitive to perceived differences in regional humour. The more that the participant feels that they have in common with – or understand – the specific 'regional humour' of an obsessive-compulsive client, the more confident they may be in using humour with that client. Having some common ground makes humour use feel 'safer' and less risky.

"What's interesting is her [a client's] very 'London humour', she references that she is from London in her humour and there is something about her expression of regional humour, as an expression of regional identity, that comes into it...She's from East London and I'm from North London and I think there is a 'London

humour', you know, when times have been tough, you use it as a resource" [Participant C]

Some participants have also experienced clients from particular regions as more 'naturally funny' than others. Again, some participants referenced cultural stereotypes when it comes to humour use.

"This is Liverpool, you know…I'll be sitting there ready to find out about the problem and people will just turn round and crack a joke and it's just very natural for them" [Participant F]

Similarly, humour use is also perceived to vary among socio-economic classes with working class clients described as having a 'grittier', and greater, sense of humour.

"I think it's also class, social and economic...as a general rule, I think working class people tend to have more of a sense of humour, they have more of that 'gritty' stuff" [Participant F]

8.3 Age/gender

Participants tend to use humour more cautiously with obsessive-compulsive clients from a different generation since it is perceived to be harder to find common ground or a shared understanding of humour. Again, many participants also feared causing offence.

"I think if somebody is from...a different generation, then it can be harder to find common ground to ensure that the humour is shared" [Participant H]

Of equal concern for participants working with obsessive-compulsive clients of a different gender, is that their humour might be misconstrued as 'flirting' and therefore threaten to compromise the professional relationship between them and the

client. As a result, participants indicated that they would proceed with caution when using humour with clients of a different gender.

"Sometimes humour can be construed as flirting...so if I have a male patient in the room with me, I might not...sort of, I don't want things to be picked up in the wrong sort of way...or misconstrued" [Participant D]

8.4 'Personality match'

The more that participants feel they have in common with – and can relate to – the personality and sense of humour of their obsessive-compulsive client, the more likely they are to use humour in session with that client. Humour was presented as an extension of the therapist's (and client's) personality and integral to their therapeutic style.

"Humour arises in the moment in therapy and, yes, absolutely my personality has a bearing on that...humour is intrinsic to my personality and that flows into my therapeutic relationship with clients" [Participant B]

For some participants, to ring fence humour altogether in therapy would be to deny the therapist's authentic self in their work with the obsessive-compulsive client.

"So, here's something [humour] that is innate...integral to my personality and it feels right...so it would feel very odd to ring fence that" [Participant C]

For some participants, the greater the personality and sense of humour 'match' between them and their client, the more likely they are to use humour in session with that client.

"Some people you just 'click with'...they instigate the humour, they make a quip…if you have a common ground with humour, that is a short cut to rapport" [Participant H]

Conversely, it may be more difficult for a therapist to work with or relate to an obsessive-compulsive client if they cannot use humour at all.

"I think people who cannot laugh at themselves...I do actually find it hard to relate to people who just cannot laugh at themselves" [Participant G]

Category 9: Intrapsychic variables which affect the therapist's use of humour in session with OCD clients[3]

Category	Sub-category	Participants
9. Intrapsychic variables	9.1 Experience/confidence	A, C, D, E, G, H
	9.2 Training/supervision	A, B, C, D, E, F, G, H
	9.3 Professional reputation	A, C, E, F, G, H

Participants also identified three 'intrapsychic' variables which affected their use of humour in session with clients: the experience and confidence of the therapist; their experience of humour in training and supervision; and their desire to maintain their professional reputation. These variables related, but were not limited, to those clients with OCD. Rather, some participants identified all three variables as applicable to their use of humour with all clients regardless of clinical presentation and/or diagnosis.

9.1 Experience/confidence

Many participants reported that the more experienced and confident that they had become in treating clients, the more likely they are to use humour in session.

[3] The less experienced/confident the participant, the more cautious they are likely to be in using humour in session. The more negative their experiences of humour in training and supervision, the more reticent the participant is likely to be about using humour. Participants also try to find a balance between their 'serious' professional reputation and using humour – sensitively and appropriately – to enhance the therapeutic relationship.

"I think [using humour] is just more about confidence and experience and perhaps infusing a bit more of your personality into how you do the job, the more experienced you are...Certainly when I was training, I was quite nervously sticking absolutely religiously to the protocols..." [Participant A]

Experience was also seen as a factor which enabled the therapist to relax, feel more confident and so reveal more of their personality in session via their use of humour.

"It [experience] gives you the confidence to think 'Actually, I don't have to be a complete robot here; I can be a bit more creative, I can use my personality" [Participant A]

Conversely, the less experienced and confident the therapist is, the more that they are likely to be focused on using appropriate interventions and other key elements of the therapeutic process and so less likely to be using humour in session.

"I think when you're learning, you're trying to concentrate and really understand what the therapeutic process is and the theory and all that kind of stuff and sort of be serious, trying to check that you're getting it right" [Participant D]

9.2 Training/supervision

Participants reported that positive experiences of humour during training and in supervision encouraged them to use humour in session with clients thereafter.

"I learned most of my OCD work from Jack Rachman...and he is, he has got a ridiculous sense of humour...he has the world's best sense of humour but it is very dry" [Participant H]

Positive feedback from, and the use of humour by, supervisors and tutors also encouraged and affirmed participants' use of humour in session.

"I shared [a funny incident with a client] with my supervisor and she said 'oh, I'm glad that you are using humour in your therapy' which felt affirming [laughs]" [Participant B]

Conversely, negative experiences of humour in training discouraged participants from using humour in session with clients during training and when they first qualified. During their training, some participants were made to feel that humour use was unacceptable or should be 'repressed'.

"I doubted the use of humour cos when I was training initially, it being totally unacceptable, so I was really, you know, cracked down on...if I ever said anything, you know, even slightly humorous...I felt that I had sort of had my hand slapped…I think also my tutor, she herself, has no humour at all…she was straight as anything and, you know, I think humour had bypassed her as well...I felt I had to repress this [humour use] for the first probably five years of my training" [Participant C]

Other participants felt that some supervisors viewed humour use in session as unprofessional and so something to be avoided for fear of reprimand or even sanction.

"Some of my supervisors, I doubt they would have used humour at all, well, I know...I think they would see it as...something very unprofessional and worthy of malpractice" [Participant F]

All this aside, over half of the participants stated that their decision to use humour – or not – in session with clients was not informed by either psychological theory or the lack of instruction on therapeutic humour use in formal training.

"My reticence to use humour is not informed by a theoretical perspective" [Participant A]

"I think that humour was, for me, not part of a formal training...I did not ever have a session on humour" [Participant H]

To this end, it appears that for some participants, there are other factors, over and above their experiences of training and supervision, which play a much more significant part in their decision on whether, when and how to use humour in session.

9.3 Professional reputation

It was suggested by some participants that, in order to maintain their professional reputation and to gain the trust of the obsessive-compulsive client, they must maintain a serious persona in session.

"Clients need to feel...that you are serious and credible, that you are genuinely telling them that what you are asking them to do [CBT for OCD] is going to work" [Participant A]

It was also felt to be important that the therapist takes the client's presentation seriously rather than appear to undermine or belittle their experience of OCD.

"A lot of people are very serious with OCD...they are real worriers and they're very serious and, in most cases, they are not coming to me to...erm...have a friendly chat and a laugh" [Participant A]

However, it was also suggested that while therapy is a 'serious business', when used sensitively and appropriately, humour can be a helpful relational tool to 'lighten' the severity of the therapeutic process.

"I think that it is a serious business to formulate, to actually understand something, so it involves some keen listening, some keen questioning...erm...in order

to sort of pull things together...there is a lot of discussion and collaboration, which I think is a serious business...but it does not have to be done more seriously than it needs to be" [Participant E]

Summary

In summary, the model sets out a number of criteria which together determine the therapist's decision on whether to use – or respond to - humour in therapy with their obsessive-compulsive clients. Central to the therapist's decision is an implicit understanding that humour may arise in session as an expression of paradox in OCD (it being at once illogical, distressing and dangerous, as well as creative, informative and absurd). Additionally, the client's response to, and use of humour, is continuously assessed by the therapist to determine the type, and function, of humour being used and whether it is likely to impact on the therapeutic relationship and so reduce or enhance the risk of therapeutic rupture.

All participants recognised that not only can humour be offensive, it can also be used to block or deny thoughts and emotions. Indeed, the obsessive-compulsive client's high desire for, but low sense of, autonomy and control manifest in their futile and distressing attempts to maintain an impossibly tight grip on their thoughts, feelings and behaviours. The inevitable sense of failure that they feel only serves to exacerbate their fear and shame. However, participants also cast humour as a panacea for these painful emotions: they described how it can make such feelings more tolerable for their OCD clients by providing a release for them; by normalising their experience; and by encouraging a shift in their thinking or perspective and, perhaps, a return to the 'healthy self'.

For participants, humour is viewed as a means to attune to their obsessive-compulsive clients, to assess their tolerances and boundaries, and so better mirror and respond to their individual idiosyncrasies. By attending to the possibility of humour, while at the same time being deeply attuned to their obsessive-compulsive clients, participants both contain their clients' inner worlds while enabling moments of deep connectedness. Similarly, clients may be encouraged to develop a more functional set of object relations to their more distressing OCD symptoms. The paradoxical nature of play within the therapeutic frame enables existing rules and rigid structures to be challenged and replaced by alternative – more flexible and forgiving – explanations, interpretations and communications.

In the next chapter, I shall discuss what these results may mean in the context of the existing literature surrounding humour, and specifically, therapeutic humour and OCD.

5. Discussion

5.1 Introduction

In this chapter, I shall draw comparisons between the findings of this research and the existing literature on both therapeutic humour and OCD as set out in the literature review, as well as introducing new relevant literature in light of the findings. I shall consider the contribution of this research to the understanding of how therapists decide whether, when, and how, to use therapeutic humour in their work with obsessive-compulsive clients; and, the contexts and processes involved in such decisions. I shall go on to assess the validity and the limitations of the research and consider its implications for practice. Finally, I shall present some recommendations for potential future research and some final reflexive comments.

5.2 Humour as an expression of paradox in OCD

OCD is a paradox (Gillan et al., 2014): it "involves contradictory but inter-related elements that exist simultaneously and persist over time" (Smith & Lewis, 2011, p.382). Indeed, obsessive-compulsive clients spend considerable time performing repetitive compulsive behaviours and wrestling with distressing obsessive thoughts and anxiety. At the same time, however, they are not deluded and most understand that their worries are improbable and that their behaviour is absurd or at least illogical and excessive.

Additionally, the 'thought suppression paradox' (Rachman, 1998; Salkovskis 1996) - born out of the obsessive-compulsive client's high desire for control but low sense of control (Moulding & Kyrios, 2007) - posits that the obsessive-compulsive's very attempts to ignore, neutralise or suppress thoughts can lead to the paradoxical effect of increasing, rather than decreasing, the frequency of the unwanted thought.

While this is not 'funny', the majority of those suffering from OCD are fully aware that their concerns are illogical and unrealistic and that their compulsive behaviours are excessive and absurd (Foa et al., 1995). Thus, while OCD is a serious condition – it is ego-dystonic, illogical and often distressing - it is also associated with the creative and comic (Cefalu, 2009). All of the participants highlighted the paradoxical nature of OCD and, thus, the findings of this study lend support to the idea of this painfully ironic contradiction (see Category 1, Humour as an expression of paradox in OCD, p.58)

In her study on the daily life of adults with OCD, Kohler (2017) identified humour as one of the key coping strategies used by those suffering with OCD and found that laughter shared with friends and family helped to normalise - and reduce the anxiety associated with – distressing OCD symptoms. Gelkopf and Krietler (1996) similarly note that therapeutic humour can be a means to release excess anxiety; and so, lower the client's neurotic defences allowing potential access to unconscious material (Roncoli 1974; Surkis, 1993). In this study, too, almost all of the participants presented humour as a means to manage emotional intensity in session and to enable the obsessive-compulsive client to discharge emotional energy. In keeping with Winnicott's (1958/2018) notion of 'holding' the client's painful emotional experiences, humour was a means for participants to demonstrate to their clients that they can contain, survive and transform painful experiences; and for their clients to experience a different way of relating to their symptoms.

5.3 Humour as an assessment tool

Allport (1968) stated: "So many tangles in life are ultimately hopeless that we have no appropriate sword other than laughter. I venture to say that no person is

in good health unless he can laugh at himself quietly and privately" (cited in Banmen, 1982, p.134). Humour has long been recognised as a diagnostic tool and often forms part of the client assessment process (Mosak, 1987; Goldin & Bordin, 1999). Some research suggests that psychiatric patients are less receptive to humour than 'normal' subjects (Levine & Redlich, 1960, cited in Banmen, 1982) and that a patient's level of ego strength is positively correlated to their appreciation of humour (Goldsmith, 1973, cited in Banmen, 1982). The findings in this study (especially Category 2, Continuous assessment process, p.61; and Sub-category 7.2, Client 'wellness', p.82)) appear to support these views: participants indicated that the ability of their obsessive-compulsive clients to engage in humour can be a useful 'signal' to gauge both their current state of emotional distress, as well as their historic personality. Participants also noted an increasing shift in their obsessive-compulsive clients' capacity to use and respond to humour over the course of therapy and interpreted this as a sign of their 'healthy self' returning.

Rosen (1963) advised that: "The obsessional individual seems to have to learn to insult and be insulted gracefully before his social development can proceed" (p. 723). Thus, humour can also be used to assess change in the client during the course of therapy. Harrelson and Stroud (1967) noticed that the use of hostile and distant humour by their clients with schizophrenia in initial therapy sessions was superseded by a friendly, warm humour later in therapy. The use of humour in the ongoing assessment of obsessive-compulsive clients during the course of therapy was again noted by all of the participants in this study. Indeed, humour was identified as an indicator of client wellness by the majority of participants and I shall discuss this finding in more detail below (in section 5.6.3).

5.4 Constructive functions of humour

5.4.1 Trust/bond

Within the existing literature, the 'alliance' between therapist and client has been found to be a 'demonstrably effective' component of the therapeutic relationship (Hovarth et al., 2011). Closely related to this is the connection or bond that develops between therapist and client, defined by Sexton et al. (2005) as the degree of intimacy and mutuality in the therapeutic relationship. It is through this bond that therapist and client can experience authentic, 'moments of meeting' (Stern, 2004; Lemma, 2000) or 'relational depth' (Mearns & Cooper, 2018) and that therapeutic healing may occur (Cooper & Knox, 2018). Indeed, Wiggins (2011) (cited in Cooper & Knox, 2018, p.185) has demonstrated a strong correlation between the experience of relational depth and positive therapeutic outcome.

All of the participants in this study suggested that one means of achieving such relational depth is via the use of therapeutic humour (see Sub-category 4.1 (Trust/bond), p.67). This approach is very much in keeping with existing research (Gelkopf & Kreitler, 1996; Richman, 1996; Scott, 2009; Adams, 2013; Gibson, 2014). Moreover, all participants in this study indicated that the use of soothing or 'light' therapeutic humour helped them to foster trust and connect with their obsessive-compulsive clients by enabling them to reveal their humanity and empathy. These findings also echo Carl Rogers' Person-Centred Therapy, which emphasises the three 'necessary and sufficient core conditions' for the development of 'relational depth' in therapy. These conditions are that the therapist is congruent or genuine; that they offer unconditional positive regard for the client; and that they experience and communicate an empathetic understanding of the client's internal frame of reference (Rogers, 1957, p.96). In succinct terms, Mearns and Cooper

(2018) define relational depth as "a state of profound contact and engagement between therapist and client" (p.44).

Again, by using humour to communicate Rogers' 'core conditions', participants felt that they were able to develop a trust and bond which enabled them to connect and demonstrate that they are on the same 'team' as their obsessive-compulsive clients, fighting the OCD together. By joining in with (appropriate and 'light') client-led humour, participants described being able to mirror clients demonstrating both their understanding of – and attunement to - the client's experience in order to deepen the therapeutic bond. In this way, such attunement is similar to the healthy developmental interactions witnessed between a child and its caregiver (Stern, 1985; Fry & Salameh, 1993; Mosak, 1987). As Stern (1985) notes, attunement is "the performance of behaviors that express the quality of feeling of a shared affect state without imitating the exact behavioral expression of the inner state" (p.142).

5.4.2 Play/lighten

From studies of primates, social play and laughter have been demonstrated to facilitate non-aggressive competitiveness and playful interaction (Bateson, 1954/2000; van Hooff, 1972; Provine, 2000; Gervais & Wilson, 2005) thus enabling those engaging in social play to hone their social skills without risky or aggressive escalation. Equally, studies on humour use in human social situations point up the function of humour as a 'social lubricant' which enhances the formation of social relationships (Weisfeld, 1993; Manke, 1998; Martin et al., 2003). Ellis (1977a) used humour as a means to playfully challenge his clients and viewed his clients' engagement in humour and play as indicative of healthy emotional adjustment.

More recently, Reddy (2008) noted children's ability to read the minds of others – and better understand both their own and others' motivations – by engaging in playful and humorous teasing. Thus, play is cast as a critical frame for developing an understanding and awareness of self and our relation to others.

The findings of this study accord with and support these views. Participants suggested that the obsessive-compulsive client's sense of self is enhanced by play and that playful humour fosters a sense of acceptance, curiosity, connectedness and empathy in these clients (see Sub-category 4.2, p.68).

5.4.3 Normalise/'being human'

In the participant interviews, therapeutic humour was presented as one means of demonstrating Rogers' 'core conditions', and so relational depth. Many participants stated that they use self-deprecatory humour with obsessive-compulsive clients as a means to normalise intrusive thoughts, to reveal their 'human side' and so demonstrate an empathetic understanding of the client's experience of OCD (see Sub-category 4.3, p.70). As Mearns & Cooper (2018) note: "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?" (p.115).

Gelkopf (2009) also notes the use of therapeutic humour to normalise and demonstrate an understanding of the client's experience which helps to replace feelings of solitude and isolation with a sense of social integration, understanding and empowerment. Again, this shift was described by the majority of participants in this study.

5.4.4 Reframe/ 'cognitive shift'

Greenwald (1987) states: "Humour can make mountains into molehills" (p.53). It can enable us to reframe problems and so gain a sense of perspective. Fry and Salameh (1993), too, note that "humor helps to liberate us from shame and blame. Its disinhibiting effects allow us to experience a new emotional ambiance, relieved by our burdens" (p. xxxi).

Similarly, all participants reported that the use of therapeutic humour to reframe the client's relationship with their obsessive-compulsive symptoms often triggers a 'cognitive shift' as the client is presented with new – often absurd and funny - ways of experiencing old problems and patterns (see Sub-category 4.4, Reframe/'cognitive shift', p.80). By developing a sense of perspective and creating a distance from symptoms, such cognitive shifts often highlight potential solutions to the client which, in turn, provide them with a degree of power and sense of mastery (Viney, 1985). Rosen (1963) suggests that in obsessive-compulsive patients, laughter may result in "a more optimal distance on the part of the patient from the subject matter or the transference" (p.717). This is helpful since, as Rosen (1963) goes on to note, such clients go to extreme lengths to separate affects from objects, a process which humour and laughter can temporarily reverse.

As participants in this study noted, obsessive-compulsive clients who can laugh at their OCD are no longer as frightened and controlled by it; they seem to develop a sense of mastery over it. Several of the participants in this study also noted the positive benefits of using humour to reduce discomfort, and gain mastery, during exposure work with their obsessive-compulsive clients; a method also advocated by Steketee (1993, p.115).

5.4.5 Change/'eureka moment'

When we laugh at a joke, conscious and unconscious material join up and can be played with and imagined, enabling the emergence of new ideas or 'imaginal capacity' (Colman, 2007). In a child's development, such imaginal capacity arises in, and through, their interaction with others. Thus, a baby's development is often encouraged by their mother through humorous and benevolent 'mirroring' – for example, via the use of exaggerated facial and vocal expression, and gentle laughter (Lemma, 2000).

Within therapy, too, Lemma (2000) suggests that humour and laughter lower clients' defences and make them more open to new ideas and suggestions. McWilliams (1994) also suggested that humour can be a helpful tool to enable obsessive-compulsive clients to achieve a lighter, more liberated perspective: "that one could *enjoy* a sadistic fantasy and not just own up to it…is news to these clients. The sharing of the therapist's sense of humour immediately lightens the guilt and self-criticism that weigh so heavily on them" (p.297).

Koestler (1964) suggested that humour creates a mental 'jolt' caused by incongruous or incompatible thoughts or experiences and that these were a prerequisite to creativity (and so change). As O'Connell (2007) notes: "All forms of the comic represent in one form or another a contrast or sudden shift in meaning..[and] a sudden shift in discovering a different, simultaneously appropriate, but non-threatening meaning: 'Everything can be everything else'" (p.322). Within therapy, such interventions are designed to challenge rigid and fixed thinking and behaviours. The use of a paradoxical intervention - one that is humorous or the opposite of what is anticipated - can help to dislodge entrenched beliefs or encourage the client to see them in a different light. This is very much in keeping with Ellis

(1977a), RET, who used humour in just such a way to 'jolt' clients out of unhelpful and limiting mindsets. It is also the mainstay of PI and the research cited earlier (Gerz, 1966; Lewis, 2016).

In this study, participants described positive change in the 'eureka moment' (see Sub-category 4.5, Change/'eureka moment', p.82) and noted that this use of therapeutic humour often triggers immediate - and profound - affective, behavioural and cognitive transformation. Indeed, some participants stated that they access humour as a means to be deliberately provocative or irreverent with their obsessive-compulsive clients in order to create an unexpected contradiction or imbalance as a catalyst for change. This, too, is reminiscent of the descriptions of the use of caricature (Surkis, 1993) and bantering (Roncoli, 1974) in the existing literature.

5.5 Negative functions of humour

This study supports the existing literature noting the destructive potential of humour in therapy (Kubie, 1971) in so much that all participants stated that they were very aware of the double-edged nature of humour; its negative, as well as positive, impact. Participants provided numerous examples demonstrating the potentially damaging effects of humour in session with obsessive-compulsive clients but also noted the lengths that they go to to avoid such damage occurring.

5.5.1 Shield/block

Winnicott (1960) first introduced the idea of the 'false self'; and, indeed, in some circumstances it might be argued that humour provides a shield for clients (and therapists) to mask or hide their authentic pain or distress. However, Freud (1905/2013) also conceived of humour as a mature defence and, as such, an effective

– and normal - means to tolerate and manage conflicting thoughts and emotions in order to remain functional and socially integrated. Thus, humour use does not always preclude the presentation of the 'true self'.

All participants gave credence to the potential harm that humour might cause in their work with obsessive-compulsive clients by blocking or shielding the clients' authentic emotions. Indeed, they all noted that by joining in with self-critical humour they would be colluding with their clients' avoidance of painful emotion. However, as a result, all participants stated that they would instead seek to unpick and explore such humour with the client (see Sub-category 5.1, Shield/block, p.84).

5.5.2 Offence and rupture

Existing literature notes that ridicule and sarcasm can make the client feel belittled and offended, thereby precluding effective therapeutic work (Kubie, 1971; MacHovec, 1991; Schnarch, 1990). And, even when used unconsciously, humour may be a form of aggression and attack (Kubie, 1971). All of the participants in this study concurred with these views. However, they also stressed that they were both cautious and circumspect in their use of humour and would positively avoid the use of humour which shamed or ridiculed the client (see Sub-category 5.2, Offend, p.85).

Two participants did describe two or three incidences of humour in session with their obsessive-compulsive clients which had gone wrong and, inadvertently, caused offence (see Sub-category 3.1, Provocative/'dark' humour, p.70) and, in one case, irresolvable rupture (see Sub-category 5.3, Rupture, p.86).

While all of participants in this study were mindful of the destructive potential of humour, they also all felt that, when used sensitively and appropriately, it can be a constructive and liberating tool. It seemed to me that, for the

overwhelming majority of the time, the participants' self-awareness and continuous assessment of their clients (and the therapeutic process) enable them to navigate away from the more negative aspects of humour (to shield or block underlying feelings, to mask hostility and negative transference and to cause offence or ridicule) which Kubie (1971), Parry (1975) and Thomson (1990), among others, feared.

5.6 Humour to monitor and manage the therapeutic relationship

5.6.1 In the moment feedback

As demonstrated by the Sub-categories 6.1 (Intuitive, see p.87) and 6.2 (Spontaneous, see p.89), it seemed to me that the often intuitive and unconscious decision of participants to use humour points to the existence of an interactive, intersubjective process in therapy with obsessive-compulsive clients. This echoes Stern et al.'s (1998) description of instances of 'authentic client-therapist connection' which bring about lasting change not only to the strength and depth of therapeutic relationship, but also in how the client perceives themselves. Some of these connections arise spontaneously, in the moment, "when a bout of free play evolves into an explosion of mutual laughter" (Stern et al., 1998, p.907).

5.6.2 Strength of bond

The findings reported in relation to Sub-category 7.1 (Strength of bond, see p.90) also highlight the participants' ongoing assessment of the strength of the therapeutic relationship via their use of humour in session with obsessive-compulsive clients. All participants noted that a client's humour often changes in nature and content during the course of therapy as the therapeutic relationship grows stronger and more trusting. Thus, there is a sense in which each of the Sub-

categories in Category 4 (Constructive functions of humour, see pp.73-83) mirror a 'developmental' process during the course of therapy which progresses from the building of trust and a bond between therapist and client, through play and mood 'lightening', to normalising experience and so 'being human', through 'reframing' their experience via a cognitive shift, to a sense of change often via a 'eureka moment'. Thus, in my view, the therapeutic process with obsessive-compulsive clients described by the participants in this study echoes developmental theories of process and change; for example, the shift during healthy development from intrapsychic (I-It) relating to interpersonal (I-Thou) relating (Buber, 1923/2000).

For those clients with a weaker sense of self and self-process, the period of intrapsychic relating may extend for a longer period. The therapist may intuitively hold back from using humour – and so introducing the 'interpersonal' – until clients are able to trust that the 'new object' is different from the 'old object' and to develop a new internal working model of attachment; and so a different way of relating to others (Holmes, 1993; Cooper & Levit, 1998).

5.6.3 Client 'wellness'

Both Maslow (1970) and Rogers (1980) argued that humour use is indicative of a 'healthy' psyche and is a constituent part of a 'fully functioning' individual. Freud (1905/13), too, suggested that there is a connection between a client's healthy adjustment and their use of humour. The use of positive, 'self-enhancing' humour is related to psychological wellbeing and an ability to cope with and survive adversity (Cann et al., 2010; Martin et al., 2003). In therapy, too, Mosak (1987) suggested that an increase in a client's ability to use and appreciate humour may indicate that a client is ready to end therapy. More recently, Albucher, Abelson et al. (1998)

demonstrated that the defence mechanisms in successfully treated patients with obsessive-compulsive disorder change and that they make greater use of more adaptive defences, such as the use of humour, as their OCD symptoms improve.

In keeping with the existing research, many of the participants in this study viewed their obsessive-compulsive clients' use of humour over the course of therapy as an indicator of their relative wellness (see Category 7.2, Client 'wellness', p.92). As their clients began to change and heal, participants reported that these clients were better able to be more spontaneous, flexible and humorous. Only one participant (H) disputed this observation noting that, in their view, humour use is more of a 'personality characteristic' which might reveal itself more as the therapeutic relationship strengthened over the course of therapy (see p.94).

5.7 Individual differences

The findings of this study indicate that, in their assessment of the appropriateness of humour use, all participants have clear regard to the strength of their relationship with their obsessive-compulsive clients and, specifically, the 'individual differences' affecting it. The less that participants perceived that they have in common with - or could relate to - their obsessive-compulsive client's cultural, socio-economic, regional and religious backgrounds and their age, gender, and 'personality', the more cautious they are in using humour in session with that client for fear of causing offence (see Category 8, Individual differences, p.94).

These findings echo Ziv's (1984) assessment of therapeutic humour in terms of the personality traits of - and individual differences between - client and therapist. They also indicate a degree of caution in humour use which respects the individual differences of clients; and which is supported by existing studies. For example,

research indicates that while the topics that provoke laughter are not specific to any culture, the way that individuals compose jokes is bound by both their culture and their understanding of the world (Alharti, 2014). Humour has also been found to manifest differently in Western and Eastern cultures: while Westerners view humour as a 'common and positive disposition', Chinese people regard humour as controversial and a 'specialised disposition' particular to comedians (Yue et al., 2016). Research indicates that people from different social classes, too, draw clear symbolic boundaries – and make negative aesthetic and moral judgements - on the basis of comedy taste (Kuipers, 2006; Friedman & Kuipers, 2013). Equally, research suggests that while elderly people enjoy humour more than younger people, they do not laugh as much and do not enjoy 'aggressive' humour as much as young adults (Greengross, 2013).

The findings in this study also suggest that some participants do not assume that humour will occur in therapy. Rather, they prefer to be led by the client in this regard, particularly if and when they feel that they have less in common with a client and there are considerable individual differences. Here, participants indicated that they may pay greater attention to the nature and quality of the *individual* relationship with that client rather than assuming the existence of any preconceived 'norms', particularly when it comes to humour. In this way, my understanding is that participants may be seen to bracket their own assumptions and values in order to better understand and respond to those of their obsessive-compulsive clients. This also accords with existing research. Kuipers (2006) notes that our responses to humour are largely spontaneous and automatic and, thus, our sense of humour is closely related to our self-image: it reflects our characteristics of age, gender, class; and our personality, too. In this way, shared humour suggests a degree of shared

identity and shared ways of confronting our reality. It seemed to me that, if they did not recognise such a 'shared identity', the participants in this study were less likely to use humour with their obsessive-compulsive clients.

5.8 Intrapsychic variables

The findings in this study indicated variations in the use of humour by participants which reflected their professional experience and confidence, their experiences of humour in training and supervision and their professional reputation (see Category 9, Intrapsychic variables, p.98). These variables were related, but not limited, to participants' use of humour with their obsessive-compulsive clients: some participants identified them as applicable to their use of humour with all clients, regardless of presentation or diagnosis. Equally, the majority of participants stated that their use of humour in session related more to these intrapsychic variables than to any theoretical stance, which concords with existing research (Scott, 2009; Egan & Reese, 2019).

Participants reported that the more professional experience they had gained, the more relaxed and confident they felt about using humour in session. While in training or newly qualified, participants were more focused on using appropriate interventions, and other elements of the therapeutic process, and so less likely to use humour with clients. In keeping with existing literature (Lemma, 2000), participants also reported that negative experiences of humour during training and in supervision discouraged their use of therapeutic humour in session. Several participants reported that they had been given the message that humour use was unprofessional and should be 'repressed'.

5.9 Implications of the study

5.9.1 Implications for practice

The participants in this study provided examples of a range of different 'humours' and what they considered to be humorous experiences with their obsessive-compulsive clients in session. However, it is my contention that humour is complex, subjective and context-driven and, as such, while the majority of the participants' examples of light and soothing humour were presented by them – and interpreted by me - as being both positive and therapeutic, it is impossible to determine how they were received by their obsessive-compulsive clients. Moreover, as we have seen, humour can - and sometimes does - have a destructive effect and can potentially hinder the therapeutic process (Kubie, 1971; Altman, 2006). Indeed, I felt that the two or three incidences of humour in session which had inadvertently caused offence (see Sub-category 3.1, Provocative/'dark' humour, p.70) and, in one case, irresolvable rupture (see Sub-category 5.3, Rupture, p.86) could hardly be constructed as 'humorous', far less therapeutic. That said, the participants suggested that the continuous assessment process in which they engage serves to minimise the negative effects of humour from their perspective. Indeed, participants felt that the use of 'appropriate' and constructive therapeutic humour helped them to build trust with their obsessive-compulsive clients, to bond with them, to engage them in social play, to lighten the mood and effect in session, to normalise their clients' symptoms, to 'be human', to reframe their clients' problems via a cognitive shift, to assist their clients in mastering their difficulties and to enable their clients to change, in particular, via 'eureka moments'.

As such, psychological therapists and related professionals (especially in their training) may be permitted - or even encouraged - to explore how they might

incorporate appropriate therapeutic humour into their work with obsessive-compulsive clients. Demonstrating to clients that they are able to face their symptoms or distress with a sense of humour and an appreciation of the absurd may be a helpful and therapeutic coping mechanism; and preferable to engaging in the defences of isolation, undoing and avoidance, as is common with obsessive-compulsive clients. Moreover, research indicates 'lower playfulness' in obsessive-compulsive adults and therefore treatment of this client population may benefit from increasing those aspects of playful humour which encourage 'uninhibitedness', 'interaction' and 'belief in positive experiences', in particular (Versluys, 2017).

In this study, participants described how humour often arose as an expression of OCD during profound moments of change when obsessive-compulsive clients became conscious of a shift in their relationship with their OCD and their experience of OCD symptoms; and were able to laugh with participants at the absurdity of their situation. Indeed, participants' accounts here are similar to the uses of caricature and bantering described by Surkis (1993) and Roncoli (1974). Thus, as Killinger (1987) suggests, humour does not simply involve telling jokes and humorous stories, it can be much more subtle and creative and involve incongruity, surprise, plays on words and even just plain exaggeration or oversimplification. Whatever form it takes, humour can provide a memorable 'marker' of a transformational experience, one which is shared between - and can be referred back to - by both therapist and client. As such, for those therapists who identify humour as a part of their authentic self, I agree with the advocates of humour use (Roncoli, 1974; Surkis, 1993; Lemma, 2000; Franzini, 2001) and would encourage therapists and other professionals working with obsessive-compulsive clients to bring that humour into session. As some of the participants in this study also highlighted, there may be risks associated with not

using any humour at all: the 'overly-sincere' therapist who takes everything so seriously may not inspire confidence and may even be perceived as condescending and detached (see Participant E in Sub-category 7.1, Strength of bond, p.92).

The participants in this study also indicated that some degree of trust and a bond may need to be established with obsessive-compulsive clients before humour is used. However, once these are established, humour use is perceived by participants as a factor in determining the likely level of engagement of clients in treatment. The introduction of humour can therefore mark a shift of focus away from the perceived weakness and fragility of the client towards a greater sense of mastery and wellness. Indeed, this would also accord with counselling psychology's promotion of wellbeing as opposed to illness and pathology (Woolfe et al., 2010). This is not to minimise the distress felt by obsessive-compulsive clients, but rather to provide them with an alternative perspective and the possibility of developing a different relationship with their symptoms.

In keeping with existing literature (Franzini, 2001; Scott, 2009), the views of the participants in this study also suggest that the assessment of what constitutes 'appropriate' humour use in session may be a learnable skill which is developed through a combination of observation and learned experience over time. In this study, the majority of participants said that they grew more confident in their use of humour the more experience that they had in treating obsessive-compulsive clients and the more that they witnessed the positive benefits of such humour use, particularly in terms of their experiences of relational depth in the therapeutic relationship. While it is beyond the scope of this study to suggest that the assessment of the appropriateness of therapeutic humour be introduced as a formal part of training and supervision, as Franzini suggested, since the participants in this

study all indicated that they do use humour in session with obsessive-compulsive clients, it seems more likely to be used appropriately if it is acknowledged and discussed in supervision and/or in training rather than being ignored or dismissed as inappropriate or even unprofessional (Gelkopf, 2009).

5.9.2 Implications for future research

To date, there have been no other qualitative studies on how therapists understand and use humour with their obsessive-compulsive clients. While this study has started the investigation, there may be value in increasing the sample size and interviewing more therapists on this same topic to get a greater understanding of their experiences of humour work with this client population. There is very little literature on service users' experiences of humour in therapy (cf. Rutchick 2013; Spragg & Cahill, 2015) and it would therefore also be vital to explore the experiences of obsessive-compulsive clients and their understanding and use of humour in therapy.

Given the reservations that the participants in this study had in using humour with those obsessive-compulsive clients with whom they had less in common, it would also be of interest and benefit to clinicians to explore the impact of cultural, religious, class, age and gender differences on both therapists' and obsessive-compulsive clients' understanding and use of humour in session.

The participants' emphasis on confidence and experience as key intrapsychic variables to determine their use of therapeutic humour may be explained by their change in attitude as much as their experience. It may therefore be of interest to research the attitudes and experiences of novice or trainee therapists in their use of therapeutic humour. Finally, it may be of interest to investigate whether the

assessment of the appropriateness of humour use is a learnable, teachable skill, as some commentators have suggested (Salameh, 1983; Killinger, 1987; Franzini, 2001).

5.10 Strengths and limitations of the study

As Willig (2013) notes, a grounded theory model, such as the one generated by this study, does not and cannot claim to be of general application: it is the product of a particular context and time – a snapshot. Rather, this study aims to provide some (limited) insight into the contexts and processes involved in therapists' understanding, and use, of humour with obsessive-compulsive clients.

Another significant limitation of this study is that the participants were all English speakers of white, British or Irish descent and so the study is limited to this frame in terms of race and culture. Thus, as already mentioned, further exploration of racial and cultural differences with a larger and more diverse participant sample would have been preferable.

There may also have been a selection bias in terms of the participants who responded to my invitation to participate in this study. All of the participants that I interviewed indicated their interest in humour, as well as OCD. Thus, the research may not have adequately reflected the views of those therapists who are more reticent about humour use.

Henwood and Pidgeon (2003) offer a set of criteria to evaluate qualitative research. They recommend that the researcher 'keep close to the data' so that the theory that is generated is a 'good fit'. The choice of Grounded Theory methodology went some way to achieve this: it focuses on data and 'bottom-up' theory generation meant that I did not depart from the data and impose my own ungrounded and

unfounded theories and interpretations. Equally, initial codes comprised direct quotations of the participants to ensure that the higher-level codes accurately reflected and were rooted in the language of the participants.

Henwood and Pidgeon (2003) also recommend that the reflexivity of the researcher is explored. Within the social constructivist framework, it is anticipated that data collection, coding and theory generation will all be influenced by the researcher's experience, knowledge and training. Indeed, in this study, I have recognised and explored my (and my supervisors') considerable influence on this study; from the framing of interview questions to the coding, modelling and interpretation of results. As such, this is not 'objective' research. I have consciously built in reflexivity to acknowledge my impact on the research process. I have explored and documented my own stance on the topic and am very aware of my impact on the data collected and theory generated.

A further criterion used to evaluate the quality of qualitative research is 'theoretical sampling and negative case analysis' (Henwood & Pidgeon, 2003). Again, I conducted a detailed analysis of the data to identify cases that were anomalous or contradictory to specific codes and highlighted these negative cases in the results. Finally, 'sensitivity to negotiated realities' was demonstrated in this study both in the independent audit of codes conducted by my supervisor (see Appendix M, Data analysis sample); and by my invitation to the participants to review the Grounded Theory model and summary results (in the event, none of the participants suggested any revisions).

6. Conclusion

This research study set out to explore how experienced therapists, from a range of different modalities, understand humour; and how they use it in session with their obsessive-compulsive clients. The treatment of OCD remains a challenge: a significant minority of clients either refuse, do not finish or fail to benefit from treatment. At the same time, research indicates that the therapeutic alliance is the primary driver for therapeutic change; and that humorous interventions help to strengthen this alliance.

A review of the existing literature indicated that there are no qualitative studies on the use of therapeutic humour in the treatment of OCD and this research was therefore designed to generate new knowledge and an understanding of some of the contexts and processes involved in the use of therapeutic humour with this client population. Grounded Theory was selected as the preferred methodology since it assumes a 'blank slate' of knowledge and uses an inductive approach to develop new theory. Eight interviews were conducted and nine theoretical categories emerged from the data analysis in an attempt to explain how therapists understand and use humour in the treatment of OCD.

The findings suggest that while OCD is a serious condition – it is ego-dystonic, illogical and often distressing - it is also associated with the creative and comic; and so well suited to humorous therapeutic interventions. Participants' ongoing assessment of the personality traits of – and individual differences between – client and therapist, as well as the appropriateness of therapeutic humour use, largely mitigate the potentially destructive effects of humour. While humour can promote the 'false self' and cause offence, it is a display of our common humanity and can promote a close bond between therapist and client to facilitate work at

'relational depth'. Humour helps clients to reframe their problems and gain a sense of perspective; and laughter can normalise and reduce the anxiety, fear and shame associated with OCD symptoms. For participants, too, humour is a means to demonstrate to their clients that they can contain, survive and transform painful experiences; and gain a different way of relating to their symptoms.

My hope is that this research encourages therapists to think about - and be more confident and creative in - their use of humour with obsessive-compulsive clients. It supports previous research that indicates that the appropriate use of, and response to, humour is a learnable skill which can be taught via observation and personal experience. While the findings in this study in no way provide a definitive approach to - or theory on - the use of humour in the treatment of OCD, they do, I hope, provide some interesting points of discussion and useful implications for practice which may serve to enhance and validate the use of humour as a vital tool in the treatment of OCD.

Reflexive Statement (Part 2)

Willig (2013) contends that a researcher should be prepared to be changed by their research. Nearing the end of this research study, I am aware of the hugely transformative nature of this process for me, both in professional and personal terms. This research 'journey' has been punctuated by numerous highs and lows: it has been, at times, frustrating, but also exhilarating. Most of all, I feel that I have learned a great deal. Coming to grips with Grounded Theory was a very challenging, but incredibly worthwhile, process. I struggled initially with the overwhelming task of data analysis and had many attempts at creating some sort of coherent structure from the initial mass of fragmented codes. I was also naïve in my understanding of therapeutic humour believing it to be an almost unqualified force for good. Additionally, beyond the basics, I had a fairly limited knowledge of OCD and its often brutal impact on this client population. Over the past five years, however, I have fully submerged myself in this research and now feel that I have come some way to address these shortcomings in my knowledge and experience.

In my view, psychological distress has a multitude of different causes and maintaining factors. As such, effective psychological treatment extends beyond the mere reduction of symptoms to treatment protocols, and embraces different models to promote, and encourage, curiosity and a respect for difference (Ashley, 2010). Such a pluralistic epistemology lies at the heart of counselling psychology and highlights the need for, and legitimacy of, different perspectives in the understanding, and treatment, of psychological distress. My own training has certainly shaped this research and the resulting (tentative) theory. Counselling psychology encourages engagement with many theoretical perspectives. This research reflects this approach and draws on multiple theories and perspectives in an

attempt to explore, and explain, the findings. While this may have resulted in multiple, and conflicting, 'truths' about how therapists understand and use humour in their work with obsessive-compulsive clients, this is very much in keeping with the spirit of counselling psychology (Woolfe et al., 2010).

I must acknowledge that I approached this research with some preconceptions and assumptions about the benefits of therapeutic humour. I have always found humour both fascinating and helpful – in my experience, it has helped me to gain a more helpful perspective in times of distress and often helps to oil the wheels of social interaction. On the one hand, my interest in humour has been beneficial: I was keen to read around the topic and had a genuine interest in the responses of the participants during the interview process. However, it has also been important for me to reflect, and keep notes in my reflexive journal, on my tendency to hone in on the more positive aspects of humour use. I have been very aware of this and have sought to address the balance by spending time and thought considering the more negative and destructive aspects of humour in the treatment of OCD.

It has been suggested by some that the analysis of humour is a distinctly unfunny task. In my experience of this study, however, this has been far from the case. My exploration of humour in the treatment of OCD has only served to deepen my appreciation of its therapeutic potential; and hardened my resolve to conduct further research in this field in the future.

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Appendix A:

Diagnostic criteria for OCD as set out in The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013)

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

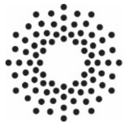
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).



Appendix B:
Open invitation letter to, and briefing document for, potential participants

Faculty of Life Sciences and Computing,
School of Psychology,
Room T6-20,
Tower Building,
166-220 Holloway Road,
London N7 8DB
Researcher:
Rachel Densham
Email: red0196@my.londonmet.ac.uk

Dear potential participants,

Invitation to participate in a research study

I am a trainee counselling psychologist at London Metropolitan University and am carrying out research to better understand how therapists, from a range of modalities, use humour in their work with obsessive-compulsive clients.

There have been various debates presented in the literature on therapeutic humour, with mixed views as to its potential use. However, there has been almost no empirical research on the use of therapeutic humour in the treatment of obsessive-compulsive disorder (OCD). I hope that by conducting this research, we will gain a deeper understanding of how therapists use humour with OCD clients and so will be better able to provide these clients with the support and treatment that they need.

I am keen to interview therapists from a range of modalities who have experience of working with clients with obsessive-compulsive disorder (which may include clients with a formal diagnosis of OCD or Obsessive-Compulsive Personality Disorder, or those who simply identify with or seek to work on their obsessions or compulsions) either within the NHS or in private practice, and, preferably, with at least five years' post-qualification experience.

Interview
I invite you to take part in a semi-structured interview with me, which will last for about one hour and be voice-recorded. The interview will explore the ways in which you use humour in your work with obsessive-compulsive clients.

Location
The interview will be carried out at a venue and time to be agreed between us. You will be reimbursed for any pre-agreed, reasonable travel costs.

Voluntary participation
Participation in the study is entirely voluntary and you should not feel coerced to take part. If you do take part, you can withdraw at any time for up to four weeks

after your interview and do so without any obligation to give a reason. You also have the right, for up to four weeks after your interview, to request that any data provided by you for this study be destroyed.

Confidentiality of the data

In order to protect your confidentiality, your name and contact details will be stored on my home computer (separately from all transcripts and written findings) in a password-protected file, to which only I will have access. Your real name and any identifying references (e.g. to the particular work setting or to the names of your clients, etc.) will be changed or, if required, omitted from your transcript. The audio recordings of your interview will be deleted as soon as the research study has been published, but the anonymised transcripts will be kept in a password-protected file on my computer.

Should you have any questions about the research study, please feel free to contact me by phone: 07730312638 or by email: red0196@my.londonmet.ac.uk.

If you have any questions or concerns about how the study has been conducted, please contact my supervisor:

Dr. Isabel Henton
London Metropolitan University
Faculty of Life Sciences and Computing
School of Psychology
Room T6-20
Tower Building
166-220 Holloway Road
London N7 8DB
(Email: i.henton@londonmet.ac.uk)

I look forward to hearing from you.

Many thanks for your time.

Yours sincerely,

Rachel Densham

Appendix C:
Consent form

Research study title: "How do therapists use humour in their work with obsessive-compulsive clients?: A Grounded Theory study."

Please read and confirm the following statements by ticking the boxes on the right hand side of the page:

Tick (√) to confirm each statement

I have read and understand the content of the invitation letter in relation to the above research study.

I have had the opportunity to ask questions about the nature and purpose of the research study and the information in the invitation letter, and have received satisfactory answers from the researcher.

I agree to taking part in a voice-recorded interview with the researcher.

I understand that my participation in the research study, and all data that I provide, will remain confidential (unless such data indicates a risk to safety).

I understand that all data that I provide will be stored either in a locked filing cabinet at the researcher's home or in password-protected files on the researcher's home computer.

I understand that my participation is voluntary and that I am free to withdraw from the research study at any time up four weeks after my interview without any obligation to give a reason.

If I withdraw from the study, I understand that any data that I have submitted to the researcher can also be withdrawn, for up to four weeks after my interview, and destroyed at my request.

I understand that, when finalised, the results of the research study will be accessible to others and that anonymised excerpts from my interview may be contained within the study.

I consent to participate in the research study.

Participant's Name (BLOCK CAPITALS): ………………………………………….

Researcher's Name: **RACHEL DENSHAM**

Participant's Signature:

Researcher's Signature:

Date: ……………………..…

Appendix D:
Demographic Questionnaire

Date:

Name:

Gender:

Ethnic and racial background:

Native English speaker?:

If no, how long have you been speaking English?:

Date of birth:

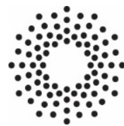
Modality (*please tick*):
CBT Therapist
Clinical Psychologist
Counselling Psychologist
Counsellor
Integrative Psychotherapist
Person-centred/Humanistic Therapist
Psychodynamic Therapist
Psychoanalytic Therapist
Other (*please state*):

Accrediting body (*please tick*):
BABCP
BACP
BPS
UKCP
Other (*please state*):

Year of qualification:

Current employer and length of service:

Relevant past experience working with OCD in NHS or private practice:



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Appendix E:
Debriefing Document

Thank you very much for taking part in this research study to gain a better understanding of how therapists, from a range of modalities, use humour in their work with obsessive-compulsive clients.

Background to research study
There has been relatively little empirical research into the use of therapeutic humour, and almost none on its use in the treatment of obsessive-compulsive disorder (OCD). While some clients with OCD respond well to therapy, others are strongly resistant. Cognitive Behavioural Therapy (CBT) is the treatment of choice for OCD within the NHS, and yet forty per cent of OCD clients do not finish CBT treatment. The literature suggests that therapeutic humour may help to address such resistance by strengthening the therapeutic relationship. I hope that by conducting this research, we will gain a deeper understanding of how therapists use humour with obsessive-compulsive clients and so will be better able to provide these clients with the support and treatment that they need.

Confidentiality
In order to protect your confidentiality, your name and contact details will be stored on my home computer (separately from all transcripts and written findings) in a password-protected file, to which only I will have access. Your real name and any identifying references (e.g. to the particular work setting or to the names of your clients, etc.) will be changed or, if required, omitted from your transcript. The audio recordings of your interview will be deleted as soon as the research study has been published, but the anonymised transcripts will be kept in a password-protected file on my computer.

Right to withdraw from research study
You are free to withdraw from this study for up to four weeks from the date of your interview, without any obligation to give a reason.

Further questions
If you have any questions or would like a copy of your interview transcript data or a summary of the research study findings, please contact me by phone on: 07730312638 or by email at: red0196@my.londonmet.ac.uk.

Concerns and complaints
If you have any concerns or complaints about the research study or the way you have been treated, please contact my supervisor:
Dr. Isabel Henton
London Metropolitan University
Faculty of Life Sciences and Computing
School of Psychology
Room T6-20, Tower Building
166-220 Holloway Road
London N7 8DB
Email: i.henton@londonmet.ac.uk

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Appendix F:
Distress Protocol

This protocol has been prepared, as a precaution, to deal with the possibility that some participants may become distressed or upset during the semi-structured interviews on therapists' use of therapeutic humour in the treatment of OCD. It is not anticipated that distress or upset will occur since both the sensitivity of the research topic, and the potential vulnerability of the participants, have both been assessed as low. As a practising therapist, the researcher also has experience of recognising and managing distress.

a. Warning signs:
The participant appears distracted or overwhelmed by emotion, has difficulty in articulating thoughts or becomes physically upset or tearful.

b. Appropriate actions during the interview:
Ask the participant if they would like to take a break from, or stop the interview, and let them know that they can choose to end the interview at any time of their choosing should they feel too overwhelmed or upset to continue. Recognise the participant's distress and reassure them that they do not have to continue. Depending on their choice, either continue with the interview when they are happy to do so or start the debriefing.

c. Appropriate actions should the participant choose to stop the interview:
Suggest that the participant brings up any painful or distressing emotions arising from the interview at their next supervision session. Let the participant know that if they continue to feel distressed after the interview, they should contact the researcher who will provide them with the contact details of appropriate organisation(s) to provide support.

Appendix G:
Interview Schedule 1

PART ONE: YOUR UNDERSTANDING OF HUMOUR AND WORKNG WITH OCD CLIENTS (c. 20 mins)

1. Can I start by asking you how you understand humour? What does it mean to you? *[15-20% interview – up to 10 mins]*

2. How would you describe your way of working with obsessive-compulsive clients?

   What is important? Beyond protocols? Inter-relationally?

3. When you think about humour in therapy, what comes to mind?

   (probes: *How do you understand therapeutic humour? What does it mean to you? How, if at all, have your views on the use of therapeutic humour changed since you started practicing?*)

PART TWO: HUMOUR USE - CHALLENGES AND OPPORTUNTIES (c. 25 mins)

4. In what way would you characterise the work you do as serious? How does this play out for you in session? Are there any risks of being serious in session?

5. When, if at all, might you use humour in sessions with your obsessive-compulsive clients?

   How might this happen?

   In what circumstances?

   What factors might be influential? Appropriateness? Interpersonal factors? Personality? Training/theoretical background?

   How might you conceptualise what happens?
   (probes: *a decision? a process? an intervention? can you think of an example?*)

   Has your use of humour ever gone wrong in session? How did you manage that? (probes: *Did you apologise? Have you had any complaints? Did it change the way you use therapeutic humour with that client or more generally? Did you 'bracket' your humour use?*)

6. Are there any circumstances in which you would never use humour in session?

Alternatively, are there any situations which, in your view, lend themselves to the use of humour?

What informs your thinking around this (probes: *theory? experience? personality? training/theoretical background? other factors?*)?

What is important?

Can you think of an example?

PART THREE: INTER-RELATIONAL ASPECTS OF HUMOUR USE (c. 15 mins)

7. How do you respond if, and when, your obsessive-compulsive clients use humour in session?

   (probes: *what might you do? think? feel? can you think of an example?*)

   Are there any factors that affect your response (probes: *theory? experience? Personality? Training/theoretical background? other factors?*)?

8. How do you think the place of humour between you and a client might reflect or affect your personal presence in the therapeutic relationship – the experience of you that the client might have of you? And, you of the client?

WRAP UP

9. Is there anything else that might be important for me to know about this topic?

   What has it been like to talk about this here?

Appendix H: Interview Schedule 2

PART ONE: YOUR UNDERSTANDING OF HUMOUR AND WORKNG WITH OCD CLIENTS (c. 20 mins)

1. Can I start by asking you how you understand humour? What does it mean to you? [15-20% interview – up to 10 mins]
   (Probe: *Do you think that there is any difference between humour and joking and other forms of humour? e.g. sarcasm, black humour, irony, self-mocking, laughing at self/other, slapstick, taking the mick, laughing at mistakes or human foibles, and so on*)

2. When you think about humour in therapy, what comes to mind?
   (Probes: *How do you understand therapeutic humour? What does it mean to you?*)

   Was therapeutic humour covered in your training programme?
   (Probe: *Are there any theories in relation to joking and humour in therapy that you are familiar with?*)

   How, if at all, have your views on the use of therapeutic humour changed since you started practicing?

3. How would you describe your way of working with obsessive-compulsive clients?

   What is important? Beyond protocols? Inter-relationally?

PART TWO: HUMOUR USE IN SESSION - CHALLENGES AND OPPORTUNTIES (c. 25 mins)

4. In what way would you characterise the work you do as serious? How does this play out for you in session? Are there any risks of being serious in session?

5. When, if at all, might you use humour in sessions with your obsessive-compulsive clients?

   How might this happen?

   In what circumstances?

   What factors might be influential? (Probes: *Appropriateness? Interpersonal factors? Personality? Training/theoretical background?*)

   How might you conceptualise what happens?
   (Probes: *A decision? A process? An intervention? Can you think of an example?*)

Has your use of humour ever gone wrong in session? How did you manage that?
(Probes: *Did you apologise? Have you had any complaints? Did it change the way you use therapeutic humour with that client or more generally? Did you 'bracket' your humour use?*)

6. Are there any circumstances in which you would never use humour in session?

Alternatively, are there any situations with OCD clients which, in your view, lend themselves to the use of humour?

What informs your thinking around this?
(Probes: *Theory? Experience? Personality? Training/theoretical background? Other factors?*)

What is important?

Can you think of an example?

PART THREE: INTER-RELATIONAL ASPECTS OF HUMOUR USE (c. 15 mins)

7. How do you respond if, and when, your obsessive-compulsive clients use humour in session?
(Probes: *What might you do? Think? Feel? Can you think of an example?*)

Are there any factors that affect your response?
(Probes: *Theory? Experience? Personality? Training/theoretical background? Other factors?*)

8. How do you think the place of humour between you and a client might reflect or affect your personal presence in the therapeutic relationship – the experience of you that the client might have of you? And, you of the client?

WRAP UP

9. Is there anything else that might be important for me to know about this topic?

What has it been like to talk about this here?

Appendix I:
Interview Schedule 3

PART ONE: YOUR UNDERSTANDING OF HUMOUR AND WORKNG WITH OCD CLIENTS (c. 20 mins)

1. Can I start by asking you how you understand humour? What does it mean to you? [15-20% interview – up to 10 mins]
(Probe: *Do you think that there is any difference between humour and joking and other forms of humour? e.g. sarcasm, black humour, irony, self-mocking, laughing at self/other, slapstick, taking the mick, laughing at mistakes or human foibles, and so on*)

2. When you think about humour in therapy, what comes to mind?
(Probes: *How do you understand therapeutic humour? What does it mean to you?*)

Was therapeutic humour covered in your training programme?
(Probe: *Are there any theories in relation to joking and humour in therapy that you are familiar with?*)

How, if at all, have your views on the use of therapeutic humour changed since you started practicing?

3. How would you describe your way of working with obsessive-compulsive clients?

What is important? Beyond protocols? Inter-relationally?

4. What are the differences in presentation among your OCD clients?

How, if at all, does their presentation affect or impact on the treatment plan or specific interventions you use in session with OCD clients?

PART TWO: HUMOUR USE IN SESSION - CHALLENGES AND OPPORTUNTIES (c. 25 mins)

4. In what way would you characterise the work you do as serious? How does this play out for you in session? Are there any risks of being serious in session?

5. When, if at all, might you use humour in sessions with your obsessive-compulsive clients?

How might this happen?

In what circumstances?

What factors might be influential? (Probes: *Appropriateness? Interpersonal factors? Personality? Training/theoretical background?*)

How might you conceptualise what happens?
(Probes: *A decision? A process? An intervention? Can you think of an example?*)

Has your use of humour ever gone wrong in session? How did you manage that?
(Probes: *Did you apologise? Have you had any complaints? Did it change the way you use therapeutic humour with that client or more generally? Did you 'bracket' your humour use?*)

6. Are there any circumstances in which you would never use humour in session?

Alternatively, are there any situations with OCD clients which, in your view, lend themselves to the use of humour?

What informs your thinking around this?
(Probes: *Theory? Experience? Personality? Training/theoretical background? Other factors?*)

What is important?

Can you think of an example?

PART THREE: INTER-RELATIONAL ASPECTS OF HUMOUR USE (c. 15 mins)

7. How do you respond if, and when, your obsessive-compulsive clients use humour in session?
(Probes: *What might you do? Think? Feel? Can you think of an example?*)

Are there any factors that affect your response?
(Probes: *Theory? Experience? Personality? Training/theoretical background? Other factors?*)

8. How do you think the place of humour between you and a client might reflect or affect your personal presence in the therapeutic relationship – the experience of you that the client might have of you? And, you of the client?

WRAP UP

9. Is there anything else that might be important for me to know about this topic?

What has it been like to talk about this here?

Appendix J:
Interview Schedule 4

PART ONE: YOUR UNDERSTANDING OF HUMOUR AND WORKNG WITH OCD CLIENTS (c. 25 mins)

1. In broad terms, when you think about humour in therapy, what comes to mind?

   (Probes: *How do you understand therapeutic humour? What does it mean to you?*

   In general terms, what do you tend to laugh or joke about in session - or use humour for?

   In broad terms, how do you conceptualise humour? Double-edged sword: Positive and negative? Light and dark? Self-enhancing or self-deprecating? Affiliative or aggressive? Any other dualism/juxtaposition?

   e.g. If mention 'dark humour'? What's your experience of that in session? How has it played out for you?)

2. What is the function of humour in session? *(e.g. Gauge for client wellness? Improve the therapeutic relationship? Help manage tone of session? Improve or hinder efficacy of potential intervention? Humour as a punctuation mark in therapy: indicative of a breakthrough moment?)*

3. How does humour relate to the way you manage the therapeutic relationship? How significant is humour in managing your interactions with clients? (*How does humour dovetail into the therapeutic relationship: is it discrete or different or does it form part of the therapeutic relationship?*)

4. Was therapeutic humour covered in your training programme?
   (Probe: *Are there any theories in relation to joking and humour in therapy that you are familiar with? Freud's theory of humour as a mature defence; a release of nervous energy?*)

5. How, if at all, have your views on the use of therapeutic humour changed since you started practicing?

6. How would you describe your way of working with obsessive-compulsive clients?
   (Probes: *Do you adhere to a particular modality or protocol?*)

   Does a diagnosis of OCD, as opposed to any other presentation, make a difference to the way that you might use humour (or not) in session?
   (Probes: *Do you use a particular type of humour e.g. irony, more with OCD clients than others?*)

PART TWO: HUMOUR USE IN SESSION - CHALLENGES AND OPPORTUNTIES (c. 25 mins)

8. In what way would you characterise the work you do as serious? How does this play out for you in session? Are there any risks associated with being serious in session?

9. When, if at all, might you use humour in sessions with your obsessive-compulsive clients?

   How might this happen?

   In what circumstances?

   What factors might be influential? (Probes: *Appropriateness? Relative 'wellness' of client? Experience/confidence? Interpersonal factors – strength of therapeutic relationship/attunement to client? Personality? Training/theoretical background?*)

   How might you conceptualise what happens?
   (Probes: *A decision? A process? An intervention? Can you think of an example?*)

   Has your use of humour ever gone wrong in session? How did you manage that?
   (Probes: *Did you apologise? Have you had any complaints? Did it change the way you use therapeutic humour with that client or more generally? Did you 'bracket' your humour use?*)

10. Are there any circumstances in which you would never use humour in session?
   (Probes: *What lies behind this? Fear of causing offence/rupture? Appropriateness? Experience? Relative 'unwellness' of client? Interpersonal factors – relative strength of therapeutic relationship/attunement to client? Personality? Training/theoretical background*)

   Alternatively, are there any situations with OCD clients which, in your view, lend themselves to the use of humour?

   What informs your thinking around this?
   (Probes: *Theory? Parallels or similarities between OCD and humour? Experience? Personality? Training/theoretical background? Relative 'wellness' of client? Interpersonal factors – strength of therapeutic relationship? Other factors?*)

   Can you think of an(y) example(s)?

PART THREE: INTER-RELATIONAL ASPECTS OF HUMOUR USE (c. 10 mins)

11. How do you respond if, and when, your obsessive-compulsive clients use humour in session?
(Probes: *What might you do?*
What might you be thinking? ("What is the purpose of this humour? What is behind it?", "Should I laugh/respond?", "Should I 'unpick' it?")?
What might you be feeling (relaxed, confident, fearful, anxious?)?
Can you think of an(y) example(s)?)

Are there any factors that affect your response to your client's use of humour in session?
(Probes: *Theory? Experience? Personality? Training/theoretical background? Relative 'wellness' of client? Interpersonal factors – strength of therapeutic relationship? Other factors?*)

12. How do you think any humour arising between you and a client might reflect or affect your personal presence in the therapeutic relationship – the experience of you that the client might have of you? And, you of the client?

(Probes: *Transference? Countertransference?*)

WRAP UP (c. 5 mins)

13. Is there anything else that might be important for me to know about this topic?

What has it been like to talk about this here?

Appendix K:

London Metropolitan University confirmation of ethical approval

London Metropolitan University,
School of Psychology,
Research Ethics Review Panel

I can confirm that the following project has received ethical approval to proceed:

Title:	Research project title: How do therapists use humour in their work with obsessive-compulsive clients?: A Grounded Theory study
Student:	Rachel Densham
Supervisor:	Dr. Isabel Henton

Ethical clearance to proceed has been granted providing that the study follows the ethical guidelines used by the School of Psychology and British Psychological Society, and incorporates any relevant changes required by the Research Ethics Review Panel. All participating organisations should provide formal consent allowing the student to collect data from their staff.

The researcher is also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: Date: 17 May 2016

Prof Dr Chris Lange-Küttner
(Chair - School of Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

Appendix L:

Full interview transcript (Participant E)

Interviewer (I): As I mentioned in the background information that I sent to you, CBT is the treatment of choice for OCD within the NHS but quite a considerable number do not finish treatment and many relapse and come back into treatment and so I am looking at ways which possibly the approach to therapy could be enhanced or that there might be a different way to engage with clients which might make that treatment more efficacious..

Participant E (E): Yes, yup..

I: Great. So in terms of the sort of structure, I will ask you a few questions about humour in general terms and then a few about OCD and your approach to treatment within the CBT protocol and finally a few questions about both your, and your clients', use of humour as you've experienced it within session. Does that sound okay?

E: Yeah, okay..well I'll do my best.

I: That's great, thanks. I, I am genuinely interested in your views..I don't have a particular stance..I am just interested in what you think about humour and what your experience has been.

E: Yes, yup.

I: Great..so just in broad terms, when you think about humour in therapy, what comes to mind for you?

E: Well, I think it is important to be able to exercise some degree of humour but, obviously, that has to be done appropriately..erm..as we are dealing with sensitive matters, difficult matters, painful and embarrassing matters, quite often, and I think being able to take, you know, a fairly client sensitive approach to this is important and my kind of take on that is that, you know, a degree of humour softens difficult subject matter somewhat.

I: Yes, yes..I see what you are saying..so that sensitive approach is necessary, too, because humour is often portrayed or has been constructed as a bit of a double-edged sword..so, while there are some potentially quite positive aspects to humour, there are also some potentially quite negative..so, there are risks associated with using humour..light humour as opposed to dark humour, humour that is self-enhancing as opposed to self-deprecating and so on..I mean what is your experience of different types of humour? How would you conceptualise humour?

E: Well, yes, that's an interesting question..erm, I think I am always conscious of the language that is used in therapy and I am often helping people to be mindful of the language that they use to describe themselves so we would always try to steer away from any kind of derogatory terminology that people might apply to themselves, you know, and to try to soften that side of things..I think, you know, sometimes a bit of ironic humour is appropriate..I think that can be useful, it can enhance a session but I think humour, like anything, has to be used sensitively and judiciously so I wouldn't be making jokes in session for one minute but to be able to help a person to feel more comfortable in session, to be able to talk about these things, I think and to be able to realise that sometimes there is a painfully ironic element, I think people see this, you know, that their safety behaviours, a lot of their compulsive behaviours are in themselves, you know, the problem, which is essentially an integral part of the treatment approach is helping them to realise that..and to be able to deal with that with a degree of humour helps people to be able to sort of then address that and recognise that it's you know, it's not a bad thing, but that it's unhelpful..but to view that in a, in a compassionate way, I guess, is what I am saying..so I think being able to use humour, I would see that as part of my therapeutic style, if you like..I mean I certainly believe in the therapeutic use of self and by the time I am working with people, you know, we are talking about quite intensive sessions, and I think people have to be able to be in the room and be fully involved in a collaborative kind of way and I think that humour is part of what oils the wheels of that process and if someone is able to feel a bit more relaxed in a session, obviously not to the extent that you are using it as a form of avoidance, I guess that could be a potential downside..but, as a I say, we wouldn't usually be sitting there having a laugh in a session, it's usually, you know, people are very anxious, they're quite distressed and, you know, embarrassed by things, and I think to be able to tackle things particularly in session in a way that a person is then going to be able to go and do the hard work outside of the session, I think they've got to feel comfortable enough in the session to keep coming back..ultimately, if we don't gain a degree of trust and the person doesn't feel that they're understood and heard and they don't feel that I am empathising, then they are not going to come back; they'll drop out..so, you know..so I would see it as, like a say, erm, a style perhaps, or a tool..you know, I don't specifically think 'And now I'm going to introduce some humour' like I might introduce a formulation diagram,

so it's not used like a vicious flower, but it's part, I would say it's part and parcel of the therapy style that I have..

I: So, it allows you allows you to broach some quite difficult, painful, embarrassing subjects in a way that makes them easier for clients to digest?

E: Yes, I would say say so..

I: But, equally, as you say, there is an element of building the client relationship there? Building trust..

E: Yes, absolutely and people want to work with someone that they can trust and they want to, they don't want to feel any more uncomfortable than they already feel and you know, essentially, it's a sensitive situation, you know, some of the stuff you are talking about is, is really quite personal and sensitive and people can be enormously embarrassed by all the things that they do and the sorts of thoughts..you know intrusive thoughts, for example, can be highly embarrassing.

I: Yes, yes..absolutely..and moving on to the functions of humour in session and you've talked about managing and improving the therapeutic relationship and the trust that is there but also helping to manage the tone of the session..

E: Absolutely, yes..

I: Helping to manage what are often quite difficult and painful subjects to become more approachable..are there any other functions that humour serves in session for you?

E: Errmm..any other functions? Erm..I can't think of any other specific..

I: Maybe..others have mentioned gauging client wellness, for example, so perhaps people's ability to engage with and understand and even broach humour might be a sign of how well they are feeling..

E: Yes, I think that's a good point..I mean it's part of the interpersonal feedback that we get so if someone is able to express some humour then that implies..well, that will have some sort of link in terms of mood at that particular point..erm..although that can potentially be misleading as just because somebody is sort of smiling or apparently making light of something, could be misleading, as I think it is, as I say, used by people as a safety behaviour sometimes, you know, or as a safety behaviour stroke coping strategy, you know, and I think if we kind of recognise as collaborative then that would be something that we would discuss as well..about is making jokes about things, you know, which people might do with their families or whatever, is that actually helpful or not helpful? It might be helpful, it might not be..

I: So that comes back to your point about potential avoidance in safety behaviours or perhaps colluding with clients?

E: Well, yes, quite, quite..so we talk a lot about the balance between the same behaviour or characteristic as being potentially helpful or potentially unhelpful and trying to sort of determine whether, in any particular context, what we are talking about *is* helpful or unhelpful, so with OCD, you know, checking the doors are locked, we could argue is perfectly functional behaviour but it is not about *whether* you have checked the doors are locked, it is *how* you have checked that the doors are locked and *why* you are checking the doors are locked and how that fits in with the rest of it..so I think we look at all behaviours in the context of, you know, whether they fit into a vicious flower or a virtuous flower and what role that plays in then helping someone to move away from the problem..

I: Yes, that makes a lot of sense..again, what seems apparent here from what you are saying is that there are potentially positive and useful aspects of humour up to a certain point and there's an appropriateness up to a certain point and there may be some benefit but assessing and evaluating where that point is is critical to whether the humour is ultimately beneficial or not..

E: Yes, yes, I think so..erm..and I think that that is a constant part of the monitoring throughout the session to see how a person is...you, know, any sign of any emotional change really can be indicative of something important, whether it is a positive emotion, which we would normally associate with humour or whether it is a negative emotion, which we might associate with anxiety or anger or frustration or sadness or something like that..

I: Yes, so there is that constant reassessment within session and outside when you are thinking about and reflecting on what has gone on within session..of what and how humour or, as you say, any other emotions may have been used or engaged with?

E: Absolutely, I think people use humour as a way of deflecting things in which case it is a form of avoidance..and, I will be up front about that in a session and, you know, if that is what I am picking up, I will reflect that back and, you know, express curiosity as to, you know, whether that is what's happening and, if so, you know, which model does it fit with – whether it's vicious or virtuous so to speak – and what we need to do about that..but I think, on the whole, it is a functional way of enabling people to get through their day and whatever it is, whether it is OCD or anything else

for that matter, people need to get through the day and we are trying to enable people to maintain a degree of occupational functioning, as well as anything else, as well as dealing with the problem that they've got..so humour is something that, you know, we really need to look at it's role and function and whether it is helping or if it is hindering in some way.

I: Yes, absolutely..and in relation to that, if you think about your therapeutic relationships with clients, how significant to you is humour in managing those interactions? Is it something that dovetails into the therapeutic relationship? Is it different or discrete from that therapeutic relationship or does it form part of it?

E: For me, it is part of the relationship. I think that's part of the way that I will interact with people so the nature of humour can change..it can be fairly light or it could be slightly more sort of ironic..erm..sometimes, I will be slightly self-deprecating and I think that is something I do deliberately as a way of trying to show my human side because I think the way that we work, certainly the way that we work in IAPT, potentially, particularly if someone has had the sort of interventions which are perhaps..erm..less person-centred..some of it can be a bit directive..erm..and I think, by the time people are doing high intensity work, you know, they are in intensive sessions and they need to know that they are dealing with a human and not, you know, a robotic follower of evidence-based treatment protocols..that you are actually dealing with a person here..you know, who's got a real life [*laughs*]

I: Yes, absolutely..so making yourself more relatable to and less judgemental..

E: Yes, yes..and that's part of normalising the whole experience..and so, with OCD, I will talk about the times when, you know, the times that I will sometimes get an intrusive thought, you know, 'Did I lock my door?' and I will go back and check, even though I know that I have probably, and so forth..and you know, I will express some, you know, slightly tongue in cheek, you know, self-deprecating thoughts like 'I know I am being daft in doing that..' but, erm, I try to temper it, anything like that, I try to..anything with a slightly negative slant, I try to temper it with a degree of compassion in terms of 'It's okay, we all do this to some extent'..and, you know, but sometimes, it's so serious that you do have to take a slightly ironic take, so some of the people we work with, I mean, veterans for example, you know, a guy I worked with recently, he was talking about gallows humour that they have in the Army and that is a part of how they get through the very difficult stuff and he was quite clear that that humour, in that context, it helps them on a day to day basis, it is definitely a

form of avoidance, it is a form of cognitive avoidance, probably, and it stops people form actually dealing with the difficult stuff and he understood that when we were working together that actually I was being a lot more serious than he normally is when he is talking to people about difficult things and he was quite clear..I mean, he could see that I could see that he was using it as a, as a distraction tool, erm..but that's not specific to OCD, that gallows humour is a more general thing..

I: Yes, I think that absolutely right..it tends to be fairly universal in any presentation and indeed in every day life humour can be a real release of angst and anxiety..flipping very distressing situations in their head and laughing about them is the bread and butter of comedy..

E: Yes, yes, so we would talk and if it looked like that was happening, we would be talking about how that can then get in the way of sort of achieving a sort of exposure effect, which is integral to all anxiety disorder work, you know, whether you are specifically trying to do exposure or are doing a degree of exposure in the context of a behavioural experiment but, nonetheless, if someone is avoiding those feelings by using humour then that is an avoidance-safety behaviour which we would then be saying 'Well, maybe you need to cut that out a bit'..

I: Although, when you are saying that I am also thinking about the fundamentally sort of paradoxical nature of OCD anyway..that you have terrifying and hugely anxiety-provoking obsessions, thoughts, intrusions, which at their most extreme, the fear is that either you will die or you will be responsible for somebody else dying..but at the same time, coupled with what can be perceived as really quite over the top, ludicrous, even ridiculous, sets of compulsions so there is a real paradoxical, on the one hand this is life-threatening, but on the other, the coping strategies I have can appear, even to the client, quite ridiculous.

E: Yes, absolutely..and it's important for me then not to reinforce the sense that the person is ridiculous just because they are doing these behaviours..

I: Yes, yes..

E: So, you know, people sometimes say, 'I am stupid doing these things..I know that it doesn't make any difference, that it doesn't prevent anything from happening but I cannot help myself from doing that' and then that's a time not to be too humorous about it, it's important to say, 'well look, we understand that is part and parcel of the problem, that's why everybody does it to a certain degree, that does not make you ridiculous, I as a therapist do not think you are ridiculous, I undertstand'..that's

where getting that clarity that one is understanding is so important because one of the fundamental tenets is that people want to know that they are being understood, that they are not being laughed at, that their problem is not ridiculous, it is a genuine problem and so and so forth..

I: Yes, yes..and you said there, as others have, that often people will come with a real sense of desperation and a sense that 'I know what I am doing is ridiculous', or 'I know that I am being silly or stupid' and therefore what you would not do in that situation would be to encourage or reinforce that idea..so using humour to lighten or to allow the exploration of the more challenging aspects of the presentation but at the same time, reinforcing, normalising and externalising the more ridiculous aspects of the compulsions is important, so using humour carefully, as you say..

E: Yes, yes, absolutely.

I: I also just wondered, was humour or therapeutic humour ever covered in your training programme when you were training as a CBT therapist?

E: Erm..not specifically, no, from what I recall..I mean, my training as a CBT therapist took on several bits and pieces so my original CBT training, which was the erstwhile A12, prior to, this is pre-IAPT, erm..I don't remember anything specifically about the use of humour..that was about treating depression, treating anxiety and, you know, there was a lot of work done on assessment and so forth but it was all very serious stuff..erm..I've subsequently done lots of top up training, including, I mean I did a fantastic OCD training with Salkovskis which was great and he is quite a humorous person, himself, erm..and, you know, he has, I think it shows, a huge degree of humanity when dealing with stuff which is hugely difficult and I very much enjoyed that particular piece of training..and I did further work with, erm..an American, whose name escapes me now..erm, Blake Stobey or something..erm, er..and he was very much along the same lines as Salkovskis as well, erm, possibly slightly more serious but, you know, still showed this degree of humour that I think is really important..and I don't think people, the people I've seen over the years have not really wanted to deal with someone who is completely po-faced and unable to show a degree of softness cos otherwise, you know, you may as well talk to a robot mightn't you? And that's not what people come to therapy for..but at the same time, as I say, you know, you don't want a therapist who is just going to sit there having a laugh with you for an hour and then you don't actually

deal with anything..that's not very helpul either [*laughs*] so it's trying to get the right balance..

I: Yes, I agree..I mean with the training, I ask the question because the vast majority of people I have spoken to have said there was no specific training on humour or how it might be broached covered in that but there were also some participants who have said 'we were very much told that humour is very much a mature defence in keeping with Freudian theory and was therefore an absolute 'no go zone', you shouldn't touch it, you know, therapy is a serious business, clients should be encouraged to sit with their anxiety rather than avoid it and therefore humour is essentially a means of colluding with the client to avoid that..was that something that was suggested to you?

E: I don't remember that..if anything, when I did my original training in occupational therapy..erm.. you know, I that the therapeutic use of self was something that was stressed and I think that is where I got my take on all this from in the first place and that humour may be appropriate but humour could be inappropriate, it all depends, you know..and you could argue that point, that it is a defence mechanism, I can see that as a sort of psychodynamic approach but I don't see that that is necessarily is what sits with CBT..I think when people are highly anxious they need a little bit of humour to get them into the room, to get them doing things, you know, that..the humour soon drops away when the person is scoring 10 out of 10 on the SUD Scale..erm..you know they are not laughing then..but actually as those SUDs drop, it is appropriate to use a bit of humour and I think that is *human* and you know, I am not sure that if there is a school of therapy called the humanist school but, if there was, I would subscribe that one, I think..

I: Yes, that makes sense..yes, so there is something in there about the use of authentic self, maybe the therapist's personality comes in, that it would feel uncomfortable and therefore maybe there would be problems of transference and countertransference if you weren't able to engage in humour..

E: Yes, I don't think it is the role of the therapist to make the client feel even more uncomfortable than they do in the first place..I think it is the role of the therapist to try to ease the process a bit cos ultimately you're trying to treat the distress that is already there, you are not trying to actually increase that distress, as such, except if you are doing specific exposure or if you are doing reliving with someone with PTSD or whatever..erm, but if you are doing it, you are doing it in the context of

them processing that distress through as well and they need to feel confident in that process and they need to feel confident in the therapist who is taking them to these sort of places that they don't want to go..

I: And so, the precursor to that is here is someone who is human, whom I can relate to, who is..

E: Yes, yes..

I: Yes, absolutely right..so have your views on humour changed at all since you have qualified, well, throughout the course of your practise, have your views evolved or have they pretty much stayed the same?

E: Erm..they have probably pretty much stayed the same, I think..I don't think my attitude about it has changed..whether I personally have become more or less humorous is a debatable point [*laughs*]..I'd have to do a survey amongst my colleagues and clients to see what they think about that..erm..no I think probably an element that comes in, is probably a personality match of both the therapist and the client to some extent..and so it's not something that I set out, to try to become a humorous therapist or anything like that, I think that would be quite inappropriate but, like I say, within the context of everything else, I don't think my views on it have changed, I think I have always been cautious, you know, about how far you go with any of these things..erm..and I think it is hugely important, you know, to be mindful of how one is oneself within the session and I think I have had that kind of view since the start of my NHS career..

I: Yes, so the authenticity point comes in there again..that humour use may be a reflection of your personality up to a point..

E: Yes, and prior to CBT, I have been working in adult mental health for quite a long time so, you know, I have worked with other client groups and in other contexts so, pre-CBT I was working more with people with psychotic illnesses and, again, you know, you've got to get the right balance of how you work with people..CBT has been a development I would say of the stuff that I was doing already anyway..

I: Right..and so taking that on a bit, how would you describe your way of working with OCD clients?

E: I would describe it as being client-centred..I would describe it as being supportive but boundaried and also quite directive..[*laughs*]..erm..and I would say that there's degrees of, I mean I try to tick the boxes on the CTSR, [*Cognitive Therapy Scale – Revised*], you know, so use Socratic dialogue while not letting the person wallow in

a mire of uncertainty too much..so I would say that I am appropriately directive but that I try to do that in a..erm..a client-centred way..[*laughs*]..if that makes any sense..

I: Yes, yes. And, when you see clients with a diagnosis of OCD as opposed to other presentations, does that make a difference or have any bearing on how you might use humour in session?

E: I don't think it would make a huge difference. I wouldn't single out any one disorder for being any more or less humorous..erm..I think I would adjust my approach according to the person rather than the problem..which I think is consistent, you know, with being client-centred..erm..so I wouldn't see OCD itself..but I like to think I would take a sympathetic approach towards all problems..I think I sympathise, I certainly do sympathise with OCD..I have worked with enough people to see how it grows and develops..erm..but likewise I think I have an understanding with the other disorders as well, I mean there is a big overlap with other disorders, of course, I mean, with GAD and OCD, we spend a lot of debating over what the actual problem descriptor [*diagnosis*], as we call it in IAPT, I mean are we working with the right problem descriptor, are we working with GAD, are we working with OCD, you know..is it actually depression with anxiety or is it panic with a bit of social phobia and it is actually driven by trauma, and it is all quite complicated really, as you know..erm, so I wouldn't single OCD out..if anything, I would say it is important not to be too light-hearted about people's compulsions because they think people already see them as being ridiculous and so I wouldn't want to reinforce any negative views that people have about themselves because of that..if anything, we would sort of look at that and see how that in itself becomes a further maintaining factor..

I: Yes, yes..and you said that, thinking of your client-centred approach, you said that you were more likely to respond to the individual client rather than the presentation, understandably..are there any similarities or differences in presentation between OCD clients which might predispose you to use humour in some cases and maybe make you much more cautious in others?

E: Erm..I probably, I mean, I might..because people present with quite similar problems in OCD..so there are some which are concerned about contamination fears, some are worried about other forms of safety, there are some – quite a group – where it's an obsessional form of OCD, much more to do with obsessional thoughts, less of the overt behavioural compulsions..so I suppose, over time, I may have become

slightly more relaxed with people with OCD cos I see what they are presenting with as a thing with a familiar pattern..erm..so whether that is exactly in the context of using humour or not, I'm not sure, but I think to be able to..I think that can be quite reassuring for people to know that what they are presenting with isn't some completely weird thing that nobody else has every presented with but actually it is actually quite well spelt out..I think there is also a degree of humour, as well, in saying 'I don't actually know everything', so I had one person who told me about a variant of OCD, which I had never even heard of, and you know, I had to have a chuckle with him that, actually, you know, 'thank you for telling me this cos I had never actually heard of it..as far as I was aware, it was all part and parcel of the same thing but I'll go and do a bit of homework', which I did, and I think he was actually quite pleased cos he was quite a young chap..it was HOCD, as it happens..

I: I don't know about that..what is it?

E: Well, no, neither did I, it is 'Homosexual OCD' and there is a whole load of stuff there about it..

I: Oh right..

E: And of course, it is a sub-category. It is to do with obsessive thoughts around being gay..erm..it's not anything to do with being gay, it is about obsessive thoughts about being gay..so, you know, it's where the significance of that is that it is a negative thing in some way, even if it's a misunderstanding of what the person is..It is very interesting working with this chap, actually, but, you know, I had to sort of use a bit of humour in as much as to say 'Well, I'm afraid I've never even heard of it and I need to go and do some reading, and, you know, tell me what you know'..and I said that to deflect what could potentially have been a bit awkward cos you know he might think 'Well, I'm coming to see you and you've never even heard of it'..'well, sorry' [*laughs*]

I: Yes, and again, as you say, maybe..you used the term 'tool' earlier on, so maybe using the tool or style that humour allows you to tap into that more self-deprecatory style or approach that may be enables you to navigate your way through what could have been a tricky scenario but in the event everyone came out of it okay..

E: Well, yeah, exactly..and I think if nothing else it shows a degree of honesty and integrity as well..I'm not pretending that I'm an expert on a slightly unusual subcategory of something if I'm not, you know, and I think that's quite

important..but I think that the message is that I am there to work with the person and to learn, as we all learn, all the time..

I: Yes, that's interesting..and right..I want to move on now, if that's okay, to talk about specific humour use within session and the potential opportunities and likely challenges that you may have encountered..

E: Yes, sure..

I: Erm..in what way would you characterise the work you do as serious and how does that play out for you in session?

E: In what way would I characterise it as being serious..okay, well, I think it is being focused initially on a problem..I think that is quite serious..I think it is a serious business to formulate, to actually understand something, so it involves some keen listening, some keen questioning..erm..in order to sort of pull things together..there is a lot of discussion and collaboration, which I think is a serious business but it doesn't have to be done more seriously than it needs to be, but it is a serious business actually getting the picture, it is a serious business gathering the data, running through the questionnaires, assessing risk, which we do with every person, every session, regardless of what problem they have, having to sort of clarify that, I think looking and comparing the data, cos we do all our data that we collect, it all appears on the electronic notes, so we, you know I use that within sessions so that we can compare changes, you know, in depression and anxiety symptoms, so I think that's quite a serious business..I think keeping focused on what the agenda is, very much relating what we're talking back to the models we are using, you know, you have to be quite serious and focused to be able to do that..erm..the whole thing about setting homework and reviewing homework, monitoring how things are going on..I mean, overall, it is quite..I mean it is called high intensity therapy..it is quite intense..so over all, I would say that the business is pretty serious..

I: Yes, yes, you mentioned all of these very serious elements to therapy – and, as you say, we are being paid to do a job and you want the best for your clients, you want them to end up feeling better at the end of therapy than they did at the start of the process – so there is a degree of seriousness in performing the job but you also said that it doesn't have to be managed in a serious or heavy way..

E: Yes, that's right..

I: So, I'm wondering if you could tell me a bit more about that? Are there risks associated with being too serious?

E: Yes..I do not want my clients to feel as though they are being punished..erm..people will often feel that there problem is a form of punishment, people often feel guilty..responsibility is a huge factor in OCD..so they already feel responsible, they feel guilty, they feel bad about themselves so I think the way that therapy is conducted is..should be about trying to minimise the..that, you know, to some extent..erm, I want people to look forward to coming to therapy...I don't want them to dread coming to therapy and I think that's probably a key thing and I will have a much more, I would consider it to be a therapeutic session with someone who actively wanted to be there, who is looking forward to coming, who does their homework, who is participating and engaging fully..erm..and to do that, we need to be on the same page and people who, you know, feel threatened by the therapy environment, you know, generally, don't particularly want to do the work..one of the messages that Sarkovskis said is that it is all about people choosing to change..well, to choose to change, you know, it's the carrot rather than the stick, I think and that's what we're looking for..the disorder itself is punishing enough so I don't want to reinforce that message, I want it to be one of understanding, I want it to be a therapeutic environment, not a sort of punitive, corrective environment..however behavioural we may be at times, it still needs to be done with a huge dose of humanity and empathy..

I: Yes, absolutely..and taking that a step or a layer closer to specific examples, can you think of particular examples of when you have or might use humour in session with one or more of your OCD clients?

E: Ok, well, I recall a case with one gentleman who had quite an obsession around, he was very concerned with things going wrong in his home environment and one particular thing, he was checking door handles hugely, and there was a point when his door, the car door handle, he was checking it so much that the car door handle had come lose and both he and I could see the horrible irony there..that the fear that the car would get broken into and stolen..but he was checking the security of it so much that he was actually damaging the door handle and therefore the security..so I think, you know, that was very much about being able to both share the understanding, the insight, that that is ironic and therefore, potentially, humorous in a certain way, whilst also being hugely serious and, in the context of him checking all of the light switches, taps, all sorts of different things in the house, it was hugely

distressing for him and taking an awful lot of time and all the rest of it..and affecting his functioning so..so that would be an example of that..

I: And you've mentioned several times now that there is a sense of irony that you've tapped into with clients which is a use of humour you use with clients. Are there any other types of humour that you tap into with clients?

E: Erm..that's a good question, well, I'm not really very clued up on different types of humour, to be honest, it's not something I've looked into..I couldn't tell you what other types of humour there are..there's ironic humour and I suppose there is sarcastic humour, which I would avoid..erm..I don't know..

I: Well, I suppose there are as many as you want to describe..I guess what you are suggesting is that you are more into the positive, the light, the self-enhancing, the kind of affiliative humour, which makes sense..and that you would steer clear of the more negative, dark, self-deprecatory, aggressive humour but also want to investigate what lay behind the latter if a client were to use it themselves..?

E: Yes, yes..

I: In terms of that use of irony, which you have mentioned several times..maybe that is quite common in the context of OCD clients..how would you conceptualise that when that humorous use of irony occurs in session? Is it something that you are consciously using, is it an intervention or is it more of a way of normalising or of..

E: I think it's part of the meaning within whatever we are talking about so, you know, thinking of a vicious flower, for example the centre of a vicious flower is the meaning or the significance of the intrusive thought which is driving the behaviour and then it is that meaning which is enhanced so the meanings often are ironic..the meaning of the behaviour is that, on the one hand, it is almost paradoxical isn't it, on the one hand, the person does the behaviour to prevent something happening..on the other hand, like the guy with the door handle, the behaviour is actually increasing the risk of it happening in some cases..erm..and that would be an example of an irony within it..and so I think that there are a lot of those sorts of paradoxes that would come out so it's trying to understand the meaning of the situation..the meaning to a person is one of 'this behaviour is ridiculous, it is disproportional, it is over the top, it is inappropriate', then you know that could be seen as a highly negative thing..so trying to look at that in a way that is more humorous is a way of getting the message across or exploring that meaning but in a less..erm..slightly less challenging way, perhaps..in a more amenable way so that someone can see that without thinking

'yeh, yeh, this is disproportionate thinking and therefore I am a defective person' which is the risk when the negative beliefs about self can come into this, you know..

I: And may be there is an element of making an intervention more memorable..that if you make something funny then perhaps it is something that is more likely to be remembered by the client?

E: Yes, yes..I would rather be remembered in a positive context than a negative context and people often talk about having me, like a parrot, on their shoulder almost, visualising me on their shoulder, you know, prompting them [*laughs*] and I think that there is humour there..the image itself is humorous but the message is serious so it's a nice, gift-wrapped, serious message, I think..so in other words, it's a style of delivering therapy, if you like, or it's part of the style, it's part of what goes into it, you know, there's times when it would be completely inappropriate to be sort of light-hearted about the mood..it's about being empathetic as well..people often are quite humorous and it's good to go with that..erm..sometimes, if somebody is very anxious or very down then you can use humour as a way of just trying to sort of break the mood a little bit, to sort of access a slightly lighter mood which may help somebody then to engage more effectively in the process...it all rather depends on what's going on..I mean I certainly wouldn't use it just to dissipate stress if it were appropriate for someone to express stress so if someone was telling me about some terrible event that has happened, then they need to be able to do that and to be feel comfortable in expressing negative emotion as well as positive ones..so it goes back to this how you use it, when you use it, why you use it question..

I: Yes, and that being very much dictated by the judgement, the experience, the personality of the therapist and also their judgement call on the strength of the therapeutic relationship and how they view the client and the relationship at that particular moment in time..

E: Yes, I think that it's absolutely context driven and it's all about the appropriateness, isn't it? So I think it's about the sensitivity of the therapist, the ability to empathise, the ability to able to reflect but also to make adjustments so it's having all of those slightly..erm..more subtle, interpersonal skills, I think that comes with, I suspect that just comes with seeing loads of people with these sorts of problems..

I: Yes, and so your experience and your confidence lead you to trust your professional gut..

E: Yes, yes, I prefer the term clinical reasoning..but people sometimes talk about gut feelings and all that, which, you know, it's a term that I always regard with a slight bit of caution, but yeah..you are going with the felt sense of shared experience in the room, aren't you?

I: Yes, absolutely..and on that note, has your use of humour ever gone wrong? Have you ever said something to a client and thought 'Ooph, I wish I hadn't said that'?

E: Erm..I'm sure I have said things and wished I hadn't said them sometimes..erm..I've certainly said things occasionally when I have misunderstood something, in which case, I will be really forward in holding my hands up and saying 'sorry, I didn't quite understand that' or 'I do apologise if I got that wrong' or whatever but I mean, I think generally, I think my approach tends ot be well received by the people I work with..erm..but I wouldn't say it was perfect or that I get it right all of the time..

I: Sure, sure..can you think of any situation in which your use of humour might have been misinterpreted?

E: Erm..I don't..I can't think of any examples..I mean the last thing I would want is for someone to think that I was not taking them seriously or that I was being judgemental or negatively judgemental or whatever..or taking the mickey out of them or something like that but I think I've got enough self-awareness to not go down that road but I can't think of any specific examples where I've got it blindingly wrong but I'm sure I have made mistakes in sessions for which I have had to hold my hands up and apologise, you know..

I: Yes, I think that's got to be right..I mean a lot of it is about how you might repair potential ruptures and holding your hands up and being honest and apologising or finding out what the other person or your client is thinking is the way to go about that..

E: And that's why the therapeutic relationship, I think, is so important..erm..because it is like any relationship, relationships have their ups and downs, don't they, and we have to be able to find the best way through what can be quite tricky and we don't always get it right, therapists, I'm sure..any more than clients don't always get it right, you know, we may misunderstand, which is why we are always asking people questions, to check out whether we have got the right understanding of their meaning..

I: Yes, yes..and are there any circumstances when you would absolutely never use humour with OCD clients in session?

E: Erm..well, I would never, I couldn't think I would exactly say that I would *never* use humour, full stop.. I mean, if someone is describing, oh, I don't know..so if someone is describing something of a very serious nature, I would very much sit on the humour side of it but sometimes there is humour even when things are really difficult but when people are talking about things that may be sensitive, for example, someone who has been abused, who may well have developed OCD subsequent to the abuse, I think, you know, they need to know that what they're disclosing is going to be treated respectfully and I think that is hugely important so I that there is this fine line, isn't there, between being humorous on the one hand but showing appropriateness and respect on the other so I think one would be..it's back to the 'judicious' word again, isn't it, you know..be cautious with that but I think sometimes when things are sensitive and someone is evidently quite vulnerable with what they are talking about then there will be less obvious humour at that point..sometimes the person just needs to be heard and listened to and to feel supported, you know..sometimes it may not be very funny so to sort of make humour when it is not actually appropriate, would be obviously inappropriate..

I: Yes, yes..by definition..and flipping it on it's head, how do you respond if and when your OCD clients use humour in session or do they initiate humour in session and how do you respond?

E: Erm..I think if..I am trying to think of any specific examples cos I think the humour is just sort of something that happens in session, I don't think people are necessarily thinking about unless they are doing it, like the veteran I was on about who was clearly using it deliberately as a deflecting mechanism in which case I reflect it back to him, humorously, that I could see what he was doing and it wasn't going to work and, you know, he totally took that in good spirit..erm..but I think people generally aren't being particularly humorous when they are coming in talking about their obsessions and their compulsions, you know, they're coming in with a significant level of distress, really..they're not finding it very funny but, as you get to know each other, as the topic gets addressed, the mood of the sessions can change..

I: Yes, that's interesting..I mean we touched on this earlier, but it seems as though there is a therapeutic timeline where there is almost a sense that a client's ability to access humour is easier as they become relatively better or feel better in themselves

and how that may also correlate to and reflect the strength of the therapeutic relationship.. Is that something that you've witnessed or experienced?

E: Yes, yes..I think so, I mean, relationships develop over time, you know, sixteen sessions that's three months, at least, I mean some marriages don't last that long [*laughs*]..so, you know, it's quite a long period of time to be spending, having intense conversations with somebody so you kind of get to know each other so the mood will shift..people are generally more anxious at the start of therapy, they've not met you before, they're gonna have to talk about all this difficult stuff, they don't know how you're gonna respond but once they've met you a few times they relax a bit more and it's actually quite normal to show humour, I mean humour is a normal emotion and I think that's something we want to capitalise on, erm, because people sometimes forget what's normal; they're more used to feeling anxious and feel sad, frustrated and feeling angry and actually forget that feeling relaxed, feeling comfortable, you know, experiencing humour, that's actually normal, too..

I: Yes, absolutely, and so humour encompasses, potentially, a hugely broad set of experiences and emotions, so it can be very light touch, even just feeling relaxed in the company of someone else, there's a lightness there..

E: Yes, I mean humour is really just a word for 'mood' isn't it, I mean you can have good humour, ill humour, can't you..I mean we are taking it in a slightly different meaning, but basically it's a bit like the word mood, which could mean lots of different things, mood could mean feeling sad, feeling angry, it could mean feeling happy, you know, humour can mean different things as well, you know, but within the context here, we are talking about humour as in what we normally understand by humour..

I: Yes, that's a good point..and may be that was what I was driving at a bit when I was asking you about your understanding of humour and what it means to you right at the beginning..perhaps it is such a broad and subjective subject, that it is so all-encompassing, that we take it for granted, like white noise, so therefore we don't tend to scrutinise it that much, that is more instinctive..but within the boundaried world of therapy, perhaps it is something that we are maybe more aware of because we have to be so careful about what we say and how we say it..

E: Yes, yes..I think the risk of being too uptight is that that can be misperceived as being condescending..erm..you know, there is that risk of the this overly-sincere therapist, the image of a very sincere therapist, who takes everything very seriously

and never smiles and I don't think that inspires confidence in most people, certainly the people I see are very much normal people, people out there, they're not people who are necessarily thriving on a very artificial environment, they're quite relieved to meet someone who is, you know, 'Oh gosh, you're normal, I thought you might be like a doctor or I thought you were going to be like a psychiatrist or you were going to get me sectioned' and all of this kind of stuff because people tend to have really mixed experiences so they meet somebody who appears to understand them, who sort of knows where they're coming from and can relate to what they're talking about and has a bit of, you know, normal life experience, I think that's kind of normal and that helps people to feel a bit more comfortable in what is potentially a hugely challenging and threatening environment, which is what the therapy room could be like..

I: Yes, yes..I was going to ask you about that, when any emotion arises between you and your client that might affect the experience of you that the client might have and maybe there is a distinction between being perceived as a doctor or psychiatrist – professional who is there only to assess and categorise you – and what therapists are trying to do?

E: Hmm, yes, I would think that if we took a poll of my various clients over the years, the ones I have had longer periods of therapy with, I think that they would all agree that there is a degree of humour that is used in the sessions and I think that they would all agree that I am actually quite serious as well..I think there's this two-edged or maybe we could call it more of a complimentary kind of persona..so it's serious business and I am there to do a serious job and I'm very much a professional and I'm, you know, reinforcing the boundaries of people all the time..but, at the same time, I'm also a human being, you know, I live in the same world that they live in as well and I don't live in an ivory tower somewhere and so I understand the stuff and so I bring that into the conversation as well..

I: Yes, absolutely..and so that brings us back to the idea of empathy and the therapeutic relationship and that being at the core of what therapy, and certainly effective therapy, is about..and so that seems to be the driving force around using humour: that need understand and empathise and use the skills, as you say, the style of delivery that is relatable to by the client?

E: Yes.

I: Well, thank you very much. What's it been like to talk about this?

E: Oh, I've enjoyed it. Absolutely, yeah, I'm always interested..it makes me reflect on my practise which is a good thing..it makes us think about what we do…and you need people so, no, it's been a pleasure.

I: Thank you. And is there anything else that you think I should have asked or that you would like to say?

E: No, I don't think so. I think you have taken a very thorough approach as an interviewer so I think you've covered everything on the topic I can think of.

I: Well, thank you again, I will be in touch in due course.

Appendix M: Data analysis sample
Individual differences and Intrapsychic variables

Quote	Open Code	Mid-level Code	Focused Code	Sub-category	Category
B518-523: I grew up in a small village where people use to smile and say 'hello' all the time so again, so it's part of our culture and upbringing, I think, whether to smile or not, and when I first went to London, everyone used to walk straight past and I used to think 'oh, I wonder if they're ever friendly in London?' but that was my first experience of a different culture I suppose	Being aware that 'smiling' and 'saying hello' will vary according to upbringing and across cultures	Being aware of different communication styles across cultures	**Being sensitive to cultural differences**	***Culture/religion***	**INDIVIDUAL DIFFERENCES** [4]
D229-232: ..cultural factors is another big one, isn't it..I might not connect in the same way with somebody who was very obviously from a very different cultural…background from mine cos you don't want to put your foot in it, do you?	Failing to "connect with"/"putting foot in it" with client from different cultural background	Being cautious about using humour with a client from a different cultural background for fear of causing offence			

[4] Individual differences are the differences between the therapist's and client's cultural, socio-economic, regional and religious background; and in their age, gender, and 'personality match'. These individual differences affect the therapist's use of humour with the client in session. The less the therapist has in common with – or can relate to – the client's variables, the more cautious they are likely to be in using humour in session with that client.

G387-390: I mean, I guess if somebody..I'm probably very careful, you know, with a male from a non-European culture..where they might not be too sure about seeing a white, European therapist..I mean, I just wouldn't go there, I would be completely professional all the way..	Being cautious about using humour with clients from a non-European culture: "just wouldn't go there"				
H298-299: ..whereas I think if somebody is from a different culture… then I think it can be harder to find that common ground to ensure that the humour is shared		Finding it harder to find common ground			
C230-232: I might not connect in the same way with somebody who was very obviously from a very different cultural, spiritual or religious background from mine cos you don't want to put your foot in it, do you?	Fearing not "connecting with"/"putting your foot in it with" client from a different cultural or religious background	Being "more wary" of humour use	**Being sensitive to religious differences**		
D236-237:..not making the assumption that if someone is wearing a hijab that they don't have a sense of humour [laughs]	Not making assumptions about client's sense of humour based on their religion	Keeping an open mind			

D237-238: ..so it's those preconceptions about like..Islam is the really serious one..of course is isn't	Challenging (inaccurate) preconceptions that Islam is the "really serious" religion				
B518-523: I grew up in a small village where people use to smile and say 'hello' all the time so again, so it's part of our culture and upbringing, I think, whether to smile or not, and when I first went to London, everyone used to walk straight past and I used to think 'oh, I wonder if they're ever friendly in London?' but that was my first experience of a different culture I suppose	Being aware that 'smiling' and 'saying hello' will vary according to upbringing and across regions	Recognising humour as an expression of "regional identity"	**Being sensitive to regional differences**	***Region/class***	
C236-244: I think, again, what's interesting is her [a client's] very 'London humour', she references that she's from London in her humour and there is something about her expression of regional humour, as an expression of regional identity, that comes into it, as well, I think..She's from East London and I'm from North London and I think there is a 'London humour', you know, when times have been tough, you use it as a resource, when everything is down, someone	Appreciating the expression of regional identity via humour; characterising "London humour" as a "a release from the stress"				

comes out with something that just hits the situation on the head and it is a release, you know..I think it is a release from the stress					
F16-18: I think where I've had experiences where I've been in working in services in Oxford, in Cambridge, where they're just very..the local culture's just sort of humourless	Finding the local culture in Oxford/Cambridge to be "humourless"				
F26-28: I've worked in different areas..I've worked in Newcastle, Liverpool..erm..Birmingham..and I think it's also a local culture thing..especially, the funniest place that I've ever worked was Liverpool	Experiencing humour differently in different regions (the "funniest place was Liverpool)				
F34-36: This is Liverpool, you know..I'll be sitting there ready to find out about the problem and people will just turn round and crack a joke and it's just very natural for them	Finding Liverpudlian clients will "naturally crack a joke"				

D365-369: What influences my use of humour with a client?..Well, I think it's your upbringing, your family and your schooling and..erm..at my school, where I was for 5 years, there was a very piss-takey, working class kind of humour	Recognising the influence of upbringing, family and schooling on use of "piss-takey, working class humour"	Identifying variations in humour among socio-economic classes	**Being sensitive to socio-economic differences**		
F36-39: I think it's also that the city [Liverpool] has a long history of deprivation and poor investment, poor infrastructure..I think if you're not Northern or if you're from an affluent area, like Cambridge, I don't think you really appreciate the actual 'black humour' that people can have	Linking deprivation in a to a greater use of "black humour"; with less appreciation of black humour in "affluent areas"				
F459-461: I think it's also class, social and economic..as a general rule, I think working class people tend to have more of a sense of humour, they have more of that gritty stuff	Linking humour type to socio-economic class: experiencing (as a general rule) working class people having more of a sense of humour, "more of that gritty stuff"				

G387-390: I mean, I guess if somebody..I'm probably very careful, you know, with a male from a non-European culture..where they might not be too sure about seeing a white, European therapist..I mean, I just wouldn't go there, I would be completely professional all the way..or may be an older person	Being "completely professional" and more careful about using humour with an older client	Being more cautious in humour use with clients from a different generations	**Being sensitive to generational differences**	***Age/gender***[5]	
H298-299: whereas I think if somebody is from...a different generation, then I think it can be harder to find that common ground to ensure that the humour is shared	Finding it harder to "find common ground" to ensure shared humour with client from different generation				
D241-243: Sometimes humour can be construed as flirting so..if I have a male patient in the room with me, I might not..sort of, I don't want things to be picked up in the wrong sort of way..or misconstrued	Not using humour with a [male] client fearing it could be misconstrued by as "flirting"	Not wanting client to "misconstrue" humour as flirting	**Being sensitive to gender differences**		
G387-390: I mean, I guess if somebody..I'm probably very careful, you know, with a male from a non-European culture..where they might not be too sure about seeing a white,	Being "completely professional" and more cautious about using humour with a [male] client				

[5] If the client is a different gender or from a different generation than the therapist, the therapist may be more cautious in using humour in session with that client.

European therapist..I mean, I just wouldn't go there, I would be completely professional all the way..or may be an older person					
B101-104: I don't actually plan to use it [humour], it just comes in occasionally..I suppose, it's because, especially in an assessment or in the first few sessions, I guess, subconsciously, I am trying to use humour, when appropriate, just to put them at their ease, and to build up a rapport	"Subconsciously" using humour to put clients at ease and to build rapport	Using humour as an extension of personality	**Bringing personality and authenticity**	***'Personality match'*** [6]	
B186-187: Humour arises in the moment in therapy and, yes, absolutely my personality has a bearing on that.	Bringing personality to bear on humour arising in therapy				
B525-526: So, in terms of humour use in therapy..it's an extension of my personality, I think	Using humour in therapy as an extension of therapist's personality				
B538-540: So it [humour] is intrinsic to my personality..and, yes, that flows over into my therapeutic relationship with clients	Using humour is intrinsic to therapist's personality and "flows over" into therapeutic relationship				

[6] The more the therapist has in common with - and can relate to – the personality and sense of humour of the client, the more likely they are to use humour, as an extension of their "authentic self", in session with that client.

C291-292: So here's something [humour] that's innate..integral to my personality and it feels right..	Using humour is innate and integral to therapist's personality				
E145-146: Humour is part of my personality, part of the way I interact with people	Using humour as part of personality				
E260-261: I think it is appropriate to use a bit of humour – that's human	Using humour a bit feels "appropriate" and "human" for therapist				
F409-411: Erm, well I think it [humour] is just part of me, part of my personality..I think it's..I just think sometimes, I am just funny and I don't mean to be and I don't know why people are laughing..and other times, I think it is just part of my personality	Using humour is part of therapist, part of their personality				
C282-284: So my views in terms of the use of humour [in session] have changed very much over the years..so..well, I was aware that it was forbidden but that would have been sort of ignoring my authentic self	Not using humour in therapy would be to deny therapist's "authentic self"	"Ring fencing" humour in therapy would deny therapist's authentic use of self			
C291-293: So here's something [humour] that's innate..integral to my personality and it feels right..so it would feel very odd to ring-fence that	"Ring-fencing" humour would feel "very odd"				

E49-51: So I think being able to use humour, I would see that as part of my therapeutic style, if you like..I mean I certainly believe in the therapeutic use of self	Using humour as part of therapeutic style: "therapeutic use of self"				
E64-67: I would see it [humour] as, like a say, erm, a style perhaps, or a tool..you know, I don't specifically think 'And now I'm going to introduce some humour' like I might introduce a formulation diagram, so it's not used like a vicious flower, but it's part, I would say it's part and parcel of the therapy style that I have	Using humour is "part and parcel of [therapist's] therapy style"				
A190-192: My choice [to use humour] is purely on an interpersonal, case by case, 'what the person is like in the room' basis	Using humour is determined on an interpersonal, case-by-case, basis	Assessing personalities before introducing humour	**Assessing personalities and shared sense of humour**		
D132-133: I think it's the personality traits of the client as well [that influence therapist's use of humour in session]	Assessing personality traits affects humour use in therapy				
E145-146: Humour is…part of the way I interact with people	Interacting with others involves humour				
E285-287: I think probably a key element that comes in, is a	Assessing whether there is a "personality match"				

personality match of therapist and the client					
H25: Humour is part of forming any relationship	Using humour as part of forming a relationship				
H157-8: I think [humour] it's more of a personality characteristic that might show itself as they [therapist and client] build up that therapeutic relationship	Identifying humour as a "personality characteristic" which develops with the therapeutic relationship				
D12-13: I also think maybe people tend to be drawn to people who have similar senses of humour	Being drawn to others with similar sense of humour	Assessing shared sense of humour			
D20-21: The times I have been aware of humour, it's been that sort of shared..in CBT, that shared 'lightbulb moment' of discovering something together	Sharing humour with client in a "lightbulb moment" of "discovering something together"				
D25-27: I guess if they [the client] come[s] in and you can sort of sense that they have a sort of similar sense of humour then that's probably a bit easier to use therapeutically as well..so it's a bit of sort of 'feeling your way' type of situation	Finding it easier to use humour if client has similar sense of humour				

G132-136: If somebody has got a bit of a sense of humour and so do you, it can lead to an alliance	Sharing humour can lead to "an alliance" [between client and therapist]				
H7-10: Some people you just 'click with' - they instigate the humour, they make a quip	"Clicking with" some clients who "make a quip"				
H20-23: So when you meet somebody for the first time and say 'hello' and 'how are you?' or whatever it is..either something is funny, there's a twinkle in somebody's eye or they tell you something funny or..or there isn't [laughs]	Assessing whether "there's a twinkle in the client's eye or there isn't"				
H279-83: If you have a common ground of humour, that is a short cut to rapport; if you get humour wrong, it's a short cut to a fractured relationship	Assessing if there is a common ground of humour and so a short cut to rapport				
H296-297: So I'm a particular age, I have kids doing whatever..and, you know, the more you have in common, probably the easier it is to find common ground to be funny about	Assessing how much in common and how easy "to find common ground to be funny about"				
F240-242: If I cannot joke with people, it's hard for me to work with them and to be myself and	Finding it harder to be authentic if cannot joke with client	Finding it more difficult to work with client if			

to give the full therapeutic style that I have developed		cannot use humour			
G209-210: I think people who cannot laugh at themselves, I think, it's just like..I do actually find it hard to relate to people who just cannot laugh at themselves	Finding it harder to relate to people who cannot laugh at themselves				
A435: I think I use it [humour] more, the more experienced I am	Using humour more as gain more therapeutic experience	Gaining greater therapeutic experience and more confidence in use of humour	**Gaining confidence with experience**	***Experience/confidence*** [7]	**INTRAPSYCHIC VARIABLES** [8]
A436-437: When I was training and newly qualified, I would have been quite nervous about doing so [using humour] and I am less so now	Becoming "less nervous" about using humour since training/newly qualified				
A440: It's my confidence in treating the disorder [OCD]..erm, my experience and sort of having more successful, more successfully treated cases under your belt reinforces your sense that what you are doing or what you have been doing is..that what you're doing [using humour] is,	Becoming less nervous about using humour because of successful experience of, and confidence in, treating OCD				

[7] The more experienced and confident the therapist is, the more likely they are to use humour in session with the client.
[8] Intrapsychic variables are the therapist's experience/confidence, relative positive or negative experiences of humour use during training and supervision, and professional reputation. These variables affect the therapist's use of humour with a client in session. The less experienced/confident the therapist, the more cautious they are likely to be in using humour in session. The more negative their experiences of humour in training and supervision, the more reticent the therapist is likely to be about using humour. They will also try to find a balance between their 'serious' professional reputation and using humour – sensitively and appropriately – to enhance the therapeutic relationship.

reasonably speaking, the right thing					
A443-445: I think it [using humour] is just more about confidence and experience and perhaps infusing a bit more of your personality into how you do the job, the more experienced you are	Gaining experience and confidence enables them to "infuse a bit more of [their] personality into the job"				
D124-125: I think the more experience you get, the more, I personally think that you feel confident about using humour	Gaining more experience brings greater confidence in using humour				
D129-131: I think, you know, that sort of lighter touch that you can use where you can weave a bit of humour into it is definitely an experience thing	"Weaving a bit of humour" into therapy is "definitely an experience thing"				
E510-512: So it's having all of those slightly..erm..more subtle, interpersonal skills [including humour use], I think that comes with, I suspect that just comes with seeing loads of people with these sorts of problems	Honing experience of using "subtle interpersonal skills" [including humour use] with OCD clients				
G391: I feel I can get away with using humour a bit more as I get older, I don't know why	Getting older enables therapist to "get away with using humour a bit more"	Gaining experience to reveal more personality and humour	**Revealing more personality and humour with experience**		
D132-133: I think with experience, you can maybe relax	Gaining experience and confidence to "go off piste"				

a bit more and go off piste [and use humour]					
A454-456: It [experience] gives you the confidence to think, actually, I don't have to be a complete robot here; I can be a bit more creative here, I can use my personality a bit	Gaining confidence "not to be a robot": Being more creative and using personality				
C462-463: I think it takes a while to integrate a sense of who you are within the sessions	Taking a while to integrate personality into sessions				
D126-128: I think when you're learning, you're trying to concentrate and really understand what the therapeutic process is and the theory and all that kind of stuff and sort of be serious, trying to check that you're getting it right	Being more serious in training: focussing on trying to understand the therapeutic process				
E234-235: I don't think people, the people I've seen over the years have not really wanted to deal with someone who is completely po-faced and unable to show a degree of softness cos otherwise, you know, you may as well talk to a robot mightn't you?	Showing a "degree of softness" and not being "po-faced" or "you may as well talk to a robot"				
D149-151: There might be a very serious take home message but in something that is quite funny and so there is a skill in sort of pulling out what that is	Gaining the skill and experience to communicate the "serious take home				

	message" in something funny				
A453-454: Positive things from people who have trained you, and supervisors over the years and things, give you the confidence [to use your personality and humour in session]	Receiving positive feedback from tutors and supervisors fuels confidence to use humour	Receiving positive feedback from tutors and supervisors on using humour encourages therapist to use humour	**Experiencing positive encouragement in humour use during training and in supervision**	***Training/supervision*** [9]	
B252-254: I shared that [funny incident with a client] with my supervisor and she said 'Oh, I'm really glad that you are using humour in your therapy' [laughs]..she's not my normal supervisor	Receiving praise for using humour: "I am really glad that you are using humour in your therapy"				
D51-53: I think, certainly, the people that trained me..certainly, the ones that can be quite amusing without coming across as arrogant are the ones that have inspired me actually	Being "inspired" by tutors who were "amusing" (without being arrogant)	Learning from/being inspired by "amusing" and respected tutors during training			
E232-235: I did a fantastic OCD training with Salkovskis which was great and he is quite a humorous person, himself, erm...and I did further work with, erm..an American, whose name escapes me now..erm, Blake	Being inspired to use humour by OCD tutors [Paul Salkovskis and Blake Stobey] during training				

[9] The more positive their experiences of humour use during training and in supervision, the more likely the therapist is to use humour in session with clients. Negative experiences of humour use during training and in supervision appear to have more of a 'shelf life': therapists less likely, when initially qualified, to use humour in session with clients.

Stobey or something..erm, er..and he was very much along the same lines as Salkovskis as well, erm, possibly slightly more serious but, you know, still showed this degree of humour that I think is really important..					
E282-283: My views [on the positive use of humour in therapy] have probably pretty much stayed the same since training, I think..I don't think my attitude about it has changed	Holding positive views on therapeutic humour use since training				
F8-10: The main introduction I had to humour in therapy was Provocative Therapy..I read the Frank Farrelly book..I've had an interest in NLP [Neuro Linguistic Programming] for ages and I read the book and just thought it was hilarious	Finding Frank Farrelly's book on Provocative Therapy "hilarious"				
G 315-316: People like Paul Salkovskis and Christine Padesky, I mean, they talked about, they're the sort of people who will talk about the benefits of using humour	Being influenced by Paul Salkovskis and Christine Padesky talking about the benefits of humour use				
H303-304: I learned most of my OCD work from Jack Rachman..and he is, he has got a ridiculous sense of humour..he	Learning from Jack Rachman who has a "ridiculous", "the world's best" sense of humour				

has the world's best sense of humour but it is very dry					
H313-315: So, I think that humour was for me, not part of a formal training, I did not ever have a session on humour..but I watched and learned from 'the master' [Jack Rachman]	Learning from Jack Rachman [therapist's tutor], "the master" of humour use				
H315-318: I remember when [Jack Rachman] was doing a spider phobia thing and he pulled a spider's leg off by mistake [both laugh]..and how he dealt with that was really, you know..it could have been traumatic, but it wasn't, it was funny	Learning informally about humour in spider phobia training [when Jack Rachman pulled off spider's leg by mistake]				
H319-321: [Jack Rachman] had a very, very gentle humour..and not rude, not sarcastic, not black but just kind of, you know, slow and gentle and warm and I think that's, that's really..I learned from him about how to use humour with clients	Learning from Jack Rachman's "slow, gentle and warm humour"				
A436-437: When I was training and newly qualified, I would have been quite nervous about doing so [using humour]	Feeling nervous about using humour when training and newly qualified	Feeling "nervous" about using humour	**Being discouraged from humour use during training and in supervision**		
A445: Certainly, when I was training, I was quite nervously sticking absolutely religiously to	"Nervously sticking religiously to [CBT]				

protocols and not using any humour at all	protocols" and not using humour "at all"				
D126-128: When you're learning, you're trying to concentrate and really understand what the therapeutic processes are..and sort of be serious and check you're getting it right	Being more serious and focused on understanding therapeutic processes during training	Being more "serious" - and perhaps "humourless" - during training			
A566-567: I found a lot of the people I trained with to be really serious and po-faced	Being aware of "serious and po-faced" peer group				
A567-568: I think perhaps it [therapist training] does attract those sorts of quite humourless people potentially	Experiencing "humourless" peer group during training				
C11-13: When I was training initially as a counsellor..erm..in the skills session I was being taught by someone that was very rigid and…she had absolutely no margin of humour	Being taught skills sessions by a tutor who was "very rigid" with "no margin of humour"	Experiencing skills training sessions as constraining humour use			
C14-15: I think I have always, in some aspects of my life, been able to access humour so I found it [skills session training] quite constraining	Finding skills session training "quite constraining"				
C203-204: I think also my tutor, she herself, had no humour at all..she was straight as anything and, you know, I think humour had bypassed her as well	Experiencing tutor as having "no humour at all": "humour bypassed her"				

C204-205: So it was her [the tutor's] take on the skill and the exchange that went on so, you know, I think it was her projection on how to be ["no humour use at all" see C203-4]	Receiving the tutor's "projection on how to be" in session ["no humour use at all"]				
C16-18: I doubted the use of humour cos when I was trained initially, it being totally unacceptable, so I was really, you know, cracked down on..if I ever said anything, you know, even slightly humorous	"Doubting use of humour" in training; Being taught that humour "totally unacceptable"	Being positively discouraged from using humour during training			
C19-20: Even though I knew there was a place for it [therapeutic humour]..I felt that I had sort of had my hand slapped [in training]	"Having [their] hand slapped" for using humour in training				
C26-28: My training left me feeling ashamed I'd got it wrong and it [humour use] was unacceptable and I was wrong to do that so I think that led me to be probably quite rigid in how I worked initially	Feeling initially ashamed of humour use in therapeutic work				
C202-203: 'It's a serious business' was the message [during training] and there was no room [for humour]	Receiving message in training that therapy "is a serious business" with no room for humour				

C212-213: I felt I had to repress this [humour use]..for the first probably five years of my training	Feeling need to "repress" humour use during training	Feeling compelled to repress humour use during training			
F67-69: [Another trainee] had also done the course and she said: "you've got to be prepared to not be yourself..you've got to be prepared to present the image of what the tutors and the supervisors are looking for"	Being prepared "not to be yourself" [to repress humour] in order to present the "image" tutors and supervisors look for				
F42-43: I knew others [tutors and supervisors] who, you know.. they still equate being professional with being distant and cold	Being taught by some tutors and supervisors that being professional equates with being distant and cold	Being taught that humour use is "unprofessional"			
F106-108: Some of my supervisors, I doubt they would have used humour at all, well, I know..I think they would see it as a sort of..something very unprofessional and worthy of malpractice	Being taught that humour use is "very unprofessional and worthy of malpractice"				
D80-81: [In professional ethics training,] there was a list of different dilemmas and some of them were quite humorous, for example, if a patient cracked onto you..it's quite humour-provoking thinking about that scenario but, in that situation, it would not be funny and you	Experiencing some ethical dilemmas in training as humorous in theory but unfunny and "uncomfortable" in practice	Receiving implicit message in ethics training that humour use can be "uncomfortable" and self-disclosing			

obviously wouldn't laugh about it with the patient because it would be uncomfortable					
H329-332: We were taught about non self-disclosure and, if you extrapolate that, that would mean..I mean..part of humour is self-disclosure, very often, so I think that would have been restrictive..if you were really not to say anything about yourself, that would be, that would limit the amount of humour you could use	Receiving training on non-self disclosure which implied humour use should be restricted and limited in therapy				
H341-342: So we were never told 'Don't use it [humour]' but..but equally, the non-disclosure message..it was probably implicit within that	Receiving "implicit" message in "non-self disclosure" training not to use humour				
A74-76: Clients need to feel..that you are serious and credible, that you are genuinely telling them that what you are asking them to do [CBT for OCD] is going to work	Being "serious and credible" so that clients know that [CBT for OCD] will work	Gaining client confidence requires therapist to take therapy – seriously	**Gaining client confidence is a serious business**	***Professional Reputation***[10]	
A80-81: I'm afraid that they [clients] would feel that I wasn't taking their therapy seriously	Fearing that [humour use] makes clients feel therapist not taking therapy seriously				

[10] Therapist aims to strike a balance and manage the tension between maintaining a serious and credible professional reputation and using therapeutic humour sensitively and appropriately to enhance the therapeutic relationship.

A164: A lot of people are very serious with OCD..they are real worriers and they're very serious and, in those cases…they are not coming to me to..erm..have a friendly chat and a laugh	Responding to clients who are "very serious" and are not in therapy for a "friendly chat and a laugh"	Being aware that clients are not in therapy to "have a laugh"			
A176-177: It's funny, cos where I work, there's this therapist, he's a CBT Therapist as well, and he is constantly roaring with laughter and everyone in the building says 'what is he doing in there?'..you don't hear the patients laughing	Being aware that a colleague is "constantly roaring with laughter" but "you don't hear the patients laughing"				
E237-239: As I say, you know, you don't want a therapist who is just going to sit there having a laugh with you for an hour and then you don't actually deal with anything..that's not very helpful	Being aware that clients do not want therapists to "sit there and have a laugh" for an hour				
E287-288: It's not something that I set out, to try to become a humorous therapist or anything like that, I think that would be quite inappropriate	Trying to be a humorous therapist would be "quite inappropriate"	Being appropriately serious			
E328-329: I would say it is important not to be too light-hearted about people's compulsions	Not being "too light-hearted" about clients' compulsions				
E385-390: I think it is a serious business to formulate, to actually understand something, so it	Recognising the "serious business" of therapy but also that	Balancing the "serious business" of	**Using humour can enhance the**		

involves some keen listening, some keen questioning..erm..in order to sort of pull things together..there is a lot of discussion and collaboration, which I think is a serious business.. but it doesn't have to be done more seriously than it needs to be	"it does not have to be done more seriously than it needs to be"	therapy with appropriate humour	**therapeutic relationship**		
G4-5: I really think it [humour] has a place in therapy but I do think that the timing of it needs to be right	Advocating humour use in therapy but acknowledging that the "timing needs to be right"				
G18-19: I really think it [humour] has a big place in the [therapeutic] relationship at times	Suggesting humour has a "big place in the [therapeutic] relationship" at times	Advocating sensitive humour use to positively impact the therapeutic relationship			
C286-287: If you use humour with sensitivity, it can be a very useful tool in the therapeutic relationship	Using humour with sensitivity can be a "very useful tool" in the therapeutic relationship				
F106: Humour is the oil that turns the wheels in therapy	Describing humour as "the oil that turns the wheels in therapy"				
C89: Humour is what human beings are able to connect with and relate to	Using humour to facilitate connection	Using humour to facilitate relationships			
H18-20: It [humour] is a way of relating to people and I..this is going to sound odd, I don't think	Using humour as "a way of relating to people				

it's that much different from any..forming any relationship					
NEGATVE CASE: [11]					
A187-188: My reticence to use humour is not informed by a theoretical perspective	Being reticent to use humour in session not a result of psychological theory	Deciding to use humour in session not informed by psychological theory	**Using humour is <u>not</u> informed by psychological theory or formal training**	***Training/supervision***	**INTRAPSYCHIC VARIABLES**
B297-298: I am not informed by theory when it comes to using humour in session	Using humour in session not informed by [psychological] theory				
C219-21: In my training, Freud's view that humour is a mature defence (with which therapists should not collude) was not cited as a reason not to use in humour in session	Avoiding humour in session not determined by Freud's view of humour as a mature defence				
A546-548: I have to admit that it [therapeutic humour] was not something that was ever covered in my training or talked about	Therapeutic humour not covered or talked about in CBT training	Reporting the absence of therapeutic humour formal training			
A549-551: I did not know what they [tutors and colleagues] were like in sessions, nobody does..and it [their use – or not - of humour] was never talked about	Tutors and colleagues never talked about their use of therapeutic humour when therapist was in training				

[11] Five participants said that their decision to use humour - or not - in session with clients was <u>not</u> informed by psychological theory or their "formal" training.

<table>
<tr><td>G306: No..in training, it [humour] was never touched on; a real no</td><td>In training, humour was "never touched on; a real no"</td><td rowspan="3"></td><td rowspan="5"></td><td rowspan="5"></td><td rowspan="5"></td></tr>
<tr><td>G315-316: It's funny, it's [the use of therapeutic humour] not in books and it's not in serious lectures</td><td>"It's funny", therapeutic humour is not covered in books or "serious lectures"</td></tr>
<tr><td>H313-316: I think that humour was for me, not part of a formal training, I did not ever have a session on humour</td><td>Humour was never part of "formal training"</td></tr>
<tr><td>B447-449: I cannot remember anything theoretically [about therapeutic humour] but think it is a good thing most of the time</td><td>Not remembering any theory on therapeutic humour use</td><td rowspan="2">Not remembering any formal training on the use of humour</td></tr>
<tr><td>E221-223: [Humour/ therapeutic humour] they were not specifically covered in training, no, from what I recall..I mean, my training as a CBT therapist, erm..I don't remember anything specifically about the use of humour</td><td>Not remembering covering therapeutic humour in training</td></tr>
</table>

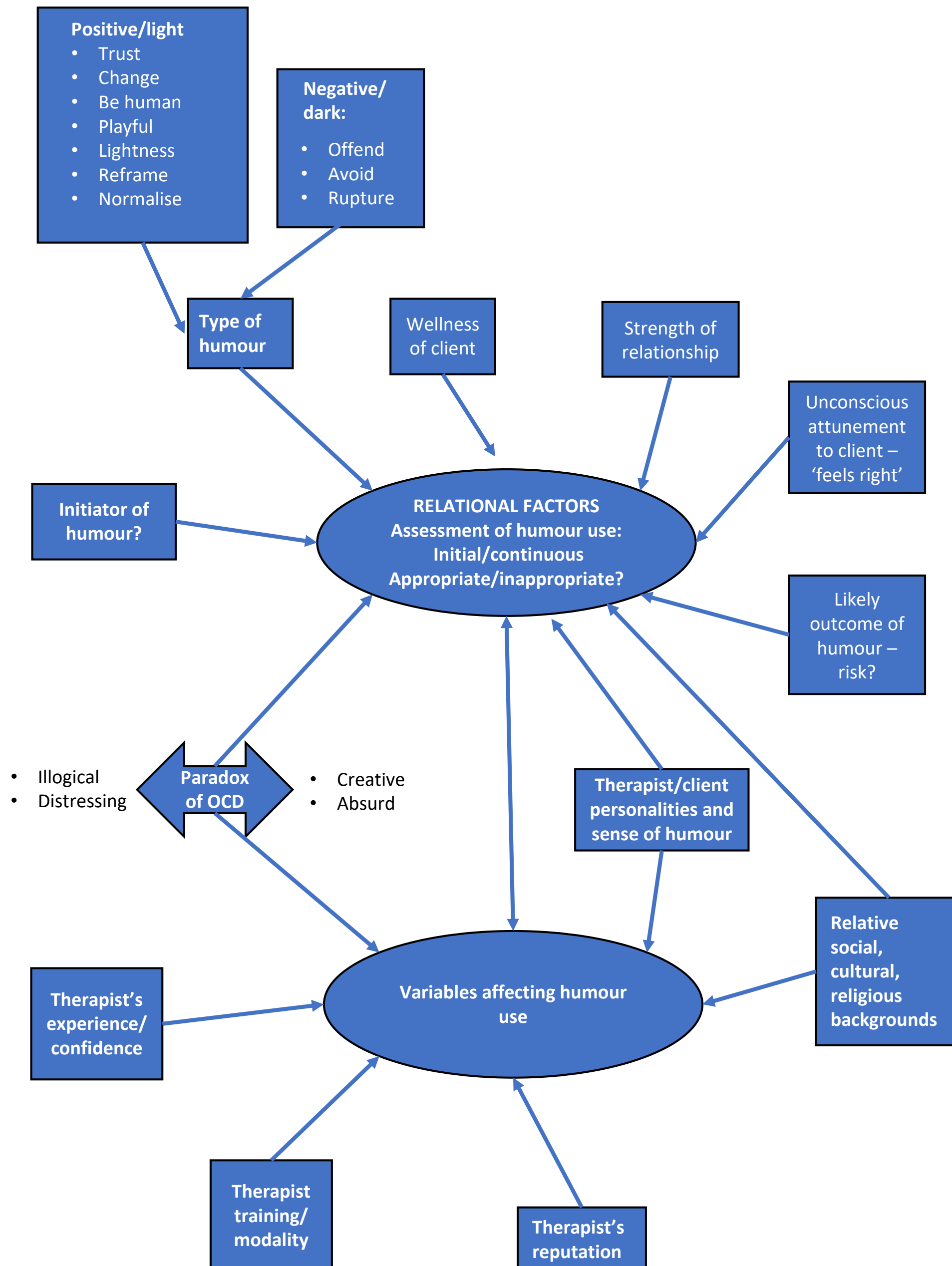
APPENDIX N: Categories, Sub-categories and Focused Codes

Appendix N: Categories, Sub-categories and Focused Codes			
Category	**Sub-category**	**Focused Code**	**Participants**
1. Humour as an expression of paradox in OCD	1.1 OCD as illogical, distressing, dangerous	Being illogical	A, B, C, D, E, F, G, H
		Being distressing	A, B, C, D, E, F, G, H
		Being perceived as dangerous	A, C, D, F, H
	1.2 OCD as creative, informative, absurd	Being creative	A, B, C, D, E, H
		Being informative	A, D, E, F
		Being absurd	A, B, C, D, E, F, G, H
2. Continuous assessment process	2.1 Initial assessment	Assessing client's ability to access humour in initial assessment	B, C, D, E, F, G
	2.2 Ongoing assessment of humour use	Assessing client's ability to access humour on an ongoing basis	A, B, C, D, E, F, G, H
3. Type of humour	3.1 Dark/Provocative	Identifying provocative/'dark' humour	A, B, C, D, E, F, G, H
	3.2 Light/Soothing	Identifying soothing/'light' humour	A, B, C, D, E, F, G, H
4. Constructive humour	4.1 Trust/bond	Developing trust	A, B, C, E, F, G, H
		Establishing a bond	A, B, C, D, E, F, G, H
	4.2 Play/lighten	Being playful	A, B, C, D, E, F, G, H
		Lightening the tone	B, D, E, G, H
	4.3 Normalise/'being human'	Normalising thoughts and behaviours	A, B, C, D, E, F, G
		'Being human'	B, C, D, E, G
	4.4 Reframe/ 'cognitive shift'	Reframing	A, B, C, D, E, F, G, H
		Enabling a 'cognitive shift'	A, C, D, E, F, G
	4.5 Change/ 'eureka moment'	Bringing about change	A, B, C, D, E, F, G
		Having a 'eureka moment'	A, D, E, G, H
5. Negative humour	5.1 Shield/block	Shielding	A, B, C, D, E, F, G, H
		Blocking	A, B, C, D, E, F, G, H
	5.2 Offend/ridicule	Avoiding offence	A, B, C, D, E, F, G, H
		Avoiding ridiculing	A, B, C, D, E, F, G, H
	5.3 Rupture	Avoiding rupture	A, B, C, D, E, F, G, H
6. In-the-moment feedback	6.1 Intuitive	Being intuitive	A, B, C, D, E, F, G, H
		'Feeling right'	C, D, E, G

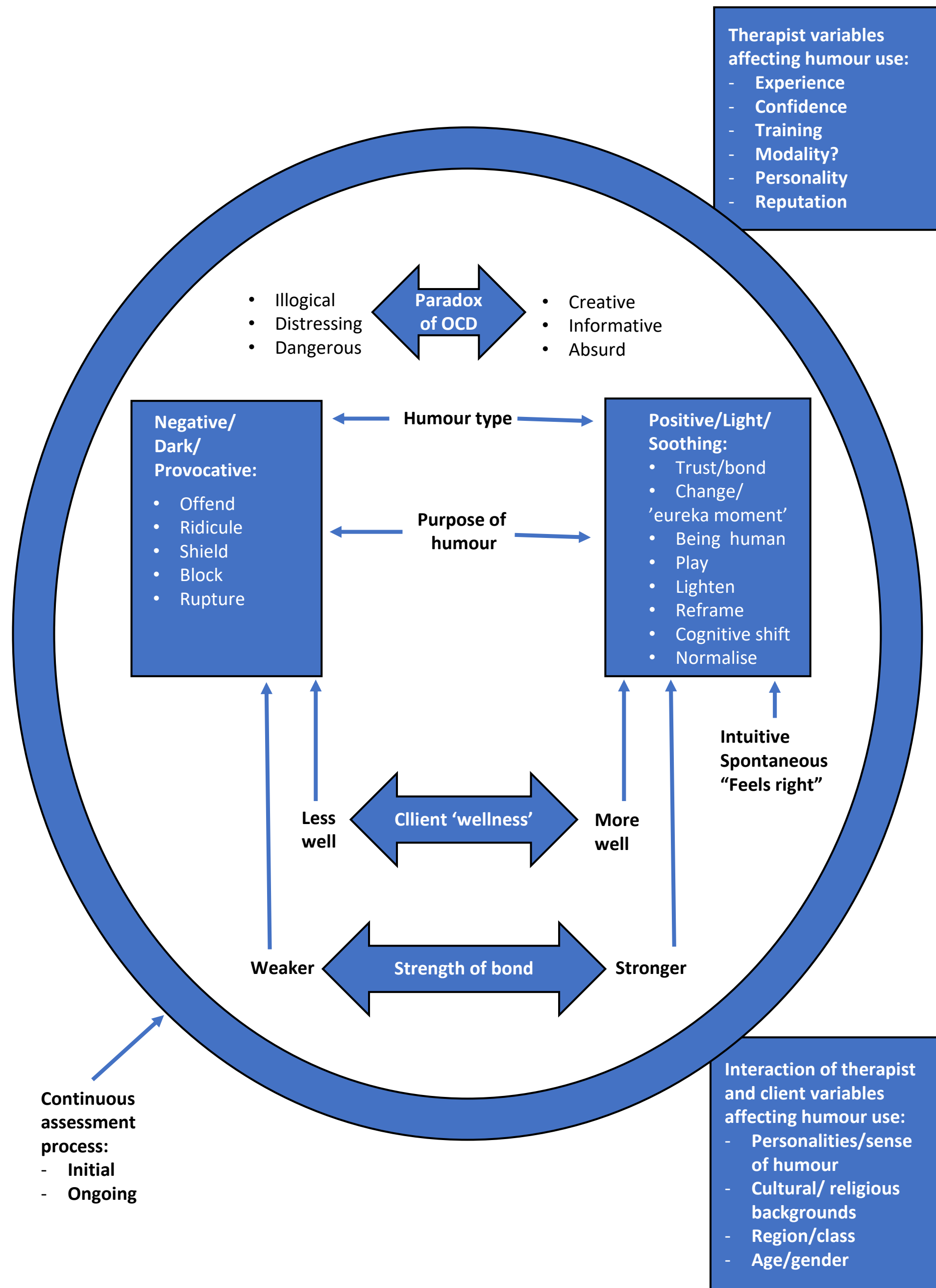
	6.2 Spontaneous	Being spontaneous	A, B, C, D, E, G, H
7. Longitudinal feedback	7.1 Strength of bond	Assessing strength of bond	A, B, C, D, E, F, G, H
	7.2 Client 'wellness'	Assessing client 'wellness'	A, B, C, E, F, G
8. Individual differences	8.1 Culture/religion	Being sensitive to cultural differences	B, D, G, H
		Being sensitive to religious differences	C, D
	8.2 Region/class	Being sensitive to regional differences	B, C, F
		Being sensitive to socio-economic differences	D, F
	8.3 Age/gender	Being sensitive to generational differences	G, H
		Being sensitive to gender differences	D, G
	8.4 'Personality match'	Bringing personality and authenticity	B, C, E, F
		Assessing personalities and shared sense of humour	A, D, E, H
9. Intrapsychic variables	9.1 Experience/confidence	Gaining confidence with experience	A, D, E
		Revealing more personality and humour with experience	A, C, D, E, G, H
	9.2 Training/supervision	Experiencing positive encouragement in humour use during training and in supervision	A, B, D, E, F, G, H
		Being discouraged from humour use during training and in supervision	A, C, D, F, H
	9.3 Professional reputation	Gaining client confidence is a serious business	A, E
		Using humour to enhance the therapeutic relationship	C, E, F, G, H

APPENDIX O: Development of grounded theory model

Initial draft



Intermediary draft



Final draft