Can I Laugh Now?
Understanding humour within psychotherapy from the client’s perspective

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Abstract

Humour is an ever-present part of affective communication, and theories abound about its proposed role within psychotherapy. However, little empirical research has been carried out, and what could be a major psychotherapeutic resource, remains essentially untested. This study utilised mixed methods (semi-structured interviews and survey), to examine clients’ experiences of humour within psychotherapy. The findings indicate humour may be a marker of therapeutic relationship health, evidenced by thematic data showing clients only bring in humour when safety and trust are present and when they feel a connection with their therapist. This finding was further strengthened by survey data, showing that clients who rated their humour as well-matched to their therapists’ or rated their therapists’ humour as helpful, were more likely to rate the relationship as good.
Chapter 1: Introduction

1.1 Background and Context

An extensive body of work, starting from the time of Freud, has been written about humour within the therapeutic relationship, much of which has advocated for its use (Franzini, 2001). As reviewed extensively by Franzini (2001), most advocates have approached humour from a psychodynamic (Mosak, 1987; Strean, 1995) or rational emotional viewpoint (Ellis, 1977a). However, despite the long history commending humour within the literature, little attention has been given to humour within psychotherapy training (certainly within the integrative humanistic psychotherapy framework), and even less attention has been given to empirical research supporting the use of humour as an intervention (Sultanoff, 2013).

Most of the literature that supports the use of humour within psychotherapy, mainly consists of statements of support, personal perspectives and clinical examples, which have been referred to as “advocacy literature” by Saper (1987, p. 363, reviewed in Sultanoff, 2013). Indeed little has moved since Franzini (2001) pointed out that the longstanding call for the use of humour within therapy remained untested empirically. For Franzini, and others like him, such as Saper (1987), and Sultanoff (2013), humour is a potentially major psychotherapeutic resource, greatly celebrated by some, but not yet evaluated satisfactorily and thus is “essentially untapped” (Franzini, 2001, p. 170).

1.2 Research to Date

Since Franzini’s appeal (2001) for empirical research, just two quantitative studies and a single qualitative study have been undertaken examining the subject of humour. These are examined in the literature section below, but are briefly described here, to contextualise the research of this thesis.

The first quantitative study (Marci, Moran, & Orr, 2004) reported on the frequency of laughter and skin conductance responses for patient-therapist pairs, during psychodynamic therapy...
The results of this study demonstrated that interpersonal laughter is highly coordinated between clients and therapists, and shared laughter is a co-constructed activity which the authors theorised may play a role in supporting the therapeutic alliance (Marci et al., 2004).

The other quantitative study, undertaken by Panichelli and colleagues (2018), investigated the association between humour and several therapeutic outcomes in psychotherapy clients. The main finding was of a strong positive correlation between the presence of humour within therapy sessions and therapy effectiveness, from both clients’ and therapists’ perspectives. The authors proposed that further research is needed to examine the direction of causality and determine whether humour enhances positive outcomes within therapy or whether positive outcomes trigger the occurrence of humour (Panichelli et al., 2018).

From a qualitative viewpoint, the only researchers to explore humour in a therapeutic setting are Gibson and Tantam (2018), who reported on psychotherapists’ experiences of humour. In their study, therapists related how humour seemed to herald psychological shifts in their clients and can help clients to realise mistakes or ambiguities in their way of being, with a mostly positive impact (Gibson & Tantam, 2018). The study however cautioned that their participants focused strongly on the positive impact of humour and neglected the negative. The authors suggested future studies could mitigate against this by using client participants, who might be more forthcoming about the negative side of humour.

1.3 The Current Study

As will be discussed in the literature section, comprehending the role of humour between clients and therapists may help us better understand affective communication during psychotherapy. There is also evident a large deficit in terms of research undertaken on humour in psychotherapy. While this has been examined to an extent by Gibson and Tantam’s (2018) qualitative study, there is a need for further research, especially in relation to the client’s perspective, as these often differ from therapists’ (Gershefski, Arnkoff, Glass, & Elkin, 1996), and this is a key focus of the current study.
Equally, there is a need to study how the presence of humour impacts the formation of the therapeutic alliance, given the viewpoint of Marci and colleagues (2004), that laughter may support the alliance. The development and maintenance of the alliance is the key beneficial component of therapy, above any specific techniques, according to Lambert and Barley (2001). The nature of the therapeutic alliance in helping clients and the possible function of humour within this, is expanded upon in the literature section below and is a focus of the research.

Furthermore, humour (as discussed below) can be a way of coping with stressful situations. Many theorists have viewed humour as an adaptive coping mechanism (Martin & Lefcourt, 1983). For example, Freud stated that humour is “the highest of [the] defensive processes” (1960, p. 233), while Rollo May (1953, p. 54) stated that humour ... “is the healthy way of feeling a 'distance' between one's self and the problem” (cited Martin & Lefcourt, 1983, p. 281).

In addition, research by Martin, shows humour as an effective stress moderator (Martin, 2001). Other studies show that humour can be used as both a short-term coping strategy (Strick, Holland, van Baaren, & van Knippenberg, 2009; Samson & Gross, 2012), as well as for longer-term stressful life situations (Martin & Lefcourt, 1983; Overholser, 1992). It would therefore be useful in the current study to examine the role of humour as a coping strategy for individuals in their everyday lives, and examine if this has an impact on their perceptions of humour within the therapeutic space.

1.4 Aims and Objectives

This study aims to improve the understanding of the impact of humour on the client’s therapeutic process as well as the client-therapist relationship, through a mixed methods study design, utilising clients, who are also trainee therapists but not yet engaged in clinical practice.

The study explores this question, quantitatively, via the use of a survey of clients’ experiences of humour within their personal therapy, as well as their therapeutic relationship. Additionally, two self-report measures, the Coping Humor Scale (CHS; Martin & Lefcourt, 1983) and Humour Styles Questionnaire (HSQ; Martin, Puhl-Doris, Larsen, Gray, & Weir, 2003) are utilised and scores on
these will be correlated with clients’ perception of their therapeutic relationship, as measured by the survey. While the qualitative stage, explores via semi-structured interviews how clients’ unique experiences of humour impacts on their therapeutic process and therapeutic relationship, using a small sample of those who completed the survey.

Finally, at the interpretation stage, the results from both the qualitative and quantitative aspects are triangulated to provide a deeper understanding than has previously been reported, of the impact of humour on clients’ experiences of therapy.
Chapter 2: Literature Review

2.1 What is Humour?

Humour is a complex phenomenon that is infamously difficult to define (Haig, 1986) and there exists significant disagreement on how to conceptualise it. Some researchers have categorised its elements, such as Sultanoff (2003, p. 113), who states “[humour] is a complex interaction involving...physiological response (laughter), emotional response (mirth), and/or cognitive response (wit). Others such as Adamle and Turkoski (2006, p. 639) define humour as “not an emotion, but rather a vehicle for expressing emotions; a universal phenomenon that occurs in all cultural groups and all settings”. Or even as Bob Mankoff (New York editor, 2014; cited Gibson & Tantam, 2017), pithily put it, humour is “the right amount of wrong”.

Laughter and humour are part of a universal human vocabulary that is highly consistent across cultures (Apte, 1985). In fact, there is no human culture, which is not familiar with the experience of humour, and all healthy individuals can easily comprehend overt humour displays (Polimeni & Reiss, 2006).

2.1.1 Evolutionary, and Neurodevelopmental View

Humour is one of many behaviours of modern homo sapiens, which have existed for thousands of years (Polimeni & Reiss, 2006). Laughter is said to originate from primates’ relaxed open-mouth play face, as distinct from the silent bared-teeth display thought to be the precursor to human smiling (Van Hooff, 1972). Wild and colleagues (2003) suggest that laughter, given how loud and incapacitating it can be, must have had a survival value for our species. Wild et al., describe Darwin’s (1871) view that laughter evolved as a social expression of happiness, giving cohesion and thus, providing a survival advantage to social groups.

From a neurodevelopmental perspective, humour begins in infants at 3-4 months, starting with laughter and tickles (Wolff, 1963), and is present long before the infant first makes gestures (6-8 months) or begins to talk (12 months), indicating that humour as a means of emotional expression is developmentally significant (Reddy, Williams, & Vaughan, 2002). Also, Reddy (2001;
observed how infants begin to deliberately create humour at 9-11 months using nonverbal, absurd behaviour, such as making odd faces (e.g. puckered face), or absurd actions (e.g. holding up smelly feet). Mireault (2015) describes such attempts at humour as universally appealing and similar to techniques employed by adult clowns.

Humour consists of several cognitive processes, such as the capacity to identify and resolve incongruity (Veale, 2005), reported in (Mireault et al., 2015). For example, infants aged 6-12 months will laugh at the incongruous use of familiar objects by a caregiver, such as putting a book on one's head (Mireault et al., 2014; 2015), suggesting they already have expectations for how everyday objects are typically used. Furthermore, Reddy (2001), observing 8 month old infants, found they perform humorous teasing, such as offering and then withdrawing an object to a parent, suggesting an early component of theory of mind at work in infants, which is an important inference of infant humour perception (Mireault et al., 2015).

The development at 6-12 months of offering and withdrawing objects, as well as humorous games such as peekaboo played by and with infants, has also been interpreted from a psychoanalytic perspective as allowing infants to distinguish between themselves and others and to master the anxiety that can be associated with their caregivers’ changes of presence vs. absence (Brandell, 2010). This principle is also exemplified in Freud’s Beyond the Pleasure Principle (1961a), where he discusses the fort-da game (‘fort’ meaning gone and ‘da’ meaning there).

2.1.2 Humour as an Attachment Behaviour

A secure attachment to parental figures is thought to be the foundation of healthy emotional development in infants and is associated with long-term positive developmental outcomes (Berlin and Cassidy 2003). Secure attachment is thought to be facilitated by emotionally satisfying and synchronous attachment between parents and infants (Ainsworth, Blehar, Waters, & Wall, 1978). As humour emerges in parallel with attachment in the first year of life (Mireault, Sparrow, Poutre, Perdue, & Macke, 2012), humour and laughter have been indicated as drivers
of secure attachment formation in infancy (Schore, 2012). The nature however of a relationship between the emergence of humour and attachment formation, is still debatable (Mireault et al., 2012).

Nevertheless, Mireault (2012) suggests that humorous exchanges between infants and parents may at the very least enhance their opportunities to develop a satisfying relationship together, a concept which is consistent with research on humour and relationship quality in adulthood. In adulthood humour has been associated with an increased capacity for intimacy, an ability to engage in deep affective relationships, as well as to trust others, all of which are necessary for attachment (Hampes, 1999). Additionally, as reviewed by Mireault (2012), humour is associated with perceived closeness in relationships (Cann, Ashley Norman, Welbourne, & Calhoun, 2008) and has a role in boosting relationship quality (Aron, Norman, Aron, McKenna, & Heyman, 2000).

Lemma (2000) writes of the connecting power of humour in relationships, stating that it can make individuals feel closer, loved, as well as fostering a sense of intimacy. An example is Hampes’ (1999) study, which found a positive correlation between individuals scoring highly in ‘intimacy’ and sense of humour scores, when they were compared to those scoring lower on intimacy (Lemma, 2000, p. 18). Hampes (1999) posited from their findings that humour helps people succeed in intimate relationships because it allows them to handle the stress within those relationships.

The section below examines the main theories of humour present in the literature, which have tried to make sense of the meaning and mechanics of humour.

2.2 Theories of Humour

Differences between definitions of humour and how we use the term ‘sense of humour’ in everyday language are reflected in a wide range of theoretical approaches to understanding humour. Morreall (1987), delineates three broad categories of humour theories: incongruity, superiority and relief. A fourth category (Morreall, 2016) is play theories and all four categories are discussed below.
2.2.1 Superiority Theories

Some humour is undeniably aimed at attacking another (Lemma, 2000). Even in ancient Greece, many philosophers (e.g. Plato, Aristotle) suggested the powerful laugh at those they feel superior to (Lemma, 2000). The 17th century English philosopher, Hobbes (1840) is associated with the superiority theory in the modern era, although for Hobbes, only ‘imperfect’ individuals laugh at the less fortunate (Lemma, 2000).

For Grotjahn (1957), humour in childhood is a quest for superiority, as he argues that starting in the oral stage, when a child smiles they generally get a favourable parental response that gives them a sense of control over the other (Lemma, 2000). Later in life, Grotjahn suggests that the point in time when the child begins to feel superior is when they also discover comic situations. Furthermore, he argues that laughter in adulthood brings us back to the pleasure of childhood and the aggression we felt towards authority and order (reviewed in Lemma, 2000 p. 27).

While some proponents of superiority theories of humour point out that we frequently find mirth in feeling superior to our own past selves (Gibson & Tantam, 2017), this does not account for humour that arises from situations where we feel inferior or even ridiculous. Therefore as Gibson and Tantam (2017) write, the superiority theory cannot account for a complete understanding of humour.

2.2.2 Incongruity Theories

This theory’s central premise is that humour lies in the discrepancy between our expectations and actual events (Shearer, 2016). The notion of incongruity can be traced back to philosophers such as Kant (1790) and Schopenhauer (1818). For Darwin (1871), nothing caused more laughter than two incongruous ideas converging and resulting in two conflicting but simultaneous emotions (Lemma, 2000).

Lemma (2000) further writes that we appear to look for what disturbs us on one level, but through humour the anxiety of the disturbance can be lessened, and we can therefore experience pleasure. Morreall (1987) believes that laughter comes from a ‘pleasant
psychological shift’ caused by incongruity (Lemma 2000). For Morreall (1987), incongruity can lead to several responses, including humorous amusement, which requires a degree of emotional disengagement. Confronting incongruous experiences with amusement rather than anger or fear, may thus be highly adaptive for humans, as it provides us with a more objective and rational perspective (Lemma, 2000).

2.2.3 Relief Theories

Morreall (2016), in introducing the concept of relief theory, describes it as “an hydraulic explanation”, whereby laughter performs a similar function to a boiler’s pressure valve, releasing pressure in the nervous system. The theory was first described by Shaftesbury’s (1709) essay, “Essay on the Freedom of Wit and Humor,” (Morreall, 2016).

Two centuries later, theorists such as Spencer and Freud updated the biology behind the Relief Theory but maintained that humour releases pent-up energy (Morreall, 2016). Aligning his views on humour with his psychoanalytic theory, Freud also suggested that humour was sublimation, and a creative means for us to express unconscious sexual and aggressive urges (Gibson & Tantam, 2017). To quote Freud, “[Humour] is not resigned; it is rebellious. It signifies not only the triumph of the ego but also of the pleasure principle.’ (1961b, p. 162)

To expand on this, Freud believed the emotions that we repress the most, are sexual desire and hostility and thus most jokes are based on either of these emotions (Morreall, 2016). Telling a sexual joke or laughing at one, allows us to circumvent our internal censor and give way to the libido (Morreall, 2016). Equally, should we tell a hostile joke we are allowing the aggression we normally suppress to escape. Either way, the psychic energy that is usually required to suppress such feelings has become redundant and is released as laughter (Morreall, 2016).

Additionally, Freud (1961b) theorised that through humour the superego comforts the ego, in the face of real stresses, by fostering a temporary illusion that the world is not so dangerous or serious (Lemma, 2000, p. 33). Freud also believed that humour attested to the ‘triumph of narcissism’ (Gibson & Tantam, 2017, p. 274). Or as Lemma (2000) says, it enables individuals to
prevail over forces of oppression or the discomfort of reality. This would account for humour that is notoriously prevalent among those who face death and trauma as a part of their job, such as firefighters, and suggests an existential dimension to such humour, which Kohut (1966) describes as a healthy transformation of narcissism that enables us to face death without denial.

2.2.4 Play Theories

Play theories have many similarities to evolutionary theories of humour, which are discussed above. An early 20th century play theory of humour was first advanced by Eastman (1926), who believed there are strong similarities between humour in humans and play in animals, especially in how chimps laugh when they are tickled (Morreall, 2016).

According to play theories, many forms of play and tickling, first developed in primates as a way of practising and social bonding (Van Hooff, 1972). Gibson and Tantam (2017, p. 276) extrapolate from this idea to suggest that humour is not actually play, but rather from play, “humour has evolved and retained a similar manifestation”. The social bonding that play theories highlight, thus emphasises the importance of the group and being inside or outside it (Gibson & Tantam, 2017).

Morreall (2016), in a review of humour theories, supports the hypothesis that laughter evolved as a play signal. Moreover, he proports that play theories are one of the more appealing humour theories, as it explains more convincingly than either the superiority or incongruity theories, the link between humour and facial expressions, body language and the expression of laughter. Play theories also clarify why laughter and humour are a social experience. For example, we are estimated to be 30 times more likely to laugh in company, than when alone (Morreall, 2016). Moreover, just as young children laugh when either chasing, wrestling or tickling, chimpanzees and gorillas performing similar activities, show their play-face and make laugh-like vocalisations. For Morreall (2016) this finding links the understanding that mock aggression is at the root of laughter and humour and illuminates why so much of our humour, can be playfully aggressive.
2.3 Humour and Wellbeing

“A merry heart doeth good like a medicine” (Proverbs 17:22)

Despite the lack of agreement on an exact definition of humour, or even a single overarching theory, clear links between humour and wellbeing have been established by psychological research studies. As summarised by Gelkopf (2011), studies indicate that humour is variously linked to improving positive emotions (Levenson, 1988), dissociating from distress (Keltner & Bonanno, 1997), facilitating emotional catharsis, and improving interpersonal processes (Gelkopf, Sigal, & Kramer, 1994). Some research findings linking the use of humour as a moderator of stress are discussed above (e.g. Samson & Gross, 2012), but in addition to these, other studies, show humour is linked with strategies for coping with stress. For instance, Lefcourt et al. (1995) state that use of humour can be a coping technique, which can allow an individual to distance themselves from negative events and reduce their emotional response to stressful situations.

Understanding humour as an adaptive coping mechanism has led many psychotherapists to advocate its use within the therapeutic session (Martin & Lefcourt, 1983), but equally there have been many detractors. The section below explores the history of humour use within therapy and examines in detail the theorists who have advocated for or against its use.

2.4 Humour within Psychotherapy

Although humour is viewed as vital to our mental health and a necessary part of the development of the therapeutic alliance, a willingness to fully endorse humour as a psychotherapeutic tool remains elusive (Shaughnessy & Wadsworth, 1992).

Freud himself is reported to have joked with his patients (Franzini, 2001), and there is plenty of humour in the writings of both Freud and Jung (Shearer, 2016). Moreover, Jung reportedly made a point of finding out whether patients had a sense of humour, as he thought that “without it they would be very difficult to work with” (cited Shearer, 2016, p. 22). Even though humour was
not taboo at the beginning of psychoanalysis, a suspicion around engaging in humour still has its basis there, where it was believed therapists should refrain from revealing anything of themselves to the patient (Gibson & Tantam, 2017).

Despite an apparent lack of endorsement for humour within psychotherapy (Lemma, 2000), it is part of our everyday affective communication, it regularly punctuates our speech, and is present at every social setting (Wild et al., 2003). As so much of the psychotherapeutic relationship is centred on the communication of emotions, then understanding the role of humour among clients and therapists may offer clues to understanding affective communication during psychotherapy (Marci et al., 2004).

2.4.1 Impact of Humour on Therapeutic Alliance

Given humour’s role in early attachment relationships, and in aiding intimacy in later relationships, authors such as Poland (1971) propose humour is associated with a good therapeutic alliance and can be useful for developing insight. The following section explains what is meant by the therapeutic alliance and expands on other theories and research since Poland’s (1971) work.

The idea of a therapeutic alliance began with Freud and his theories around transference, which he thought could lead to a helpful attachment between the client and therapist, and not necessarily as a projection (Ardito & Rabellino, 2011). According to Ardio and Rabellino (2011), the most commonly used definition of the therapeutic alliance is one proposed by Bordin (1979) and applicable to any therapeutic approach. Bordin (1979) stated that the alliance consists of three key ingredients, which are: an agreement on the treatment goals; agreement on the tasks; and development of a bond with reciprocal positive feelings (Horvath & Luborsky, 1993). The optimal alliance then is where the treatment goals and the manner in which these will be achieved are shared by both parties, within the context of a good and respectful relationship (Ardito & Rabellino, 2011). Interestingly, Bordin thought that the alliance can impact therapy
outcomes, as it enables the client to accept and believe in the therapy, rather than it being healing in and of itself (Ardito & Rabellino, 2011).

Further work by Cann et al., (2008), suggests that humour helps create the alliance as it contributes to greater personal connection. Moreover, Gelkopf (2011), in a review of humour in mental illness, believes the main contribution of humour is its benefit to the therapeutic relationship. As evidence, Gelkopf cites Richman’s (1996) theory that humour can deepen the therapeutic alliance by increasing feelings of acceptance for clients, and enhancing empathy and a sense of belonging. Additionally, Poland (1971; reviewed Gelkopf, 2011), suggested that through humour, therapists can display their humanity as well as reduce barriers between patients and psychotherapists. Squier (1995) theorises that a therapist’s spontaneous laughter, can help improve a client’s trust in the therapist as well as the therapeutic process. Finally, on a similar note, the psychoanalyst Bader (1994) presented clinical cases demonstrating the therapist’s humour can reveal something of their own internal thoughts and help cultivate safety and confidence for the client in the therapy relationship.

2.4.2 Functions of Humour in Therapy

Besides aiding the therapeutic alliance, humour has other functions within psychotherapy which are outlined below.

Humour within psychotherapy can exist at the conscious and also unconscious level. It can thus serve many different purposes, as reviewed in Dionigi and Canestrari (2018), such as: diffusing an awkward moment by reframing the situation (Dziegielewski, Jacinto, Laudadio, & Legg-Rodriguez, 2003); creating a relaxed and open space for conversation (Goldin & Bordan, 1999); enabling a client to tolerate criticism by revealing their shortcomings (Ellis, 1977b); nurturing a positive therapeutic alliance (Nelson, 2008). Similar to Dziegielewski et al. (2003), Buttny (2001) suggested that via humour, therapists may disarm clients, which breaks down their resistance, which in turn allows clients to reframe and examine alternative reasons for their current situation (Dionigi & Canestrari, 2018). Humour can also encourage clients to examine certain topics in
more depth, allowing the “unravelling of the unconscious and the integration of the elements thereof with the conscious” (Korb, 1988, p. 50).

For Freud (1961b), the role of humour within therapy, from the client’s perspective, is as both a coping strategy and an expression of their superiority, suggesting the client may use humour as a form of resistance, to ease their feelings of inferiority (Dionigi & Canestrari, 2018). Moreover, Allport (1961) theorised that clients may use humour to communicate feelings of rebellion and frustration, and so express their true feelings, while hiding behind the cover of humour.

2.4.3 Humour in Psychotherapy: Research Evidence For and Against

There are few direct studies of humour within psychotherapy, but there are authors who have addressed the topic. Taking a particularly negative stance are psychotherapists such as Kubie (1971), who viewed humour as destructive and dangerous, as it could stop the patient’s stream of thoughts and feelings (Marci et al., 2004). Consequently, Kubie suggested humour should only be used in a very limited manner in psychotherapy. However, it should be noted that Kubie’s ideas are based on anecdotal evidence (Marci et al., 2004). Additionally, Kuhlman (1984) felt that if humour is ill-timed, it can impair the therapeutic process by reducing trust.

On the positive side, a review by Saper (1987) concluded that when humour is integrated in a meaningful way by a psychotherapist, it can benefit clients. Also, Bader (1993), suggested humour can be most meaningfully employed when there is an impasse or when resolving defences, or can even work as a metacommunication regarding the therapist’s own internal emotions, which could imbue safety and confidence in the relationship for the client (Gibson & Tantam, 2017).

Also on the advocate side, Richman (1996) stated that sensitively applied humour could enrich therapy, by drawing therapist and client closer and increasing their mutual enjoyment. Moreover, Lemma (2000) suggests that failures and disappointments in therapy can feel more tolerable with successful integration, and humour is one method for creating such integration (reported in Gibson & Tantam, 2017).
While many of the examples provided above support the use of humour within psychotherapy, this literature mainly consists of statements of support, personal perspectives and clinical examples, which have been referred to as “advocacy literature” by Saper (1987, p. 363, review Sultanoff, 2013), and there is very sparse empirical research to support the use of humour. Sultanoff (2003) is one of the few theorists to present a model for humorous interventions that included a clinical rationale and theoretical basis for its use. The model suggested that humour can help change clients' feelings, behaviours, thoughts and biochemistry (Sultanoff, 2013).

Only two quantitative studies, have been undertaken to date; the first of these is Marci et al. (2004), which looked at laughter, a correlate of humour. This study reported the frequency of laughter and skin conductance responses for 10 patient and therapist pairs during a videotaped psychodynamic therapy session. The findings indicated that patients laugh more than twice as often as therapists and when patients laughed, it was usually following their own comments. However, therapists were also more likely to laugh in response to comments from patients, rather than their own comments (Marci et al., 2004).

Interestingly, Marci’s (2004) study also showed that during shared laughter episodes, skin conductance responses were higher in patients than when they laughed on their own, indicting greater arousal for patients during these times. This finding indicates interpersonal laughter is highly coordinated and shared laughter is a co-constructed activity, which may play a role in supporting the therapeutic alliance (Marci et al., 2004).

The only other quantitative study (Panichelli et al., 2018), examined the association between humour and different therapeutic outcomes in a group of 110 psychotherapy clients. Here both clients and therapists evaluated the frequency and intensity of humorous events, how effective therapy was, and a measure of therapeutic alliance. The authors observed a strong positive correlation between presence of humour within therapy sessions and therapy effectiveness from both the clients’ as well as the therapists’ perspectives. The authors also indicated that more
research is needed to determine whether humour enhances outcomes or whether positive outcomes trigger the occurrence of humour (Panichelli et al., 2018).

Qualitative research exploring humour in the therapeutic setting is also limited. Indeed, Gibson and Tantam (2018) are the only researchers to date, to have reported a qualitative study on the use of humour in therapy, where they examined therapists’ experiences. The study results showed that “humour is a way of the therapist reaching out to the client and the client reaching out to the therapist”. When they examined the theme of reaching out more closely, they found careful use of humour can help develop an existential maturity, and can help clients to realise mistakes or ambiguities in their way of being with a mostly positive impact (Gibson & Tantam, 2018). The study also reported that humour heralded psychological shifts in clients, but did caution however that if the timing is wrong, or the therapist uses humour defensively, it can limit the psychotherapeutic process, by obscuring or preventing self-awareness and/or interrupting deep understanding.

Some limitations are reported in Gibson and Tantam’s (2018) study, one of which was that participants focused strongly on the positive impact of humour and neglected the negative. The authors suggest future studies could mitigate against this by using client participants, who might be more forthcoming about the negative side of humour.

2.5 Summary

In summary, there is a rich seam of literature examining the nature of humour, and its proposed function and purpose in humans. Much also has been made of the role of humour within psychotherapy, with some theories proposing humour can support the therapeutic alliance, but there has been very limited research to confirm such theories. The current study seeks to address the role of humour within the therapeutic alliance, and examine clients’ perceptions of humour within psychotherapy, such as its impact on their personal process.

Two research approaches will tackle these questions, firstly using quantitative methods to survey clients’ experiences of humour within their personal therapy, and rate the strength of the
therapeutic relationship (a measure of therapeutic alliance). Kuiper (2012) suggests any study researching the role of humour, must clearly differentiate between humour styles. Therefore the HSQ is used, which measures four styles of humour (affiliative, self-enhancing, aggressive and self-defeating), not all of which lead to positive functional relationships (Martin et al., 2003). For instance, affiliative humour is self-accepting (Martin et al., 2003) and could help a positive therapeutic alliance develop (Nelson, 2008), while self-defeating humour, (poking fun at oneself), is used to ingrati ate and seek approval within relationships (Martin et al., 2003). Scores from each humour style will be correlated with participants’ rating of how good the therapeutic relationship is. Moreover, the study will examine the relationship between scores on the CHS, which examines how clients use humour to cope with stress in their daily lives, and clients’ perceptions of humour within therapy.

Additionally, the lack of qualitative work examining humour within psychotherapy was highlighted above, with only one study to date (Gibson & Tantam, 2018). The current study thus also qualitatively explores the function of humour within psychotherapy from the client’s perspective.

2.5.1 Expected Findings Quantitative

Based on the literature reviewed, the following hypotheses were made:

H1: A positive correlation between ratings of how well-matched clients and therapists are in their sense of humour, with ratings of the therapeutic relationship.

H2: A positive correlation between frequency of shared moments of laughter and ratings of the therapeutic relationship.

H3: A positive correlation with scores for the effectiveness of their therapists’ humour to influence changes in their feelings or thoughts, with ratings for the therapeutic relationship.

H4: A positive correlation between how helpful clients find humour is to their process and ratings of the strength of the therapeutic relationship.

H5: A positive correlation between scores on the CHS and self-instigation of humour.
H6: A positive correlation between an affiliative humour style and strength of therapeutic relationship, but a negative correlation between self-defeating humour style and strength of therapeutic relationship is predicted.
Chapter 3: Methods

3.1 Introduction

This chapter explains the research methodology of the study and how this methodology has shaped data collection and analysis. The chapter starts by describing the details of the research design, which is a mixed methods design. This is followed by a section on the data sampling and collecting procedures for the quantitative aspects of the study, as well the data analysis. There is another section describing the same areas of data sampling, collection and analysis for the qualitative portion of the study. The chapter finishes with an account of the ethical issues associated with the research.

3.2 Rationale for Research Design

The study utilises a sequential explanatory mixed methods design. Here, the quantitative data were collected first and analysed, followed by the qualitative data. Data analysis in such a design is typically connected, and integration occurs at the data interpretation stage and in the discussion (Hanson, et al., 2005).

Combining both qualitative and quantitative research methods enables researchers to better understand the research question at hand, and gives greater validity of the study findings, than using either approach in isolation (Creswell, 2009). The qualitative and quantitative data in this study were given equal priority and the study is therefore an equally dominant mixed analysis (QUAL + QUAN; Hanson et al., 2005).

3.3 Quantitative Method

The quantitative data consist of a survey of clients’ experiences of humour within their personal therapy as well as two short questionnaires, the Coping Humor Scale (CHS) (see Appendix 1) and Humour Styles Questionnaire (HSQ) (see Appendix 2).
3.3.1 Survey of Clients Experiences with Humour in Therapy

A paper and pen questionnaire with 11 items was created (see Appendix 3). The first 4 items collected participants’ demographic details (age, gender, year of training and number of hours of personal therapy completed (with current therapist)). In the rest of the questionnaire, one item asked participants, whether their therapist ever instigates humour within the session (frequently, sometimes, never) and in another separate question, participants were asked whether they themselves instigate humour (frequently, sometimes, never). The other 5 items queried (using 5-point Likert scales) whether client participants perceive their therapists’ humour as helpful to their therapeutic process; how effective they feel their therapists’ humour is at instigating change; how well matched they feel they and their therapist are in terms of sense of humour; how often they share laughter; and a rating of how good the therapeutic relationship is.

3.3.2 Coping Humour Scale (CHS)

The CHS (Martin & Lefcourt, 1983) was designed to assess the degree to which individuals report using humour to cope with stressful events. It contains seven items that are self-descriptive statements such as, “I have often found that my problems have been greatly reduced when I tried to find something funny in them”. Each item is rated on a 4-point scale from Strongly Agree (1) to Strongly Disagree (4). Higher scores on the scale correlate with an individual’s tendency to use humour to cope with stress. The measure has high internal consistency and Cronbach alphas of .70 to .79 have been obtained (Martin & Lefcourt, 1983).

3.3.3 Humour Styles Questionnaire (HSQ)

The HSQ (Martin et al., 2003), consists of 32 items measuring four different styles of humour. Each item is measured using a 7-point Likert scale from “totally disagree” (1) to “totally agree” (7). Two of the humour styles can be described as adaptive (affiliative and self-enhancing humour) in relation to psychological well-being, and two are maladaptive (aggressive and self-defeating humour) (Hugelshofer, Kwon, Reff, & Olson, 2006). In relation to affiliative humour,
questionnaire items ask about sharing humour such as telling jokes and making others laugh. Self-enhancing humour questionnaire items focus on whether there is a tendency to maintain a humorous outlook on life and do individuals tend to cheer themselves using humour (Martin et al., 2003). For the self-defeating humour style, items examine whether individuals laugh along when others put them down or hide their feelings using humour. Aggressive humour style questions focus on ridiculing and putting others down or using humour in an offensive way (Martin et al., 2003). When tested for internal consistency, Martin et al., (2003) found Cronbach’s alpha values, ranging from .77 for aggressive humour style to .81 for self-enhancing.

3.3.4 Sample Collection

The target population were male and female clients, who were also trainee-psychotherapists. Inclusion of clients who were trainees, was due to having a ready pool of students engaged in their own personal therapy within a college, as well as the time constraints of this project, which severely limited the ability to access clients in the public sphere, rather than having a desire to specifically use trainee therapists per se. To keep the sample as homogenous as possible, only trainees who were in their first two years of training, and who had not yet commenced clinical work were recruited.

Participants were recruited from two different courses of an undergraduate programme (second years only) and a postgraduate programme (first and second years) within a single college, but both sets of participants undergo the same integrative and humanistic approach to training. The researcher recruited by attending the end of student classes and inviting students to read an information sheet (Appendix 4) about the study. Students were given time to read the information sheet, and if they consented to take part, they could then fill out the questionnaire and scales.

3.3.5 Study Participants

The study sample consisted of 72 (female N=59 and male N=13) participants. Students from the undergraduate course constituted 19.4% of the sample (14 students), with a further 18.1 % (13
students) from the second year postgraduate course, and 62.5% (45 students) from the first year of the postgraduate course. The age range was from 23 to 55 years (mean age = 32.92; SD = ±7.73).

3.3.6 Data Analysis

Total CHS scores were entered into the Statistical Package for the Social Sciences (SPSS). Scores for each of the different humour styles from the HSQ were also entered as individual variables into SPSS. Other factors entered were the demographic data and survey question answers.

Six participants indicated their therapists’ humour did not affect any changes in them, and subsequently did not answer part B of this question: what form the change took; thoughts, feelings or behaviour. This additional part B had not been intended to be included in the multiple regression analyses, therefore the missing data were not dealt with any further.

There was 1 participant who reported never having initiated humour within their sessions, as well as their therapist never initiating humour, moreover this participant also left blank 3 other questions. This participant’s data was therefore removed from the analysis.

A series of standard multiple regression analyses were carried out on the remaining 71 participant’s data, to test the predictive value of several predictor variables on single criterion variables.

3.4 Qualitative Method

The qualitative research used semi-structured interviews, which aim to understand the world from participants’ perspective and reveal the meaning of people’s experiences (Kvale, 1996). The data from these were analysed using a thematic analysis, to understand in depth clients’ experiences in therapy with humour. Qualitative thematic analysis was chosen, as this type of analysis can help researchers detect patterns and themes in the data, which can lead to a rich foundation from which to explore theory (Langdridge, 2004). Thematic analysis was chosen rather than other methods of qualitative analysis such as IPA, which maintains a more idiographic
focus on data, as thematic analysis allows greater theoretical freedom and is a more flexible research tool, and it can still potentially provide a rich and detailed, yet complex account of data (Braun & Clarke, 2006).

3.4.1 Recruitment of the Sample

After collecting the survey data, the researcher invited students to take part in future research (explaining this would entail an individual face-to-face interview), to write their e-mail address on a sign-up sheet handed around the classroom. From the original 72 participants who had volunteered for the initial part of the study, 22 participants gave their email addresses for future contact. Approximately two months after the survey, 5 email addresses were randomly chosen from those who had expressed interest, and individuals were invited to take part. The researcher waited 4-5 days for a response, before emailing another random choice of 5 addresses, until enough participants had responded. From the original 22 interested, 19 participants were contacted, from which 7 replied and 6 ultimately interviewed. The individual who was not interviewed was due to timetabling difficulties in arranging a meeting time.

3.4.2 Data Sample and Collection

After reading Information Sheet (B) (see Appendix 5), participants (female N = 5; male N= 1) spoke with the researcher in a semi-structured interview, within college premises and recorded using a digital recorder, with participants’ permission (See Appendix 6, Consent Form). Participants ages ranged from 29 to 55 (mean 35.5), with 1 undergraduate participant and 5 postgraduates (3 in year 2; 1 in year 1). It is important to note that participants’ identities have been protected by the use of pseudonyms (see table 1 below for pseudonyms, and demographic information).
Table 1

Pseudonyms for interviewees, together with their age, gender, hrs of therapy and year of training.

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Age</th>
<th>Gender</th>
<th>Hrs Personal Therapy</th>
<th>Year of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Lara</td>
<td>29</td>
<td>Female</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>2) Olga</td>
<td>55</td>
<td>Female</td>
<td>&gt; 50</td>
<td>2</td>
</tr>
<tr>
<td>3) Mel</td>
<td>32</td>
<td>Female</td>
<td>&gt; 40</td>
<td>2</td>
</tr>
<tr>
<td>4) Connor</td>
<td>36</td>
<td>Male</td>
<td>&gt; 40</td>
<td>2</td>
</tr>
<tr>
<td>5) Deirdre</td>
<td>27</td>
<td>Female</td>
<td>&gt; 40</td>
<td>2</td>
</tr>
<tr>
<td>6) Fiona</td>
<td>34</td>
<td>Female</td>
<td>&gt; 40</td>
<td>2</td>
</tr>
</tbody>
</table>

From the start, participants were informed of the research question and that the interview would be recorded for later transcription. The interviewer used a question guide with open-ended questions (see Appendix 7), which allowed participants to share their experiences in their own words. Prior to data collection, the research questions were presented informally to student peers for their opinions, and then to the research supervisor for approval. The researcher was open to additional information that could arise during the interviews and so was flexible regards the interview structure and format.

The interviews were approximately 40 minutes in duration and the main interview questions were. “What do you think humour adds to your relationship with your therapist?” and “How do you think humour impacts on your personal process?” This type of questioning is thought to help qualitative interviews be an “in-depth mutual exploration of the phenomenon as it appears and is understood from the perspective of the participant’s lifeworld” (Eatough, 2009).

3.4.3 Qualitative Data Analysis

After each interview, the recordings were transcribed verbatim and analysed using the thematic methodology of Braun and Clarke (2006). According to Braun and Clarke (2006) there are 6 phases to thematic analysis which are: 1) Familiarisation with the data; 2) Coding; 3) Searching for themes; 4) Reviewing the themes; 5) Defining and naming themes; and 6) Writing-up the analytic narrative.
These steps were followed closely, in that the transcripts were initially read and re-read several times, to become as familiar as possible with each participant’s account, and some initial notes were made (Braun & Clarke, 2006). Next the data were coded, bearing in mind that this was a theoretical thematic analysis rather than an inductive one (Maguire & Delahunt, 2017), which meant that each segment of data that seemed relevant to the research question was coded, rather than coding every single line. Open coding was employed, so that codes were developed and modified as the researcher worked through the coding process.

Initially, a short description of each data segment was generated, which aided in coding the data and identifying the hierarchical structure of themes. The structure for developing the themes within each transcript began with an emerging theme, which led to the development of subthemes and then major themes (see Appendix 8, coded transcript example for participant ‘Fiona’). This was repeated across all transcripts, and the generated themes were reviewed, so that additional themes were added or alterations of themes occurred. Also in this step, themes were cross-referenced to salient topics in the literature. The review stage led to the many subthemes and major themes finally being whittled down to just three main themes, each of which had a few subthemes.

3.5 Ethical Issues

This study was approved by the Dublin Business School Ethics committee prior to commencement.

3.5.1 Confidentiality

All participants received an information sheet about each study part, informing them of its nature and were assured that all data collected would be anonymised, treated with full confidentiality and not be identifiable as theirs.

All survey and scale information collected was anonymised using codes known only to the researcher, and stored in a password protected folder, which only the researcher has access to. This data will be deleted 3 months post submission. Regarding the interview data, the write-up
of the results was careful to anonymise the interviewees. Audio files from the interviews are stored on a password protected computer until 3 months post-submission, and thereafter they will be deleted.

3.5.2 Informed Consent

Each participant was informed of the voluntary nature of the study and the right to withdraw at any point; before, during or after participation. Participants were issued with consent forms either as part of the invitation to participate in the survey, and again before the interview section.

3.5.3 Debriefing

After each interview a short 5 minute debrief took place. None of the participants described uncomfortable feelings about anything that had arisen in the interview, and there was no need therefore to provide any further advice.
Chapter 4: Results

In this chapter, results from the quantitative portion of the study are presented first, and include the descriptive statistics, as well as multiple regression analyses of the questionnaire and scale data. The qualitative results follow next, with descriptions of the themes that emerged from the data after thematic analysis. Also included are excerpts from the participants’ transcripts that substantiate the themes. Appendix 8 provides the full transcript of an example interview. Pauses present in the transcript are marked as “…” and other paralinguistic properties are noted in the same appendix. Theories that arise and deserve further exploration will be noted and will then be discussed in Chapter 5. Relevant links between the quantitative and qualitative work will also be examined in Chapter 5.

4.1 Quantitative Results

4.1.1 Descriptive Statistics for Demographic Data

The tables below provide descriptive statistic (frequency and percentages) for gender distribution (table 2), year group distribution (table 3) and number of hours of therapy (table 4) completed.

**Table 2**

*Frequency and percentage of the data sample for gender*

<table>
<thead>
<tr>
<th>Gender</th>
<th>No. of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>58</td>
<td>81.7</td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>18.3</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 3  
*Frequency and percentage of the data sample year groupings*

<table>
<thead>
<tr>
<th>Year Groups</th>
<th>No. of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>BA2</td>
<td>14</td>
<td>19.7</td>
</tr>
<tr>
<td>HDip1</td>
<td>44</td>
<td>62.0</td>
</tr>
<tr>
<td>HDip2</td>
<td>13</td>
<td>18.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4  
*Frequency and percentage of the number of hours personal therapy with current therapist.*

<table>
<thead>
<tr>
<th>Hours of Therapy</th>
<th>No. of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>10</td>
<td>14.1</td>
</tr>
<tr>
<td>5-10</td>
<td>16</td>
<td>22.5</td>
</tr>
<tr>
<td>10-15</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>15-20</td>
<td>3</td>
<td>4.2</td>
</tr>
<tr>
<td>20-30</td>
<td>12</td>
<td>16.9</td>
</tr>
<tr>
<td>30-40</td>
<td>8</td>
<td>11.3</td>
</tr>
<tr>
<td>&gt; 40</td>
<td>20</td>
<td>28.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Most frequent response was > 40 hours therapy and least frequent response was 10-15 hrs

4.1.2  Survey Results

4.1.2.1  *Shared Laughter*

When asked if they ever share laughter with their therapist, participants responded with 80.3% saying sometimes, while 9.9 % never share laughter, and an equal number said they frequently share (9.9%).

4.1.2.2  *Therapists Humour Helpful to Clients Process*

Most participants claimed to find their therapists’ humour helpful to their process, with 43.7% finding it mostly helpful and 12.7% finding it very helpful. 25.4% found that humour was helpful sometimes, while 9.9 % thought it was mostly unhelpful and 1.4% said it was not at all helpful.
4.1.2.3  Who Initiates?

Only 4.2% stated their therapist frequently initiates humour (figure 1), and 76.1% reported their therapist sometimes initiates humour, while 19.7% stated this never occurs.

In contrast, 38% of participants said they frequently initiated humour in their sessions, and a little over half (56.3%) reported sometimes initiating humour (figure 1). While 5.6%, described never initiating humour. No participants reported that neither they nor their therapist ever initiate humour.

**Figure 1**
*Percentage values for the initiation of humour by therapists (a) and clients (b)*

![Pie chart A) Therapist Initiates Humour (percentage)](chart.png)

![Pie chart B) Client Initiates Humour (percentage)](chart.png)

4.1.2.4  Matched Humour

The majority of participants believed they and their therapist had well matched sense of humour (36.6%), while 15.5% thought that they were very well matched. 29.6% of the sample thought they matched sometimes. However, 12.7% believed they and their therapists’ humour was somewhat unmatched and 5.6% thought they were not at all matched (See Figure 2).
4.1.2.5 Can Humour Lead to Changes Within the Client?

7% of participants found their therapists’ humour is not at all effective in causing changes, and 18.3% said it was mostly ineffective. 43.7% were undecided rating it as neither effective or ineffective. A further 18.3% believed it was effective, and 7% thought it was very effective. In part (B) of this question, participants were asked what changes occurred - thoughts, feelings and/or behaviour. 38% reported changes to their thoughts, 32.4% to their behaviour and 67.6% to their feelings. As noted above, 6 individuals had missing data on this part (b) and percentage data are from a total of 65 participants.

4.1.2.6 Strength of Therapeutic Relationship

Most participants rated their therapeutic relationship as good (40.8%) or very good (32.4%). At the opposite end, just 1.4% rated their relationship as very poor, and 2.8% as poor. While 22.5% of participants rated the relationship as neither good nor poor (See figure 3).
4.1.3 Scale Data (Humour Styles Questionnaire (HSQ) and Coping with Humour Scale (CHS))

Provided below are the descriptive statistics for CHS and HSQ values in Table 5.

4.1.3.1 CHS

The mean value for CHS (N= 71), was 19.88, SD = ± 3.8 with the minimum value a score of 11 and maximum score of 28.

4.1.3.2 HSQ

Table 5
Descriptive statistics for HSQ data.

<table>
<thead>
<tr>
<th>Humour Style</th>
<th>No. of Participants</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affiliative</td>
<td>71</td>
<td>22</td>
<td>56</td>
<td>45.30</td>
<td>± 7.56</td>
</tr>
<tr>
<td>Self-enhancing</td>
<td>71</td>
<td>10</td>
<td>54</td>
<td>35.23</td>
<td>± 9.19</td>
</tr>
<tr>
<td>Aggressive</td>
<td>71</td>
<td>9</td>
<td>41</td>
<td>26.69</td>
<td>± 8.05</td>
</tr>
<tr>
<td>Self-defeating</td>
<td>71</td>
<td>14</td>
<td>54</td>
<td>31.08</td>
<td>± 9.45</td>
</tr>
</tbody>
</table>

Number of responses, minimum and maximum scores, mean scores and standard deviation are displayed.
4.1.4 Multiple Regression Analyses

Preliminary analyses were carried out to ensure that there were no violations of the assumptions of normality, linearity, multicollinearity and homoscedasticity for any of the multiple regression analyses presented below.

4.1.4.1 Survey Measures and predicting the strength of the therapeutic relationship

To test hypotheses H1-H4 a standard multiple regression analysis explored how 6 different measures from the survey (therapist initiates humour; number of hours of therapy; therapists’ humour helpful to process; shared laughter; matched humour; change brought by humour) can predict the strength of the therapeutic relationship.

The total variance explained by all predictors was 49.4% of the variance in the strength of the therapeutic relationship and had quite significant explanatory value. As the sample size of the study population was relatively small, this value was taken from the adjusted $R^2$ statistic, which corrects the $R$-square value to provide a better estimate of the population value (Tabachnick & Fidell, 2013) (adjusted $R^2 = 0.494$, $F(6,67) = 11.24$ $p = < 0.001$).

The model showed the strongest significant standardised regression coefficient was the predictor variable for matched humour, $\beta = 0.63$, $p < 0.001$, (showing a positive correlation) and explained 24% of the variance in the therapeutic relationship. ‘Therapists’ humour helpful to process’, had the second strongest significant standardised regression coefficient $\beta = 0.34$, $p < 0.01$ (also showing a positive correlation) which explained a further 5% of the model.

From these results, the null hypothesis is rejected and the alternative H1 accepted, that there is a positive correlation between ratings of how well-matched clients and therapists are in their sense of humour, and ratings of the therapeutic relationship. Also, the alternative hypothesis H4 is accepted, of a positive correlation between how helpful to their personal process clients find their therapists humour and ratings of the therapeutic relationship.
In the case of H2 and H3, the null hypothesis is accepted and there is no relationship between frequency of shared moments of laughter and ratings of the relationship or between the helpfulness of their therapists’ humour to effect emotional or cognitive changes, with ratings for the therapeutic relationship.

4.1.4.2 Correlation between CHS scores and survey measures.

A standard multiple regression analysis tested whether shared laughter, therapist humour helpful to process, therapist humour leads to change, hours of therapy, and self-initiates humour, were predictors to scores on the CHS. This multiple regression also allowed testing of the hypothesis H5: a positive correlation between scores on the CHS and self-instigation of humour. The analysis revealed that the variance explained by the model was 14.8% (R² = 0.148, F (5,66) = 2.26, p = 0.059). The effect of all the predictor variables combined, however, did not have explanatory value in relation to CHS scores. Although it was found that the predictor self-initiates humour had a significant positive correlation with scores on the CHS (β = .269, p < 0.05), and explained almost 7% of the variance in the scores CHS.

Therefore, the null hypothesis can be rejected and the alternative H5 accepted, which suggests the more likely a client is to use humour as a coping strategy in everyday life, the more likely they are to instigate humour within the therapy room. The other predictor variables had no significance in predicting scores on the CHS.

4.1.4.3 Correlation between scores for affiliative humour style and survey measures.

A multiple regression analysis examined whether shared laughter, humour helpful to process, therapist humour leads to change, strength of the relationship, and self-initiates humour, were predictors to scores for affiliative humour style. The variance explained by the model was 15.3% and was borderline for significance (R² = .296, F (5,66) = 2.36, p = 0.050). The predictor, self-initiates humour, most strongly predicated scores for affiliative humour style (β = .32, p < 0.001), and explained about 9.6% of the variance. No other predictor variable had significance in predicting scores for affiliative humour style.
From these, the alternative hypothesis H6 can be rejected, and there is no correlation between affiliative humour style and strength of therapeutic relationship. Although, the result does suggest the greater the use of an affiliative humour style, the more likely clients are to initiate humour, there was no hypothesis formulated to predict this result.

**4.1.4.4 Correlation between scores for self-defeating humour style and survey measures.**

A multiple regression analysis (standard) assessed whether shared laughter, humour helpful to process, therapist humour leads to change, strength of the relationship, and self-initiates humour, were predictors to scores for self-defeating humour style. The variance explained by the model as a whole was 29.6% and had significant explanatory value ($R^2 = .296$, $F (5,66) = 5.47$, $p < 0.001$). The predictor, self-initiates humour, had a strong positive correlation with scores for self-defeating humour style ($\beta = .406$, $p < 0.001$), and explained 14.75% of the variance. Thus, the more likely an individual is to use a self-defeating humour style (where they put themselves down), the more likely they are to initiate humour in therapy.

The strength of the relationship also had a negative correlation with self-defeating humour style and explained a further 8.8 % ($\beta = -.349$, $p < 0.01$). Interestingly, this correlation suggests that the greater the amount of self-defeating humour that a client uses, the lower they rate the relationship with their therapist.

The results also show the greater the use of a self-defeating humour style, the more likely clients are to initiate humour, and the more negatively they rate their relationship with their therapist; however, there were no hypotheses formulated to predict these results.

**4.1.4.5 Correlation between scores for aggressive humour style and survey measures.**

A standard multiple regression analysis tested whether shared laughter, therapist humour helpful to process, therapist humour leads to change, strength of the relationship, and self-initiates humour, were predictors to scores for aggressive humour style. The variance explained by the model as a whole was just 8%, and was not significant ($R^2 = .082$, $F (5,66) = 1.17$, $p = 0.34$).
4.1.4.6 Correlation between scores for self-enhancing humour style and survey measures.

A standard multiple regression analysis explored whether shared laughter, matched humour, therapist humour helpful to process, therapist humour leads to change, hours of therapy and self-initiates humour, were predictors to scores for self-enhancing humour style. The variance explained by the model as was just 2.6% ($R^2 = .026$, $F (5,66) = 0.35$, $p = 0.88$), and the effect of all the predictor variables combined therefore did not have explanatory value in relation to self-enhancing humour style scores.

4.2 Qualitative Results

Interviews from six participants were transcribed and coded using a thematic analysis approach as described in the methods section. From this analysis three themes unfolded: 1) emergence of humour; 2) emotional and cognitive shifts; 3) perceived function of therapist’s humour. Within each theme there were also consistent sub-themes (see Table 6).

Table 6.
Table of themes and associated subthemes

<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUBTHEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergence of Humour</td>
<td>Initial Slowness</td>
</tr>
<tr>
<td></td>
<td>Heavy Boundaries</td>
</tr>
<tr>
<td></td>
<td>Safety and Trust</td>
</tr>
<tr>
<td>Emotional and cognitive changes</td>
<td>Relief</td>
</tr>
<tr>
<td></td>
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4.2.1 Emergence of Humour: Can I laugh now?

The theme of ‘emergence of humour’ was apparent in all participants interviewed. This theme stood out as there was marked consistency in participants expressing their hesitancy to use humour in the initial stages of therapy, and it seemed as though they had a question in their mind of, ‘Can I laugh now?’ Within this theme, there was also a number of prominent subthemes; the first, discussed here, is initial slowness in the emergence of humour.

4.2.1.1 Initial Slowness

4 of the 6 participants (Olga, Mel, Connor and Deirdre) described how humour took at least several months to appear. Moreover, the moment participants decide humour can enter their personal therapy, seems to coincide in their mind, with when they feel comfortable with their therapist and have made a connection, or there was ‘a click’ (Deirdre).

For instance, Olga described how it took a long time for any humour to become apparent within her sessions and later talked of humour coming in when her therapist ‘got her more’:

\begin{quote}
O8: It has taken it a long time for it to come into it. I think he’s quite a serious fellow my therapist. Am…Oh it took maybe …… four or five months before it really lightened up.
R14 (Researcher): And how do you think humour started to come in?
O13: Eh…I think, am… Almost accidentally…. I’d say when the relationship had, had, really got somewhere. …. I think around that time there was a definite shift in the relationship and I felt more that… I felt he got me more.
\end{quote}

Mel spoke of a longer period of time for humour to appear in her sessions (approx. 1 year), though she also talks of how this then became too much at a later point.

\begin{quote}
M71: So it came in …, kind of probably midway through the two years with her. I’d say that would be true. So there has been a change over time. And for no humour, then it kind of came in …, and now and then became a little bit suffocating.
\end{quote}

Also Deirdre spoke of humour arriving after 6 months, following which there was a deeper connection or ‘click’ with her therapist:

\begin{quote}
D43: … when I realised we had a similar sense of humour ..... I probably would have held myself back that little bit, because he was a therapist, and it wasn’t making a new
\end{quote}
friend… So obviously, I was very guarded. But when I realised that we had a similar ..., I was like, Okay! ...., it was that click that I really needed with him to understand, this is .... going to work out fine

**R42 (Researcher)** Am..., when did you realise that he had that?

**D46**: It probably took about six months.

Two other participants (Lara and Fiona), said humour became more natural over time or talked of still working out if they could reveal more of their humour then they had already. Lara was relatively new to therapy (15 sessions), and talked of still evaluating her therapist and sizing her up, in order to work out if she could ‘to let go’ and be humorous.

**L42**: So it has evolved. .... and ..... it’s probably true of just, if you’re going for therapy. ..... but you’re also inclined to evaluate your therapist a bit. Checking them out to see if, like, are they talking nonsense?

Also, she mentions that humour requires two people to ‘click’.

**L44**: I think the humour is part of it. It’s a bit like do you..., it’s almost kind of like a relationship, do you click with the person.

Fiona however, claimed that humour had been there right from the beginning, yet she later talked about holding back in her humour out of a sense of respect for the relationship, and that overtime she has allowed her humour to be expressed more openly:

**F133**: ... it becomes more natural, more comfortable, the more I think that’s, the side effect of the development of the relationship.

### 4.2.1.2 Heavy Boundaries

Another prominent subtheme in ‘emergence of humour’, was of heavy boundaries too rigid to allow humour in. Here, participants’ frequently described therapy as a serious event and worried that if they used humour, it might suggest they were not taking therapy seriously. Some also evaluated their therapist, almost to determine whether humour was allowed. Others outrightly expressed that therapy involved more boundaries than normal, which limited their humour. This is not a theme already present in the literature and may be particular to this sample as they are
trainee therapists, who may have held back more than typical clients, perhaps out of a sense of professionalism.

For example Fiona says:

\[F62\ldots\text{ It's like the boundary between the therapist and the client. That's I think, that needs to be there for the relationship to work because she's not ..... your friend.}\]

Then later:

\[F126\ldots\text{ not laughing too much or engaging too much in humour because ..... you get to a certain point where you don't engage in too much humour because it's almost like you're not taking this therapy seriously. Like you're, you don't give the impression that you're not engaging in the relationship respectfully.}\]

While Lara expressed a difficulty in knowing when she could use humour:

\[L4: \text{I think there is always ah, a sort of a grey area of ah.. what humour is acceptable and ah.. when humour is acceptable. So it's interesting even the psychotherapy part, how appropriate is it within that setting?}\]

And much later:

\[L103: \text{Yes. Such odd boundaries compared to other.... It's like so incredibly intimate at times. And then there's, there's really definitely boundary}\]

Additionally, Mel spoke of holding back on her humour out of a sense of respect for her therapist’s age (there also seems to be a grandparent transference), and feeling it was too dark for the therapist:

\[M17: \text{I am very conscious of that. I do hold some things back, because I'm conscious of her, it's almost like a grandparent.}\]
\[M21: \text{I would find my sense of humour would be quite sarcastic, a little bit darker..... it certainly wouldn't be that kind of humour that I would bring to this person}\]

Connor talked of personally enforcing a greater sense of boundaries within his therapeutic relationship:

\[C24: \text{And even actually how I sort of treat my relationship with my therapist, it's very, I like to put boundaries there}\]

While Olga implied she tried to work out the boundaries of therapy before going to humour:
067: ..... having never ever been in therapy before .... it was safer not to do it. It was just safer to keep everything pretty serious.

068: Keep the timing right .... to build up, a sort of a .... an expectation of what therapy hour looks like. ..... And to have that all worked out quite nicely before that came in.

4.2.1.3 Safety and Trust

Two key ingredients required for the client’s own humour to emerge were feelings of safety and trust within the relationship, which leads to a third subtheme of emerging humour. The moment clients decide humour is safe, appears to coincide with feeling comfortable in the relationship. This is also the point when participants felt they could go deeper with their emotions. There are variances though in the perceived causality, with clients either deciding humour allowed them to feel safer to be open with emotions, or waiting for feelings of safety and trust, before introducing humour. Below are examples from Lara, Olga, Mel and Fiona in relation to the subtheme safety/trust:

L43 (Lara): .... so it evolves, .... when you can start to just trust a bit more and let go of that. ..... there has to be an element of sizing someone up because..., you have to have a sense of whether you can trust them

O61 (Olga): .... I think it's interesting even when I'm thinking about it .... this feeling that the handshake came at about the same time as it (humour) came, so obviously I think there was, a feeling of safety before it ever came in.

M120 (Mel): ....but with my own experience, I've seen that it's difficult. I think it's a real balancing act...., and I think it would require a huge amount of trust

F143 (Fiona); ... humour is a kind of nice tool for like an introverted type..., to put the toe in the water and step out again, in a safe way. ...... whereas, humour allows me to..., a safe expression of feelings and emotions

Deirdre described feeling that because of humour she could transition into something deeper:

D38:...... So it’s [humour] ..... nearly a transition for me to go into then and he’s like, yeah, and then we'll go further.

This sentiment was echoed by Connor:
C66: I may be open initially, if I’m relaxed and find something funny, but then the conversation might start to take a serious turn. But I don’t think it would have started to turn that way, or am…, gotten serious had I not actually started light about it.

While Fiona talked in terms of humour within her therapy leading to deeper exploration:

F88: ...., if that was through humour, then it’s almost like it's, it’s almost like the humour is like an accelerated process of dealing with something.

F89....rather than if it was just totally ruining. I think humour helps you to kind of shift on

4.2.2 Emotional and Cognitive Shifts

Humour marked definite ‘emotional and cognitive shifts’ for all participants, and hence it was a major theme to emerge. This theme can be divided into 3 subthemes, the first of which is a sense of relief.

4.2.2.1 Relief

Humour often arrived after a cathartic moment, especially the expression of emotional pain, and it seemed to mark a shift from that discomfort, to a sense of relief. For many, after relief come feelings of absurdness or ridiculousness. Perhaps too, in finding humorous relief after catharsis, the further humour at the ridiculousness of the situation is a response to the incongruity of the different emotions?

Both Deirdre and Olga stated they felt relief when humour entered therapy whether initiated by them, or their therapist:

O59 (Olga) : I think from my own experience, it’s such a relief when it happens....

D96 (Deirdre): I sometimes that’s what I need in saying it. And then you just laugh it better. And I’m like, that was just eating me up inside and then I said it out loud and it’s like?

R94 (Researcher): So .... Relief?

D97: Big time
Connor stated how humour brought relief after experiencing intense sadness, but also a change in his perspective, where he could suddenly see the ridiculousness of the situation.

C28: I could probably have just said something that was really gut-wrenching, or something that made me cry. And then suddenly, I'll just kind of be laughing ..... It's almost like a relief laughter. But it's like, looking at the absurdity of ..., the situation.

Fiona talked at several points about laughter bringing a similar relief to crying and how easy it is to go from one to the other:

F122 : Okay, I'm gonna go for the laughter route because it's like I'm feeling this is the way to go... not to say that I don't cry in therapy, and it is relieving .... the same way that laughter is relieving. ...... it's actually really interesting how you feel the same way almost, after engaging in either ...... to the point where you might laugh until you cry

Equally, Fiona stated her humour has the function of firstly bringing relief and then allowing her to see the ridiculous:

F81: I think the first, the got to, is relieve the tension .... it’ll be, am ..., this is, ‘oh my god I’m laughing at it’. And then it’ll be like, oh how’s, how ridiculous is that.

Mel described her humour as easing uncomfortable emotions, and helping perceive the ridiculousness in a situation:

M95: I always laughed about it, because it’s so ridiculous. And ..... and the more I talk about it, the less scary it is..... because suddenly you can see the ridiculous aspect of it.

4.2.2.2 Revealing the Unconscious

Another subtheme present was revealing the unconscious beliefs and/or emotions of participants. Here study participants reported becoming aware of unconscious thoughts and finding the humour within that, or a new understanding of a connection between their emotion and cognition, highlighted by their humour. This also ties with the previous subtheme where clients found the ridiculous in their own situation which could be further viewed as revealing.

Olga talked of how the unconscious coming to the forefront brings her amusement:
O54 (Olga): And then you can say something that even to my own ears is extremely childish. And then you realize this sort of, this unconscious person still living on, in the adult, and that can be very funny when you actually catch yourself.

And later again:

O57 (Olga): it's more that something is revealed... and then ...... to make it bearable perhaps. Or to make it a little more acceptable to myself, or to sort of test it out, in a, in a lighter way.

Fiona talked of finding humour when something unconscious has been revealed:

F99 (Fiona): .... is that kind of like the unconscious coming in like that? That you're kind of like, confronted with something that you haven't really dealt with before. And you're like, Oh, my God that is, that was quite funny because it's, you know, that kind of when someone says it's funny because it's true?

......And then the funny part of it is - How did I not realize that before? Like, it's kind of having a lightbulb moment

Connor and Deirdre state that finding humour led to a new understanding:

C36 (Connor): Or sometimes as well, if I hear my words, repeated back to me ..... then..., I'm like, Oh, yeah, that that just sounds really funny .... it helps me kind of reflect on it differently.

D63 (Deirdre): Yeah, it was nearly like, the humour was the icebreaker of that part and it just cracked it. ..... And I could burst out laughing because I'm like- Did you just hear what I said! Like?

4.2.2.3 Reframing or Normalising

A final subtheme of ‘emotional and cognitive shifts’ that emerged, was of reframing or normalising, as participants variously stated humour was normalising or they had gained a sense of objectivity or perspective through using humour within therapy. This could be viewed as one way that humour makes difficult emotions more palatable for clients to deal with within the therapy room. Below are examples from 4 interviewees:

O46(Olga): And somehow, when you can laugh about it, it sort of lightens it, and there’s this feeling of well, normality almost. It sort of normalizes the situation.

C31 (Connor): Yeah. It’s like you’re laughing at yourself..., but it's like, Jaysus..., the head on me... Am ..., and it sort of gives me a little bit of a distance, it makes me think, it makes me think that something has been worked through.
L27 (Lara): ... it helps you to keep things in perspective a bit..., It’s almost like it removes you a bit from like, you can even get very embroiled in something and all the worry say that goes in through the sadness and am, sometimes it’s kind of helpful.

F81 (Fiona): ..... You’re rationalizing events through humour.

4.2.2.4 Return to Wellness

The subtheme of humour as return to wellness was present in only half the participant sample. However it was felt important to include, as it has been a question in the literature (Panichelli et al., 2018), whether humour leads to positive outcomes in therapy or positive outcomes lead to humour? The data examples below suggest the direction of causality between humour and wellness, namely that wellness arrives before humour can come in.

For instance, Connor found that after several months working through difficult material he moved from feeling very serious, to allowing humour in:

C56: .... early on in my therapy, I was very...... I was sort of in more distress, kind of going into it. .... I had much, much more of a seriousness going in..., whereas now I can ..., I feel a lot freer. And it doesn’t have to be as serious as anything as well.

Mel also indicates a change in tone within therapy after she had ‘purged’ everything:

M70: I went through the crying ..., and came out the other end. ..... then there was kind of a lull where you’ve gotten every feel, like you’ve gotten everything out. ..... that’s probably when the kind of humour came in. .... I don’t think it was there at the start, because things were too heavy.

For Fiona, there were points within her therapy where she felt low, and at those points she noticed an absence of her humour:

F136: It's kind of like .... my little flag. Like a metaphor, I suppose..., would be the, the ability to not make a joke or laugh is ..... it's like usually if there's no banter or jokes, there's something not right.
4.2.3 Perception of Therapists’ Humour

Participants’ ‘perception of therapists’ humour’ and its presumed function was very mixed. Broadly participants ranged from feeling their therapists used humour to try and mirror/match them, which created a sense of being understood (‘met’), to some perceiving their therapists’ humour as bringing them more into the here and now.

Connor and Mel stated their therapist mirrored their humour which made them feel met.

M77 (Mel): She would respond in kind, she would match ....my tone. ...... Am ..., she does, she does mirror quite a lot...., if I was smiling she would smile.... Yeah, she kind of meets me.

C41 (Connor): Or maybe light-hearted cursing.... And I kind of laugh .... it feels like a bonding..., that he’s not trying to change my words to suit an ideal, or to be more polite. It kind of feels like it's a matching. I feel like ‘okay, yeah, that's, that's me.’

While for Deirdre, Fiona and Lara their experience was their therapists’ humour led to a change in focus of their attention. For Deirdre and Fiona this change was into feeling more present.

D40 (Deirdre): I can see a humorous side looking now in hindsight on our sessions, he’ll go to a humorous side, and will bring me back into wherever we are, need to go.

F71 (Fiona): Like it.., allows us to be kind of present and... what's going on at the moment like ..,to be in the present moment. It sounds cheesy, but like, it brings you into the present ..... a little bit of humour it just causes such a shift , so quick.

For Lara, her therapist’s humour brought a matching and an altered awareness:

L52: A lot of time humour can be conveyed without making any jokes.... It can be ..... a very subtle thing...... I've definitely had that experience of some things reflected back and you kind of Oh?

While Olga believed it gave their work a renewed energy:

O52: I’d experience it as a sort of break. It sort of gives me a break and it gives him a break. It gives the whole atmosphere a break. And then we can sort of get back to it.

It is noteworthy there was no consistency in participants having a negative experience of their therapists’ humour, with only two individuals reporting anything negative. Deirdre stated her
therapist’s humour has on a “rare” occasion been “mistimed”, while Mel stated her therapist is sometimes “distracting” when she brings in humour.

4.2.3.1 Antidote

The only consistent subtheme from participants in their ‘perception of therapists’ humour’ was of it being metaphorically an antidote to the negative emotions they experience. In particular, Deirdre, described how her therapist uses anecdotes in their session, which she referred to (in a slip) as an antidote, and it fitted neatly her description of his humour being the antidote to her emotional suffering.

D30: He would tell me, nearly like slight humorous stories….. To have that little bit in it, it kind of eases me into a little bit more. ….. I feel more at ease, so I can sit in - what is going on easier. By not, feeling like I’m gonna crawl out of my skin. I’m relaxed then because it’s a joke. It’s an antidote then….no?

For others, the therapists’ humour (often anecdotes) as an antidote fitted as they described becoming more relaxed by it. The data examples below taken from interviews with Connor, Olga, Mel and Fiona, show this theme at play.

C65 (Connor): …. it helps me relax much more. …. because I think how he's reading the situation, I can kind of take a cue from that.

M34 (Mel): We were sharing these funny little stories …. where we were kind of frustrated at something silly ….. that kind of a thing, that she would kind of say probably yeah to amuse me.

O48 (Olga): And then he answered …. that quote. Yeah, we really got it. …, it was such a good quote, and…..we just sort of immediately laughed …. And sometimes it sort of breaks the atmosphere and you don’t have to go down the road of blaming and shaming.

F67 (Fiona): She kind of tells little anecdotes sometimes. To use an example like, if I'm stuck with something, she's like, “oh, I'll tell you a story about this person”……

F70 (Fiona): Think it brings us a bit closer. It's kind of like... It's like I don't I don't know if before I've said it …. it lightens the mood.

The meaning and implications of the 3 major themes just outlined, together with the quantitate data, will be considered next in chapter 5.
Chapter 5: Discussion

5.1 Introduction

This is the first mixed-methods research study to investigate clients’ experiences of humour within their personal therapy. The principal research questions were to examine whether humour aids the therapeutic alliance, and to assess clients’ perceptions of the role humour plays. These questions were approached from two different research angles.

Firstly, through a quantitative survey, the data indicated a significant positive relationship between clients feeling their humour is a good fit with their therapists’, and positive ratings of the therapeutic relationship. It was also observed that clients who found their therapists’ humour positively impacts on their process, are more likely to rate the relationship as robust.

The second research angle was via semi-structured interviews, from which the data produced three themes (examined in Chapter 4): the ‘emergence of humour’; ‘emotional and cognitive shifts’; and ‘perceived function of therapists’ humour’. Broadly, the data produced from the interviews were supportive of the survey results, indicating the importance for clients of engaging in humour within their therapy, and further confirmation that humour can enhance the therapeutic bond.

The current chapter compares the existing literature’s view on the role of humour within psychotherapy, to the findings in this study. Additionally, the data from both research angles will be compared and contrasted.

5.2 Humour and the Therapeutic Relationship

A connection between the emergence of humour and attachment formation in humans is still a matter of debate, but at the very least, humour has been proposed to enhance the development of satisfying relationships (Mireault et al., 2012). We also know that humour is associated with an increased capacity for intimacy and trust, necessary ingredients for attachment in adult relationships (Hampes, 1999; Cann et al., 2008). This view of humour as an aid to attachment,
especially in adults, led to theories that humour is beneficial to the therapeutic relationship (Gelkopf, 2011) and can help nurture the alliance, as it contributes to greater personal connection Cann et al., (2008).

The current study supports these theories, firstly via the survey data, where there was a positive correlation between clients’ perception of having a matched sense of humour with their therapist and how good they rated the relationship. The results additionally revealed that not all humour styles are equal, in terms of supporting the therapeutic relationship, as the greater the reported self-defeating humour style, the poorer the therapeutic relationship rating. This makes sense in light of other research showing that self-defeating humour can occur more frequently in those with an anxious attachment style (Cann et al., 2008), where individuals reportedly lack confidence in interpersonal relationship security (Brumbaugh & Fraley, 2010).

‘Emergence of humour’ as a theme in the interview data, supported a link between the presence of humour and a good therapeutic relationship. Humour typically seemed to arise when clients started to feel comfortable in the relationship. It was notable that this stood out to clients as a feeling of a sudden ‘click’, or that they had forged some connection with their therapist. This would fit with many theories that propose humour enhances the therapeutic alliance (Shaughnessy & Wadsworth, 1992; Gelkopf, 2011). In particular, it strengthens Cann’s (2014) proposal that humour helps to create the alliance, as it contributes to greater personal connection. Some clients spoke of intuiting their therapist had suddenly ‘got them’, which the study interpreted as a sense of acceptance, which tallies with Richman’s (1996) theory that humour deepens the therapeutic alliance by increasing clients’ feelings of acceptance.

Humour emergence when clients discern a connection with their therapist, could shed light on why having a matched sense of humour had a significant positive correlation with the relationship bond. This would also fit with what we know about relationships more broadly, for example when couples are asked what is important in their relationship, a shared sense of humour frequently features (Lemma, 2000). Perhaps, when clients feel well-matched (humour-
wise), this enables a better connection with their therapist, and could be expected to generate feelings of safety, which in turn feeds into the development of a better relationship. Although not consistent across all participants, some interviewees also described when their humour was mirrored/matched by the therapist, they felt well understood (‘met’). This complements the survey findings around matched sense of humour. The findings from both survey and interview around matched sense of humour, complement Marci’s (2004) skin-conductance study, which suggested shared laughter in therapy is a co-constructed activity, which may help support the therapeutic alliance.

Evidence that clients need to feel comfortable for humour to emerge, came from the subtheme of safety and trust as requirements. Alternatively, clients brought in humour, when they felt more at ease within the relationship. Trust is necessary for effective attachment in relationships, and humour may increase the capacity for intimacy and trust (Hampes, 1999). Other theorists propose therapists’ humour can aid clients’ trust (Squier, 1995) and cultivate safety (Bader, 1993). The current data suggest that clients’ own humour plays a significant role in fostering a safe environment. Perhaps most significantly, the ‘emergence of humour’ appeared to feed into clients’ ability to go deeper in their therapy work. This data then provides evidence contrary to popular opinion that clients who tend to use humour, do so to deflect from their emotions (e.g. Reynes & Allen, 1987). Rather here, there is evidence that clients’ ability to use humour can be an indication of trust in the relationship which allows enough feelings of safety for clients to deepen their process.

The marked initial slowness, for clients, in allowing their humour to emerge was a further subtheme. As stated in Chapter 4, this felt as though clients had the constant question in mind of, ‘Can I laugh now?’ For most, this meant a period of several months, before being able to bring in humour. Linked to the subtheme of slowness was the subtheme of heavy boundaries, which played a part in delaying the emergence of humour. Many participants described how initially the boundaries of therapy prevented them from allowing their humour to show. Here too
participants expressed how therapy was a serious affair, and worried that if they used humour, it might suggest they were not taking therapy seriously. This subtheme may be particular to the research sample as trainee therapists, who perhaps hold back more in their sessions than typical clients, out of a sense of professionalism.

5.3 Functions of Humour in Therapy: Emotional and Cognitive Influence

Sultanoff (2003) developed a model suggesting that humour can help change clients’ emotions, behaviours, cognitions and biochemistry. Similarly, Gibson and Tantam (2018) reported therapists found humour heralded psychological shifts in their clients. The results from the interview data provide evidence for clients’ own humour changing their emotions and cognitions, as described within the theme of ‘emotional and cognitive shifts’. The survey also found evidence of changes, however the questions focused on whether therapists’ humour was effective in bringing changes. The results revealed that therapists’ humour led to changes in clients’ thoughts (38% of cases) and behaviour (32.5%), and feeling (67.6%).

The subthemes of ‘emotional and cognitive shifts’, were relief, revealing the unconscious, reframing and normalising and return to wellness. These fit with literature on the proposed functions of humour in therapy (Dionigi & Canestrari, 2018). The first subtheme, relief, was an emotional change that accompanied participants’ humour, after emotional distress. This supports both the cathartic role of humour in psychotherapy, and also the extensive literature on relief theories of humour, which emphasise that humour arises when the psychic energy suppressing difficult feelings has become redundant, and is released as laughter (Morreall, 2016). Additionally, Hurley et al., (2011) theorise that humour results in relief from revealing negative thoughts, most likely by halting negative feedback cycles. The survey data showed that those who had high scores on the CHS were more likely to initiate humour within their therapy sessions. This is complementary to the idea that clients use humour to find relief, as it demonstrated that the more an individual uses humour in their everyday life to cope with stress, the more likely they are to use humour in therapy.
Relief expressed by clients in the interviews, was closely intertwined with feelings of ridiculousness, which tallies with incongruity theories of humour (Lemma, 2000). It was apparent from participants’ descriptions of humour at the ridiculous, that this frequently arose in response to the incongruousness of their differing emotions, such as finding they could suddenly laugh again after a moment of emotional distress. Sometimes however, feelings of ridiculousness arrived with a moment of clarity or a new sense of objectivity about a situation.

Reframing and normalising was an additional subtheme. This could be viewed as a cognitive shift that provided clients with a greater sense of objectivity of their experiences. As noted above, reframing through humour could be a way to make difficult emotions more palatable for clients.

Many previous authors have claimed the potential of humour for reframing (Panichelli et al., 2018), with one study finding a correlation between individuals’ sense of humour and perspective taking abilities (Kuiper, McKenzie, & Belanger, 1995).

Like dreams, the jokes we tell are another road to the unconscious (Lemma, 2000). One of the proposed functions of humour within the therapy room is to “allow the unravelling of the unconscious” (Korb, 1988) and another subtheme, the revealing of unconscious beliefs and emotions corresponds well with this theory. Participants found that when previously unconscious thoughts surfaced, this was suddenly amusing. Alternatively, they found that connections between certain emotions and cognition were highlighted to them by their humour.

Finally, there is a question in the literature of whether humour heralds positive outcomes in therapy or positive outcomes lead to humour (Panichelli et al., 2018). Certain groups of individuals e.g. those with depression, have reduced levels of humour (Kuiper, Martin, Olinger, Kazarian, & Jette, 1998) and medical practitioners consider an ability to take pleasure from life (including humour) as a marker of recovery (Demyttenaere et al., 2011). Although the subtheme a return to wellness was present in only half the participants, it was felt important to include as there was an indication of the direction of causality and participants remarked that humour seemed to come after they started to return to better emotional health. Despite not being a
clinical group, the fact participants still moved from a position of no-humour to humour, after working through difficult emotions seemed significant, as this effect might be much more significant for example in a group who are depressed.

5.4 The Therapist’s Humour

One of the proposed roles of a therapist’s humour is to create a relaxed and open space for conversation, thus disarming clients, and breaking down their resistance (Goldin & Bordan, 1999). The only other study to examine therapists’ use of humour, observed that therapists used it to reach out to clients (Gibson & Tantam, 2018). The data from the third theme, the ‘perception of therapists’ humour’, corresponds with these theories, as many participants suggested their therapists’ humour increased their feelings of safety in the relationship.

This theme highlighted how clients imagined their therapists’ humour as an aid to making the therapeutic environment more comfortable and relaxed, which further allowed the metaphor of therapists’ humour as an antidote (to emotional pain) to arise. An easing of their emotional discomfort most likely helps breaks down boundaries (Buttny, 2001), and could explain why humour seemed to allowing a deepening of the clients’ process. The survey data dovetails with this idea, as it was found that the more likely clients were to rate their therapists’ humour as helpful to their process, then the more positively they rated their relationship.

As noted in Chapter 4, only two participants reported a negative experience in relation to their therapists’ humour (humour was distracting, or mistimed) and even here, one of the experiences was described as occurring only rarely. In this way, the study findings echo Gibson and Tantam’s (2018) who reported difficulty in getting therapists to speak about humour in therapy in a negative light.
Chapter 6: Conclusion

The research presented in this study constitutes a first step towards understanding humour within therapy from a client’s perspective. As a mixed methods design was used, the triangulation of both data sets allowed a closer examination of the complexity of humour within client-therapist interactions, then would have been possible with just one method.

In line with the literature, the interview participants all gave examples of humour being an indicator of ‘emotional and cognitive shifts’ within their therapy, which they viewed as largely beneficial. These shifts were an ability of their humour: to bring relief; to reframe a situation; to reveal the unconscious; and for some, a sign of a return to mental wellness.

The study also indicates the many benefits of humour in the relationship between client and therapist. In particular, the presence of humour could be viewed as a marker of therapeutic relationship health. This was evidenced by interview data showing that clients bring in humour with their therapist, only when they feel comfortable and safe in the relationship, when trust is present, and also when they can connect with their therapist in some way.

In turn, therapists’ humour was perceived as introducing an element of safety and comfort, and bringing relief to clients’ sessions. This latter theme was complemented by the finding that ratings for the therapeutic relationship were positively correlated with how helpful clients rated their therapists’ humour. Also, when clients rated their own humour as well-matched to their therapists’, they were more likely to rate the relationship as good. However, a note of caution should exist around clients who engage heavily in a self-defeating humour style, the use of which appeared to have a negative impact on the development of the therapeutic relationship.

To conclude, it is hoped that through this research, therapeutic practitioners can finally learn to value humour within the therapy room. Humour has so many other roles, rather than purely a defence mechanism, not the least of which is its benefit to the therapeutic alliance. It would also
appear to bring a normality and even a state of play, to what is otherwise a very serious experience for individuals.

So too it is hoped that this research might encourage conversation around the topic of humour within training courses. The trainee therapist clients were extremely hesitant to use humour in their own therapy, partly it is suspected because the topic was not covered within their training and their perception that therapy should be a serious event. However, they all expressed a desire that humour is discussed in their training, and wished it was not made to feel quite so taboo, simply by its absence.

6.1 Limitations

There are limitations to choosing trainee therapists as participants, as opposed to clients from a community sample. It is very possible that trainees are more restrained in using humour, due to a wish to appear professional. This could mean that the initial slowness to engage in humour reported, was exaggerated by clients’ concern that their therapist might view them as frivolous for allowing humour in. It was also found, that the interviewees wished to impart how therapy is a serious event for them, and how they are good at keeping boundaries. Which brings the question of whether participants felt under social pressure to present themselves in a good light to the researcher (another trainee therapist).

Another limitation is that trainee therapists are very familiar with the technical language and theories of psychotherapy and it is doubtful a community sample would have used terms such as ‘reframing’, ‘defence mechanism’ or even talked of boundaries. With a community sample then, quite different themes may have emerged. However, this familiarity by participants of psychotherapy concepts could also be viewed as a strength, in that participants may have had a greater capacity to verbalise how they use humour. An obvious way to mitigate against this issue is of course to run a future study, using clients who are not also trainee therapists.

After completing the interviews, and with the benefit of hindsight, it was clear that certain aspects of the study design, could be improved. For instance, in the interviews, clients had
focused much more on their own use of humour than their therapists. However, the survey was heavily directed towards asking clients about the influence of their therapists’ humour. A more balanced approach in the survey questions therefore would have helped to tie the data from the two research approaches together more closely.

6.2 Suggestions for future research

In line with what has been mostly a theoretical standpoint to date, the current study suggests humour is beneficial to the therapeutic relationship. However, there is scope for this to be examined more thoroughly. As pointed out in the limitations, trainee therapists were used as participants and a study utilising a community sample needs to be carried out, especially to examine whether the slow emergence of humour in clients is unique to trainee therapists’ or present in general.

Future research could also examine whether humour plays different roles in therapy, depending on client presentation. For example, do those with depression utilise humour very differently from those with addiction issues? Equally, given the results which were indicative of humour presence possibly marking a return to wellness, it would be informative to know whether this is the case in clients in general, as well as understanding if it differs in clients with diverse presentations and whether their therapists also view the occurrence of humour as indicative of positive therapy outcomes.
References


https://doi.org/10.1080/00221300109598906


https://doi.org/10.1093/ecam/nep106


https://doi.org/10.1080/10503309612331331768


Appendices

Appendix 1: Coping with Humour Scale

**Humour Scale 1**

Please read the following statements below and indicate the extent to which you agree or disagree with each statement by circling the appropriate number, where 1 = strongly disagree and 4 = strongly agree.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>(strongly)</td>
<td>(mildly)</td>
<td>(mildly)</td>
<td>(strongly)</td>
</tr>
<tr>
<td>(disagree)</td>
<td>(disagree)</td>
<td>(agree)</td>
<td>(agree)</td>
</tr>
</tbody>
</table>

1) I often lose my sense of humour when I am having problems.

1 2 3 4

2) I have often found that my problems have been greatly reduced when I try to find something funny in them.

1 2 3 4

3) I usually look for something comical to say when I am in tense situations.

1 2 3 4

4) I must admit my life would probably be a lot easier if I had more of a sense of humour.

1 2 3 4

5) I have often felt that if I am in a situation where I have to either cry or laugh, it's better to laugh.

1 2 3 4

6) I can usually find something to laugh or joke about even in trying situations.

1 2 3 4

7) It has been my experience that humour is often a very effective way of coping with problems.

1 2 3 4
Appendix 2: Humour Styles Questionnaire

People experience and express humour in many different ways. Below are a list of statements describing different ways in which humour might be experienced. Please read each statement, and indicate the degree to which you agree or disagree with it, by filling in the number of your response in the blank before each item, where 1 = totally disagree and 7 = totally agree.

1 = Totally Disagree; 2 = Moderately Disagree; 3 = Slightly Disagree; 4 = Undecided; 5 = Slightly Agree; 6 = Moderately Agree; 7 = Totally Agree

Please respond as honestly and objectively as you can.

1) __________ I usually don’t laugh or joke around much with other people.

2) __________ If I am feeling depressed, I can usually cheer myself up with humour.

3) __________ If someone makes a mistake, I will often tease them about it.

4) __________ I let people laugh at me or make fun at my expense more than I should.

5) __________ I don’t have to work very hard at making other people laugh -- I seem to be a naturally humorous person.

6) __________ Even when I’m by myself, I’m often amused by the absurdities of life.

7) __________ People are never offended or hurt by my sense of humor.

8) __________ I will often get carried away in putting myself down if it makes my family or friends laugh.

9) __________ I rarely make other people laugh by telling funny stories about myself.

10) __________ If I am feeling upset or unhappy I usually try to think of something funny about the situation to make myself feel better.

11) __________ When telling jokes or saying funny things, I am usually not very concerned about how other people are taking it.

12) __________ I often try to make people like or accept me more by saying something funny about my own weaknesses, blunders, or faults.

13) __________ I laugh and joke a lot with my friends.

14) __________ My humorous outlook on life keeps me from getting overly upset or depressed about things.
15) _______I do not like it when people use humour as a way of criticizing or putting someone down.

16) _______I don’t often say funny things to put myself down.

17) _______I usually don’t like to tell jokes or amuse people.

18) _______If I’m by myself and I’m feeling unhappy, I make an effort to think of something funny to cheer myself up.

19) _______Sometimes I think of something that is so funny that I can’t stop myself from saying it, even if it is not appropriate for the situation.

20) _______I often go overboard in putting myself down when I am making jokes or trying to be funny.

21) _______I enjoy making people laugh.

22) _______If I am feeling sad or upset, I usually lose my sense of humor.

23) _______I never participate in laughing at others even if all my friends are doing it.

24) _______When I am with friends or family, I often seem to be the one that other people make fun of or joke about.

25) _______I don’t often joke around with my friends.

26) _______It is my experience that thinking about some amusing aspect of a situation is often a very effective way of coping with problems.

27) _______If I don’t like someone, I often use humor or teasing to put them down.

28) _______If I am having problems or feeling unhappy, I often cover it up by joking around, so that even my closest friends don’t know how I really feel.

29) _______I usually can’t think of witty things to say when I’m with other people.

30) _______I don’t need to be with other people to feel amused -- I can usually find things to laugh about even when I’m by myself.

31) _______Even if something is really funny to me, I will not laugh or joke about it if someone will be offended.

32) _______Letting others laugh at me is my way of keeping my friends and family in good spirits.
Appendix 3: Survey

MA2 Research Project Questionnaire

This questionnaire seeks your opinion on the role that humour may play in your personal therapy sessions. Humour here includes, making a joke, a witty remark, humorous facial gestures, as well as laughter. There are also a few demographic questions (1-4) at the beginning of the questionnaire.

Please circle as appropriate or fill in the blank

1) What is your year of study?
   BA 1/  BA 2/  HDip 1/  HDip 2/  MA 1/  MA 2

2) What is your age? __________

3) Are you? Male / Female

4) Number of hours of personal therapy completed to date?
   0-5/  5-10/  10-15/  15-20/  20-30/  30-40/  >40/

5) Please indicate, by circling one of the numbers on the scale below, whether your therapist initiates humour within your personal therapy sessions?
   1 = never  2 = sometimes  3 = frequently
   1  2  3

   b) If appropriate, please circle from the list below, what form this humour usually takes? You may circle more than one answer
      Jokes/ witty remarks/ humorous facial gestures/ laughter

6) How helpful do you feel humour is to your therapeutic process?

   1 = not at all helpful, 2 = mostly unhelpful, 3 = sometimes helpful, 4 = mostly helpful, 5 = very helpful
   1  2  3  4  5
   Not at all helpful   Helpful all the time
7) Please indicate, whether you ever personally initiate humour within your therapy sessions?

1 = never   2 = sometimes and 3 = frequently

8) Do you feel you and your therapist are well matched in terms of sense of humour?

1 = not well matched, 2 = mostly unmatched, 3 = sometimes matched, 4= well matched, 5 = very well matched

9) How often do you and your therapist have shared moments of laughter?

1 = never   2 = sometimes and 3 = frequently

10) How effective do you feel humour initiated by your therapist is, in instigating any changes within you?

1 = not at all effective, 2= mostly ineffective, 3 = sometimes effective, 4= mostly effective, 5 = effective all the time

b) Please circle from the list below, what (if anything) changes for you? You may circle more than one answer here

thoughts/ feelings/ behaviour

11) How would you rate your current therapeutic relationship with your therapist?

1= very poor, 2 = poor, 3= neither good nor poor, 4= good and 5 = very good
INFORMATION FORM (Part A)

Role of Humour in Psychotherapy

You are invited to participate in a research study with me (Olivia Longe) examining the role of humour within psychotherapy as viewed by clients. As a student of psychotherapy, who has experience of your own personal therapy and knowledge of what it is to be a client within the therapeutic relationship, you have been identified as a suitable participant, and so are being invited to participate in this research. This study will form part of my research project for the MA in Psychotherapy.

Why Study Humour?

Humour is a familiar tool to us all, in our everyday communication with others, but this type of affective communication has been rarely studied within the psychotherapeutic relationship. Hence this study seeks a greater understanding of the impact of humour between client and therapist.

What is Involved?

If you do agree to participate in this research, you will be asked to complete a short survey and two different scales that measure aspects of your use of humour in everyday life. This should take no more than 10-12 minutes to complete.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked filing cabinet. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way.

Your participation in this research is entirely voluntary. You are free to withdraw at any point of the study without any disadvantage.

Consent

If after reading this information sheet you would like to do the survey and scales, please turn over the sheet and read the instructions to begin. Please note that by completing the survey, you are consenting to participate in the study.

If you have questions regarding your rights as a participant in this research, please contact Dr. Gráinne Donohue, Research Co-ordinator, Dept. of Psychotherapy, School of Arts, Dublin Business School grainne.donohue@dbs.ie
Appendix 5: Information Sheet (B)

INFORMATION FORM (Part B)

Role of Humour in Psychotherapy

You are invited to participate in a research study with me (Olivia Longe) examining the role of humour within psychotherapy as viewed by clients. This study will form part of my research project for the MA in Psychotherapy. You are being invited to take part, as you have already participated in an earlier piece of this study, during which you expressed an interest in further participation.

Why Study Humour?

Humour is a familiar tool to us all, in our everyday communication with others, but this type of affective communication has been rarely studied within the therapeutic relationship in psychotherapy. Hence this study seeks a greater understanding of the impact of humour between client and therapist.

What is Involved?

If you do agree to participate in this research, you will be interviewed with myself in a setting of your convenience, which will take no longer than an hour to complete. During this interview, I will ask you a series of questions relating to the research question. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked filing cabinet. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location.

Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.
DECLARATION

I have read this information form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) __________________________________________

Signature ________________________________________________________________

Date / /
CONSENT FORM: Part B (Interview)

Protocol Title: Role of Humour in Psychotherapy

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered. □ Yes □ No

I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving reason. □ Yes □ No

I understand that my identity will remain confidential at all times. □ Yes □ No

I am aware of the potential risks of this research study. □ Yes □ No

I am aware that audio recordings will be made of sessions □ Yes □ No

I have been given a copy of the Information Leaflet and this Consent form for my records. □ Yes □ No

Participant ___________________________ ___________________________

Signature and dated Name in block capitals

To be completed by the Principal Investigator or their nominee.

I the undersigned, have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/her to ask questions on any aspect of the study that concerned them.

_________________ ___________________________ __________
Signature Name in Block Capitals Date
Appendix 7: Interview Questions

Questions for Semi-structured Interview

1. What place does humour have in your life in general?

2. As part of your course you had to choose a therapist, did having a shared sense of humour play any part in how you choose them? What about later, did a shared sense of humour play a part in sticking with your therapist?

3. In general, would you say therapy is a serious event for you, or can there be lighter moments between you and your therapist?

   Prompt for more information on what kinds of humour come into play?

4. Can you tell me of one of your experiences that stands out in relation to humour within your personal therapy?

5. Has the humour in your therapy sessions evolved or changed in any way, from when you first started (with current therapist)?

6. Can you tell me how your therapist tends to respond to your humour?

7. Has humour ever worked against you in therapy?

8. How does humour add to your personal process?

9. Has a joke or humour ever revealed something to you (in your personal therapy)?

10. Can you imagine using humour within your own work as a therapist, when that eventually happens?

   Prompt if not forthcoming - Do you feel humour has an important place in the therapeutic relationship?
<table>
<thead>
<tr>
<th>Fiona (S6)</th>
<th>Line Identifier</th>
<th>Verbalisation</th>
<th>Descriptive</th>
<th>Emergent Theme</th>
<th>Sub Theme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>F59</td>
<td></td>
<td>I think it's because the therapist is... There's a kind of a give and take, push and pull... so maybe you kind of feel like you could... you're only expressing as much as you feel the relationship can hold?</td>
<td>A feeling that the relationship can only hold so much humour</td>
<td>Humour is tempered for therapeutic environment</td>
<td>Withholding Humour</td>
<td>Humour emergence</td>
</tr>
<tr>
<td>L49</td>
<td></td>
<td>So, am I hearing it's like a tailored humour for your therapist?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F60</td>
<td></td>
<td>Yeah but not conscious like... you know it's unconscious. I think, the more I think about it, I'm thinking do you know what actually I think it is a little bit... unconsciously restrained.</td>
<td>Alters humour for therapist but realises this has been unconscious</td>
<td>Unconscious processes leading to tempering of humour</td>
<td>Withholding Humour</td>
<td>Humour emergence</td>
</tr>
<tr>
<td>F61</td>
<td></td>
<td>Am... it's kind of strange thinking about that... but yeah, it's a little bit... but it's still there but it's kind of a little bit holding back...</td>
<td>Alters humour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L50</td>
<td></td>
<td>And the thing that's constrained... the thing that's making you refine it unconsciously as you say is... and you said something like barriers that would...?</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>F62</td>
<td></td>
<td>Yeah, yeah. It's like the boundary between the therapist and the client. That's I think, that needs to be there for the relationship to work because she's not your... It's like, she's not your friend.</td>
<td>Different boundaries of therapeutic relationship to a friendship</td>
<td>Humour reveals difference between therapy relationship and a friendship</td>
<td>Heavy Boundaries present</td>
<td>Humour emergence/ therapy relationship</td>
</tr>
<tr>
<td>F63</td>
<td></td>
<td>Even though you might think there are elements like... she's not like, what my therapist... I don't know how old she is, but like to me, like, there is kind of like, a transference of like a mother figure. So, like, I'm aware that like, to me, she's a mothering figure. Not a friend.</td>
<td>Maternal transference is present</td>
<td></td>
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<tr>
<td>F64</td>
<td></td>
<td>And you know I wouldn't want her to be your friend because I know like a lot, like a lot of people are, they have friends, like they tell their deepest secrets and thoughts to a friend, but sometimes there's something nice about having that mother figure, kind of unconditional... am... you know, the core conditions that are... the unconditional regard, I think that comes through very much in that... in our relationship.</td>
<td>While people tell their deepest secrets to a friend, there's something nice about being a mothering figure with unconditional positive regard</td>
<td>Feelings of ease in the relationship due to transference?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F65</td>
<td></td>
<td>Yeah, am yeah, but there's a boundary I know that she's not who I think she is...</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>L51</td>
<td></td>
<td>Okay... so</td>
<td></td>
<td></td>
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<tr>
<td>L52</td>
<td></td>
<td>Hmm, am... and your therapist herself. Does she ever use humour within the sessions?</td>
<td></td>
<td></td>
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<tr>
<td>F67</td>
<td></td>
<td>Am... Yeah. She kind of, she kind of tells little anecdotes sometimes. To use an example like, if I'm stuck with something, she's like, &quot;oh, I'll tell you a story about this person&quot;. Like, I don't even know if they're true or not, I don't really care. Cuz it's kind of nice to listen to her talk (laughs here). And sometimes they can be quite humorous like, but like they're not intended. There, almost like, oh I remember when I was a kid... I did this. I'm like, it could be something silly, like.</td>
<td>Therapist uses humourous anecdotes that she enjoys. Sometimes these seem to be unintentionally humourous</td>
<td>Therapist humour enjoyable</td>
<td>Therapist Humour adds enjoyment to relationship</td>
<td>Therapy Relationship/Alliance</td>
</tr>
<tr>
<td>F68</td>
<td></td>
<td>But like, yeah, so she does humour but in a different way to what I'm used to or how I express humour, but that doesn't mean, that like, she doesn't accept my humour and I don't accept her type of humour, because like we kind of meet somewhere in the middle.</td>
<td>Their humour is different but both are accepting of each other</td>
<td>Humour highlights differences and acceptance</td>
<td>Promotes tolerance</td>
<td>Therapy Relationship/Alliance</td>
</tr>
<tr>
<td>F69</td>
<td></td>
<td>So yeah, I kind of, yeah she does. But it's, it's never very obvious. It's not like, yeah, it just feels natural.</td>
<td>Therapist humour feels natural</td>
<td></td>
<td>Humour has a place</td>
<td>Therapy Relationship/Alliance</td>
</tr>
<tr>
<td>L53</td>
<td></td>
<td>Okay and what do you think that does within your sessions, when she uses humour?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>F70</td>
<td></td>
<td>Think it brings us a bit closer. It's kind of like... It's like I don't know if before I've said it, before I said it lightens the mood.</td>
<td>Therapist humour lightens the mood</td>
<td>Humour Lightens mood</td>
<td>Humour relaxes</td>
<td>Therapy Relationship/Alliance</td>
</tr>
</tbody>
</table>