“You get me”: a three-paper research project exploring how trainee psychotherapists experience and understand humour in psychoanalytic psychotherapy with young people in the context of professional training programmes.

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A thesis submitted for the award of professional doctorate in child and adolescent psychoanalytic psychotherapy (DPsych)

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Date of submission: October, 2024

For all my clowns.

Box 1 – Statement of personal interest in the research subject

This research project was developed from my own lived personal experience as a trainee psychotherapist offering intensive psychoanalytic psychotherapy to adolescent patients as part of professional training (DPsych) towards full accreditation as a child and adolescent psychotherapist. In this work, always without consciously willing it, and often in the context of the most unlikely of circumstances, I found that humour would happen between myself and my patient. Despite being in personal analysis and regular supervision, I went on to discover that I did not know how to make good sense of these therapy experiences. Specifically, I found that I struggled to take them up as relevant clinical data in supervision, case presentations, and training seminars. Unlike the experience of aggression or sexuality, humour seemed to sit awkwardly outside the recognised bounds of the psychotherapy training task. And yet, still it seemed important in the room – often appearing to accompany moments of change and deep resonance with psychotherapy aims. I wondered if others had experienced something like this, and, in this research project, I set to find out.

Contents

Paper one – How are experiences of humour in psychotherapy understood in existing research literature? A literature review

ABSTRACT

This literature review critically examines a selection of existing research literature about how experiences of humour in psychotherapy are understood. The author found that stringent inclusion criteria were necessary to demarcate 'humour-as-experience' from its instrumental utility and manualisation in psychotherapy explored elsewhere. In this review, the author also recognised distinct ontological foundations underlying varying accounts of humour explored in existing literature. Upon close examination, these different, basic perspectives on humour were seen to correspond with the author's identification of historical paradigms informing understanding of this phenomenon of interest. In this review, these are named as: *Superiority*; *Relief*; *Humility*; and *Play*. In conclusion, humour is found to be a curiously neglected phenomenon of interest (to some) in psychotherapy. Further investigation is indicated and is taken up elsewhere in this research project – about the lived experience of humour in psychotherapy with adolescents (see: *paper two – interpretative phenomenological analysis*), and about how this experience is then understood (see: *paper three – framework analysis*). Research questions developed from the critical examination and organisation of existing literature in this review have informed the rationale for interview-based empirical investigations presented elsewhere in this project (see: papers *two* and *three*). Limitations of this research study are identified and discussed.

LINKING PASSAGE

This literature review is part of a larger three-paper project exploring the lived experiences (see: *paper two – interpretative phenomenological analysis*) and understanding (see: *paper three – framework analysis*) of humour in child and adolescent psychotherapy. In this review (presented here as paper one), and project (presented across papers one-three), humour is recognised as a richly considered human phenomenon, also encountered in therapy. Understanding its nature is seen to involve several distinct ontologies appraising what humour essentially is for the purposes of psychotherapy. For instance, this review recognises one body of research which understands humour to be an essential and inextricable component of health (see: Kuhlman et al., 2021; Berger et al., 2018). However, looking elsewhere, humour is distinctly understood as a (potentially) damaging defensive mechanism which can unseat reality, and which ultimately makes or keeps us ill (see: Kubie, 1971; Marcus, 1990). In support of the aims of this research project, the author has attended to this breadth and heterogeneity in current academic understanding concerning the experience of humour in psychotherapy by widening scope to consider it in its general form (i.e., as a human, and not only a clinically-bound phenomenon). In this review, the author has identified the distinct ontological and epistemological foundations underlying disparate research bodies on the subject. These are defined and used as subheadings to mark discrete areas of research understanding of the phenomenon in therapy, located by the author in emergent historical paradigms (i.e., humour is: [3.1] ‘Superiority’; [3.2] ‘Relief’; [3.3] ‘Humility’; [3.4] ‘Play’).

1 | INTRODUCTION

1.1 | (The experience of) humour

This review of existing literature about humour encountered in psychotherapy has discovered an abundance of clinical experience – but curiously, little studied interest – informing understanding of this phenomenon. Most commonly, in available literature, such experience is represented by informed speculation about how a given 'technique of humour' could be brought into the service of psychotherapy practice (e.g., LiButti, 2015; Irving, 2019; Pack et al., 2020; Kastner, 2024). Consequently, a great deal of research has been identified which examines the instrumental 'efficacy' and 'utility' of humour in therapy ('use it here, in this way, to achieve these results')[1].

By way of contrast, comparatively little work is found to be available about what can be understood of experiences in psychotherapy where humour *happens,* outside of individual authority and governance, in the context of a therapy relationship (e.g., Briggs, 2022, see: p. 34). Accordingly, it remains unclear how such an experience is understood in the profession – or whether it is recognised as relevant clinical data at all.

In this review of existing literature, the author has not circumscribed the meaning of humour in psychotherapy – as this is born out in the critical examination of this investigation and in the interpretative phenomenological analysis (see: *paper two*) and framework analysis (see: *paper three*) presented elsewhere in this research project. However, the identification of search terms, presented in *Table*

[1] An example of many such studies excluded from consideration is: '*The therapeutic "aha!": 10 strategies for getting your clients unstuck'* (Armstrong, 2015).

1, below, underlines how the author's research interest in this literature review and three-paper project is about the *experience* of humour. Such a focus is distinguished from the instrumental *utility* of the phenomenon considered elsewhere. This is clarified in *Box 1*, below.

Box 1.

For the purpose of this literature review (paper one) and research project (papers one-three), humour is understood as an experience taking place between two or more people. This distinguishes it from an undertaking of 'funniness' or 'the comic' which is defined as instigated by a desiring person or persons who utilise understood rules to (try to) achieve an anticipated effect[2]. An experience of humour is not done to, or by, us. Rather it happens between, and in conjunction with, ourselves and another. In consideration of the psychoanalytic ontology of this research project, and following appraisal of existing literature in this review, 'funniness' may be seen to operate in 'paranoid-schizoid functioning', and humour in 'depressive functioning' (Klein, 1935). This claim is examined elsewhere in this research project (see: *paper two – 3.4 'Findings'*).

Humour-as-experience.

2 | LITERATURE SEARCH METHODOLOGY

2.1 | Databases

The stricture analysis of this literature review is of research held in the four American Psychological Association (APA) databases to which the author's training institution has access[3], together with a selection of imported foundational psychoanalytic texts from the databases of the required reading of every child

[2] Ron Britton (2003), following V.S. Naipaul, raises a similar distinction in psychoanalytic clinical work between defensive 'jokiness' and a 'humorous attitude' capable of insight.

[3] The APA offers a reputable library for literature of this kind, but its use limits the scope of this review, as it only includes work from journals to which the APA subscribes. This focus favours Anglo-American scholarship, rooted in a Western, individualist tradition, over research from other intellectual contexts (e.g., collectivist traditions), as well as untranslated works, which make up about 15% of the results. While this is a methodological limitation, the interview-based empirical part of this project (papers *two* and *three*) focuses on humour in psychotherapy within the UK, where the author is based. Thus, the predominance of British psychotherapy research (and its Western, individualistic context) does not compromise the validity of this study's findings, though it highlights that it's scope is not generalisable.

and adolescent psychotherapy training (Freud, [1905; 1908; 1927]; Winnicott, [1953]; Klein, [1935]; Bion, [1962]), whether or not this work also appears in the APA databases[4].

2.2 | Search terms

Chosen literature search terms are: 'PSYCHOTHERAPY' [AND][5] 'EXPERIENCE' [AND] 'HUMOUR OR HUMOR' which produced a total of 181 results in the *APA* databases *PsychInfo*, *PsychBooks*, *PsychArticles* and *PsychExtra*[6]. *Table 1*, below, explains the identification of these terms:

Table 1.

Search term	Identification
'PSYCHOTHERAPY'	Of 'PSYCHOTHERAPY', it transpired that the greater precision of specifying 'intensive psychotherapy', or 'adolescent psychotherapy', proved too restrictive to the yield of search results. Fortunately, within the APA databases, there are many different 'psychotherapies' which investigate the phenomenon of humour – e.g., existential psychotherapy; psychoanalytic psychotherapy etc. – including with young people, so a great deal of variety and richness exists within this inclusion criterion.
AND	
'EXPERIENCE'	As defined in Box 1, above, of the search term 'EXPERIENCE', it was necessary to include research work which makes explicit the distinction between an experience of humour in psychotherapy (that which happens between therapist and patient) and the utility or efficacy of humour employed by the therapist alone (i.e., research work with some variation of the findings: 'use it here, in this way, to achieve these results'). All work is excluded from consideration which instrumentalises humour as a deliberate tool of psychotherapy practice. As represented by the PRISMA diagram in Figure 1, below, this exclusion criterion reduced literature search results by more than 50%.
AND	

[4] This decision has been made on the basis of the psychoanalytical ontology of this research project, which takes as axiomatic the existence of the 'dynamic unconscious'. This phenomenon is detailed by those foundational authors whose work has here been imported. It is defined elsewhere in this research project (see: *paper two*, *Table 2*).

[5] The Boolean operator 'AND' was employed for search terms, to optimise the yield of results.

[6] This literature search was first completed in 2022, producing 181 items. Repeating the procedure in 2024 generated a yield of 189 search results, evidencing a reasonable representation of newly published work between the undertaken literature search and the time of writing (n =10, between 2022-24). To support the relevance of findings, contemporary work was reviewed at an additional later stage, with certain items (e.g., Hersh, 2022; Brooks, 2023) satisfying inclusion criteria, and entering selection for critical examination in this study.

'HUMOUR OR HUMOR'	The specification of the search term 'HUMOUR OR HUMOR' distinguishes between the phenomenon of humour and that, for instance, of 'funniness' or its associated characteristics, including laughter, smiling, and the state of amusement. As is detailed below, there are many different ways to understand the experience of humour, but for the purposes of this research project it is necessary to specify the inclusion of that work which recognises this phenomenon as an independent subject of inquiry, and which does not conflate it with what is here understood to be associated phenomena and ephemera, such as those listed above, as well as jokes and comedy.

Identification of literature search terms.

2.3 | Inclusion criteria

In this review of available literature, all work has been excluded from consideration when it has failed to meet the criteria for humour stated in *Box 1* (see: p. 5). This is regardless of whether or not the excluded study's author employed the term 'humour' in their own thinking about the subject. By way of contrast, for ease and coherence of description and illumination**,** the term is understood in place of 'joking' and/or 'comedy/the comic' where these latter terms have been employed by an author or researcher to describe an experience of humour as it is understood in this study: as a non-directive encounter between two or more people (see: *Box 2,* p. 5)[7]. The aspects of this inclusion/exclusion criteria are listed below, in *Table 2,* and the procedure of their application is presented below as *Figure 1.*

Table 2.

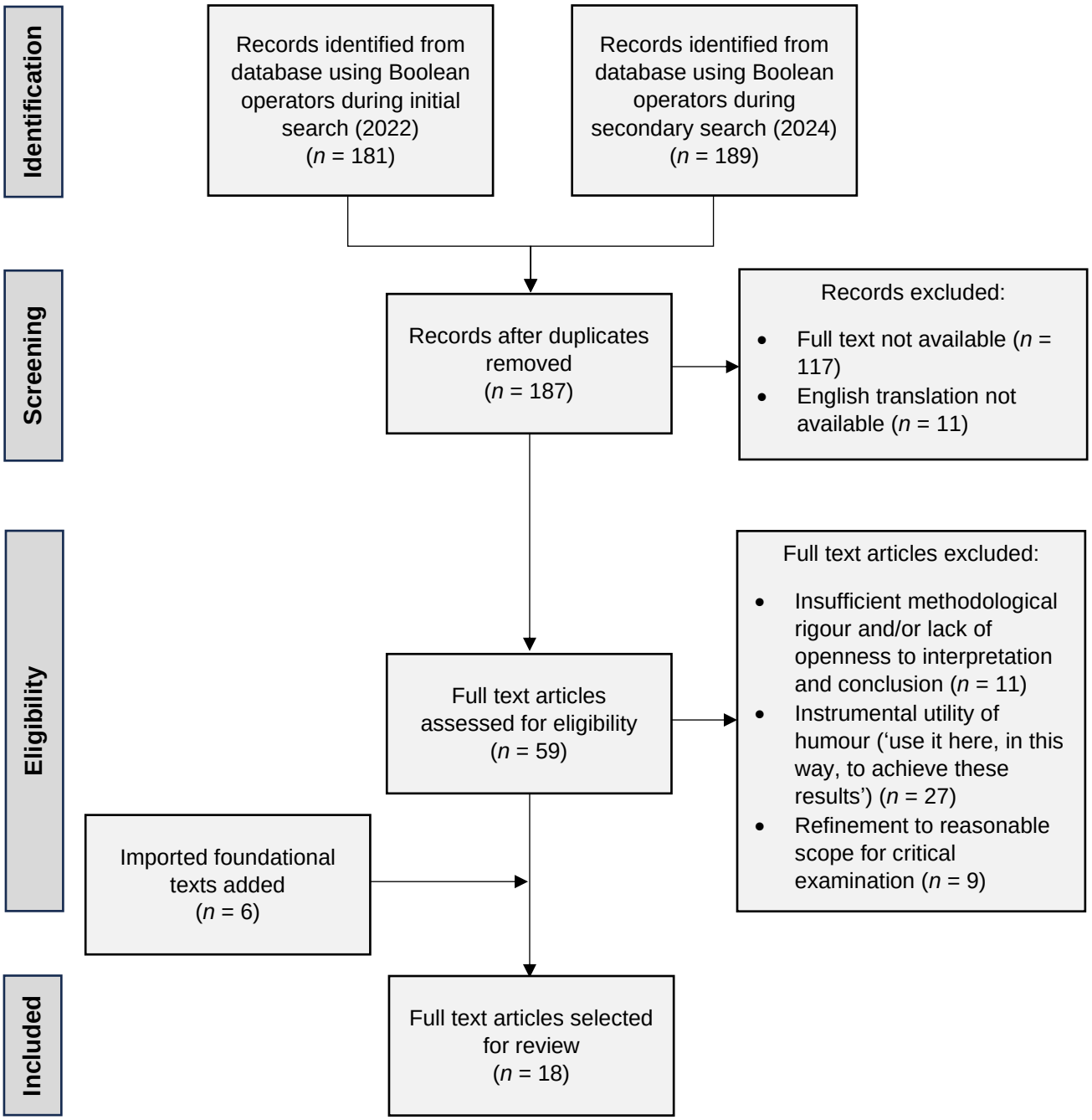
Inclusion	Exclusion
• Humour-as-experience • Sufficient methodological rigor • The experience is open to interpretation • Outcomes are understood as particular	• Instigated funniness • Personal anecdote / clinical description • The experience has been/will be instrumentalised • Outcomes are claimed as universal

Inclusion and exclusion criteria for literature search.

[7] One example is the theory of 'comedy' [sic] as the 'universal at work', in the work of philosopher Alenka Zupančič (2008).

2.4 | PRISMA diagram

Figure 1.



PRISMA flow diagram showing identification, screening, and application of inclusion and exclusion criteria.

2.5 | Literature selection

In this literature review, for reasons of adequate depth of analysis, ten texts have been selected for detailed review and examination from a total sample of eighteen. Justification for selection is presented below, in ***Table 3*****.**

Table 3.

Selected Study	Key Words	Justification for Selection
Berger et al. (2018) 'Frontal hypoactivation and alterations in the reward-system during humour processing in patients with schizophrenia spectrum disorders'	Humour processing; fMRI; schizophrenia; reward-system; cognitive affirmation	Selected for its empirical investigation of the neural correlates of humour experience. Highlights how disruptions in humour processing in mental illness contrast with the integrative, affirming role of humour in health, thereby supporting the research's interest in humour as relationally and cognitively meaningful.
Briggs (2022) 'Funny, right? How do trainee and qualified therapists experience laughter in their practice with clients?'	Laughter in therapy; catharsis; moments of change; therapist training	Chosen for its direct alignment with this thesis's empirical aims. Uses a similar methodology (interview-based) and explores humour as a meaningful, cathartic moment in therapy, offering comparative insight into how humour is felt and understood across training levels.
Freud (1905) 'Jokes and Their Relation to the Unconscious'	Joke technique; psychical economy; unconscious processes; humour as relief	Included as a foundational psychoanalytic text articulating humour's role in releasing repressed psychic energy. Serves as a basis for the 'relief' ontology of humour and supports the theoretical framing of humour as an unconscious and economised psychic process.
Freud (1927) 'Humour'	Superego; humility; palliation; ego consolation; perspective	Selected for revising Freud's earlier economic model of humour into a structural one, positioning humour as a compassionate function of the superego. This perspective informs the 'humility' ontology of humour and raises important questions about the developmental and consolatory role of humour in psychoanalytic work.
Haydon et al. (2015) 'A narrative inquiry: Humour and gender differences in the therapeutic relationship between nurses and their patients'	Nurse-patient dynamics; humour and gender; therapeutic relationship; clinical roles	Included for exploring gendered dimensions of humour in clinical care. Offers rare experiential data on humour as play within therapeutic relationships and contributes to understanding humour's social and relational dynamics in clinical practice.
Hersh (2022) 'Inspiring laughter, humour, joy, and playfulness'	Humour vs. laughter; cognitive-emotional experience; subjectivity; therapist well-being	Chosen for its differentiation between humour and its physical manifestations, such as laughter. Emphasises the subjective, cognitive-emotional dimensions of humour, aligning closely with the thesis's concern with humour as lived, intersubjective experience in therapy.
Lemma (2000) 'Humour on the Couch'	Psychoanalysis; play; transitional phenomena; authentic therapeutic relationship	Selected for its clinical insights into humour as an authentic therapeutic encounter. Challenges rigid transference interpretations and argues for humour as a means of accessing deeper relational and emotional truth in the therapy space.
McCann et al. (2015) 'Being the butt of the joke: homophobic humour, male identity, and its connection to emotional and physical violence for men'	Humour as 'orchestrated cruelty'; masculinity; gender norms; humour as discourse; broad participant sample; mental health implications	Selected for its methodological sophistication, particularly in sampling, recruitment, and data analysis related to humour as a subjective experience. Although not directly concerned with psychotherapy, its insights into humour's social and psychological dynamics informed the development of research questions concerning the complexity and nuance of humour experiences within therapeutic relationships.
Porterfield (1987) and related studies under 'Humour experience and mental health'	Coping; humour as moderator; stress and depression; non-causal correlations	Included for investigating humour's role as a correlate – but not a preventative factor – of mental health outcomes. These findings support the thesis's exploration of the limitations and contextual conditions under which humour may support emotional resilience in therapy.
Stalikas et al. (2008) 'Positive emotions as generators of therapeutic change'	Psychotherapy and positive psychology; "broaden-and-build" theory; emotional relief and expansion	Selected for linking positive emotion, including humour, to therapeutic change. Provides a valuable counterpoint to the predominant psychoanalytic focus on negative affect and supports exploration of humour as an agent of therapeutic broadening and relief.
Talens (2020) 'When working in a youth service, how do therapists experience humour with their clients?'	Youth psychotherapy; therapist experience; humour and play; service context	Chosen for its rare focus on therapists' experiences of humour with young clients. Highlights a significant gap in literature concerning humour in youth psychotherapy and supports the thesis's emphasis on developmental, intersubjective dimensions of humour.

Justification for study selection

2.6 | Research questions

From the critical examination of selected literature passing through the inclusion and exclusion criteria, presented above in *Table 2*, research questions have been developed for further consideration and investigation, including elsewhere in this research project (see: papers *two* and *three*)[8]. These research questions are summarised in *Table 4* (see: p. 36).

3 | LITERATURE REVIEW

Introduction

One need not look far into the collective store of human understanding to find regard for the experience of humour as valuable and ubiquitous. Immanuel Kant (1892) listed laughter alongside Voltaire's designation of hope and sleep as the divine counterbalances to the miseries of life, and understood joking as 'the play of thought'. William Shakespeare (1609) writes in his *Sonnets* of the reciprocal self-deception in ironical humour that binds love necessarily against the austerity of time and of reality. Looking outside of the Western canon, in the Navajo tradition, a ceremony (*A'wee Chi'deedloh*) is held by a family to celebrate their baby's first laugh, signifying the infant's successful transition from the spirit world of the *Diyin Din'e*, and marking their readiness to join their family in earthly life (Randall, 2011)[9].

[8] These research questions have been enclosed in grey boxes embedded within the text, e.g., on page 16.
[9] This is an example that interestingly corresponds to some of the epistemological assumptions underlying the psychoanalytic psychotherapy training of this study's author, and this research project, in that Melanie Klein's theoretical framework of infant development confers a similar movement from the part-object 'spirit world' of the paranoid-schizoid position towards the whole object 'earthly reality' of the depressive position (Klein, 1935).

Hurley et al. (2011) observe humour to be an innate and pervasive6. experience across all human cultures, with laughter appearing ontologically early in infancy and presenting itself apparently spontaneously in congenitally deaf and blind children – where an inveterate ‘humour trait’ is seen to have genetically persevered within every human population. Dispatches from the annals of history and geography clearly suggest that we all experience something like humour, in our different ways, and always have. And yet, a preliminary survey of existing literature on the subject has clarified that there is less information about what can be understood to be happening *within* these different experiences of humour. For instance, what is, or what we can speculate to be, actually going on for the laughing baby and their family in their encounter of the *A’wee Chi’deedloh* Navajo ceremony. Further research is also indicated regarding the nature of humour experiences *between* axioms of particularity and difference (e.g., between age-groups, or between economic classes), with one of few exceptions to this in psychotherapy being a literature review by Maples et al. (2001), which found that a therapist must be cautious when introducing humour into a therapy relationship with a client from another cultural or ethnic background. This lack of consideration of the phenomenon *between* axioms of particularity and difference – specifically, in the relationship between a patient and their therapist – has been taken up as a research justification elsewhere in this research project (see: papers *two* and *three*).

In what follows, the author presents a review of a representative, but not exhaustive, selection of existing research from distinct areas of academic literature which explore experiences of humour in psychotherapy. As stated above, these discrete research areas have been identified by their underlying

foundational ontologies of humour, which have been used here as subheadings. One finding from this investigation is that existing literature on the subject *can* be organised in this way – arranged by this study's author according to distinct ontologies about what humour is ultimately seen to be. This finding in itself does not correspond widely with existing literature, which typically maintains an implicit but rarely explicit understanding of what humour is – despite obvious variations between such understandings, as this review makes plain. A selection of ontologies is listed below, in *Table 3.* These have been identified and chronologically ordered by the author, according to the periods of historical relevance and the corresponding 'scientific paradigm' in which they have been understood as central (Kuhn, 1996). For example, the ontology of humour as 'superiority' is here recognised to have been first described in antiquity, and to have been 'shifted' only by the emergence of a new paradigm of scientific rationalism in the age of European Enlightenment more than two millennia later (Morreall, 1986). This study's author understands this to have advanced a novel foundational theory that humour was ultimately about 'relief', before this paradigm was itself supplanted by ideas of humility, and, subsequently, play.

Table 3.

3.1	(Humour is) Superiority	400BC – 1800s
3.2	(Humour is) Relief	1900s
3.3	(Humour is) Humility	1927
3.4	(Humour is) Play	1950s – (present)

Distinct ontologies for humour with identified dates of historical relevance.

3.1 | Superiority

The original Latin use of the word ‘humour’ is taken from ancient Greek, meaning a balance of bodily liquids or fluids. According to the physician Hippocrates (400 BCE/1983), to be ‘in good humour’ involves having the right store of bile, blood and phlegm flowing through our bodies. Many years later, the phenomenologist philosopher Maurice Merlau-Ponty (1962) similarly conceived of all human experience – including that which is expressed in humour – as passing through the lived body “opened onto being-towards-the-world”. Empirically, this claim is born out in research exploring humour’s role in the dynamic, flowing processes of ‘embodied cognition’ upon heart-rate, breathing and muscular movements (Varela, Thompson, & Rosche, 1991), as well as in Dunbar et al.’s (2012) linkage of experienced humour to the “fluid-like” release of endorphins.

This early ‘flowing’ framework for experienced humour was famously applied when Hippocrates was asked to medically examine the purportedly insane ‘laughing philosopher’ Democritus, only to declare his patient’s mind to have grasped a deeper and greater plane of sanity than any of his accusers[10]. The cackling Democritus, whose early stoical philosophy was characterised: ‘it is more civilised to laugh at life than to lament over it’ (Democritus, 1991, pp. 79-80), was otherwise recognised for his contribution to an atomic theory of existence: believing the universe to be constituted by finite, indestructible particles called atoms. Democritus’ philosophical position thus conceptualised –

[10] Although excluded from formal selection in this study due to insufficient methodological rigour (see: *Table 2,* above), psychoanalyst Gilbert Rose (1969) marks a similar wisdom in the figure of the Fool in Shakespeare’s *King Lear.* Rose writes that, like a good therapist, the Fool acts as a reality-tester for Lear – judiciously administering doses of reality through humour. “While sanity requires a critical mirror” generally, in circumstances of low tolerance for reality, “the mirror had better be tinted or funny” (Rose, 1969, p. 929).

first, that the universe is atomically composed of indomitable finite elements; second, that it is better to unbridle humour upon what cannot be influenced or changed – and the additional claim that this position was recognised by the venerable Hippocrates as deep wisdom, provides a philosophical foundation for what has elsewhere been named the 'superiority theory' of humour (see: Morreall, 1986). This theory has it that our laughter expresses the attainment of superiority over other people or over a former state of ourselves: we employ humour in order to attain ascendance over what we take pleasure in seeing as beneath us. In so doing, by venting our spleen upon an Other, we can hope to maintain the healthy flow of our bodily good humours. For Aristotle in *Poetics* (1996), we laugh at ugly and inferior individuals; for Socrates in Plato's *Philebus* (2010), it is the self-ignorance involved in experiencing the ridiculousness seen in others which brings us joy. In *Leviathan,* Thomas Hobbes has this as 'Sudden Glory':

> *"The passion which maketh those Grimaces called LAUGHTER; and is caused either by some sudden act of their own, that pleaseth them; or by the apprehension of some deformed thing in another, by comparison whereof they suddenly applaud themselves"* (Hobbes, 1996, p. 43).

<u>*McCann et al.* (2010) – *Humour as cruelty*</u>

In qualitative research, McCann et al. (2010) examined the role of superior humour, which was found to be central to the formation of Australian male identity. In interviews (n = 45) and focus groups (n = 18) with 63 men about '*what shapes Australian men's ideas of appropriate gender*?', these researchers found an overwhelming prevalence of homophobic humour. 43 out of 45 interviews contained ideas about a sexual 'Other' pursued through homophobic humour,

with experiences coded along a continuum from "good-natured banter" to an abusive humour which indicated emotional harm, a pattern also observed by Espelage & Swearer (2010). Brooks et al. (2023) found a similar prevalence of banter in psychotherapy, with 62 out of 68 sessions across various therapeutic interventions containing bantering humour. McCann's study revealed that men of all sexualities were targeted by superior humour, expressing both latent and overt homophobia. This humour was seen to act as a tool among men for policing gender norms, a process termed "*orchestrated cruelty*". The study also linked experienced homophobic humour in childhood to depression in later life. The findings highlighted the fluidity of sexuality, shaped by cultural and temporal factors (Kinsey et al., 1949; Foucault, 1980), with humour reinforcing identity through the distancing of the "Other" (Goffman, 1973). In existential psychotherapy research, similar humour has been found to increase session energy, particularly in interactions with a designated "Other" (Gibson, 2018).

The study by McCann et al. (2010) is notable for its broad purposive sampling. The sixty-three participants, drawn from a variety of locations in New South Wales and the Australian Capital Territory, were mostly Australian-born Caucasians, though the sample included men from six other countries, with three Aboriginal participants and one Pacific Islander. The participant group spanned ages 19 to 100 and included men from diverse professional and personal backgrounds, including those who had been in prison. Sexuality varied, with most participants identifying as heterosexual, though some had engaged in

consensual same-sex relationships or had experienced sexual assault (by men and women)[11].

Despite this rich participant sample, the study's final analysis did not fully explore how variables such as age, ethnicity, or place of birth affected humour experiences. For example, differences between young Pacific Islanders and older Australian farmers were not examined. As is described above, under-developed research consideration *between* axioms of particularity is typical of literature on this subject.

In a similar way, the large sample size and open-ended narrative approach, which yielded over 1,800 pages of transcripts, allowed for the identification of general themes but limited deeper, more focused observations. The use of NVivo software for grounded theory analysis highlighted widespread patterns – e.g., as stated, 43 out of 45 interviews revealed themes of superior, homophobic humour targeting a sexual "Other" – but the scope is such that it is hard to know what happens in what happens. Here, the study struggled to capture the complexity of individual experiences. This aligns with the idea that a smaller, more focused sample might allow for richer, more detailed insights, a point supported by Yardley (2007) and Smith (2015). From this, a research question may be developed for further investigation[12]:

[11] The link between humour and sexuality will be drawn out elsewhere in this research project (see: paper three, 'Discussion – "sexuality"', p. 150).
[12] This question will be further explored in comparison between the investigative methodologies used elsewhere in this research project (see: paper two, *Table 5,* page 98).

RQ1: What amount and type of detail – with respect to the 'thickness' and 'thinness' of description (Geertz, 1973) – supports a meaningful understanding of an account of an experience of humour?

The researchers note that their recruitment took place amid a national conversation on homophobia and gender norms, which likely influenced participants' engagement with the study. The study's aim was less about impacting research or professional practice and more about influencing societal behaviour, including of children in schools. This alignment with a broader cultural discourse (Foucault, 1980), notwithstanding its political legitimacy, suggests that the participant sample may have been uniquely motivated to contribute to this dialogue on gender and power. The researchers describe their approach as "the layout of an argument," which seems to diverge from the principle of systematic naivety in grounded theory (Glaser & Strauss, 1967). However, this identified link between humour and political mobilisation is interesting and uncommon within existing literature[13].

Where the researchers value the dataset of interview transcripts for its contribution to the overall weight of the study's central thesis ('homophobic humour is a pervasive aspect of accounts of acceptable male identity in Australia'), these are not weighed in the analysis as separate data, valuable unto themselves. As a result, the study names the possibility of different types of humour between men, but this is presented speculatively in advance of an argument, and not as experiential content available for analysis. For instance:

[13] This link is also found in the findings of this research project (see: *paper three*, *Table 2*).

> *"Members of minorities will use humour that plays on stereotypes that reference how they see themselves in the broader social world – and the nastier power dynamics can be negated when a group makes a self-referential play on them".*

To have access to experiential data as to how this statement might be born out, instead of merely claimed, would offer a different kind of research contribution. For one thing, the principle researcher names at one point his personal feeling of exhaustion when interviewing his participants, and it may be that a more manageable sample size would allow for a yield of experiential data within the interview data itself, in the 'double hermeneutic' of dual interpretation between researcher and respondent (Giddens, 1984). A more iterative ('noticing; going back; refining') and idiographic ('focus upon individual differences and experiences') approach might help to substantiate how the data that are codified could begin to be understood (including how one might begin to understand McCann's personal exhaustion in the context of his particular research undertaking). The taking up of an interpretative phenomenological analysis may offer a more explicit idiographic focus upon the meaning-making involved in what a humour experience was like (i.e., its *phenomenology*), and how this experience could be made sense of (i.e., through *interpretation*) in the analysis of an interview relationship. This raises a second research question for further investigation, including in comparison between the research methodologies presented elsewhere in this research project (see: papers *two* versus *three*):

RQ2: Does a model for data analysis with an explicit ideographic focus – such as interpretative phenomenological analysis – support the understanding of a humour experience?

3.2 | Relief

The ontology of superior humour began to lose favour in the eighteenth century, concurrent with the epistemological movement of rationalism and biological advancements in understanding of the central nervous system. A new paradigm emerged (Kuhn, 1996), which linked humour experiences to neural pathways, sense organs, and muscular expression – “fluid and subtile [sic] matter, passing through the Conduits of the Nerves” (Locke, 1823, p. 432) – towards a physical outcome experienced as relief. About laughter, Lord Shaftesbury (1709) wrote that “the natural free spirits of ingenious men [sic], if imprisoned or controlled, will find out other ways of motion to relief [sic] themselves in their constraint”; for Herbert Spencer (1898), nervous energy “always tends to beget muscular motion, and when it rises to a certain intensity, always does beget it”. In *Jokes and their Relation to the Unconscious* (1905), Sigmund Freud took up the relieving psychological processes and techniques of jokes in a psychical economy that is compared with mechanisms involved in dreamwork and in the unconscious. Put simply, for Freud, jokes, wit, a sense of the comic, and the experience of humour were here seen to release a store of pent-up energy that would otherwise have been employed in the service of repression, thinking, or affect. This excess reserve of energy is then discharged as laughter or as amusement. In this early work, Freud outlines different aspects of the relief-producing undertaking: first, jokes and associated ephemera to do with the repurposed energy conventionally employed in the repression of sexual and hostile desires and anxieties; second, ‘the comic’, involving the expenditure of surplus energy usually employed for thinking or understanding something; and

finally, ‘humour’ which comes about as libidinal economy in the expenditure of affect, for instance, of pity. This was known to writers such as Mark Twain:

> *“Everything human is pathetic. The secret source of Humour itself is not joy but sorrow. There is no humour in heaven”* (Twain, 1897, p. 326).

Stalikas et al. (2008; 2018) – *Humour promotes positive feeling*

Literature which follows the ontology of this ‘relief hypothesis’ includes that by Anastassios Stalikas et al. (2008; 2018), who emphasise the role of positive emotions in the psychotherapeutic process. This includes the relief found in humour as encountered in the emotional presence, expression, and experience of a ‘broaden-and-build’ model in the psychotherapy relationship (see also: Fredrickson, 2001; Seligman & Rashid, 2006; Waugh & Fredrickson, 2006). Apparently standing in opposition to a hegemony in psychotherapy which focuses upon negative feelings such as pain and guilt (see also: Lemma, 2000; Alvarez, 2012), such an approach emphasises the value of an “upward spiral in which positive feelings and broadening feed one another, which enlarges current psychotherapeutic conceptualisations by suggesting that positive emotions are not just indicators but are also generators of change” (Stalikas & Fitzpatrick, 2008). In a similar vein, Kramen-Kahn et al. (1998) suggest that such positive change generation achieved through humour is also necessary for the relief experienced by psychotherapists, and not only by their patients. In their survey put to 208 psychotherapists, 171 were found to maintain that a sense of humour was a “highly satisfying career-sustaining behaviour” (Kramen-Kahn & Hansen, 1998). Grotjahn (1971) finds a similar conclusion, with a therapist’s personal humour seen as demonstrating ‘emotional freedom’ (for the benefit of their

patient). From this, a question for further investigation – including elsewhere in this research project (see: papers *two* and *three*) – may be developed:

RQ3: Does humour produce relief or relief produce humour?

Following this hydraulic economy ontology of humour experienced as relief, in a finite libidinal system, surplus libido must be discharged as 'positive emotions'. One question this raises is: what if such recycled energy could (also) be put in service of other ends, such as creativity and the birth of a new thought, or, as Democritus had alleged earlier, as wisdom? What if there is a fusing potential of such energy which may link it to other potentially cathected (meaning: linked and activated) systems, or what if the energy can be employed in a renewable way as a means to replenish its host system, instead of being rendered only as a waste product – merely suitable for discharge through the exhaust valve of laughter and amusement? Drawing upon the nomenclature familiar to the author's psychotherapy training: is humour an aspect of 'alpha-function', drawing upon sense impressions to create 'elements' usable for thinking, dreaming, and meaning, or is the assuming of a humorous attitude more akin to the encrusting of a 'beta-screen', precipitating only meaningless sensory and emotional content, fit only for evacuation (Bion, 1962)[14]?

[14] Here, the research consideration raised above between a humorous attitude and a state of funniness may be instructive. Although too clinically precise to be developed as a general research question, papers *two* and *three* of this research will examine the extent that humour works more like alpha-function and funniness works more like a beta-screen.

Berger et al. (2018) – Humour confirms that we 'get it'

From a physiological perspective, Berger et al. (2018) investigate the neural correlates of humour processing in patients with schizophrenia spectrum disorder (SSD) by collecting regional brain frontal hypoactivation and parametric modulation of brain responses through Functional Magnetic Resonance Imaging (fMRI) in thirty-one patients with SSD and a control group, when performing a humour processing paradigm. These researchers found indications of impediments in reward-related processing of humour for participants with SSD, suggesting that the nature of the disorder obstructs the kind of relief in humour that may be experienced in brains [sic] which are non-schizophrenic.

To the author of this literature review, such research suggests that we find relief in humour because our humour confirms that we *get it* – what is happening within ourselves, with others, and in the world – in conditions of health. This is supported by findings presented elsewhere in this research project (see: *paper two – 3.4* '*Findings*'). In child psychotherapy research, Schneider and Robin (2006) find a similar role for humour in supporting the development of cognitive abilities such as perspective-taking and understanding others' mental states. On this subject, Hersh (2022) distinguishes between 'the physiological event of laughter' and the 'cognitive-emotional experience of humour', acknowledging that the wealth of available empirical findings supporting the physiological benefit of laughter (e.g., upon cortisol and blood pressure reduction, as well as upon the capacity to name emotions [relief from alexithymia]) tends to be taken from studies which do not explore the experience of humour as an independent variable, "such is the reality of subjective difference found in every humour

experience". In this literature review, this body of research is seen to suggest that in humour there is no measurable physical 'outside' of a person's subjective experience: the possibility of humour *is* subjective experience in conditions of health. From this perspective, humour provides relief – or really, safety and satisfaction – because it confers an internal and external world that is comprehendible to us, unlike the fragmented existence that may be experienced in a state of schizophrenia. As Stern (1985, p. 68) writes, you cannot tease other people unless you guess what is in their minds and make them suffer or laugh because of your knowing.

Humour experience and mental health

Research studies which do seek to interrogate humour as an independent variable in a link with mental health and pathology include those which involve administering humour and mental health scales to participants (see: Porterfield, 1987; Lefcourt, 2002; Kuiper and Martin, 1993). This area of research generally indicates a correlative link between elevated humour and relief: finding evidence of lower depression, anxiety, and stress (see: Bizi et al., 1988; Martin & Dobbin, 1988; Martin & Lefcourt, 1983). However, while humour is seen in these studies to mitigate symptoms of depression directly (i.e., it helps coping and improvement in periods of depression [see: Strick, Holland, Van Baaren & Van Knippenberg, 2009]), no interaction is found between humour and stress in the *prediction* of depression. Significantly, in causal research studies which examine the relationship between experiences of humour (as independent variable) and mental ill-health (as dependent variable), humour is indicated to be a correlate, but not a causal moderator, of mental and emotional health. Such findings

suggest that having access to humour won't prevent the onset of mental ill-health (such as depression [Porterfield, 1987]), but it will help to mitigate the symptoms when illness comes. This is robustly expressed in work by Lefcourt (2001), who offers the support of experiential data from qualitative interviews combined with quantitative measures, including standardised scales and psychometric tools, to emphasise humour's role as a moderator of stressful experiences, anxiety, and depression – but only at times, and under certain conditions[15]. This review has found that such studies are generally without experiential data to consider, and further investigation is needed to interrogate and corroborate this central finding i.e., that humour can mitigate but will not prevent mental ill-health. The tension that such confounding literature creates between the expectations and beliefs among therapists (such as the author of this review) about experiences of humour and what evidenced outcomes may actually reveal is a rationale for the framework analysis presented elsewhere in this research project (see: *paper three*).

3.3 | Humility

Within psychoanalytic literature, a complicating of the superiority ontology of humour – and its dynamic inversion with the principle of inferiority or emptiness – is taken up in Freud's 1927 article 'Humour', which supersedes his earlier work dealing with the principle of relief. Here, Freud sees the humour phenomenon to involve one part of the psyche – the 'superego', or morality principle – looking

[15] As a clinician, I am helpfully challenged by the findings of this research body, which run counter to some of my own assumptions and beliefs about progressing and ending well with my patients. In my own psychotherapy work, I have been ready to attach an auspicious hope and expectation to the 'good humours' that can emerge and begin to flow healthily over the course of treatment. But here is a confounding point in the research literature. According to this body of research, my expectation is mistaken, and such humour will do nothing to prevent my patients from becoming ill.

with kindness upon the inevitable limitations of another part: the struggling ‘ego’, or reality principle. In *Jokes and their Relation to the Unconscious* (1905), outlined above, a brief account of humour was understood by Freud to be a pleasure-yielding economised expenditure upon feeling – for instance, upon pity, as in the Mel Brooks aphorism: “tragedy is when I cut my finger, comedy [sic] is when you fall into an open manhole and die”. In 1927, Freud developed this account beyond a strictly economic formulation, informed by his structural model of a poor ego, beset by danger on three sides: from the external world, from the libidinal impulses of the id (or ‘pleasure principle’), and from the internalised sense of guilt in the superego (or ‘morality principle’). In this later model, Freud suggests that the ego, as a means of surviving its distress, defers its psychical investment onto the authority of the superego which is capable of bringing about a humorous attitude. The superego, thus hyper-cathected and omnipotent, consoles the ego through its humour, and renders its suffering insignificant. As a result of bringing about the humorous attitude, the superego repudiates reality and therefore serves an illusion which safeguards the psyche from becoming overwhelmed by its failures. Freud here anticipates a new function for the superego under the auspices of humour as a protective – as opposed to principally critical – influence over a subservient ego, claiming: “Look! Here is the world, which seems so dangerous! It is nothing but a game for children – just worth making a jest about” (Freud, 1927, p. 166). This consoling influence of humour found in the experience of humility and appreciation for limits also appears elsewhere in psychoanalytic literature, including across the work of Wilfried Bion. To provide just one example of many, when Bion was asked to republish his papers on group work, he wrote:

> *"It was disconcerting to find that the committee* [The Professional Committee at the Tavistock Clinic] *seemed to believe that patients could be cured in such groups as these. It made me think at the outset that their expectations of what happens in groups of which I was a member were very different from mine. Indeed, the only cure of which I could speak with certainty was related to a comparatively minor symptom of my own—a belief that groups might take kindly to my efforts"* (Bion 1961, p. 29).

In this later model of humour, Freud seems to see things differently to the findings of McCann et al. (2010), who found the statement 'it's just a joke' to be central to a humour experience which disguised real violence. For Freud, humour does not act, but responds; it is not a substance or fluid, but a perspective with which to resource us in relation to what is – or isn't – already there. We don't experience humour in order to become empty (e.g., projected relief of self-hatred), we experience humour because we are (to some extent) empty and we need help to cope with this. For Freud, humour does not transform or transfer, but compensates. Although this is achieved in a vainglorious way – as a triumph of narcissism over the ego's struggles with reality – an emphasis is here placed upon the futility of humour as a phenomenon of illusion in service to palliation alone ('there, there – seen from this way, it's not so bad') and Freud seems to leave open whether anything can be learned from, or done with, any such understanding of what we do with how we suffer[16].

The question of whether humour is developmental in any way is seen to be a central contentious point in literature of the subject. Studies, including by Bloch

[16] However, Freud does seem to recognise elsewhere the concurrence of humour at the threshold of insight in psychoanalysis: "*Many of my patients…are regularly in the habit of confirming the fact by a laugh when I have succeeded in giving a faithful picture of their hidden unconscious to their conscious perception; and they laugh even when the content of what is unveiled would by no means justify this*" [Freud, 1905, p.170].

(1987), Hussong & Micucci (2021), and Briggs et al. (2022), which interview and survey clinicians about their practice, commonly find expressed caution by therapists about what can realistically be expected of humour introduced in work that is ultimately with vulnerable people. When humour is understood as a non-directive, inter-subjective experience between the therapist and their patient (see: Altman, 2006), and not as an instrumental utility under the therapist's control, a question is raised in existing literature about why any therapist would take such risks with the phenomenon when its outcomes can be so unclear. From this, a research question for further investigation can be developed:

RQ4: Can we learn or develop from an experience of humour? Does humour actually do anything, or is it simply an appeasement (e.g., of the patient's narcissism, or that of their therapist) – a convenient fiction deluding us from an inconvenient reality?

Freud's emphasis upon illusion in 'Humour' helps to clarify this contention, as it engages us in reckoning with the extent to which we can know an entertained illusion to be baldly and solely a de facto departure from reality, versus the extent to which we can consider the illusion of humour to offer a loosening of constraint and a broadening of insight that may help us to better understand, through laughing at it, internal and external reality (see: Lemma, 2000; Steiner, 2020). This insight-broadening and constraint-loosening aspect of the phenomenon is also investigated in mentalisation-based models of child psychotherapy, which similarly affirm a playful and humorous engagement with reality (Fonagy & Target, 1996). In the framework of Freud's later theory of humour, we do not seek out superiority over others or over our former selves, but rather, we use humour to make better contact with our inevitable inferiority and experience of

failure about who we think and feel we should, but can never, be. So, in psychotherapy, an experience of humour may help to transform a lofty, morally ascendent interpretation or relational position into a more grounded and realistic encounter involving one struggling person trying to understand another.

3.4 | Play

In a survey of literature about the subject of humour (Talens, 2020), it is suggested that work concerning young people lacks commensurate thought as equivalent research dealing with adults. For Talens, terminology and theoretical orientation is seen by those commenters of available literature on humour with young people in psychotherapy to orient towards the role of play and playfulness, or frameworks of learning, development and education. The findings of such psychotherapy research, it is here suggested, frequently relate to the educational domain, with a particular bias towards interventions and their outcomes as validation: “evidencing results, instead of an interest in what emerges in the relational research process” (Talens, 2020, p. 87). This author argues that psychotherapy *through* play has been long-established, codified, systematised, sold on the marketplace – but psychotherapy *as* play continues to suffer conspicuous disregard within the discipline. A notable exception to this is offered by Talens in the work and legacy of DW Winnicott, who, it is argued, understood in the experience of humour, as in play, the same “multi-modal haven for feelings”:

> *"I suggest that we must expect to find playing just as evident in the analyses of adults as it is in the case of our work with children. It manifests itself, for instance, in the choice of words, in the inflections of the voice, and indeed in the sense of humour"* (Winnicott, 1971, p. 50).

Winnicott (1953) – "*The natural thing is playing"*

Winnicott names humour as among the so-called transitional phenomena involving mother and baby in negotiation of the infant's grasp of the not-me possession. For this author, through play, children can discover 'what is real'. We can understand mother and baby to engage one another – through teasing, through humorous play – in that which unites them, but which at the same time underlines their separation and distinction from one another, including through the child's ultimate destruction of the imagined mother and discovery of the surviving real mother waiting to be found. To the mind of this author, the humorous game peekaboo is an illuminating example of this, as is child development research which highlights the 'mirroring' faces produced by caregiver ("our first clown" [see: Lemma, 2000]) and baby in acts of humour play (Trevarthen, 1979; Beebe & Lachmann, 2002), where, "I who was seen saw myself" (Sartre, 1981). Related research into therapy process includes that by Hall et al. (2010), who find in qualitative interviews and video analysis evidence of non-verbal cues, including facial expressions, body language, and tone, which play a role in humorous exchanges between therapists and patients.

Contrary to Melanie Klein's interest in the *usages* of play, Winnicott discriminates his interest in the verbal noun 'playing', meaning 'the experience of'[17]. What is

[17] This is much like the distinction raised by the author of this study and research project between the 'usages', as opposed to experiences, of humour encountered in psychotherapy (see: *Box 2*, p. 5).

seen as crucial is that mother and baby are understood to collaborate in the shared undertaking of the humour experience found in playing, the significance of which is corroborated by both in an unchallenged and sacred space between them. One can imagine a caregiver dutifully conveying: “I am the tickle monster because you have made me so in our play, but you also know that such transitional metamorphosis is only made possible by the foundational wisdom that I remain your mummy, waiting to be found”. This conceptualisation is found elsewhere in this research project (see: *paper three – 3.3* ‘***Findings***’).

Lemma (2000) *– Humour for its own sake*

With respect to psychotherapy practice, Lemma (2000) extends this model to suggest that allowing entry into the humorous space is the same as allowing entry into an analytic space in therapy. Writing with clinicians in mind, Lemma reminds us that there is an important difference between a patient merely sitting with a therapist/analyst in a room and the experience of being with someone in a therapeutic relationship, in an interactive space that is real and felt. In this respect, for Lemma, experiences of humour in therapy offer an alternative to stereotypical ‘you mean me’ transference interpretations – which she suggests may more commonly function to keep real experiences out of sessions. The contrived seriousness of many analytic encounters is seen by this author to so often stifle true transitional and transferential phenomena and experience, and to obstruct entry to the therapist’s ‘real’ emotional responses (“as if the actual content of what the patient says – and the felt reaction of their therapist – could ever be subordinate to the transference implications of this” [Lemma, 2000, pp. 86-87]). Lemma goes on to argue that change in psychotherapy rests upon

participation in experience (for instance, a humour experience), but also in an understanding of the conflicts and inhibitions that may have prevented therapist and patient from having felt such experiences before. For this author, this is all relevant clinical data. What today strikes us as humorous is what yesterday might have overwhelmed us. As Freud writes in his paper 'Creative Writers and Day-Dreaming':

> *"As an adult he can look back on the intense seriousness with which he once carried on his games in childhood; and, by equating his ostensibly serious occupations of the day with his childhood games, he can throw off the too heavy burden imposed on him by life and win the high yield of pleasure afforded by humour"* (Freud, 1908, p. 144).

For Lemma, underlying any humorous exchange in psychotherapy is a negotiation about whether to transpose the communication into a more serious discussion of further exploration. Psychoanalysis [sic] is seen as a 'pretend experience' in which play, including the play of humour, is central. Lemma here follows Winnicott: "the natural thing is playing, and the highly sophisticated twentieth century phenomenon is psychoanalysis" (Winnicott, 1971, p. 41). A research question developed for consideration, including elsewhere in this research project, is:

RQ5: As a subset of play is humour therefore a subset of psychotherapy?

Haydon et al. (2015) – *Humour as play at work*

Haydon et al. (2015) investigate the play of humour in therapeutic work through a narrative inquiry of sixty-minute interviews with a small sample of four nurses recruited from regional hospitals in New South Wales, Australia, in consideration

of the place of humour in the nurse-patient relationship. These researchers make the helpful observation that within the abundance of qualitative research into humour in the medical professions, very little attention has been accorded to the place of humour within the intricacies – the textural playing – of the clinical relationship itself. This literature review has found that a basic but neglected truism in literature of the subject is that *an experience of humour takes place between people*. This study is therefore unusual among existing literature for its consideration of how the partners in a clinical relationship play with each other when their contact is not saturated by the task of getting on with treatment and recovery (i.e., when professional rule- and role-bound participants in humour are 'playing' instead of 'working' at work).

Overall, the researchers found that their nurse participants held a positive view of humour on the wards, appraising it as valuable to the formation of a therapeutic relationship, and as generally supportive of health outcomes (see also: Tremayne & Sharma, 2019). Interestingly, a dominant theme of gender differences was found in the interviews, with the nurses observing a typical 'bonding' in the humour experiences encountered in their playful exchanges with female patients. This included when such patients would use humour to reassure their family members, and indeed the nurses themselves, in moments of distress (the interviewed nurses notably described quite complicated feelings, including of strong dislike, for such patients who sought to bond by reassuring them in this way). By way of contrast, male patients were seen by the nurses to use humour in a more forceful way that inverted the patient-clinician dynamic along lines of socially constructed dynamics of power. For instance, male patients were reported as using sexually inappropriate humour, which belittled the nurses and

denied their authority over the patients on the ward – obstructing the work of treatment and recovery. Otherwise, defensive, overblown displays of 'ruddy humour' were described, which were seen by the nurses to deny the reality of the male patients' illnesses or injuries altogether.

The findings concerning sexual differences in reactivity to humour are inconclusive in research literature. Some studies have found that females can prefer humour more than males (e.g., Bear, 2024), whereas others have yielded directly contradictory results (e.g., Evans, 2023). The intricacies of these differences are richly considered in studies including by Lampert et al. (2006) who examined humour in transcripts of naturally occurring conversations in mixed and same-sex groups of friends, and who found multiple patterns, connections, and relationships in different configurations. Further empirical investigation is indicated.

The finding by Haydon et al. (2015) of the obstruction caused by humour to the progress of therapeutic work is well represented in existing literature, with frequent citations of a clinical commentary by Kubie (1971), who cautioned that humour may be "potentially[18] destructive" to the therapeutic alliance: "humour has its place in life. Let us keep it there". Other studies expressing similar humour-scepticism in therapeutic outcome include those by Kuhlman (1984) and Bloch (1987), and more contemporary experiential data is found by Sultanoff (2013) of experiences in psychotherapy where humour has "backfired", leading to ruptures and misunderstandings. An important question then can be

[18] To the mind of this study's author, this "*potentiality"* named by the cautionary Kubie (1971) nevertheless seems to leave open significant scope for what may or may not happen in the intricacies of humorous therapeutic contact and play.

developed for further consideration, including elsewhere in this research project (see: papers *two* and *three*):

RQ6: Is the experience of humour helpful to therapeutic work?

Briggs (2022) *– Humour as cathartic change*

The ambi- and multi-valent 'playing' functions of humour within the playing of a clinical relationship, with respect to its uses and misuses to the progress of treatment, is also taken up by the findings of a study by Briggs et al. (2022), with a similar research design to the interpretative phenomenological analysis presented elsewhere in this research project (in *paper two*). This study interviewed six trainee and qualified counsellors about their experiences of humour in their work and training. One central finding identified 'key moments' of humour which offer both 'catharsis' and 'a sign of change and progress'. It is interesting to consider these findings, from a small interview sample group within the professional discipline of counselling, and to anticipate how they may contrast with a corresponding sample group taken from the sister discipline of psychotherapy, as is undertaken elsewhere in this research project (see: *paper two*). To this author's mind, the findings of both 'catharsis' and a 'signification of change' (Briggs et al., 2022) are at one step removed from a dynamic relational understanding that may be more particular to psychotherapy practice and training. Which is to say, the catharsis achieved through humour in counselling may offer a key moment of laughing out painful mental content, but, in this author's understanding, by definition, it is not exactly clear what has happened in the cathartic experience (we just feel better for having done it). A relevant analogy to this may be drawn to the ancient Grecian practice of 'komos', where

worshipers of Dionysian destructive revelry engaged impulsively in a disturbing but frolicsome dismemberment of social conventions and inhibitions (from which we are given the Greek word ‘komodia’ [‘song of the komos’], and the proceeding tradition of comic theatre and comedy). In the view of this study’s author, this komos-like experience of *cathartic* humour may be contrasted with the clinical transference interpretations more typical of (psychoanalytical) psychotherapy process, where a felt experience is likely to be interrogated to (try to) better understand who and what has done what to whom. A question for further consideration that this raises is:

RQ7: Does it matter how humour in psychotherapy feels?

Different to the findings of other studies, including those by McCann et al. (2010) on the subject of Australian maleness, the studies by Haydon et al. (2015) and Briggs et al. (2022) do not extrapolate broader cultural implications from their findings (despite Haydon et al. [2015] gathering data from their nurse participants about such themes as ‘Aussie blokeyness’). Future research, including in this research project, might pay closer attention to participants’ own professional roles and personhoods in the part that they can be understood to play in the humour experiences they encounter and later describe. For instance, it is assumed as understood that the four nurse participants interviewed by Haydon et al. (2015) are female. However, this is not made explicit, nor is it brought into the study’s analysis. If implications can be drawn from the findings of similar research studies to the broader helping professions, it would be further interesting to learn more about the role of medical colleagues (including doctors; lead and junior nurses; hospital porters etc.), as well as relationships with the medical organisation and institution itself [the ‘organisation-in-the-mind’, see: Armstrong, 2005]), in how

clinical practitioner participants encounter their patients in the generation of the humour experiences taking place between them. This suggests that there may be important 'conditions', or, following Winnicott (1965), 'environmental factors', that determine an experience of humour as play. A research question may be developed for further consideration:

RQ8: What conditions are necessary to experience humour in psychotherapy?

4 | SUMMARY OF DEVELOPED RESEARCH QUESTIONS

Listed below, in *Table 4,* are research questions developed from critically examined selection of literature belonging to distinct underlying ontological foundations which have been identified in this literature review to have emerged in historical paradigms. These developed research questions are taken up in further investigation in interview-based empirical investigations presented elsewhere in this research project (see: papers *two* and *three*).

Table 5.

(Humour is) Superiority
• **RQ1:** What amount and type of detail – with respect to the 'thickness' and 'thinness' of description (see: Geertz, 1973) – supports a meaningful understanding of an account of an experience of humour? • **RQ2:** Does a model for data analysis with an explicit ideographic focus – such as interpretative phenomenological analysis – support the understanding of a humour experience?
(Humour is) Relief
• **RQ3:** Does humour produce relief or relief produce humour?
(Humour is) Humility
• **RQ4**: Can we learn or develop from an experience of humour? Does humour actually *do* anything, or is it simply an appeasement (e.g., of the patient's narcissism, or that of their therapist – a convenient fiction deluding us from an inconvenient reality)?
(Humour is) Play
• **RQ5**: As a subset of play is humour therefore a subset of psychotherapy? • **RQ6**: Is the experience of humour helpful to therapeutic work? • **RQ7**: Does it matter how humour in psychotherapy feels? • **RQ8**: What conditions are necessary for an experience of humour in psychotherapy?

Developed research questions for further investigation.

5 | LIMITATIONS

This literature review has faced several key limitations in its attempt to critically examine how experiences of humour are understood within psychotherapy. A primary challenge relates to the experiential and subjective nature of humour (see: Hersh, 2022, in *3.2 'Relief',* above). As a phenomenon that occurs between individuals, humour resists empirical measurement and often eludes systematic capture. This has necessitated the use of strict inclusion criteria (see: *Table 2*, p. 7) to distinguish humour-as-experience from humour-as-instrument, which may have excluded studies offering valuable insight despite methodological shortcomings.

Another limitation arises from the cultural and linguistic scope of the review. While the search included APA databases and seminal psychoanalytic texts from psychotherapy training syllabi, the resulting literature is primarily Western and English-language. This introduces a cultural bias and limits generalisability to non-Western psychotherapeutic contexts where humour may be conceptualised and experienced differently.

There are also theoretical constraints linked to the psychoanalytic ontology that underpins this research. While this has provided a coherent interpretative lens, it may have limited engagement with other therapeutic models – such as systemic, behavioural, or integrative approaches – that conceptualise humour differently. The focus on psychoanalytic literature also reflects the author's professional training context, and this influence is acknowledged.

In attempting to clarify the theoretical foundations of humour in therapy, this review identified four ontological paradigms – superiority, relief, humility, and play. However, this categorisation is itself interpretative. Some studies could arguably belong to multiple paradigms, and the typology may oversimplify the complexity of humour experiences that often resist fixed theoretical classification.

Lastly, this review underscores a broader evidentiary gap in the literature: namely, a lack of detailed, idiographic accounts of humour as it is lived and experienced within therapeutic relationships. Even where humour is referenced, it is often described in terms of its instrumental utility rather than its relational or affective dimensions. This gap strongly justifies the empirical investigations pursued in papers two and three of this thesis, which seek to explore and interpret the lived experience and meaning-making of humour within the specific context of psychoanalytic psychotherapy with adolescents.

Together, these limitations illuminate the challenges of researching humour in psychotherapy and support the methodological shift in this thesis towards qualitative, experience-near inquiry that aims to better capture this complex and under-theorised phenomenon.

6 | **CONCLUSION**

This literature review has critically examined a comparatively underexplored aspect of humour in psychotherapy: its experience as a dynamic interaction between people. Through a detailed analysis of key ontologies, identified by this study's author – 'Superiority', 'Relief', 'Humility', and 'Play' – humour has been recognised as a multifaceted phenomenon that can play a significant role in

therapeutic processes and psychotherapy practice. It has been seen to facilitate emotional relief, to reveal the underlying power dynamics in relationships, to promote humility through self-awareness, and to enable therapeutic play as a tool for deeper engagement.

However, this review has also affirmed a gap in the existing literature: while humour's potential benefits in therapy are often recognised, there is a notable absence of detailed experiential data that explores the texture and complexity of these lived experiences. Additionally, the reasons for why humour is seen to function effectively in therapeutic settings – and how these effects are understood by both therapists and patients – remain underexplored. This gap underscores the need for further investigation, which is addressed in papers *two* and *three*, presented elsewhere in this research project.

LINKING PASSAGE

This review of existing literature about experiences of humour in psychotherapy has raised a number of considerations inviting further investigation. It has suggested that what is missing from available understanding on this subject is: first, experiential data about the lived experience of humour in psychotherapy; and second, an understanding of the reasons for how a lived experience of humour is understood as such. These outstanding considerations are taken up elsewhere in this research project: in an interpretative phenomenological analysis (which investigates the lived experience of humour in psychotherapy) and a framework analysis (which examines how such an experience is then understood) (see: papers *two* and *three*).

7 | WORKS CITED

Altman, N. (2006). Commentary on paper: 'And Now for Something Completely Different: Humour in Psychoanalysis' by Joseph Newirth. *Psychoanalytic Dialogues*, 573-577.

Alvarez, A. (2012). *The Thinking Heart: Three levels of psychoanalytic therapy with disturbed children.* London: Routledge.

Aristotle. (1996). *Poetics.* London: Penguin Classics.

Armstrong, C. (2015). *The therapeutic 'aha!': 10 strategies for getting your clients unstuck.* New York: WW Norton & Co.

Armstrong, D. (2005). *Organisation in the Mind: Psychoanalysis, Group Relations, and Organisational Consultancy.* London: Routledge.

Baudelaire, C. (1956). *The Essence of Laughter.* London: Meridian Books.

Bear, J. (2024). Understanding the role of gender in humour expression: directions for future scholarship. *Current Opinion in Psychology*, Vol. 55.

Beebe, B., & Lachmann, F. M. (2002). *Infant research and adult treatment: Co-constructing interactions .* London: Taylor & Francis.

Berger, P., Bitsch, F., Nagels, A., Straube, B., & Falkenberg, I. (2018). Frontal hypoactivation and alterations in the reward-system during humour processing in patients with schizophrenia spectrum disorders. *Schizophrenia Research*, 149-157.

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

Bloch, S., & McNab, D. (1987). Attitudes of British Psychotherapists Towards the Role of Humour in Psychotherapy. *British Journal of Psychotherapy*, 216-225.

Briggs, E., & Owen, A. (2022). Funny, right? How do trainee and qualified therapists experience laughter in their practice with clients? *Counselling and Psychotherapy Research, 22(2)*, 278-287.

Britton, R. (2003). Humour and the superego. In R. Britton, *Sex, Death, and the Superego.* London: Routledge.

Brooks, A., Baumann, A., Huber, D., Rabung, S., & Andreas, S. (2023). Banter in psychotherapy: Relationship to treatment type, therapeutic alliance, and therapy outcome. *Journal of Clinical Psychology, 79(5)*, 1328-1341.

Democritus. (1991). The Essential Democritus. In *The Presocratics: A New Translation and Commentary.* New Jersey: Princeton University Press.

Dunbar, R. I., Baron, R., Frangou, A., & Pearce, E. (2012). Social laughter is correlated with an elevated pain threshold. *Proceedings of the Royal Society B: Biological Sciences*, 1161-7.

Espelage, D. L., & Swearer, S. M. (2010). A social-ecological framework of bullying among youths . In D. L. Swearer, *Bullying in North American Schools* (pp. 1-12). New York: Routledge.

Evans, J. (2023). Gender and humour. *Current Opinion in Psychology*, Vol. 54.

Fonagy, P., & Target, M. (1996). Playing with reality: Theory of mind and the normal development of psychic reality. *International Journal of Psychoanalysis*, 217-233.

Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977.* New York City: Pantheon Books.

Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: the broaden-and-build theory of positive emotions. *American Psychologist*, 218-226.

Freud, S. (1905). *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume VIII (1905): Jokes and their Relation to the Unconscious.* London: Hogarth Press.

Freud, S. (1908). Creative Writers and Day-Dreaming. In S. Freud, *Standard Edition Vol IX* (p. 141). London: Hogarth Press.

Freud, S. (1927). Humour. In S. Freud, *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. XXI* (pp. 159-166). London: Hogarth Press.

Geertz, C. (1973). Thick description: toward an interpretive theory of culture. In C. Geertz, *The interpretation of cultures: selected essays* (pp. 3-30). New York: Basic Books.

Gibson, N. (2018). The Best Medicine? Psychotherapists' Experience of the Impact of Humour on the Process of Psychotherapy . *Journal of the Society for Existential Analysis*.

Giddens, A. (1984). *The Constitution of Society.* Los Angeles: University of California Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory. Strategies for qualitative research.* London: Weidenfeld and Nicolson.

Goffman, E. (1973). *Stigma: Notes on the Management of Spoiled Identity.* Saddle River, NJ: Prentice Hall.

Grotjahn, M. (1971). Laughter in group psychotherapy . *International Journal of Group Psychotherapy* , 234-38.

Haydon, G., Van der Reit, P., & Browne, G. (2015). A narrative inquiry: Humour and gender differences in the therapeutic relationship between nurses and their patients. *Contemporary Nursing, 50(2-3)*, 214-26.

Hersh, M. A. (2022). Inspiring laughter, humour, joy, and playfulness. In M. A. Hersh, *The thriving therapist: Sustainable self-care to prevent burnout and enhance well-being* (pp. 245-253). American Psychological Association.

Hippocrates. (400 BCE/1983). On the Nature of Man. In J. &. Chadwick, *Hippocratic Writings.* London: Penguin Classics.

Hobbes, T. (1996). *Leviathan.* Cambridge : Cambridge University Press.

Hurley, M. M., Dennett, D. C., & Adams, R. B. (2011). *Inside Jokes: Using Humour to Reverse-Engineer the Mind.* Cambridge, MA: MIT Press.

Hussong, D. K. (2021). The use of humour in psychotherapy: Views of practicing psychotherapists. *Journal of Creativity in Mental Health, 16(1)*, 77-94.

Irving, K. (2019). The role of humor in priming intersubjectivity. *Psychoanalytic Psychology*, 207-215.

Kant, I. (1892). *Anthropology from a Pragmatic Point of View.* London : George Bell & Sons.

Kastner, C. (2024). A lighthearted approach to mindfulness: Development and evaluation of a humor-enriched mindfulness-based program in a randomized trial. *Frontiers in Psychology*, Vol. 14.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1949). *Sexual Behaviour in the Human Male.* Philadelphia: W.B. Saunders Company.

Klein, M. (1935). A contribution to the psychogenesis of manic-depressive states. *International Journal of Psychoanalysis*, 145.

Kramen-Kahn, B., & Hansen, N. D. (1998). Rafting the rapids: Occupational hazards, rewards, and coping strategies of psychotherapists. *Professional Psychology: Research and Practice*, 130-134.

Kubie, L. (1971). The destructive potential of humour in psychotherapy . *American Journal of Psychiatry*, 861-66.

Kuhlman, K., Kelci, S., Mousavi, Z., Tran, M.-L., & Rodgers, E. (2021). Predictors of Adolescent Resilience During the COVID-19 Pandemic: Cognitive Reappraisal and Humour. *Journal of Adolescent Health*, 729-736.

Kuhn, T. (1996). *The structure of scientific revolutions .* Chicago, IL: University of Chicago Press .

Kuiper, N. A. (1993). Humour and self-concept in stress relief. In P. McGhee, *Handbook of humour research Vol. 2* (pp. 41-71). New York: Springer-Verlag.

Lampert, M., & Ervin-Tripp, S. (2006). Risky laughter: Teasing and self-directed joking among male and female friends. *Journal of Pragmatics*, 51-72.

Lefcourt, H. M. (2001). *Humor: The psychology of living buoyantly .* Amsterdam: Kluwer Academic/Plenum Publishers.

Lemma, A. (2000). *Humour on the Couch.* London: Karnac Books.

LiButti, D. J. (2015). The efficacy of humor within psychotherapy. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, Vol. 75.

Locke, J. (1823). *The Works of John Locke. Vol. III.* London: Thomas Tegg.

Maples, M. F., Abramson, S., & Arnold, W. (2001). Humour in Therapy: A Review of the Literature. *The Journal of Cognitive Psychotherapy, 15(3)*, 299-310.

Marcus, P. (1990). Humour in Psychotherapy: A Cawes of Creative Resonance. *American Journal of Psychotherapy, 44 (1)*, 96-107.

Martin, R. A., & Dobbin, J. P. (1988). Sense of humor, hassles, and immunoglobulin A: Evidence for a stress-moderating effect of humor. *International Journal of Psychiatry in Medicine*, 93-105.

Martin, R. A., & Lefcourt, H. M. (1983). Sense of humor as a moderator of the relation between stress and mood. *Journal of Personality and Social Psychology*, 1313-1324.

McCann, D., Plummer, D., & Minichiello, V. (2010). Being the butt of the joke: homophobic humour, male identity, and its connection to emotional and physical violence for men. *Health Sociology Review*, 505-521.

Merleau-Ponty, M. (1962). *Phenomenology of Perception.* London: Routledge.

Morreall, J. (1986). *The philosophy of laughter and humour.* New York City: SUNY Press.

Pack, S., Arvinen-Barrow, M., Winter, S., & Hemmings, B. (2020). Sport psychology consultants' reflections on the role of humor: 'It's like having another skill in your arsenal'. *The Sport Psychologist*, 54-61.

Plato. (2010). *Philebus.* Cambridge: Cambridge University Press.

Porterfield, A. L. (1987). Does humour facilitate coping with life stress? *International Journal of Humour Research*, 135-154.

Randall, M. (2011). *First Laugh. Essays, 2000-2009.* Lincoln: University of Nebraska Press.

Rose, G. (1969). King Lear and the use of humour in treatment. *Journal of American Psychoanalytic Association*, 927-40.

Sartre, J.-P. (1981). *The Words: The Autobiographty of Jean-Paul Sartre.* New York: Knopf Doubleday Publishing Group.

Schneider, B. H., & Robin, M. (2006). The role of humour and play in children's psychotherapy. *Journal of Clinical Child and Adolescent Psychology*, 631-638.

Seligman, M. E., & Rashid, T. (2006). Positive psychotherapy. *American Psychologist*, 774-788.

Shaftesbury, A. (1709). *Characteristics of Men, Manners, Opinions, Times.* London: J. H. and R. Smith .

Smith, J. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain*, 41-42.

Spencer, H. (1898). *The Principles of Sociology, Vol. 1.* New York City: D. Appleton and Company.

Stalikas, A., & Fitzpatrick, M. R. (2008). Positive emotions as generators of therapeutic change. *Journal of Psychotherapy Integration*, 137-154.

Steiner, J. (2020). *Illusion, Disillusion, and Irony in Psychoanalysis.* London: Taylor & Francis.

Stern, D. (1985). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology .* New York: Basic Books.

Stringer, E. T. (2013). *Action Research.* Thousand Oaks, CA: SAGE Publications.

Sultanoff, S. (2013). Integrating Humour into Psychotherapy: Research, Theory, and the Necessary Conditions for the Presence of Therapeutic Humour in Helping Relationships. *The Humanistic Psychologist 41(4)*, 388-399.

Talens, P. (2020). 'When working in a youth service, how do therapists experience humour with their clients?'. *European Journal of Psychotherapy & Counselling*, 80-96.

Tremayne, P., & Sharma, K. (2019). Implementing laughter therapy to enhance the well-being of patients and nurses. *Nursing Standard*.

Trevarthen, C. (1979). Communication and cooperation in early infancy: a description of primary intersubjectivity. In M. Bullowa, *Before Speech: The Beginning of Interpersonal Communication* (pp. 321-347). Cambridge: Cambridge University Press.

Twain, M. (1897). *Following the Equator.* Hartford, CT: The American Publishing Company.

Van Baaren, R. B., & Van Knippenberg, A. (2009). Humor as social regulation: self-serving and affiliative consequences of humor. *Psychological Reports*, 831-842.

Varela, F. J., Thompson, E., & Rosche, E. (1991). *The Embodied Mind: Cognitive Science and Human Experience.* Cambridge: MIT Press.

Waugh, C. E., & Fredrickson, B. L. (2006). Nice ot know you: Positive emotions, self-other overlap, and complex understanding in the formation of a new relationship. *Journal of Positive Psychology*, 93-106.

Winnicott, D. (1971). *Playing and Reality.* London: Routledge.

Winnicott, D. W. (1953). Transitional objects and transitional phenomena . *International Journal of Psychoanalysis*.

Winnicott, D. W. (1965). *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development.* London: Hogarth Press.

Winnicott, D. W. (1971). Chapter 3. Playing: a theoretical statement. In D. W. Winnicott, *Playing and Reality* (pp. 38-52). London: Tavistock Publications.

Yardley, L. (2007). Demonstrating validity in qualitative psychology. In J. Smith, *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 235-251). SAGE Publications.

Zupančič, A. (2008). *The Odd One In: On Comedy.* Cambridge, MA: MIT Press.

Paper two – How do five trainee child and adolescent psychotherapists experience humour in their intensive psychotherapy work with adolescent patients? An interpretative phenomenological analysis

ABSTRACT

In this paper, the author presents a semi-structured interview-based study exploring how five trainee child and adolescent psychoanalytic psychotherapists from four distinct UK training schools experienced humour in intensive psychotherapy with their adolescent training cases. Interpretative phenomenological analysis was employed for data analysis. Four superordinate themes were identified: “Now I can see who you are”; “Putting it out there”; “Two folk in the room”; and “You get me”. The findings make plain the importance of humour for these therapists, who see it as essential to their work. Each therapist experienced humour to be congruent with psychotherapy aims, emphasising its role in deepening understanding and in overcoming difficulty. Experience of the phenomenon was seen to function to safely express aggression through healthy deprecation (of the patient themselves and of others). Humour was here recognised as involving deliberate activity by patient and therapist alike – and it was seen to develop the nature of the therapy relationship itself. Exactly how humour was experienced was seen to depend upon categories of explanation, such as the degree of institutional support available, and here certain ideas – for instance, about the principle of spontaneity – were typically applied in a post fact rationalisation which invites further investigation. Understanding the reasons for the lived experiences recounted in this study is beyond the scope of this paper. It is taken up in paper three of this research project (a framework analysis).

LINKING PASSAGE

This paper is part of a larger three-paper research project exploring experiences of humour in psychotherapy. As a general rule, humour is commonly recognised as a universal phenomenon experienced between people (see*: paper one – literature review*). However, in psychotherapy, systematic reviews of available literature exemplify that the greatest concern in the profession lies with the instrumental utility of humour – where humour is 'applied' as an instrument by the agent of the therapist. Such literature is seen to generally support the co-option of humour as a component of psychotherapy technique ('use it here, in this way, to achieve these results'). By way of contrast, there is limited understanding of experiences encountered in psychotherapy where humour happens outside of the therapist's authority and governance. This interpretative phenomenological analysis will investigate the lived experience of such 'happenings' in the work of five trainee child and adolescent psychotherapists. Close attention to the granular detail of the experiential data recounted here will address the following research questions, developed from a review of existing literature:

Table 1.

- **RQ1:** What amount and type of detail – with respect to the 'thickness' and 'thinness' of description (see: Geertz, 1973) – supports a meaningful understanding of an account of an experience of humour?
- **RQ2:** Does a model for data analysis with an explicit ideographic focus – such as interpretative phenomenological analysis – support the understanding of a humour experience?
- **RQ3:** Does humour produce relief or relief produce humour?
- **RQ4**: Can we learn or develop from an experience of humour? Does humour actually *do* anything, or is it simply an appeasement (e.g., of the patient's narcissism, or that of their therapist – a convenient fiction deluding us from an inconvenient reality)?
- **RQ5**: As a subset of play is humour therefore a subset of psychotherapy?
- **RQ6**: Is the experience of humour helpful to therapeutic work?
- **RQ7**: Does it matter how humour in psychotherapy feels?
- **RQ8**: What conditions are necessary for an experience of humour in psychotherapy?

Developed research questions from a review of existing literature (see: paper one).

1 | INTRODUCTION

1.1 | Background

Humour and psychotherapy

Humour is ubiquitous in the lives of people, with evidence demonstrating its prevalence across history, geography, and culture (see: Hurley et al., 2011, in paper one of this research project – *literature review*). Despite this, conspicuously little has been understood of experiences of humour in psychotherapy and its training institutions, with further evidence suggesting a significant degree of contestation regarding its nature(s) and function(s), and its place within clinical practice and training (see: Bloch & McNab, 1987, in *paper one*).

Freud included humour with those aspects of everyday life to which he tried to bring psychoanalytic understanding – dreams, mistakes, day-dreams, literature, religion – writing significantly on the subject twice (in 1905 and 1927). It has been recognised widely as a phenomenon in clinical psychoanalysis, of interest to some (see: Janus, 1975; Britton, 2003; Newirth, 2006; Steiner, 2020). And yet, the greatest representation of research about the subject in psychological therapies has largely been relegated to ‘evidence-based’ formulations of clinical usage and application – a kind of ‘lightning-in-a-bottle’ pronouncement of ‘use it here, in this way, to achieve these results’ – with consequent attempts to manualise the phenomenon as an instrument of psychotherapy technique (see: *paper one*).

In other areas of research, including psychoanalytical, caution can be expressed and advised against the slippery substance of humour in treatment (see: Kubie, 1971; Kuhlman, 1984; Pierce, 1994 in *paper one*). Most generally, research of this kind has

suggested that we don't really know what we're doing when we're being humorous with one another (see: Altman, 2006, in *'Discussion'*). If we value our patients and their becoming well, we are encouraged by these authors to tread carefully in this respect. And so, although humour may be ubiquitous in the lives of people, it can also be felt to run somehow counter to what (we think) we are doing when we do psychotherapy. This may be felt most acutely by student therapists in training institutions who are learning their trade.

Humour and adolescence

Personal clinical experience has indicated that the task of taking up an experience of humour in psychotherapy appears to correspond in interesting ways to the challenges of working with the age group of adolescence. As a psychotherapist-researcher in training, the study's author understands adolescence to be a time of life when the development and discovery of certain internal and interpersonal capacities makes possible an enhanced opportunity to experience humour (see: Radomska, 2007: pp. 189-197). It is concurrently a time when the churn of relational and developmental disturbance may also heighten the risks involved in taking up this experience (see: Waddell, 2018). Adolescents can experience humour, in ways perhaps formerly obscured by their latency defences (typically encountered between the years 6-12), but they also have reason to fear and resist doing so – being made vulnerable for this same reason.

Anecdotal clinical experience also indicates a particular kind of correspondence between an adolescent patient and a trainee therapist, which may support the generation of experienced humour to become uniquely possible. Finding themselves

in different ways struggling upon a similar precipice of becoming established in their lives, during therapy, these two people, trainee and adolescent, can go on to spend most days of the working week in one another's company, for a duration of between one-four years. In intensive psychotherapy (the identified intervention investigated in this study), this typically amounts to several hundreds of hours of clinical contact. Anecdotal and personal experience from the author's course of training suggests that intensive psychotherapy with adolescents can offer a potentially fertile environment for experiences of humour because of what intensive psychotherapy involves – with respect to its length, depth, and intimacy (see: *Table 2*, p. 52) – and to do with who a trainee and an adolescent are to one another, by virtue of their shared outsider status with respect to adult and professional life. For this reason, the interview schedule for this study has been organised to focus upon the therapy relationship between these two people – trainee and adolescent – specifically (see: *Appendix 1*), in order to maximise the opportunity to understand the nature of the humour that this particular relationship may yield.

Training institutions themselves – which form the recruitment base for this interview-based research study – also seem to have some part to play in how humour is experienced and understood in psychotherapy with adolescents, as does the generationally-defined model of teaching and learning (see: *paper three;* see also: Kernberg, 1996). There are patients, there are parents and carers, there are training therapists, supervisors, training analysts, clinic receptionists, and teachers of different kinds. Humour is presumably being experienced somewhere in this system, but by whom, with whom, how, and to what end? In the author's own training institution, it is said that long ago there was once a room at the top of the hospital building purpose built for the smoking of pipes and cigars and the drinking of brandy

at the end[19] of the working day. Who got to use it? Men, women? Trainees, consultants? Clinical directors or members of the estates team? Was this a room for humour, or a place for tears and recriminations – some mixture of these things? If there was humour, what was the humour, and what did it do? Was it gainful, or at someone's expense – both? Why was the room torn down in the end?

1.2 | Rationale and purpose

A review of available literature on the subject (see: *paper one – literature review*) has raised an important distinction between '(an experience of) *humour'* – "a phenomenon which happens between, and in conjunction with, ourselves and another" – and '(an undertaking of) *funniness'*, which is "instigated by a desiring person or persons who utilise understood rules to (try to) achieve an anticipated effect" (see: *paper one*). In the language familiar to child and adolescent psychotherapy training, funniness has been suggested as indicative of paranoid-schizoid functioning and humour as being operative in depressive functioning (see: *paper one, Box 1*). This claim, and eight other research questions developed in review of existing literature, have informed the interview schedule of this interview-based study (see: *Appendix 2*). They are listed in *Table 1* (see: p.46). Where outstanding research questions have remained outside the idiographic focus of this interpretative phenomenological analysis, they are formally taken up elsewhere in this research project (see: *paper three – framework analysis*).

[19] (Hopefully the end).

1.3 | Definition of clinical terms

In this research study, the following clinical terms will be used as defined below in *Table 2.*

Table 2.

Term	Definition
Psychoanalytic psychotherapy	A model of talking therapy committed to the working of a dynamic unconscious – an unknowable plane which corresponds to an aspect of the mind and of experience that is separate from, but at the same time mutually influencing of, the plane and corresponding mental component of consciousness familiar to lived experience. This ontology – the existence of a dynamic unconscious – underlines this research project (papers one-three) and the approach of the four UK training institutions from which the participant sample for this study was recruited.
Intensive psychotherapy	Three-times weekly individual psychoanalytic psychotherapy under weekly supervision for a duration of at least one year.
Trainee psychotherapist	A practicing therapist who is part-way through full clinical training, up to doctoral level.
Service supervisor	A lead psychotherapist in a mental health service who is tasked with overseeing the caseload of those training within that service.
Intensive case supervisor	An experienced psychotherapist external to the trainee's training placement, who meets weekly to think with the trainee about their assigned training case only.
Training case	One of the age-groups: under five, latency, adolescent, who are seen in intensive psychotherapy three-times-a-week for a minimum of one year. A qualifying paper written in support of the trainee's application to their professional organisation as a full member is about their work with one such training case.

Definition of clinical terms.

2 | METHODOLOGY

2.1 | Design

Interpretative phenomenological analysis (IPA)

IPA was chosen for the current study as a psychologically informed approach that is used to gain a deep understanding of a group of peoples' lived experience of a phenomenon (Smith et al., 2009). For the purpose of this study, IPA offers an explicit

idiographic focus (a detailed individual analysis) upon the meaning-making involved in what humour in psychotherapy was like for these participants (*phenomenology*), and how this experience can be made sense of (*interpretation*) in the context of an interview relationship. This is a particular qualitative method of inquiry which seeks to investigate "what the data means, not what it is" (Chamberlain, 2011, p. 52). This distinguishes this study's data analysis from a 'nomathetic' attempt which may seek to better understand the objective basis of humour or its general laws (as might be worked towards in a grounded theory analysis), or a 'diagnostic' focus upon how the experience has been understood as such (see: *paper three – framework analysis*)[20]. In this way, the IPA design of this study is congruent with psychoanalysis – the ontological framework for the study's methodology and the theoretical grounding for both researcher and participant group – in that it offers close attention to how *these* participants experienced humour in ways both known and unknown to them.

2.2 | Participants and recruitment

In keeping with the IPA principles (Smith et al., 2009) of idiographic depth over breadth using relatively small, purposive samples for detailed exploration, a homogenous participant sample was recruited for whom the research questions were identified as being meaningful. These were all trainees with at least one year of three-times weekly intensive psychotherapy experience with an adolescent training case, under weekly case supervision – ensuring experiential coherence within the IPA methodology. Appropriate ethical approval was secured from the researcher's host institution (see: *Appendix 9,* p. 175).

[20] *Table 5* (see: p. 95) clarifies this distinction with examples.

To promote maximal variability within this identified sample, five trainee child and adolescent psychotherapists were recruited from four distinct UK training schools different to that of the study's researcher, by way of reply to an invitation-to-interview letter circulated on each institution's bulletin (see: *Appendix 3).* In this way, the study aimed to generate maximally rich, contextually grounded insights, consistent with IPA's focus on the meaning-making processes of individuals situated within specific relational and institutional settings. All interview participants were female, and in the third and fourth years of their professional training. Four identified in the interviews as either British or English – with two expressing an identification of importance with a specific region of Britain. Four were ethnically Caucasian and one identified as being from a country in the Middle East. One was a young woman, and four were middle aged. None were formerly known to the researcher. All names and clinically sensitive information have been anonymised. A reflexivity statement of the researcher's own identity is included below, as Box 1.

Box 1.

Reflexivity statement.

I am a White, male, middle-class, able-bodied researcher aged thirty-one and in my third year of clinical training at the time of the interviews. As the findings of this study will show, I was most closely identified by my participants with issues relating to psychotherapy training – with assumptions made about my training institution in contrast to their own. Dissimilarities, and potential blind spots between myself and my participants, were identified as those relating to motherhood, regional professional experience, and systemic health inequalities. Considerations of difference, including those regarding race, ethnicity, class, ableism etc., came up infrequently in the interviews, despite these being raised as an explicit area of possible interest and exploration in the interview schedule (see: *Appendix 2*).

2.3 | Data collection

A semi-structured interview schedule was developed to promote both a deliberate focus (specifically, around experiences of humour in a therapy relationship with an adolescent training case, as distinct from an abstract discussion on a philosophy of humour), combined with a high degree of flexibility and opportunity to freely associate (see: *Appendix 2*). This design supports established IPA principles (Smith et al., 2009) by allowing participants to articulate their lived experiences in their own terms, while ensuring alignment with the study's research questions (see: Table 1, p. 47). The open-ended format enabled rich, idiographic accounts of complex emotional and relational events, while the flexible structure preserved the interpretative depth characteristic of IPA's double hermeneutic – where the researcher seeks to make sense of the participant making sense of their experience (Giddens, 1984). Each interview was completed in around sixty minutes. Four interviews were conducted via *Zoom* video conferencing, with the author located in a private office in his host clinic. One interview (with Sally) was conducted face-to-face in this same office, with this participant travelling to the clinic to meet with the researcher in person.

Each participant signed a consent form before interviews began, and all were informed of a one-month withdrawal window in which to retract their contribution to the study. All interviews were audio recorded and transcribed after the interview concluded. Transcripts were checked for accuracy using a combination of *Zoom*, *Otter.ai*, and *De-script* transcription software. Additional details (for instance, a non-verbal moment of tearful upset in Sally's interview) were subsequently annotated to each transcription through analysis of the audio recording and a reflective diary kept by the researcher throughout the research process.

2.4 | Data analysis

A systemic method for IPA proposed by Smith et al. (2009) was employed for data analysis. This is a six-step protocol that navigates the study from the beginning to writing-up. It follows the guidelines: [1] To begin the analysis, the researcher reads the transcripts iteratively to become familiarised with the data; [2] In order to develop the initial notes, three types of exploratory notes – namely descriptive, linguistic and conceptual – are identified (see: *Appendix 4*); [3] To develop emerging themes, data are consolidated through identifying their inter-relationships; [4] To identify connections across emerging themes, data are grouped together; [5] Before moving to the next case, the researcher completes every analysis case-by-case sequentially; [6] To identify patterns, the researcher identifies the themes shared by the participants.

To ensure the precision of the data analysis, one further procedural strategy was employed for all transcripts, involving bracketing associative comments coming from the author (see: *Appendix 5*). This supplementary step was indicated by the analysis of two data-sources: the interview transcripts and the researcher's reflective diary (see: *Appendix 7*), where associative detail from the researcher suggested careful management in the methodological procedure. This additional layer of reflexivity is consistent with IPA's commitment to researcher transparency and interpretative rigour.

3 | FINDINGS

A total of four superordinate themes were developed from the interpretative phenomenological analysis of interview data, with the quotations from the participants used as headings: "*Now I can see who you are*"; "*Putting it out there*"; "*Two folk in a room*"; and "*You get me*". *Table 3,* below, lists these superordinate themes with a summary and list of subordinate themes.

Table 3.

Superordinate theme	Summary	Subordinate themes
1. *"Now I can see who you are"*	Humour bursts into the therapy and enlivens something first seen as dead, absent, or distorted.	*i. Vacancy and distortion* *ii. A bringing to life* *iii. The quality of something human and painful*
2. "*Putting it out there"*	After it has appeared, the (aggressive) humour that is experienced is furthered by deliberate activity involving both patient and therapist. This is named as 'play'.	*i. Experiencing humour involves deliberate activity.* *ii. Humour's aggressive function is expressed as deprecation of oneself and others*
3. "*Two folk in a room*"	The quality of the humour experienced is informed by the personalities and cultures of those involved in its construction.	*i. "Humour is ordinary"* *ii. "Where we're from"*
4. "*You get me*"	It requires work and support, for the experienced humour to mean something, and to last.	*i. It matters* *ii. It is work towards contact made, a 'building up to'* *iii. "A later, more mature phenomenon"*

Table of themes.

3.1 | "Now I can see who you are"[21]

i. Vacancy and distortion

For all five participants, the missing vitality of humour in the early part of the therapy was understood in terms of relational and developmental disturbance. Each therapist felt that their patient's difficulties with humour indicated other problems.

a. *Absent humour*

For three of five participants, including Rubi quoted below, in the place of a capacity for humour, their patients first presented a feeling of lifelessness:

> "*When he first came he was really, really silent, really sort of withdrawn. Nothing positive or negative going on…He would tell me about movies, you know, 'I was watching a movie; I was with a friend', but the friends would never have names, the movies would never have names. There wasn't really a kind of sense of something really alive*".

For Shantel, her patient's early *"vague presentation"* left her *"anxious about what exactly I could offer to her"*. This adolescent's initial humourlessness was experienced by her therapist as a vacancy – a *"not having been filled in"* – for a young person who was *"not very good at the in-between states"*. For Shantel, this

[21] This theme of discovering a patient through humour is made up of three subthemes: [i.] Vacancy and distortion; [ii.] A bringing to life; and [iii.] The quality of something human and painful. The theme refers to a common presentation across all five interviews of either a conspicuous absence or a distortion of humour at the beginning of therapy. Humour is seen as anticipated, natural, ordinary, and human. For all five participants, clinical transformations took place with experiences of humour during treatment. For each therapist, this was encountered as a kind of 'enlivening': a bringing to life of something that had been hitherto dead, absent, or distorted.

absence of humour highlighted *"the fact that* [Shantel's patient] *didn't really know what it was to be alive"*.

Interestingly, Shantel is the only participant who described an initial consideration of autism in her patient's humourless presentation. This was found to be "*not clinically indicated*", and the phenomenon was instead understood within her clinical team as "*more about the way she manages*".

Abigail details her patient's entry into treatment via an eating disorder service, and that *"prolific self-harm"* and *"frequent attendance to A&E"* had taken place in a context of domestic violence. Abigail sees her patient's absence of humour as a measure of this disturbance, describing an *"emotionally abusive father"* who would cruelly mock her patient's mother, for instance *"by trapping her in a room and then laughing at her"*. In Abigail's understanding, her patient had been taught humour *"in a persecutory kind of mocking way, which probably made it more difficult for her to find her way to ordinary laughter, and specifically laughing at herself*".

b. *Distorted humour*

For two interview participants, Vera and Sally, humour in the beginning of the therapy was not absent, but was felt instead as fierce, attacking, and destructive – a distorted humour. Sally explains:

> "*This was a young girl with a very kind of 'anorexic state of mind' type defences, where nothing really was allowed to get inside, everything was evacuated out. Either in attacks, or just a stream of explicit material. Sometimes there was a humorous edge to the story, but the real experience of it was horrific and I would feel sick, cold. Obviously, those moments, they're*

> *not funny*. *Even if the young person is bringing laughter and humour to something*".

Similarly, at an early stage of intensive psychotherapy with an adolescent patient with a history of sexual abuse, Vera experienced a distorted humour which veiled a real threat and communication:

> "*There was something very false about her humour. I know that. But there was also something behind it. How do I even explain it? I think it was her expectation that I was going to hurt her – that I was going to sexually abuse her in the room. That I would want her in that way. That's what was behind it*".

> "*She would come in and she would flirt with me. She would tell me the most horrific, horrific stories of sexual abuse. But she would laugh and kind of smile at me. It took me a long time to say, 'You're telling me this, but you're laughing about it, what's going on?' And I was thinking, 'Oh she thinks this is what I'm going to do, oh this is awful".*

At this stage of the therapy, Vera's patient was "*very clear about what was going to be allowed into the room*", and this therapist came to understand her patient's humour as assuming two distinct 'types' at two separate stages in the treatment, which is further detailed below in the fourth theme ("*You get me*"):

> "*I think the first type, as I'm thinking about it, it was, it was not, I don't like the word 'weaponised', but it was definitely used as something. I was definitely being used and it felt horrible to sit in it*".

ii. A bringing to life

a. *"A bursting"*

For two participants, the eventual enlivening of humour came about in significant, transformative moments: a "*bursting into life*", as put by Rubi.

For Shantel, these were "*little comments and things, where I was like 'Okay, there's the humour…it was more that she wrote down something* [humorous] *or I could see the humour than she could actually speak it…I don't know if she recognised herself how much was hidden.*" For this therapist, "*when it was there, it was just like 'Oh, now I can see something of who you are*'".

Rubi similarly recalls memorable examples of sudden flashes of humour with her patient – a selection of which appear in the findings to follow. For this therapist, these involved a startling moment of contact with who her patient essentially is:

> "*I think the relief was a bit kind of like, 'Oh my God, you're in there, you know, you're alive! There's somebody in there!*'

As described by Shantel, work in therapy offered "*glimmers of humour*" which she equated with "*glimmers of life*".

b. *"Spontaneous", "genuine" contact*

Four participants speak about the spontaneous aspect of humour, and three use the word "*genuine*" when describing, as Rubi does, such "*genuine moments of connection*". For Sally:

> "*She did make me laugh a lot spontaneously. And I never felt like I had to keep that under control or under wraps. I think my own therapist probably helped me with that. I remember the first time he laughed and it was like, 'it's so genuine. It's such a proper…and you realise that you're with a human being*".

The explanatory importance of formative experiences with supervisors and analysts will be taken up elsewhere in this research project (see: *paper three*). But here, of Sally's experiences in personal psychoanalysis of the moments of genuine, spontaneous humour named above, she tells me through tears:

> "*There's something about somebody being able to see something – sorry I'm going to get emotional – there's something about somebody being able to see something different in you, despite all the ways that you're behaving and acting out, and all of the struggles, and all the terror. That someone can see something different in you. And it's pleasing. And it's delightful."*

iii. Humour is human

a. *"Basic human things"*

Variation upon the "human aspects" of humour was also articulated in each interview. For all participants, this (human) way of being (together) was experienced as desirable, and for three participants, it was seen as an implicit achievement or goal for the therapy: a private theory (Werbart & Levander, 2006) common amongst these therapists.

For these three participants, the humour in their intensive therapy work was seen to engage with some variation of what Rubi calls "*basic human things*". Descriptions used place emphasis upon the "*uncovering*", or "*revealing*" of a hidden foundational

layer or "*base*". "*It underlines something essential*", Shantel tells me, "*to who we are*".

For Vera, experiencing humour with her patient was "*a way of being human*", an ambition for psychotherapy that she describes as "*ordinary*", as is described in greater detail in the third theme of this study's findings ("*Two folk in a room*"). Thinking of her patient's specific developmental stage, Abigail elaborates that "*to have a bit of a joke feels kind of quite a natural thing to do, I think, as well for adolescents*".

b. *Suffering*

For three participants, including Rubi below, the humanity of humour is expressed by glimpses which facilitate contact with pain, named by Rubi as "*coming to life a little bit*":

> "[Rubi's adolescent patients] *almost have like a bodily reaction of the sort: 'this feels strange to inhabit this body that's laughing and having fun and being playful with an adult'. So a real mix of things, I think. But then sometimes…after we've got that experience in the moment and there's something happening for them, then we get a sense of how painful it is actually, I think, to have those moments".*
>
> [I ask Rubi to say more].
>
> *"Well, I think probably if you are used to abuse, neglect, or adults not caring at all – or either being really intrusive or really horrible, then to have a genuine moment of connection must be incredibly painful, really. 'Cause I think there's a real kind of closing off to something good, something alive – and not wanting to be alive".*

3.2 | "Putting it out there"[22]

Without prompting, each participant described their experience of humour as a subset of play. Significant for most participants, as is detailed below, was that in psychotherapy, a patient's playmate is the person of their therapist.

i. Experiencing humour involves deliberate activity

a. *Born of frustration*

For Shantel and Rubi, as described above, their patients first presented "*a total kind of blankness in the room*". For these therapists, as for Abigail, where something more lively was expected, instead frustration was encountered. This experience of frustration was understood by each therapist to have prompted the first humorous exchanges in the therapy. As Rubi describes:

> "*It sort of just started out from there, tiny little moments where it made sense…I don't really know why I did it. I think I was partly a bit frustrated. Wanted to bring something to life."*

For Shantel:

> "*She actually was really difficult to work with in the early days because you could really dislike her, and I think the humour was really helpful in sort of just dismantling something*".

[22] This theme refers to the active process described by all five participants of surrendering oneself to moments of humour in therapy. This involves deliberate activity undertaken by both patient and therapist which follows the initial, spontaneous spark of contact made through humour. Here, humour is seen to involve both giving and receiving, in an activity identified as 'play'. The theme has three subthemes: [i.] *Experiencing humour involves deliberate activity*; and [ii.] *Humour's aggressive function is expressed as healthy deprecation of oneself and others.*

Rubi provides the interesting example of struggling with her patient's "*way of talking to me without really. It's sort of like I need to 'fill in the blanks' type thing*". One day, hearing again an only partially sketched story involving watching a TV programme without a name, Rubi bursts out "*Come on, you're going to have to tell me what it is! Otherwise I'll have to assume you're watching* X! [Rubi names an unfashionable property programme popular with the middle-aged]".

This therapist's humorous attention to such "*fill-in-the-blanks type things*" is also represented by Shantel in her patient's "*struggles with in-between type states*". In work with her particular training case, the first moments of humour experienced were described by Shantel as involving a literal 'filling in' of a blank sheet of paper, with the young person one day presenting their therapist with a humorous cartoon.

b. *"A bolstering" and an emboldening*

Contrasting the above, Sally understood through supervision that her way of "*being natural*" – meaning "*quiet*" and "*thoughtful*" – had led her patient to *"take her softness as weakness*" and to "*brutally cut her down*" with ferocious attacks of mocking humour.

Being "*quite a serious person*", in her intensive case supervision, Sally deliberately created the conditions for something humorous to become possible *between* patient and therapist by consciously taking up a "*bolstering*" humorous attitude. This was described as being unnatural for her, but it succeeded in meeting her patient "*with a similar…not an aggressive energy, but with the same kind of energy that she brings to me, so humour has been quite important for that*":

> "*My supervisor might get me to say something like, 'Woah! That's a lot! Oh my goodness. You really needed to get all of that out! I think I need to take a breath!'. And I think that helped to give a sense that I was robust enough in those moments to handle her. And perhaps I hadn't always been before. I think in the early work together, it was just like a bombardment – and I felt like I had to shield myself. Sometimes I felt like it was a volley of bullets being shot at me and I didn't quite know what to do with it. So I think that finding a bit more of an edge in me enabled her to see or to feel that I was robust enough to take what she was giving without retaliating, and I think that has been quite central in our work*".

Such an experience, described by Sally as a "*bolstering*", is taken up in a related way by two further participants as an "***emboldening"***, where a first successful experience of humour invited risking another. Rubi expands upon this as a "*giving of licence*", and Abigail as a "*freeing up*". For Abigail, allowing for the potential of humour created what she described as a **"***thread*" connecting her to her patient. This thread, a kind of synapse, was denuded of particular and personality characteristics, but along it passed the experience of humour and the faithfulness that this experience could be possible.

c. *A disentanglement*

Similarly to Sally, and unlike the others, for Vera, movement towards a detoxified 'second type' of humour with her patient was less momentous and was more technically driven. For this therapist, it specifically involved the interpretation of anxieties that arose in the churn of the therapy relationship. This entailed the careful, delicate disentanglement of the humour that was already present, but which had become violating, strangled by the pressing horror of experienced sexual abuse.

> "*She gave me the creeps to be honest, but there was something underneath that made me think: 'stay back'… She pretty much told me like, 'I don't trust you. I don't want to get close to you', but she desperately does at the same time of course*".

Vera here describes deliberately meeting a disturbed humour with prepared, serious-minded openness to understanding (sometimes described in psychoanalytic parlance as 'reverie' [Bion, 1989]) – and it is this that she felt allowed a genuinely felt 'second type' of humour to become possible later in the relationship. "*So slowly, slowly, slowly*", Vera reports, "*we could come into thinking*".

> "*It's interesting – but she uses humour in a really different way now. I suppose she uses it in a 'do you get me, do you understand what I'm saying' kind of way…She's like running with it. She's ten steps ahead of me. She's a clever, clever girl*".

d. *Deliberate activity for whom?*

A personal want or need to find oneself in humour is represented in the opening exchanges of three interviews, whose participants offered without delay intimate accounts of humour in the participants' own childhoods, family lives, and personal analyses, with a will to openness that surprised the author's experienced research supervisor.

For different reasons, all participants expressed a strong motivation to find themselves in an experience of humour with their patients. Each therapist found justification of clinical expedience for their patient (i.e., it was concluded as helping), but all also gave some indication of a personal want or need for themselves to "*really be into something with someone*" through humour, as is put by Sally. This seems to

be additionally represented by the expressed high motivation to participate in this study – with two participants, including Rubi, saying they did so "*quickly, without thinking*". A third participant, Abigail, reported identifying this research subject as: *"a bit of me".*

For Abigail, how she experienced *herself* in relation to the humour encountered with her patient was consistent with her clinical practice because it informed an understanding of her patient's internal objects and ways of relating.

> *"I think she thought I was kind of coming in a particular position and that I was this sort of stony person who didn't have any life to them. And I think her internal objects are either really idealised or really shit and I think that she feels that people are kind of just going to drop her and that there's no life to people that she interacts with, or people that she cares about, you know. So I would either get told off, or it'd all be perfect".*

> *"So I think the use of humour is a way of enlivening the room a little bit and also me being something that wasn't just a sort of stony person sat in the corner without any personality".*

The transference function of humour is taken up as an explanatory category of understanding elsewhere in this research project (see: *paper three*). Important to the lived experience here recounted is that Abigail and others may be argued to do more than mere identification of their patient's internal objects with humour – in the above example: actively "*enlivening"* them. This is taken up below in the *Discussion* section of this paper.

ii. Humour's aggressive function[23] is expressed as healthy deprecation of oneself and others.

All five participants expressed an interest in the function of what was going on in exchanges of humour with their patients. It was also the case that for four of five participants – this interest in humour's function was taken up reluctantly, begrudgingly, in the interviews, with these therapists each suggesting that it was a concern that originated from outside themselves, and was part of the scrutinising psychoanalytical culture in which their training work was taking place. This was an expression of 'professional naughtiness' recorded in the author's reflective diary for four of five participant interviews (see: *Appendix 7*). As Abigail puts it, "*There is that thought isn't there, like what's the function of it…it's probably not the psychoanalytical thing to do*". The extent that perceptions of a training culture may inform experiences of humour in therapy will be taken up as an explanatory category of understanding elsewhere in this research project (see: *paper three*).

This analytic framework (see: *paper three*) will also detail the explanatory category employed by all five participants: that experiences of humour had the function of the safe expression of aggression. The idiographic focus of this present study will now detail how, common across all five interviews, this aggressive function of humour was experienced by these participants as their patient's healthy deprecation of themselves and others.

[23] That experienced humour is ultimately about expressed aggression is an explanatory category of understanding taken up elsewhere in this research project (see: *paper three – framework analysis*), with a summary of humour's expressed function across this three-paper research project. An idiographic focus upon lived experience in this study concentrates upon how this aggressive function is expressed as healthy deprecation (of oneself and others).

a. *Where deprecation was missing*

Shantel understands her patient's offering of a humorous cartoon in terms of "*fresh starts*", a sense of gratitude and a hard-won new perspective on herself:

> "[The cartoon meant:] *It's a new year, it's a new me'; thank you for putting up with me all this time'. I think her humour was quite self-deprecatory in parts.*"

The capacity to laugh at oneself was also considered a significant developmental achievement for Abigail's patient, whose therapist thought that earlier "*piercing*" experiences of humour understood as persecution "*made it difficult for her to just kind of find her way to ordinary laughing, and she would often get into a space where if she did something, she couldn't just laugh at herself, about something being a bit silly or ridiculous – it then became something else. And I think maybe having the humour* [in therapy] *helped to lighten that up*".

Throughout our interview, Abigail demonstrates her willingness to "*put herself out there*" as the object of deprecation in the work – often upon lines of specific dimensions in her personality, about which is detailed in the next theme ("*Two folk in a room*"):

> "*My patient often talks about [a current pop star] and all these other things, and then just is exasperated with the fact that I don't know who any of these people are, you know? And we have a bit of a joke about me kind of being old and boring and, you know, not knowing anything really. And that feels quite a natural thing to do, I think, as well for adolescents. To know that it kind of puts something out there that can be handled a little bit easier*".

For Rubi, similarly, the most important expression of the aggressive function of humour was understood as deprecation *in* the therapy relationship itself, and most often *of* the object of Rubi-as-therapist:

> "*He'll laugh and laugh, and there's this idea of this 'useless Rubi' and it's almost like: 'actually, I can have these thoughts and feelings, but it's not this terrible thing. That I can be sort of thought about and worked with*".

Vera also located the most important deprecation as taking place inside the therapy relationship itself:

> "*Early on,* [Vera's patient] *probably laughed at other people's expense, I suppose. She would tell me stories about friends and we would laugh together. But we couldn't do it in our own relationship maybe. Maybe that's what I'm trying to work out. We couldn't laugh at things between us, and I think we can now. I think that's a much more ordinary relationship, which was where it always had to go.*"

For Vera, "*sometimes life is funny. Sometimes it's okay to laugh at me, sometimes. Do you know what I mean? Because I do things wrong, and it's all right. It's ordinary*".

b. *Where deprecation developed out of denigration*

For Sally, as is described above, direct deprecation of herself by her patient had already been given full expression in the "*bombardments*" to which she was subjected early in the work. However, this was experienced as a denigrating attack and was "*not funny*", despite being accompanied by her patient's laughter.

Unique amongst this study's participants, as the therapy progressed, Sally noticed that when humour was able to be collaborated on with her patient, it seemed to facilitate and to pacify her patient's aggression, which was typically seen before or after experiences of humour. Although there was aggression *in* the humour too, it was felt most acutely in developments *upon* the humour.

For instance, Sally tells me about her patient one day creating an avatar of her therapist using an app. This was a "*little old lady with grey hair*" to whom she could write "*Hi, I'm feeling sad*", and the avatar would respond "*I'm sorry to hear you're feeling sad, do you want to tell me about it?*".

Sally has grey hair, but is not elderly. In this example, her patient's teasing recreation of her as an older woman was experienced by this therapist as deprecatory, rather than denigrating. In the interview, Sally was unable explain to me why in this moment, this was the case. For herself and her patient, looking at this avatar was "*simply a moment of absolute, spontaneous laughter*" which "*couldn't be interpreted or analysed*". Although in our interview, Sally does interpret: "*is that what she thinks I say? We were really falling about laughing over it*".

It was only after this explosion of mirth had happened and ended that Sally and her patient could draw their attention to the need underlying the humour. This involved a wish for Sally to be forever available to her patient, like a pocket avatar. "*That then followed a rage about like, 'You never give me your number. And what if I'm, when we finish therapy, what if I need to talk to you in the middle of the night*!'"

For Sally, the deprecating avatar creation of the "*little old lady*" was a necessary envelope for her patient's more aggressive feeling about abandonment and loss:

> "*I think because you have that moment of connecting through the laughter, and the playfulness, and she brought it with laughter, otherwise maybe I might have responded to it differently*."

c. *Aggression experienced with me*

A further striking finding in this study is of my own multiple self-deprecations (average, n = 4) across four interviews. With these participants, I often presented as overly apologetic – for instance, about the quality of the communication technology. In two interviews, I also (unsuccessfully) attempted to 'join in' with humour, by making occasional quips, which included a shameful instance of joking laughter accompanying a participant's disparaging comment against a sister mental health profession with less intensive training. Such activity was most prominent (n = 8) in an interview which began with my participant underlining the extent of the regional health deprivation which was the context of her work with her adolescent patient – asking me if I could understand what this meant, and why a variation upon a purist psychoanalytical model could be understood as necessary[24].

In reflection, I think that in these interviews, I-as-researcher-participant may have been drawn into a form of humour – expressed through quips, connecting laughter, (self-)deprecation etc., – as a means to deflect the aggression that might otherwise have been felt with or against me. Put simply, in my experience of conducting these interviews, my self-deprecations may have functioned defensively, as an 'identification with the aggressor' (Freud A.,1966).

[24] I work and train in a psychotherapy and public infrastructural environment of comparative privilege compared with that of this participant and recorded a feeling of guilt after this interview in the study's reflective diary.

3.3 | "Two folk in a room"[25]

i. "Humour is ordinary"

For two participants – Vera and Abigail – a personal penchant for humour was identified and understood as divergent from assumptions about what the canonical figures in psychotherapy and psychoanalysis may have thought and done, suggesting that humour was experienced as guilty relief from a certain anxiety of influence – which is coded above as 'professional naughtiness'. Vera tells me that her humour is "*not the Dilys Daws thing to do*" and by incorporating it into her practice she had to finally accept that she would "*never be Margaret Rustin*" [two eminent child psychotherapists].

In the interview relationship itself, I came to understand in three of the five interviews that I myself was being held as representative of my training institution, here associated by my participants with the name-dropped doyennes that they mention (who worked and taught there). For these participants, I was "*someone from the Tavistock*", as described by Abigail. In those interviews, my participants self-deprecated throughout, and often appeared to do so in reaction to an experience of scrutiny in their respective experiences in training, from psychoanalysis in general, and by the institution of which I was taken to be a representative. As Vera puts it, "*we probably use humour up here because away from the eyes of the Tavi, we can just piss about*".

[25] This theme refers to the significance of the personalities of both patient and therapist in the nature of the humour experienced in the therapy, as well as the role of the personal cultural groundings in which this work is taking place. The theme's subthemes are: [i.] Humour is ordinary; and [ii.] Where we're from.

For Vera, a psychotherapy culture that might support humour is one which promotes what is "*ordinary*":

> "*I always wanted experiences in the room to be ordinary, even though it's an extraordinary thing we're doing. I always wanted them to be ordinary so that children* [sic] *felt 'this is okay, actually I can tolerate this'. To me, it's important. So perhaps I use humour as a way of saying: 'no, I'm ordinary. This is an ordinary thing that we're doing together. It's not terrifying. It's not gonna end up with one of us hurting the other. I'm fallible, you know … it's all right. It's ordinary. I think ordinary is such an important word, and I don't think I ever read about it in psychoanalysis.*"
>
> *"Look, we're just 'two folk in a room trying to figure out what's going on with your mind and why these things keep happening to you'. You know, 'you can think about our relationship'. It's a way of being gentler. I think it's a way of way of being human*."

Understood in this way, humour becomes possible in a dynamic of power involving the oppressive and the ordinary. This explanatory category of humour understood through a relationship to the perceived culture of psychoanalysis will be taken up thematically in *paper three* of this research project.

ii. "Where we're from"

Explaining the cultural background that she shares with her patient, and the consequent vocabulary of humour "*ordinary*" to them, Vera tells me:

> "*I mean there's something cultural as well. I think [people from where we're from] are quite self-depreciating and we like a bit of craic, don't we? So there's definitely something in my personality…I think in my head, it's the way I've been brought up and I can't lose it. There is no royalty [where we're from]. We*

> *are sovereign, we are the royalties. So everyone's equal. So from that basis, we're just all the same. And that enables a certain kind of humour, I think, of 'I'm not buying your status. We're all the same, we're just as good as each other or as bad as each other'. And I think there were bits of* [Vera's patient] *that I could identify with which maybe led me to risk a bit of humour that might have felt a bit cheeky, but there was something…I knew she could take it and I knew she would take it the right way*".

For three participants – Vera, Abigail, and Rubi – humour underlines something important about "us" and about "them", designating who is "inside" and who "outside" the culture to which humour belongs and is active. Similar to Vera, Rubi's descriptions of work with her patient included examples of humour specific to the geographical region in which the therapy was taking place. Like Vera, Rubi felt that consequently she knew her patient would "*get it*".

3.4 | "You get me"[26]

i. It matters

For each of these therapists, the humour they experienced with their patients was understood as highly consequential – part of "*the point*" that is identified by several participants.

For Abigail:

[26] This theme underscores that the expressed meaning "you get me" confers both 'you understand me' and also 'I entrust you with (a part of) me'. Thus understood, for these participants, humour is experienced as a later, more mature phenomenon that is 'built up to something capable of "getting" someone"'. In this way, humour is about recognition of limits, and of what we are capable of doing to, and for, each other. It is here seen as a depressive phenomenon, and as something able to provide "edges" for containment. This theme has three sub-themes: [i.] It matters; [ii.] It is a building up (to becoming something); and [iii.] A later, more mature phenomenon.

> "*The whole point of therapy, psychoanalytical therapy, is 'how do you reach your patient? How do you establish a relationship in which to do something helpful and useful?' And if some of that is using a bit of humour, then I guess that's the helpful thing to do*".

This is a finding shared across all five interviews: where humour is seen as a means to the end of an "*arrival*" – a "*there*" – in the therapy. For Rubi and her patient:

> "*We could acknowledge that actually something has shifted, to get to that point where actually both of us are laughing about something*."

For Vera, moving beyond a "*first phase*" where "*there were such strong feelings in the room, and the humour that was used was quite loaded*" involved reckoning with her patient's difficulties in "*getting there*", which for Vera meant a humour built upon the principle of "*collaboration*":

> "*I said to her, 'I want this to be a different relationship. I want it to be collaborative'. And she said, 'To me, that is disgusting. Even the thought of that is disgusting. The thought that you'd be in my head, that's, eurgh'…So it was really complicated and everything was in tiny doses*".

ii. It is a building up (to becoming something)

Three of the five adolescent intensive psychotherapy patients were described in the interviews as having entered treatment with eating disordered presentations. A link explicitly made by Abigail, and also made separately by Sally, was that for their patients, the 'building up' of their bodies to a healthy weight took place concurrently with the building up of a capacity for humour in the therapy relationship.

For Sally, her patient's recovery from hospitalisation and return to physical health is symbolised in the interview by Sally's own (meta)physical transformation, through developing a capacity for humour – a "*straightening up"*:

> "*My process with her has been to straighten myself up a little bit and be ready. And humour's been really important for that*".

In the interview with Abigail, it was noticeable that descriptions of an early withdrawn clinical presentation featured a greater proportion of mechanical, inanimate language – for instance, when this participant described a general "*need for lubrication*" and for something to "*become lightened*" in the work. As the interview progressed to describe a later period in the therapy, Abigail began to employ fuller, more bodily, 'built-up' language. For instance, when describing her young patient who was struggling to "*handle*" the humour that was being "*handed over and around",* for whom, when "*piss is taken*", can "*take it straight to heart*"; one who "*is pierced"* by humour, instead of *"eased into it*". This relationship to humour involving a kind of emergent bodily animation out of mechanisation will be taken up in the '*Discussion'* of these findings, below.

iii. A later, more mature phenomenon

a. *Humour provides "edges" for containment*

In different ways, all five participants reflected upon how *they as therapists* were changed by the intensive psychotherapy undertaking, and how such transformations facilitated a deeper, more sophisticated experience of humour with their patients.

For Vera, as has been described, understanding the nature of the disturbing, erotic transference in the therapy relationship made space for a different "*do you get me,*

do you understand what I'm saying?" kind of humour. For this therapist, *going there* with her patient – pursuing understanding of the early disturbed humour – ultimately amounted to an entrusting. Vera was invited to "*get*" her patient – both to understand her, but also to receive her, or part of her, in an act of safekeeping. Thus understood, drawing upon psychoanalytic parlance, the content of humour was recognised by this participant as the contained, and the therapist with capacity to experience this as the container (Bion, 1989).

Of all five participants, Sally gives fullest expression to this containment function of a matured humour. For this therapist, as with Vera, understanding what was being done to her, and demonstrating her bearing witness to this with humour, functioned to vouchsafe the anxieties beneath her patient's scorching explicit assaults.

> "*To begin with, she saw therapy as somewhere to just evacuate everything. I felt like I was being pushed back in my seat."*

As described above, when Sally was prepared to take on her patient's assaults *with good humour*:

> "*I think that she had a sense that I was robust enough in those moments to handle her. And perhaps I hadn't always been before. Finding a bit more of an edge in me enabled her to see or to feel that I was robust enough to take what she was giving without retaliating. And I think that has been quite central in our work*".
>
> *"She was able to take in something of me being somebody that could provide her with something good. And I'm not sure that she would have been able to risk showing me that if I had stayed in that kind of, probably what she saw as quite a fragile, precarious place. I think humour helped us together."*

b. *Humour is depressive*

In her interview, Vera worries about rejecting her patient's offering of humour, and the implications of this for "*getting*" one another in what Sally describes as "*a moment of meeting*":

> "*I wonder if there's a need to meet her humour. So that she got me, we got each other. And if that's how she does it, if that's her way of communicating, well then that had to be mine too, so we could meet each other. I mean, I would've been rejecting a part of her, in her mind, if I hadn't…It would feel rejecting of her not to because she's giving me something*".

This depressive anxiety – of inflicting harm to the other when humour fails – seems to be interestingly distinct to instances of funniness (where the injury [of shame: a persecutory anxiety] is suffered by the instigator of the funniness, instead of an impact upon its recipient or partner, as it is anticipated here, in humour). A similar depressive anxiety about humour is also taken up by Abigail, who reflects upon what consequence there may be when the experience falls flat:

> "*If the association that I've made is something humorous, but they don't know the association or understand the association, then it is a bit difficult because you're left almost chuckling to yourself, and then it feels private and kind of excludatory* [sic]*, and that can sometimes feel a bit difficult*".

For Abigail, these "*jarring*" experiences of mis-stepping humour can nevertheless often offer greater elucidation than the "*smoothness*" of when something lands easily and well:

> "*It's always interesting anyway, isn't it? When something lands in the room and one person's mind goes one way and the other person goes the other*

> *way, you can kind of think about what that split is about. So, I think in that sense, it can feel a bit jarring, actually, in a way that shared humour doesn't. When you've shared something, quite sort of smooth*".

Shantel takes up a similar point when reflecting upon the rare, shared moments of humour that are hard-won, and how these feel more valuable than "*gushing*" contact with young people more eager to engage in a humorous exchange[27]. In her interview, Shantel contrasts the "*serious*", effortful humour that she eventually came to experience with her patient, with the inconsequential "*horseplay*" that the patient would mindlessly engage in with her siblings. This serious-mindedness of humour – of an adult consciously choosing to step into a playful role – versus the carefree fun enjoyed by siblings or peers, is taken up as an explanatory category in this research project (see: *paper three*), and is discussed in a review of existing literature (see: *paper one – 3.4* '*Play*').

4 | **DISCUSSION**

This section discusses a selection of findings from this research study in consideration of what has been found elsewhere in existing literature. This selection of identified discussion points include: *Vitality; Relief and spontaneity; Help; Deprecation; and Collaborators and collaborationists.* Discussion of these findings focuses upon the outstanding research questions developed in a review of existing literature (see: *paper one*). These are listed above in *Table 1* (see: p. 47). A summary of the extent that the research questions have been answered – in

[27] The author would distinguish this second type as the patient's attempt to be funny.

anticipation of further research investigation (see: *paper three*) – is presented below, in *Table 4* (see: p. 93).

Vitality

In this study, experiences of humour are presented by these five therapists as essential to their work with their adolescent training cases (e.g., "*She would have walked without it*" [Vera]; "*We couldn't have got there otherwise*" [Rubi] etc.) Humour is seen to really matter for this work and to these professionals (see: p. 75), a finding which corresponds to Freud's decision to return to the subject when fatally ill with cancer and in his final decade of life. Most commonly, humour experienced in psychotherapy is identified as a "*there*" to get to – a destination of arrival, or "*a marker of progress*" [Shantel] – but it is also recognised as a means of travel: an "*enlivening*" [Abigail] of the therapy in motion. For these participants, humour is here understood as a bringer of life into their therapy relationships erstwhile characterised as dead, absent, or distorted (see: p. 59). This directly resuscitative or animating function of humour is not well represented in other research literature, which more commonly presents humour as an achievement upon something already alive in the therapy (see: Berger, 2018; Briggs, 2022 in *paper one*).

The vitality of experienced humour, in relationships otherwise characterised as mechanical and lifeless (for instance, as illustrated by Abigail's initial preference for mechanical language [see: p. 76]) is also recognised by Henri Bergson in *Le Rire* ('Laughter'), published five years before Freud's *Jokes and their Relation to the Unconscious*, in 1900.

For Bergson, one succumbs easily to mechanisation – including the reification of time, and the defences encountered in psychotherapy (such as those achieved through defensive humour) – because it enables us to live out our lives without confronting the total openness, and pain, of each moment. A mechanical model of humour, exemplified in *Le Rire*, argues that authentic humour contributes to the struggle against this betrayal of openness, or spontaneity, in so far as it makes us aware of the hidden absence of life where we expect to see life. Instead of natural spontaneity, we find artificial mechanisation, and this discrepancy produces necessary insight experienced as humour. Understood in this way, therapists and patients know on some level that humour is somehow inevitable ("*where it always had to go*" [Vera]), once the artificial deadness of their patient's ways of relating has been properly recognised. Following Bergson, deadness in something actually alive generates a contradiction inviting – somehow, necessitating – humour.

But can this be supported by the evidence of clinical experience generally? Of working in psychotherapy with the kinds of 'mechanisation' found in severe depression, for instance? Or in work with schizophrenic participants, explored elsewhere in the literature (Berger et al., 2018 in *paper one*). Is there really extant humour ready to be encountered here – never mind inevitably, but even some of the time? Can we learn to live with this contradiction – an aspect of deadness inside life – and should we? Are we realising our duty of care in meeting our patients as they are (as severely depressed, for instance) – or would this instead constitute a betrayal of these same patients' innate claim to a natural openness, artificially constrained by their experience of illness, of which Bergson writes? Despite this study's participants' positive cathexis towards humour, this finding does little to supplant the degree of contestation found elsewhere in literature of the subject on this matter (see: *paper*

one), where in response to *RQ6* (see: *Table 1,* p. 47), it remains inconclusive whether it is helpful or harmful to anticipate humour where there is none.

Relief and spontaneity

This study's participants claim that when humour is able to "*burst into*" (see: p. 59) the therapy relationship in order to "*bring something to life*" (see: p. 63), it is experienced as multiple reliefs in the room: a "*bolstering*", "*emboldening*" experience that invites "*risking*" a further attempt. In answer to *RQ3,* developed from a review of existing literature (see: *Table 1,* p. 47), the findings of this study suggest that humour both produces *and* is produced by an experience of relief. However, a further question that this raises is of who gets to be the beneficiary of this relief, how, and to what end? Each participant describes in rich detail their different understandings of the benefits of humour to their patient – i.e., the degree that it is seen to help and to 'do something' (see: *RQ4* in *Table 1,* p. 47). This includes: help in arriving at "*ordinariness*" with oneself and others (see: p. 72); finding appropriate grounding with the vocabulary of an adolescent peer group (see: p. 69); and, centrally, of safe expression of aggression through healthy (self-)deprecation in the room (see: p. 67).

However, what participants appeared less ready to speak to, but what was present in each of the interviews nevertheless, were their own various motivations, wants and needs to find themselves in humour with their patients. Coded in this study are the therapists' feelings of frustration with these struggling adolescents (see: p. 62), and their (understandable) need to resist various "*bombardments*" (see: p. 64) and to disentangle "*weaponised*" forms of distorted humour (see: p. 65). Important to each of these participants is the "*spontaneous*", "*bursting*", "*genuine*" quality of humour

encountered – but were these experiences so very spontaneous, really? Sally is moved to tears by recollection of the spontaneous genuineness of being seen in humour by her own therapist, but could the subjective value in "*being seen*" for this participant perhaps also be indicated by her being the sole respondent to travel to interview in person? What if, as is so often born out in psychotherapy, we tend to find what we are (unconsciously) looking for in situations otherwise encountered as happenstance?

This importance of spontaneity to an understanding of humour in psychotherapy is elsewhere illuminated by Neil Altman (2006) in a commentary of a psychotherapy text of the 'use it here, in this way…' variety (Newirth, 2006). Altman here considers the ways that an inter-subjective space of humour can become asymmetrically dominated by the therapist, who, by enjoying the spontaneous moment, illegitimately prejudges what they think they are doing with it. Altman contrasts this with a more symmetrical inter-subjective context of 'co-constitution' in therapy, in which meaning-making always awaits the other's response (see also: McLeod, 1997; Elliott & Timulak, 2005; Gergen, 2009). Altman argues that if humour in psychotherapy is to be considered in a truly inter-subjective context, the impact of any comment or action by analyst [sic] or patient cannot be predicted with much confidence. An interaction that is experienced by both parties as humorous depends on an unconscious confluence that is indeed largely spontaneous. Efforts to orchestrate a particular outcome to an intervention that is meant to be humorous may well reveal more than was intended, and thus have an unpredictable unconscious resonance. Such concerns are well established in research literature (see: Kuhlman, 1984; Bloch, 1987; and Sultanoff, 2015 in *paper one*).

Following this line of thinking, the "*pleasing*, *delight*" and "*joy*" of spontaneous humour (see: p. 60) requires much further interrogation in therapy than was arrived at in these interviews. For instance: Rubi's example (see: p. 63), of teasing her patient with an unfashionable property programme, purports only that the spontaneous humour – "*born of frustration*" (see: p. 62) – functioned here to positively "*dismantle*" something which consequently "*freed up*" work with her patient. Rubi expresses no interest in the substance of her own humour intervention with her frustrating patient (e.g., what it may have meant to this particular adolescent – a recent care-leaver – for his therapist to humorously goad him with a TV show ultimately about acquiring a home). Instead, it is claimed in this interview only that the spontaneous experience of humour was thought to help. This example of a purely spontaneous humour is consistent with the finding of 'catharsis' (following the Greek 'komodia') in research of humour experiences explored elsewhere (see: Briggs et al., 2015, in *paper one*]).

Altman and others (see also: Sullivan, 1953; Marcus, 1990**)** contend that we must not bask in our spontaneous moment of humorous achievement – and entrust it to just do what we think it's doing. Rather, we need to learn how to work (seriously) with humour in therapy in a spontaneous way. And the findings from this study suggest that for this we need help. As Sally tells me: "*I appreciate it's a contradiction: I'm telling you that something happened spontaneously, but also that I developed how to do it in supervision*". Although contradictory to Sally, 'learning how to be surprised' is a long-standing ambition in certain approaches to psychotherapy (Adam Phillips [2024] defines it as the core belief for those who follow the teaching of DW Winnicott [see: *3.4* '*Play'* in *paper one*]). Would it be valuable for every therapist to give up

something of the ‘natural genuineness’ enjoyed in spontaneity in order to learn how to be surprised (e.g., with humour) in the room? Would we be willing to?

Help

A central finding from this study (and research project) is that those participants (Sally, Shantel) who had direct supervisory support in their work with humour were able to take it up as a measure of technique. Whereas those participants (Vera, Rubi, Abigail) who felt that they were to a significant degree without this support placed a greater emphasis upon the spontaneous achievement of the phenomenon – in a post-fact rationalisation about humour after its initial bursting. As Rubi tells me: “*it was more that it happened and we were able to think about what had happened”.*

So, for these five therapists, the availability of supervisory support to work with humour helped to clarify a distinction, commonly used in psychotherapy, between *process* (i.e., what the humour does) and *content* (what the humour is) (Held, 1991). This study’s findings suggest that therapists working without supervisory support about humour are more likely to focus upon the spontaneous process of humour than upon its content. So, in answer to *RQ7* (see: *Table 1,* p. 47)*,* ‘how it feels’ does matter, but only if you have the right kind of attention and support in place. Exactly how the nature of this support might be understood is taken up elsewhere in this research project (see: *paper three – framework analysis*).

This conviction in process over content, may also indicate this set of therapists’ wish to practice more like the ‘developmental object’ described by Anna Freud (1936) (“*Woah! You really needed to get that out*!” [Sally]) than as the blank transference object (“*He doesn’t even look at me*” [Abigail]) that can be seen, rightly or not, as the

psychotherapy ideal of certain training schools (see: Lemma, 2000 in *paper one*). However, a further interesting finding from this study is of the prevalence of exceptional figures of support who made possible working with humour *in spite of* the prevailing psychoanalytic culture of training i.e., whether it was steeped in developmental approaches or not. Rubi and Abigail attended the same training institution but both participants felt that they were in receipt of support that was an exception to the rule experienced generally (where humour was assumed as forbidden). What are the chances that multiple students in the same course of training are experiencing something exceptional? Could it be equally plausible that a deeper, foundational belief – for instance, about the prevailing psychoanalytic culture, or training institution, itself – is in effect? This is the substance of investigation taken up in *paper three* of this research project (a *framework analysis*).

Deprecation

Where humour was seen by these participants to achieve deprecation of oneself and others, the findings of this study can be seen to run counter to those expressed elsewhere (e.g., McCann et al., 2010, and much of the 'Superiority theory' of humour [see: *paper one – 3.1 'Superiority'*]), which more commonly understands in humour a destructive envelope for cruelty. In this study's findings, deprecation was not experienced as destructive or cruel. Rather, it was generally seen as a developmental achievement: something that helped things to be(come) OK.

This particular ontology of humour as deprecation is codified in an earlier text: *The Essence of Laughter* by the poet Charles Baudelaire (1855). Here, laughter is understood to be of 'satanic origin', attributed to the original Fall from paradise, in a

degradation of both the body and the mind. For Baudelaire, man [sic] laughs as an expression of his superiority to the beasts (or really, *his* beasts) – and yet, also according to Baudelaire, alongside this sneering denigration of the bestial located in the Other is the recognition of an anguished sense of inferiority encountered by the humourist in their relation to the Absolute, in whom no laughter is found. For Baudelaire, at the same time that man employs a personally comforting humour which inflicts the pain of laughter upon his subordinates, he is also confirmed in his helplessness. Humour, thus conceptualised, is internally hollow. It is the practise of a dog being compelled to chase its own tail which was never really there.

So what happens relationally here, really, in deprecation? Is this a true developmental achievement, as is claimed by this study's participants – or, could it just as authentically be understood as a way to join in with something counter-developmental, such as, following Baudelaire, the therapist's obliging 'identification with the aggressor' (Freud, 1966), including Sally laughing at herself presented in avatar as an old lady (see: p. 70)? I have suggested above that my own (self)deprecations in the interviews – as researcher-participant – could be understood in this way: as a defence against aggression landing where it was intended in a case of the tail wagging the dog.

Collaborators and collaborationists

In the interviews, an importance is placed upon the ordinariness of humour (see: p. 72) – as distinct from the elevation of the 'Superiority' hypothesis (see: *paper one*). Consistent with Freud's later (1927) model, humour is seen as the developmental process of two struggling people, "*two folk in a room*", who work in humility towards a

more mature phenomenon of contact made (in thinking, in vulnerability) upon the basis of limits that *constrain* ("*I will never be Margaret Rustin*"), but which also render possibilities, capabilities, and "*edges for containment*" (see: p. 77). This is consistent with an identified research area which emphasises in humour an appreciation for limits (see: *paper one – 3.4* '*Humility*').

As described above, Vera's patient once blanched at the idea of the therapy relationship being a "*collaborative*" one (see: p. 76). For Shantel, in the end, the undertaking of humour, when properly understood, "*is almost always a collaborative act".* For this therapist, humour is about "*valuing"* the parts of ourselves that are unearthed in therapy, and in so doing, the phenomenon is about engaging "*with what we <u>don't</u> know about ourselves and others"* [Abigail]*.* We take something from outside ourselves when we embark upon experiencing humour with another.

But when our patients collaborate and willingly do this with us, what are the terms of the collaboration, and are we prepared to know about this? If we can't bear the "*blankness*", "*unfilled-in-ness*" of our patients (see: p. 63), can we really claim a spontaneous act when they present us with a filled-in cartoon, for instance? If the patient is to survive in their therapist's mind, is any kind of activity moving in this direction truly a surprise? Whose needs are being unconsciously attended to here? Who is being humoured by the humour, and to what end?

5 | LIMITATIONS

This study employed an Interpretative Phenomenological Analysis (IPA) methodology to explore the lived experience of humour in psychotherapy among five

trainee child and adolescent psychotherapists. While IPA offers rich idiographic insight, several important limitations must be acknowledged.

First, IPA's privileging of subjective meaning introduces a fundamental methodological constraint: a gap between narrated and actual experience. Participants' accounts are retrospective and interpretative, not direct records of what occurred in session. Moreover, they reflect only the therapists' perspectives. This is especially limiting given humour's inherently co-constituted nature (Altman, 2006) between therapist and patient. Without an adolescent perspective, the study presents only half of the interpersonal picture. Future research would benefit from a more dialogic approach, incorporating patients' reflections to more fully understand humour's occurrence and meaning in therapy.

A further limitation arises from the nature of phenomenological enquiry itself. While participants offered coherent accounts of clinical moments, the researcher's reflective diary (see: *Appendix 7*) frequently recorded questions such as, "what was this really about?" or "how has this been understood?". An impression was given that the data being produced was 'about' something other than the 'about-ness' named directly by the study's participants. This reflects an interpretative ambiguity at the heart of the data: that what is narrated may not fully disclose the emotional or relational dynamics at play. Although IPA offers thick description, it may underplay underlying influences such as institutional culture, professional identity, or unconscious beliefs. In this project, this concern was addressed through the use of a second, complementary method – framework analysis – applied to the same dataset in paper three. This allowed for a more diagnostic understanding of how humour was not only experienced but also conceptualised and constrained by wider institutional

discourses. The differences between methodologies are illustrated with examples in *Table 5* (see: p. 95).

6 | CONCLUSION

Addressing a research gap in existing literature (see: *paper one*), this paper has presented an interpretative phenomenological analysis of the lived experience of how five trainee child and adolescent psychotherapists have experienced humour in their intensive psychotherapy work with adolescent training cases. The findings of this study have underlined the importance for these participants of a phenomenon seen as essential to their work. Even when it was connected to pain and disturbance, humour was generally experienced as congruent with psychotherapy aims: a worthy objective to get to, and a means with which to overcome the challenges faced along the way. Interestingly, certain ideas – for instance, about the principle of spontaneity – were typically applied by participants in a post fact rationalisation. Humour is recognised in this research project as a non-instrumental, co-constituted experience between people (see: *paper one, Box 1)*. However, key findings in this study indicate the existence and influence of necessary 'conditions' for the realisation of humour (see: *RQ8* in *Table 4,* below), which also may determine how this experience is consequently understood.

The degree to which a methodological analysis of lived experience has successfully answered developed research questions from existing literature is outlined below, in *Table 4.*

Table 4.

Research questions for further consideration developed from a review of existing literature (see: paper one)		**Summary of address to research questions provided by an interpretative phenomenological analysis of five semi-structured interviews with trainee therapists**
RQ1	'What amount and type of detail – with respect to the "thickness" and "thinness" of description (see: Geertz, 1973) – supports a meaningful understanding of an account of an experience of humour?'	Close attention to lived experience (using IPA methodology) provides a wealth of "thick" description. However, a reflective diary kept throughout this process indicated a need for further investigation – with a "narrow" or "precise" focus of detail – as to how this experience had first come about, and to how it had then been understood.
RQ2	'Does a model for data analysis with/without an explicit idiographic focus – such as interpretative phenomenological analysis – support the understanding of a humour experience?'	A reflective diary kept throughout the research process suggested that greater understanding of these five participants was achieved, but further questions were raised regarding the 'about-ness' in the (implicit) reasons, beliefs, customs, and cultures which informed their espoused experiences.
RQ3	'Does humour produce relief or relief produce humour?'	Humour was found both to produce relief and vice versa. However, who stood to gain from this, and how, remained unclear.
RQ4	'Can we learn or develop from an experience of humour? Does humour actually do anything, or is it simply an appeasement (e.g., of the patient's narcissism, or that of their therapist – a convenient fiction deluding us from an inconvenient reality)?'	Humour was seen to have multiple, "vital" functions. It was seen to "do" many things, including: 'enlivenment'; 'disentanglement'; 'softening the blow'; 'safe expression of healthy aggression'; 'finding edges for containment'; 'an achievement of ordinariness'.
RQ5	'As a subset of play is humour therefore a subset of psychotherapy?'	Humour is named, clearly and unprompted, as a subset of play by each participant. This is presented as congruent with psychotherapy practice.
RQ6	'Is the experience of humour helpful to therapeutic work?'	Participants presented a mixed picture of this. Some kinds of humour were experienced as directly supportive of therapeutic aims, whereas others were seen as contrary to these objectives.
RQ7	'Does it matter how humour in psychotherapy feels?'	A central finding is that how it feels does matter, but only if you have the right kind of support in place.
RQ8	'What conditions are necessary for an experience of humour in psychotherapy?'	Identified 'conditions' include structural ones (e.g., the provision of supervision), as well the personal and cultural grounding of therapist and patient, e.g. "where we're from".

Summary of address to developed research questions (see: paper one) in this IPA study.

The real-world implications of the findings in this study are presented below, in *Box 1*. Identifying the reasons why the lived experiences recounted in this study were understood as they were is beyond the scope of this paper. This will be taken up in *paper three* of this research project (a *framework analysis*).

Box 1.

The findings from this IPA study suggest that humour in psychotherapy with adolescents can serve as a powerful medium for emotional contact, boundary-testing, and mutual recognition. Trainees described using humour instinctively, often to express or contain difficult affect, including aggression, expressed as deprecation. However, they also highlighted uncertainty about how to understand or discuss these moments within supervision.

These results indicate a need for training programmes and supervisors to engage more directly with humour as a valid site of clinical meaning. Rather than treating humour as incidental or off-topic, it should be approached as a relational event worthy of reflection and interpretation – much like other affect-laden material. Encouraging therapists to explore the function and timing of humour could help to integrate it more meaningfully into therapeutic practice, and to reduce the risk of it being used defensively or unconsciously.

Summary of real-world implications.

LINKING PASSAGE

In this study, close analysis of five trainee therapist participants' subjective experiences of humour suggested that these were informed by explanatory categories of influence – meaning: the possible reasons for how their experiences were understood as such. A reflective diary kept by the researcher throughout the research process consistently recorded: "but what was this about?; How is this being understood?" (see: *Appendix 7*). Being outside the idiographic focus of this interpretative phenomenological analysis, such categories of explanation are instead taken up in the 'diagnostic' methodological procedure presented in the third paper of this research project: a framework analysis. Examples comparing these distinct methodological approaches are listed below, in *Table 5*.

Table 5.

Interpretative phenomenological analysis (IPA) idiographic descriptions	Framework analysis (FA) diagnostic categories
• Supervisors are understood by three of five participants to be of a generation too far removed from the humour expressed by the therapist's adolescent patient to understand it. • Culture-carriers in psychotherapy training (psychoanalysts, course teachers, supervisors) are experienced by these trainee participants to broadcast an elevated superiority which cannot be related to, and which transforms experiencing "ordinary" humour into a transgressive act.	• Participants turn to omnipotent justifications because their supervisors are sorely needed but are found lacking. • Feeling left outside the perceived culture of psychoanalysis, participants instead identify with the humour expressed by the culture of their personal grounding, including their nationality of origin.

Examples of distinction in data analysis between IPA and framework analysis.

7 | WORKS CITED

Altman, N. (2006). Commentary on paper: 'And Now for Something Completely Different: Humour in Psychoanalysis' by Joseph Newirth. *Psychoanalytic Dialogues*, 573-577.

Baudelaire, C. ((1855)1956). *The Essence of Laughter and other essays, journals, and letters.* London: Meridian Books.

Berger, P., Bitsch, F., Nagels, A., Straube, B., & Falkenberg, I. (2018). Frontal hypoactivation and alterations in the reward-system during humour processing in patients with schizophrenia spectrum disorders. *Schizophrenia Research*, 149-157.

Bergson, H. (1900). *Le Rire: Essai sur la signification du comique.* Paris: Felix Alcan.

Bion, W. (1989). *Learning from Experience .* London: Karnac books.

Bloch, S., & McNab, D. (1987). Attitudes of British Psychotherapists Towards the Role of Humour in Psychotherapy. *British Journal of Psychotherapy*, 216-225.

Briggs, E., & Owen, A. (2022). Funny, right? How do trainee and qualified therapists experience laughter in their pratice with clients? *Counselling and Psychotherapy Research, 22(2)*, 278-287.

Britton, R. (2003). Humour and the superego. In R. Britton, *Sex, Death, and the Superego.* London: Routledge.

Chamberlain, K. (2011). Troubling methodology. *Health Psychology Review, 5(1)*, 48-54.

Elliott, R. &. (2005). Descriptive and Interpretive Approaches to Qualitative Research. In J. C. Norcross, *Psychotherapy Relationships that Work* (pp. 225-248). New York: Oxford University Press.

Freud, A. (1936). *The Ego and the Mechanisms of Defense.* London: Hogarth Press.

Freud, A. (1966). Identification with the Aggressor. In A. Freud, *The Ego and the Mechanisms of Defence.* London: Routledge.

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

Freud, S. (1927). Humour. In S. Freud, *Standard Edition of the Complete Psychological Works Vol. 21* (pp. 159-167). London: Hogarth Press.

Gergen, K. J. (2009). *Relational Being: Beyond Self and Community.* New York: Oxford University Press.

Held, B. S. (1991). THe process/content distinction in psychotherapy revisited. *Psychotherapy: theory, research, practice, 28(2)*, 207-217.

Hurley, M. M., Dennett, D. C., & Adams, R. B. (2011). *Inside Jokes: Using Humour to Reverse-Engineer the Mind.* Cambridge, MA: MIT Press.

Janus, S. S. (1975). The Great Comedians: Personality and other Factors. *American Journal of Psychoanalysis*, 169-174.

Kernberg, O. F. (1996). Thirty methods to destroy the creativity of psychoanalytic candidates. *International Journal of Psychoanalysis*, 1031-40.

Kernberg, O. F. (1996). Thirty methods to destroy the creativity of psychoanalytic candidates. *International Journal of Psychoanalysis*, 1031-1043.

Kubie, L. (1971). The destructive potential of humour in psychotherapy. *American Journal of Psychiatry, 127(7)*, 861-866.

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

Lemma, A. (2000). *Humour on the Couch.* London: Karnac Books.

Marcus, P. (1990). Humour in Psychotherapy: A Cawes of Creative Resonance. *American Journal of Psychotherapy, 44 (1)*, 96-107.

McLeod, J. (1997). Narrative and the Therapeutic Process. *Counselling Psychology Quarterly* , 357-367.

Newirth, J. (2006). And Now For Something Completely Different: Humour as a Signal of Reparation in the Psychoanalytic Process. *Psychoanalytic Dialogues*, 517-536.

Phillips, A. (2024, June 20). On Getting the Life You Want. *London Review of Books*, p. Vol. 46.

Radomska, A. (2007). Understanding and appreciating humour in late childhood and adolescence. *Polish Psychological Bulletin 38(4)*, 189-197.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method, and Research.* London: SAGE Publications.

Steiner, J. (2020). *Illusion, Disillusion, and Irony in Psychoanalysis.* London: Taylor & Francis.

Sullivan, H. S. (1953). *The Interpersonal Theory of Psychiatry.* New York: W. W. Norton & Co.

Sultanoff, S. (2013). Integrating Humour into Psychotherapy: Research, Theory, and the Necessary Conditions for the Presence of Therapeutic Humour in Helping Relationships. *The Humanistic Psychologist 41(4)*, 388-399.

Waddell, M. (2018). *On Adolescence: Inside Stories.* London: Routledge.

Werbart, A., & Levander, S. (2006). Two sets of private theories in analysands and their analysts: Utopian versus attainable cures. *Psychoanalytic Psychology*, 108-127.

Paper three – According to what explanatory framework do trainee child and adolescent psychotherapists understand experiences of humour in intensive psychotherapy with adolescent patients? A framework analysis

ABSTRACT

In this paper, the author presents a developed analytic framework which has sought to identify and better understand the reasons why trainee child and adolescent psychotherapists experienced humour in their intensive psychotherapy work with adolescent patients as they did. The methodological procedure of a framework analysis has been chosen to complement an interpretative phenomenological analysis of this same dataset – presented elsewhere in this three-paper research project (see: *paper two*). From developing an analytic framework, the author found that how participants understand their experiences of humour in therapy is significantly informed by four organising 'levels' or 'fields' of consideration: [1] The experience of the therapist; [2] The experience of the patient; [3] The therapeutic process (i.e., what the therapist understands to happen between [1] and [2]); and [4] The institutional/socio-cultural/general context (in which all other considerations – [1], [2], and [3] – are taking place). Participants were seen to engage in humour regardless, but explanation for how their experiences of humour were understood could be roughly divided into the *technical* (when a particular kind of institutional support was experienced to be in place) and the *omnipotent* (when it wasn't). Participants could understand their experiences of humour on multiple levels, and it was seen as congruent with psychotherapy aims – facilitating transference and transitional phenomena often associated with expressed healthy aggression, and understood as play.

LINKING PASSAGE

This paper is part of a larger three-paper research project exploring experiences of humour in psychotherapy. In a review of existing literature on the subject (see: *paper one*) and an interpretative phenomenological analysis of five interviews with trainee child and adolescent psychotherapists (see: *paper two*), a number of questions and instances of challenging data were raised, inviting further investigation to be undertaken in this study. The phenomenon of experienced humour in psychotherapy was shown to be a contested subject, with different explanatory frameworks relating to beliefs, cultures, and customs seen as implicitly drawn upon (see: *paper two*).

Following the methodology of framework analysis (see: Ritchie & Spencer, 1994; refined by Parkinson et al., 2016), this study will draw upon the 'data corpus' (Braun & Clarke, 2006) of interviews conducted with five trainee psychotherapists engaged in intensive psychotherapy with adolescent patients (a dataset formerly subject to an interpretative phenomenological analysis in *paper two* of this research project), in addition to the reflective diary kept by the author as researcher-participant during this process (see: *Appendix 7*). Framework categories for this corpus were informed by both 'a priori considerations' expressed in research questions developed from existing literature on the subject (see: *paper one*) and the degree to which these had been successfully answered by an interpretative phenomenological analysis (see: *paper two, Table 4*), as well as emergent 'data-driven issues' in the procedure of the methodology (see: *2. 'Methodology'*, p. 104). A table of a priori considerations, with identified questions for further investigation in this study, is presented below as *Table 1*.

Table 1.

Research questions for further consideration developed from a review of existing literature (see: paper one)		Summary of answers to research questions provided by an interpretative phenomenological analysis of five semi-structured interviews with trainee therapists (see: paper two)	Identified questions for further investigation in this study (a framework analysis)
RQ1	'What amount and type of detail – with respect to the "thickness" and "thinness" of description (see: Geertz, 1973) – supports a meaningful understanding of an account of an experience of humour?'	Close attention to lived experience (using IPA methodology) provides a wealth of "thick" description. However, a reflective diary kept throughout this process indicated a need for further investigation – with a "narrow" or "precise" focus of detail – as to how this experience had first come about, and to how it had then been understood (see: *paper two – 'Limitations'*).	How can experiences of humour be arrived at and understood? Which levers of explanation inform 'thick descriptions' of experiences in therapy?
RQ2	'Does a model for data analysis with/without an explicit idiographic focus – such as interpretative phenomenological analysis – support the understanding of a humour experience?'	A reflective diary kept throughout the research process suggested that greater understanding of these five participants was achieved, but further questions were raised regarding the 'about-ness' in the (implicit) reasons, beliefs, customs, and cultures which informed their espoused experiences.	What lies outside of an idiographic attention to detail (i.e., beyond what participants say, and how they say it)? Can 'zooming out' from scrutiny of participants' 'espoused values' (Schein, 2004) on humour offer a different perspective?
RQ3	'Does humour produce relief or relief produce humour?'	Humour was found both to produce relief and vice versa. However, who stood to gain from this, and how, remained unclear (see: *paper two – 'Discussion'*).	Who is the (purportedly relieving) humour in therapy for, really?
RQ4	'Can we learn or develop from an experience of humour? Does humour actually do anything, or is it simply an appeasement (e.g., of the patient's narcissism, or that of their therapist – a convenient fiction deluding us from an inconvenient reality)?'	Humour was seen to have multiple, "vital" functions. It was seen to "do" many things, including: 'enlivenment'; 'disentanglement'; 'softening the blow'; 'safe expression of healthy aggression'; 'finding edges for containment'; 'an achievement of ordinariness' (see: *paper two – 'Findings'*).	What invests humour's achievements in therapy with meaning? Who/what says it does anything at all?
RQ5	'As a subset of play is humour therefore a subset of psychotherapy?'	Humour is named, clearly and unprompted, as a subset of play by every participant. This is presented as congruent with psychotherapy practice	If humour's mere stating as 'play' is not explanation enough, what is this play, how does it work, upon what does it depend, and what does it do?
RQ6	'Is the experience of humour helpful to therapeutic work?'	Participants presented a mixed picture of this. Some kinds of humour were experienced as directly supportive of therapeutic aims, whereas others were seen as contrary to these objectives (see: *paper two – 'Findings'*).	What are the salient categories of explanation informing when humour helps and when it doesn't?
RQ7	'Does it matter how humour in psychotherapy feels?'	A central finding is that how it feels does matter, but only if you have the right kind of support in place (see: *paper two – 'Discussion'*).	Why, when, and how does it matter how humour in psychotherapy feels?
RQ8	'What conditions are necessary for an experience of humour in psychotherapy?'	Identified 'conditions' include structural ones (e.g., the provision of supervision), as well the personal and cultural grounding of therapist and patient, e.g. "where we're from" (see: *paper two – 'Findings'*).	How do the espoused (personal and institutional) 'conditions' of humour work, interrelate, clash?

Summary of 'a priori considerations' for a framework analysis.

1 | INTRODUCTION

Exactly how experiences of humour are understood in psychotherapy is not shared across the profession. Instead of an embraced variability – for instance, as may be argued of approaches to experienced silence, or sexual desire, in the therapy relationship – a literature review (see: *paper one* of this research project) and interpretative phenomenological analysis of five semi-structured interviews with informed participants (see: *paper two*) have identified areas of contestation, with instances of challenging data regarding how this phenomenon can be understood, including in the context of psychotherapy training. This is presented above, in *Table 1,* and is illustrated as an example below, in *Box 1.*

Box 1.

To illustrate with one example, all five therapist participants in the aforementioned interpretative phenomenological analysis of semi-structured interviews (see: *paper two*) shared an impression of humour as "*vital*" to their psychotherapy work, and to the process of their patients becoming well. Every participant felt that the humour they experienced achieved something, and was part of a substantive shift in their patient's treatment towards recovery. However, this 'belief', 'feeling', or 'expectation' expressed by these interview participants about humour can be seen to run counter to the outcomes of a body of research which suggests that experiences of humour offer nothing to the prediction of mental health or well-being (see: Porterfield, 1987; Lefcourt, 2001; Van Baaren & Van Knippenberg, 2009, in *paper one*). This research suggests that humour has no substantive bearing upon the outcomes of mental health treatment at all: we are merely helped by humour to feel better in the moments when we are actually not better. If the 'worthiness' of humour experienced in psychotherapy can be questioned in this way by findings of this kind, by what framework of understanding do these five interview psychotherapist participants recognise its "vitality" in the treatment of their work? What beliefs or variations upon outcomes of change are operating in the understanding of experiences recounted here?

An example of contestation about experienced humour.

As a trainee psychotherapist-researcher, I myself experienced a number of interesting responses – from colleagues, peers, and supervisors – when first broaching my research interest in this subject. These are gathered below in *Table 2*.

Table 2.

Type of response	**Example**
Something excessively appreciative, or cloying, to the point of becoming dismissive.	*"I think it's really nice that you're thinking about that".*
Dismissive responses in a more openly negative light, where the subject is positioned as frivolous/decadent or irrelevant, or indeed as something contrary to our psychotherapeutic aims.	*"What's the point of looking at that? It's hardly the central thing/what they come to therapy for".*
Directly confronted responses.	*"There's very little humour in my work/personal therapy. Is it not a bit outrageous to take such serious work unseriously?".*
Directly confronting responses to my own (presumed narcissistic) reasons for entertaining this research interest, where I have here experienced myself to be positioned as someone wishing to broadcast himself as being (dubiously) endowed in humour's work.	*"Oh! That's a surprise. Do you have a personal interest in this area?* [with eyebrows raised]*".*
Responses suggesting a strong advocacy for the importance of humour within the profession. I have here felt paired in a kind of vestigial alliance, fighting the good fight in the psychotherapy discipline.	*"I don't care what anyone says, it is such an important part of our work".*

Anecdotal responses to the author's research interest in the subject of humour in therapy.

1.1 | Rationale and purpose

In the outcomes of this research project, trying to understand experiences of humour in psychotherapy is shown to involve certain considerations that fall beyond the focus of an isolated examination of the phenomenon at work (as has been undertaken in *paper two* of this research project). Thorough understanding of what happens, and how this understanding is arrived at, appears to lie beyond mere attention to lived experience, as is illustrated with an example below in *Box 2.*

Box 2.

At the very end of our interview about experiences of humour with her adolescent training case, participant Shantel clarifies that she is humorous with this patient and age group in a way that she would never be in her work with young children or with parents. Shantel here raises an important consideration, with reverberations beyond the granular detail of her lived experience. Namely: are experiences of humour, and the therapist's willingness to engage in them, organised around the age category of the client-group? Could an important component of an explanatory framework for humour in psychotherapy therefore be that such experiences are seen as necessarily confined to the specific developmental age of adolescence, and if so, what influence does this possible explanatory category have upon what then happens in therapy?

An example of understanding beyond experience.

By considering such data categorically (in the example above, where humour is seen to 'go with' adolescence and 'not go with' other age groups), we can begin to identify the reasons for how experiences of humour have been understood. Indexing experiential data in this way can support the generation of new research questions. For example, do some therapists (like trainees) see themselves as 'adolescent-adjacent' (and therefore humour-valuing), with an older generation of experienced therapists (perhaps represented by Shantel as the 'parents' she would never experience humour with) positioned as non-adolescent-adjacent, and therefore presumably humour-sceptical? Regardless of the veracity of any underlying belief of this kind, developing a functional analytic framework which recognises existing categories of explanation – such as here: 'humour is seen as age-specific' – may help to better understand how experiences of humour are ultimately taken up in the room.

This 'framework analysis' methodology was chosen for the reasons of its similarity to thematic analysis, which claims to be "essentially independent of theory and epistemology" (Braun & Clarke, 2006), unlike alternative methodologies such as grounded theory. This supports the ambition of the present study to develop a

generic framework of explanatory categories from a data corpus of lived experiences, which functions without theorising and extrapolation of meaning. However, framework analysis is also unlike thematic analysis in that it emphasises how both ‘a priori considerations’ (from previous research [see: *Table 1,* p. 100]) as well as emergent ‘data-driven themes’ (discovering the unexpected through the process of re-familiarising with the data corpus) can guide the development of the analytic framework. This supports the aims of this study insofar as there are existing a priori concerns informing a potential analytic framework (see: *Table 1,* p. 102), but also a need to create space for unexpected, emergent data-driven considerations to arise.

In summary, the framework analysis methodology of this study complements the explicitly idiographic focus upon the detail of unique individual experiences in the interpretative phenomenological analysis of this same interview dataset (see: *paper two*). Following the outline of Ritchie & Spencer (1994), a framework analysis can here be seen to take up a “diagnostic”, rather than “idiographic”, mode of analysis. If the former investigates “what the data means, not what it is”, then a framework analysis can examine “the reasons for, or causes of, what is” (Parkinson et al., 2016). And so, in this research study: the aim is to examine the reasons for how experiences of humour are understood in psychotherapy.

2 | METHODOLOGY

Framework analysis is a structural approach in qualitative research, commonly employed in medical science, and used to manage and analyse large datasets[28]. A thematic framework is developed from a process of familiarisation with a data corpus – this is based upon key issues or concepts, which is used to systematically index (or categorise) coded data. Charts and matrices are then created to organise themes corresponding to the categories. These are then interpreted by mapping patterns, connections, and relationships to answer developed research questions (see: *Table 1*, p.100) and to draw conclusions. In this methodological procedure, the analytic framework is refined in an iterative process, until it acquires functionality for the entirety of the data corpus.

Ritchie & Spencer (1994) summarise the procedure for developing an analytic framework in five stages: [1] *Familiarisation* with the data corpus; [2] *Identifying a framework*; [3] *Indexing*; [4] *Charting*; and [5] *Mapping and interpretation*. The first two stages of this research study – *Familiarisation* and *Identifying a framework* – are outlined in this section ('*Procedure'*); the third and fourth stages – *Indexing* and *Charting* – are outlined in the next section ('*Data analysis'*); and the final stage – *Mapping and interpretation* – is detailed across the final two sections ('*Data analysis'* and '*Discussion'*).

[28] In this study, the author's employment of framework analysis for a comparatively small dataset of five semi-structured interview transcripts, supported by a reflective diary, appears to be somewhat unusual. From the author's survey of existing research literature, IPA, grounded theory, or RTA appear to be more typical for a dataset of this size. As a result, the application of framework analysis for a comparatively small data corpus, as a complement to a study with greater idiographic focus (see: *paper two*), can be considered an experiment of sorts, to be reviewed at the '*Conclusion'* stage.

[1] ***Familiarisation***

The data corpus of transcripts from five semi-structured interviews with trainee child and adolescent psychotherapists, and a reflective diary kept during this research process (see: *Appendix 7*), is familiar to this researcher, following the undertaking of an interpretative phenomenological analysis of this same dataset (see: *paper two*). Consequently, an additional stage of re- and de-familiarisation was necessary to bracket off meaning-making comments and interpretations from the generic codes and explanatory categories that this data also conferred (see: *Appendix 5*). Throughout this process of re-reading the data corpus, it was instructive to move deliberately from consideration of "what experience is here being described?" (taken up in the idiographic focus of *paper two*) towards the questions: "what is this about? And how is it here being understood?"[29].

NVivo

The process of de- and re-familiarising with the data corpus could also be taken up in appraisal of an a priori consideration from the first research question developed from a review of existing research literature (see: *Table 1,* p. 102):

RQ1: What amount and type of detail – with respect to the 'thickness' and 'thinness' of description (Geertz, 1973) – supports a meaningful understanding of an account of an experience of humour?

[29] This process of de- and re-familiarisation reflects the model of 'organisational culture' as described by Edgar Schein (2004) – a guide for the author in this procedural stage. Understanding the participants of this study to be describing experiences as workers at work in organisations, Schein's framework promotes 'zooming out' from the 'artefacts' (the 'sayings and showings' in an overt culture of labour) and 'espoused values' (the official philosophies also claimed) of this work, to allow perspective upon the 'underlying assumptions' also in play. Such assumptions are the largely unconscious, deeply embedded, and typically elusive essence of the 'real' organisational culture at work – the unexpressed 'actual' purpose of the organisation and its members. Among the justifications for this study are that all therapists engage in their work with active 'blind spots' of this kind.

This research question is informed by a review of existing literature of the subject (see: *paper one*), where a question was raised about the use of digital data analysis software in qualitative investigation versus conducting all analysis by hand, and whether this could have any bearing upon the 'intimacy' versus the 'generality' of findings developed (see: *paper one,* p. 15). Having conducted an interview-based interpretative phenomenological analysis without digital software (see: *paper two*), in this framework analysis study, NVivo digital software has been employed for the *Charting* procedural stage. Assisting the task of de- and re-familiarisation, the adoption of a contrasting approach to data analysis will also help to compare and contrast the contributions made between: extracting 'thin' categories of explanation from a totality of material, represented with digital software (as is undertaken here, in the 'diagnostic' approach of a framework analysis) versus a more subjective interpretation of 'thick' experiences of meaning, as recounted by individual people in an interview relationship (as was undertaken elsewhere in this research project [see: *paper two*]) (see: Geertz, 1973). In this way, a research question (*RQ1* in *Table 1,* p. 102) can be answered, with conclusions drawn, and aspects of the methodological approach itself can be reviewed and further refined.

[2] ***Identifying a framework***

As has been stated, this methodological approach develops a functional analytic framework of explanatory categories used to understand the phenomenon of humour experienced in therapy. So far, a priori considerations (see: *Table 1,* p. 102), together with emergent data-driven items developed from a process of de- and re-familiarisation with the data corpus, have been taken up as suggested components for a provisional analytic framework. A next stage involves: attempting to apply this

analytic framework to the entirety of the data corpus; noticing where it loses functionality; adapting and refining the framework; and then re-applying it to the data corpus.

The purpose of this iterative stage in the procedure is not about producing a *comprehensive* framework – with every data point represented – but a *functional* one, with representation of the salient 'explanatory categories' relevant to the dataset in entirety. To 'identify a framework' therefore means to identify the categories of explanation that promote understanding of the dataset as a whole. For this data corpus, such a framework is presented below, in *Table 4* (see: p. 115).

Pilot

An early procedural step towards identifying a framework involved piloting the a priori framework with one interview transcript (in this study, with 'Rubi') (see: *Appendix 8*). Piloting a provisional framework at this stage in the methodological procedure supported the opportunity to become informed of so-called 'unruly data' (Parkinson et al., 2016) – when it was unclear where and how to code a chunk of text – and of possible research bias. Engagement with these issues is presented below in *Table 3* and *Box 3.*

Table 3.

Example	Explanation
1. Double, triple, and quadruple coding	Doing this for the same data point allowed for recognition of multiplicity and richness at the stage of data analysis. For example, participant Shantel recounts her mixed experience of her patient turning their chair around in a moment of humour. This is experienced by this therapist as both a rejection of the therapist; negotiating distance from her; as well as "showing something quite psychoanalytic" [the chair now resembled a psychoanalyst's couch]. In the procedure of 'Identifying the analytic framework', this was coded as: 'problematic humour can repel the therapist [experience of therapist]'; 'humour is experienced as a transitional phenomenon [therapeutic process]'; 'humour invites understanding in the transference' [therapeutic process]. The framework was here supported to operate with multiple fields of explanatory meaning (the reasons for how the humour experience had been understood as such).
2. Preserving – i.e., not absorbing – similar codes, when meaningful	Considering the repeated proximity of codes – e.g., 'softening the blow (therapeutic process)', 'managing difficulty (therapeutic process)', and 'humour achieves a grounding in ordinariness (therapeutic process)' – helped to underline a significantly weighted claim of the particular organising level (in this example: of therapeutic process [see: *Table 4*, p. 115]). By considering these codes by virtue of their proximity, it became possible to understand a multiply-influencing particular aspect of the experienced phenomenon. The explanatory categories here worked together to generate analytic meaning from the framework.
3. Careful distinction between similar themes	Distinguishing between, for instance, 'humour draws upon a therapist's personal and cultural grounding (experience of therapist)' versus 'humour employs personalities (therapeutic process)' allowed for important and subtle clarifications to be taken up in later discussion. (E.g., here: who the participant thinks they are ['personal and cultural grounding'] versus how the participant understands themselves to be (in the world, with others) ['humour employs personalities'].
4. Recognition of one code relating to multiple categories and organising fields	This helped to underline the extent that a single code may be experienced across multiple categories and organising fields at the same time. For example, the prevalence of the recounted experience expressed by the category 'being left without support by a parent of some kind' can become compounded and mutually influencing when – as, in this example, for participant Shantel – it is experienced in relation to both the institution of CAMHS; to the therapist's experience of supervision; and to the patient's experience of their actual parents.

Examples of decision-making with unruly data.

Box 3.

Testing a provisional analytic framework informed by a priori considerations (see: *Table 1,* p. 102) in a pilot study with one interview transcript, described above, also helped to clarify researcher bias. If a priori concerns that I-as-sole-researcher developed from a review of existing literature and analysis of semi-structured interviews with five participants were not functionally represented in close analysis of one transcript, there was an opportunity to reflect upon whether this was due to it not being a functional item of concern, rather than a particular interest belonging to the researcher. An example includes an a priori concern about the importance of gender and sexuality to how humour is experienced and understood in therapy. This was informed by a review of existing literature (e.g., in the findings of Haydon et al., 2015 [see: *paper one*]) as well as through consideration of reflexivity in the empirical methodology of this research project (in that the author is a male researcher interviewing five female participants [see: *paper two*, '*Reflexivity statement'*]). However, it transpired that the influence of gender and sexuality was not a significant explanatory category in a functional analytic framework for this data corpus, and was removed during the process of refinement (see: *Table 4,* p. 115). Nevertheless, in this example, the conspicuous absence of concern for gender and sexuality as an explanatory category in psychotherapy with adolescents was itself interesting, and this is returned to in the '*Discussion'* section of this paper. In this way, concern for not only what is maintained, but also for what was removed, during refinement – and is consequently conspicuously missing from the functional analytic framework – can all be taken up as meaningful data.

Working with 'researcher bias'.

In summary, conducting a pilot for a provisional analytic framework helped to remain maximally responsive to unexpected issues thrown up by the data. The development of the framework was taken up as an iterative, on-going process which was continually adapted as a functional framework was refined and established. This developed framework is presented below as *Table 4* (see: p. 115)*.*

3 | DATA ANALYSIS

[3] *Indexing*

The procedural stage of *Indexing* the data is founded upon the previous *Familiarisation* and *Identification* stages, with the conducting of a pilot study, as described above. This produced initial codes which could be gathered into first

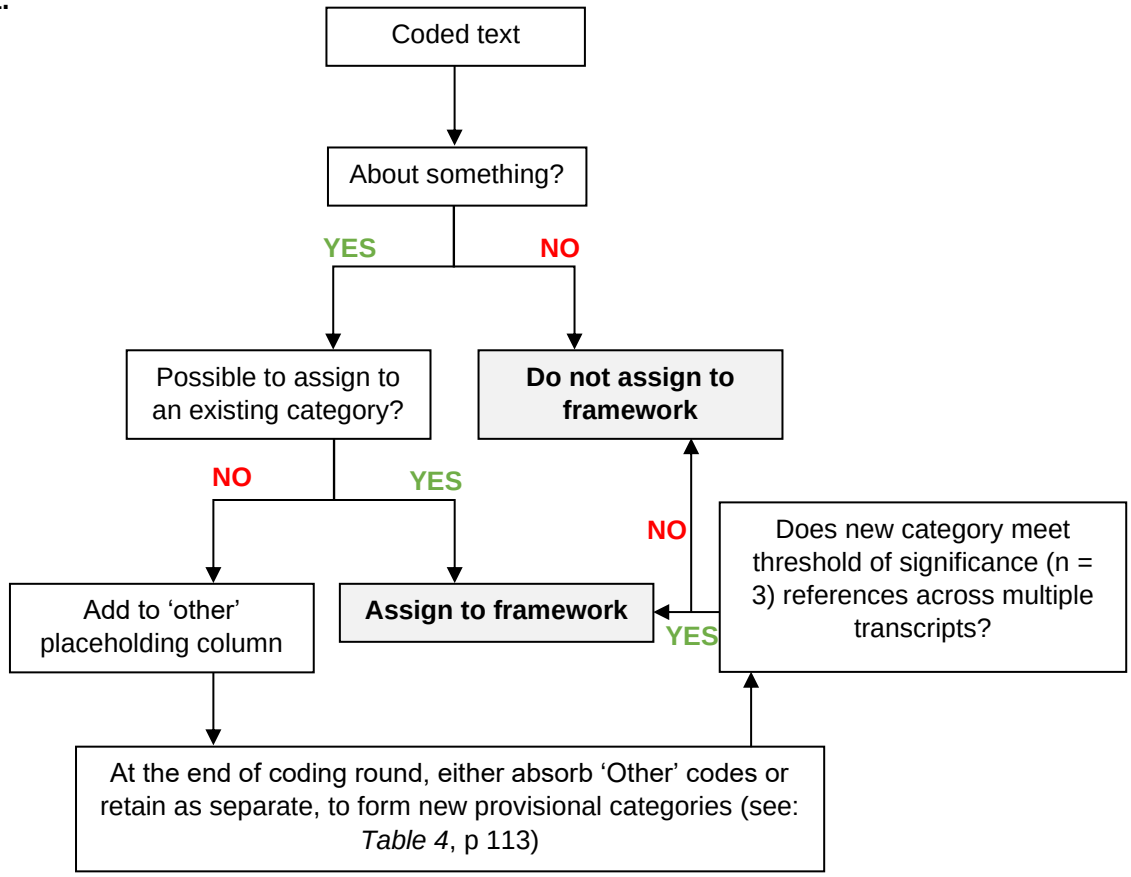
categories to join the a priori categories collected prior to analysis (see: *Table 1,* p. 102). As has been stated, these categories were ‘maintained’ upon the strength of their representation in the pilot study). Using NVivo digital software, the next stage involved working through every transcript and highlighting chunks of text to be assigned to the designated categories (Parkinson et al., 2016).

Refinement

Inevitably, a significant proportion of the data corpus seemed to be ‘about something’ which could not be accurately gathered into any preliminary category. For this, a temporary ‘Other’ column was assigned for the placeholding codes applied to any text chunk which exceeded the functionality of the working framework (see: *Appendix 8*). After the coding round, additional categories were drafted out of these superfluous codes and the analytic framework was iteratively refined. If the functionality standard was met (i.e., if ‘chunks’ of the data corpus could be justifiably assigned to the newly introduced categories), then they were preserved within the improved framework. However, if any explanatory category – either developed out of a priori considerations and initial coding, or through emergent ‘unruly data’ – did not reach the significant number (n = 3 [chosen by the researcher[30]]) of references across multiple interview transcripts, these categories were either absorbed within related categories when this was meaningful, or they were removed (exceptions to these are listed above, in *Table 3*, see: p. 111). This refinement process is presented below as *Figure 1.*

[30] The author was helped to identify this number following consideration of the distinction between ‘statistical’ and ‘practical’ significance in qualitative research (Onwuegbuzie, 2004). Where statistical significance shows that an effect may exist in a study, practical significance shows that the effect is large enough to be meaningful in the real world.

Figure 1.



Decision tree showing the refinement process for data analysis, creation and allocation of codes to categories in development of a functional analytic framework.

[4] *Charting*

At the end of the *Familiarisation, Identification,* and *Indexing* stages, the *Charting* stage helps to organise the data into a more manageable format to facilitate subsequent analysis. Looking at the entire data corpus while refining the analytic framework, the author found that it was meaningful to organise explanatory categories into four distinct organising 'levels' or 'fields' about experienced humour in the undertaking of psychotherapy. These are: *the institutional/socio-cultural/general context*; *the therapeutic process*; *the experience of the therapist*; and *the experience of the patient.* These organising levels/fields are presented on the following page in *Table 4* – a refined and functional analytic framework for this dataset.

Table 4.

1. Institutional/socio-cultural/general context			**2. Therapeutic process**		
Category[31]	*# of transcripts*	*# of codes*	*Category*	*# of transcripts*	*# of codes*
1. A parental generation of psychotherapists (e.g., case supervisors) are seen to not understand.	3	8	1. Humour achieves a grounding in ordinariness.	4	19
2. A supervisor or analyst is experienced as exceptional in encouraging humour.	4	22	2. Humour employs personalities.	4	16
3. Humour emerges from environmental deprivation.	5	9	3. Humour invites understanding in the transference.	5	22
4. There is an impact of COVID and its lockdowns.	1[32]	4	4. Humour is experienced as a transitional phenomenon, a kind of play.	4	18
5. A personal analyst or the psychoanalytical culture of training is seen to be non-humorous.	4	27	5. Humour modulates difficulty.	5	17
6. A supervisor or the system of supervision is taken to be opposed to humour in the therapy.	4	15	6. Humour takes time to emerge.	5	7
7. There is little space for humour in CAMHS or the NHS.	2	7	7. Humour underlines relational strength.	3	6
			8. Humour involves a chosen 'stepping out' of the 'serious' adult role.	2	4
3. Experience of the therapist			**4. Experience of the patient**		
Category	*# of transcripts*	*# of codes*	*Category*	*# of transcripts*	*# of codes*
1. An interest is expressed in the function of humour.	3	18	1. Humour is experienced in a moment when parents are felt to not understand.	3	4
2. An expression of wariness about relating to the patient as like a peer or sibling.	5	18	2. Humour is experienced as an achievement of understanding.	5	20
3. Humour disillusions the therapist.	1[33]	9	3. Humour is attacking and is felt to offer no relief.	4	13
4. Humour draws upon a therapist's personal and cultural grounding.	5	22	4. Humour is felt to offer relief.	4	17
5. Humour draws upon the therapist's professional experience.	5	14	5. The experience of humour works to soften the blow.	2	10
6. 'Problematic humour' can repel the therapist.	2	8	6. Humour underlines cleverness. It is enjoyment of a kind of 'showing off'.	2	4
7. The national identity of the therapist is understood to inform experiences of humour.	3	6	7. Humour works to entertain assumptions made of the other. It expresses: "I think I know about you".	3	9
8. The therapist feels emboldened or bolstered by experiences of humour.	5	14	8. Humour is about saying 'No' to what isn't right.	4	6
9. The therapist has a want or need to be humorous.	5	14	9. The intimacy of humour can repel the patient (at least, initially).	2	6
10. The therapist intuits between humour that is worth taking up and that which is less valuable	4	12			

Explanatory categories of a functional analytic framework.

[31] These categories have been organised chronologically, according to the coding procedure.
[32,31] Despite being coded in one transcript only, these categories have been preserved in the analytic framework because it was decided that they were represented with an 'implicit relevance' across multiple transcripts. This is described above in terms of 'underlying assumptions' (Schein, 2004).

'Levels' or 'fields'

Sometimes, the author found that the overarching organising categories, presented above in *Table 4,* functioned as 'levels' in the framework, and at other times as 'fields'. These distinct behaviours are identified and summarised below, in *Table 5.*

Table 5.

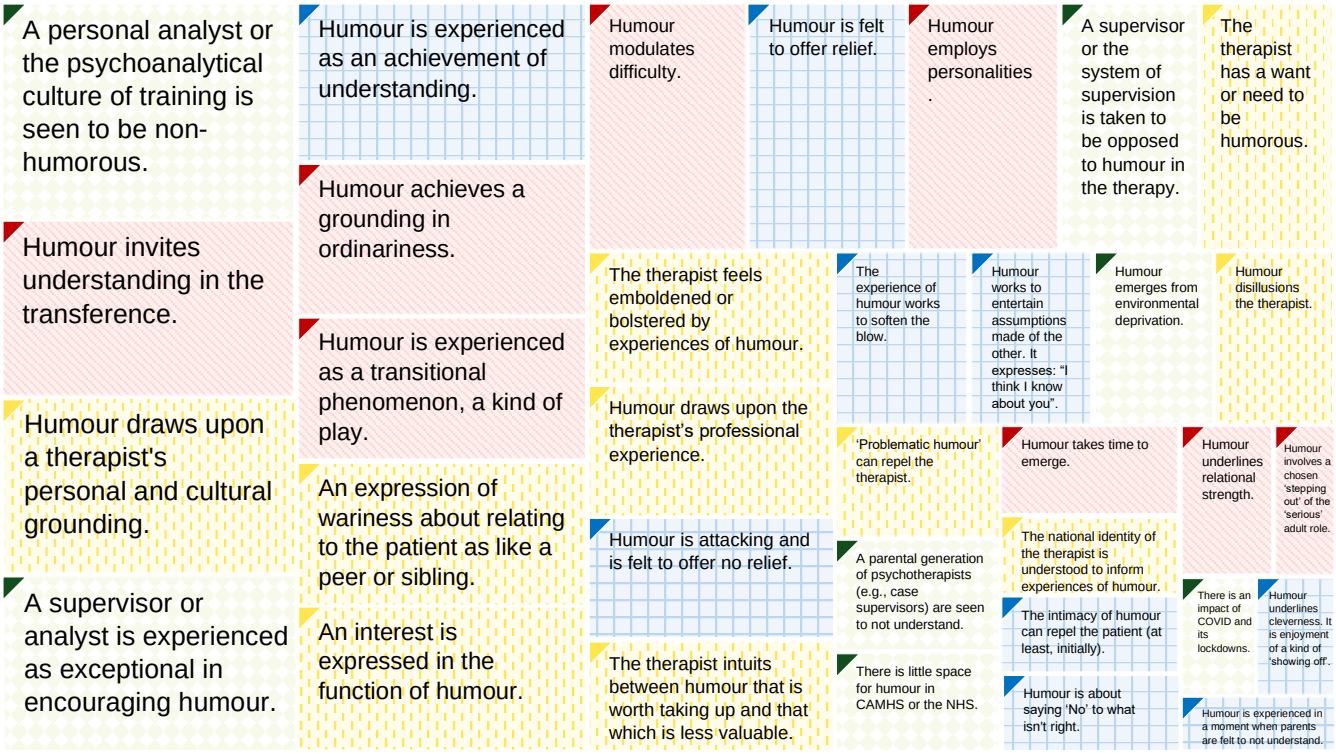
Levels	**Fields**
When categories functioned as 'levels', they essentially operated 'above' or 'below' one another in a vertical relationship of meaning – in the same way that 'buying bread' is foundational, i.e., the vertical basis of, 'making a sandwich'. For example, in re-appraisal of the dataset, the explanatory category of the therapist being 'bolstered and emboldened by experiences of humour' (category 3.8 in Table 4 [at the level of the experience of the therapist]) was seen to follow directly from the category: 'a supervisor or analyst is experienced as exceptional in encouraging humour' (category 1.2 in Table 4 [at the organising level of the institutional/socio-cultural/global context]). In this example, the framework functions with organising levels (and, not fields) because the category 1.2 is found to be foundational to the category 3.8. As is described in greater detail below, across this dataset, institutional support is seen to engender the therapist's experience of being bolstered and emboldened.	At other times, the four overarching categories, presented in Table 4, above, instead functioned more like 'fields' – in a horizontal relationship with one another, where they became significant as a consequence of their adjacency. For example, 'new cheese at the supermarket' is not foundational to 'making a sandwich', but these categories may acquire a particular meaning by recognition of their lateral relation to one another. For instance, as is detailed below, in the dataset, the category 'an interest is expressed in humour's function' (category 3.1 [experience of the therapist] in Table 4) can be seen to commonly 'go near' – i.e., function in adjacency with – the category 'humour employs personalities' (category 2.2 [therapeutic process] in Table 4). Charting the adjacency of these categories supports the later interpretation that interest in what humour does (i.e., it's function) may have some later relation of concern for who is involved in doing this (the personalities implicated). This relation is seen to be horizontally-bound.

Explanatory categories functioning as 'levels' or 'fields'.

Weighting

Using NVivo digital software, it has also been possible to chart aspects of the data beyond the coding and categorisation of the *Indexing* stage. This includes a graphical weighting of codes per category, presented below in *Figure 2*.

Figure 2.



Graphic representation of weighting for each explanatory category. The box sizes are proportional to the quantity of coded data. The coloured patterns correspond to the organising 'levels' or 'fields' of analysis, as presented above in Table 4.

Sentiment

The author's employment of NVivo software also allowed for the coding and charting of 'sentiment' across the data corpus, meaning: how the software recognised across all interview transcripts 'warmth of expression' in what was recounted, ranging between 'Very positive' and 'Very negative'. This automised digital procedure was far from perfect – for instance, in struggles with nuance, and some outright misunderstandings (such as a 'Very negative' coding for a description of "*feistiness*" by Sally about her patient, which was actually a statement of positive affirmation). However, interestingly, this analytic charting procedure has succeeded in illustrating that discourse on the subject of humour took place with greatest representation by a sentiment that was 'Very negative'. This is presented below in *Table 6* and supports

a composite finding from across this three-paper project, presented in *Box 4* (see: p.147).

Table 6.

Sentiment	Auto-coded references
'Very positive'	72
'Moderately positive'	116
'Moderately negative'	89
'Very negative'	154

Auto-coded 'sentiment' across five interview transcripts.

[5] *Mapping and interpretation*

Upon the conclusion of procedural stages: *Familiarisation; Identifying a framework; Indexing; and Charting,* and following the methodological guide outlined by Ritchie and Spencer (1994) and Parkinson et al. (2016), the objective of the stage *Mapping and interpretation* involves moving beyond data management towards understanding of this data. Using the four organising levels/fields (identified in *Table 4,* see: p. 115) as locating coordinates of a 'map' with which to interpret the dataset as a whole, this section identifies patterns, connections, and relationships, and articulates sense made of this data.

Institutional/socio-cultural/general context[34]

The psychoanalytical culture of training (*category 1.5* in *Table 4,* p. 115)

For every participant, a culture of psychoanalysis, and the training institutions which take this as their ontology, were recognised as generally antithetical to experiences of humour in therapy (*category 1.5* in *Table 4*, p. 115). In response to *RQ6* (see: *Table 1,* p. 102), the underlying culture of training and work is seen to be opposed to any idea that experienced humour could be helpful.

Similarly, but with less weighted representation in the analytic framework, the underlying organisational context of Child and Adolescent Mental Health Services (CAMHS) and the NHS were mostly seen to constrain experiences of humour (*category 1.7* in *Table 4,* p. 115), with the exception of circumstances where compounding systemic deprivations were seen to necessitate a relaxing of 'purist' therapy models and the taking up of humour (*category 1.3* in *Table 4,* p. 115). Experiencing humour in psychotherapy in spite of the training therapist's underlying anti-humorous cultural and institutional context, was commonly understood as a transgressive act. As is put by participant Vera:

> "*And there's maybe something – not so much in the training, certainly in the literature – about this kind of expert stance that I just can't tolerate. In the reading, in psychoanalysis, I really can't stand that. It's just not me and I can't do it well. I think humour has the capacity to cut through all that".*

[34] This organising level or field refers to the societal, cultural, organisational, and institutional context in which the therapy is taking place. This might refer to a place (e.g., a CAMHS clinic) or a group of people (such as service supervisors or training analysts). Altogether, this level/field confers the basic superstructure in place to support the psychotherapy work and its participants. From the findings pertaining to this organising level/field, the following aspects have been selected: The psychoanalytical culture of training; and What matters is support.

However, for two participants (Sally and Shantel), more consistently positive experiences with supervisors and training analysts (who were felt by these participants to value humour as clinical data) (*category 1.2* in *Table 4*, p.113), meant that the underlying cultural psychoanalytic context of training – recognised as non-humorous – was not as consequential: it wasn't a significantly weighted category of explanatory meaning for these participants (see: *Figure 2,* p. 115). Put simply, experiences in supervision and analysis superseded whatever difficulties there may be in the underlying culture of training. Therefore, in response to *RQ8* (see: *Table 1*, p. 102), missing supportive 'conditions' for humour, such as encouragement to work with it in the institution of CAMHS, may be lamented by practicing therapists, but it will not put a stop to their work with humour if other conditions, such as the support of precious helping figures, are in place.

However, for those participants (Vera, Rubi, and Abigail) for whom experiences with humour in supervision or in analysis had been less affirming (at least in part), and where they specifically felt that their clinical engagement with humour was likely to be criticised and challenged by authority figures, experiences of the conditions of the underlying organisational training culture was more impactful. For Rubi:

> "*At first, I wouldn't have dreamed of presenting something like that, being okay with it, and I felt really wary about hearing comments like, 'Is this defensive? What are you doing? And why did you say that?' Because I think the real question is, 'Why did you say that with this particular patient at this particular moment? And let's think about it.' That would be really helpful. But sometimes that hasn't been my experience*".

For Abigail:

> "*I'm just thinking about some words of my service supervisor, which was about, 'How do you authentically become a psychotherapist within the boundaries of your personality, you know, within yourself, so that you're not kind of a cookie cutter. You are actually you, with this psychoanalytical aspect. And I think that was difficult for me – to try and manoeuvre myself in that, because everything is so sort of…looked on".*

Interestingly, for these three participants (Rubi, Abigail, and Vera) – as is detailed below – the province of a personal, cultural, national humour was seen to correspond inversely to the culture of psychoanalysis. Cultural and national identity was thought by these participants to make one an insider of humour but an outsider of psychoanalysis, and vice versa. A central finding, in response to *RQ4* (see: *Table 1,* p. 102), is that if therapists feel obstructed from claiming humour in their work, they may turn to justify its use upon the site of personal learning, experience, and development (that of the individual).

What matters is support

A significant finding from this research study is that despite every participant having a detailed personal view, or 'espoused value' (Schein, 2004) about humour in psychotherapy, the most important explanatory category in how humour is ultimately experienced and understood is the degree of institutional/socio-cultural/general support they experienced themselves to be resourced by. This was particularly the case with respect to a training analysis or case supervision (*category 1.2* in *Table 4,* p. 115), as is graphically represented by the weighting of explanatory categories in *Figure 2* (see: p. 117).

An associated central finding from the development of an analytic framework is that when therapists experience themselves to be resourced with institutional support for working with humour experiences – as stated, specifically in supervision and analysis – they are more likely to understand the humour as therapeutic process and technique. When this support is not experienced to be in place, including when its availability is partial and experienced as being of insufficient strength to arrest the underlying cultural context of training, therapist-participants will undertake and experience humour nevertheless, but will understand their experience with reference to their own personalities, philosophies, and personal histories (this is described in greater detail below). Put simply, if institutional support is in place, experienced humour can be understood *technically* (involving a process including others); if needed support is instead found to be missing, experienced humour is more likely to be understood *omnipotently* (at the site of the individual and their lived experiences).

Therapeutic process[35]

Transitional phenomena

Looking at the representation of coding and explanatory categories in examples of humour across the data corpus has helped to clarify these participants' understanding of the 'play' of humour (see: *paper one – 3.4* '*Play*'; see: *paper two – 3.2* '*Findings'*) as a kind of transitional phenomena (*category 2.4* in *Table 4,* p. 115). An example, listed above in *Table 3* (see: p. 111)*,* is of participant Shantel describing an ambivalent experience of humour involving her patient presenting her with a

[35] Where adequate support was felt to be in place, participants could understand and explain their experiences of humour in terms of the work of the therapy: its therapeutic process. A selection of findings belonging to this organising level/field include: Transitional phenomena; and Transference phenomena.

humorous cartoon, and then turning her chair away from the therapist for the next period of work. Taking the lead from Shantel's own curiosity in this act, the example has been coded as both: rejection of the therapist by the patient (*category 3.6* in *Table 4*, p. 115), negotiating a distance from her (*category 4.9* in *Table 4,* p. 115), as well as "*showing something quite psychoanalytic*", in that the chair now resembled a psychoanalyst's couch (*category 2.4* in *Table 4,* p. 115).

This humour experience was explicable to this therapist as a kind of 'transitional phenomenon'[36]. This helps to clarify *RQ5* (see: *Table 1,* p. 102) in that play, following Winnicott, operates in a transitional space. It here involves the patient playfully introducing an external medium of shared exploration – the humorous cartoon, as a 'not-me possession' – before carefully negotiating the distance from her therapist, as a "*new me*"[37] waiting to be found. Following Winnicott's model, Shantel's patient's questions in therapy are recounted as then becoming about 'what is real' in the relationship in thrall to the transitional play: "*What is this? Who are you, really?*".

This explanation of humour as play in terms of transitional phenomena (clarifying *RQ5* in *Table 1*, p. 102) is here recognised as serious, adult, playful work (with a child) (*category 2.8* in *Table 4,* p. 115) – of an adult willingly stepping out of an assumed role to aid developmental disillusionment (*category 2.2* in *Table 4,* p. 115). It is by no means childish play. This is categorised by a wariness, expressed with significant weighting by multiple participants across the dataset (see: *Figure 2,* see: p. 117), of being seen to relate to their patients through humour as akin to peers,

[36] The manner in which this was enacted by Shantel's patient physically turning her chair around, putting her therapist in mind of the psychoanalytic couch, shows the playful relational transitional space of humour to correspond to the analytic space of therapy – consistent with Lemma (2000 [see: *paper one – 3.4* '*Play*']).
[37] This is a direct quote from Shantel giving voice to her patient's experience: "*the cartoon meant*: '*it's a new year, new me*'".

friends or siblings (*category 3.2* in *Table 4,* p. 115). For these participants, part of the explanation of the legitimacy of humour in psychotherapy in general, strengthening a position in response to *RQ4* (see: *Table 1,* p. 102), is that therapists can experience humour with their adolescent patients without becoming adolescent themselves.

Transference phenomena

For all five participants, feeling in correspondence with how each were linked up with aspects of themselves through experiences of playful humour was understood to support their work in the transference with their patients (*category 2.3* in *Table 4*, p. 115). For these therapists, it was not enough to merely experience humour with one's patients, but to understand *who we are* when we do (or don't).

Three participants, all female, explained that this followed the shape of a *maternal transference*, where their adolescent patients could organise themselves through humour in relation to their therapists. For these participants, this was generally experienced as what Rubi describes as "*a self-obsessed mum type thing",* enacted even through something as basic as the sound of her patient's laugh. Here, *RQ7* (see: *Table 1,* p. 102), can be answered definitively: feeling matters, as long as therapists are able to make good use of their feelings. Where the maternal transference was powerfully felt, the patient's humorous relation with their therapist – and, here, even the quality of their laughter – opened up consideration for how the patient may be in their relationships outside of therapy. So, humour, when taken up in the maternal transference, supported the therapy relationship to operate as the prototypical one.

For the three participants for whom this maternal transference phenomenon was the case – Rubi, Sally, and Abigail – a more common type of experienced humour was expressed as a kind of *self-deprecation*. Here, healthy aggression could be expressed against the 'mother therapist'. This is described in detail in the second paper of this project (see: *paper two – 3.2* '*Findings'*). Abigail recounts:

> "*I've been a bit self-deprecating, but in a kind of funny way, in a way that's like, oh, aren't I old? What do I know about X, Y, and Z? And I think that's been helpful*".

What is understood in the transference helps to underline a core finding from across all five interviews: for every participant, the function of humour in the therapeutic process was unanimously explained in terms of the *healthy expression of aggression*. The most coherent answer to *RQ4* (see: *Table 1*, p. 102) is that this is what humour is understood to do: express aggression. Exactly *how* this aggression was expressed – commonly, as deprecation of oneself and others – in the experience of these participants is taken up in the idiographic focus of the interpretative phenomenological analysis presented elsewhere in this research project [see: *paper two*]. A summary of humour's functions expressed in findings across the entirety of this three-paper research project is presented below in *Table 7*.

Table 7.

Paper	Focus	Key functions of humour	Description
Paper one – Literature review	*What is humour in psychotherapy?*	Conceptual/Analytic	Humour is theorised through four ontologies – Superiority, Relief, Humility, and Play – each describing humour as a way of understanding psychic processes, interpersonal dynamics, or developmental states.
		Epistemological	Humour is understood as a way of knowing and interpreting experience that may sit outside clinical orthodoxy but reveals underlying assumptions about self, other, and reality.
Paper two – Interpretative phenomenological analysis	*How is humour experienced in the clinical encounter?*	Relational	Humour functions as a co-constructed moment of recognition, resonance, or relief between therapist and adolescent. Its presence often marks key moments of therapeutic movement or emotional accessibility e.g., aggression expressed safely as deprecation.
		Affective	Descriptions of humour as emotionally regulating, disarming, or connecting suggest that humour acts as a vehicle for processing affect, creating safety, or transforming impasse.
		Identity forming	Humour is described by participants as central to their therapeutic identity and a way of affirming their authenticity, humanity, and presence in the work.
Paper three – Framework analysis	*How is humour understood and explained?*	Interpretive	Humour's function is understood through five explanatory frameworks developed from participant discourse: connection (e.g., p. 124), containment (p.122), resistance (p. 132), repair (p. 123), and play (p. 123). These categories reflect how therapists theorise humour's clinical purpose.
		Meta-clinical	Humour is seen to become a lens for reflecting on therapy itself – how trainee therapists position themselves, their technique, and their developmental learning about therapeutic boundaries and responsiveness.

Summary of the functions of humour across this three-paper research project.

Among others, Rubi seemed to reflect deeply on the explanatory function of her patient's humour in "*softening the blow*" and "*making it okay*" (*category 4.5* in *Table 4*, p. 115) throughout the interview – returning to, and expanding upon these themes over the course of our time together, with data points peppered evenly throughout the transcript. For Rubi, this function for humour drew her attention to:

> "…*the kind of depth of things for him, and just how incredibly painful it is for him either to express how shit I am, or whatever it is, but also to have anything positive. It's just anything at all, the extent of it – of actually how terrifying it is! And it feels like it's very basic sort of human things, but actually incredibly painful ones. So I suppose that it sort of deepened my understanding of what was going on for him*".

Like Vera, but unlike the other three participants, Rubi here understands her patient's humour to be principally ameliorating (*category 2.5* in *Table 4,* p. 115). However, perhaps counter-intuitively, experiencing this actually functioned to "*deepen her understanding*" of her patient, the "*flavours of his personality*", and the fact that "*he feels more than he lets on, and some things…quite aggressive really*".

For all participants, understanding experienced humour as the safe expression of aggression was easily explained as a legitimate component of therapeutic process: a basic relational strength (*category 2.7* in *Table 4*, p. 115).

The experience of the therapist[38]

Functions and personalities

A central finding from this research study is listed above: that when institutional support to work with humour is in place, experiences of the phenomenon can be understood in terms of therapeutic technique (a *technical* understanding), and when this needed support is felt to be missing, there is a greater likelihood that such experiences will be understood at the level of the experience of the therapist (an *omnipotent* understanding). Also described above is the finding that humour can be understood to have the function of the healthy expression of aggression in the therapy relationship – seen by these participants as a component of therapeutic process.

Looking at the data categorically, a further observation from the development of an analytic framework for the data corpus is that when the aforementioned institutional support is experienced as not entirely adequately in place, participants were seen to become dissatisfied by the explanation of humour's (aggressive) function in their work. Without prompting, these participants invariably turned to explanations at the level of the personalities of those involved in the humour undertaking (*category 2.2* and *category 3.4* in *Table 4,* p. 115). Put simply, if inadequate institutional support is experienced, therapists can lose conviction in the therapeutic process of humour, and begin to explain it in terms of their own experiences, histories, and beliefs. This

[38] Understanding found at the organising level/field of the experience of the therapist was expressed by all participants throughout the dataset. Explanations corresponding to this level/field informed a deeper understanding of how humour happened, and the reasons for why this might be. This is detailed below in this section, and in the following *'Discussion'* section of this research study. A selection of findings from this organising level/field include: Functions and personalities; Previous professional roles; The co-ordinates of Me; and National identity.

complicates an answer to *RQ4* (see: *Table 1,* p. 102), and suggests a possible move from ‘function’ to ‘appeasement’ (posed in *RQ4*), depending on the degree of institutional support available.

In three of the five interviews, the framework showed that the reverse was also true: consideration for the personalities involved in humour experiences led to a proximate examination of the function of what was happening between these personalities. So, in every instance, attention to the *personalities* of the persons involved in the experience of humour in therapy – who they are (together) – either followed or was preceded by consideration for the *function* of that humour experience: what it did[39]. For these five participants, in appraisal of humour experiences, function and personality were seen to be inextricably linked. Particularly when we feel alone with it, the experience of humour (only) becomes explicable because we (persons) do humour (as a function).

Previous professional roles

One relevant (‘omnipotent’) characteristic presented, unprompted, by all five participants as an explanatory category at the level of the experience of the therapist was the role of previous work and professional identities in informing the experiences of humour later encountered in psychotherapy (*category 3.6* in *Table 4*, p. 115). For three participants, pre-psychotherapy professions prepared them to anticipate a kind of humour that was seen as possible in work with this adolescent client group.

[39] This is summarised above as an example of an organisational ‘field’ (see: *Table 5*, p. 116).

For both Rubi and Shantel, when working as an academic tutor and a classroom teacher respectively, humour between adult and child was considered effective practice, and a manifestation of a healthy working relationship.

For Abigail, similarly, a background in youth work had instilled a conviction in the possibilities of what could be achieved for troubled adolescents. This conviction extended to an expectation that working with humour ought to be supported by supervisors (as was the case in youth work), instead of the "*posh, White, Radio 4, M&S twin set*"[40] supervisory response that Abigail thought was particular to the "*first wave*" of psychoanalytic psychotherapists in her training institution (*category 1.6* in *Table 4,* p. 115). Abigail understood her own training experience to be exceptional, describing her good fortune in working with supervisors with a similar professional background to her own, who also use humour in their work, and who "*get it*" (*category 1.2* in *Table 4,* p. 115). This corroborates the stated finding, above, in response to *RQ8* (see: *Table 1,* p. 102), that the most important 'condition' for humour experienced in therapy are the precious helping figures who are felt to support it.

By way of contrast, for Vera and Sally, who interestingly both had experience of former training and work in other forms of psychological therapy (CBT and early years, respectively), the fact of being able to take up humour in earlier therapy work did not lend itself to an expectation of experiencing humour in psychotherapy. They instead felt disillusioned with the prospect (*category 3.3* in *Table* 4, p. 115). Here, Sally described her fear before beginning in psychotherapy with adolescents and

[40] This was the most explicit reference to social class across the dataset. Class was not seen to be an (overt) significant category of explanation for how experiences of humour were understood in this study or research project.

how redundant she felt this made her former experience with younger children: "*the little ones might trash the room, but this felt different*".

For Vera, working to a manual in her former CBT work meant that her "*whole person*" could be accepted as a practitioner, so long as she remained on task. But in psychotherapy, "*it's a bit like being told you need to restructure your entire personality, and not those bits. Like, 'you're fine, but not all of you…Are you sure you wanna say that? Are you sure you want to be like that? Do you want to cover those tattoos?' It's a bit like having your soul stripped apart and judged and being found wanting*".

The coordinates of Me

As is described above, a central finding from the development of the analytic framework for the data corpus is of the kinds of personal and personality explanations participants drew upon when forms of coherent institutional support – such as the availability of working with humour in supervision and analysis – were experienced as missing.

Generally, humour – when experienced with greater representation at the level of the experience of the therapist (e.g., explained 'omnipotently') – is understood in terms of socio-cultural identity by three of five participants (*category 3.4* in *Table 4,* p. 115): as something which includes and excludes.

For two participants – Abigail and Rubi – experiencing humour in their sessions put them directly in contact with experiences of humour as children. Both suggested that a basis in understanding what this had meant for them personally had put them in a

good position to understand both the uses and misuses of humour in psychotherapy generally – what it gives and what it takes.

For Abigail, an unusual childhood where humour was central is enriched by and contrasted with later experiences as a mother to an adolescent girl who "*is rubbish at banter!*". For this therapist, an ambivalent personal relationship to the phenomenon facilitated an informed understanding of its significance for children and adolescents in psychotherapy. The challenges of developing a dispassionate technical perspective on the phenomenon as a psychotherapist are here expressed:

> "*I remember finding that book of Freud's on jokes and being like, Oh God, I don't want to read that. And I think it has made me think about when I've used humour defensively, or aggressively, or, you know, to dismantle something quickly*".

Reflecting upon herself, Abigail tells me:

> "*I am someone that does make jokes. I can be quite, sort of, sharp in that sense. It is easy. You know, I can be quite quick tongued*".

National identity

One surprising finding – to this researcher – from the development of the analytic framework is that the explanatory reach of personal and socio-cultural meaning is extended for these participants to the experience of identity found in nationality of origin (*category 3.7* in *Table 4,* p. 115).

"*It is a British thing*", suggests Abigail, who links humour to the "*banter*" and "*piss-taking*" proximate to healthy adolescent development and functioning (in Britain).

When thinking about the absence of thinking about humour in her personal training analysis – identified in this study as a key component of institutional support for working with the phenomenon – this participant also wonders whether a possible explanation could be to do with working with a non-British analyst.

National identity is similarly appraised as important in understanding experiences of humour in therapy for Rubi, who sees it as a collective defence mechanism for people from her country of origin, in a geographical region with experience of war.

> "[Where Rubi grew up] *there's so much trauma on so many different levels, and humour is a way of managing and talking about things that otherwise would be really difficult to talk about. I mean, don't get me wrong, I think it is used defensively. And I can definitely use it defensively. My patients can use it defensively, and I can see why there would be worry about it*."

For Vera, in a different way:

> *"So there's definitely something in my personality…I think in my head, it's the way I've been brought up and I can't lose it. There is no royalty [where Vera and her patient are from]. We are sovereign, we are the royalties… which maybe led me to risk a bit of humour that might have felt a bit cheeky, but there was something…I knew she could take it and I knew she would take it the right way*".

These two therapists – Vera and Rubi – suggest that only upon the basis of a shared socio-cultural landscape could they feel assured that their patients "*would get it*" [the humour] (*category 4.7* in *Table 4,* p. 115).

The experience of the patient[41]

Time and quality

For every participant, the resource of time in therapy was taken up as a category of explanation for experiences of humour (*category 2.6* in *Table 4,* p. 115*)*. Humour is unanimously seen as something that must be 'built up to', and adequate time could be considered a core 'condition' for this, in response to *RQ8* (see: *Table 1,* p. 102). There is a clear distinction in chronology coded for earlier experiences of dead, absent, or distorted humour, compared with later, more "*mature*" and "*collaborative*" humour experiences[42], where relief for the patient could be recognised by the therapist (*category 4.4* in *Table 4,* p. 115). In response to *RQ3*, humour may produce relief – and in response to *RQ6,* it can help – but only in good time, and as decided by the professional.

To provide one example, four of five participants describe the treatment histories of their training case at the start of their interviews. Each of these patients are presented as having had some experience of other forms of psychological therapy prior to beginning in intensive psychotherapy.

With varying degrees of emphasis, the earlier interventions undertaken are presented by each of these four participants as (generally disappointing)

[41] Similarly to that of the therapist themselves, the organising level/field of the experience of the patient corresponded closely to the reasons for how humour happened in the work. What was (seen to be) happening inside this experience of each patient was recognised (by their therapist) as needing the resource of time. Also significant is that, invariably, this was not articulated by the patient themselves, but by was intuited by each respective therapist. In this way, the patient's experience was understood at a lower 'level' to that of the therapist's own (see: *Table 5*, p. 116). A selection of findings relating to this organising level/field are: Time and quality; and Intuition. The methodological limitation of having only interviewed therapists, and not patients, about their experiences of humour is taken up in the '*Limitations'* section, below.

[42] This is detailed elsewhere in an interpretative phenomenological analysis of this dataset (see: *paper two – 'Findings'*).

attempts/steps that were without humour, but which ultimately led to experiences in intensive psychotherapy where humour could happen, and could matter. In this way, humour is recognised as a kind of affirmative statement eventually made by the patient upon the basis of a personal treatment history spent saying 'No' to what wasn't right (and wasn't humorous) (*category 4.2* and *4.8* in *Table 4,* p. 115). For instance, about Shantel's patient:

> "*She tried doing CBT in a group. She didn't want to do group work. She didn't want to do anything task-based. And so she did start doing STPP. But then after I think about six sessions, she was like, 'Meh! Not really into it. Don't really like it'. [Int. laughs]. Which was gutting for the therapist. That's quite a decisive comment, isn't it? 'It's a bit meh!'*"[43].

For Shantel, the offer and acceptance of beginning longer-term psychotherapy following abandoned shorter-term interventions meant recognising that important things hadn't been got to. In the understanding of this therapist, this took the form of a humourlessness associated with remaining ill:

> "*I think there was a sense that she wanted to show me what she wanted to show me. But it took a long time, like four months, before it kind of made itself known. So I think for her, there was something about hiding a part of herself. And actually, in the way that she talked about herself, she was very conscious that there was a part of her that didn't want to get better*".

[43] This extract is indicative of the way that a patient's own testimony about frustrated experiences in their treatment history can be carefully considered – as it is here directly quoted – by their therapist. As has been stated, in the experience of a 'turning point' (see: *'Discussion',* below) involving humour, where frustration then tips into relief, the detail of patient testimony was seen to lose favour to the therapist's own formulation.

Intuition

In this study, development of an analytic framework has suggested that recognition of a newfound 'mature' humour, offering relief in a different way to earlier humour attempts, is intuited *by* the therapist *about* the patient's experience of the humour. No therapist in the study explained the value of this 'mature' humour by becoming informed by their patient (i.e., asking them) about what this experienced different kind of humour was like for them. In short: a clarifying response to *RQ3* (see: *Table 1,* p. 102) is that *a therapist decides* what relieves and doesn't.

All five participants suggest that intuition of relieving humour (*category 4.4* in *Table 4,* p. 115), compared with attempts that perseverate difficulty and offer no relief (*category 4.3* in *Table 4,* p. 115), is achieved on the basis that *something has been understood* by the therapist (*category 3.10* in *Table 4,* p. 115). Generally, this is when healthy aggression – commonly expressed as (self-)deprecation (see: *paper two*) – is felt to have become alive in the therapy relationship.

According to the explanations of this study's participants *about* the experience of their patients, this 'turning point' understood by the therapist helps to overcome the patient's initial repulsion to the scalding intimacy provoked by 'too early' humour experiences in the work (*category 4.9* in *Table 4,* p. 115). At the point of humour maturity, resourced with the conviction of having been understood, the patient is thought (by their therapist) to be able to achieve their own markers of understanding through ventured humour (*category 4.2* in *Table 4,* p. 115). They are here also seen as able to enjoy the pleasures of the humour experience itself – its intimacy –

including as a ‘showing off’ and an assertion of personal cleverness (*category 4.6* in *Table 4,* p. 115).

4 | DISCUSSION

Upon the conclusion of the methodological data analysis, this section continues the process of *Mapping and interpretation* by discussing a selection of findings from the research study for the purpose of further understanding and future consideration. The following discussion points have been selected: *Turning points; Pay-off; Frustration; Compulsion; Release; and Sexuality.*

Turning points

This discussion point was developed out of composite recognition of singular codes relating to multiple organising fields (see: 1.4 in *Table 3,* p. 111). This involved consideration of categories listed as *1.2*; *2.8*; *3.8*; and *3.10* (see: *Table 4,* p. 115). Whether achieved momentously, or by systematic development in supervision, every participant understood the impact of humour through the mechanism of a ‘turning point’ moment, session, or period in the work. For four participants, this took explicit shape with respect to transitional and transference phenomena in the room (whereas for Sally, the turning point was instead an acute experience of containment in supervision and analysis). This finding is consistent with those presented elsewhere in this research project (see: *paper two*), and by Gunnar Carlberg in ‘Laughter Opens the Door’ (1997), where the ‘turning point session’ in child psychotherapy is recognised as a kind of ‘now-moment’ in the room (Stern, 1985)[44]. In this study, such

[44] This concept of Stern’s is also directly referred to by participant Sally in the dataset.

moments were analysed when a therapist noticed that something qualitatively new had become known concerning the behaviour of a child or a child's way of showing his/her inner world, or where something new had entered into the interplay between the child and their therapist.

In Carlberg's (1997) study, the turning point phenomenon is explored with five experienced therapists in interviews taking place immediately after one such experience in their work; then one year later; and finally, approximately two years after that. Value was found in studying: the therapeutic process preceding the turning point session[45]; the countertransference of the therapist[46]; and changes in the setting of the therapy[47]. The researchers in the 1997 study found that therapists would often identify changes when something unpredictable, unusual, or abrasive had happened in the usually rather predicable therapeutic space, including incidents of a therapist and patient sharing an experience of mutual laughter.

Among other interesting consistencies between the findings of Carlberg (1997) and the present study, is that both sets of child psychotherapists – those "with experience" (in Carlberg's methodology) and trainees (in the present study) – did not recognise as relevant clinical data the direct (conscious) testimony of the named patients about their experience of participation in the turning point moment. Like in Carlberg's [1997] findings, 'the experience of the patient' is the one level/field that is not coded with respect to turning point moments in this study. Put simply, therapists

[45] This is also identified as an organising level/field in this research study (see: *Table 4,* p. 115).
[46] Similarly named in this study as: 'the experience of the therapist' (see: *Table 4,* p. 115).
[47] Named in this study as: the 'institutional/socio-cultural/general context' (see: *Table 4,* p. 115).

in both studies were at no point informed about turning points in their work by exploring with their patients whether they had experienced one[48].

Grounded in a psychodynamic approach, Carlberg (1997) here stresses the principle of 'inter-subjectivity' (Stern, 1985): "Like the parent and child, the therapist and the child are a dynamic, and mutually linked dyad". But elsewhere in this research project (*paper two – 'Discussion'*) a "truly intersubjective" co-constituted therapy space of mutual meaning-making is instead recognised as one which always awaits the response of a (separate, distinct) Other (see: Altman, 2006). This contrasting conceptualisation pre-empts the existence of a 'whole (other) person', but such an object is restricted by Carlberg (1997) as impossibly outside the child-therapist mutual interplay. Other studies (e.g., Briggs et al., 2015 [in *paper one – literature review*] similarly constrain identification and valuing of turning points to the clinical authority of the therapist. But, from this study's findings, one wonders what we would lose by simply asking our patients: "I notice that we can now be humorous about X in a way that we couldn't before. Do you think so?" If the phenomenon of humour truly happens *between* people, can we really support any claim to its place in therapy if we keep its significance to ourselves?[49] Future studies interviewing patients, and not (only) therapists, about turning point moments of humour in psychotherapy would here be a welcome further contribution.

[48] As stated in [43], this is recognised in terms of methodological '*Limitations'*, described below.
[49] Real world implications of this study's findings are summarised below in section 5 ('Summary of real-world implications').

Pay-off

Consistent across the dataset is the finding that sufficient time (*category 2.6* in *Table 4,* p. 115) and degrees of institutional support (level/field 1 in *Table 4,* p. 115) are needed for humour to be taken up and worked with technically. One problem this raises is about what place humour can be expected to have in training and work structures within CAMHS and the NHS (*category 1.7* in *Table 4,* p. 115). One finding from these participants' testimony is that service supervisors (in CAMHS) were experienced as more constitutionally resistant to humour (*category 1.6* in *Table 4,* p. 115), with case supervisors and some analysts being seen as available to humour as an exception (*category 1.2* in *Table 4,* p. 115). Consideration is here due to the impact of the unique relationship between service supervisors and trainee psychotherapists, which might itself inhibit humour (i.e., trainees and service supervisors typically experience a day-to-day, line manager-to-employee role relationship, with all of the tensions therein. By contrast, case supervisors and training analysts only 'visit' the trainee's work, and consequently they may feel more liberated by their 'outside' role to ascribe value to humour experiences) [50].

However, it may also be the case that a contemporary CAMHS clinic, and the institutional culture which supports it, is simply too preoccupied to have space for humour in its work. And so, where a capacity to institutionalise experiencing humour is more readily held outside of statutory frameworks (i.e., of NHS placements, where thinking about humour with service supervisors was found to be rare [*category 1.4* in *Table 4,* p. 115]), and where it is instead more consistently held, following participants' testimonies, inside the intensive case discussions with supervisors

[50] In the author's own training institution, such figures are 'contracted in' as 'visiting lecturers'.

contracted in for this piece of work alone, or with psychoanalysts who work tangentially with training schools, and who are employed privately, the infrastructure for humour is consequently held outside of the public health system itself – increasingly and ultimately in the private free market.

Elsewhere, in existing literature, certain theorists have suggested that the experience of humour in the context of consumer society is highly complicated and consequential. This includes the philosophers Theodore Adorno and Max Horkheimer (1944/2002), who write of the need to explore the potential for insight into one's own rigidity, manifested through humour, in 'historical terms' (referring to an analysis of the exploitation of economic classes), and not only as a clinically or relationally-bound phenomenon. For Adorno and Horkheimer, any laughter produced in the context of the 'culture industry' – a phenomenon referring to the systematic manipulation of desire in the context of advanced market capitalism and its commodities (a construct particularly relevant to an adolescent patient population explored in this study, to whom the 'commodification of desire' is most vociferously targeted) – is directed towards its own 'reification' (where social relations are concretised as 'things'). As a consequence, humour must be interrogated if it is to become meaningful and not manipulable or self-defeating. A similar consideration also appears in Henri Bergson's *Le Rire* (1900 [see in: *paper two* – '*Discussion*']):

> *"The illusion of a machine working inside of a person is a thing that only crops up amid a host of amusing effects; but for the most part it is a fleeting glimpse that is immediately lost in the laughter that it provokes. To render it permanent, analysis and reflection must be called into play".*

Frustration

In a way that is perhaps particularly prescient in the current age of compulsive social media clips and funny *TikTok* videos – popular with the adolescents who form the subject of the empirical components of this project (presented in papers *two* and *three*) – following the findings of this study, an additional layer of work can be seen as indicated to consolidate a humour experience after it has happened. This could be seen as a further 'condition' of humour in psychotherapy, in answer to *RQ8* (see: *Table 1,* p. 102). Following Carlberg's (1997) work on turning points, in psychotherapy practice, a professional implication of this may amount to a 'what has just happened here between us?' kind of debrief and reassessment of where patient and therapist are now that this moment has taken place.

Such an interrogative framework is elsewhere advanced by Marcus (1990), who presents an approach to working with the experience of "*pathological aspects of humour*" when "*treating those who fail to take themselves seriously*" in therapy. For Marcus, this involves the psychotherapist reflexively bringing the patient's attention to the experience of humour that is unfolding, and, according to Marcus, specifically making the patient aware of their holding an unconscious idealising belief in, respectively: 'their irresponsibility'; 'the incongruity of their humour and the wider reality'; and 'the inconsequentiality of their position' (Marcus, 1990). Marcus' expressed "*frustration*" with such patients is consistent with the finding, presented in the second paper of this research project, that humour in psychotherapy can be "born of frustration" (see: *paper two – 3.2* '*Findings'*).

Here, the therapist would give deliberate voice to their frustration in/with the humour (e.g., “we’re laughing because our attempts to think about X have been frustrated”). This interrogative framework, advanced elsewhere, would be a different use of felt frustration to the cathartic “*bursting*” achieved by humour described elsewhere in this project (see: *paper two – ‘Findings’*). Such an approach, indicated by the ‘omnipotent’ understanding of humour also identified in this study, offers an ambivalent response to *RQ6* (see: *Table 1,* p. 102). On the one hand, maybe humour doesn’t necessarily help – as is indicated by other research (see: Porterfield, 1987; Lefcourt, 2001; and Van Baaren & Van Knippenberg, 2009). It just leaves patients feeling better when actually they are not better: suggesting a want for experienced humour without concern for foundational knowledge of what it does and does not do. On the other hand, corroborating Marcus (1990), maybe it is helpful to know how unhelpful humour can be.

Compulsion

Concern with the pay-off of humour in psychotherapy can also foreground that what is compulsive about such moments, which seem to offer a glimpse of liberation from something that has become artificially constrained (see: Bergson, 1900). Using the above example from social media, one can see from this perspective that a momentary freedom from entrenched expectations in a funny *TikTok* video will precipitate the appetite for a second one, and a third: a ‘do it again’ characteristic of humour that may be consistent with experiences of the humour phenomenon encountered with young children.

Thus conceptualised, humour can become part of the process of ‘repressive de-sublimation’ (Marcuse, 1964). Here, the market offers a taste of freedom from repression – e.g., in the flash of humour which offers liberation from mechanisation in psychotherapy, or on *TikTok*, following Bergson’s theory (this is the ‘de-sublimation’ part). But this can only be repeated under conditions set by the entrenchment of the consumption of products, services, and content organised by actors and industries who work to manufacture the desire for these (which is the ‘repression’ part under capitalism). Replacing the reduced role for the state in coordinating psychotherapy as treatment, the culture industry says to the adolescent: ‘you can gain entry to the liberation and insight found in humour only if you (continue to) purchase these stand-up comedy tickets, if you subscribe to this *Twitter* feed, if you maintain your *Netflix* subscription – and, increasingly, if you pay your therapy bill’.

Following this line of thinking, through a compulsive relationship to the pay-off of humour in psychotherapy held ‘outside’ the public health system (and perhaps now on post-capitalist ‘Techno-feudal’ cloud-based platforms [see: Varoufakis, 2023]), which offer only flashes of liberation at a price, a patient’s need, born of repression, to be ‘de-sublimated’ only increases further – and the cycle continues. In the present socio-political context, longer-term psychotherapy – such as the intensive psychotherapy intervention explored in papers *two* and *three* of this research project – is increasingly being drawn into the private market sector (for instance where *Better Help* private digital platform psychotherapy is mass-marketed as advertising

on many of the more popular podcasts, of which adolescents are the principle consumers [see: Hollis, 2022])[51].

One question raised by this study's findings is that without the necessary self-scrutiny advanced by Bergson (1900), Adorno and Horkheimer (1944/2002), Marcus (1990) and others, could contemporary patients-as-consumers find in the 'pay-off' 'now-moments' (Stern, 1985) of humour, not a cause for insight and help, but a source of compulsive gratification that will keep them attending, and paying for, their sessions – for which they have been incentivised and marketed? Where such compulsive humour ultimately serves a greater repression and dependency upon consumption (including of psychotherapy services), might these very experiences in therapy ultimately obstruct such patients from becoming well?

Release

In this research study, each participant suggested that the release experienced in the humour encountered in psychotherapy functions as the safe expression of aggression (recognised as deprecation of oneself and others [see: *paper two*]). However, it has been detailed elsewhere, including by Adorno and Horkheimer (1944/2002), and Marcuse (1964), referenced above, that the repressive de-sublimation typically encountered in pay-off is principally of a sexual, and not an aggressive, kind. For many psychoanalytic theorists, including the post-Freudians of the Frankfurt School, it is human sexuality, and not aggression, that is in greatest need of repression/expression.

[51] The author recently heard one such advertisement: "therapy helps with everything".

And yet, with the exception of Vera's working through of experienced sexual abuse in the transference relationship with her patient, it is striking that expressed sexuality was so little represented in this study's findings, despite it appearing elsewhere in literature about humour-as-experience (see: McCann, 2010; Haydon et al., 2015 [*paper one – literature review*]).

Among the findings from this analytic framework is that adolescent patients can be initially repelled by the intimacy of "too early" experiences of humour (*category 4.9* in *Table 4,* p. 115). Tellingly, in this study's findings, it is shown that this 'too-early-ness/much-ness' is invariably intuited by the therapist, and not necessarily explained to them by the patient (a finding that is corroborated elsewhere [Carlberg, 1997]). Looking back through the dataset to such moments, it becomes possible to wonder whether sexuality may have had a more significant part to play in what makes humour difficult for these adolescents (and by extension for their therapists) than is recognised in this study's findings. Moreover, it may be for this very reason that a prism of humour – as a "tinted mirror" (Rose, 1969) – is so sorely needed.

An example of this could be participant Rubi's early resisted entreaties about what her male adolescent patient was watching when alone at home (see: *paper two – 'Findings'*). Instead of direct consideration of ordinary adolescent struggles with masturbatory loneliness, interestingly, this data was taken up by this therapist as expressing her patient's difficulties in experiencing humour with her. Not feeling able to include Rubi in what he was watching/doing was seen by this therapist as a humour problem rather than (also, potentially) a sexual one. Why might it be

particularly challenging to consider the links between humour and sexuality in therapy?[52]

Sexuality

Can humour authentically be understood as sexual – as an intercourse between people? Following Freud (1905) and the relief hypothesis (see: *paper one*), there is a long history in psychoanalysis which recognises in humour a 'libidinal expenditure' upon repression – succeeded by an insistence upon psychosexuality as the core psychoanalytic explanatory concept (Freud, 1905). But this is a one-body perspective, overcome only after Freud's death, in 1939, with a re-centring around the difficulties of intimate relationships over individual psychic and auto-erotic life. In psychoanalytic psychotherapy, we are trained to conceive of the intimate sexual experience *between* the adolescent and whoever the psychoanalytic therapist is taken to be. Rubi's example, above, could here be understood not only as her patient's difficulties with social intercourse (i.e., naming and sharing things), but these difficulties as an expression of intercourse *with her*. Understood in this way, could humour and its vicissitudes more properly be understood to function as a subcategory of erotic transference in psychotherapy? Such questions are raised only obliquely in the interviews – for instance, in Sally's musing about humour as "*really being into something with someone",* or in Shantel's patient's teasing: "*you're just in it* [the therapy] *for the ride*".

[52] The difficulties of this 'flirtatious/sexual' aspect of humour in therapy is a finding helpfully raised by Gibson (2018), in a thesis exploring experienced humour in semi-structured interviews with existential psychotherapists (see: paper one – literature review).

Understood in this way, for therapists working with adolescents, humour could be considered as acutely relational at a stage of development when relationships are closely bound with the predicament of nascent sexuality: the former is an envelope for the latter. It has long been recognised in psychoanalysis that adolescence renders a reworking of oedipal conflicts and desires – notably the wants and terrors associated with exclusion – now in the host of a sexual body and developed mind. If we are able to properly face down the fact of a therapist's humour playmate being the person of their adolescent patient – who is, following this theory, someone invariably in a state of sexual awakening and tumult – could we as practitioners better foresee the challenges and vulnerabilities (and achievements) of taking up humour with this age group? And if we suppress this – the unavoidably sexual in the humorous – do we meet our adolescent patients only halfway? Do we meet them at all?

5 | SUMMARY OF REAL-WORLD IMPLICATIONS

This research project offers important implications for the practice and training of child and adolescent psychotherapists, particularly in relation to humour experienced in clinical work. Drawing on the findings of this study, a central concern emerges: humour routinely appears in therapy but is often left unspoken or unexamined in supervision and institutional discourse.

The study shows that humour arises spontaneously, often at moments of emotional intensity. The issue is not whether therapists use humour, but whether they are equipped to reflect on it clinically rather than defensively, unconsciously, or omnipotently. When neglected, humour risks becoming a site of enactment or

avoidance. When thought about with technical care, it can foster connection, emotional repair, and therapeutic change.

A key finding relates to the role of supervision and training culture. Participants reported a consistent lack of support in discussing humour, even when it featured prominently in their sessions. Some felt humour sat outside the scope of “serious” analytic work; others sensed an implicit discouragement from raising it. This silence created a gap between clinical experience and what could be spoken about in training, leaving humour unformulated as clinical material.

Importantly, this study suggests that humour occupies a distinct place in the affective and relational economy of psychotherapy. Unlike sexuality – another powerful and often charged aspect of transference – humour is frequently perceived as benign or trivial, and thus more easily dismissed or bypassed. While sexuality tends to be formally theorised and consistently addressed within psychoanalytic training, humour is often treated informally or not at all, despite its similarly disruptive and communicative potential. This lack of formal recognition leaves therapists without a technical language for interpreting humour’s meaning or effects, and without guidance for how to think about humour ethically and clinically. As a result, humour risks being handled from a position of omnipotence (assumed to be always helpful) or anxiety (assumed to be too risky), rather than from a stance of reflective, therapeutic engagement.

The study suggests that specific, specialist support is needed to work with humour in psychotherapy, particularly in supervision. Supervisors and training institutions must be equipped to take seriously the emotional, technical, and theoretical challenges

posed by humour. This includes helping trainees to recognise humour not as a deviation from therapeutic seriousness, but as a meaningful and often affect-laden event that can signal moments of truth, rupture, play, or even aggression. Technical support should guide therapists in discerning when humour opens up the work – and when it defends against it.

Ultimately, the study argues for a shift in institutional culture: from implicit disavowal to explicit recognition. If therapists are not helped to think about humour clinically, they may resort to managing it from positions of omnipotence (assuming humour is harmless, or always helpful) or avoidance (fearing it is inappropriate or dangerous). In either case, opportunities for therapeutic contact are lost. The findings advocate for a training ethos in which humour is not just permitted but legitimated as clinical data – requiring thought, interpretation, and supervision like any other transference and countertransference material.

In short, this study calls on the profession to meet humour where it already is: in the room, between therapist and patient, waiting to be worked with.

6 | LIMITATIONS[53]

Several limitations emerged in the conduct and interpretation of this framework analysis that merit careful consideration. First, the explanatory framework developed in this paper is derived from the same small, homogenous sample of five trainee psychotherapists interviewed elsewhere in this research project. As such, it is shaped by a narrow band of clinical experience and professional positioning. While

[53] As a sole researcher and single coder, the very claim to identified limitations is limited by the author being without access to estimate of inter-coder reliability.

the framework provides a meaningful structure for understanding how humour is conceptualised within the context of psychoanalytic psychotherapy training, it does not claim to be generalisable across the wider psychotherapeutic profession. The thematic patterns identified here are therefore best understood as illustrative rather than representative.

Second, although the analytic framework developed in this paper is intended to capture how humour is understood, it draws exclusively on therapist perspectives. These interpretations are necessarily limited by the subjective vantage point of practitioners and cannot access how humour is experienced or made sense of by patients themselves. This absence is particularly relevant given the inherently relational and intersubjective nature of humour in therapy. Without the voices of adolescent patients, this analysis cannot fully account for the reciprocal or co-constructed dimensions of humorous encounters. Future work might consider incorporating parallel data from patients to explore how therapist understandings align – or diverge – from those of the young people they treat.

Third, there is a degree of conceptual circularity in this paper. The analytic framework was constructed by applying categories to interview data that were themselves first organised by the author. While efforts were made to bracket assumptions and work inductively, the process was nonetheless shaped by the author’s clinical training and prior research engagement with the subject of humour. Reflexivity was maintained throughout, but the risk remains that the framework reflects not only what participants said, but also what the author was trained to hear.

Finally, the structure of the framework analysis presumes a degree of coherence and systematisation in participants' thinking about humour that may not fully reflect the complexity or spontaneity of actual therapeutic practice. Participants often spoke in richly metaphorical or associative language, and the movement from these idiosyncratic accounts to discrete explanatory categories involves a loss of nuance. This abstraction, while analytically necessary, may risk reducing humour to a set of fixed theoretical positions when in practice it is often fluid, ambiguous, and context-dependent.

Taken together, these limitations point to the need for further research that draws on more diverse practitioner perspectives, includes the voices of adolescent patients, and employs complementary analytic approaches that can capture the dynamic and multifaceted nature of humour in psychotherapy.

7 | CONCLUSION

The following conclusion of this study supports the overall outcomes of the research project as a whole:

> Depending upon the degree of experienced institutional support, the explanatory categories informing therapists' experiences of humour can be roughly gathered into two superordinate categories: [1] a *technical* understanding of experienced humour; and [2] an *omnipotent* understanding of experienced humour.

This conclusion can be seen to roughly correspond to that of a review of existing literature (see: *paper one*), where empirical accounts of humour in psychotherapy could be organised with the categories: *humour is seen as helpful/developmental*

versus *humour is understood to be defensive or harmful* (see: *paper one – 'Conclusion'*)[54].

Furthermore, looking carefully at the chart presenting the NVivo auto-coded analysis of the entire transcript dataset for the sentiment expressed (see: *Table 6*, p. 118), it is possible to observe a similar, and perhaps related, rough division between 'positive' (43%) and 'negative' (57%) sentiment expressed. Carefully reviewing the auto-codes here applied to the dataset of five interview transcripts, it is possible to further observe that 'Very positive' sentiment appeared to most greatly align with the participant testimony which expressed being resourced with the institutional support that enabled experiences of humour to be understood with a technical explanation. One can observe that the opposite is also true: testimony of more complicated experiences of institutional support in working with humour, which tended to be explained with more omnipotent justifications, was auto-coded with a more greatly negative sentiment.

Gathering these findings together, from across the three papers of this research project, produces an overall conclusion to the outcomes of this research project. This is presented below as *Box 4*:

Box 4.

Experienced humour can be understood as helpful and developmental, or as defensive and harmful. In the lived experience of psychotherapy, this may correspond to the degrees of available institutional support which can make possible a technical understanding of the phenomenon in therapy; such experiences are more likely to be understood positively. In turn, defensive accounts of humour in psychotherapy may correspond to experiences of support found missing – this can produce an omnipotent understanding of the experienced humour that is more likely to be related to negatively by the therapist. The alignment of proportions in the findings supporting this composite conclusion from across this research project is presented below, in *Table 8*.

[54] The basic distinction also raised in this study (*paper one – literature review*) between *funniness* and *humour-as-experience* could be understood in a similar way.

Table 8.

Data source	Potentially correlating findings across three papers (grouped vertically)	
Review of existing literature (see: paper one)	Defensive or harmful accounts of humour	Helpful or developmental accounts of humour
Interview participants' testimony (see: *paper two*)	Lack of institutional support n= 255 codes[55], **74%** of organising level/field '*institutional/socio-general/cultural context*' (see: *Table 4*, p. 115).	Available institutional support n=88 codes[56], **26%** of organising level/field '*institutional/socio-cultural/general context'* (see: *Table 4,* p. 115).
Auto-coded sentiment of transcripts (see: *paper three*, *Table 11*)	Greater proportion of negative sentiment (at level of data, related to degree of institutional support) [roughly **57%**][57]	Greater proportion of positive sentiment (at level of data, related to degree of institutional support) [roughly **43%**][58]

Composite conclusion to the outcomes of this research project, with an alignment of proportions in findings supporting this conclusion (Table 8).

From this composite conclusion, it is possible to make the following assessment, gathered into *Box 5*, of the psychoanalytic theory underlining this research project, compiled in paper one – literature review:

Box 5.

The literature review in the first paper of this research project proposed four distinct psychoanalytic ontologies of humour – Superiority, Relief, Humility, and Play – offered as useful theoretical lenses through which to understand the historical conceptualisation of humour within psychoanalysis. However, the findings of this paper (a framework analysis) challenge the utility of asserting any single theoretical ontology as definitive for how humour is experienced and understood in clinical practice. Based on participants' testimonies, it appears more accurate to suggest that different theoretical positions are drawn upon at different times – often shaped by contextual factors such as the degree of institutional or supervisory support available.

This fluid movement between theoretical frames is more consistent with an object-relations model of psychotherapy, in which therapist and patient dynamically inhabit shifting roles and internal positions throughout the therapeutic process. Clinical experience supports this view: therapists and adolescent

[55,56] Each number was found by the number of codes expressing institutional support, or support missing, multiplied by the number of coded transcripts (see: *Table 4*, p. 113).
[57, 58] Each number is a percentage of the total sentiment expressed and auto-coded across the dataset (see: *Table 6*, p. 118).

patients alike often engage different affective or relational modes at different times, and the same appears to be true for how humour is experienced and enacted. Rather than conforming to a singular meaning, humour functions as a transitional phenomenon, carrying different valences depending on the moment and the relationship.

Taken together, the findings across this research project suggest that humour works in psychotherapy precisely because it is by nature ambiguous – and that is its value. This observation aligns closely with object-relations thinking, which privileges complexity of movement, multiplicity of meaning-making, and relational responsiveness.

Summary of implications for psychoanalytic theory compiled in paper one – literature review.

In conclusion, humour is a deep, multi-modal phenomenon – of interest to some who work as therapists. Myriad explanations may be offered which motivate its place in psychotherapy, but the most influential factor remains whether therapists are supported in doing this. Working technically in humour with others – although famously “killing the joke” – may ultimately accompany a relieving, positive experience (see: *Table 6,* p. 118), where something can be understood (*category 4.2* in *Table 4,* p. 115) and shared. A final comparison of the extent to which the project’s research questions have been answered is presented in *Table 9* below.

Table 9.

Research questions for further consideration developed from a review of existing literature (see: paper one)		Summary of answers to research questions provided by an interpretative phenomenological analysis of five semi-structured interviews with trainee therapists (see: paper two)	Summary of answers to questions provided by a framework analysis of interview transcripts
RQ1	'What amount and type of detail – with respect to the "thickness" and "thinness" of description (see: Geertz, 1973) – supports a meaningful understanding of an account of an experience of humour?'	Close attention to lived experience (using IPA methodology) provides a wealth of "thick" description. However, a reflective diary kept throughout this process indicated a need for further investigation – with a "narrow" or "precise" focus of detail – as to how this experience had first come about, and to how it had then been understood (see: *paper two – 'Limitations'*).	Focused attention upon 'thin' description of explanatory categories of influence supported greater understanding of institutional factors.
RQ2	'Does a model for data analysis with/without an explicit idiographic focus – such as interpretative phenomenological analysis – support the understanding of a humour experience?'	A reflective diary kept throughout the research process suggested that greater understanding of these five participants was achieved, but further questions were raised regarding the 'about-ness' in the (implicit) reasons, beliefs, customs, and cultures which informed their espoused experiences.	A research investigation with a distinct methodological approach (e.g., a 'diagnostic' framework analysis) may complement an idiographic focus undertaken elsewhere and may generate collective findings (see: Table 7, see: p. 153).
RQ3	'Does humour produce relief or relief produce humour?'	Humour was found both to produce relief and vice versa. However, who stood to gain from this, and how, remained unclear (see: *paper two* – '*Discussion'*).	Humour may be more 'for' therapists, and what they are struggling with, than these professionals may entertain in their 'espoused values'.
RQ4	'Can we learn or develop from an experience of humour? Does humour actually do anything, or is it simply an appeasement (e.g., of the patient's narcissism, or that of their therapist – a convenient fiction deluding us from an inconvenient reality)?'	Humour was seen to have multiple, "vital" functions. It was seen to "do" many things, including: 'enlivenment'; 'disentanglement'; 'softening the blow'; 'safe expression of healthy aggression'; 'finding edges for containment'; 'an achievement of ordinariness' (see: *paper two – 'Findings'*).	This is generally 'decided' by the therapist (and, unless challenged, decidedly not by/with the patient). Decision-making about what can be achieved with humour may be significantly informed by the degree of institutional support available.
RQ5	'As a subset of play is humour therefore a subset of psychotherapy?'	Humour is named, clearly and unprompted, as a subset of play by every participant. This is presented as congruent with psychotherapy practice	Specifically, humour-as-play may be understood in terms of transitional and transference phenomena.
RQ6	'Is the experience of humour helpful to therapeutic work?'	Participants presented a mixed picture of this. Some kinds of humour were experienced as directly supportive of therapeutic aims, whereas others were seen as contrary to these objectives (see: *paper two – 'Findings'*).	Experienced humour is generally understood to help, but what happens as a consequence of this 'help' is less clear e.g., where the infrastructure for 'helping humour' is held in the private free market.
RQ7	'Does it matter how humour in psychotherapy feels?'	A central finding is that how it feels does matter, but only if you have the right kind of support in place (see: *paper two – 'Discussion'*).	There is a big difference between 'technical' and 'omnipotent' approaches to feeling about humour.
RQ8	'What conditions are necessary for an experience of humour in psychotherapy?'	Identified 'conditions' include structural ones (e.g., the provision of supervision), as well the personal and cultural grounding of therapist and patient, e.g. "where we're from" (see: *paper two – 'Findings'*).	Conditions of importance include the interplay between institutional support and personal identity. Other conditions include: adequate time, 'reflection points', and the resource of precious helping figures.

Summary of address to developed research questions.

8 | WORKS CITED

Adorno, T. W. (1944/2002). The culture industry: Enlightnement as mass deception. In T. W. Adorno, *Dialectic of Enlightenment* (pp. 94-136). Stanford, CA: Stanford University Press .

Altman, N. (2006). Commentary on paper: 'And Now for Something Completely Different: Humour in Psychoanalysis' by Joseph Newirth. *Psychoanalytic Dialogues*, 573-577.

Bergson, H. (1900). *Le Rire: Essai sur la signification du comique.* Paris: Felix Alcan.

Braun, V. &. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* , 77-101.

Carlberg, G. (1997). Laughter opens the door: Turning points in child psychotherapy. *Journal of Child Psychotherapy*, 331-349.

Freud, S. (1905). *Three Essays on the Theory of Sexuality.* New York: Basic Books.

Geertz, C. (1973). Thick description: towards an interpretative theory of culture. In C. Geertz, *The interpretation of cultures: selected essays* (pp. 3-30). New York: Basic Books.

Gibson, N. (2018). The Best Medicine? Psychotherapists' Experience of the Impact of Humour on the Process of Psychotherapy . *Journal of the Society for Existential Analysis*.

Haydon, G., Van der Reit, P., & Browne, G. (2015). A narrative inquiry: Humour and gender differences in the therapeutic relationship between nurses and their patients. *Contemporary Nursing, 50(2-3)*, 214-26.

Hollis, C. &. (2022). Ethical Considerations in the Marketing of Online Mental Health Platforms . *Journal of Medical Internet Research*, 29(7).

Lefcourt, H. M. (2001). *Humor: The psychology of living buoyantly .* Amsterdam: Kluwer Academic/Plenum Publishers.

Marcus, P. (1990). Humour in Psychotherapy: A Case of Creative Resonance. *American Journal of Psychotherapy, 44 (1)*, 96-107.

Marcuse, H. (1964). *One-Dimensional Man: Studies in the Ideology of Advanced Industrial Society.* Boston: Beacon Press.

McCann, D., Plummer, D., & Minichiello, V. (2010). Being the butt of the joke: homophobic humour, male identity, and its connection to emotional and physical violence for men. *Health Sociology Review*, 505-521.

Onwuegbuzie, A. (2004). Enhancing the Interpretation of "Significant" Findings: The Role of Mixed Methods Research. *The Qualitative Report, Vol. 9*, 770-792.

Parkinson, S., Eatough, V., Holmes, J., Stapley, E., Target, M., & Midgley, N. (2016). Framework analysis: a worked example of a study exploring young people's experiences of depression. *Qualitative Research in Psychology, 13(2)*, 109-129.

Porterfield, A. L. (1987). Does humour facilitate coping with life stress? *International Journal of Humour Research*, 135-154.

Ritchie, J. &. (1994). Qualitative data analysis for applied policy research. In B. &. Bryman, *Analysing qualitative data* (pp. 173-194). London: Routledge.

Rose, G. (1969). King Lear and the use of humour in treatment. *Journal of American Psychoanalytic Association*, 927-40.

Schein, E. (2004). *Organisational Culture and Leadership.* Hoboken, NJ: John Wiley & Sons.

Stern, D. (1985). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology .* New York: Basic Books.

Van Baaren, R. B., & Van Knippenberg, A. (2009). Humor as social regulation: self-serving and affiliative consequences of humor. *Psychological Reports*, 831-842.

Varoufakis, Y. (2023). *Technofeudalism: What Killed Capitalism.* London: Random House.

Appendices

Appendix 1: Complete list of tables, figures, and boxes

Appendix 2: Indicative interview schedule

The Tavistock and Portman
NHS Foundation Trust

Indicative Interview Schedule

Interview is semi-structured, so after providing basic structure, and specific interest in the participant's experience of humour in the therapy relationship with their adolescent training case, encourage maximal free association (e.g., "tell me more") and only prompt when necessary.

Part 1 – Introduction

Chart the time frame of the interview. Provide assurance that the participant will remain anonymous in any written reports growing out of the study, with responses held in the strictest confidence.

- Acknowledge that the participant is free to interrupt, ask clarification of the interviewer, disagree with a line of questioning etc. Acknowledge that there are no right or wrong answers about the subject and that I am interested only in the participant's opinions and personal experiences.

- Explain something of myself, my background, training, and basis of my interest in this area of inquiry.

- Ask participant about their current and previous roles including their clinical training posts.

- Acknowledge obvious differences between us (e.g., sex, location, age), and wonder whether such differences could be meaningful in how humour is ultimately experienced and understood in therapy.

Part 2 – experience of humour with adolescent training case

- Ask participant about their adolescent training case specifically, and their experience of humour in this work with this young person.

Prompts

- Ask about a time when humour was relevant to this piece of work: either as an encounter, or an occasion when the participant experienced the absence of

humour: what did the participant make of this experience; what do they think their patient made of it?

- Ask participant what it is about their patient that allows their humour to be taken up, or not. Does the development stage of adolescent have any part to play?

- Ask participant about what they understand of the impact of this experience upon their work, and their therapy relationship, with their adolescent training case.

- Was the participant called upon to understand their patient in a different way as a result of this humour experience?

- Ask whether the participant understands this experience any differently now than how they did at the time – ask what the participant puts this down to.

Part 3 – other humour experiences

- Ask whether participant can think of any other experiences of humour in their work with their adolescent training case that come to mind.

Prompts

- Observe that people might think about humour in different ways, and perhaps as having different aspects, effects, and functions. Provide examples of different humour types if helpful.

- Ask participant to reflect upon the differences in the other example they may have provided of a humour experience: why did this other humour example have a different quality at this different time in the work? What changed?

- If an experience of another type of humour is hard to bring to mind, ask the participant about their thoughts on why this might be.

Part 4 – humour experiences in the psychotherapy and training context

- Ask participant what they understand of the role that their personal identity, including as a trainee child psychotherapist, may have had, if any, in producing a humour experience with their adolescent patient.

Prompts

- Ask participant whether they think being a trainee may have had any bearing upon how humour is experienced in their adolescent intensive psychotherapy work.

- Observe that trainees receive once-weekly supervision for their training cases. Ask what impact this supervision may have had upon the participant's experience of humour in this piece of work.

- Ask whether the participant has any thoughts on whether non-professional aspects of personal identity – such as age, race, sex, class, disability etc. – factored into the experience of humour in this work. Ask whether the participant thinks that a clinician who was different to themselves in some way might have experienced the humour with their adolescent patient any differently.

- Observe that in my preparation for this research project, I came to understand that very little has been written about the experience of humour in psychotherapy. One study showed that about half of surveyed psychotherapist respondents thought there was any place for humour in psychotherapy work at all. Ask participant whether they have any thoughts about this.

Part 5 – concluding remarks

- Ask participant whether there is anything that they feel has been missed from our conversation that they would like to say.

- Ask participant about their experience of meeting with me for the interview.

- Thank participant and provide with debrief information.

Appendix 3: Participant information sheet

The Tavistock and Portman
NHS Foundation Trust

Participant Information Sheet

ProfDoc research project title: "*How do trainee child and adolescent psychotherapists experience humour in their intensive psychotherapy work with adolescents?*"

Thank you for expressing an interest in participating in this qualitative research study which will form part of my professional doctorate. This information sheet describes the study and explains what will be involved if you decide to take part.

The aim of the research is to better understand what trainee child and adolescent psychotherapists make of the humour experienced in their intensive psychotherapy work with adolescent patients.

Who am I?

Will Parkinson, a Child and Adolescent Psychotherapist in Doctoral Training at the Tavistock and Portman NHS Foundation Trust and on placement at [redacted] and at [redacted]. I am the principal investigator of this study and I have designed the research study and will conduct the interviews and data analysis.

What is the purpose of this study?

The purpose of this research is to better understand what happens in an experience of humour between a child and adolescent psychotherapy trainee and their adolescent training case when engaged in intensive psychotherapy work – a subject that I have found to be little researched within our profession and its associated disciplines in the helping professions. A secondary research aim will be to better understand how an understanding of an experience of humour is worked towards, including in the context of an interview relationship with me as a participant-researcher.

What is meant by humour in this project? Have I had the right kind of experience to take part?

In my preparatory literature search, I found there to be vastly different perspectives on what is happening in an experience of humour, in life as well as within psychotherapy work.

In this research study, I will propose no set criteria for how to define humour, and I will be interested in whatever you may like to say about the subject, drawing from your own personal experience.

What will participating in this study involve?

An interview lasting one hour which will take place during the coming six months. If you agree to participate, I will arrange a convenient time to meet with you to discuss your experience of humour in your intensive psychotherapy work with an adolescent patient. Where possible, these interviews will take place in person at the Tavistock Clinic – 120 Belsize Lane, London, NW3 5BA – but where this is not feasible, they will be offered via zoom.

I will also provide you with post-interview Confidentiality and Debrief Information which will help to inform you about how your privacy will be secured.

What are the criteria to take part?

- Participants will need to be a trainee who is presently engaged in, or has completed, a three-times weekly intensive psychotherapy intervention with an adolescent patient (aged 13-25) as part of their ongoing professional training in Child and Adolescent Psychotherapy.

- Participants will need to be English speaking.

What are the possible benefits of taking part?

There are no formal benefits, but I hope that the opportunity to reflect upon an anecdotally prevalent, and yet under-researched, area of clinical practice will be an enriching experience, that may better resource you to future clinical undertakings which touch upon this subject. You will also be contributing to the knowledge base of the discipline of child and adolescent psychotherapy, and to the broader ecosystem of the helping professions.

What will happen to what I say in the interview?

The interviews will be audio-recorded using a voice recorder which I will use to playback and transcribe in full, at which point the recording will be deleted by recording over. The transcription will then be anonymised and analysed by me as part of an interpretative phenomenological analysis.

Your name and personal details will be stored separately from the transcript in accordance with the University of Essex Data Protection Policy and the General Data Protection Regulations 2018 (GDPR, see below). This means that all electronic data will be digitally encrypted and stored on a password protected computer which only I will have access to. Any paper copies will be kept in a locked filing cabinet. All data will be destroyed no later than 3 years after the study has been written up for academic submission.

My sample size – of five participants – may be considered small in comparison to larger scale research projects; please be advised that this may have possible implications for confidentiality / anonymity, but I will do all I can to ensure that ordinary professional standards are upheld.

General Data Protection Regulation (2018) arrangements

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 2 years after the study has finished.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, [redacted]

In the very unlikely event that you say something during the interview that suggests you or someone else is at risk of harm, I would need to discuss this with you and potentially breach confidentiality.

What risks are there?

There are no direct risks, but in the event that reflecting deeply upon clinical experiences may bring up challenging thoughts and feelings, you will be provided with information for services and individuals who may be able to help you to think about your experience in the interview.

Do I have to participate after I agree?

No, you are free to withdraw from the research project at any time during your participation, including up to one month following the date of your interview.

You will have the opportunity to discuss with your intensive case supervisor what your participation in this study may involve prior to meeting with me for an interview, and I encourage you to do this should it be helpful.

You are also welcome to think through the implications of your participation with my research supervisor, Dr [redacted], whose contact details are listed below.

What approval has been gained to protect you, and information about you, in the research study?

This research study has received formal approval from the sponsor of the research, the Tavistock and Portman Trust Ethics Committee (TREC). These processes ensure I conduct the study within legal and ethical standards. If you have any concerns or queries regarding my conduct you may contact [redacted], Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Additional accountability is provided by the study sponsor for this project, [redacted], Interim Deputy Director of Education and Training and Dean of Postgraduate Studies, Tavistock and Portman NHS Healthcare University Foundation Trust, 120 Belsize Lane, London NW3 5BA, [redacted].

Contact details:

I am the main contact for the study. If you have any questions about the study, please do not hesitate to ask. My contact details are:

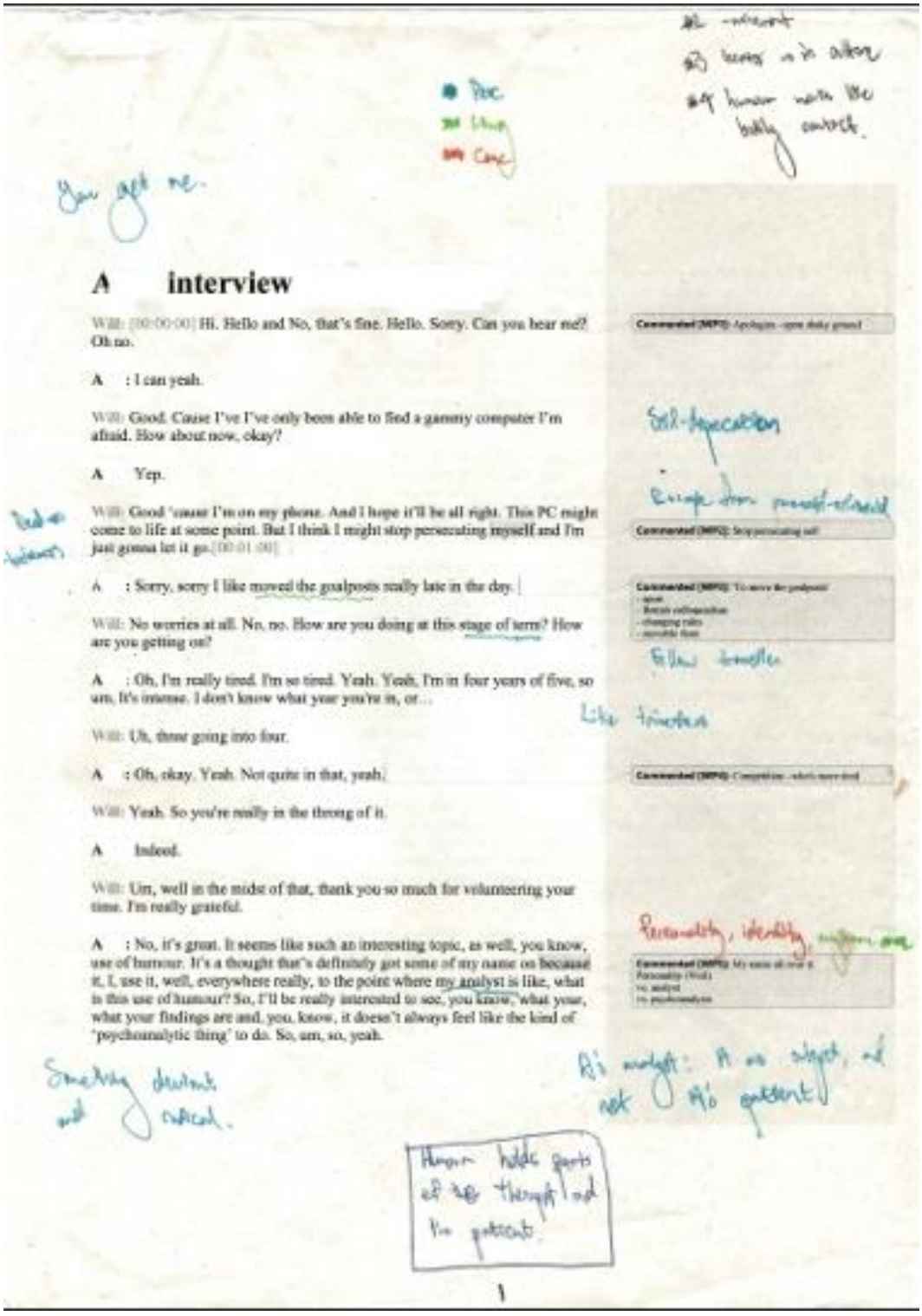
Will Parkinson
Email: wparkinson@tavi-port.ac.uk
Telephone: 07706655122
Address: 120 Belsize Lane, London, NW3 5BA

Alternatively, any concerns or further questions may be directed to my research supervisor

Dr [redacted]

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to be interviewed for this research project, please complete the accompanying consent form.

Appendix 4: Three types of exploratory notes



A interview

Will: [00:00:00] Hi. Hello and No, that's fine. Hello. Sorry. Can you hear me? Oh no.

A : I can yeah.

Will: Good. Cause I've I've only been able to find a gammy computer I'm afraid. How about now, okay?

A Yep.

Will: Good 'cause I'm on my phone. And I hope it'll be all right. This PC might come to life at some point. But I think I might stop persecuting myself and I'm just gonna let it go.[00:01:00]

A : Sorry, sorry I like moved the goalposts really late in the day.

Will: No worries at all. No, no. How are you doing at this stage of term? How are you getting on?

A : Oh, I'm really tired. I'm so tired. Yeah. Yeah, I'm in four years of five, so um, It's intense. I don't know what year you're in, or…

Will: Uh, three going into four.

A : Oh, okay. Yeah. Not quite in that, yeah.

Will: Yeah. So you're really in the throng of it.

A Indeed.

Will: Um, well in the midst of that, thank you so much for volunteering your time. I'm really grateful.

A : No, it's great. It seems like such an interesting topic, as well, you know, use of humour. It's a thought that's definitely got some of my name on because it, I, use it, well, everywhere really, to the point where my analyst is like, what is this use of humour? So, I'll be really interested to see, you know, what your, what your findings are and, you, know, it doesn't always feel like the kind of 'psychoanalytic thing' to do. So, um, so, yeah.

Um, and I guess I was thinking that, you know, beginning the training really, um, and, and I thought along the way – particularly when I was working with adolescents in that service, and particularly most of all when I began with my training case, I guess – I started to think about these experiences of humour that would happen and, um, I began wondering about what that was about and um, you know, the fact it was taking place within this, the [00:03:00] psychotherapy relationship.

And, um, I guess I got interested in that, um, through working with her – my training case. Um, and then basically yeah, in this research study, I wanted to ask other trainees about that and about what they've experienced. So I wonder, it would be good, , just to hear a bit about you and where you're based in your training and (*mm-hmm*). It'd be good to hear about your, um, adolescent training case and where you're up to with them.

Um, just finished second year at the . So that's the only training in . Um, there's five of us in training – and we train differently. We do like a four year cohort and then it stops, and then the next five go in. (*Okay*). So we, we don't have like, people above us. (*Yeah*) to, you know, to, to learn from.

So it's just us on our own trying to make sense of what are we doing? (*Yeah*). What, what are we doing? Um, so yeah. So I work in [00:04:00] which is, I dunno if you know , but it's like west of . That patch from up to . own to . Um, and I'm part of NHS and covers the whole of in the north and then all down the west coast as well.

So I'm the only trainee in that geographical area, bigger than Belgium. (*Yeah*). That helps you understand. We're all fairly isolated, so it's exciting to meet another trainee. It's just really nice to meet someone else, um, who understands what, what, what I might be going through. Um, I worked in this Camhs team for nearly 10 years.

I worked here first and then, big long story, but the training placement managed to happen here as well. So that's good. So the girl I was going to speak to you about is, she's complicated because, because in rural areas, I [00:05:00] suppose, (*yeah*), there's health inequality and people have to take what they can get. So I saw her when she was 12 as a Camhs clinician, as I was a CBT therapist.

So I saw when she was 12, she left, I left, I started doing my training, and she came back. So we've known each other for a long, long time. She's 18 now. Um, we've known each other a long time, but she knew me in in both capacities, so that's complicated. Anyway, um, and she uses humor. I thought of her straight away when I read your proposal and it really, it really kind of jarred with me because I didn't understand what she was doing at first.

So she would come in and she did kinda know me anyway, but she would come in and she would flirt with me. She was really uncomfortable and she would tell me the most verbally, the most horrific, horrific stories of sexual abuse, really detailed. And then [00:06:00] she would laugh and

(2)

There wasn't really a kind of sense of something really alive. And then one day, I don't know, he was telling me he was watching something and then I was just like, "come on, you're gonna have to name it, or else, you know, I'm gonna have to assume you watch or something!" And he just burst out laughing.

And it sort of just started out from there, where just tiny little moments where it made sense… Um, and I don't really know why I did it. I think I was partly a bit frustrated. (*Mm-hmm*). [00:06:00] Wanted to bring something to life. Um… and that's really how it started with him. In particular. (*Mm-hmm*). Um,

and interestingly, more recently he has started to be a bit more humorous and will kind of, you know, give me anecdotes and sort of laugh about it. 'cause I… it's not really sort of like, oh, we just joke around or something like that. But, um, I don't know. It's sort of a way being with him, I. I don't know how to describe it really.

I dunno if that made any sense, but yeah.

Will: Yeah. I wonder…it sounds like, um, this sort of, perhaps you almost took a risk in sort of engaging with him in this way – the ! in thing – and um, that it sort of, you sort of, something different happened as a result of that, this different way that you're [00:07:00] describing.

Um, I dunno if I understood that right, but it felt like something shifted, I suppose.

R Yeah, because I think, I mean, when you kind of, you know, when you're training, there's a very particular way of doing things, I think. And um, I think I was quite wary about that very much the beginning of my training about like, could I really do this?

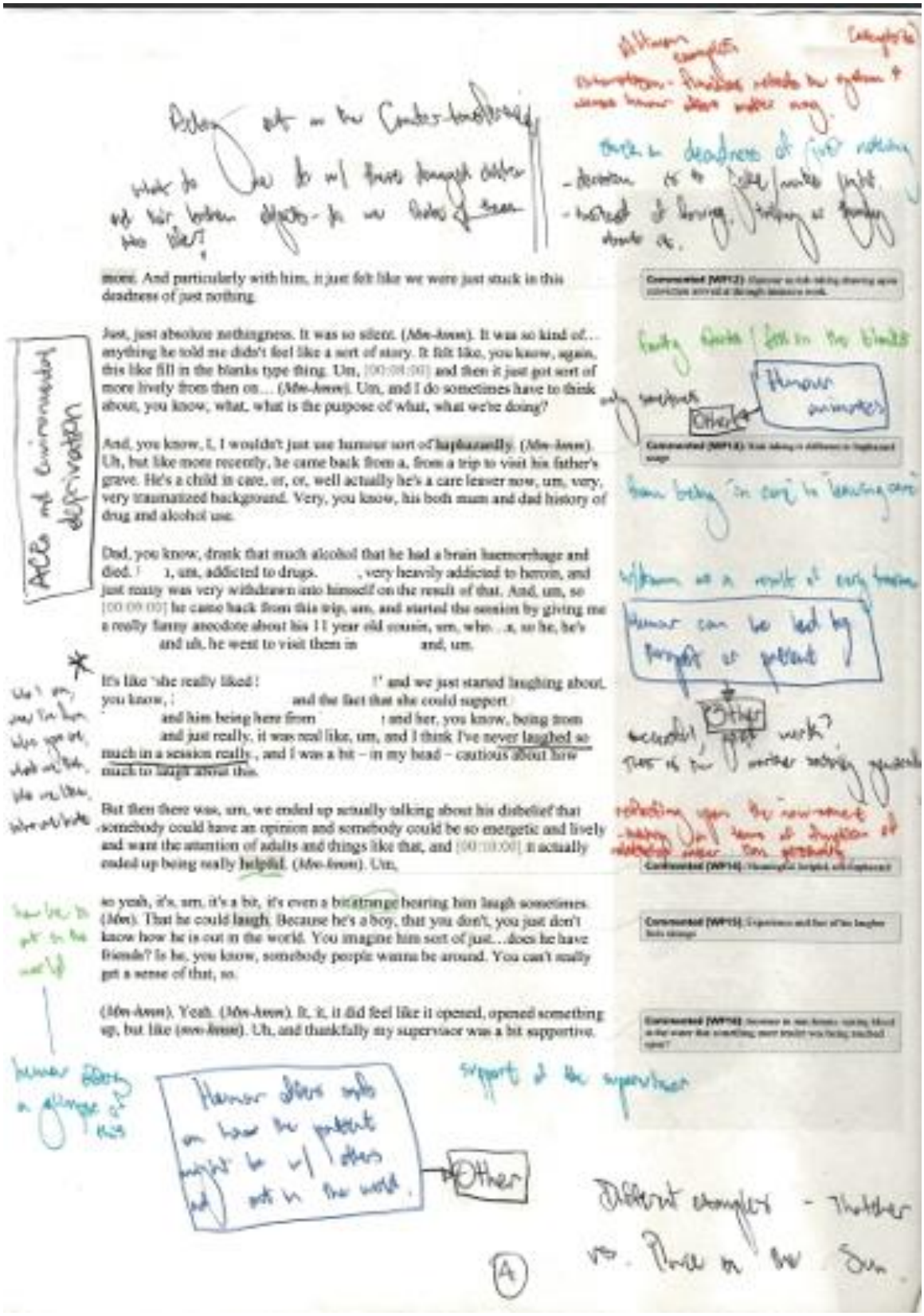
What am I avoiding if I do this? Is it defensive, you know? We need to take everything really seriously. (*Mm-hmm*). And as, as of, actually, I think it's partly been through the intensive work that I've been able to take those risks a bit more. And particularly with him, it just felt like we were just stuck in this deadness of just nothing.

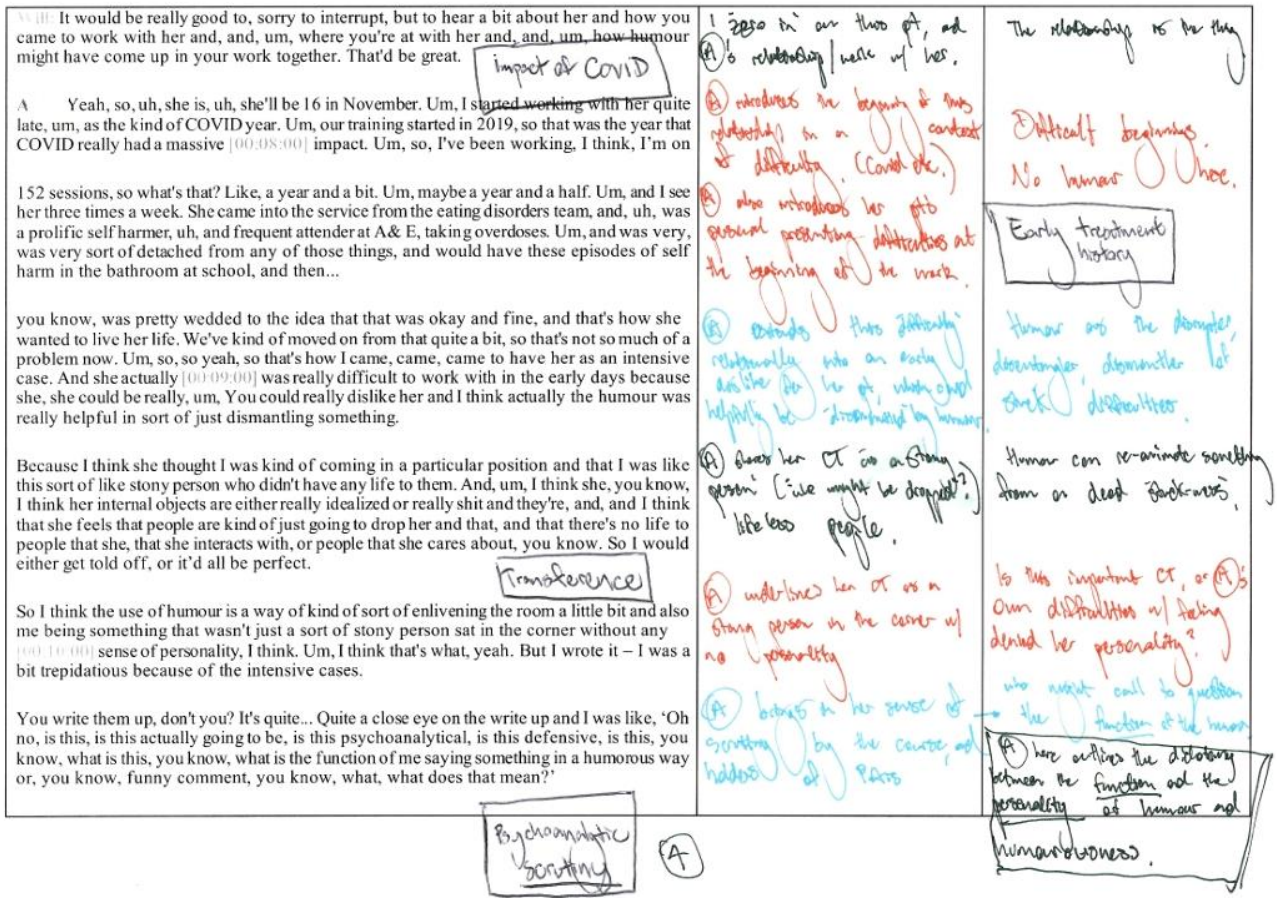
Just, just absolute nothingness. It was so silent. (*Mm-hmm*). It was so kind of… anything he told me didn't feel like a sort of story. It felt like, you know, again, this like fill in the blanks type thing. Um, [00:08:00] and then it just got sort of more lively from then on… (*Mm-hmm*). Um, and I do sometimes have to think about, you know, what, what is the purpose of what, what we're doing?

And, you know, I, I wouldn't just use humour sort of haphazardly. (*Mm-hmm*). Uh, but like more recently, he came back from a, from a trip to visit his father's grave. He's a child in care, or, or, well actually he's a care leaver now, um, very, very traumatized background. Very, you know, his both mum and dad history of drug and alcohol use.

(3)

Appendix 5: Bracketing off meaning-making comments





VS (II): It would be really good to, sorry to interrupt, but to hear a bit about her and how you came to work with her and, and, um, where you're at with her and, and, um, how humour might have come up in your work together. That'd be great.

impact of COVID

A Yeah, so, uh, she is, uh, she'll be 16 in November. Um, I started working with her quite late, um, as the kind of COVID year. Um, our training started in 2019, so that was the year that COVID really had a massive [00:08:00] impact. Um, so, I've been working, I think, I'm on

152 sessions, so what's that? Like, a year and a bit. Um, maybe a year and a half. Um, and I see her three times a week. She came into the service from the eating disorders team, and, uh, was a prolific self harmer, uh, and frequent attender at A& E, taking overdoses. Um, and was very, was very sort of detached from any of those things, and would have these episodes of self harm in the bathroom at school, and then...

you know, was pretty wedded to the idea that that was okay and fine, and that's how she wanted to live her life. We've kind of moved on from that quite a bit, so that's not so much of a problem now. Um, so, so yeah, so that's how I came, came, came to have her as an intensive case. And she actually [00:09:00] was really difficult to work with in the early days because she, she could be really, um, You could really dislike her and I think actually the humour was really helpful in sort of just dismantling something.

Because I think she thought I was kind of coming in a particular position and that I was like this sort of like stony person who didn't have any life to them. And, um, I think she, you know, I think her internal objects are either really idealized or really shit and they're, and, and I think that she feels that people are kind of just going to drop her and that, and that there's no life to people that she, that she interacts with, or people that she cares about, you know. So I would either get told off, or it'd all be perfect.

Transference

So I think the use of humour is a way of kind of sort of enlivening the room a little bit and also me being something that wasn't just a sort of stony person sat in the corner without any [00:10:00] sense of personality, I think. Um, I think that's what, yeah. But I wrote it – I was a bit trepidatious because of the intensive cases.

You write them up, don't you? It's quite... Quite a close eye on the write up and I was like, 'Oh no, is this, is this actually going to be, is this psychoanalytical, is this defensive, is this, you know, what is this, you know, what is the function of me saying something in a humorous way or, you know, funny comment, you know, what, what does that mean?'

Psychoanalytic scrutiny

(A)

1 year in our third yr, and (A)'s relationship/work w/ her.

(A) introduces the beginning of this relationship in an (Covid etc.) context of difficulty.

(A) also introduces her pt's personal presenting difficulties at the beginning of the work.

(A) extends these difficulty relationship into an early dislike for her pt, which she helpfully has 'disentangled' by humour.

(A) draws her CT as a stony person (like might be dropped?), lifeless people.

(A) underlines her CT as a stony person in the case w/ no personality

(A) belongs in the sense of operating by the counter, and hidden of P.D.D.

The relationship as the thing

Difficult beginnings. No humour there.

Early treatment history

Humour as the disrupter, disentangler of stuck difficulties.

Humour can re-animate something from an dead particulars.

Is this important CT, or (A)'s own difficulties w/ feeling denied her personality?

who might call to question the function of the humour

(A) here outlines the distancing between the function and the personality of humour and humanisedness.

General experiential themes

Theme 1 – "Now I can see who you are".

a. Humour renders contact with something natural and basic in how we are with ourselves and others.

Participant	*Selected supporting quotation*	*From PET theme*	*Page/line*
A	"To have a bit of a joke feels kind of quite a natural thing to do, I think, as well for adolescents."	(3v – '*It is a natural thing*')	5.9
	"I think it did sort of humanise something."		5.34
R	"It, it feels like it's basic sort of human things, but actually incredibly painful ones."	(1vii – '*Humour engages basic human things*')	7.27
	"It's sort of a way of being with him."	(1vi – '*A way of being with*')	3.18
	"A relief of like, 'Oh my god, you're in there, you know, you're alive! There's somebody in there!"	(1v – '*Bringing to life*')	5.33
Sh	"When it was there, it was just like, 'Oh, now I can see something about who you are'."	(3v – '*It underlines something essential, who we are*')	7.15
V	"'Look, we're just two folk in a room trying to figure out what's going on with your mind and why these things keep happening to you'. You know, you can think about our relationship. Um, it's a way of being gentler. I think it's a way of being human." **Move to theme 3**	(2i-x – '*Humour is ordinary*')	10.8
S	"I remember the first laugh and it was like, it's so genuine. It's such a, it's such a proper…you realise you're with a human being".	(4iv – '*Humour is about genuineness*')	11.28

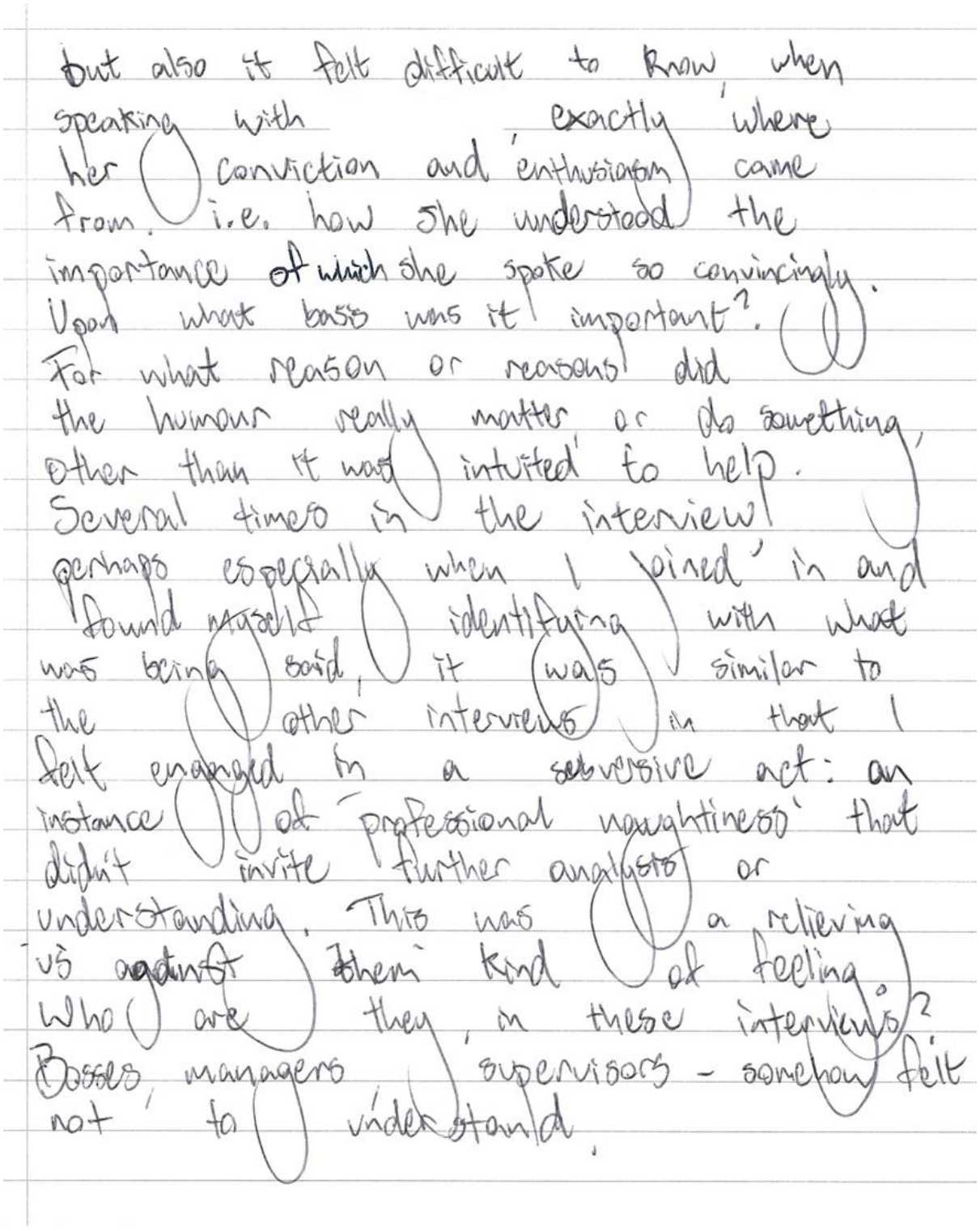
b. The human, natural contact of humour in psychotherapy can be experienced as play.

Participant	*Selected supporting quotation*	*PET theme*	*Page/line*
A	"It just felt that I was someone that plays with things in my mind rather than, um, I was going to say than always being serious…"	(2x – '*It is a playing*')	6.15
R	"…it's part of playing…just, sort of, playing with ideas."	(1vii – '*Humour engages basic human things*')	13.4
Sh	"I think I equate humour with play. Your ability to be playful kind of comes through the way that you might be able to engage someone with humour."	(2v – '*It is an ability for play*')	5.9
V	"I think she does think she's quite funny. She tells me about times with her friends and what they say and tells me about humour quite a lot actually."	(2x – '*Humour opens up ordinary things like friendship*')	14.25
	"Well if *children* want to joke and make, play games, then tat's what's happening, *actually*."	(2xi – '*By being ordinary, humour helps things to be okay*')	11.6
S	"…she just needed me to be more playful, and I guess being…being, having a playful approach to, to challenge and interpret seemed to be one way of kind of connecting with her."	(2vii – '*Humour expresses a need to be playful*')	6.14

c. At the beginning of treatment, patients can express an 'inhuman quality' that is generally understood as defensive. This early presentation can include something inanimate, empty, or dead, or else/also something fierce, attacking, and destructive. When this presentation preponderates, the humour experienced is absent or distorted.

Participant	*Selected supporting quotation*	*PET theme*	*Page/line*
A	"I think the use of humour is a way of enlivening the room a little bit and also me being something that wasn't just a sort of stony person say in the corner without any sense of personality."	(2vi – '*Its absence is a withholding*')	4.27
	"She came into the service from the eating disorders team, and was a prolific self-harmer and frequent attender at A+E" / "…quite a bit of domestic violence."	(3ii – '*…'s patient's presenting issues pre-therapy were located in the body*'	4.9 /7.15
	"I think her internal objects are either really idealised or really shit and I think that she feels that people are kind of just going to drop her and that there's no life to people that she interacts with, or people that she cares about."	(3iii – '*…'s patient first presents an inanimate quality*')	4.22
	"She totally internalises the humour as not being about a kind of language amongst peers, but being really persecutory about her. And then she projects it straight back out and gets really defensive about people just being adolescents and saying stupid things."	(3iv – '*…patient presents early projective tendencies*')	9.5
R	"When he first came, he was really, really silent, really sort of withdrawn. Nothing sort of positive or negative kind of going on."	(1i – '*Early in the interview, … describes a sense of he patient's initial presentation of lifelessness*')	2.18
Sh	"It was more about the fact that she didn't really know what it was to be alive. And she didn't like the feelings that that stirred up in her – and that was where the wanting to die came from."	(1iii – '*What's missing is something to do with life*')	2.31
	"She becomes very black and white in her thinking 'cause she's not very good at the in-between states."	(1v – '*Something is missing "in-between"*')	3.14
	"When we went into lockdown, she pretty much just disengaged. She stopped taking her medication, she stopped engaging with her therapy."	(1vi – '*The experience of lockdown underlined what was missing*')	3.26
	"There was a part of herself that was invested in just staying exactly where she was, not leaving the house, not going to college, not engaging with her friends, who were trying. It sounded like people were trying to get in touch with her and see how she was doing."	(1vii – '*The patient's vacancy created anxiety around her*')	4.21
	"I was slightly anxious about what exactly it is that I can offer her. Like, it sounded like a very vague presentation."	(2i – '…'s patient first presented vaguely')	4.22
	"She'd gone through a phase of self-harm, but that was over now. It wasn't really what she was into and she felt it was a bit of a peer thing, rather than something more personal to her."	(3ii – '*At the beginning of treatment, …'s patient lacked a defined personality*')	2.25
	"Little comments and things where I was like 'Okay, there's the humour'." / "It was more that she wrote down something or I could see the humour than she actually could really speak it." / "I don't know if she recognised herself how much was hidden."	(4iv – '*The humour would be there, but is blocked or hidden or withheld*')	5.5 / 5.14 / 6.1
V	"She would come in and she would flirt with me. She would tell me the most horrific, horrific stories of sexual abuse. And then she would laugh and kinda smile at me. It took me a long time to say, 'You're telling me this, but you're laughing about it, what's going on?' And I was thinking, 'Oh, she thinks this is what I'm going to do, oh, this is awful.'"	(1i – '*…understands her patient to move from using dark, projective humour towards a humour of whole object reality*')	3.13

Appendix 7: Extract from the author's reflective diary



but also it felt difficult to know, when speaking with her, exactly where conviction and enthusiasm came from. i.e. how she understood the importance of which she spoke so convincingly. Upon what basis was it important? For what reason or reasons did the humour really matter or do something, other than it was intuited to help. Several times in the interview, perhaps especially when I 'joined' in and found myself identifying with what was being said, it was similar to the other interviews in that I felt engaged in a subversive act: an instance of 'professional naughtiness' that didn't invite further analysis or understanding. This was a relieving 'us against them' kind of feeling. Who are they, in these interviews? Bosses, managers, supervisors - somehow felt not to understand.

Appendix 8: 'Other' placeholding column for pilot 'Rubi'

R

Other

- Humour involves risk-taking
- Humour can be born of frustration.
- Humour facilitates contact with 'difficult things'.
- Humour supports ambivalent feelings in one relationship.
- Humour has an existential quality. What is created in it is present in all other aspects of the therapy relationship.
- Humour supports work in the transference.
- Humour lets our patients let loose upon us Compact without damage.
- Humour shows the depth of things
- What it does depends on who does it.
- Therapists can value what is particular in humour. Why then? why now?
- Therapists need proper support (in supervision and/or analysis) for humour to be taken up in a meaningful way.

Appendix 9: Trust research ethics approval form

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane London, NW3 5BA
Tel: 020 8938 2699
https://tavistockandportman.nhs.u

William Parkinson

By Email
20 April 2023

Dear William,

Re: Trust Research Ethics Application

Title: 'How do trainee child and adolescent psychotherapists (CPTs) experience humour in their intensive psychotherapy work with adolescent patients?'

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

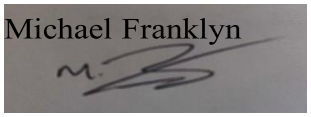
Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,



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cc. Course Lead, Supervisor, Research Lead