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Capacity for humanity : an exploratory study into the use of affiliative humor with clients who experience paranoid symptomatology

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Capacity for Humanity: An Exploratory Study into the Use of Affiliative Humor with Clients Who Experience Paranoid Symptomatology

A project based upon an independent investigation,

submitted in partial fulfillment of the requirements

for the degree of Master of Social Work.

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ABSTRACT

The purpose of this exploratory study was to investigate clinicians' experiences and perceptions about the use of affiliative humor as a means of establishing a bond with a client whom experiences paranoid symptomatology. This population in particular is the most difficult to initially engage and develop a therapeutic alliance with due to their severe level of mistrust and propensity towards misinterpreting interpersonal situations. Therefore, the objective of this study was to explore one means of navigating this barrier. Additionally, the findings of this study not only indicate that affiliative humor can be used successfully while working with this population, but also show the essentiality of establishing an strong therapeutic bond in order to engage these clients initially in treatment. Affiliative humor when used appropriately and thoughtfully, navigates impasses, difficulties, and misinterpretations inherent in clinical work. Much of the previous research noted that clients who experience clinical paranoia do not have the capacity for humor. The findings of this study serve as a foundation for future research concerning this population and their capacity for humor.

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Introduction

The purpose of this study is to answer the following question: "*What are clinicians' experiences and perception of using affiliative humor in fostering a therapeutic alliance with individuals who experience clinical paranoia?" Affiliative humor* refers to a humor style that is "an essentially non-hostile, tolerant use of humor that is affirming of self and others and presumably enhances interpersonal cohesiveness and attraction" (Gray, Larsen, Martin, Pulhik-Doris & Weir., p. 53, 2003). The operational definition of a *therapeutic alliance* for the purposes of this study refers to three crucial dimensions within the client-therapist relationship: agreement on therapeutic tasks, agreement on goals, and development of affective bonds (Tracey & Kokotovic, 2011). Lastly, for the purposes of this study, a person with *paranoid symptomatology (*PS) includes individuals where "suspiciousness, mistrustfulness, and frank misreading of meaning and intentions dominate the clinical picture" (Stone, M., 2014).

One reason for conducting this study is to explore through empirical means a strategy for working with individuals with paranoid symptomatology. Although paranoid symptomatology, including Paranoid Personality Disorder (PPD), are present in at least 4.4% of the population, there is a limited amount of research concerning effective treatment strategies because of the behavioral avoidance of individuals with PS and PPD in participate in research due to paranoia/mistrust (Chou et al., 2004; Edens, Marcus, & Morey, 2009). Therefore in order to explore possible effective treatment techniques and interventions, one must start by gathering

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CHAPTER ONE

Introduction

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narrative data on the experience and narrative of individual clinicians who have had long term and positive therapeutic relationship with this population.

A second purpose of this study is to explore a specific strategy (affiliative humor) to developing a therapeutic relationship with individuals who experience clinical paranoia. A therapeutic alliance as an essential component to a positive therapeutic outcome and is therefore an essential feature to the therapeutic process (Davis, Garske, & Martin, 2000). Barriers that emerge in developing a therapeutic alliance with clients diagnosed with PS and PPD are due to the interpersonal components of the diagnosis and subsequent negative impact on the client-clinician relationship. Individuals with clinical paranoia often experience resentment, mistrust, skepticism and rejection in their transference[1] towards their clinician, which is also often experienced by clinicians in their countertransference[2] (Colli, Dimaggio, Lingiardi & Tanzilli, 2014). McWilliams (2011) noted that the use of humor by clinicians with clients with paranoid symptomatology is essential as a means to traverse these interpersonal reactions and as a means to develop trust and begin to cultivate a therapeutic alliance (p. 227). That being said, there is a dearth of research to support this notion.

For this study I conducted interviews with 12 licensed clinicians who have had their license for at least 5 years and have had at least 5 sessions with a client where paranoia dominates the clinical picture[3]. Participants were gathered from one clinic whose clinicians

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[1] *Transference* is the "thoughts and feelings for a therapist that have their roots in earlier relationships and in subsequent emotional experiences with others" (Berzoff, 2011, p. 28).

[2] *Countertransference* is defined as the "thoughts and feelings and reactions to the client rooted in one's own history and current world". (Berzoff, 2011, p.28)

[3] Within the framework of the Diagnostic Statistical Manual (2013) this includes individuals diagnosed with: Paranoid Personality Disorder; Delusional Disorder, Persecutory Type; Schizophrenia; Bipolar I or Bipolar II

serve in an outpatient capacity to a primarily low-income urban population in Western Massachusetts.

As mentioned before, the majority of research on therapeutic engagement considers a strong therapeutic alliance an essential feature to positive therapeutic outcome. Considering the intention of this study to research and explore strategies in cultivating a therapeutic alliance with a population that is notoriously difficult to establish a therapeutic bond with and is therefore underserved, the implications to the findings of this study are great. Furthermore, there is a significant amount of disagreement and lack of research into the capacity for humor within this population, as well as possible therapeutic uses of humor during treatment. Therefore the findings of this study could have an impact as to not only the field's understanding and perception of clients with clinical paranoia, but it could further inform and expand the use of self by therapists.

Disorder with Psychotic Features; and Depressive Disorder with Psychotic Features; Personality Change Due to Another Medical Condition, Paranoid Type; and presence of paranoid ideation in Schizotypal Personality Disorder.

CHAPTER TWO

Literature Review

The following literature review examines the historical and current research on persecutory delusions, establishing a therapeutic alliance with paranoid clientele, and the therapeutic effects of humor in psychotherapy. There are three main sections within this review: paranoia, the therapeutic alliance, and humor in psychotherapy. The first section of this literature describes the history and theory of paranoia. I then present the modern clinical definition and conceptualization of clinical paranoia followed by a review of the manifestation of persecutory delusions as well as treatments. The second section describes the components of a therapeutic alliance, paying particular attention to the first phase of this relationship in which the essential bond is formed between client and clinician. Finally, this review addresses the definition, different types, and therapeutic effects of humor used in psychotherapy, particularly when working with individuals with PS.

Paranoia

History

Within Aubrey Lewis' (1970) paper *Paranoia and Paranoid: a History Perspective*, Lewis traces the usage and conceptualization of the terms *paranoia* and *paranoid* since its first mention in Greek literature. Initially the terms were used in Greek literature colloquially either as a means of calling someone 'crazy', 'demented' or simply 'thinking amiss' and 'folly' (p. 2). It was not until the 18th century that the psychiatric community began to utilize and conceptualize the term clinically, though it would be another hundred years before the term, paranoia, was used

as an independent diagnosis. From its earliest conceptualization in 1818 until the early 1900s *paranoia* was theorized as an "incurable disorder [in which] ideas of persecution and of grandeur...were always secondary to a preceding acute or primary mental illness" (p. 2).

That being said, there was continual debate and disagreement as to the classification of paranoia within mental health disorders. Though there were some theorists who noted more mild, subclinical forms of paranoia, the psychiatric community rejected this perspective and regarded paranoia as a sign and symptom of the early stages of schizophrenia (a diagnosis long attributed to purely biological etiology and therefore incurable).

In 1911, Sigmund Freud published *The Case of Schreber*, an in depth case study where he posited a new theory of delusion formation that distinguished paranoid delusions from other delusions present in schizophrenia. Freud also raised fundamental etiological questions between paranoid psychosis and paranoid personality traits in those affected (Lewis, 1970). In this paper, Freud posited that paranoid delusions stemmed from the individual feeling so significantly withdrawn from emotional contact with others that persecutory delusions are formed as a paradoxical result of the mind's self-curative tendency to attempt to relate to other people . Freud's publication had a significant effect on the understanding of persecutory delusion formation and veered the field away from a purely biological conceptualization.

Definition

According to the *Gale Medical Encyclopedia* (Carson-De-Witt, 2013), *paranoia* is defined as "a symptom in which an individual feels as if the world is 'out to get' him or her...causing intense feelings of distrust, and can sometimes lead to overt or covert hostility" (p. 841). Individuals that experience PS, except during times of extreme stress, are usually in touch with reality, except for their misinterpretations of others' motives and intentions (p. 843).

Though this definition encompasses the outcome of paranoid thinking, a significant amount of research regards paranoia as a process with phases of development having a systemic link between the current life situation or events during this process (Bentall, Backwood, Corcorn, Howard & Kinderman, 2001; Bullimore, 2012, p. 78). This seemingly slight difference in the overall conceptualization of paranoia has serious implications in further understanding and treating individuals whose mental illness has paranoia as the primary symptom[4].

Psychosocial Etiology

A systematic review of the research and theories of persecutory delusions as of 2001, a group of investigators found that purely genetic etiology was not empirically founded (Bentall, Blackwood, Corcoran, Howard & Kinderman, 2001). In terms of etiology, Bentall, et al. (2001) found that although there may be genetic factors to this sort of cognitive abnormality, most often clinical paranoia stems from early relationships which have impacted the social-cognitive development in these individuals. There is a significant amount of research and evidence that individuals who present with paranoid symptoms experienced an abnormal frequency of adverse events in their past such as discrimination and victimization (Bentall, et al., 2001; Bentall, Dayan, Moutoussis & Williams, 2007). Therefore, these individuals often perceive aversive interpersonal outcomes regardless of the current situation because of the tendency for all humans to rely on recollections of the past were predicting the future, i.e. availability heuristics (Bullmore, 2012; Edens, Marcus & Morey, 2009). Furthermore, there is a significant amount of

[4] Psychiatric classification of this symptom is diagnostically associated as a primary symptom of a variety of mental disorders including: Paranoid Personality Disorder; Delusional Disorder, Persecutory Type; Schizophrenia; Bipolar I or Bipolar II Disorder with Psychotic Features; and Depressive Disorder with Psychotic Features; Personality Change Due to Another Medical Condition, Paranoid Type; and presence of paranoid ideation in Schizotypal Personality Disorder (APA, 2013).

research noting that individuals in urban areas, those from minority populations in racist societies and/or having dysfunctional family relationship increases the risk factor of later developing persecutory delusions (Bentall, et al., 2001; Mahfouz, Parens, Scharff & Twemlow, 2007).

Stages in the Development of a Delusional/Psychotic Episode

Peter Bullimore (2012), founder of the Paranoia Network and co-creator of the Maastricht Interview for people who hear voices and experience paranoid beliefs, further elaborated on the link between paranoia and trauma as well as the phases of development of paranoid/psychotic episodes. Bullimore (2012) noted that there are three stages of paranoia: 1) trigger/thoughts, 2) feelings (threat)/conspiracy and 3) behavior/conviction. A trigger for paranoid individuals depends on their earlier dramatic experience and their current stress level. Triggers can include lack of sleep, strangers, increased responsibility and other life situations that often exacerbate feelings of stress and/or experiencing a reminder in their current life of their early dramatic experience(s) (i.e. a perfume smell, a time of day, a type of car...etc.) (2012).

These triggers can spark feelings of anxiety and being threatened by another person and thus leads to feelings of distrust. This increased hypervigilance leads to an emotional overload because, regardless of their current life situation, paranoid individuals anticipate significantly aversive future events because of their traumatic experiences of the past. Therefore, in the last phase of paranoia, these individuals often utilize socially avoidant behaviors in order to relieve their current emotional overload which they consider protecting themselves from further perceived threat.

Though these avoidant behaviors relieve these individuals of the significant emotional anguish and perceived threat in the current moment, disengagement from both reality and others

leaves the individual believing that the threat, which are often delusional, remains and that their behaviors have saved them from experiencing the type of betrayal and emotional devastation they had experienced in childhood. Therefore, avoidant behaviors further propel these individuals into what Bullimore (2012) calls the *conviction stage* where the delusion becomes fixed and impenetrable by intervention until they recover from the episode.

In summation, individuals with paranoia have had traumatizing interpersonal experience in their life, most often during childhood. The significant event(s) changes the physiological pathways within their mind and their perception of threat becomes heightened and more frequent. These individuals are constantly both consciously and unconsciously hypervigilant and fearful of experiencing the same momentous level of interpersonal fear and subsequent emotional distress they experienced within their past in their current life (heuristic availability).

Therefore when in the presence of or engaging with unknown or new people (i.e. trigger stage), these individuals experience a significant amount of distress in anticipation of being wounded or destroyed by the unknown person/people (thought/feeling stage). If this overwhelming thought and/or feeling is not addressed and squelched through reality checking within the moment, these individuals withdraw from the situation and isolate thereby wherein their thoughts/feelings about the situation or person usually becomes even more exaggerated and persecutory delusions are formed (conviction stage).

Treatment

As noted in the introduction chapter, there is a significant dearth of empirical research of effective long-term treatment for individuals who experience clinical paranoia, psychotherapeutic, psychotropic, or otherwise (Edens, Marcus, & Morey, 2009; Chou, Dawson Grant, Hasin, Pickering, Ruan & Stinson, 2004). That being said, purely medicinal interventions

have been found to be limited and temporary in effectiveness (Karon, 1989). In terms of non-medicinal interventions, some research has shown that cognitive-behavioral and psychodynamic therapy can be effective in diminishing the frequency and severity of the impact of persecutory delusions (Collip et al., 2013; Bebbington, Dunn, Emsley, Fowler, Freeman & Kuipers , 2013; Karon, 1989; Ridenour, 2014). Regardless of treatment type, research on these interventions has noted both the importance and difficulty in establishing a therapeutic alliance with this population.

Therapeutic Alliance

Broadly speaking, the *therapeutic alliance* (also known as *working alliance, alliance, therapeutic relationship, working relationship, helping alliance, and therapeutic bond)* refers to the collaborative and affective bond between therapist and client. There has been a significant amount of research regarding the components of the therapeutic alliance and its direct correlation to positive treatment outcome since its first conceptualization in early psychoanalytic theory (Davis, Garske & Martin, 2000). Research has shown that a therapeutic alliance is an essential feature to successful treatment of individuals with mental illness across a variety of different diagnoses and intervention types including but not limited to: behavioral therapy, cognitive therapy, gestalt therapy, and psychodynamic therapy (Horvath & Luborsky, 1993).

A common factor amongst these therapeutic interventions is the requirement of the client to trust not only in the therapeutic process in order to establish and maintain engagement, but also the particular clinician with whom they are working. The essential interpersonal and intrapersonal factor if not initially established and continually maintained by the clinician will lead to clients pre-emptively disengaging with the therapy (Bender, 2005; Creaser, Howard, Luctgert, Saltzman & Roth, 1976; Horvath & Luborsky, 1993). Though the importance of this

component to positive therapeutic outcome has been greatly researched and supported, there is a limited amount of research regarding teachable clinical techniques in establishing and maintaining a therapeutic relationship with clients who experience PS (Horvath & Luborsky, p. 567, 1993).

In a meta-analysis of the empirical research on client and therapist factors that influence the alliance, conceptualization of the alliance, and its main components of the therapeutic alliance in psychotherapy, Horvath and Luborsky (1993) evaluated and synthesized their findings and discussed possible clinical implications. They identified three components to the therapeutic alliance: *Tasks, goals* (outcomes), and *bonds*. *Tasks* refer to the behaviors and understanding of the therapeutic process within the framework of the particular intervention. Both the clinician and client must perceive these *tasks* as relevant and efficacious, as well as accepting each of their responsibilities in the therapeutic process (1993, p. 563). Furthermore, the client and clinician must wholeheartedly agree and value the particular *goals* that are the target of the intervention.

The concept of *bonds* refers to mutual trust, acceptance, and confidence between the client and clinician that is essential in initially engaging and maintaining the client in treatment (Horvath & Luborksy, 1993, p. 563). Horvath and Luborsky (1993) noted that "the presence of a strong alliance helps the patient deal with the immediate discomfort associated with the unearthing of painful issues in therapy and makes it possible to postpone immediate gratification by using both cognitive (i.e., endorsements of the tasks of therapy) and affective (i.e., personal bonds) components of the relationship" (p. 564).

Along with synthesis of the main components of the therapeutic alliance, Horvath and Luborsky (1993) found that that there are two critical phases that need to occur in the development of a therapeutic alliance. During the first phase the therapist must establish trust

with the client and cultivate an affective bond. This bonding phase takes place within the first five sessions and peaks during the third session (p. 567). Horvath and Luborsky (1993) also noted a significant amount of evidence related to a poor therapeutic outcome if a bond was not initially developed (p. 568).

Clients who experience clinical paranoia are regarded as the most difficult population to establish a therapeutic alliance due to their interpersonal distress and hypersensitivity to criticism (Dominguez, Knappe, Lieb, Schruers, Schutters, van Os & Wittchen 2012; Martens, 2004; Thewissen et al., 2011). Several studies have shown that paranoia may be related to social phobia due the common experience of perceived interpersonal threat (Bender, 2005; Bredenpohl, Kesting, Klenke, Lincoln & Westermann, 2013; Collip et al., 2013; Edens, Marcus & Morey, 2009; Chou et al., 2004; Schutters et al., 2012). Considering the triggering nature of engaging in a new and intimate interpersonal relationship with a clinician during treatment, clients who experience paranoia engage in avoidant behaviors and disengage from treatment once a threat is perceived.

Though there is a dearth of research within this area, some literature expounds on the underlying needs that this population has during the bonding phase of the therapeutic alliance as well as how clinicians can make best use of themselves in order to traverse this barrier. Overall, Escher (2012) notes that individuals who experience PS need to feel safety, trust, normalization of their experience, and indications that the therapist is interested in them as a whole rather than merely a case study (p. 45). In that same light, Karl Rogers (1980) noted that "A schizophrenic ceases to be a schizophrenia when he meets someone by whom he feels understood." (p.152). Since individuals with PS are hypervigilant and hypersensitive towards external criticisms and prone to low self-worth, it is imperative for clinicians to explicitly, implicitly, and consistently

convey to individuals with PS that their work with their therapist is collaborative and that they are seen as a whole person rather than merely a constellation of problematic symptomatology (Escher, 2012; Horvath & Luborsky, 1992).

In discussing the needs of individuals with PPD, Benjamin (1993) refers to this dynamic as "verbal holding/comforting" where the therapist consistently conveys accurate empathy, genuine affirmation of accomplishments, and understanding support to their client (p. 337). Furthermore, concerning strategies in establishing trust and safety, some literature notes the importance to consistently convey, accept and affirm that their perception (delusional or not) are experienced as real to the individual (Bender, 2005; Benjamin, 1993; Escher, 2012). That being said, it is often noted in literature that there is an ongoing need for further research on the treatment and strategies in traversing and forming a therapeutic alliance with this population (Bender, 2005; Edens, Marcus, & Morey, 2009; Chou et al., 2004; Schutters, Dominguez, Knappe, Lieb, van Os, Schruers, & Wittchen 2012; Thewissen et al., 2011).

Humor

Merriam-Webster defines *humor* as "that quality which appeals to a sense of the ludicrous or absurdly incongruous; the mental faculty of discovering, expressing, or appreciating the ludicrous or absurdly incongruent or something that is or is designated to be comical or amusing" (humor, n.d.). A frequently used, reliable, and validated measure for humor called the Humor Styles Questionnaire (2003) categorizes humor into four interpersonal styles: *self-defeating* (self-directed and maladaptive), *aggressive* (other-directed and maladaptive), *self-enhancing* (self-directed and adaptive), and *affiliative* (other-directed and adaptive). *Self-defeating humor* involves significantly self-disparaging jokes or comments made at the expense of the employer in order to gain approval and/or attention from others (p. 54). *Aggressive humor*

refers to the use of "sarcasm, ridicule, derision...or disparagement humor" towards another person (p. 54). Both of these maladaptive humor styles are noted as being malignant towards the self or others, particularly when used by a therapist during treatment (2003).

In terms of more benign and healthy uses of humor, *self-enhancing humor* is regarded as closely allied to coping humor in which the individual "demonstrates amusement with the incongruities of life...and maintains a humorous perspective even in the face of adversity (p.53) Lastly and most relevant to this study, *affiliative humor* refers to a humor style that is "an essentially non-hostile, tolerant use of humor that is affirming of self and others and presumably enhances interpersonal cohesiveness and attraction" (p. 53). While the use of *self-defeating* and *aggressive* styles of humor is often associated individuals with low interpersonal competence and success, lower self-esteem, and lower personal well-being, *affiliative* and *self-enhancing* humor styles have been reported as having more positive interpersonal and intrapersonal outcomes (Martin et al., 2003; McCosker & Moran, 2012). In particular, individuals who use *affiliative humor*, as opposed to no humor or maladaptive humor styles, have been found to have higher self-esteem, more resilience under stress, an increased capacity to face problems rather than avoiding, lower rates of anxiety and depression, and high overall interpersonal competence (Martens, 2004; Martin et al., 2007; McCosker & Moran, 2012; Panichelli, 2013; Sultanoff, 2014).

In terms of humor styles utilized in therapeutic treatment by clinicians, a humorous attitude has been defined as "a form of mental play with a serious purpose, to combine self-understanding with the emergence of forbidden or unacknowledged thoughts in socially acceptable manner" (Richman, 1996). Historically, some of psychological literature concerning the potential dangers and issues with using maladaptive humor styles by a clinician in the

therapeutic process (Kubie, 1971). Therapists' use of maladaptive humor styles with clients can b regarded as a defensive coping strategy against the clinician's discomfort and may elicit significant interpersonal risk that can often lead to a rupture in the therapeutic relationship (Dewane, 1976). What seems to be missing from these outdated studies that regard humor as dangerous in session is a further exploration into the use of adaptive and benign styles of humor, as well as their differing effects on the therapeutic process and relationship. That being said, there is some more current research that notes the possible positive effects of using *affiliative humor* therapeutically (Edwards & Martin, 2014; Gray, Larsen, Martin, Puhlik-Doris & Weir, 2003; Jacobs, 2009; Kuiper & Maiolino, 2014; McCosker & Moran, 2012; Meyer, 2007; Panichelli, 2013).

Use of *affiliative humor* by clinicians when working with individuals of various mental illnesses have been shown to have a positive effect as it can serve as a means of adding levity and gaining perspective on a particular situation or feeling that is overwhelming (i.e. observing ego) (Freud, 1928; Poland, 1971). Moreover use of humor by a clinician can serve as a means of modeling more mature and productive ego functioning that, over time, the client can internalize and use during times of stress (Rosenheim, 1976). Additionally, though there is no empirical evidence to support this assertion, there are some psychologists who warn against using more subtle and ambiguous humor with paranoid clients due to the increased possibility of misinterpretation and injury (Dewane, 1978; Rosenheim 1976). That being said, some clinicians note the essentiality for therapists to utilize humor when working with clients who experience PS as a means of demonstrating warmth, genuineness, acceptance, and traversing and repairing inevitable alliance ruptures (Martens, 2004; McWilliams, 2011)

Considering the fact an individual who experiences PS is willing to engage in a new and unknown interpersonal relationship with a therapist due to their desperation for relief from their symptoms, it stands to reason that at least for the first five sessions (i.e., the bonding phase in alliance development) during which trust is established, the client is open and desiring of establishing a therapeutic alliance, particularly a bond. Though also limited, there is some empirical evidence that indicates that affiliative humor can contribute to the formation and maintenance of a therapeutic alliance (Gelkopf, 2011; Meyer, 2007; Panichelli, 2014; Sultanoff, 2014).

Utilizing affiliative humor to traverse the barriers and interpersonal difficulties inherent in working with paranoid clients has multiple benefits. Affiliative humor has been shown to reduce interpersonal tension between clients and therapists and also increase client's capacity to face problems while maintaining the therapeutic relationship (Panichelli, 2013). Additionally, affiliative humor conveys openness to experience, warmth, and positive regard for others which is often interpreted as acceptance and sincerity, which are essential characteristics and feelings for a therapist to convey particularly while working with mistrustful clients (Martin, 2007).

Furthermore, affiliative humor "can relax rigid defenses, promoting communication with unconscious processes, widening the repertory of available coping options and strengthening ego" (Gelkopf, 2011, p. 3) which is essential with working with this interpersonally hypervigilant and deeply fearful clientele. Lastly, as noted before, dropout rates for clients with paranoid symptomatology is a significant issue, but in a study exploring the use of affiliative humor and its effects on the therapeutic alliance, Meyer (2007) found that therapists who did not use affiliative humor had twice as many clients terminate early as opposed to therapists who did.

As noted previously, our current understanding of paranoia as a shifting and dynamic experience depending on level of stress or triggers the individual experiences in the moment. As Bullimore (2012) noted, there are three stages of paranoia, where the last stage (conviction) is when the persecutory delusion becomes fixed and the clients ability to discern reality from fantasy diminishes. When in the conviction stage, individuals who experience persecutory delusions frequently isolate and avoid interpersonal contact. Therefore one can assume that when an individual who experiences paranoia initially engages in therapy they are in either the first or second stage of paranoia where intervention and interpersonal communication can be effective. Therefore, the therapeutic benefits of using affiliative humor remain if the individual continues to engage with treatment. If the client is reaches the "conviction stage" and is still attending sessions, and if spontaneous humor occurs, the clinician's intervention may be misinterpreted and taken as an insult. However, this misinterpretation will not only inform the clinician about the significant level of stress their client is under but also indicates that an increase of vigilance with the use of self for that session is warranted.

Implications for Research and Summary

Considering the anecdotal evidence and literature concerning the potential for use of affiliative humor by clinicians in establishing and maintain a therapeutic alliance with clients who experience PS, therefore empirical research is warranted. It is the intension of this study to explore clinicians' experiences in using this strategy in session with this population as a means of further exploring the potential of this assertion.

CHAPTER III

Methodology

Research Design

This qualitative, exploratory study focused on the potential effectiveness of counselors' use of affiliative humor in psychotherapy with individuals who experience paranoid symptomatology. Thus, the overarching research question was: "*What are clinicians' experiences and perception of using affiliative humor in fostering a therapeutic alliance with individuals who experience clinical paranoia?"*

A qualitative method comprised of semi-structured interviews with open and closed-ended questions was chosen for a variety of reasons. Utilization of semi-structured, open-ended questions was chosen in order to elicit spontaneous and in-depth responses about clinicians' techniques and experiences. Furthermore, a qualitative method was utilized given the lack of research on this topic and the unique nature of its purpose (Chou et al., 2004). One pertinent reason for the minimal previous research has to do with the frequent mistrust and paranoia clients experience towards counselors, and in turn, often result in short-lived therapeutic relationships (Edens, Marcus, & Morey, 2009). Therefore in order to gather more information about potentially effective treatment techniques and interventions, one must investigate the experiences and narratives of experienced clinicians who have worked with this population.

Sample

Recruitment of the sample. The methods for recruiting participants for this study centered on networking within a particular agency. A major reason for choosing to recruit from

this particular agency had to do with the many satellite offices in which clinicians practice outpatient therapy with a very diverse population, depending on the particular site. A second major factor had to do with the significant amount of outpatient clinicians as well as my connections to the agency and access to their email server. Recruitment of 12-15 participants through this avenue was most likely fruitful and feasible.

I first e-mailed a copy of my thesis proposal and a copy of the recruitment letter (Appendix A) to the clinical director of the agency for his review. After receipt of the agency approval and the letter of approval from the Smith College School for Social Work Human Subjects Review Committee (see appendix B and C approval letters), the clinical director forwarded the proposal and recruitment letter in an email to every outpatient clinician within their agency. Clinicians who met the inclusion criteria (described below) and who had the time and interest to participate in this study then contacted me through email to set up a time and place to participate in the study.

Inclusion criteria. The sample for this study included mental health counselors (i.e. psychiatrists and individuals with a Master's and/or Ph.D. in a counseling field) who had been practicing individual therapy (in particular cognitive, behavioral, psychodynamic, or gestalt therapeutic frameworks) for at least 5 years. Furthermore, participants had to have worked with at least two clients who have had a diagnosis with paranoia being the foremost symptom and who engaged in therapy for at least 5 sessions. Diagnoses included within this client criteria are as follows: Paranoid Personality Disorder; Delusional Disorder, Persecutory Type; Schizophrenia; Bipolar I or Bipolar II Disorder with Psychotic Features; and Depressive Disorder with Psychotic Features; Personality Change Due to Another Medical Condition, Paranoid Type; and presence of paranoid ideation in Schizotypal Personality Disorder. Though a

diagnosis of traumatic brain injury and substance induced psychosis feature paranoia as a common and primary symptom, these diagnoses were excluded from this study due to the ideology being primarily physiological and chronic and not trauma-induced.

Ethics and Safeguards

Confidentiality. In order to insure confidentiality, names and identifying information were stored separately in a locked briefcase. At the beginning of the interview participants were reminded to exclude any identifying information regarding their clients. A numerical code was assigned to each audiotape and transcript. After the interview was completed, the recordings were transcribed.

Interviews were audio taped on a digital recorder. Field notes were also taken during the interview. The auto recording and notes were kept on an encrypted flash drive that was stored in a secured and locked space. A professional transcribed the recordings (see Appendix D). All research materials including recordings, transcriptions, analysis, and consent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secure until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. All participants were informed that they were able to drop out of the study any time before during or after the interviews until April 1st when the data analysis began.

Risks. There were no risks associated with participation in this study as the interviewees were mental health professionals. No compensation for participation was provided due to the limited monetary resources.

Benefits. Both the researcher and participants had potential benefits by engaging in this study. Firstly, this research project directly benefits this researcher as it is a degree requirement

for a Master's in Social Work. This researcher acquired additional information for future clinical work with individuals who experience paranoia from the experiences gathered from the participants in this study.

Data Collection

Informed consent. Before the interview took place, two copies of the consent form were distributed. One copy was signed and kept on file. One copy was given to the participants for their records. After consent forms were returned, participants were contacted by phone or email in order to schedule a time, date, and location for the interview that was mutually convenient for both the participant and researcher. Interviews lasted between 30 and 45 minutes and were audio recorded. Interviews took place in person within an environment that assured privacy and convenience to the participant.

Instrument. Narrative data was gathered via self-developed, semi-structured interviews comprised of open and closed ended questions (Appendix E). Demographic questions gathered information about each participant's age, race and ethnicity, gender identity, and geographic location of practice. The rest of the interview involved open ended questions regarding participants' experiences working with clients who have paranoid symptomatology (i.e. "How many clients have you worked with that have paranoid symptomatology" and "For how long did you work with them? And "Tell me about the beginning of your work with them?"). These open-ended questions were self-developed in order to gather in-depth, narrative responses about each participant's unique experience in working with this population. After data regarding the clinicians' general experiences in working with and bonding with this population, participants were asked both closed and open ended questions regarding their opinion and clinical use of humor (i.e. " Have you ever used affiliative humor in your work with clients" and "How about

using affiliative humor with paranoid clients"?). Open and close-ended question regarding the use of humor, in particular affiliative humor, were included in order to obtain specific answers about the particular focus of this study. Definitions of paranoid symptomatology and affiliative humor were given to the participants during these interviews.

Data Analysis. Data analysis was done by looking for patterns and trends in responses across participants. After which, these responses were reviewed in comparison to the research presented in the literature review. Furthermore, responses that touched on concepts that were not touched upon in the literature review were discussed. The discussion of this analysis will be reported, as well as the implications for future research and social work practice, in the last chapter. The following chapter will report the patterns and trends found in the responses, as well as provide some direct quotes from clinicians that exemplify answers.

CHAPTER IV

Findings

This chapter is a presentation of the findings from fourteen semi-structured interviews with licensed, practicing mental health clinicians who have treated at least one client with paranoid symptomatology as the prevailing diagnosis for at least five sessions. All participants have been practicing for at least five years post-Master's degree and currently work as individual therapists in a community-based mental health agency in a low-income urban area in New England.

In order to clarify any ambiguity around definitions regarding *paranoid symptomatology* and *affiliative humor*[5], all interviewees were given definitions before eliciting responses. For further clarity, examples of diagnoses where paranoid symptomatology dominated the clinical picture were also provided. Furthermore, clinicians were informed that past clients with paranoid symptomatology rooted in diagnoses such as Traumatic Brain Injury and Substance-induced Psychosis should be excluded from their responses. Of particular note, all participants disagreed that clients with paranoid symptomatology did not have the capacity for humor. Furthermore, all clinicians utilized affiliative humor with all clients, including those with paranoid symptomatology.

The interview guide contained of four sections: 1) demographic characteristics of the sample clinicians, 2) history of engagement with paranoid clients, 3) initial treatment strategies, and 4) perception and experience in using affiliative humor

[5] Please see the *Interview Guide* in Appendix E for the exact definitions given to participants.

Demographic Characteristics of the Sample Clinicians

Participant Demographics: The sample for this study was comprised of 12 licensed social workers: 8 females and 4 males[6]. All participants work in the same urban community-based mental health agency in Western Massachusetts. Participant ages ranged between 34 and 68, with 7 under 50 years old and 5 over 50 years old. One person self-identified as African-American, another as Middle Eastern, and the remainder (n= 12) identified as having Anglo-European heritage. Participants identified their religious affiliation as: Catholic, Protestant, Universal Unitarian, Jewish, and no-affiliation/not practicing.

Clinicians' clinical background and experience: The following section offers information pertaining to clinicians' clinical background and experience with working with paranoid clientele. Most clinicians (n=11) responded to this question with absolute numbers, but one interviewee had difficulty recalling on the spot answered "at least 20 years". The range of experience practicing social work was anywhere from five to 30 years, with six participants reporting that they had more than 14 years of experience. (See Table 1)

[6] Two interview participants (PT2 and PT13 - a female and male respectively) were excluded from data analysis because they reported not having experience building a dyadic therapeutic alliance with clients with paranoid symptomatology due to their primary clinical experience as mental health agency administrators.

Table 1
Demographics

n= 12	Age Range:	<45 n=4	45-50 n= 2	51-60 n=4	>61 n=4
Gender					
	Female	2	1	2	3
	Male	2	1	1	-
Ethnicity					
	African American	-	-	1	-
	European-American	3	2	3	3
	Middle Eastern	1	-	-	-
Religion					
	Christian	1	1	3	1
	Jewish	-	-	-	1
	None	3	1	-	1
Years in Practice					
	5-10	4	1	1	-
	11-19	-	1	1	1
	>20	-	-	1	2

History of Engagement with Paranoid Clients

After clinicians were given the definition of paranoid symptomatology, as well as the possible corresponding diagnoses within the DSM-IV-TR, they were asked about their history of engagement with paranoid clientele. This section included two close-ended questions: 1) At least how many clients have you worked with that have paranoid symptomatology? And 2) How long did you work with them? What was your longest therapeutic relationship?

Answers to both questions ranged from exact numbers to estimations with statements such as "At least # clients/years" And "More than # clients/years". More participants (n=10) were able to recall exact numbers when asked about their longest therapeutic relationship, whereas only half of the interviewees (n=6) were able to remember the exact number of paranoid clients served. The difficulty in recalling exact numbers of clients whom fall under the inclusion criteria initially given is most likely due to the setting in which these clinicians work. Each clinician at this agency has around 75 clients on their caseload at one time and diagnoses initially given during intake are often inaccurate and change fairly often.

Responses to the number of clients with paranoid symptomatology that participants had engaged with ranged from 4 to "over one-hundred". That being said, the individual whom responded "over one-hundred" has only been practicing for 5 years, but specializes in treatment of substance abuse. Therefore, most likely this individual included clients whom have substance-induced psychosis and though this diagnosis was noted as being excluded from this particular study, this individual might have either been confused by my phrasing or the exact etiology of the paranoid clientele she had worked with. The majority of interviewees (n=8) reported having engaged with more than 20 clients with paranoid symptomatology of at least 5

sessions since obtaining their Master's. The remaining individuals reported having seen 4, 10, 10, and 15 clients with paranoid symptomatology.

In recalling their longest therapeutic relationship they had engaged in from the aforementioned clients, participants' responses ranged from 1 year to "over 3 years". With a couple of exceptions, the more experienced clinicians reported longer therapeutic relationships. For example, participants who had reported having more than 50 paranoid clients and over 14 years clinical experience (n=6) had reported at least 2 years as their longest therapeutic relationship. The exceptions include the aforementioned Participant 5 and Participant 9. Participant 5 reported their longest therapeutic relationship as a year and a half, despite reporting having served over 100 paranoid clients. That being said, Participant 9, having seen only 10 clients with paranoid symptomatology and having 5 years post-Master's experience, responded that she had a therapeutic relationship that lasted 3 years (the only interviewee with less than 20 paranoid clientele and less than 15 years clinical experience who reported as such). These two responses in comparison to the rest of the data indicates that, overall, years of experience and number of paranoid clients served post-Master's may indicate an ability to engage paranoid clientele in longer-term treatment . (See Table 2)

Table 2

Participant Responses

	# of Paranoid Clients	Years in Practice	Longest Therapeutic Relationship (in years)
PT1	15	30	>3
PT3	>20	10	2
PT4	>50	>20	3
PT5*	>100	5	1.5
PT6	10	7	1
PT7	75	28	2.5
PT8	>20	5.5	2
PT9	10	5	3
PT10	4	5	1
PT11	>30	17	>3
PT12	>25	15	3
PT14	50	14	2

*PT5 specializes in treatment for individuals with comorbid substance abuse diagnosis. Therefore although I specified exclusion criteria of substance-induced psychosis as a diagnosis, there is a possibility that this clinician was unsure as to the etiology of the paranoid delusions in her clinical experience.

Initial Treatment Strategies

Clinicians were asked two questions regarding their strategies in traversing the first five sessions with paranoid clientele in terms of establishing trust and a bond. These questions were: 1) What strategies did you use to navigate their mistrust and paranoia during the first 5 sessions? and 2) What, if anything, have you learned about strategies with navigating establishing trust and a bond since first starting?

In response to the first question, most participants' (n=13) initial strategies revolved around establishing a safe, empathic, and understanding environment and relationship with the clients. Participants noted particular strategies in navigating these overall goals within the first five sessions including: not challenging their client's delusions (n=7), setting clear boundaries for their work together and explaining what to expect (n=5), and focus on building a relationship between themselves and their client (n=7). Many clinicians' answers incorporated at least two of the three aforementioned strategies, but PT10's response touched on all three:

> Definitely working on just building a rapport and making them feel comfortable in the office, even in regards to confidentiality. Just a general rapport. Making them feel comfortable, often not even talking therapeutically, just trying to build common ground. Finding what their interests were, and talking about things that interested them, so that it didn't feel quite as therapeutic to begin with.

Two participants stated that they utilize forms of reality testing and further exploration into the delusions during the first five sessions. That being said, one of these two participants noted that this form of reality testing during the bonding phase of therapeutic alliance was a means of assessing how fixed the delusions were rather than a direct challenge of their beliefs.

This interviewee also mentioned trying to "establish an alliance in areas that were not paranoid" as a coinciding strategy during the first five sessions.

In response to what the participants have learned about navigating the first five sessions since starting as a clinician at least 5 years ago, the two aforementioned participants both noted that they need to be more empathically attuned, know when to push and when to back off and engage in normalizing their experience. Half of the clinicians (n=6) mentioned the importance of cultivating trust within the first 5 sessions, noting the importance of remaining genuine, consistent, honest, and non-judgmental. One respondent with over 20 years clinical experience explicated on how genuineness impacts the paranoid client's feeling of safety and subsequent ability for therapeutic engagement:

> Basically, the key is being real and genuine. I really think, especially people with mood disorders and people with mental illnesses, a lot of them are very perceptive. They're very intuitive. When you get them out of their paranoid place, they pick up whether you're real and genuine or whether you just think they're crazy or whatever. If you're real and genuine to them, they will feel safer and they'll be able to work with you.

Furthermore, participants (n=4) stated that they had learned to not challenge their client's belief system within the first 5 sessions. In that same light, all interviewees (n=12) indicated the importance of practicing patience and vigilance to the use of self as well as the importance of meeting the client where they are psychologically.

Perception and Experience Using Affiliative Humor

Clinicians were asked the following question: “Some literature notes that clients with paranoid symptomatology do not have the capacity for humor, what are your thoughts on this in

your experience?" The clinicians unanimously (n=12) disagreed. That being said, some clinicians (n=7) noted that although they disagree that all paranoid clients do not have the capacity for humor, some do not recognize humor at different points depending on the delivery and/or subject of the joke and the intensity of symptoms of that particular day. The remaining five participants "strongly" or "absolutely" disagreed. One participant stated that ability to use humor with this population takes time and a therapeutic alliance must first be established:

> No, I disagree. However, I can certainly say that to get to this person I was just referring to that I've been working with for years. I think it has been harder to have maybe some humor, when, especially at the beginning before the therapeutic alliance has really been developed and deepened because to get to a place of pure good humor, anyway. I mean that's fun, that's a vulnerable place to be in a fun place. When one is paranoid and certainly delusions you want to get to some place of pure humor. I think it's difficult when there's not some safety and trust involved but I disagree that there's no good sense of humor in people I've worked with. I find that they can have a really great sense of humor actually.

Prior to asking the final question, the definition of affiliative humor was given, along with three other humor styles developed by Martin et al. (2003). Two close-ended questions about their use of humor in therapy were presented. Furthermore, a third open-ended question to further explore their experiences in utilizing affiliative humor with paranoid clientele. These three questions were presented as follows: Do you use affiliative humor in your work with any of your clients? How about with paranoid clients? If you have, what was your experience?

Respondents (n=12) all stated that they utilize affiliative humor with all of their clients, and the majority (n=11) also reporting having utilized this type of humor with paranoid clientele. The one participant excluded here stated that they do use affiliative humor with clients with paranoid symptomatology, but only depending on their level of stability. In reflection of what he meant by "stability", this individual added:

> If they're stable, its perceived well. It makes them feel normal...No, I use humor especially with paranoid people but again once they're stable and stable doesn't equal elimination of symptomatology, stale means acceptance or, you know, medication to the appropriate level.

The last open-ended question was asked to further explore the clinicians' experience in using affiliative humor with clients with paranoid symptomatology in particular. Most participants (n=7) reported that their utilizing this humor with this population doesn't always work, but that repairs are always possible and this sort of misunderstanding has never led to a rupture in the therapeutic relationship. Furthermore, many respondents (n=6) noted the importance of using humor cautiously and mindfully. One clinician went into depth about not only her experience in using affiliative humor but the purpose it has served in her work therapeutically with this population:

> When it’s non-threatening, which is the definition in and of itself, I have used it. I have received some glances that clearly say, 'Ooh, that' didn't work', because okay that wasn't funny. Yes, I have used it when I have some opposition. However, I use it with everyone because I think having humor whether it’s in therapy or in relationship keeps things light, because as we all know...humor can be used in so many unhealthy ways...I use it in treatment, he or she that laughs at themselves

never runs out of things to laugh at. To be able to use just a light humor, not only in ourselves, but just in life and experiences. I do use it with all of my clients, including psychotic clients. I find it helpful and I find it effective and I think its speaking of establishing the bond and trust within. The more difficult with psychotic clients is when we can bring some lightness and laughter and its non-threatening, it can only increase the relationship.

Along with utilizing as a means of opposition or cultivating a relationship with their clients, other participants noted that affiliative humor has had a positive therapeutic effect in terms of facing delusions, demonstrating understanding and acceptance, and making the client feel "normal" or "human". One clinician in particular stated that the use of affiliative humor has served him as a means of assessing their capacity for humor as well as a way of joining with the client during the initial stages of the therapeutic alliance:

> In the initial stages, I'll use humor that has nothing to do with either one of us, just something that would be funny, but not necessary have anything to do with either one of us, or anybody. Just something funny, to test the waters. Just to see how they react.

Summary

Major findings gathered from twelve interviews with experienced mental health clinicians concerning their clinical experiences in working with clients who experience PS have been presented in this chapter. Significant findings were predominately derived from the open-ended more exploratory questions in the last two-thirds of the interview. The following chapter will explore the interpretations of these findings in comparison with the current research mentioned in the literature review. Additionally, strengths and limitations to the methodology of

this study will be addressed, as well as implications of these findings to the future of social work practice and research.

CHAPTER V

Discussion

The underlying question that propelled the focus of this study is as follows: "*What are clinicians' experiences and perception of using affiliative humor in fostering a therapeutic alliance with individuals who experience clinical paranoia?"* In regards to the findings of this exploratory study, all of the clinicians not only noted having utilized affiliative humor when working with clients who experience PS, but that it is a technique with which they have found fruitful with this population in particular. This finding directly contracted literature of Kubie (1971) and Dewane (1976) who regarded individuals who experience PS as not having a capacity for humor. Additionally, the findings of this study have further confirmed and paralleled previous research in regards to the various therapeutic uses and positive effects with using affiliative humor with clients who experience PS.

The major sections of this chapter are presented in the following order: 1) key findings: compared and contrasted with the previous literature, 2) implications for social work practice, 3) Strengths, limitations, and biases of the study in terms of its design and implementation and researcher bias, and lastly 4) recommendations for future research.

Key Findings

Strategies in Establishing a Therapeutic Alliance with Paranoid Clientele

In regards to the goals and effective strategies in maintaining clients with PS engaged in treatment and establishing a therapeutic alliance, participant responses were supported by the literature reviewed previously (Benjamin, 1993; Escher & Romme, 2012). One hundred percent

of the interviewees noted the importance of utilizing strategies that would establish a safe, empathic, and understanding therapeutic environment when working with this population in particular. In that same light, all clinicians in the study noted the importance to keep particularly vigilant to their use of self when working with this population. Benjamin (1993) referred to this as "verbal holding" in which the therapist consistently engages in "accurate empathy, genuine affirmation of accomplishments, and understanding support" in order to establish an environment and relationship similar to mother and child where the client with PS can feel safe and trust the therapist in order to participate in treatment (p. 336). Escher (2012) further noted the essential feature of consistently establishing an environment of safety and trust when working with clients with PS in particular in order for the individual to be able to open up and engage in treatment (p. 46).

In terms of specific techniques utilized while working with clients that experience PS, over half of the clinicians noted the importance of not challenging their clients' beliefs and delusions during this first phase of treatment which was noted as imperative in the current literature (Bender, 2005; Benjamin, 1993; Escher & Romme, 2012). Additionally, over half of the participants stated that during the first phase of treatment a focus on the interpersonal relationship between themselves and clients with PS was critical in order to enhance trust and solidify the therapeutic bond. As previously noted, both Horvath and Luborsky (1992), Rogers (1980), and Escher and Romme (2012) stated the importance for clinicians to regard and convey to this client population that they were seen as more than a constellation of symptoms in order to foster a therapeutic alliance.

Lastly, almost half (n=5) interviewees stated that they have learned the importance of setting clear boundaries and conveying transparency of treatment procedures when working with

this population. Although these ideas were not explicitly stated in the literature reviewed, Escher and Romme (2012) noted the importance for clients with PS to feel safe within the therapeutic relationship therefore this sort of transparency in what the client should expect within the therapeutic relationship as well as treatment most likely lends to a greater feeling of safety and trust.

Affiliative Humor and Treatment

The literature of the 1970s stated that individuals with PS do not have the capacity for humor. One hundred percent of interview responses contradicted this outdated literature. Additionally, all participants (n=12) noted that using affiliative humor with clients with PS have led to positive or productive outcomes and a powerful tool in traversing a therapeutic alliance with this population. This finding supported the assertion McWilliams (2013) made in which she recommended clinicians to utilize as an "indispensible tool in therapy" when working with clients with PS (p. 227).

In terms of the therapeutic uses, affiliative humor can serve when working with clients who experience PS, literature has noted: a means of establishing a bond and relationship, demonstrating authenticity, providing non-threatening opposition, and testing reactions (Martens, 2004; McWilliams, 2013; Panichelli, 2013). Participant responses regarding their use of affiliative humor with clients who experience PS echoed this research directly as the majority of the interviewees noted these exact uses.

Regarding the overall efficacy of using affiliative humor with this population, half of the participants noted the importance of utilizing humor cautiously and mindfully and how depending on the delivery and emotional state of the client, it is not always effective. That being said that same 6 clinicians stated that their use of affiliative humor, even when ineffective or

damaging, has never led to a rupture in the therapeutic alliance and repair was always successful. In a longitudinal study exploring and comparing outcomes of therapeutic relationships where affiliative humor was utilized to ones where no humor was utilized by the clinicians, Meyer (2007) found that clients were twice as likely to disengage with therapists who did not use humor at all as opposed to those who did. Furthermore, Meyer found that even misused and misinterpreted humor did not lead to relationship ruptures. Therefore, the findings of this study further support and strengthen the benefits to utilizing affiliative humor, even if misunderstood or misinterpreted as opposed to more rigid and formal use of self by a therapist in terms of maintaining client engagement.

Implications for Social Work Practice

Given the limited sample size of this study, the implications are fairly limited. However, this small sample of experienced clinicians did make it clear that there is a place for affiliative humor in treatment and work with clients with PS. These preliminary results may have implications as to the current clinical understanding of the PS population. Furthermore, considering the findings supporting the use of affiliative humor when working with clients who experience PS, using affiliative humor along with the use of self may enhance the therapeutic bond with any client population that experiences social anxiety.

Strengths, Limitations and Biases

Strengths

In terms of strengths of this study, though only few regarding the population sampled, they are nevertheless noteworthy. Though the inclusion criteria required that participating clinicians had engaged in at least 5 sessions with clients who experience PS, all interviewees reported having at least one year of a therapeutic relationship with at least one client.

Furthermore, half of the participants had over 14 years clinical experience and more than 50 clients with PS. Therefore, even though the sample obtained was limited in size, the narrative data gathered from thesis experienced clinicians enhanced the trustworthiness and credibility of the findings.

Limitations

The scope of this exploratory, qualitative study was constrained by time, access to populations, and financial restrictions. There were also several limitations affecting the results and methodology of this study. First, the narrative data obtained from this small and ethnically homogenous sample size (twelve participants) is not enough to be generalizable to the larger PS population. Furthermore, since the sample was obtained from one community mental health agency that serves a mostly low-income urban population, the manifestation of PS that these clinicians have treated could be different than individuals with PS in different socioeconomic and/or geographic areas. Lastly, the guidelines of the Human Subjects Review did allow direct interviews with PS clients as I worked in the same agency. Thus, there was a limitation because experiences and feelings from the perspective of the clients about their therapist's techniques and use of affiliative humor in establishing a therapeutic alliance is missing. Therefore, the results could be biased in that the perspective and experiences found in this study are from the lens of the clinician which is inherently subjective and therefore limited.

Additionally, all initial interview recordings were accidently deleted. The data analysis and findings were drawn from the second round of interviews with the same clinicians. Though the clinicians were as vigilant as they could be about answering the questions with essentially the same content, it is possible that since they were already aware of the interview questions that their second round of interviews could have been biased and altered slightly. Moreover,

considering the nature of the work within this agency, these clinicians are extremely over-worked and hard-pressed for time. Therefore it was necessary to design a manageable number of clear questions that clinicians could answer more concisely for the sake of time. This compressed set of questions may have led to a paucity of details in the responses.

Biases

The conception for the idea of this study stemmed from two sources which could have led to inherent biases within its implementation and findings. The first had to do with my lived experience of successfully utilizing affiliative humor in my therapeutic work and I attribute this technique to navigated positive long term therapeutic relationships with multiple clients with severe PS clients. Furthermore, when the idea was presented to some of the academics/clinicians of Smith College, these individuals not only stated that my use of affiliative humor was dangerous and not therapeutic, but that individuals with PS do not have the capacity for humor. Therefore in the conception of the questions chosen for the interview, focus towards proving my experience and disproving their misconception was a focus which could have easily detracted from the true purpose of the study. Furthermore, in terms of focus within the literature review, my secondary purpose was to empirically justify my therapeutic experience. Due to the limited time and requirements for a Master's level thesis, deeper exploration into research that contradicts my experience and perception regarding this population was constricted.

Recommendations for Future Research

Considering the findings and implications of this exploratory study, a larger scale and more in-depth empirical study is warranted in order to further explore and validate the findings. In terms of procedural and methodological differences recommending in this future research, not only including samples of more ethnically and geographically diverse population is essential, but

also recruiting a much larger sample size may add credibility. Furthermore, more exploratory questions regarding clinicians' previous training and use of supervision in working with clients with PS and use of affiliative humor should be included. Lastly, interviews with clients who experience PS would be fruitful in exploring their experience of engaging in therapy, personality factors helpful in therapists, and their experience and perception when affiliative humor is utilized by clinicians.

Summary

This thesis topic and study came to be as a happenstance when I was discussing possible thesis topics with my thesis advisor. Humor, levity, and comedy are not only tools I use in my clinical work, but a core part of my genuine personality. As an intern who utilizes relational techniques, humor inevitably was injected into the therapeutic relationship because that is how I genuinely form bonds. Additionally, I strive to be continually self-reflexive and vigilant about when, how, and for what purpose I use humor in my clinical work. That being said, I have found humor to be an indispensible tool in both my personal and professional life, intra and interpersonally, as a means of forming a genuine connection and bond with people of differing identities, life experiences, and cultures (of which I have extensive experience). Furthermore, I am also greatly interested in the philosophical tenets behind long form improvisation and the parallels there are with clinical work (i.e., the idea of accepting the reality that your "partner" or "client" presents and working within that reality rather than negating or deflecting which would end the scene in improvisation and most likely rupture the relationship therapeutically). When I shared my use of humor with all clients, particularly my success with its use with individuals with paranoid symptomatology, I was given articles stating that individuals who experience clinical paranoia "do not have the capacity for humor". And thus this study was born.

The implications of generalizing all individuals who experience or carry a diagnosis conjoined with clinical paranoia as not having the capacity of humor is significantly problematic as it indicates that these individuals do not have a *capacity* for such an innately human experience of laughter, joy, and play. Though there are differing conceptualizations and manifestations of dehumanization, this form, though more subtle, is no less problematic as it involves treating or seeing people "as not *completely* human" (Gervais, p.4, 2013). In general dehumanization occurs "when humans attributes, such as morality, self-control, or emotions are attributed to some, but not others, those people who are denied such attributes are said to be dehumanized, despite the fact that they may still be more human than animals or objects" (p.4). Although one can assert that some, if not many, individuals who experience clinical paranoia may not automatically call upon humor internally depending on their personality, defensive functioning, and coping skills, to state that they do not have the capacity is inherently dehumanizing and particularly problematic as a perspective of any clinician striving to engage these individuals in therapeutic treatment. As discussed in the literature review and throughout this thesis, the underlying cause and ongoing issues for individuals who experience clinical paranoia are rooted in single or multiple interpersonal traumas and betrayals in which are currently manifested in interpersonal misinterpretations, mistrust, severe social anxiety, and hypervigilence. Therefore, as noted before, it is imperative when working as a clinical social worker with this population to initially focus on and work towards establishing a genuine and meaningful bond in the therapeutic alliance in which interpersonal trust can be cultivated in order to traverse the goals and tasks of therapeutic treatment. To assume such a dehumanizing quality within this population due to their diagnosis, upon referral or presence of paranoid symptomatology, limits the clinician's ability to allow the individual client to manifest their true,

fully human self in the therapeutic space and therefore creates a significant barrier in establishing a genuine relationship between the two.

Furthermore, individuals who experience a lifetime of oppression (relationally, societally, and/or systemically) can present with paranoid symptomatology due to the fear and anticipation of not being seen and/or treated by unknown individuals as a full human being. In reflecting on the psychological effects on individuals in societally and systemically oppressed populations (not holding similar identities to the population in power, i.e. for the US: White, male, heterosexual, Catholic, affluent...etc.) who experience internalized and external prejudice, Gilligan (2007) stated that:

> Nothing creates more anxiety and requires more ego strength than to tolerate the anxiety or even panic that result from ignorance, uncertainty, doubts, and bafflement, and to resist the temptation to reduce the anxiety to bearable levels by resorting to crude, paranoid distortions of reality (p. 56).

Therefore, there is a great risk for the clinician to further perpetuate external oppression and stereotypes, as well as reinforcing internalized oppression and paranoia, with this particular false conceptualization. Of particular note is the well-studied fact that that males who physically present as Black are misdiagnosed with paranoid schizophrenia four times more often than any other population, despite consistent research indicating that this diagnosis occurs at the same rate (1%) among all ethnic and racial backgrounds (Metzl, 2009). Though the cause of this disturbing clinical phenomenon has significant historical roots of development which coincided with the civil rights movement, to perceive and act as if all clients (particularly Black males) who present or have been diagnosed with paranoid schizophrenia as not having the capacity for

such a human quality, as humor, may lead to further perpetuation of prejudice and dehumanization of the most currently and historically oppressed population in the United States.

In sum, the need for deeper and ongoing reflection, research, and dialectical practices is needed to continually investigate, challenge, and shift the institutional manifestations of inherently oppressive practices and perspectives. Additionally, further investigatiion is needed to limit the complex and more subtle perpetuation of systemic dehumanizing conceptualizations in clinical social work, particularly in reference to working with such vulnerable populations such as individuals who experience mental illness. As indicated in this summary, oppression of varying dynamics and degrees of subtlety continues to occur, even within the field of social work, a profession in which social justice is an inherent value and goal. Therefore , it is essential to keep a space for ongoing critical thinking and constant investigation of not only these manifestations, but also of our own continual role and perpetuation of these issues from a place of inherent privilege integral for all those who engage in academia and professionalism.

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Appendix A

Recruitment Letter

Hello *** clinicians,

I am a social work intern at the *****. I am a student at Smith College School for Social Work and am conducting a study for my degree requirements. I am looking for participants who would be willing to share their experiences working with individuals who present with paranoid symptomatology. Even if you do not meet the criteria to participate, it would be very helpful if you know someone who might be eligible.

Here is a short summary of my study:

I am planning to interview 12 mental health counselors/clinicians who have had at least 5 sessions with clients whose primary symptoms involve paranoia. This study will focus on how clinicians have navigated engaging with this population. Individuals with paranoid symptomatology have been reported as being the most difficult to engage in individual therapy due to their frequent mistrust and paranoia thus often leading to termination of treatment early on. This research could help give clinical insight as to some possible techniques and strategies for establishing a therapeutic alliance with this population.

Participants must have:

· Worked in as a mental health counselor for at least 5 years post Master's and are licensed to practice independently.

· Have had at least 5 sessions with clients who had/have at least one of the following diagnoses: Paranoid Personality Disorder; Delusional Disorder, Persecutory Type; Schizophrenia; Bipolar I or Bipolar II Disorder with Psychotic Features; and Depressive Disorder with Psychotic Features; Personality Change Due to Another Medical Condition, Paranoid Type; and presence of paranoid ideation in Schizotypal Personality Disorder.

· In working with the aforementioned client, utilized at least one of the following treatment modalities: cognitive, behavioral, psychodynamic, or gestalt therapeutic frameworks.

Participation in this study will only take no more than hour of your time. Interviews will be recorded but kept private. This study is not a part of Behavioral Health Network, Inc. and participation is confidential. Because I am a student with limited resources, no compensation is available. If you are interested in participating, please contact me. If you know someone who may be interested in participating, or are a professional who may know where to locate participants, please have them call or email me. Or, with permission, I can contact the potential participant.

Thank you for your help!

Appendix B

Approval Letter from Agency

From: Jim **** (Clinical Director)
Sent: Monday, December 15, 2014 4:33 PM
To: Mark ******(Program Director)
Subject: RE: Agency Clinician Thesis Participation

Sorry, forgot to let you know, it has been approved.
Jim

From: Mark ***** (Program Director)
Sent: Monday, December 15, 2014 4:32 PM
To: Jim *****
Subject: RE: Agency Clinician Thesis Participation

Do you know if Lisa's thesis proposal has been approved for her to interview clinicians.
You should have the proposal and a copy of "recruitment letter" sent as attachments to an email on 12/8.
Thanks,
Mark

Appendix C

Approval Letter from SSW HSR Committee

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 8, 2015

Lisa Orenstein

Dear Lisa,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Jean LaTerz, Research Advisor

Appendix D

Transcriber Confidentiality Agreement

Volunteer or Professional Transcriber's Assurance of Research Confidentiality

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

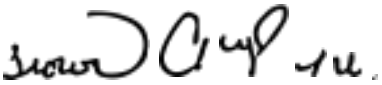
- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.

- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.

- The researcher for this project, Lisa Orenstein shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines. PLEDGE I hereby certify that I will maintain the confidentiality of all of the information from all studies with

which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, - insert name of researcher - for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

Signature



March 12, 2015

Lisa Orenstein

March 12, 2015

Appendix E

Interview Questions

- What is your age, sex, ethnicity, race, religion, city/town of origin
- How many years have you practiced since obtaining your Master's?
- *For the purposes of this study, a person with paranoid symptomatology includes individuals where "suspiciousness, mistrustfulness, and frank misreading of meaning and intentions dominate the clinical picture"* (examples of diagnoses include: Paranoid Personality Disorder; Delusional Disorder, Persecutory Type; Schizophrenia; Bipolar I or Bipolar II Disorder with Psychotic Features; and Depressive Disorder with Psychotic Features; Personality Change Due to Another Medical Condition, Paranoid Type; and presence of paranoid ideation in Schizotypal Personality Disorder. (Exclusion criteria includes clients who's diagnosis is not a result of substance induced paranoia nor psychosis)
- At least how many clients have you worked with that have paranoid symptomatology?
- How long did you work with them? What was your shortest therapeutic relationship and what was your longest?
- What strategies did you use to navigate their mistrust and paranoia during the first 5 sessions?
- What, if anything, have you learned about strategies with navigating establishing trust and a bond since first starting?
- Some literature notes that clients with paranoid symptomatology do not have the capacity for humor, what are your thoughts on this in your experience?
- [After defining affiliate humor and three other humor styles] *Affiliate humor refers to a humor style that is "an essentially non-hostile, tolerant use of humor that is affirming of self and others and presumably enhances interpersonal cohesiveness and attraction" (Martin et al., p. 53, 2003).*
- Do you use affiliate humor in your work with any of your clients? How about with the paranoid clients? If you have, what was your experience?