Hospital nurses use of humor
by Sheila Marie Johansen

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University
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Abstract:
Humor is one aspect of the human experience that has not been the focus of nursing research. The lack of nursing inquiry in this area has been attributed to humor's complex and paradoxical nature. Nurses have traditionally been trained to believe that using humor or laughing was unprofessional behavior. In addition, health care is considered to be "serious" business. However, humor does occur, is frequently present, and has been reported to make a positive difference in the health care setting. The purpose of this exploratory, descriptive study was to explore nurses' use of humor in the hospital setting.

Spradley's (1979) ethnographic methods were used in data collection and analysis. Informants were a convenience sample of nurses (N = 11) working in two Montana hospitals identified by a key informant as "nurses with a good sense of humor." These "experts" were interviewed about their use of humor in the hospital setting. Content analysis of interviews resulted in descriptive findings.

The nurse-informants supported the use of humor in the hospital and reported several important functions of humor both with patients and with staff. They reported that they use humor judiciously and carefully assess the appropriateness of their use of humor. They reported differences in their use of humor with patients and with staff.

For these nurse-informants, humor was a necessary element in their work environment. They reported that with care, humor has many positive functions and is worthy of continuing investigation.

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TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

ABSTRACT

Humor is one aspect of the human experience that has not been the focus of nursing research. The lack of nursing inquiry in this area has been attributed to humor's complex and paradoxical nature. Nurses have traditionally been trained to believe that using humor or laughing was unprofessional behavior. In addition, health care is considered to be "serious" business. However, humor does occur, is frequently present, and has been reported to make a positive difference in the health care setting. The purpose of this exploratory, descriptive study was to explore nurses' use of humor in the hospital setting.

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CHAPTER 1

INTRODUCTION

> The perception of the comic is a tie of sympathy with other men, a pledge of sanity. We must learn by laughter as well as by tears and terror. (Emerson, n.d., p. 428).

The focus of nursing inquiry is the human experience. Human experience is context dependent, that is it can only be understood within its context or environment (Newman, 1983). This study focused on humor, one aspect of the human experience.

To emphasize the importance of humor, Zijderveld (1983) attempted to imagine a world entirely devoid of humor and laughter. Imagine a world of eternal and perpetual seriousness in which people are relentlessly confronted with reality. He would, as would most other people, find such an environment intolerable. This world devoid of humor described by Zijderveld is certainly not descriptive of the health care setting. Robinson (1977) found that despite the "serious" business of health and illness, humor occurred in almost any circumstance or situation. However, the role of humor, one of the most prevalent forms of human social

behavior, has not been the focus of nursing study (Lieber, 1986).

A possible explanation of this lack of focus on humor in nursing research may be attributed to the complex and paradoxical nature of humor. The historical views of humor have been both positive and negative. On the positive side, there is the historical belief that humor and laughter had healing and other beneficial effects on both mental and physical health. "Laughter is the best medicine" is a well-known phrase which reflects this belief. In contrast, the moral view of humor and laughter has been quite negative. The negative views ranged from emphasizing the impolite and hostile nature of humor to crediting humor with sexual and aggressive impulses (Goldstein, 1982; Robinson, 1977).

Lieber (1986) suggested that the role of humor in nursing practice has been largely ignored for two reasons. One is that laughing and joking have not been considered professional behavior for nurses. The other is that illness, hospitalization, and death are simply not funny. However, even in grim situations, humor was often found to be present and had made a positive difference.

Purpose of the Study

Humor is an integral part of the human experience. Even though humor is frequently present in the health care setting, its role has not been the focus of nursing study. The purpose of this study was to explore nurses' use of humor in the hospital setting.

CHAPTER 2

LITERATURE REVIEW

> Humor can be dissected as a frog can, but the thing dies in the process and the innards are discouraging to any but the scientific mind. (White, 1941, p. xvii)

Humor has been the topic of interest of many disciplines. This review focused on humor from the various perspectives of sociology, psychology, anthropology, medicine, and nursing. Definitions and theories from the different disciplines were explored.

Definitions of Humor

According to Steinberg, "Trying to define humor is one of the definitions of humor" (cited in Levin, 1972, p. 16). Certainly there is no single definition of humor and the diversity of definitions reflect its complexity. The definitions, when attempted, reflect each author's perspective. There is no universal agreement. However, some common themes evolved.

Humor was a form of communication and self-expression (Coser, 1960; Hankins-McNary, 1979). Robinson (1977) defined humor as communication which any

of the participants described as humorous and resulted in laughter, smiling, or amusement.

Heuscher (1980) contended that the universal feature of humor is that it provides "...a sudden change in or widening of the recipient's experiential horizons" (p. 1546). The way the world is structured is suddenly altered and reality is modified, at least temporarily. Since an individual's identity is closely connected with his world design, this sudden restructuring would be anxiety producing in situations other than humorous ones.

In a similar manner, sociologist Zijderveld (1983) defined humor as playing with institutional meanings. Humor is able to disturb definitions of reality by playing with meanings. Ziv (1984) viewed humor as being able to perceive situations in an incongruous manner. Reappraisal of a situation can transform injustice into absurdity and make outrage tolerable (Tavris, 1982).

For Bloomfield (1980) humor directly expressed unconscious processes bringing together opposites and contradictions. It is this paradox and the absurdity of bringing together irreconcilable wishes which evoke laughter. This laughter reflects sudden insight and

recognition. Leo Rosten (cited in Boskin, 1979) defined humor as the affectionate communication of insight.

"Humor is the collision of the possible and the impossible" (Kopp, 1983, p. 195). Assumed orders and priorities are brought into question. The contrasts and paradoxes of humor prevent escape from or denial of the contradictions of life's polarities. "Humor abruptly interrupts our complacency as it exposes us to all that we so often would prefer not to know that we already know" (p. 198).

Humor, then, is a way of communicating with others. Through humor, insights and alternative perceptions of reality can be revealed and shared. Humor offers choices to those who engage in playing with their reality.

A framework for understanding and explaining reality is called a paradigm. A paradigm shift involves a new way of thinking or a new framework with which to view reality (Ferguson, 1980). Humor might then be considered a paradigm shift for it, too, offers a new perspective and reframes reality.

Theories and Functions of Humor

Theories depend upon and attempt to explain observations. Since different disciplines and areas of study have diverse points of reference, their observations differ, as do their assumptions about those observations (Pollio, 1983). Robinson (1977) observed that one of the problems in the study of humor is that there is no universally accepted language or theoretical framework. The study of humor has been the subject of many disciplines. Each discipline with its own unique perspective has formulated theories or speculations about humor.

Early Theories of Humor

According to Keith-Spiegel (1972) the nineteenth and early twentieth centuries were a particularly fruitful time for humor theorizing. Biological, instinctual, and evolutionary theories proposed that humor and laughter were "good for the body" and served an adaptive function. Superiority theories, subscribed to by Hobbes and Aristotle, were based upon the assertion of one's superiority over another. Incongruity, surprise, ambivalence, and conflict theories all depended on an unexpected outcome which

produced absurdity or ludicrousness. Proponents of these theories included Kant, Schopenhauer, Bergson, and Koestler (Robinson, 1977).

Psychological Theories

Psychoanalytic theory, developed by Freud (1928), viewed humor as a defense mechanism, but one that has a liberating element. It is a "...triumph not only of the ego, but also of the pleasure-principle, which is strong enough to assert itself here in the face of the adverse real circumstances" (p. 3).

Salameh (1983) identified two trends in psychotherapy research of humor. The first trend dominated the literature to 1970 and was largely psychoanalytical in approach focusing on regression and defenses. After 1970 a second trend in humor research emerged which was more empirical and non-psychoanalytical. These newer approaches focused on growth. The focus was on the effects of humor in the therapeutic process, on client and therapist reactions to the use of humor, and on humor in group therapy.

One theory in which humor plays a major role is Provocative Therapy developed by Farrelly & Brandsma (1974). A number of other therapists have used humor in therapy but have not necessarily built their therapeutic

system around humor. Among these are Ellis, Haley, and Grotjahn (Salameh, 1983).

Provocative Therapy hypothesizes that when therapists humorously provoke patients to continue their self-defeating behaviors, the patients will move in an opposite direction from the therapist's definition of them and will adopt both a positive self-concept and self-affirming behaviors. In their use of Provocative Therapy Ferrelly and Brandsma (1974) made several assumptions. One assumption was that patients are not as psychologically fragile as previously assumed; another was that maladaptive behaviors can be altered no matter how chronic. Challenging the patient's pathology can be a catalyst for growth and change.

Frankl, in his Logotherapy, applied "paradoxical intention" a technique of exaggerating patient's symptoms until they become absurd (Salameh, 1983).

> Such a procedure, however, must make use of the specifically human capacity for self-detachment inherent in a sense of humor.... the patient is enabled to put himself at a distance from his own neurosis. (Frankl, 1959, p. 197)

Ellis (1977) discussed his use of humor in a treatment technique called Rational-Emotive Therapy. He

maintained that people become disturbed emotionally, cognitively, and behaviorally. Humor acts on all three areas.

> Cognitively, it presents new ideas to the absolutistic, rigid client in an insightful, hard-hitting way. Emotively it brings enjoyment and mirth, makes life seem more worthwhile, and dramatically intrudes on gloom and inertia. Behaviorally, it encourages radically different actions; it constitutes an anti-anxiety activity in its own right; and it serves as a diverting relaxant. (p. 269)

Bloch, Browning, & McGrath (1983), Bloomfield (1980), Hankins-McNary (1979), Heuscher (1980), Rossel (1979), Schimel (1978) also discussed the role of humor in psychotherapy. Bloch, Browning & McGrath (1983) identified uses and benefits of humor in group therapy as did Rossel (1979). For Bloomfield (1980) humor was essential to the therapeutic process.

> Humor challenges preconceived and sacred notions, puts things into perspective, highlights contradictions within us, and makes it possible to see things from a new angle, with new eyes. (p. 141)

Bloch, Browning & McGrath (1983), Ellis (1977), Rossel (1979), Schimel (1978) also mentioned the ability of humor to present to patients new possibilities and choices that may have been previously unknown to them. Patients, thus released from the logjams in their

thinking, can become less rigid and more flexible. This ability to be flexible and to see problems from another perspective provides a distancing from the problem with a consequent reduction in anxiety and in feelings of helplessness (Martin & Lefcourt, 1983).

Sociological Theories

Sociologists are beginning to explore humor, though they have not done so to the extent that psychologists and anthropologists have (Zijderweld, 1983; Fine, 1983). Davies (1984) believed that sociologists are beginning, as anthropologists have before them, to recognize that social phenomena must not be ignored simply because it is considered superficial in one's own society. Zijderweld (1983) found the lack of humor research in sociology puzzling for two reasons. One is that humor is social in nature. Humor requires a partner and depends on social context. Secondly, humor and sociology both subject the routines of daily life which have been taken for granted to examination, analysis, and interpretation.

Fine (1983) agreed that humor is socially situated and that it is grounded in a particular social environment.

> For humor to work - that is, to be funny - it must be responsive to the immediate situation and to be appropriate to the normative properties of the more general social circumstances. Participants must define these behaviors or speech events as humorous, and this evaluation is socially constructed (or negotiated) in context. (p. 164)

Coser (1959) agreed that laughter (humor) among others presupposes a common definition of the situation.

Humor indicates some sort of discontinuity in the social system (Fine, 1983). Koestler (1964) coined the term "dissociation" to describe the pattern of perceiving a situation or idea in two incompatible frames of reference. Zijderweld (1983) thought that this kind of juxtaposition of incompatible views of a situation to be humor's most important function because it works to de-ideologize and disillusion. Socially accepted and traditional structures of meaning are exposed to an entirely different structure of meaning. Thus, everything humor touches is made relative.

According to Fine (1983), the dominant theoretical paradigm in sociology is functionalism. The three significant functions of humor he identified were promotion of group cohesion, provocation of intergroup (or intragroup) conflict, and social control.

Zijderweld (1983) also discussed the functions of humor in communication, marking the boundaries of a group, and linking the powerful and their subordinates.

In her study of humor in a hospital setting, Coser (1959) too, referred to the functions of humor. Humor invites others to come closer, decreases social distance, allays anxiety, involves an element of reciprocity, conveys information, and is a means of rebellion against authority. She noted that while Freud stressed the "psychic economy" that humor affords the individual, the "social economy" should be stressed--humor is highly valuable in groups whose membership is constantly changing. In a changing and threatening environment, a timely bit of humor can entertain, reassure, release tension, draw others nearer, and convey information more effectively than lecturing or other academic approaches.

Anthropological Theories

Anthropologists have studied many aspects of humor. In reviewing anthropological humor research, methodology, and theories, Apte (1983) noted that the most widely researched topics have centered on joking relationships, humor in religion or ritual humor, and

trickster studies. These studies, he observed, do not focus on any analysis of humor per se, but rather, on the relevance of humor to other aspects of the culture. Humor has not been researched to the degree that other topics such as kinship, marriage, and political institutions have been.

Anthropological theories of humor, like sociological ones, emphasize context and focus on inter-relationships to other sociocultural traits. Most of these theories are both structural and functional in orientation (Apte, 1983).

> A major theme recurring in anthropological theories is that expressions of humor are the result of attempting to resolve ambivalence in social situations, roles, statuses, cultural values, and ideologies. (Apte, 1983, p. 207)

In the interest of brevity, only a few examples from the field of anthropology will be cited. Tavris (1982) wrote that humor is an effective antidote to anger among the Mbuti and Eskimos. Song duels or ridicule help to resolve conflicts in a bloodless manner. Draper (1978) in writing about the !Kung, a hunting and gathering tribe, described how humor in the form of gossip and ridicule is used as an informal

mechanism of social control. Group solidarity is essential to survival and outright aggression cannot be tolerated, therefore humor has proven to be an effective control mechanism among the !Kung.

Humor and Health

Historically, laughter and humor were considered to be therapeutic and health-giving. In Proverbs 17:22 it is written, "A cheerful heart is a good medicine, but a downcast spirit dries up the bones" (The Holy Bible: Revised Standard Version, 1952). Moody (1978) and Goldstein (1982) reviewed some of the historical views of the health benefits (both physical and psychological) of humor and laughter. A few scholars from the time of Aristotle have advocated laughter as a means to strengthen the lungs and improve over-all health. Court jesters were used to maintain or restore the monarch's physical or emotional health. Mondeville, a surgeon in the thirteenth century, proposed that laughter and joy be used as an aid in his surgical patient's recovery and he guarded them from negative emotions. Mulcaster in the sixteenth century believed that laughter was an excellent physical exercise. Kant believed laughter was a psychosomatic phenomena and that mental ideas resulting in laughter had a beneficial physical and

psychological effect. James Walsh, an American physician in the twentieth century, wrote about the beneficial physical and psychological effects of laughter. So, the belief that laughter and humor are beneficial and good for physical and psychological health is not a new one.

However, Goldstein (1982) in his historical overview, noted that the moral view of laughter has largely been negative. Emotions were thought to be located in some organ of the body. Laughter was assigned to the spleen and was meant to be viewed as a "low" form of behavior. The Pilgrims in America and Victorian England were equally disapproving of laughter. Freud lent credibility to the negative view of laughter when in 1905 he wrote that humor could be an outlet for sexual or aggressive impulses.

While laughter is generally perceived to be healthy, it can be a sign of physical disease. Pseudobulbar palsy, amyotrophic lateral sclerosis, and multiple sclerosis are characterized by aberrant laughter that is beyond the control of the patient and does not express any sense of happiness. Other diseases in which inappropriate laughter is found are Wilson's disease, gelastic epilepsy, kuru, acute alcohol

intoxication, manganese poisoning, Alzheimer's disease, and Pick's disease (Goldstein, 1982; Moody, 1978).

Fry (1971, 1979, 1982) has done extensive research of the physiological effects of laughter. He studied the effects of laughter on heart rate, catecholamine levels, respiration, the skin's electrical conductivity, and oxygen saturation levels. The effects of laughter are comparable to physical exercise. Generally, there is stimulation followed by a period of below baseline activity. His findings suggested that laughter may have preventive qualities with regard to heart disease, cancer, depression, cerebral vascular accidents, and other stress-related conditions.

Martin and Lefcourt (1983) presented three studies in which the role of humor in attenuating stress was examined. Their report found that humor serves to moderate the deleterious effects of stress. Safranek and Schill (1982) found that while humor may be momentarily helpful in coping with stressful situations it does not, at least by itself, moderate the effects of life stress.

In 1979 Norman Cousins popularized the notion that laughter and humor have positive, healing effects on the body. He was afflicted with a serious, irreversible illness. He had read that negative emotions can have

negative effects on the body. He speculated that the reverse was also true and demonstrated in his recovery that positive emotions can have a healing effect. He found that laughter provided him with an analgesic effect and lowered his sedimentation rate, an indicator of the severity of inflammation or infection.

The role of humor in pain relief was discussed by Peter (1982). He stated that humor and laughter control pain in four ways: (1) by distracting attention, (2) by reduction of tension, (3) by changed expectations, and (4) by increased production of endorphins. As laughter stimulates the brain to produce catecholamines, the endorphin level in the brain increases and the perception of pain decreases.

Humor in Nursing

In nursing, as in the areas of sociology and anthropology, humor is a phenomena that was previously thought to be superficial but has now become the subject both of speculation and rigorous investigation. Robinson (1970, 1977) has done extensive research on the topic of humor in nursing. She found that humor served three primary functions: a communication function, a social function, and a psychological function. These appear to be the primary themes found in reviewing

nursing literature. In addition to discussing the use of humor with patients, the role of humor among health care providers will be discussed.

Humor was an indirect form of communication that was valuable in decreasing discomfort and in managing the emotionally-laden messages which often must be communicated in the health care setting. Because direct expression of anger, fear, anxiety, embarrassment, concern, and hope are not always acceptable, humor was a means of conveying these messages (Robinson, 1970, 1977). Coser (1960), Ellis (1978), Hankins-McNary (1979), Van Zandt & LaFont (1983, 1985) also viewed humor as a means of communicating. Hankins-McNary (1979) and Warner (1984) discussed the role of humor in group therapy. Humor revealed important information that would be difficult for the patient to reveal more directly. Humor as a form of self-expression or self-disclosure enhanced the patient's self-awareness. Thus, the process of changing behavior was facilitated (Warner, 1984).

According to Robinson (1970), in addition to being an indirect form of communication, humor also served

1. To establish warm interpersonal relationships.
2. To relieve anxiety, stress, and tension.
3. To release anger, hostility and aggression in a socially acceptable way.
4. To avoid or deny feelings that are too painful and too stressful to deal with at the time.
5. To facilitate the process of learning. (p. 133-134)

Humor can aid in establishing relationships by decreasing social distance, encouraging trust, and reducing the fear of the unknown (Robinson, 1970, 1977). Ellis (1978), Herth (1984), and Osterlund (1983) concurred that humor is a helpful adjunct in establishing relationships with patients.

Leiber (1982) conducted a descriptive correlational study of nurses' use of humor in both "high" and "low" stress areas in an acute hospital setting. She developed a Nurse Humor Survey Form and a Patient Humor Survey Form to collect data regarding frequency of humor use, circumstances and outcome of its use, attitudes and perceptions of patients toward nurses' use of humor, and relationship between patient characteristics and their attitudes and perceptions regarding nurses' use of humor. The medical-surgical intensive care unit was designated the "high" stress area. An oncology and post open-heart surgery unit were designated "low" stress areas. Fifty-three registered nurses from the

"high" and "low" stress areas and forty randomly selected patients from the "low" stress area participated in the survey.

Leiber (1982) found little difference in the amount of humor reported by the nurses in the "high" and "low" stress areas. However, she found nurses in the "low" stress areas reported using humor more with patients and families, while nurses in the "high" stress unit used humor more with nurses and other staff. Nurses reported using humor to help patients adjust to hospitalization and the transition to the "sick-role", to reduce stress and anxiety, and to deal with depression and anger. In addition, nurses reported using humor to deal with job-related stress and tension. Patients (98%) reported they preferred a nurse with a sense of humor and agreed that humor helped them cope with hospitalization, depression, anger, and not feeling well.

Van Zandt and LaFont (1983) also did a study of nurses' use of humor in a hospital setting. They used a questionnaire adapted from Leiber's (1982) and Robinson's (1977) instruments. Their questions addressed circumstances of humor use, perceived effect of the use of humor on the recipient, its effect under stressful or depressing conditions, and its use in

patient care. Participants in the study were nurses working day shift in both "high" and "low" stress areas. Nineteen registered nurses and twenty-three licensed practical nurses participated in the study. The intensive care unit and oncology units were designated "high" stress and all other units were designated "low" stress areas. They found that there was general support among the nurses for the use of humor in caring for patients. Nurses most often used humor to help patients cope with hospitalization. Humor was thought to be effective in helping patients deal with depression, anxiety, and stress. Humor was a helpful outlet for patients' anger and aggression but was used least often for this purpose by the nurses. No differences were found in the use of humor in the "high" and "low" stress areas.

The findings of these studies were difficult to interpret. Questionnaires used in both studies primarily required forced-choice answers. This approach leads to results which are lacking in richness and depth. Meaning and understanding can be lost when forced-choice answers are required. Leiber (1982) noted that the different data collection techniques and the different types of questions asked of nurses and

patients were limitations of her study. In interpretation of terms such as "high" and "low" stress, there were discrepancies. Leiber (1982) designated the oncology unit as a "low" stress unit while Van Zandt and LaFont (1983) designated the oncology unit as a "high" stress unit. Leiber (1982) noted that terms used on the questionnaire might also be subject to a variety of interpretations. Neither study made allowances for clarification of precise meanings of terms, such as, "stress", "depression", or even "humor" itself. Both researchers noted the limited testing of the reliability and validity of their tools.

Osterlund (1983) reported that humor helped to ease tension, anger, frustration, and the sense of powerlessness felt by those who are hospitalized. Better relationships with those "impossible-to-please" patients were facilitated through humor. According to Warner (1984) humor was known to reduce tension and provide catharsis. In addition, humor therapy had several other positive outcomes which included increased congruence, pleasure, and self-esteem.

Humor, while not a reliable analgesic, can help patients handle mild or moderate pain (Osterlund, 1983). Van Zandt & LaFont (1985) also discussed the role of

humor and laughter in gaining control over pain. The exercise of laughing had an impact on body systems similar to the positive effects of physical exercise. Among those effects were an increase in circulation, release of endorphins, and exercise of a variety of muscles.

Nurses not only used humor with patients but also among themselves and with other staff members. Humor among colleagues served important functions. Humor was effective in dealing with job-related stress (Leiber, 1982; Robinson, 1977), was a means of socialization (Coser, 1960), and created an environment that generated energy, creativity, and improved morale (Goodwin, 1986).

Coser (1960) in a descriptive study of social functions of humor among the staff of a mental hospital found humor was a

> ...means of socialization, of reconciliation, of affirmation of common values, of teaching and learning, of asking for and giving support, of bridging differences. (p. 83)

Humor created a group consensus which permitted members to withdraw together from the seriousness of the group concerns.

For Robinson (1970, 1977) the hospital was a place in which the staff must deal with problems such as death

and depression from which most people in society insulate themselves. Humor was often used in an attempt to manage emotionally-charged events. In areas where tension and anxiety were high and the possibility of death was great, there was often a great deal of humor and joking (Robinson, 1977). Leiber (1982) found that the nurses in "high" stress areas tended to use humor more with other RN's and other staff than with patients and families; nurses on the "low" stress unit used humor more with patients and families.

Nurses reported using humor most often to cope with the stress and anxiety related to their job (Leiber, 1982). Nurses might be encouraged to examine the role of humor to prevent or reduce the "burnout" phenomena, to deal with job-related stress, pressure, and depression (Leiber, 1982; Robinson, 1977).

Donnelly (1979) encouraged the use of humorous images to deal with difficult situations. These images were especially helpful in dealing with aggressive or hostile persons. Humorous images freed the self from tension by creating a new perspective. Bunde (1981) reported that joking among rural nurses released tension, encouraged group cohesiveness, and was used in

tense situations to lessen the feelings of those involved in the situation.

To be appropriate and well-received by patients, humor must be used judiciously by the nurse. Humor can have both positive and negative effects. It is important that there be reciprocity and intimacy (Warner, 1984). The use of humor should not be undertaken at the patient's expense nor should the use of humor be motivated by aggressiveness, hostility, or annoyance toward the patient (Hankins-McNary, 1979; Herth, 1984; Leiber, 1986; Osterlund, 1983; Robinson, 1970, 1977). Humor was healthy when it dealt with immediate issues and assisted in dealing with reality (Robinson, 1977).

Hankins-McNary (1979), Herth (1984), Leiber (1986), and Osterlund (1983) all discussed the importance of assessing the patient's receptivity to humor. Herth (1984) developed a "funny-bone" history to help her assess her patients. Her tool assessed personality, culture, background, and levels of stress and pain which all affect reactions to humor. In her assessment, Osterlund (1983) recognized that receptivity to humor was not a fixed point for either the patient or the nurse and receptivity depended on level of stress,

pain, and mood. Hankins-McNary (1979) assessed the status of the therapeutic alliance, assessed her own motivation for using humor as an intervention tool, determined how humor was used in the patient's family, evaluated each group member, and attempted to understand how the patient's jokes related to efforts at self-disclosure. Leiber (1986) delineated three criteria for determining whether the use of humor was appropriate or inappropriate: timing, receptiveness, and content. Further, she cautioned that in addition to the appropriateness of humor, the conditions of humor use and the effect on others not directly involved, must be considered.

There was, unfortunately, little indicated in the literature on how each of the variables mentioned affect reactions to humor. Leiber (1982) found that male patients responded more positively to humor and appreciated humor more when they were angry than did female patients, that older patients responded more favorably to the usefulness of humor in coping with hospitalization than did younger patients, and that the longer the period of hospitalization, the less the patient appreciated the use of humor when angry. In addition, Leiber found patients with fewer prior

admissions responded more positively to the use of humor when they were depressed. She concluded humor use was especially effective in helping patients make the transition to the "sick role" and to adjust to hospitalization.

Robinson (1970) reported successful use of humor in the care of a depressed patient. Osterlund (1983) reported using humor with patients who were in mild to moderate pain, and with the terminally ill and "difficult" patients. Milligan (1987) reported using humor to help a young transplant patient cope with the lack of privacy; and Warner (1984) reported using humor with psychiatric patients.

Gallows humor, or bravado in the face of death or a dangerous situation, described by Obrdlik (1942), has the positive effect of strengthening morale and the negative effect of the disintegrating influence among those against whom it is directed. In work fraught with uncertainty, medical staff often use gallows humor (medical humor) to relieve anxieties and concerns and to prevent tragedy by their skills and knowledge.

> The paradox is that the medical humor brings him closer to his colleagues, to share in the realization that he is not a hero, is not perfect, is still human. Yet the patient is depending upon him to prevent death, to avoid disability, and to cure his illness. He is expecting and praying for seriousness, and miracles, and godliness. (Robinson, 1977, p. 71)

Since it is the staff's needs which are being met, Robinson saw limited use of this type of humor with patients, although there may be times when it is appropriate.

CHAPTER 3

METHODOLOGY

> Somewhere in the heart of experience
> there is an order and a coherence which
> we might surprise if we were attentive
> enough, loving enough, or patient enough.
> (Durrell, 1957, p. 221)

The purpose of this study was to explore nurses' use of humor in the hospital setting. "Descriptive or qualitative research should be undertaken when there is little information available or when a science is young" (Tinkle & Beaton, 1983, p. 34). Descriptive research is preferable in areas of study that are not conducive to traditional forms of scientific research, such as "...the attitude toward an experience or the meaning that experience has for the participant" (Omery, 1983, p. 53). Nurses' beliefs about and use of humor are areas in which there is little information available. The choice of descriptive, qualitative research in this area is helpful in describing and understanding those beliefs and experiences.

Design

"Ethnography is the work of describing a culture. The essential core of this activity aims to understand another way of life from the native point of view" (Spradley, 1979, p. 3). The researcher is in the position of learning from the informant. The researcher begins with a "conscious attitude of almost complete ignorance" (Spradley, 1979, p. 4). The goal is to describe and "...to understand both the cognitive subjective perspective of the person who has the experience and the effect that perspective has on the lived experience or behavior of the individual" (Omery, 1983, p. 50).

According to Polit and Hungler (1978) there are certain advantages and disadvantages to the unstructured observation method of ethnography. Advantages are that the technique can provide a rich understanding of human behavior and can lead to understanding of the complexities of the human experience. It also allows the researcher flexibility in viewing the situation once it becomes more familiar. Disadvantages are the possibility of observer bias and influence through lack of objectivity in selecting and recording events and through "memory distortions" in recording events.

Another disadvantage is that the method is "...highly dependent on the observational and interpersonal skills of the observer" (p. 308). However, Polit and Hungler do agree that unstructured observation methods are "...extremely profitable for exploratory research in which the investigator wishes to establish an adequate conceptualization of the important variables in a social setting" (p. 309).

For Spradley (1979) ethnography reveals the culture-bound nature of social science theories and "...seeks to document the existence of alternative realities" (p. 11). Ethnography provides a means for discovering grounded theory, for understanding complex societies, and for understanding human behavior.

Sample Selection

Spradley (1979) identified five qualities essential in a good informant. These were" (1) thorough enculturation, (2) current involvement, (3) an unfamiliar cultural scene, (4) adequate time and (5) nonanalytic" (p. 46). To satisfy these requirements a convenience sample of eleven registered nurses were selected from a population of registered nurses working in hospitals in two cities in Montana. Key informants

were contacted and asked to identify nurses who have a "good sense of humor." The nurses identified by the informant were contacted for interviews.

Pelto and Pelto (1979) stated there are no guidelines to determine the number of informants required for adequate representation. Their general rule was "...when addition of informants has little effect on the general structure of a complex pattern of data, then the present sample is satisfactory" (p. 139). Chenitz & Swanson (1986) stated data collection continues until categories become saturated. After eleven interviews, the researcher determined that additional data would not change the patterns identified in previous interviews.

Method of Data Collection

Data collection followed the developmental research sequence (DRS) as described by Spradley (1979). In these interviews the informant is the interviewer's colleague and the researcher depends upon the informant for wording and framing of relevant questions (Evanshko & Kay, 1982). "In ethnographic interviewing, both the questions and answers must be discovered from informants" (Spradley, 1979, p. 84).

Two pilot interviews were conducted using broad open-ended questions. These questions (see Appendix A) covered topic areas identified in the literature. All interviews were done by the researcher. Interviews were from 50-90 minutes in length. The interviews were recorded with the informant's consent and later were transcribed verbatim. Notes, impressions, and interpretations were kept in addition to the transcriptions. Demographic data were collected including age, sex, education and work experience.

The pilot interviews revealed that the questions divulged a great deal of descriptive data which were consistent with the humor literature. The data from the pilot interviews were, therefore, included in the analysis of data collected from all the participants.

After the pilot interviews, interviews of four to five nurses identified as "experts" (people with a good sense of humor) were done using descriptive questions. From the transcriptions and notes of the interviews, key concepts were further identified.

One of the aspects of ethnography is that "...data collection and analysis are done concurrently" and are not separate processes of the research (Agar, 1980, p. 9). Once data are collected, an attempt is made to

interpret it. Then the researcher gathers more data to see if the interpretation is accurate, and the interpretations are further refined or analyzed. "The process is dialectic, not linear" (Agar, 1980, p. 9).

Content analysis to reveal domains, cover terms, and semantic relationships was done. Structural questions to verify the domains identified were asked in the final interviews along with additional descriptive questions. The responses of the informants were similar and some distinct patterns did emerge. These are discussed in Chapter 4.

CHAPTER 4

RESULTS

> The passion of humor is its vitality, intensity, and its commitment to affect life rather than passively watch it go by. The compassion of humor is its sagacious understanding of the human condition, its concerned yet zesty solace, and its affirmation that we are all travelers on the same sea. The acceptance of humor is its celebration of the continuity of life, its recognition of human finitudes, and its transformation of the human boundary into the human promise. Salameh (1983, p. 85)

Sample

Eleven nurses from two large Montana hospitals participated in this study. All participants were identified by key informants as "a person who has a good sense of humor." All were working or had recently worked in medical-surgical areas. The sample consisted of two male and nine female nurses with ages ranging from 33 years to 48 years (M = 37.8). Five worked full-time and six worked part-time. They had been in nursing from one year to twenty-two years. The average length of time in nursing for this sample was just over twelve years. In this sample five had up-graded their

basic nursing degrees; for example, one moved from associate to baccalaureate to master's degree. At the time of data collection two had master's degrees, seven had baccalaureate degrees, one had an associate degree, and one had a diploma.

Interviews lasting 50 to 90 minutes were conducted with each participant at their convenience. Participants responded to questions about their use of humor in the acute care hospital setting. All interviews were taped and transcribed. From the mass of information gathered in these interviews came the task of organizing the informants' responses.

According to Spradley (1979) there are a number of approaches to analyze phenomena. "Domains are the first and most important unit of analysis in ethnographic research" (Spradley, 1979, p. 100). A domain is any symbolic category that contains subcategories. A domain has a cover term which is a name for a category of cultural knowledge. The domain has two or more included terms which are linked by a semantic relationship to the cover term. Because the number of semantic relationships in a culture is small, the use of semantic relations is an efficient way to identify domains in ethnographic analysis (Spradley, 1979). For

domains in ethnographic analysis (Spradley, 1979). For example, vegetables might be considered to be a category of cultural knowledge. Vegetables, then, is the cover term of the domain. Included in this domain of vegetables are tomatoes and radishes whose semantic relationship to the cover term vegetable is: is a kind of.

Several of the universal semantic relationships discussed by Spradley (1979) did appear in these interviews. Among them were functions where X is used for Y and means-end where X is a way to do Y. One of the informant-expressed semantic relations "things humor does" or "uses for humor" appeared to be equivalent to the semantic relationship of function. The nurse participants identified uses for or functions of humor with patients and with staff.

These nurse-participants agreed that humor was an essential component of their work. "I think it is imperative to have fun at work because it can get so damned dismal." In addition to external demands, there were also internal ones. "I couldn't function without it because the use of humor is such a part of me. So, I couldn't be therapeutic unless I could use humor." Among these nurses there was consensus that

there was no humor. In fact, several reported that they had quit jobs in areas where humor was lacking. The content analysis of these ethnographic interviews provided some clues to the uses of, or function of, humor in the hospital setting.

Functions of Humor with Patients

"Humor empowers them to get well, it gives them the strength and the mood to do that" reflected the belief of one nurse regarding how humor functions for patients. The nurses' perceptions of humor's functions for patients fell into two primary categories. Humor served a social-communication function and a psychological function.

Social and Communication Functions of Humor with Patients

The nurse-informants believed humor facilitated the communciation between the nurse and the patient. The nurse might use humor to "get the patient to respond." Humor was considered to be a "door-opener," a way to "break-the-ice," or to "get the patient's attention." Sometimes humor was the "key to getting through to patients." Nurses perceived that the use of humor with patients "creates trust, then they can open-up". Humor

was a way to "get more information - they tell you things that maybe they wouldn't have told you. This will help you assess what special care that patient might need. It's important to get to know them as well as possible." "You can get into their personal space quicker with humor" was another statement which reflected the belief that humor was a way to "get to know people." For those patients who have difficulty expressing themselves, "humor will bring that out."

Humor was perceived to be a way of making the patient more comfortable with hospitalization, the nurse/patient relationship, and unpleasant procedures. Nurses reported using humor with patients to "put the idea of the hospital in a different light, make it not so much of a foreign place, and make it a more home-like atmosphere." "The patient's life has been interrupted, his life-style has been interrupted, and a joke or a laugh can bring some normalcy back into an abnormal situation."

Using humor with a patient allowed the patient to "see the nurse as a person". They could "see me as a human rather than as a person with a needle." The nurse attempted to convey through humor to the patient that

"we are just like you are, we can understand how you feel."

Hospitalization frequently involves routines and procedures which are unpleasant for patients. Nurses perceived that humor helps to make these "unpleasantries" more tolerable. Humor makes the "hospital routines, bad tasks not as difficult to deal with, not quite as unpleasant." With reference to the "whole range of inconveniences, procedures, and invasions of privacy," humor acted to "make them feel better about what we are doing." One way the nurse communicated her/his comfort in carrying out unpleasant or embarrassing procedures was through the use of humor. "It keeps their mind off what we are doing, it's distractive, it takes their mind off pain and fear for awhile."

Psychological Functions of Humor with Patients

Nurses perceived that humor functioned psychologically to relieve patient's tension or anxiety, to keep things "light," and to give the patient a sense of perspective. Humor was believed to "diffuse, relieve, release, and break" tension and anxiety. It helped patients to "deal with tension" and made them

"not so nervous." Humor was thought to have a "calming effect." When patients were not tense, they were "not so on-guard" and could relax. When the patient was relaxed "procedures are easier," "they can get higher up on Maslow's scale", and the patient was "open to learning."

A phrase frequently repeated was that humor helped to "keep things light." Humor set a lighter tone which "improves sense of morale and elevates their mood." "Taking things lightly" conveyed the idea that "the situation isn't so grim."

Humor also "gives the patient a sense of perspective" and acted to redirect focus. Humor "redirects their focus outward and not so much inward." Humor acted to "get them out of a sick mode and into a well mode." Humor "gets them out of that frame of mind." Through humor the patient "can see there is something else in the world" and that "life goes on."

Humor was one way the nurse helps the patient to "re-interpret" a situation in order to gain a new perspective. The patient can then "look at the situation instead of being so involved in it." The nurse can "exaggerate situations to the point of

absurdity" because sometimes the patient "can't see it unless it's made real absurd."

Physical Functions of Humor with Patients

Physical functions were reported least often by the nurse particpants. They did, however, report using humor to "decrease recovery time, make recovery easier, and to increase activity." Humor, through distraction, took the patient's mind off pain and fear. It helped to make painful procedures more tolerable, though not necessarily less painful.

Assessment of Patients' Receptivity to Humor

While humor had many apparently positive functions for patients, the nurses in this study stated that they used humor "if appropriate, not with everyone." "My life's goal isn't to use humor with every patient in every situation," summed up the nurses' perceptions regarding their use of humor with patients. These nurses used a variety of factors to assess whether the use of humor was appropriate or if the patient was receptive to its use.

There were "no absolute contraindications" or "hard and fast" rules for the nurse to apply when assessing a

patient's receptiveness to the use of humor. Many factors were taken into account. Among those factors were the nurse's intuitive sense of the patient, nonverbal and verbal cues given by the patient, the nurse's relationship with the patient, the nurse's assessment of the patient's needs or condition, the nurse's assessment of the patient's family interactions, and the context of the patient situation.

Nurses described their "sense that it would be good to use humor" as intuitive. "You can just tell, sort of vibration, spur-of-the-moment feeling" were phrases which depicted the process of how they decided whether to use humor with a patient or not. This intuitive process was grounded on signals, cues, and the context of the patient situation.

Nonverbal cues were the primary indicators the nurses used when deciding the appropriateness of using humor with a patient. Nonverbal cues that indicated the patient would have a negative response or was not open to the use of humor have been referred to as "back-off" signals or "leave-me-alone" cues. These signals or cues might include closed body postures, such as, lack of or poor eye-contact, folded arms, and looking or turning away. Otherwise ignoring or not paying attention to the

nurse were cited as indicators that the patient may not be receptive to humor at that time. Nonverbal cues such as facial expression, in this case frowning or even tears were also indicators that the patient was not receptive to humor.

Based on the patient's nonverbal cues and the patient's response to the initial introduction to the nurse, the nurse might do what has been referred to as "testing." Testing was "trying out some humor" to evaluate the patient's response. The nurse "experiments" to see if its going to be "received well". The nurse might try to "throw out something" or "try a little humor out" to see how the patient responded. This "testing" was generally a "mild" joke or something subtle that might be interpreted as humorous by the patient and elicit a smile or other positive response. If there was no response, then the nurse "backed off" and did not continue to attempt to use humor at that time. If there was a positive response to the "initial application of humor," i.e., a smile or a rejoinder, then the nurse would continue to use humor with that patient. "That (a positive response) allows me to do that some more."

The patients themselves might initiate the use of humor. "If they use humor with me, that's a green light." The patient might initiate humor through "sharing humorous cards, telling stories, relating humorous incidents, or telling jokes." They might talk about how ridiculous they look, use humor either in response to the nurse or might use it first. Asking personal questions or otherwise indicating that they want to establish a relationship with the nurse can be an indicator that humor might become a part of the nurse/patient relationship. Laughing was also a cue that the patient was receptive to the use of humor.

Another parameter the nurse assessed in determining the appropriateness of using humor with a patient was the nurse's level of comfort or familiarity with the patient. "Until I get to know patients, I usually don't joke around with them much" expressed the nurse's need to have some familiarity with the patient. When the nurse could "see where they are at" or "know I wouldn't offend them" they were then more comfortable in using humor with the patient. "The more comfortable I get with a patient, the more likely I am to use humor. The other side of that is, I use humor to get familiar with the patient."

The patient's level of wellness was another factor the nurse assessed in determining the appropriateness of humor use. Patients who were "too sick," "too into themselves," "too apprehensive about their illness," "extremely anxious," or were "egocentric" due to their illness were described as not receptive to the use of humor. The patient had to "feel well enough to enjoy the use of humor." Here, wellness was not limited to the physical sense of wellness. "Wellness in a psychological or spiritual sense" might enter in and the appropriateness of humor use may "have nothing to do with the physical situation at all." "People who are in pretty incredible physical pain can still respond to humor." "How the person was dealing with it" (their illness) had to be assessed. "If they are too far into themselves, then you can't use it, but if they are kind of on the edge, then humor takes them out of themselves a bit or expands that." Another nurse similarly stated, "The feeling bad or good in itself isn't the key because so many people who are feeling bad need something to draw them out of that." Perhaps the key was whether the patient was "open to any kind of reinterpretation" of their situation.