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Seriously Funny: The Clinical Role of Humor in the Grief Process

Jessie Rae Rayle

University of St. Thomas, Minnesota

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Seriously Funny: The Clinical Role of
Humor in the Grief Process

by

Jessie Rae Rayle, BFA
May, 2013

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members:
Collin Hollidge, Ph.D., (Chair)
Elizabeth Rezek, LICSW
Kristi Johnson, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

With the introduction of laughter groups and laughter yoga to such distinguished medical facilities as the Mayo Clinic and Cancer Treatment Centers, the use of humor as a therapeutic tool is beginning to emerge. This study aims to gain an understanding of what motivates therapist's to use humor while working with grieving clients through a qualitative approach. Four licensed therapists were interviewed on the topics of theoretical orientation, intentional use of humor with grieving clients, the clinical risks and benefits of using humor and the therapist's personal preferences of humor. The major themes found in this study were the role that humor plays in creating alliances, measuring safety, assessing the client and self care. This study concluded that humor could play a very significant role in the grief process by improving the therapeutic alliance, assessing the client's recovery and acting as a tool for self-care on the part of the therapist.

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Introduction

“Perhaps I know best why it is man alone who laughs;
he alone suffers so deeply that he had to invent laughter. “

Friedrich Nietzsche

People often speak of laughing so hard they cry, but never of crying so hard they laugh. Many people don't think about humorous things when in a state of despair yet, according to Norman Cousins, that is exactly what we should be doing. Norman Cousins is cited in almost every current research article as a major catalyst in moving humor's effects on medical patients to a more respected and noted level. In his article, "Anatomy of an Illness", Cousins (1976) describes his journey of healing himself from Ankylosing Spondylitis through the use of humor and laughter. Perhaps even more famous than Cousins was Hollywood's favorite doctor, Patch Adams, who used his clowning abilities to bring humor and a more humanistic point of view to the delivery of care among his patients. In fact, he has taken groups of "clowns" to hospitals, orphanages, prisons and nursing homes around the globe in hopes of improving the lives of suffering people (Adams, 2000). Although both of these men have made headlines through their use of humor in practice, there have also been numerous scientific studies completed that claim there is more truth to the term, "Laughter is the best medicine" than one may think. Many studies in the area of humor find it causes positive emotional states along with creating lower levels of distress and anger (Martin, 2007; Papa & Litz, 2011); and as it would be, high levels of anger and distress are symptoms commonly found in a grieving

person (Utz, Caserta, and Lund, 2011; Bonanno & Keltner, 1997).

Grief is a state that almost every person comes to know at some point in his or her life, be it through the death of a loved one, the loss of an identity or diagnosis of a terminal illness. The clinical world has been working with Elisabeth Kubler-Ross's five stages of grief since 1970, but these stages were originally intended to describe stages a dying person may go through, not a grieving family. While Kubler's model was a good start, clinicians are now looking for alternate ways to work with grieving clients in a more holistic and humanistic approach (Konigsberg, 2011). This search for a more holistic approach to grief opens a new frame of thinking in relation to humor in the grief process. In fact, a study done with widowed adults found experiencing humor and laughter was strongly associated with lower grief and depression (Lund, Utz, Caserta and Vries, 2009); and while there may be minimal research on this correlation, clinicians seem to be interested in the use of humor in their practice.

With the introduction of laughter yoga, laughter therapy and other humor-based practices in places like the Mayo Clinic and Cancer Treatment Centers, humor is also making its way into the social work world. Since social workers work with grieving clients understanding the role of humor as a curative agent may be a useful tool. This qualitative study aims to answer the question; what is the role of humor in the grief process as understood by licensed therapists?

Literature Review

The following literature review focuses on grief and humor as separate entities. It then reports on research linking the two in order to best understand the possible role that humor could/does play in the grief process.

Grief

“Grief is a natural response to loss. It’s the emotional suffering you feel when something or someone you love is taken away” (Smith, 2012). Although this definition may seem very simple for those experiencing grief, it encompasses all that grief is and can be, when a person loses their health, receives a mental health diagnosis, or loses a loved one. In the year 2011, over 2.5 million people died in the United States alone (CDC, 2011). Each of those deaths left numerous family members and/or friends to wade through the emotions from the loss of their loved ones. Although they all experience grief from similar losses; it can be stated with much confidence that each person went through a different and individualized grief process. Because people deal with grief in dramatically different ways, two different categories of grief have been established to better assist in the treatment of those suffering from grief; Normal Grief and Complicated Grief, also called Pathological Grief (Papa & Litz, 2011; Lichtenthal, Cruess & Prigerson, 2004; Boelen & Bout, 2008).

Normal Grief is usually accompanied by symptoms that can include sadness,

longing, guilt, and anger (Papa & Litz, 2011). These symptoms are usually at heightened levels for the first 2-4 months after a loss, but the grieving gradually regain the capacity for interests and relationships; eventually returning to a new normal (Tomita & Kitamura, 2002; Papa & Lite, 2011). Most people who are dealing with bereavement and loss will experience Normal Grief, while only 10-15% of this population struggles with Complicated Grief (Lichtenthal, et al., 2004).

Complicated Grief, or Pathological Grief, has similar symptoms to normal grief but complicated grief differs in the time that it takes the grieving person to return to a “normal” routine. If someone is suffering from complicated grief he or she will continue to have persistent mourning, yearning, emotional pain, and withdrawal (Papa & Lite, 2011). Complicated Grief can be so debilitating that it has been proposed as a clinical diagnosis in the upcoming DSM-V (Boelen & Bout, 2008; Papa & Lite, 2011; Lichtenthal, et al., 2004).

Physical and Psychological Effect of Grief. As previously discussed, no two people deal with grief in the same way, yet there are similar physical and psychological effects that can manifest from a significant loss. Sadness, anxiety, helplessness, irritability and lowered self-esteem are just a few of the psychological symptoms of grief reported in Casarett, Kutner, and Abrahm’s (2001) consensus paper which describes a clinician’s role in both normal and complicated grief. Casarett et al. (2001) goes on to explain the importance of normalizing these reactions in order to allow a person to move through the mourning process (p. 210).

The physical symptoms of grief can range from fatigue, sleep problems, chest

pains, headaches to gastrointestinal distress (Casarett et. al, 2001; Jeffreys, 2005; Banonno & Kaltman, 2001). Banonno and Kaltman (2001) also discuss past research focused on effects of grief on the immune system. They report on numerous studies that have concluded a “compromise” in a grieving person’s immune system (p. 720), though it is conclusively stated that more studies need to be conducted to make a concrete connection between the grief and the immune system. Jeffreys (2005) emphasizes the importance of a care provider to identify the physical symptoms of grief in order to better treat the grieving client. Jeffreys (2005) also suggests “advising good sleeping habits, physical relaxation, physical exercise and specially designated time-outs from active grieving” (p. 49).

Grief Therapy. For years grief has been dissected by numerous researchers from Elisabeth Kubler-Ross’ famous five stages of grief, to more recent studies of Robert Neimeyer who focuses on meaning reconstruction after a significant loss (Jeffreys, 2005). There are many different break-downs of phases, tasks and processes to better handle grief, yet according to Lichtenthal, Cruess & Prigerson (2004), who conducted a critical review of clinical interventions for grief, “the proposed stage theories of grief have not found evidence supporting the resolution of grief by clearly cut stages” (p. 643). In fact, there is yet to be a specific grief therapy that has proven to effectively treat all types of grief.

In a meta-analysis done by Neimeyer and Currier (2009) involving the review of 61 outcome studies, including 48 peer-reviewed articles, it was found that general psychotherapy was more effective when compared to grief-focused therapy.

The affects of non-randomized grief therapy did yield a high level of effectiveness immediately following therapy (.5 effect size), but the effect size dropped to almost zero only eight months following treatment. Psychotherapy on the other hand, stayed the same level (.8 effect size) from the last day of treatment to eight months after treatment was completed. Though the Niemeyer and Currier (2009) study was very comprehensive, it did not take into consideration other forms of therapy that may have greater or lesser effects.

In a meta-analysis by Papa and Lite (2011), which primarily focused on Normal and Complicated Grief, a similar conclusion to Neimeyer and Currier (2009) was found. After reviewing numerous studies, Papa and Lite (2011) found no empirical support for using “grief work” to assist with a person going through Normal Grief to return to pre-bereavement functioning (p 235). However when focused on Complicated Grief, it was concluded that Exposure Therapy and Cognitive Behavior Therapy (CBT) together was most successful when compared to stand-alone grief treatment. Papa and Lite (2011) also discussed the notion that an early intervention may end up being inappropriate and consequently worsen symptoms down the road (p 230).

Because there is a lack of empirical evidence to favor a specific grief-focused therapy, it can be concluded that it is necessary for future research to continue exploring the outcome of different types of therapy to best help those suffering with grief.

Humor

A person can use many types of humor in their daily lives to include satire, political, low-brow, gallows and intellectual. These types of humor all have one thing in common; not everyone will laugh at them. Because not everyone finds the same jokes or situations funny, it may be difficult to categorize what will cause laughter and what will possibly offend (Hayworth, 1928). The quest to find one type of humor that is more effective at producing laughter than another has demonstrated to be a difficult and endless path by many researchers (Smuts, 2009). However, it has been determined that there are categorically two types of laughter, Duchenne Laughter, laughter which is stimulus driven and emotionally connected (ie, a joke, funny situation and/or joy), and non-Duchenne Laughter, self-generated and emotionless laughter (Mora, 2008). Smuts (2009) also explains phthonic laughter – laughter from malice or envy. Though it may come from a dark place, phthonic laughter is also a form of Duchenne laughter. A group may share this type of laughter if they share the same supposed assumptions that would be considered offensive or inappropriate by another person or group. Smuts (2009) also explains that humor can be used as an effective way to bring up a difficult subject or point out fault that may otherwise be difficult to address.

Physical Effects of Humor. According to Rod A. Martin's, *The Psychology of Humor* (2007), physical health is a "complex concept"; therefore it is difficult to attribute humor, another "complex concept", as a reason or contributor to an increased level of physical health (p. 313). In Norman Cousins article, "Anatomy of

an illness”, Cousins (1976) describes his journey of healing himself from Ankylosing Spondylitis, through the use of humor and Duchenne laughter. He claimed that 10 minutes of Duchenne laughter could give him 2 hours of pain free sleep. Bennett and Lengacher’s (2006) meta-analysis also supports Cousin’s (1976) claim that there is a definite connection between the use of humor and self-reported physical health. Bennett and Lengacher (2006) reviewed numerous studies that found exposure to a humorous video can increase a person’s SIgA (a measurable part of the immune system found in saliva) levels of their immune system (p. 160). Thus supporting the fact that humor can play a role in a person’s physical health, but because of possible methodological issues in the studies, more research is required to make this a definitive statement.

Just like grief therapy, many researchers have concluded that there is not enough evidence to prove that an increase in physical health can happen solely through the use of humor. After a critical review of published research on the topic of humor and health, Martin (2001) alternately concluded that there are only a few significant correlations that can be made between humor and physical health. Martin (2001) also states that there is too much conflicting research on the effects of humor and laughter on physical health for a notable relationship to be assumed. Though many researchers agree with Martin, Mora (2011) argues that laughter, the result of humor, has yet to prove any adverse physical effects on the body (Mora, 2011).

Psychological Effects of Humor. One area that all of the literature agreed

upon was the positive affects that humor and laughter seems to have on psychological outcomes. Though Marin (2001) was weary to claim physiological benefits, he did state that laughter was found to cause positive emotional states in the majority of the research reviewed. This conclusion is echoed in Bennett and Lengacher's (2006) findings, which found higher scores on the Coping Humor Scale (CHS) and/or the Situational Humor Response Questionnaire (SHRQ) in participants who had lower levels of loneliness, depression and stress. This research was supported by Danzer, Dale and Klion's (1990) study on the effects of humor stimuli on induced depression. Danzer et al. (1990) discovered that a group of students who watched a depressing video followed by a humorous video, returned to their pre-experimental baseline while those who did not view a humorous video after the depressing video did not return to their base line. Lastly a study by Wanzer, Sparks, & Frymier, (2009) interviewed 205 older adults and found that those who used humor on a regular basis reported greater coping efficacy and a higher overall satisfaction with life. These research conclusions could possibly lead a future researcher to make assumptions about the positive role that humor and laughter may have in the grief process.

Effects of Humor in Bereavement. Lund, Utz, Caserta & De Vries (2008), in their study of 292 recently widowed men and women investigated not only the effects of humor, but also the importance the participants put on having a sense of humor. The outcome proved to support past conclusions; the participants who were found to be making the most positive bereavement adjustments were the

participants who were also experiencing humor and laughter in their lives (Lund et al., 2008). The outcome of this study gives concrete evidence for grief counselors promoting not only the use, but also the importance of humor in the grief process (Lund et al. 2008). According to the research study by Keltner and Bonanno (1997), it was found that Duchenne laughter predicted a lower level of grief severity. The previously discussed benefits and explanations of humor and laughter painted a broad picture of the psychological benefits of humor, but this research, focusing specifically on the grief process, seems to justify humor's role in the grieving process.

Humor-based Treatments. Humor therapy is just one of the modalities that is promoting the use of humor as an effective therapeutic tool. The popularity of laughter yoga has been increasing in the United States since its conception in India in 1995 (Martin, 2007). A study of 70 women diagnosed with depression were put through both exercise and laughter yoga; it was concluded that laughter yoga had the same effects as exercise did on improving depression and increasing life satisfaction (Shahidi, Mojtahed, Modabbernia, Mojtahed, Shafiabady, Delavar & Honari, 2010). Another study of laughter yoga found an immediate improvement of mood and an improvement in the subject's long-term anxiety after 10 sessions of laughter yoga (Dolgov-Kaspar, Baldwin, Johnson, Edling, & Sethi, 2012).

Franzini (2001) conducted a meta-analysis review of research on the use of humor in therapy. The review was so thorough that he created a three-page list of past research and theorists that supported the benefits of using humor in

psychotherapy. According to Fanzini (2001) the past research has found humor benefits the clinical treatment in a myriad of ways to include; reducing discomfort anxiety, serving as a cathartic release, making therapy sessions more memorable, and display genuine emotion (p 189). On the converse side of promoting humor, Fanzini (2001) also created a list of cautions in using humor in psychotherapy, which included concerns that focused on; patients assumption that the therapist is “making fun”, the patient may feel attacked, using humor to hide conflict, and possible countertransference problems (p 192). Martin (2007) also discussed the use of humor in psychotherapy and stated, “humor has been a recommended and useful tool in individual therapy, counseling and group therapy” (p 337). Because of these recommendations Martin (2007) states that humor can either be used as a “therapeutic technique” or a “communication skill” (p 337).

Methodology

After a thorough review of the literature on grief and humor, the research question for this study investigated the role humor plays in the grief recovery process. The answer to this research question was discovered through a qualitative study using exploratory methodology to better investigate the specific ways in which social workers use humor with grieving clients.

Sample

The participants of this study were obtained through a purposive strategy by creating a snowball sampling of licensed therapists who had identified themselves as using humor with grieving clients. This allowed for a more in-depth look at the role humor could play, as opposed to interviewing participants who did not use humor. The sample for this study was composed of licensed therapists in the state of Minnesota who were actively working with grieving clients at the time of their interview. There were four participants in the sample who fit the previously stated qualifications. These participants had self-identified as using humor in their current practice. One (25%) of the participants was working with grieving clients in a group setting and three (75%) of the participants were working with clients on an individual basis.

Data Collection

The data for this qualitative research study was gathered through a semi-

structured interview (See Appendix A), allowing for probing questions to be included to best fit the real-time scenario. After approval from the University of St. Thomas IRB, an email was sent out to possible participants explaining the purpose of the study and possible risks/benefits of participating. This email asked that the recipient consider participation as well as requesting they pass along this information to someone that may fit the participation criteria for this study. Interested participants were then asked to email the researcher to confirm their eligibility. After minimal response, a follow-up email was sent to promote response. After a participant replied, a follow up email with the interview questions and consent form (See Appendix B) was sent and a phone call was made to schedule the interview time, date and location. The interviews lasted approximately 45 minutes and focused on the interviewee's use of humor with grieving clients. Prior to recording the interviews, the researcher confirmed the participant had read the consent form and interview questions, and gave the participant an opportunity to ask questions or clarify any of the process information. The researcher then recorded the interview on a digital recording device and downloaded the file to her computer upon completion. The participant was also reminded that they could drop out of this project at any time for any reason.

Measurement

The measurement instrument used by this researcher was a semi-structured interview. The researcher of the study created eight primary questions based on the reviewed literature and guidance from the research chair and committee members.

These questions included the following topics; the type of therapy that is preferred by the participant when working with a grieving client, the participant's intentional or unintentional use of humor within preferred therapy, the hindering and/or beneficial aspects of humor in counseling clients with grievance issues, types of humor that increase or decrease recovery and a specific type of humor that the participant leans towards.

Data Analysis

Being an exploratory study, the data from the semi-structured interviews was analyzed through content analysis. By using content analysis the author of the study identified themes and patterns solely based on the interviews conducted for this research project. After the verbal interview recordings were transcribed, the author of the study scoured the written transcriptions for repetitive words and/or excerpts, which were then turned into codes and given meaning through analyzing commonalities and comparisons to previous literature. Finally these codes translated into the main themes of the research. The conclusive themes of the interviews made up the findings of this research project and were then applied to future use and studies with the purpose of defining humor's role in the grief process.

Protection of Human Participants

In order to maintain confidentiality, the author of this study created a consent form based on St. Catherine University/University of St. Thomas consent form template and checklist. It focused on background information, the specific research procedures and risks, explained the confidentiality and also informed the

participants that the interview will be audio recorded and transcribed. This consent form and research question was distributed to each participant prior to the interview. The participants signed the consent form prior to starting the interview. The initial interview recordings were kept on a memory stick and kept locked file cabinet the home of the interviewer. The written transcriptions of the verbal interviews were also completed by the interviewer and kept on the same thumb drive as the interview recordings. The recordings and transcriptions were not labeled with the names, nor did they include any identifying information of the interviewees. Both the interview recordings and the transcription files will be destroyed no later than May 25th, 2013.

Conceptual Framework

Humor and Grief are found at opposite ends of the spectrum when considering the stereotypical displayed emotions of each. Because of this obvious difference, this research project will be examined through Person Centered Theory. This broad theory encompasses the entire spectrum from grief to humor.

Person Centered Theory

Person Centered Theory prizes the relationship between the therapist and client in order for the client to achieve psychological wellbeing (Patterson and Joseph, 2007). Carl Rogers, who developed the framework for Person Centered Theory in the 1950's, stated this about his theory well:

“As persons are empathetically heard, it becomes possible for them to listen more accurately to the flow of inner experiencings. But as a person understands and prizes self, the self becomes more congruent with the experiencings. The person thus becomes more real, more genuine. These tendencies, the reciprocal of the therapist's attitudes, enable the person to be a more effective growth-enhancer for himself or herself.”

In order to achieve psychological well-being and become a “fully functioning person”, Rogers suggests three qualities that a therapist must nurture in order to better serve his or her client based in Person Centered Theory (Truscott, 2010). The first of which is genuineness, or congruence. It is important for the therapist to not only be genuine in his or her reactions and emotions involving the client, but also pay attention and be open to his or her own experiences outside of the client's.

The purpose for this genuineness is to promote both the client and the therapist to be in the moment of the session and therefore both be “emotionally present and available” (p. 74).

The second quality that a therapist must nurture while using Person Centered Theory is “unconditional positive regard”. This characteristic is essential for building trust in the therapeutic relationship through an ever-present accepting attitude toward the emotions and thoughts of the client in the present moment. It is important however to not begin to use this to reward good behavior or thought with positive regard. This could create an unhealthy relationship based on trying to please the therapist instead of trusting that the therapist will accept the client at all times (Truscott, 2010).

Lastly, a therapist must practice “empathic understanding”. By striving to understand the client’s perspective and experience of the world, the therapist will better understand and better communicate with the client. It isn’t enough just to understand empathetically but also to ensure that the client feels the therapist is empathetic to his or her situation (Truscott, 2010). All three of the characteristics are vital to all therapist’s ability to help the client move to a fully functioning person.

Person centered theory states that a client should be empowered and encouraged to act as a “fully functioning person” who is “organismically congruent” (Patterson and Joseph, 2007). Poland’s (1971) findings seem to complement Roger’s theory perfectly. According to Poland (1971), not only has humor been found to be useful in developing insight, but it has also been associated with the mark of a good therapeutic alliance. Thus understanding the importance of the

therapeutic alliance and how to help a client create a congruent self through Person Centered Theory will help to evaluate how the participants in this study use humor when working with grieving clients. As this research dissects the role of humor in the grief process, it will be important to remember that humor is not a linear tool, but a constantly growing and developing trait for both the client and the therapist.

Findings

This research project focused on the use of humor in the grief process and, after the interviewing process, numerous applicable themes surfaced. Four participants were interviewed in this project; each participant had identified using humor in their work with clients prior to participating in this research project. All four participants were working with grieving clients on a regular basis and the cause of their client's grief ranged from loss of a loved one, diagnosis of mental health, loss of housing, to loss of physical health. The interview questions focused on the participant's theoretical orientation when working with grief which was operationalized by the question, "What theoretical orientation do you use when working with grieving clients and why", the therapist's intentional use of humor, which was operationalized by the question, "Do you use humor intentionally in the therapeutic process? In what part/way", and the benefits and risks of using humor with grieving clients, which was operationalized by four questions; "Do you avoid using humor? In what part/way", "Tell me about a time that you have used humor and found it to be beneficial to a client's recovery", "Tell me about a time that a client has used humor and found it beneficial to their recovery" and "In what situations is the client most/least likely to use humor". Three major themes arose from these questions; positive uses of humor with grieving clients, humor as a tool, and participant's use of humor in self-care.

Each participant stated that he/she used a different theoretical orientation, strengths perspective, person-centered, mindfulness based and narrative

transformational therapy, when working with grieving clients. Although all four participants used a different theoretical lens, each theme uncovered in this study was highlighted in every participant's interview.

Positive use of Humor with grieving clients

Each of the participants stated they intentionally used humor in the therapeutic process when working with grieving clients, yet all mentioned numerous times that the therapist should take the client's lead when considering the type and timing of humor. All participants could identify risks of using humor with clients that are grieving in an unhealthy manner and/or clients diagnosed with anti-social personality disorders; yet, all agreed that the benefits outweighed the risks if used in an appropriate and sensitive way. Many benefits of using humor arose during the interviews; two of the most prominent benefits were building an alliance and the "safety" of the relationship.

Building an Alliance. All of the participants stated that the use of humor helps to build a healthy working alliance with their grieving clients. Two of the participants used similar verbiage about alliances while discussing their use of humor with a client. The first discussed the alliance that is created through trusting the therapist by using humor:

“So to the extent the person can either appreciate humor or even use humor, it is saying to the therapist that they trust them, otherwise I don’t think that they would engage in it. So I use that as a mark of the therapeutic alliance.”

The second participant discussed the creation of an alliance by establishing personal ground through the use of humor:

“So I really wanted to be thoughtful about ok, ‘later on when you’re away from here and these emotions are at the surface, I want you to be aware of that. What are you going to do?’ And he said, ‘I don’t know’ and I said, ‘You know what works for me is ice-cream.’ And we laughed and then we talked about it, what flavor of ice cream we like. Now every time he sees me and he leaves, he says, ‘don’t worry I got ice cream in the freezer.’ And it creates an alliance and personal ground, and it also helps when he comes back into session and it could be really difficult again like, to kind of normalize it.”

The following participants did not use the term “alliance”, but both discussed the concept of making a connection in order to join with the client at an appropriate level. Both stated that humor could be a catalyst for a stronger therapeutic alliance.

“Your being genuine and every one comes with a sense of humor, and sometimes I think that flexibility that we have to meet them where they are and being accepting of that and not shaming and being able to connect with them through humor and especially when they come with that [grief].”

“She was able to relax and able to laugh and so we bonded . . . that was just part of our rapport building in general was her formal use of humor as a coping skill and so we would joke about some of the stuff with that and I think it reminded us of the fact that we had things in common because I don’t want to be in there and have somebody feel like I am above them and I think it breaks down that barrier because humor can, unless there is really active MH symptoms that are going on. I think humor is a way to just generally join with people.”

Safety. The second most prominent benefit of using humor with grieving clients was “safety”. Participants were asked about the benefits of using humor and the responses all stated, at some point, that humor either created or accurately tested the safety of the relationship. The word safety came up numerous times in the interview process with each client. Thus bringing safety into the themes of using humor in the grief process.

Two participants stated that when the client uses humor it could be a way for him or her to create safety in the situation:

“I think that humor is a way of normalizing situations which make us feel uncomfortable in many aspects, so I would say that it is consistent to see humor as deescalating situations or creating an alternative view that allows us to feel safer and that’s why I think humor is so important in the therapeutic realm, because more than anything, therapy should be a safe environment.”

"I think it's attachment, I don't think they ever learned that safety piece. They never had humor in their home or they were neglected or needs weren't met emotionally so they never learned how to use it [humor] appropriately."

Other participants discussed using humor to create a safe space for talking about difficult situations.

"That's something I talk about with humor and pain management, sometimes talking and joking about it gives them a little more distance from it, so it makes it a little more safe to talk about."

"I think it's a safety thing. I think it can be safe. It's a safer place to go back to."

"Sometimes her laughing about something, about some incident that I feel it's safer for me to kind of join in and reflect back on her joy, and so I guess, I mean that's probably the safest way to do it."

Humor as a tool

According to all four participants the use of humor with grieving clients can be a useful therapeutic tool not only to assess the client's stage of grief, but also to reframe the grief and give an alternate perspective of the client's loss. All four of the participants shared the idea that humor can be used as a therapeutic tool. Of the many tools available to the participants, humor can be a very applicable tool when working with grieving clients.

Assess. As previously stated, each participant agreed that there are times when humor would not be a useful tool. One participant explained how to assess if the use of humor by the client is healthy:

“In a word, unhealthy humor is not funny. . . if you don’t see humor in it, I mean it doesn’t have to be hilarious, but if you don’t see humor in it then there is something wrong with it. I just tell the person that I am confused, I say I am not sure and I don’t push them on it but I say well I am a little confused and I am not sure what that indicates or what that threads back to, but we can come back to that later.”

This participant continued to explain the negative effects on specific types of grieving clients;

“Detached individuals, there is that kind of nervous laughter “the titters” as I refer to them as. Then there’s the individuals in the enmeshed; if there’s any kind of laughter it usually also produces some negative affect as well, I refer to that as wailing flaughts.”

Two participants identified a client’s ability to use humor as a gauge of the client’s recovery process.

“A few sessions later I introduced metaphors and some humor and he was actually able, about three months or so, to respond to the- he saw some elements of it that contained some humor that he had never been able to talk about it because if he lightened the load about that, it meant that he took his

brother off the issue of responsibility . . . before that he wasn't willing to consider. So it is a very incremental process and it was helpful and he was able to use humor"

"I think it should be part of an assessment like, when was the last time you laughed?"

Reframe. The second way that humor is used as a tool is in the client's ability or willingness to reframe a situation. Three of the participants discussed humor as a tool to reframe the client's grief and help the client to move forward in the process.

"She brought that into the therapy session, we talked about it and she was finally able to understand that laughter is a river that continues to move forward and laughing is not necessarily disrespect for the person but in a sense honoring the individual. It says I can put my feet in these waters and move forward"

"I will see if whether or not they are willing to consider alternative interpretations to things. If they are willing to consider alternative perspectives to things."

"He comes in and he's laughing about it, and he says, "Now I could sit here and lie to you, but you know", I think he called me sergeant or something, "Your just going to call me out so this is what I have done." So now he is able to be honest about it and my sense is he isn't comfortable being direct so he uses his own humor to help him be honest."

"I have seen humor actually deescalate some very tense situations that could have escalated to physical conflict and then suddenly somebody says something and it is funny and the other person starts laughing and you can just see the tension . . . so that's what I want clients to see about humor in the grief process that it is a way of deescalating things and creating space to view it differently."

The participants were also asked a clarifying question as to why and/or when they use humor as a tool for reframing;

"The point of using humor is to give them a different vantage point of view within the paradigm. That's the whole point I mean if I were to boil it down that's what its all about to get the person to look at something in a new way"

"I use it when the client is feeling pretty heavy in the room. And . . . to help the client normalize the situation that is going on"

"If we are laughing, we are here. Our mind isn't someplace else."

"Laughter is just one way to keep us in the present moment."

Use of Humor for Self-Care

When asked what type of humor each client used, the conversations all turned into the participant's history of using humor. All stated that they were brought up with humor as a coping skill in their families. When asked about gallows humor, the use of dark sarcastic and sometimes grotesque humor in order to

“maintain one’s sanity” (Martin, 2007, p. 48), three of the participants stated that they use it as a coping skill, but only in a professional manner. Each participant expressed utilizing humor as an intervention for self-care in different ways. Two participants stated that they felt it helped them to have a healthier relationship with their clients and those around them. As one participant stated:

“I think that in mental health if we are going to be healthy clinicians and healthy workers; if we are not doing that in an appropriate way outside of this, part of your personality, if your not acknowledging that, its going to filter into your work with your clients.”

Another participant agreed with this notion by stating:

“We had to find a way to laugh about other things, just to kind of hold that all together. You can have ‘both-and’.”

Three participants spoke about the positive role that laughter and humor plays in their lives. Each of the three participants made the following quotes that suggest the importance of laughter and the participant’s opinions of their personal use of humor:

“I guess I have always liked to have a sense of humor and be silly. Plus I was already a laughter yoga leader, so I just knew we needed to laugh every day to stay present and focused and focus on what was going right.”

“It’s jut a skill that you develop and I kind of have done it my whole life, and its who I am, it’s a sense, kind of intuitive.”

"I mean laughter is a part of life and laughter is the best medicine. People don't die you know when people say 'I died laughing' I don't think you die from laughing I think you die when you don't."

Discussion

Summary

This study set out to explore the role of humor in the grief process as described by licensed therapists currently working with grieving clients in a group or individual setting. Three main themes emerged from the data; positive uses of humor with grieving clients, humor as a tool, and participant's use of humor in self-care. Among these themes was the overall conclusion that not only is there a role for humor when working with grieving clients, but the intentional use by either therapist or client could have a great impact on the therapeutic process. Though many of these themes did not align directly with those studied in the literature review, strong correlations can be made between the two.

Comparison to Literature Findings

Each participant explained that building and maintaining a therapeutic alliance through the use of humor could be a benefit to the client's ability to move through grief. All of the participants also agreed that using humor could connect, build trust, and normalize the relationship between client and therapist. This supports McCallum, Piper and Ogrodniczuk's (2002) research that focused on the dropout rates with complicated grief clients. The authors found that a good alliance and cohesion was a stronghold for a client stay in therapy (McCallum, Piper, Ogrodniczuk and Joyce, 2002). It could then be concluded that if humor helps to

build an alliance when working with grieving clients, then the use of humor should be seen as positive and useful therapeutic tool. Though the exact verbiage of “alliance” was not found in the literature review, it was found by Martin (2007) that humor is a useful tool and can either be used as a “therapeutic technique” or “communication skill” (p. 337). It should be noted that there has been research on humor’s role in building an alliance and it was reported by Poland (1971) that the use of humor is a good measure of the therapeutic alliance. Poland’s claim also aligns with this research project’s findings that the use of humor can help construct the important therapeutic ingredient of “safety.” Numerous times the participants talked about clients using humor in order to create safety in the situation; participants used the words, “normalize, deescalating, and attachment”. All of these themes were found and/or inferred in Fanzini’s (2001) meta-analysis review of research on the use of humor in therapy.

When using humor as a therapeutic tool, this research found that it was mostly used to gauge the client’s recovery progress. The most common theme that this research and the findings of the literature review found, were the client’s lower levels of grief symptoms. In previous research (Lund et al. 2008; Keltner and Bonanno, 1997), it was found that grieving clients, who used humor, either unintentionally or intentionally, reported lower levels of grief. While this research project and those reviewed were congruent in overall themes, this research project also found that most participants explained the decrease in levels of grief when a client was able to reach a different perspective of their grief.

This research also uncovered the theme of self-care on part of the therapist. It was concluded from this project that humor is a vital tool for all participants in the role of self-care in order to work better with both the client and coworkers. Though it should be noted that this finding was not supported by the reviewed research. The participants discussed using humor throughout their lives, and spoke well of the benefits it has provided. Participants also stated that they used different types of humor, but all could agree that it was an important aspect of the work they do as therapists.

Limitations Of Project

There were numerous limitations of this project, the first being the small sample size. Although many invitations were emailed, only four respondents followed through with the interview. This limitation may have been because of the researcher's recruitment method. Because this research used a snow-ball sample, the researcher may have been incorrect in her assumptions that the initial emails would continue to be passed on to potential participants. Also due to the small sample size, it is difficult to generalize the findings of this particular project.

This research project was designed with qualitative questioning and the researchers interpretation of the data collected. This can be a limitation not only because of the researches unknown biases but also the participant's interpretation of the questions. This limitation was unavoidable in this particular research;

however, future research may look at this topic through a quantitative lens in order to avoid these limitations.

Another limitation of this research was the participant's role in the therapy process; this study looked solely at the therapist's opinions and processes when using humor in the grief process. It would be beneficial to question either in a qualitative or quantitative study, the client's viewpoint on the role of humor in the grief process. This type of study may uncover similar themes that could then be applied to future studies.

Contributions to Social Work

The likelihood that a social worker will work with a grieving client is almost guaranteed; therefore knowing what tools to have at one's disposal is an important factor in a client's success in therapy. Ensuring that a strong therapeutic alliance is built is imperative to the client's health and well-being. Social workers are also constantly assessing client's recovery; this project has proven that humor has the potential to be a gauge in the recovery and progress in therapy. As social workers continue to take on more therapeutic roles in society, it will be imperative that they practice healthy self-care. This research project has also shown that humor can be an imperative role in the stress levels and self-care rituals of social workers.

There were also themes in the literature that did not surface in the participant's interviews. It should be noted that social workers also work with

clients with physical ailments that may precipitate mental health. According to the literature discussed, it would benefit social workers to consider introducing humor into their practice with such clients, as the possible physical benefits of humor has proven to promote recovery in some studies.

Another important aspect for social workers to take into consideration is that each client is unique in his or her own use of humor. It is essential that a Social Worker allow the client to lead the use and type of humor, in order to avoid offending or breaking the therapeutic alliance.

Suggestions to Future Research

It is the hope that this research project has sparked an interest of current and/or future social worker to look more deeply into the role of humor in the grief process. A qualitative study of the client's thoughts on the role of humor in the grief process would be beneficial to augment current research on the therapist's views. There were few studies completed that discussed the daily use of humor as an individual and the possible benefits or risks. It would benefit each person working with grieving clients in therapy to have a more well-rounded view point of this topic would.

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Appendix A

Interview Questions

1. What theoretical orientation do you use when working with grieving clients and why?
2. Do you use humor intentionally in the therapeutic process? In what part/way?
3. Do you avoid using humor? In what part/way?
4. Tell me about a time that you have used humor and found it to be beneficial to a client's recovery.
5. Tell me about a time that a client has used humor and found it beneficial to their recovery.
6. In what situations is the client most/least likely to use humor?
7. What type of humor, sarcasm, cartoons, self-deprecating, have you found to be the most useful/detrimental in your self-care as a therapist?

Appendix B

CONSENT FORM

Please read this form and ask any questions you may have before agreeing to participate in the study.

Please keep a copy of this form for your records.

Project Name	Grief and Humor	IRB Tracking Number	400370-1
General Information Statement about the study:			
<p>The rising use of humor as a therapeutic tool has brought this subject to the attention of social workers across the country. From the Mayo Clinic to Cancer Centers, humor is slowly making its way into clinical work. Humor is currently used in numerous ways from Laughter Yoga to Humor Therapy and has been found to be both physically and psychologically beneficial to a client with a mired of issues. Many studies have also been conducted in the use of humor with clients bereaving a loss of a loved one and were found to have substantial benefits in the recovery process. Although numerous studies have been conducted to prove the benefits, there have been just as many studies that have found the opposite. All studies have come to the conclusion that more research is needed in the use of humor in a clinical setting.</p> <p>The proposed research project takes a closer look at the use of humor in the social work field, primarily in social workers working with grieving clients. It strives to uncover ways that therapists are intentionally using humor to better serve their clientele through qualitative interview with local social workers. The findings will then be presented at the University of St. Thomas as part of the School of Social Work requirements.</p>			
<p>You are invited to participate in this research. You were selected as a possible participant for this study because:</p>			
<p>You were selected as a possible participant for this study because you were identified by a colleague as someone who uses humor in his/her work with grieving clients.</p>			
Study is being conducted by:	Jessie Rae Rayle		
Research Advisor (if applicable):	Colin Hollidge		
Department Affiliation:	MSW		
Background Information			
The purpose of the study is:			
<p>The purpose of this study strives to uncover licensed therapist's thoughts on the use of humor, ways that licensed therapist are using humor and the benefits and/or negative consequences of using humor with grieving clients.</p>			
Procedures			
If you agree to be in the study, you will be asked to do the following:			

<p><i>State specifically what the subjects will be doing, including if they will be performing any tasks. Include any information about assignment to study groups, length of time for participation, frequency of procedures, audio taping, etc.</i></p>
<p>You will be asked to participate in one 45 minute interview with the primary investigator at a convenient and private location. The interview will be based on 7 questions that will be provided prior to meeting. The audio of this interview will be digitally recorded and transcribed by the primary investigator.</p>
<p>Risks and Benefits of being in the study</p>
<p>The risks involved for participating in the study are:</p>
<p>There is minimal risk involved in participating in the this study. Possible risks include difficult recollections of memories, the participants will know this ahead of time and be sent a copy of the questions.</p>
<p>The direct benefits you will receive from participating in the study are:</p>
<p>There are no benefits to participating in this study.</p>
<p>Compensation</p>
<p>Details of compensation (if and when disbursement will occur and conditions of compensation) include: <i>Note:</i> In the event that this research activity results in an injury, treatment will be available, including first aid, emergency treatment and follow-up care as needed. Payment for any such treatment must be provided by you or your third party payer if any (such as health insurance, Medicare, etc.).</p>
<p>There will be no compenstaion for participating in this study.</p>
<p>Confidentiality</p>
<p>The records of this study will be kept confidential. In any sort of report published, information will not be provided that will make it possible to identify you in any way. The types of records, who will have access to records and when they will be destroyed as a result of this study include:</p>
<p>The principal investigator, research advisor and committee members will have access to the data and records obtained from the interviews. All identifying information will be removed from the data and records before any viewing from research advisor and committee members. The consent forms and written notes will be kept in the principal investigator's home, in a locked file cabinet. The audio recordings and trasncriptoins will be downloaded to the principal investigator's personal computer and kept in a locked file with a secure password. The consent forms, written notes, audio recordings and transcripts will be destroyed by May 25th, 2013.</p>
<p>Voluntary Nature of the Study</p>
<p>Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with any cooperating agencies or institutions or the University of</p>

<p>St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until the date\time specified in the study. You are also free to skip any questions that may be asked unless there is an exception(s) to this rule listed below with its rationale for the exception(s).</p>			
<p>You are also free to skip any questions that may be asked during the interview that you feel are too invasive or of concern.</p>			
Should you decide to withdraw, data collected about you		will NOT be used in the study	
<p>Contacts and Questions You may contact any of the resources listed below with questions or concerns about the study.</p>			
Researcher name	Jessie Rae Rayle		
Researcher email	rayl7447@stthomas.edu		
Researcher phone	507-382-2215		
Research Advisor name	Colin Hollidge		
Research Advisor email	CFHOLLIDGE@stthomas.edu		
Research Advisor phone	651-962-5818		
UST IRB Office	651.962.5341		
<p>Statement of Consent I have read the above information. My questions have been answered to my satisfaction and I am at least 18 years old. I consent to participate in the study. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent to participate in the study.</p>			
Signature of Study Participant <input type="checkbox"/> <i>Electronic signature</i>		Date	
Print Name of Study Participant			
Signature of Parent or Guardian (if applicable) <input type="checkbox"/> <i>Electronic Signature</i>		Date	
Print Name of Parent or Guardian (if applicable)			
Signature of Researcher <input type="checkbox"/> <i>Electronic signature*</i>		Date	
Print Name of Researcher			

*Electronic signatures certify that:
 The signatory agrees that he or she is aware of the polities on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.

- The information provided in this form is true and accurate.
- The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.
- The research will not be initiated and subjects cannot be recruited until final approval is granted.