


***EXPERIENCING HUMOUR: A CRITICAL  
CARE PHENOMENON***

***Jan Skinner  
RN., Dip. App. Sc - Nursing, BN***

  
AUSTRALIAN CATHOLIC UNIVERSITY  
53 Prospect Road,  
MITCHELTON, Q. 4053  
P.O. Box 247,  
EVERTON PARK, Q. 4053  
Phone: 5855 7124

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**The work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text. This thesis has not been submitted, either in whole or in part, for a degree at this or any other university.**

A handwritten signature in black ink, appearing to be 'J. Skinner', with a long horizontal line extending to the right.

**Jan Skinner**

*I wish to acknowledge the support of the Critical Care staff at Logan Hospital and I would like to thank them for their participation in this research project. Their ability to laugh at themselves and find the humour in most situations made the work interesting and less of a trial.*

*I also wish to thank my husband, John, for his support during this time. Without his determination to see me finish, the work might still be sitting on a desk.*

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## **ABSTRACT**

Humour, whilst frequently occurring within the Critical Care environment, has been traditionally viewed as both macabre and in poor taste. However, for the Registered Nurse working in this setting, humour plays a vital role in the day to day functioning at the unit level, and is identified as an important component in the development of interpersonal relationships between both co-workers and clients. Therefore, by describing this experience, the thesis seeks to elucidate this concept of humour and the experience of this phenomenon for the Registered Nurse working within the Critical Care environment

On reviewing the literature it becomes evident that humour is identified as conducive to both the physical and psychological wellbeing of an individual. In many ways, humour provides positive benefits in times of stress, as well as in the event of personal disillusionment and crises. Humour's role in one's daily life, as well as the recognised paucity of literature concerning the topic of humour in the area of Critical Care, and the Critical Care Unit's bent toward jocularly and play then lends itself to further exploration of this fascinating topic. Therefore, it is from this foundation that the impetus for this research thesis emerges.

The research study engages Husserlian phenomenology (Kersten, 1982) as the methodology for the explication of the meaning of humour as experienced by the Registered Nurse working within the Critical Care environment. Colaizzi's (1978) method for data analysis is employed to explicate the formulated meanings which evolve from the data. As an adjunct to this, aspects of both Bergum (1994) and Wolcott's (1990, 1994) notion of narrative storytelling of critical events, and the importance of this concept within data collection and analysis, have been incorporated within the work.

Six themes emerging from the data focus on humour as it is experienced for the participants within the study. The first of these themes identifies humour in response to the culture of the environment and is evidenced by the group's socialisation, supportive relationship and role referencing through the use of jocularly and play. The second theme emerges through the consistent use of humour in response to the event of cardiac arrests and death or dying. Registered Nurses make constant reference to the use of humour at these times as a coping mechanism, to relieve tension and support co-workers during stressful situations.

In conjunction with these two themes, the four remaining themes relate to the use of humour. Firstly is the use of humour in response to the receptiveness of other individuals. The timing and nature of humorous interplay has been described as dependent on the feedback from the recipient. Co-workers and clients alike are often



tested informally as to their response when mirth is employed and the nurse gauges this response as a trigger for future interactions.

Furthermore, the use of humour as a method for communication is identified as a theme emerging from the data. Participants cite this strategy as an aid in the development of co-worker and client relationships. Communicating through humour enables life experiences to be better understood, bringing a humanness to the relationship that builds rapport and provides the basis for shared understanding between individuals. The data also outline the use of humour as a means for cheering co-workers and clients. The essence of this theme consistently weaves a path through much of the research study.

Finally, the very nature of nursing practice undertaken during the nurse's daily working life within the Critical Care Unit sets the scene for episodes of jocular and wit. Care of the client involves the development of personal relationships whereby the nurse may perform the most intimate tasks for that individual. This milieu gives rise to the generation of humorous play that may place the client at ease during stressful and embarrassing times.

Whilst the participants' data have been analysed for the development of each theme, the thesis has then returned to the current literature for discussion. From this discussion, the implications for future nursing practice and the subsequent questions for future research have been outlined. This then paves the way for further research

into the area of humour within the Critical Care environment, and indeed other settings.

In conclusion, it would appear that the essence of humour as it is experienced for the Registered Nurse working within the Critical Care environment, whilst informally acknowledged, has not been well understood or explicated within the literature. Therefore, this thesis seeks to illuminate this for the reader by describing the experience of humour for the Registered Nurse working within the Critical Care Unit.

## **CHAPTER 1**

### **GENESIS: WHERE DOES THE STUDY BEGIN?**

#### **Introduction**

Nursing as a profession has undergone a multitude of changes from its historical roots grounded in the fundamental philosophy of clean air and pristine hygiene practices of the Florence Nightingale era, to the high powered techno-medical world of the present day. Whilst diverse in scope of practice, one of the fundamental tenets on which the nursing profession is based continues to be embedded in the caring role of the nurse. Although the essence of nursing can not always be clearly defined as encompassing any one concept, it is evident that the epicentre of the nurse's practice continues to be the client who may be confronting either a physical or psychological health crisis, brought about by an acute or chronic illness phase. Today, as part of this unique and everchanging environment, the nurse is able to excel within a specialised field of practice, nursing the client amidst a diverse range of clinical settings.

Specialisation in nursing practice has generated a clinical environment that is now able to meet the nurse's own interests, knowledge base, learning needs and clinical skills. This changing face of nursing provides an environment conducive to excellence within clinical practice, the development of team functioning and the creation of camaraderie at the ward or unit level. It is within this milieu that relationships are born, due to the cohesiveness that is often present in various specialised units or wards. At the unit level one may then be able to witness the emergence of key players significant to the particular clinical area. These nurses personify the philosophy of the specialist area and subsequently embody the meaningful ownership of the specific field of practice. This ownership consequently instils in the team players a sense of 'being' in the area, as the day to day happenings within the unit become a way of life.

This chapter will focus on one specialist environment, the Critical Care Unit, and seek to develop an understanding of the nurse who works within this area. This introductory chapter will address the concept of stress which is often associated with this closed environment, consider the 'highs and lows' which in many cases become a way of life and how both these issues are woven into the day to day functioning of the ward environment. To give credence to this 'topsy turvy' nursing lifestyle, the study will focus on only one aspect of the environment that has become evident in the Critical Care area. This aspect relates to the use of humour identified through witticism and play. If one took the time to consider, one might find the recurrent use of humour within Critical Care both macabre and in poor taste. However, this setting

has produced a jocularity that is not often formally identified as a key component in the functioning at the unit level. Whilst the use of humour may be viewed as a common practice for the Critical Care nurse, there is little formal recognition of this phenomenon.

### **Is the Critical Care Unit stressful?**

As mentioned, the diversity in nursing and the increasing trend toward specialisation within practice has given rise to a range of areas where nurses may further develop skills, knowledge and expertise. This concept is reflected in the development of the Critical Care Unit, as there is an increasing trend towards life-sustaining techniques, advancements in medical technology and the advent of sophisticated intervention. This then necessitates the establishment of an environment conducive to the wellbeing of the client experiencing a complex health breakdown. From these foundations has evolved a need for specialist nurses who can function within these distinct units, providing specialist nursing practice for those clients experiencing acute crisis or a life-threatening illness. Topf (1994) discusses the uniqueness of the Critical Care environment identifying environmental stressors such as noise and ongoing societal and technological development as conducive to increased stress. This author emphasises the need for control and management of environmental stress to circumvent the threat to the individual's wellbeing

Heuer, Bengiamin, Downey and Imler (1996) state that nurses who work in the Critical Care environment may experience increased levels of stress due to the nature of the environment. This is often related to staffing/management levels, death, family

needs and continual decision making processes in critical situations. If one considers the speed at which technology changes, one may understand the importance, for the Critical Care nurse, to move with the times and meet the challenges of this ever expanding field of professional and medical knowledge and how this may test the nurse's coping mechanisms. This constant shift in the foundations of practice generates a stress within the unit as the nurse seeks to "... bridge the gap between modern technology and the needs of the critically ill" (Ruppert, Kernicki & Dolan, 1996, p.3). This stress often places untold hardship on the nurse and his/her coworkers, as the nurse seeks to cope with day to day issues associated with the life and death situations.

Mastery (1992) suggests that the costly effects of psychological stress within the Critical Care Unit may manifest in various symptoms. This author goes on to discuss that this can present in the form of "... diminished work performance, low morale and personal dysfunction ..." (p.208). Stress not only produces problems with staff recruitment and retention but can also contribute to feelings of helplessness, guilt and responsibility amongst team members when confronted with issues related to death and dying (Heuer, Bengiamin, Downey & Imler, 1996; Oehler, Davidson, Starr & Lee, 1991; White & Tonkin, 1991). The expectations of group members are often 'put to the test' in times of traumatic situations such as during complex nursing procedures or, as often expressed by staff, in times when the client experiences a cardiac arrest or as more aptly termed by the team, a 'code'.

It is at the completion of these situations or procedures that nurses most need to de-stress and separate from the day to day events of living and dying. Selye (1976, cited in Crickmore, 1987) identifies the main components of stress as the individual's interaction with the environment. Although variations occur among individuals, the frequency of stressful situations can perpetuate the problem, facilitating the need to refocus and isolate the 'self' from the immediate episode. The constant demands placed on the nurse in this area often forces a detachment from the situation as a measure of self preservation. Wooten (1996) concurs with this, suggesting that this must surely take a toll on the individual's everyday existence if a person experiences the full gamut of emotions in any one working day. Doing so then will surely lead to emotional disaster. Therefore, the nurse must discover some form of outlet for the pent up emotion that becomes part of everyday's agenda.

Although stress affects each individual differently, the results are recognised in a specialised area, where the staff turnover can often be considered higher than in other unit environments. Both Hay & Oken (1972, cited in Crickmore, 1987) and Mastery (1992) support the notion that 'high tech' nursing is the basis for the increase in nurses' stress, manifesting in a decrease in job satisfaction. Hay & Oken (1972, cited in Crickmore, 1987) go further to suggest that "... in this special environment the psychological burdens imposed on the nurse are extraordinary ... her (sic) situation resembles, in many ways, that of the soldier serving with an elite combat group" (p.21). The increasing incidence of stress within the environment can then result in a decrease in the quality of patient care, thereby generating a decrease in job

satisfaction. This cyclic effect then provides the catalyst for a further increase in the level of stress under which the nurse functions.

### **The 'Highs and Lows' of Critical Care**

It is no surprise to see that Crickmore (1987), Leiber (1986), Mastery (1992), and Wooten (1996) all suggest that often nurses within the area of Critical Care are observed to be joking and laughing. Some nurses may even be seen whistling or singing. Practical jokes and humorous interludes become a common component of the Critical Care nurse's repertoire. An outsider may view this nonchalance as a sacrilege to the sanctity of the environment, and may not understand from where this jocularity is spawned. However, the Critical Care nurse knows, because he/she has been bred through a process of socialisation and experiences unique to the environment.

Mastery (1992) purports that this socialisation is two fold. She suggests that it is primarily initiated through formal channels under the guise of orientation, competency achievement, policy and procedures, whilst informal machinations of reference grouping and role modelling weave an insidious path to assimilation amongst group members. The emergence of humour among staff members in Critical Care coincides with this relationship development with the reference group where humour is seen amongst group members as the 'norm'. The benefits of using humour are soon identified as new members observe the alteration in mindset by other more experienced nurses when confronted with complex client scenarios.



Wooten (1996, p.50) states that “Finding humour in a situation and laughing freely with others can be a powerful antidote to stress”. The use of humour provides a sense of control over situations that can be undermined in nursing practice as events are often shaped through unforeseen circumstances. The nurse, whilst grappling to understand the life and death events that occur during the course of a shift, may seek to make light of events in order to gain ground and perspective.

### **Humour: From day to day**

It is now commonly recognised that humour is of therapeutic value to the individual. Human survival may, and often does, occur through the use of comic relief and laughter. Humour also restores both the physical and psychological wellbeing of the recipient (Gilligan, 1993; Harries, 1995; Leidy, 1992; Robinson, 1993) and can assist in the promotion of health. Ditlow (1993) suggests that humour not only disperses anxiety and strengthens one’s resolve, but it also gives one a sense of sanity, bolsters one’s faith in the future and provides a means by which one may view chaos from a safe distance. To go further, humour not only facilitates self reflection but also plays a major role in client care and people interactions.

McDermott (1989, p.23) believes that “The most utterly lost of all days is that in which you have not once laughed”. Although the perceived benefits or results may not be immediate, humour does raise the spirits and heighten the recipient’s awareness, enabling the individual to focus on any immediate issues. This is necessary in the Critical Care Unit where day to day life can often traverse the path from elation to depression merely whilst caring for one client. Issues of guilt and

helplessness resurface as the nurse attempts to mentally bargain for the life of this individual for which he or she has been responsible for the past eight hour shift. Strickland (1993, p.24) postulates that "... humour bridges the gap between the perfection we seek and the imperfections we are stuck with". The Critical Care nurse may seek or expect for the client, that which is impossible or improbable depending on the person's health status. The nurse may then choose humour as an outlet for the hidden emotions that secretly scream "Why can't I do more?".

If one considers the interactions that occur on a daily basis between clients, peers and allied health care workers, relational behaviour and actions often produce a 'domino' effect initiating subsequent reactions among all staff members. With the incorporation of humour in the workplace, a more playful style of interaction can produce a higher level of competence and professionalism, reduce stress and facilitate workplace effectiveness (Gilligan, 1993). The use of humour as a nursing strategy also provides the client with a coping mechanism to counterbalance the psychological impact of the disease process.

## **Conclusion**

Humour as an important component of nursing practice has been overlooked for too long. Behi (1992) remembers being reprimanded by a senior staff member for sitting and laughing with a client. Although told to get on with the 'real' work, she sees humour as an important facet of nursing practice which is still devalued. Humour has been evidenced not only in Critical Care but within other specialised areas of oncology, the operating theatre, emergency and trauma where staff incorporate stress

relieving techniques to enhance group cohesiveness among team members as well as to promote individual wellbeing. Often, the biopsychosocial wellbeing of clients may be enhanced by immersion in the 'festive spirit' engendered by the jocularity common to many specialist clinical environments.

Humour may also become the cathartic 'conduit' through which to traverse the difficult times. Using humour on a daily basis facilitates a dichotomous role as it has the potential to improve collaborative practice and provide immense therapeutic benefits for the individual or recipient. To tap into this resource pool is to experience a phenomenon that has become second nature to many Critical Care nurses. Therefore, it is at this point that the research focus and subsequent study emerges. The following study seeks to illuminate these experiences which are a very real component of the Critical Care nurse's practice. The aim, then, is to describe these experiences, thus providing an understanding of humour for the nurse working within this environment.

## CHAPTER 2

### REVIEWING THE LITERATURE

#### **Introduction**

The following chapter seeks to provide some clarification of the intricacies of humour and how the concept of this phenomenon has been framed within the current literature. To do this, one must first consider: What is humour? What does it mean to experience humour in one's life? These questions have long been contemplated, going as far back as the times of both Plato and Aristotle. Historically, the incidence of humour was seen as evil (Snyder, 1992) with philosophers describing this phenomenon as wicked and immoral. Snyder (1992) goes on to state that in ancient times there were four aspects essential to sustaining one's good humour - choler, melancholy, sanguine and phlegm. If one or another of these components was missing then the person was said to experience poor humour.

Currently, Matte (1997, p.58) defines humour as occurring when one's "... moral and political restrictions on certain thoughts and feelings ..." are suspended allowing an accelerated release of built up tension. Whilst the question of humour appears to be simple enough, the fact remains that humour is difficult to define and the scope of this phenomenon, whilst clouded in mystique, continues to be diverse in its nature and dimension.

With this in mind and in their attempt to define humour, various authors (Biley & Maggs, 1996; Ferguson, 1989; Groves, 1991; Harries, 1995; Pasquali, 1990) have concluded that there is no one answer to this phenomenon. The very nature and experience of humour is such that it is individualised and dependent on the context in which this entity is experienced. In support of this, Pasquali (1990) articulates that humour is still whatever people find funny. To clearly define the concept of humour is to wrap this wonderful experience in a neat parcel using definitive parameters in which humour may be applied. However, this can severely jeopardise those experiences on which the individual relies for succour in times of need.

In 1916 Sigmund Freud (Thorson & Powell, 1993) discussed the structure and function of humour. He purported the use of humour as a strategy in the implementation of psychotherapy and behavioural modification. Over time, an interest in how one may utilise humour, laughter and play as therapy has developed as an emerging theme within the literature. Biley and Maggs (1996) go on to suggest that humour's definition revolves around various languages based on the English,

Polish and German meaning. These two definitions relate to humour as a form of amusing wit and also one that denotes mood and state of mind.

Whilst joking, laughter and play is extolled as conducive to an individual's health and wellbeing, review of the literature pinpoints a limited selection of 'hard' evidence expounding the diversity of this phenomenon and its relationship with various age groups and clinical settings. A number of studies have engaged in the inquiry into divergent areas of interest with humour surfacing as a recurrent underlying theme, whilst others have linked humour with the concept of health.

After consideration of this literature, it has become evident that the role of humour documented within the field of nursing is two-fold. Firstly, it provides a method for communication in both coworker interactions and nurse-patient relationships. Secondly, the role of humour has therapeutic worth and becomes the vehicle for the development of trusting relationships, team building and purging the soul of discontent. It is also evident that nurses incorporate humour in their everyday lives as a communication technique, using jocularly as a coping mechanism as well as a method for cleansing the spirit. Within nursing the frustrations often associated with daily events and stressful clinical situations are habitually tackled through the use of storytelling, laughter and play.

Humour has been identified as an integral component within the context of human life and is displayed frequently through this use of laughter, jokes and play. By returning to the roots of this phenomenon, it is hoped that perceptual clarity of the essence of

humour will occur. Review of the literature has unearthed a plethora of personal experiences, anecdotal stories, assumptions concerning the positive benefits of humour and theoretical frameworks that provide justification for the incorporation of this phenomenon, not only in nursing, but in one's everyday existence. Historically, writings concerning humour and research into the use of humour examined mainly the physical benefits conducive to a patient's health and wellbeing.

It will be demonstrated that using a quantitative methodology to measure the pathophysiological response to humour, studies however did not clearly provide an understanding of this phenomenon and its relationship to the individual's experience. Only within the past decade has there been an increasing interest in humour, filling the noticeable gap in the understanding of this phenomenon. This interest is demonstrated by anecdotal tales rather than substantial research in the area of humour.

Within humour, the paucity of qualitative research is apparent and humour itself is often given a 'back seat' to other more noble research interests. Whilst humour within nursing occurs covertly amongst coworkers, it is often displayed only through 'inhouse' jargonistic jokes, macabre tales and camaraderie. Humorous interchange between staff and patients has long been considered taboo and 'frowned on' by the 'establishment'. Whilst not sanctioned by health care professionals and fellow workers, these interactions persist, posing the question: Is this phenomenon an essential component of nursing practice?

Nurses are renowned for story telling and participating in practical jokes. This is discernible by the diverse range of literature related to personal tales from the clinical area. Humorous events are graphically depicted, providing a lasting impression of the experiences of nurses, their relationships with patients, as well as nurses' interactions with the medical profession. These tales act as a means for communication and often facilitate group cohesion among coworkers as well as enhance collaborative practice.

### **The Essence of Humour**

White and Howse (1993) espouse humour as a communication strategy that facilitates humanness within the environment, increasing job satisfaction and creating a positive work environment. These authors go on to reflect that humour is "... a culturally universal means of communication ..." (p.80) and as such, becomes a necessary component of an individual's physical and psychological development.

Robinson (1986), known as the 'Fairy Godmother of Humour' in nursing has been researching the use of humour within the clinical setting for some years. As testimony to her work, there is evidence of the exploration into the concept of humour, considered from all professional angles. Through various works, researchers have attempted to categorise this phenomenon to obtain a better understanding of the origins, uses and effects of humour. In doing so, this researcher intends to extend these understandings of this unique but fundamental component of the individual's life.



Humour's very uniqueness and individuality for those experiencing this phenomenon perpetuates its complexity when one attempts to theorise a model for its practical application. There appears to be no single entity that can be labelled as humour and each experience, similar to a prism of light, generates a myriad of humorous repercussions for the recipient. Robinson (1977) suggests that humour is a "... combination of many factors and it serves many purposes; and the nature and purpose will vary depending upon the situation" (p.4). Therefore, to try and capture the essence of humour is to understand this experience for each individual.

From these beginnings, various authors (Hulatt, 1993; Leiber, 1986; McGhee, 1993; Rosenberg, 1989; Snyder, 1992; Strickland, 1993) have extensively utilised Robinson's work as the 'springboard' from which to journey the field of humour research. This current review of the literature has not, however, delved into the copious studies undertaken within the philosophical, psychological, sociological, arts and literary field. Exploration has focused on nursing's domain with a view to understanding humour's role within the clinical environment, and the explication and value of humour within nursing practice. In support of this Kennedy (1995) suggests that although much of the literature available considers the need and application of humour as a nursing intervention, there are currently few actual studies documented by nurses. Therefore, this precipitates the need for pursuit of humour's many facets as glimpsed through the eyes of nurses.

Literature focussing on health care and nursing issues has provided new insight into the phenomenon of humour. Various authors (Balzer, 1993; Black, 1984; Ferguson,

1989; Groves, 1991; Hunt, 1993; Pasquali, 1990; Robinson, 1986; Struthers, 1994; Woodhouse, 1993) proclaim the use of humour as an innovative strategy in the facilitation of health and wellbeing. Gilligan (1993) discusses the use of humour in the oncology setting as a beneficial addition to nursing practice, stating that as cancer often inflicts psychological suffering on patients and nurses alike, there is the need to incorporate the practice of humour as a stress management technique, ensuring the establishment of effective coping strategies.

Thus it can be seen that while humour as a nursing strategy must be used appropriately, the benefits are boundless and patients who actively seek to incorporate humour into their lives can therefore maintain control whilst facing daily adversities. Not only are there benefits for the patient who makes use of humour. The nurse who incorporates humour in his/her daily routine may create a stress free zone in the workplace through the development of insight and awareness of personal feelings, as humour provides the medium through which pent up emotions may be dispersed.

### **Humour in Specialist Environments**

As testimony to this, the incidence of humour within specialist environments such as Critical Care is quite commonplace. Joking and play is used to relieve tension and is often a means for maintaining a tolerable climate (Crickmore, 1987). Warner (1986) emphasises the importance of humour within the area of Critical Care and identifies this as an essential component in an environment where the nurse often uses humour to distance him/herself from the trials of dealing daily with critical illness and death.

She goes on to suggest that jokes become the “safety valve” (Warner, 1986, p.168) where the nurse and the patient may express pent up anxiety and vulnerability. As Critical Care nurses remain cloistered in a setting that demands attention to the ‘here and now’, this environment necessitates a display of emotions conducive to the cathartic process facilitated by jocularly.

Socially taboo subjects which may relate to bodily functions such as elimination patterns or sexuality are dealt with in a macabre and often blasé fashion. Spawned through camaraderie, interpretations of events are also laced with humorous metaphor that can only be appreciated and condoned by those within this elitist environment. McGhee (1993) agrees with this premise, confirming that the areas of operating suites, accident and emergency, and critical care are the ideal environments to experience genuine commitment to humour. He reiterates that “... stress levels are also generally higher in these areas ...” (p.37) generating the need for humorous interchange.

Whilst this is so and humour in the Critical Care and other specialist environments is often taken for granted, there is minimal research that establishes a benchmark for these assumptions and the resulting anecdotal tales. Once again, returning to the literature only reinforces the notion that there is the need to ground these well meaning thoughts, comical tales and age old assumptions within a theoretical framework that is based on documented clinical data.

## **Communicating through Humour**

Humour as a communication strategy plays a key role in one's daily relationship with others. By nature, humans are social individuals that communicate both verbally and nonverbally on a daily basis. These interrelationships are enhanced through the use of comical interplay and can facilitate a closer relationship among individuals. From the review of the literature it is apparent that the essence of humour encompasses many aspects of communication. Noticeable is humour's role within education, the generation of coworker relationships in the clinical area and the often personal relationships which develop between nurses and patients when humour is employed as a strategy. In this way it becomes evident that the practice of humour as a form of communication has the potential to be of benefit within the field of nursing.

To clearly explicate the nature of humour as a communication strategy one must first tease out these facets within the literature. As testament to the first of these conceptual branches of communication, various authors (Pease, 1991; Rosenberg, 1989; Struthers, 1993) discuss the benefits of humour in education, identifying methods for improving student retention and providing meaningful learning through use of humorous strategies. Pease (1991, p.262) goes further to suggest that a classroom characterised by frequent laughter "... even at the teacher's mistakes, is a safe classroom ..." where students will take risks and feel free to experiment with new concepts. Within the teaching environment, the use of cartooning and caricature is utilised with both students and patients alike as an aid to retention in information giving sessions.

Armstrong (1992), Carroll (1989), Dirr & Katz (1989), McDermott (1989), Rhodes and Wooding (1989) support the use of humour as an important strategy, suggesting that jocular interludes may form 'quick communicators', simplifying complex messages and enabling visual understanding when performing information giving sessions. Exaggeration or distortion is often used within the picture to highlight or emphasise a point of view. This technique attracts the observer to the humorous context without offending, while focussing on the message. Nurses also incorporate this strategy within the context of educational sessions and do so often without realising that humour then plays a key role in this exchange of information.

Cartoons are also used in educational settings to examine stereotypes, question assumptions, promote group process, as well as to facilitate creativity and flexibility within the teaching/learning environment. There is significant evidence within the literature to support the concept of cartooning and caricature within education. This translates to the field of nursing where it is common practice to observe nurses using cartoons or posters, depicting comical events, as a method for communicating messages that often only coworkers will comprehend.

Therefore, humour plays an important role as a communication strategy. It is also beneficial as a means for educating others through improved memory retention with the use of humorous sessions. Group cohesiveness results through this positive environment and may be undertaken in the clinical setting to enhance both patient and nursing relationships.

## **Development of Coworker Relationships**

Communication also plays a key role in the development of coworker relationships and as such brings the essence of humour to the forefront of these interludes. This development of coworker relationships through the use of humour forms yet another branch of the literature. The use of humour as a positive communication strategy is seen to promote improved team functioning in both everyday clinical situations and in the event of stressful events.

This positive approach may then lead to increased job satisfaction amongst staff members and, as Crickmore (1987) suggests, ensure that the nurse is in a better position to care for the patient effectively. Booth (1993) discusses the essence of humour within the workplace as currently evolving within the United Kingdom, citing the developing trend of 'Yuleopathy' within nursing practice during the Christmas season. Despite views that this form of festivity is a waste, many nurses take on the challenge of providing their patients with an environment conducive to positive health and wellbeing.

Within Australia there is some evidence of this phenomenon in the clinical setting during the Christmas period, however, this type of festivity is often identified as 'childish' when performed outside the recognised holiday boundary. One might question the reason for abandoning the camaraderie and jocularly throughout the year, and the relationship between humour and coworkers' perceptions of professional behaviour, or the lack of understanding of the benefits of humour as a therapeutic

technique. Review of the literature emphasises the importance of including humour in some form into all aspects of nursing practice.

A number of authors (Barra, 1986; Leff, 1993; Strickland, 1993; Walter, 1994) regale the reader with tales of humorous travels and unique experiences suggesting the universal power of laughter and humour as ‘opening the hearts’ of patients and nurses alike. Strickland (1993, p.20) expounds humour as a means for “... establishing or strengthening the various relationships in the health care setting ...” and accentuates the use of communication as an important component of humour within nursing.

### **Humour as a Healing Process**

Whilst extolling the virtue of humour as a communication process, the literature has also identified the therapeutic value of this phenomenon and the physical and psychological benefits to those recipients who share in the jocularity. Robinson (1993) postulates the physical benefits attributed to humour and how the use of humour in one’s everyday life may produce these physical and psychological benefits enhancing the individual’s overall wellbeing. However, there is little insight into the experience itself and how this is reflected within the individual’s daily life.

The research does however contemplate humour as facilitating the restoration of homeostasis within the body, manifested by a positive biochemical change such as a decrease in muscular tension through laughter, an increase in respiratory function facilitating hyperoxygenation of cell tissue, a decrease in cortisol production through the suppression of stress and an increase in heart rate, central nervous system

stimulation and metabolism. These physical attributes then significantly contribute to the healing process.

This is determined through the writings of Cousins (1979) who proclaimed the phenomenon of humour as a 'wonder drug' instrumental in his recovery from ankylosing spondylitis. Cousins (1979) goes on to postulate that ten minutes of hearty belly laughter, comical movies and humorous text enabled him to experience periods of pain-free sleep. Ferguson (1989) supports this notion suggesting that humour is advantageous as a therapeutic nursing intervention when utilised appropriately.

Various authors (Ackerman, Henry, Graham & Coffey, 1994; Descamp & Thomas, 1993; Harries, 1995; Kennedy, 1995; Leidy, 1992) discuss the miraculous healing event experienced by Norman Cousins and comment on the lack of officially documented examples of research using humour as the foundation. Each author, in turn, utilises this one example of healing through humour as the foundation for further study.

Descamp & Thomas (1993) emphasise the impact of humour on the nurse and how this is precipitated by the day to day stresses and strains of the nurse's clinical role. Whilst focussing on general practising nurses, these authors predicted that "... active physical play is a buffer of stress" (p.624). This measure facilitates the expression of nurses' frustrations with the daily 'grind' and as such is an essential component in overcoming the stress of clinical situations.



## **Trusting Relationships and Team Building in the Workplace**

Balzer (1993), Davidhizar (1995), Forsyth (1993), Gibson (1994), Hague (1994) and Warner (1986) focus on the practical application of humour within the workplace and provide various strategies for the use of humour as a nursing practice. It would appear however that the essence of this literature depends greatly on previously researched areas that pool information from the study undertaken by both Cousins (1989) and Robinson (1993).

These authors (Balzer, 1993; Davidhizar, 1995; Forsyth, 1993; Gibson, 1994; Hague, 1994; Warner, 1986) discuss the appropriateness of humour in caring for the patient but give very little emphasis to the theoretical framework which underpins their philosophy. There is a need to make evident the foundations for this covert knowledge base and this will only be achieved through rigorous searching within the area of humour and its meaning for the individual.

Ackerman et al (1994) identify the benefits of humour within the health care setting and discuss the introduction of humour programs within the clinical environment. The project highlights a clinical area that displayed signs of a decrease in morale among staff members and patients alike, and an increase in staff turnover. To combat this problem, objectives and a model essential to the facilitation of the humour program was developed and implemented. Programs were then evaluated and found to be both beneficial and constructive in the care of patients and retention of staff within the clinical area.

Nurses who incorporate humour into their working environment have been identified as more productive and less intimidated within the clinical setting (Ackerman et al, 1994; Balzer, 1993; Gilligan, 1993) . Stressors that affect health care professionals relate to various aspects of responsibility and accountability within the clinical arena. These stressors may include such issues as shift work, case load, institutional policy and the closed environment of specialist areas.

Paquet (1993) considers these problems in relation to the operating suite environment. With the use of research, she identifies ways in which humour can be included into nursing practice as a strategy for relieving tension, thereby improving group relationships and collaborative practice. With this as the focus there are currently over 300 hospitals throughout America that have established programs involving the use of humour in the workplace and which are achieving positive results. Leidy (1992) suggests that an organisational climate that is supportive of humour in the workplace is one that employs a powerful countermeasure to burnout and turnover.

### **Purging the Soul**

One aspect that emerges from the literature is the frequent use of humour in written text as a means to purge the soul. Whilst the literature provides a channel for the illumination of anecdotal tale and theorising, there are those (Herd et al, 1995; Kane, 1992; Radcliffe, 1993; Winters, 1992) who have used this medium to express their disillusionment and cynicism within nursing. Metaphorically, these authors communicate their feelings of discontent, using humour in the text as a forum to vent perceived inadequacies or inequity within the health care system.

This communication between fellow workers is embellished with anecdotal tales that 'strike a chord' into the hearts of supporters instilling cohesiveness during both the good times and the bad. Once again this use of humour acts as a communicator, framing issues within the context that coworkers may understand. It also provides beneficial and therapeutic cleansing of the spirit for the writer, as well as for those that experience the collective 'nod' of understanding and empathise with the yearnings of the scribe.

### **Australia's contribution to the Process**

In Australia, the concept of humour within nursing practice is slow to be recognised and there is minimal research regarding the positive benefits of humour within the field of nursing practice. One author (May, 1996) provides inspiration through a brief glimpse into the realm and use of humour at the Moruya District Hospital and clearly demonstrates the applicability of utilising this untapped resource. May (1996) goes on to state that "Moruya Hospital's Laughter Room, believed to be the first in Australia, is roughly modelled on overseas humour rooms" (p.6).

Whilst cautious about the success, trialed for an initial 12 months and only informally evaluated at present, staff and patients alike have reacted positively to the incorporation of this innovative strategy (May, 1996). Once again, this research is in the embryonic stage and provides a starting point for its incorporation within nursing practice. However, this does reaffirm the growing trend toward recognising this phenomenon as a viable entity within the scope and context of nursing. Rosenberg

(1989) suggests that the concepts of humour and professionalism are not mutually exclusive, and a professional who can appreciate the humour of a situation and laugh, embodies qualities of empathy and self-confidence.

The aim within this work, therefore, is not to redefine the concept of humour or bracket it into a 'neat box' that reaffirms formal boundaries set in place by societal norms, but to contemplate the uniqueness of this entity and negate its denigration within the professional sphere of nursing practice. Therefore, it is imperative that one looks to the researched literature to understand what has gone before and where the road is leading.

### **Reviewing the Research Field**

Fundamental to the review of humour as a phenomenon is an understanding of the evolutionary changes within the research literature. As previously mentioned, the notion of humour and its role within everyday life has been considered to varying degrees as early as ancient times. That humour has developed as an underlying theme within a significant portion of current literature is not surprising due to its potential worth and therapeutic value.

Many studies have examined humour from the client's perspective (Parse, 1994; Richman, 1995; Townsend, 1994) as well as considering the impact of humour on the nurse's role (Dunn, 1993). Parse (1994) has researched aspects of laughter and stress, using a phenomenological approach to develop an understanding of the relationship between humour and health. The lived experience of laughter and health is described

as a “... potent buoyant vitality sparked through mirthful engagements, prompting an unburdening delight deflecting disheartenment while emerging with blissful contentment ...” (p.59).

Participants, as part of the project, related personal tales of laughter, identifying the concept as a ‘safety net’ in times of distress, a facilitator of social interaction and a ‘comfortable companion’ in times of interpersonal encounters (Parse, 1994) . This phenomenological approach has provided a grounding for the explication of the themes through the use of extraction-synthesis and heuristic interpretation. The essence of the lived experience is unveiled and forms the basis of renewed understanding of the relationship between laughter and health. Parse’s research project is one of the few that provides the clear, concise understanding of humour in relation to the individual’s understanding.

Within the literature there is also evidence of a recurrent overarching theme. This relates to the concept of humour from the individual’s perspective and centres on how the individual perceives and uses humour in his/her life. Currently, much of the work related to the individual focuses on the ageing community. Due to the proportion of elderly within society, authors (Buckwalter, 1995; Herth, 1993; Mitchell, 1993; Richman, 1995; Thorson & Powell, 1993) identify the importance of valuing this lifestage in humour research.

It has been postulated by these authors that many elderly individuals express their individuality through the use of humour, reacting positively to others who incorporate

humour into social interaction. Elderly individuals often initiate humour through storytelling and thrive on self-included jokes. This social interaction generates feelings of being 'in the world' and not partaking a spectator sport. Buckwalter (1995) suggests that those elderly who enjoy humorous tales and songs may retain anecdotal vignettes long after other aspects of memory and communication skills have abated.

Elucidation of descriptive studies with both the elderly and the psychiatric patient in the clinical setting produces an understanding of the current role of humour. Richman (1995) identifies humour as a life affirming strategy and advocates the use of this technique as a complementary therapy which promotes cohesiveness among co-recipients. Interactive in nature, humour acts as a stress reduction strategy and coping mechanism, providing the medium through which communication may be optimised and social interaction established.

Research into humour from the nurse's perspective is evident in Astedt-Kurki and Liukkonen (1994), Descamp and Thomas (1993), Dunn (1993), Schaefer and Peterson (1992), Summers (1990) and White and Howse (1993). The nurse's view of humour within nursing practice and the individual's use of this strategy in the clinical setting have been the focus of this work. Engaged research varies from quantitative measurement to a more descriptive, qualitative methodological approach. Much of the work addresses the use of humour with a client group or how often the nurse uses humour in his/her daily practice.

Dunn (1993) incorporates a phenomenological process to explicate the perceived therapeutic use of humour envisioned by psychiatric nurses. Within the study, participants define humour as a concept and discuss its usefulness within the clinical environment. Rich data is gained through this technique as nurses reflect on instances of memorable episodes where they have experienced humour in their working day. Many nurses subsequently identified this form of humour as an important component of their clinical practice but felt that this technique was under utilised and undervalued as a clinical practice.

It is this process and this form of research study that has not been well documented within the area of Critical Care. As an environment, this setting provides a surfeit of resources that may bear rich data from an area that is rife with personal experiences. These experiences provide the foundations for further understanding and integration of the humour process in the nurse's clinical practice.

Sumners (1994) and White and Howse (1993) provide evidence of quantitative research in an attempt to explicate humour's role in managing stress in the clinical environment. Although beneficial in an understanding of measurable outcomes concerning the number of nurses using humour, a quantitative approach clouds the theme underpinning the research and produces little in the way of understanding the essence of humour as experienced by the nurse. Astedt-Kurki and Liukkonen (1994) support the use of a more qualitative approach using semi-structured and unstructured questions.

These authors (Astedt-Kurki & Liukkonen, 1994) go on to suggest that previous quantitative work has not fully provided an understanding of the development and meaning of the phenomenon of humour. As humour plays a key role in an individual's life and is significant in the promotion of health and wellbeing, there is the need to engage in a more appropriate method of inquiry. Astedt-Kurki and Liukkonen (1994) suggest that quantitative research is not enough and a more in-depth contextual analysis of the phenomenon is warranted.

### **Research Proposal**

From review of the literature, it is important to realise that, at present, humour is still identified by many within the clinical area as 'taboo' and not formally valued as a nursing practice. By some it is seen as unprofessional rather than a strategy that may be successfully incorporated into nursing practice. Whilst evident in specialist areas such as Critical Care, Accident and Emergency and Operating Suites, examples of humour have not been explored as extensively in other clinical settings.

As mentioned, isolated events have been present where staff commit to the concept and these are often ridiculed as 'childish' expressions of unprofessionalism. However, literature suggests that the essence of humour is part of one's existence and essential to everyday life. This chapter has sought to make some sense of the essence of humour as depicted within the literature. A framework for the explication of this phenomenon has focused on its utilisation as a communication strategy with coworkers and in nurse-patient interactions.



The chapter has also considered humour's therapeutic value in the development of trusting relationships, team building and as a cathartic measure within the nursing practice milieu. There is also clear evidence of the role of humour in specialist environments such as the Critical Care setting, and it is towards this clinical environment this research will be directed.

Rosenberg (1989) purports that ultimately the pleasures and pain of living in the real world take on a new meaning when viewed with a sense of humour and this is never more true than within the field of nursing practice. Whilst it would appear that within Australia there is limited research that focuses on humour in nursing practice, it is also recognised that like many specialist fields of practice, the Critical Care environment provides a surfeit of humour that has not been clearly explored or identified.

Therefore, it is proposed that this research will be undertaken with a group of registered nurses in the Critical Care environment in order to describe the phenomenon of humour as it occurs for the nurse within this setting. From these descriptions, it is anticipated that an understanding of the experience of humour for the Critical Care nurse will become explicit.

## **CHAPTER 3**

### **THE METHODOLOGY AND METHOD**

#### **FRAMING THE RESEARCH**

##### **Introduction**

Whilst the previous chapter framed the concept of humour within the context of current literature, this chapter seeks to show how the phenomenon of humour within the field of Critical Care nursing may be represented through the incorporation of an appropriate methodology and method. After consideration of relevant literature, it was concluded that research should be undertaken to describe the experience of humour for the nurse within the Critical Care environment. This study aims to:

Describe the lived experience of humour as understood by the Registered Nurse working within the Critical Care environment.

This chapter will describe one methodology that may be used to illuminate this understanding. This chapter will also outline the method for data analysis undertaken by the researcher.

### **Changes in Nursing Research**

Nursing, as a profession, has undergone a number of changes. The focus of nursing research and practice has moved toward the development of new relationships between the client and the nurse. This relational aspect, in turn, necessitates a shift from research that was based on a scientific perspective to one that accommodates a more holistic view of the client's world. The aim of nursing research, then, is to incorporate methods of inquiry that develop an understanding of the individual's lived experience of the world rather than merely quantifying outcomes.

Whilst quantitative research played a key role in research synthesis and credibility of the findings (Jasper, 1994), there is now significant interest in a more interpretive approach using qualitative methodologies as a foundation for research undertaken within nursing. In this way, qualitative nursing research aims to enhance practice through the understanding of those realities and experiences embedded in nurses' clinical experiences. Koch (1995) and Walters (1994) acknowledge that nursing has long been founded on a scientific research base. Habermas (1987 cited in Emden, 1991) agrees with this notion, further suggesting that nursing research has not always produced all the answers required by human beings.

Fjelland and Gjengedal (1994) discuss the origins of nursing practice as both an art and a science. Science in nursing is a starting point that can produce improved practical nursing and therefore contribute to the theoretical foundations of practice. Nursing practice incorporates, as well, the notion of art, as nursing is seen as a “... basically practical discipline ... [with] ... criteria for what is good and bad independently of theories ...” (Fjelland & Gjengedal, 1994, p.5). Traditional views of nursing research and nursing practice, however, have evolved from the scientific foundation on which nursing has functioned.

Nursing continues to be a dynamic field of practice and inherent in these shifting trends is the importance of developing new methods of nursing research in accord with the needs of the profession as an evolving discipline. Nursing, by its very nature, encompasses both the nurse and the patient in a unique relationship. It is imperative, therefore, that the research methodologies selected, facilitate the explication of the life experiences of the nurse, the patient and his/her significant others. As mentioned, the methodology that ‘teases out’ these experiences, as they exist in the context of the individual’s everyday life, provides a rich description of the experience that may not be gained from a more quantitative approach.

As research plays a key role in the development of theory to guide practice, it is important to remember that there is no right or wrong approach, only the opportunity to incorporate the methodology that ‘fits’ the research focus. Taylor (1993, p.123) suggests that one should consider the “... methodological congruence ...” before commencing the task, thereby ensuring compatibility with the research focus.

Benner and Wrubel (1989) and Dunlop (1994) reflect on these changing trends within nursing practice and suggest that the 'science of caring' has become a significant component of nursing practice. This altered focus elucidates the notion of the professional shift from a scientific phase of 'universal truths' to the more holistic approach to nursing practice within the profession and provides the foundation for the adoption of research that reflects the knowledge and expertise embedded in clinical nursing practice.

### **Husserlian Phenomenology**

For the purpose of this research, Husserlian phenomenology has been selected as the appropriate methodology for the explication of the experiences of humour for the Registered Nurse working with the Critical Care environment. Husserlian phenomenology has been used in numerous projects not only to develop an understanding of a particular phenomenon, but to also reflect on the meaning of this experience for the individual. It considers the humanistic, holistic approach to the lived experience and in this way is compatible, not only with nursing research, but with the tenets of nursing practice (Parker, 1995; Rose, Beeby & Omery, 1983).

Kersten (1982) supports this notion suggesting that Husserlian phenomenology is where natural cognition commences with one's experiences and remains within that encounter, thereby providing a perception of that experience 'in the world'. He further expounds that the world is made up of a significant number of possible experiences that form the foundations of theoretical thinking.

Husserl identifies phenomenology as a “... purely descriptive discipline, exploring the field of transcendently pure consciousness by pure intuition ...” (Kersten, 1982, p.136). Husserlian phenomenology seeks to make explicit the “... meaning of human experience ...” (Koch, 1995, p.828) and contributes to the individual’s understanding of the lived experience (Hughes, 1990). The fact that this experience may not be replicated in another setting does not detract from the subsequent understanding of the experience, but rather adds to the richness of the experience.

Whilst considering the lived experience of the individual living in the real world, Husserlian phenomenology encompasses these borrowed experiences and reflections to facilitate a deeper and richer meaning of the lived experience (Beck, 1994). This then provides a description of the world as experienced by the individual without overarching interpretation from the researcher. Gelven (1989 cited in Walters, 1994, p.138) supports this notion suggesting that it is important to “... let the facts speak for themselves”.

Taylor (1993) reflects on this experience of traversing the phenomenological trail and emphasises that this methodology suits well as both a methodology and a method. She extols the philosophical virtues of this methodology, reiterating that phenomenology may be used as a “... vehicle for mobilising ... thinking in relation to the research interest” (p.114). Ray (1990 cited in Beck, 1995, p.499) suggests that the philosophy of nursing is “... holistic and interactive and its epistemology is based on

experiencing human persons”. In this way, Husserlian phenomenology gives the licence to describe experiences and provides the method for achieving this.

### **Applicability to the Study of Humour**

It is imperative to establish congruence between the research question and the chosen methodology, to facilitate a deeper understanding of the individual’s experience. With this in mind, the topic of humour provides the stimulus for ‘teasing out’ those experiences within the area of Critical Care. Hence, the essence of humour as it is experienced for the nurse working within this environment is explicated, recapitulating what it means to be that individual. This ‘knowledge’ can not only contribute to the overall understanding of this phenomenon but may also enhance future nursing practice through the emerging perceptions and use of humour. This notion then provides the rationale for this research approach in the quest for an understanding of humour and its ‘fit’ within the scope of nursing practice.

Unravelling the foundations of this methodology, as well as mapping the origins of humour research from its inception to the present will ultimately assist in the applied compatibility of the two. This provides the window through which one can visualise the range and depth of the research trail and subsequently encompass a richer understanding of the methodological ‘fit’ essential to the explication of the research focus.

This then also assists in situating research on humour within the context of nursing practice. As previously mentioned in the literature review, extensive research

pioneered by Robinson (1977) has been undertaken by a number of researchers. Until recently, this research into the occurrence of humour or laughter has hinged on a biological focus that has been measured by physiological changes within the body. Within the field of nursing practice there is minimal research concerning that which can be seen as a very personal and often emotive experience.

If one takes into account humour within nursing practice, this provides some interesting thoughts on the individual's experience and how Husserlian phenomenology may assist in the explication of this phenomenon. A methodology that reflects the individual's lived experience of the essence of humour can not only enhance previous research projects, but also provide a richness that will not be evident from purely empirical data. Van Manen (1990) suggests that, ideally, the phenomenological description should recollect the lived experience and be validated by the lived experience it seeks to illuminate. This then is recognised as the "... validating circle of inquiry" (p.27).

Hughes (1990, p.140) suggests that Husserlian phenomenology is to "... describe this everyday experience of the 'life world' ...". With this in mind, the experience of humour as understood within the consciousness of the individual can facilitate a deeper understanding of this phenomenon. Jasper (1994) and Walter (1995) discuss phenomenology as the relationship between the phenomenon and the experience, and suggest that access is generated through pre-reflective description. Husserl (Beck, 1994) believes that the observer is not separate from the observed entity. Both the



subjective and objective is one in the world and the individual experiences life by attending to perceptions and meanings in the consciousness.

This is known as intentionality and becomes one's description of the world as seen by the person. Symbolic understanding of these events and images is reflected in the individual's consciousness as an interpretation of reality and the world in which he/she lives (Beck, 1994; Hughes, 1990; Jasper, 1994). Therefore, transcendental consciousness progresses beyond the realm of just the person or object, and focuses on the essence of the phenomenon as it has meaning for the individual. This essentially propitiates a melding of the subjective and objective, uniting this within the world and yielding one's description of reality.

This notion of intentionality is highlighted in the case of humour, as experienced by the individual. Humour is intrinsic to, and permeates one's existence within the world and "... can be very individual, what is very funny to one person may not be funny at all to another ..." (Robinson, 1977, p.6). Therefore, as this experience is very personalised and individual, Husserlian phenomenology provides the lens through which these perceptions may be visualised. Dreyfuss (1988 cited in Walters, 1994) and Koch (1995) reinforce this concept of man's relationship to the world and identify it in terms of subjects knowing objects or phenomena, emphasising this interaction that appears through the consciousness. Humour aligns well with this philosophical structure, as the individual will develop a unique and personal reflection of the concept within the consciousness, and it is this that will provide the foundation of the phenomenological experience.

As nursing moves away from a purely scientific focus to that of a profession which incorporates holistic nursing practice, one can visualise the role that humour may play in the explication and implementation of day to day nursing care. Integral to this role may be future nursing practice that reflects the philosophy of humour within the clinical environment. Through the perceptual lens of phenomenology, the individual's experience of humour is envisioned, providing a richer understanding of the lived experience, with the ultimate goal being improved holistic nursing practice.

### **Research Method**

To develop an understanding of the experiences of the participants it is important to describe the phenomenon of humour as experienced by the individuals within the study. It is also important to remember that the descriptions of the essence of humour, as experienced by the nurse in the Critical Care Unit, should not be generalised as these are personal expressions of reality as depicted through the consciousness of the individual. As mentioned, it is this intentionality or 'marrying' of the objective with the subjective, reflected within the individual's subconscious entity, that provides the impetus for these rich descriptions of humour.

Within the following work the researcher seeks to make plain these descriptions and the method in which this research was undertaken. The following sections will discuss the selection of the participants for the study. Included are the criteria necessary for acceptance into the study. Also outlined are the data collection method utilised and data protection processes undertaken.

The method for data analysis is clearly identified within the work, providing a framework from which to guide the findings of the project. Attention has been given to the ethical considerations underpinning this study and these are identified within the following text. Reference is also made to the timeframe of the research project's inception and the path the researcher travelled to the work's final completion. This has been included in diagrammatic form (Refer Appendix 1), so as to provide the reader with visualisation of the progression of the study.

### *Bracketing*

Throughout the development and implementation of the research study and prior to the interviews, the researcher reflected on the process of epoch (Kersten, 1982), or bracketing of presuppositions, so as to focus on the experience. The researcher maintained a journal throughout the research project as a medium for which personal reflections or preconceived notions could be explicated and set aside. Koch (1994) supports this strategy as the journal becomes the record of the relationship between the process, content and the interactions or reactions to various events. This then provides material for the researcher's personal reflection.

This transcendental reductionist approach or bracketing narrows the attention to the essential or basic elements by eliminating previous prejudice about the world and therefore focuses on, and fosters understanding of the 'entity' under investigation (Emden, 1991; Kolakowski, 1975; Walters, 1995). Therefore, the importance of engaging in the use of transcendental reduction or bracketing is an essential

component in the development of a description of the participant's lived experience. The researcher also remained conscious of these thoughts when performing interviews, transcribing and analysing the data. This set the scene for the researcher to return frequently to her own journal notations to ensure that no bias was placed on the information.

### *Participant Selection*

It is also imperative that one has an understanding of the origins of the data and the trustworthiness of this project. At the commencement of the research study, a Critical Care Unit was selected as a focus environment for the research project. This unit was located within a major suburban tertiary teaching hospital. The hospital was chosen because the researcher had worked in the environment and developed a rapport with both the nursing and management staff. Whilst the hospital is currently commissioned to 214 beds, it is expanding to 350 beds over the next 18 months. The Critical Care Unit comprises 8 beds, 3 of which are intensive care beds with the remaining 5 beds for coronary care patients.

Initially, the researcher approached the Director of Nursing for approval for the study. Once approval was gained from the hospital's Ethics Committee the researcher approached the Clinical Nurse Consultant within the Critical Care Unit requesting a time that was suitable for visiting the staff. Once a time was arranged, the researcher visited the Unit and Registered Nurses working in the Critical Care Unit were invited to participate in the study. An initial focus group was held and an explanation of the purpose of the research was given. The duration of the interview was also discussed,

as well as the use of an audiotape for the purpose of retaining interviews for transcription. The Registered Nurses were given the opportunity to ask questions of the researcher and it was explained that, whilst volunteering as a participant, they had the option of withdrawing at any time or having their interviews scribed in note form if they so wished.

From the focus group, volunteers were sought and five Registered Nurses chose to participate. Of the five participants, four were female and one was male with the nurses' ages ranging from 35 years to 50 years. All participants have worked in the Critical Care environment as full time staff members for a number of years. The participants' clinical experience range from 10 to 25 years in this environment. Therefore, it was evident that these nurses would provide a myriad of tales from the Critical Care environment.

Drew (1986 cited in Koch, 1995) emphasises that data produced from memory and recall is not collected with the intention of generalising to a larger population but rather to add to, and to enhance the composite human phenomena with which we understand lived experience. Therefore, it is considered unnecessary for this research method to have a large population participating in the project.

Letters were formulated, stating the focus of the research project, the goal of the study, the requirements for participation, the limitations of the work, as well as reiterative statements reaffirming the voluntary status of the participants. Enclosed with the letters were consent forms to be completed and returned by the participants.

These were posted to the individuals with an explanation of both the research project and the implications of consent. The consent forms were then signed and returned by the five Registered Nurses prior to organisation of interviews. An appointment time was then negotiated with the five participants ensuring that both the time and venue were most suitable to their needs.

### *Participant Interviewing*

Unstructured interviews were performed to describe the lived experience of humour as used by Registered Nurses within the Critical Care environment. Interviews were undertaken at various venues, all of these negotiated as most suitable and comfortable for the participant. As each Registered Nurse attended at the appointed time, the research project was once again explained in detail and the use of the audiotape was also 'flagged' for their notice, as well as the participant's right to withdraw from the project at any stage. It was reinforced to participants that at no time should they feel obligated to continue. Each participant once again stated that he/she felt comfortable with the taping and able to perform the interview without fear or self doubt.

The use of audiotapes when interviewing provides an aid to transcription as often words are lost in an emotive moment and rich descriptions may be missed with no hope of retrieving the event. Barriball and While (1994, p.332) support this use of audiotaping whilst performing interviews, suggesting that it provides "... a detailed insight into the performance of both the respondent and the interviewer ..." and serves to highlight nuances in voice tone, emotive intonation and pauses which may be

significant to the overall content of the interview. It is important to also realise that the use of taping greatly decreases the error rate through this auditory evidence.

The interviews were conducted in the privacy of each participant's home, with the initial interview lasting for approximately 45 minutes and subsequent interviews of varying length to clarify and verify information. Each Registered Nurse chose a pseudonym with which he/she may identify and all subsequent audiotaping included reference to these names only. The interviews commenced with the Registered Nurse being asked to think of a past experience when he/she had used humour within the Critical Care environment. The nurse was given five minutes to reflect on this situation. The participant was then asked "Can you describe to me a situation when you used humour within the Critical Care environment?"

From this initial question, the subsequent discourse was generated from the information which the participant provided through reflection of each individual situation. The researcher's role within the interview was to encourage this reflection through the use of statements, such as "What do you mean by ..." and "Could you explain/elaborate on ..." or "You mentioned ..., could you tell me more?" In this way, the Registered Nurse was not coerced or guided in his/her interpretation of events, but was encouraged to describe the lived experience of the preconceptualisation of humour within the Critical Care environment.

### *Data Management*

On completion of the interview, it was explained to each participant that the tapes would be transcribed in total and the transcripts would then be returned to the individual for perusal as validation of the content. It is important to note that this review was not undertaken with the purpose of changing information, rather it provided an opportunity to rectify any words or phrases that were misquoted through transcription, as well as to give credence to the value of the data.

This was summarily achieved once transcripts were completed and all Registered Nurses returned the work identifying that the transcripts were a realistic representation of their interviews. The data were then analysed for significant comments, formulated meanings were developed and subsequent recurring themes were identified. This then resulted in a description of the lived experience of humour within the Critical Care environment. It is necessary to mention also that tapes from the interviews were kept in a locked cabinet for the duration of the research project and remain so as they are the property of the University. These tapes will be stored for a period of 5 years from the completion of the research project.

### *Data Analysis*

For the purpose of this research project, Colaizzi's method of data analysis was incorporated (Refer Appendix 2). Colaizzi (1978) employs the method of returning to the participant for validation of the content, regarding the participant as of equal status and a co-researcher within the study. Although Husserlian phenomenology purports the use of prereflection and understanding the experience within a moment in time



(Kersten, 1982; Oiler, 1982), this researcher believes that one may still use Colaizzi's (1978) method for data analysis as a framework for the explication of those experiences. The researcher does not believe that returning to the participants to clarify sentencing and nuances tainted these descriptions.

One must remember that the significance of the project is in the richness of the findings and these must be described without bias. This can be achieved with the use of Colaizzi's framework and the subsequent development of themes generated from interviewee's comments. Beck (1994) discusses the use of Colaizzi's method for data analysis and purports that "No longer is there a distinction between researcher and subject ..." (p.261) and proposes Colaizzi's notion of 'dialogal research' between the researcher and participant.

Consequently, Colaizzi advocates the use and importance of participant's validation of the descriptive data to illuminate the experience. This then provides the opportunity for the participants to feel a part of the project. In response to this, all five Registered Nurses actively sought to participate in the project, displaying keen interest in the discussion generated by the interview process and the resultant relationship of this to the emerging themes.

Additional to Colaizzi's method for data analysis, the researcher has also considered the work of Wolcott (1990, 1994) when engaging in data analysis. Wolcott (1994) suggests that the qualitative researcher, in essence, needs to be a storyteller who constructs his/her description from narrative accounts within the data. This author

goes on to outline the use of critical or key events as one method for organising descriptions from the data. This method is incorporated more for its process and as a valuable adjunct to Colaizzi's method.

Wolcott (1994, p.19) suggests that the use of critical events is to "... focus on only one or two aspects, creating a story-within-a story in which the essence ... of the whole is revealed or reflected in microcosm". He goes further to suggest that life stages or events should be presented and reflected on, in their entirety, emphasising the cultural ethos which is reflected in the experience. Research often becomes transfixed on the wider picture, that attends unselectively, documenting events at the same distance. Wolcott (1994) believes that the descriptive narrative moves backward and forward "... like zoom lenses ..." (p.17) as the world is not flat, but rather a dynamic, multidimensional environment.

To this end, participants were encouraged to tell a story about events that related to their use of humour in their work environment. The rich data that emerged through this narrative often supported themes that were developing from the data. Bergum (1989) agrees with this, reiterating that knowledge often gets lost in the surge toward obtaining research data in the search for objectivity. "In contrast, knowledge revealed through stories is contextualized, personal, never replicable, and full of life experience which is not explained" (p.49). It became clear that critical events and story telling in each nurse's daily working life provided an important aspect in communicating his/her experiences of humour.

Therefore, for the purpose of this research project, using both the theoretical basis of Colaizzi (1978) and the concepts from Bergum (1989) and Wolcott (1994), the researcher has chosen to describe the lived experience of humour as experienced by the Registered Nurse working in the Critical Care Unit. This has been achieved by utilising significant comments taken from the transcripts which often include storytelling narrative, formulating meaning and providing a general description of this experience of the Registered Nurse.

Notable statements were extracted from the nurses' transcripts and listed as significant comments. These were then grouped into clusters of recurring themes and validated against the original transcripts to ensure that no information was overlooked. Whilst related subthemes became evident within the data, these groupings were then allocated a distinct formulated meaning, which provided an overall summary of the information evident in the comments. These meanings then became the essence of the lived experience of humour for the Registered Nurse within the Critical Care environment. In addition, examples of critical events that embodied the essence of humour for participants were included.

The researcher believes that these are necessary components of the whole and reflect the lived experience of the individual. Wolcott (1994) emphasises the value of including such events as a 'story', depicting activities such as a birth, marriage and death to reflect the ethos of the participant. He identifies this as "... doing less more thoroughly ..." (Wolcott, 1994, p.20). These critical events enhance, as well as

integrate, the experience of humour within the context of the nurse's individual experience in the milieu of Critical Care.

To conclude, the formulated meanings and critical events then formed the basis of the results which are reported in the following chapter.

## **CHAPTER 4**

### **FINDINGS FROM THE DATA**

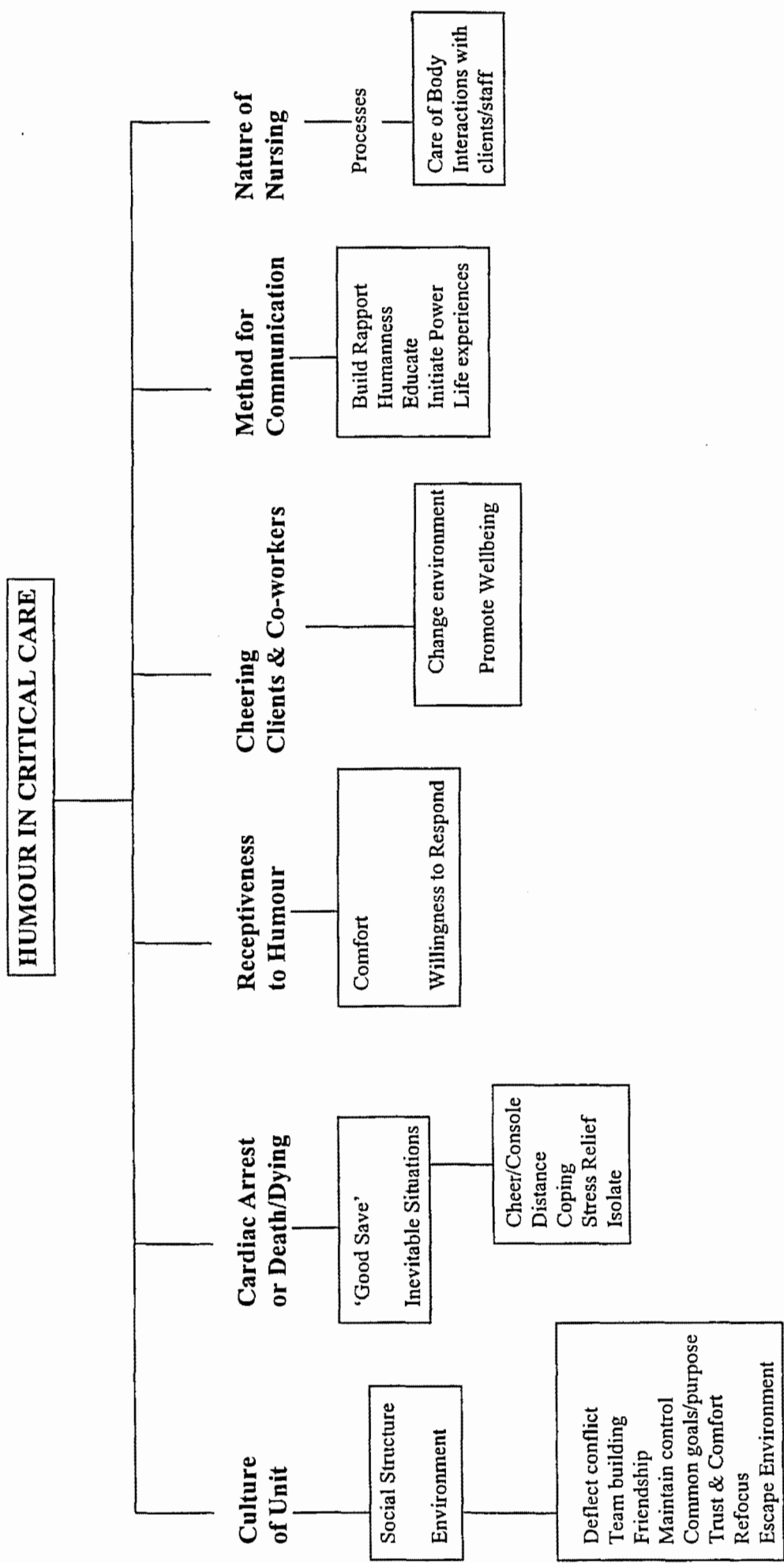
#### **Introduction**

This chapter will describe the findings from the research data. Significant comments which describe the participant's experience of humour whilst working in the Critical Care environment, and formulated meanings underpinning this information, will be outlined to assist the reader to gain an understanding of these experiences for each individual. It is from these transcripts and the formulated meanings that six distinct themes have emerged. To complement this development of the formulated meanings, related sub-themes which have emanated from participant's comments will also be incorporated. In much of the data there is a definite bent towards storytelling of critical events. This has been incorporated as an important component of the data and is seen as relevant to the emergent themes.

The six themes linked to the experience of humour within the Critical Care environment have been identified as occurring:

- In response to the culture of the Critical Care environment
- In the event of cardiac arrests ('codes') or situations where the client is dying or has died.
- In response to the recipient's receptiveness to humour
- As a mechanism for cheering patients and co-workers
- As a method for communication
- In response to the nature and practice of nursing

Figure 4.1 illustrates the six themes, which have emerged from the data. The diagram also depicts the related sub-themes that have originated from significant comments within the participant's descriptions. As mentioned, these six themes have stemmed from the relationship developed between significant comments and formulated meanings. The diagrammatical concept map provides visual representation of the data from the research project.



**FIGURE 4.1 CONCEPT MAP OF PARTICIPANT DATA**

## **Culture of the Critical Care Environment**

The first theme focuses on the culture of the environment. Participants identified 'being' in the specialised environment of Critical Care as a significant catalyst to the emergence of humour in their day to day nursing practice. The magnitude of jocularity that the nurses incorporate into their everyday practice and the gaiety that is exhibited is identified by the significant comments within this theme.

These statements centre on the nature or culture of the Critical Care environment. Participants describe how this culture plays a key role in determining the working relationships that are formed, as well as the lasting impressions left on clients, visitors and staff who frequent the setting. This cultural milieu is unique in the 'norms' that are displayed by individuals within this sanctum and the interchange that takes place during everyday nursing practice. Essential to this is the social structure and defining characteristics of the Critical Care environment that are enmeshed in the essence of witty repartee.

Significant comments indicate that humour within this environment provides social structure through the development of individual and group identity. Group members use humour to function as a team for the purpose of achieving a common goal or purpose in times of crisis. Conflict is deflected through the use of satire and lasting friendships are determined through the development of trusting relationships.

This environment also supports the nurses' collective identity as a unit, as often the staff perceive themselves to be isolated or marginalised from the mainstream hospital



setting. Underpinning these issues is the nurse’s use of humour to maintain control over his or her environment in times of personal and professional crises. Whilst this is so, significant statements describe how humour is also used to metaphorically escape from the environment at these times and to refocus the nurse’s own personal values in relation to the group ‘norms’.

Figure 4.1.1 depicts the focus for significant comments within the data. This serves as a reference point for the discussion of the following data. It is interesting to note that within this theme, the comments reveal the distinctive culture of both the Critical Care environment and the Critical Care nurse.

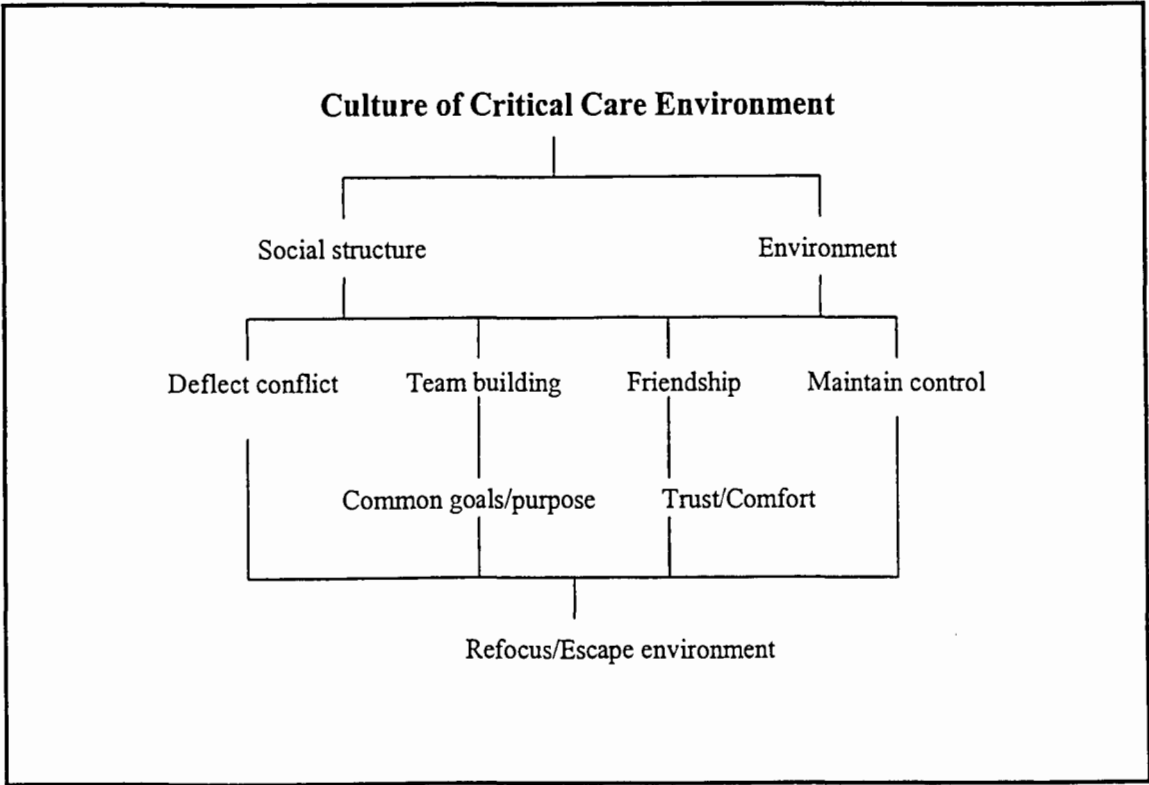


Figure 4.1.1 Humour in Response to the Culture of the Critical Care Environment

Humour is not peculiar to one area of nursing, however within Critical Care there is a special affiliation with and abundance of jocularity. Nurses within this setting describe this as a unique attribute that is often not well understood by 'outsiders'.

One nurse comments:

*Many people looking from outside in, most probably can't see the humour ... because they have got no idea of what we are talking about. They think "What are they doing there?" I think it is very hard to walk into the situation ... you can't see the humour. You've got your own dry humour that relates only to your own section. It's not over the rest of the hospital because they can't see it either ... because you are so specialised here.*

This specialist environment serves as succour for group members who identify both personally and professionally with the philosophy of Critical Care. As this is a relatively small and often considerably autonomous environment, the nurse may feel a sense of oneness with other members of the group. This then facilitates reliance on team members to assist and support co-workers when needed. This co-reliance and self-determination is characteristic of the Critical Care setting.

A nurse describes it this way:

*I think in Critical Care it does lend itself more to relying on others because you are a small area. You've got a central nurses' station where everyone gathers when they're not busy. If somebody's busy you notice and you go and help.*

She goes on to suggest that it is not only the staff members with whom you develop a close relationship, but also the clients and their families. The close proximity that staff maintain with their clients makes this an environment quite different to that of the general hospital wards.

*In CCU you're there for them. You're their eyes, ears, legs, arms. You're everything and you develop quite a close relationship with some patients. When they do die ... it is a bit more stressful because you've developed that link, and not so much even with the patients, sometimes it's with their families. That you don't quite get in the ward!*

The use of humour then within this environment is often observed by those outside this circle as something inappropriate, if not morbid. However, the nurses that work in the area believe this to be part of everyday practice and concomitant with the processes inherent in their nursing practice. One participant suggests that:

*I think to newcomers coming in or people onlooking, they might think 'What are these people doing? Something life threatening is happening there and they're laughing'. But I guess, I would be more worried if we weren't laughing.*

Another nurse remarks that:

*humour is used to make you feel comfortable with other people as well, because you can't walk around serious all the time.*

Nurses working in the Critical Care environment maintain that outsiders will view their jocularly as aberrant and gruesome.

*They perceive that it's inappropriate and I think that's what happens with the unit. We mess around and we joke around and we're told we're 'laid-back'. But yet, when we have to be all hands to the deck and do things properly, then it is done. I think it's people who don't understand the dynamics of the place.*

Apparent within the data is the allusion to 'other's' perceptions of the unit, thereby identifying the Critical Care environment as a separate component segregated from other sections of the hospital. This then implies a sense of solidarity within the area and specialisation that brings about its own values, norms and mores. The result is the need to maintain control over one's own environment and socialise group members. As the data shows, humour is an important factor in the development of these group dynamics.

*It's like anything, you see people messing around and joking and laughing ... and maybe it doesn't fit their idea of what it should be like ... that it is intense and go, go, go ... and people are dying and it is an emergency. Yes that happens but we are usually in control of those things. If not, the patient dies (laughing).*

One nurse describes the social structure of the Critical Care unit and how this then can affect the individual nurse's use of humour in this way:

*It's a bit like a culture isn't it. It's got to do with where you stand in that social group at work. If you are just right at the bottom and have just come in ... you're going to be very hesitant about opening all your cards out. Whereas if you've been there and are like a part of the furniture then you don't really care what you've said. People are going to judge you but it doesn't seem to matter as much because you've made your place in that social structure anyway.*

Another nurse goes on to say:

*You are allowed to laugh ... doctors and the other staff that are coming into the unit ... they see it as a happy place. You don't have to walk around with a long face all day.*

As a consequence of the cloistered environment, this closeness may bring about the incidence of conflict that can ultimately contribute to staff discord. Participants comment on the use of humour in these situations to deflect the anger and generate a sense of team cohesiveness whilst 'down playing' the stress of the situation. One participant describes the use of humour during these times in this way:

*When you find a stress between a couple of people ... sometimes you can break it by talking with a bit of humour in it, because people relate to this and realise there maybe another way of looking at the problem. You can talk about it and have a bit of humour with it because you will just accept it better*

*than if you just go to them and say "Listen, we don't want to do it, this is the way to do it". It feels threatening.*

A co-worker supports this use of humour and adds:

*Well, it doesn't become a 'she did this'. It doesn't become a conflict, an issue of so and so said so ... and so and so did such and such. When two people have had a conflict and you try and resolve the conflict, it breaks the tension sometimes and they start laughing about whatever it is ... and they know they have mutual ground and they go on to be able to sort out what their problems are. Breaks that circle of hostility.*

From the data, this use of humour to smooth over confrontations between staff members, patients and visitors emerges as a recurrent sub-theme within the cultural milieu of the Critical Care Unit. The following comments attest to nurses' beliefs that humour contributes to the wellbeing of team members in times of conflict.

*I tend to try and make jokes. I don't like confrontations or people who are uptight and getting 'ancy'. So I make a joke and it's often relief.*

*I really don't like people bickering. All the agro. I can think of a few situations where people have been arguing and I'll just break it up with a joke. I guess for confrontations I find it really useful.*

Resolution of conflict and the use of humour to allay negativity within the environment, implies an endeavour toward optimal team functioning. This sense of group unity is apparent through the incorporation of jocularity in everyday nursing practice. Descriptions coming out of the data recount episodes where humour has become a determinant in team building and goal setting, providing the opportunity for staff members to experience the notion of 'belongingness' within this specialised environment. One nurse sees humour as a means "*to cheer yourself up and maybe cheer the co-worker with you*".

Another common practice relates to the use of practical jokes to alleviate boredom through whimsical tomfoolery. Practical jokes are frequently incorporated into everyday nursing practice, as the nurses attempt to lighten situations and maintain friendships with other members of the staff.

*We give people (staff members) showers when they leave the unit to go to another hospital. With the right staffing, you can do things like that. Like have a syringe fight with your uniform on. After they've had a shower we throw them with gel and talcum powder, to leave a nice happy family from here and as a goodbye present. Then they will remember us forever. It's something we do as a team. Quite often it is more the people that have been longest in the unit who team up together.*

Some comments relate to the 'boringness' of the Critical Care environment as nurses become familiar with the intricacies of the unit and caring for the critically ill client.

Between the 'highs and lows' of the shift, these nurses still find time to commit themselves to mirthful episodes of fun. Remarking on this, one nurse states:

*They have boring shifts ... Oh, good, you are on tonight. We'll have some fun. It doesn't matter if you are busy or quiet.*

One tale exemplifies how the nurse's band together to use humorous interplay in 'down' times to generate this friendship and team building behaviour. This nurse describes it in this way:

*Just the other night on night duty last week, I made a chocolate cake and took it in and one of the doctors on is cute, so we thought we'd do over his room. We gelled his doors and things. He wasn't around. So me and a co-worker crept into his room and we were all running around gelling doors and the telephone and then I hear a noise. The co-worker and I bolted for the door, he was in the toilet. Here we were running around his room making all the noise under the sun and he was in the toilet.*

*So then after he went out we got this big hunk of icing, and we rolled it into a big bog and layed in on his bed. He came out and he said "Oh, the Easter bunny has been through here". So then we made it into a little curl and dropped it in the middle of the Cardiac Technician's floor. He had to put the final touches on it. He got his shoe and scuffed a little bit with his foot. I don't know why we do it. I think probably because I know the people I work with so well. I know the people well and they all respond pretty well to it.*



Another story describes the nurse who uses practical jokes not only with nursing staff but also with wardpersons who attend the Critical Care environment. These situations facilitate an attachment with other staff members, as co-workers remember the experience and form a connection through the development of friendships with those nurses with whom they have shared this jocularity. The story continues:

*I laid inside a sheet and they wrapped me up like a dead body and called the wardies up. They were all such big macho men. They rolled me over and I was stiff as a board. They rolled me back and then I sat up and I went "Uhhh!" It was only a pity I couldn't see their faces, because apparently they went white.*

Within the data, it is apparent that all participants clearly identify themselves as part of a team and espouse group cohesiveness as one of the motivating forces that binds them together. Two of the nurses suggest team building as the impetus for humour and practical jokes, and view this as an important component of the everyday working environment. The first nurse states :

*I think as a group we work pretty cohesively together. I think a bit of that is that we laugh together and joke together. We get on really well together as a group which is pretty unusual ... that we all get on ... or we seem to. I mean in the end there is a few odd balls that don't, but I mean they're not so odd that they don't fit in.*

The next nurse goes on to support the importance of team building within this area and reiterates that:

*I think team work is important everywhere. But in Critical Care you can't run away from it. Critical Care is usually a small unit and you can't go and hide anywhere, so you have to build team work. You have to try and build the bond, and you have to try and build the team. It is hard because people don't understand common goals.*

Cheerful rejoinders are also used to lighten the situation when the nurse or co-worker makes a mistake on the ward during the course of the shift. This conviviality serves as a team building strategy to maintain cohesiveness and offer support to the group member. One nurse comments on her use of humour to diffuse situations when an error has occurred:

*You feel like you're just going to make a mistake and everyone is going to look at you. If you see someone floundering like they really don't know what to do next, you just make a joke of it so they don't feel bad. They can do their job and still keep their self esteem.*

The culmination of these playful interludes is seen during the Christmas festive season, where staff tend to allow their natural flair for the ridiculous flourish. Nurses within the Critical Care area relate stories where they have taken part in refurbishing the unit in conjunction with a specific theme. Participants denote this action as a trademark of the specialist environment and identify this as inherently common within the Critical Care setting. This decorative and often bizarre ritual facilitates a sense of shared belonging among co-workers and provides comic relief for those who enter this domain.

One nurse describes this initiative:

*That's when we let our hair down ... and I really wanted to have a heavenly Christmas and they won't let me. They have the competition for the best decorated wards and the unit is a funny shape. Well, I wanted to have a heavenly Christmas and the front doors made as the pearly gates.*

The nurse goes on to suggest:

*It is a way that everybody joins in. It is just wonderful team work. Someone will start and run with an idea and then everybody else's creativity just takes on a little bit more and they just add a little bit more and then somebody else adds a little bit more and before long you have got everybody sucked in and they are all doing it. We have done some really nice things with our Christmas. One Christmas we had a hearty Christmas and the theme was hearts. We had a heart that had everybody's name on it. Now that is team building! Everybody felt that my name is up there, I belong. It is important to feel like you belong.*

Another participant remembers her experience of Christmas in the Critical Care environment, describing the use of decorations to instil a jovial spirit:

*We've moved on from teddy bears to Christmas cottages and last year we had the little town of Bethlehem. Christmas things have a way of drawing the whole unit together. People that don't even normally participate do. I think it develops a bond between people because people find they can contribute in*

*many different ways towards the decorating of the ward and it builds a festive atmosphere.*

Trusting relationships and close friendships are often developed within this specialist environment through the use of amusing exchange. The data describes events where these nurses seek to include co-workers and clients alike in practical jokes and humorous interplay.

*Why do I do it. I don't know. I'll just walk past the office and if everyone's sitting in there quietly, I like to disturb the peace. I just go and pull a face.*

*We used to get dressed up in pyjamas and walk round the ward just to make the patients laugh. Makes you feel good to laugh. It makes everyone feel good.*

Essential to the initiation and maintenance of these friendships within the unit is the security and comfort that others receive from the comic interlude. Participants describe its use as consistent with co-workers involvement within the working environment and subsequent feelings of support as a nurturing process. This becomes important when functioning in an area where stress, trauma and boredom may occur within the confines of one eight hour shift. One nurse comments:

*You get to know them really well. You get to know what they can and can't do.*

*I mean I know one girl who I constantly make laugh to make her feel at ease.*

*She is very insecure and she has no confidence in herself and her abilities, although she can do it. She needs a little bit of a push sometimes. She hasn't got much confidence and I often make her laugh to make her feel at ease.*

Once again, woven into the data are the tales of practical jokes that group members utilise as a means for the development and maintenance of friendships. It appears that these nurses seek comfort and identification with other group members through the incorporation of obscure actions, that within other areas of the hospital may be linked to inappropriate behaviour unbecoming a professional. However, within the inner sanctum of the Critical Care environment this form of lateral thinking is important in the creation and sustenance of the unit culture.

Information taken from the transcripts reflects this concept, as one nurse narrates stories of the nurses' perverse wit and how this often transposes into unconventional actions. Those who are the recipient of these actions must be able to identify with the context in which these 'crimes' are committed and experience some affiliation with that environment. This is clearly evident in the Critical Care environment where an abundance of tales concerning these unorthodox practices are carried out.

One nurse describes such an incident:

*I've been on and taken people's shoes out of their lockers and been into the men's lockers and taken shoes and taken another birds shoes who wasn't very impressed. We plastered them. I put them in plastic bags first and plastered them and put them back on top of their lockers. When I put hers back I just fell into the lockers behind me laughing. It was just these two clumps of plaster on top where her shoes should have been.*

The culmination of this jocularly is evident through the relationships that staff members develop and maintain within the culture of this environment. As mentioned, participants describe this specialist setting as conducive to team building, the generation of friendships, the maintenance of control over situations and the resolution of conflict. As a result of this, the data also describes how the use of humour assists both the individual and group to refocus and escape in times of crisis.

One nurse describes the need for her escape from the environment in this way:

*If you are down to three staffing in the unit, you cannot physically leave the unit, say if you have had enough of the place and you just want to get away from it all. You can maybe go back to the tearoom and sit down and try and have a cup of tea, but that is inevitably interrupted, or you can still hear the buzzers going and you can still hear the alarms going ... there is nowhere to go. You feel like there should be these blinds that come down and you can isolate yourself from it, but you can't. I think you need to be able to go and refocus.*

Escapism, therefore, seems to be the only recompense for survival in this 'fishbowl'. Humour channels frustration and refocusses thoughts during the uncertain times. Finally, one nurse describes her jocularly as a means for dispersing the negativity of the environment thus:

*I do act the goat a lot. I think that the intensive care unit is a very stressful place for a lot of people. I act the goat and muck around and try and make everyone else be part of that and give them something to laugh at as well,*

*because sometimes they just need something to laugh at because of what is going on in the unit.*

Only briefly described is the need for nurses to remain in control of their environment. Succinct descriptions reflect this concept as participants touch on the philosophy that it is 'ok to laugh' when all is running smoothly. Divergent from this is the seriousness of the situation when there are lives at stake and care is not proceeding as planned. Comments made by two nurses ponder on this notion as they consider clients they have cared for and the role that humour plays when events occur for which they are not prepared. They discuss when it is appropriate to laugh and when it is not. The first nurse tells:

*She'd been in a long time ... over a week. We thought we'd got her better and then she died. I guess we were all sad and disappointed that she didn't. We weren't all prepared for it. It was a bit of a shock.*

The second nurse adds this:

*Maybe if we feel that we are not in control, that we are not mastering what is going on ... and it depends who you are on with. We know each other and we know what each other is thinking, how each other is going to react. Something will be happening and no one is telling anybody to do anything, but everything is being done. That is when you do have the banter and the jokes. You lose that sense of humour if you can really see that things are out of control and you don't have control over what is happening.*

## **Humour in the Event of Cardiac Arrest and Death/Dying**

Whilst it is clear from the data that humour is initiated and generated in the Critical Care environment due to the nature of this unique area, there has emerged the recurrent theme encompassing the participants' reference to humour in times of crises. In many cases participants relate the incidence of cardiac arrest and the imminent demise of clients as the foundation for, and generator of, humorous situations. These situations often bringing forth a macabre sense of merriment in times when others would assume this as inappropriate. Participants considered these episodes humorous even when retelling the tales at interview.

Notable within the data is reference to the relationship between a 'code' procedure or a death experience and the nurse's humour, which often comes to the fore during these events. An adjunct to these episodes is the co-worker's response to these events and the individual nurse's keen sense of the ridiculous in a given situation.

Figure 4.1.2 outlines this theme which emerges from the data and is developed from the diverse number of significant comments described by participants within the data. As shown, the two key elements within the data focus on those situations that can be changed, producing a 'good save' and those that the nurse can not change. Both situations bring about a humorous response from each participant in an effort to console and cheer the group, in turn triggering the use of humour as a mechanism for coping, stress reduction, isolation of self and distancing from the event.



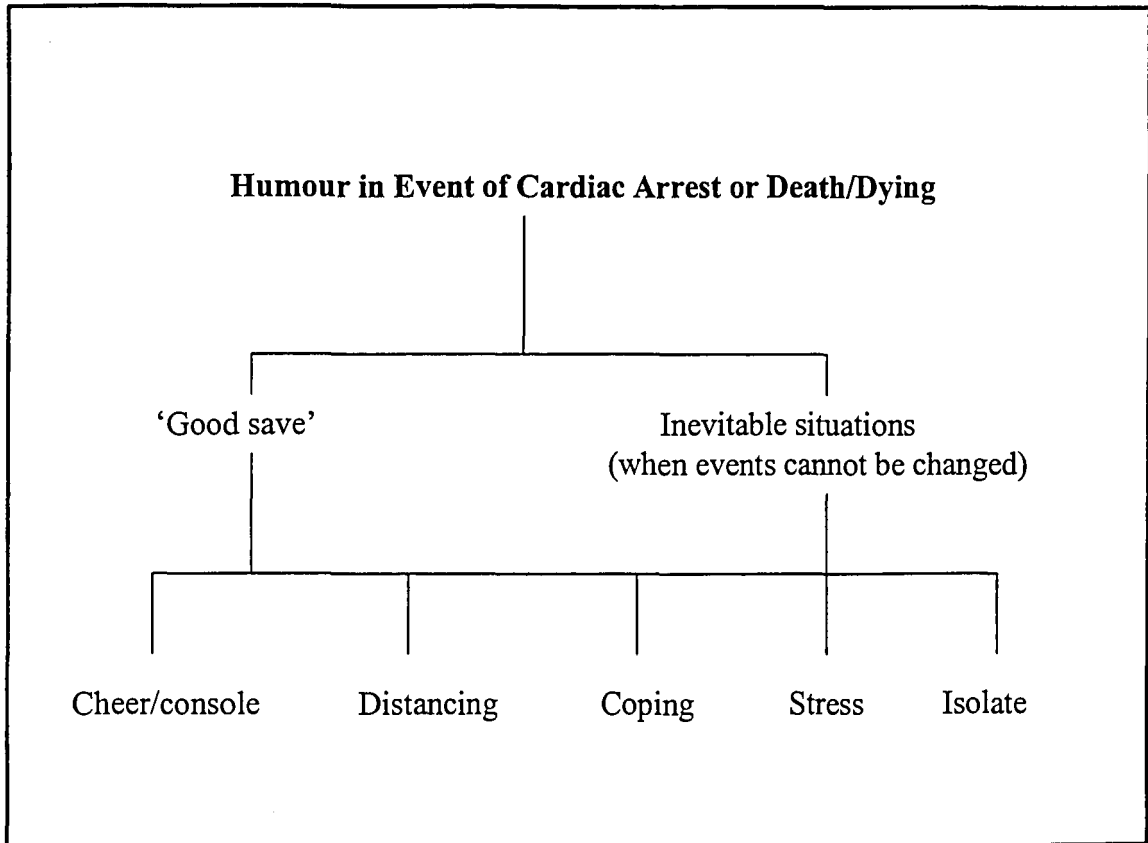


Figure 4.1.2 Humour in the Event of Cardiac Arrest ('Codes') or Death/Dying

All participants describe events where they had incorporated humour within the Critical Care environment when 'codes' occurred. Each nurse identified issues relating to his or her need for humour to provide relief when faced with adversity. These 'codes' perpetuated the need to distance oneself from the event, as each nurse attempted to lighten the mood, as well as cope with those situations for which there was no positive outcome.

One nurse describes her experience during a code as memorable:

*During a code ... I had a cable needle stuck behind my ear and in the middle of all this silence, my needle actually fell out and dropped on the floor. Everyone*

*just sort of stopped and went "What was that?". I said "It's all right, it's only my knitting needle". It was quite funny ... it really eased the tension.*

Another nurse discusses the use of statements made during a 'code' procedure to provide some light relief and bring realism to the situation. The inference to cost efficiency is used as banter when the circumstances do not reflect well in the nurse's view. This nurse describes the humour of this event thus:

*I think we should turn off the ventilator to save some power.*

*They said, "What do you want to keep the power for?"*

*I said, "Maybe you need it for later on. Maybe you get sick and we've got no power".*

This discussion also relates to the use of humour to communicate messages that may be causing conflict between staff and is outlined further in one of the following themes.

One nurse takes a philosophical stance when considering the client who has experienced a cardiac arrest stating:

*The patient is already dead. The worst that you can do is that they die and they are dead already. But if you bring them back, well hey, you've done something good haven't you?*

This statement not only exemplifies the nurse's justification of her feelings during the 'code' but also appeases her sense of guilt if all does not go well. This relationship

between how events occur during the 'code' and how the nurse wishes these events to take place has arisen from the data, as each nurse barter with his or her own values when confronted with issues of life and death. Comic relief and this reflective approach plays a profound role in the stories which come from the transcripts.

This then sets the scene for the storytelling of events when 'codes' occur and the unusual tales of medical and nursing practice which are often peculiar to the Critical Care setting. One such event relates to the participant nurse who was rostered on a night duty working with a medical officer on loan from the Emergency Department, and attending a 'code' in the unit with the nurse.

The story continues:

*We worked and we weren't really getting very far. I said, "Do you want to do a pericardial tap?" "All right we'll do a pericardial tap". So ... I got the syringe out, set it all up and handed it to the registrar and he looks, and he looks again and he looks over at the other registrar and says "Have you done many of these?" He says "Noopphh". He hands me back the syringe and he says "I think we'll pass". Well that cracked me up.*

This nurse not only finds humour in the 'code' situation but also describes this experience in relation to the medical officer's ineptness at performing the procedure during this stressful time. She goes on to suggest that the humour also comes from the medical officer's response to the situation and the absurdity of the situation in an

environment where the staff, be that medical or nursing, are perceived to be invincible.

*It was just this confident "Oh yeah" and then when he saw what he had and he looked. It was the look on his face. It was just "My God, what am I going to do with this?"*

This release in tension during a time when events are not following any preordained plan is important to the nurse and remains a common thread throughout the data. Also common to the data is the nurse's experience with dying. The nurse's proximity to death becomes more pronounced within the Critical Care unit when the client is in cardiac arrest. However, the data suggests that it is during these times that the nurse discovers ways to use humour as a method for distancing and isolating him/herself from the potential demise of the client.

One nurse comments:

*You really do isolate yourself from the patient and their situation to protect yourself. You use it as a protective mechanism ... against allowing your feelings to come right through ... like you're distancing yourself from the patient and yourself.*

Another participant explains it in this way:

*It's like depositing the baggage before you go home ... it's like a dividing line. If you get rid of that stress and if you have that healing within ... like laughing that afternoon ... it makes me feel better. It gives me the ability to go and do what I have to do.*

Much of the data reflects the relationship between the participants and co-workers at the time of a 'code'. One participant relates an incident that was not only unique to the Critical Care environment, but also triggered a sense of jocularly amongst fellow co-workers. The story continues thus:

*A patient that came in with an MI, about 54 years old and he went into cardiogenic shock. He was very confused and he then did die. He'd been gone about 10 minutes ... then he sat up and spoke. He said "I'm back, I'm here to fool the doctors. Don't tell them that I'm back". We were just so flabbergasted. We just laughed about it when really it was a serious situation.*

One nurse's narrative recounts a comedy interplay concerning a client she cared for:

*She died in one of the end beds and now we have to wrap them in plastic (it is disgusting, so noisy). I refused to wrap her up in the ward. So I gave her a wash, we were really busy, so I snapped an oxygen mask over her face and I started to wheel her out. I got halfway down the corridor and a colleague said "What are you doing?" I said "I'm taking this lady to the storeroom". "What are you taking her down there for?" I said "It'll be nice and quiet down there". He didn't even realise that she'd died. So we were in fits.*

The story continues as the colleague assists the nurse:

*We got to the storeroom and started to wrap her up. The colleague decided that it was time for a cigarette, so we thought we'd leave her. We thought we'd better put a screen up in case the wardsman comes. Later on when we*

*came back we 'plasticed' her (shrouded her). The next thing that happened was I lost my scissors. I couldn't find the things anywhere. I hunted everywhere. I lifted her legs up and there were my scissors stuck underneath them.*

Retelling these tales provides a sense of buoyancy that cloaks the nurse and his or her co-workers, demystifying the solemnness of death and serving as a medium through which the stress of 'codes' may be diluted. A pervasive feeling of optimism is introduced through the use of humour introducing optimism during this often traumatic and dire incident. This nurse tells of the necessity to incorporate humour through the storytelling of these situations as:

*You could never stay long enough to grieve ... you have to get on with the job.*

*That's your way of coping.*

The use of humour to make some sense during these episodes when the client is dying often incorporates mirthful metaphors as a means for alienating one's self from what is really happening. One nurse describes it in this way:

*You come to work and see the same patient over and over and over again and they are just lying there and you make the comment like "Oh yes! We have come to nurse the vegie patch", because you have got three ventilated patients that you know you are not going to get anywhere with.*

Aspects of death and dying remain the focus of most data as the participants describe examples where more than one client has died during the shift. One nurse tells of this

occurring, exclaiming *“I just can’t tell anyone else that their family has died”*. This nurse goes on to outline the importance of talking and joking with members of the team after the event using humour to *“get over that”*. She goes on to suggest

*I just think sometimes we talk about incidents and make jokes of it ... its probably our coping mechanism.*

An individual’s response to death is often tempered by that person’s ability to cope with this final life stage. One method is to find humour in the situation and keep these thoughts at the heart of future experiences. One example follows:

*We were washing a patient in bed one and there were some relatives right next door. We turned her over and we rolled her. She was quite a big lady and I used quite a bit of force. I just about landed her on the floor by the other registered nurse’s feet. I just lost it completely. Every time now we wash a patient I say “Don’t you roll her out of bed on top of me”.*

Further to this, the closeness that develops with each client can also facilitate a gamut of emotions when that person experiences a crisis. The nurse caring for the client often traverses the path from crying to hilarity in one single moment. Participants explain:

*I think it is just that sometimes we work in stressful situations. I can cry when the situation arises. Sometimes with crying ... I act the goat.*

*When it is just the situation ... you think ‘Oh God, don’t let it get you down’.*

*I think just because people get uptight, they've got a job to do and they're all a bit afraid they are going to forget it ... or look a fool. I just help them along.*

*When things are just so bad that you can't do anything else but laugh.*

*Here you are with gloves on, with hands just covered with faecal matter, and you are thinking 'Well what am I doing here?'. If you didn't laugh about it, you would cry.*

*It's not normality it restores to you ... it doesn't put anything into perspective ... but it just makes you feel better.*

*When I walk out those doors I like to leave work and come home and be a wife and a mother, and not bring what has happened at work home here. It is hard for the kids to understand why you come home crying. If you've gotten that out of your system at work ... laughing is a good way of getting rid of it and making you feel better. It makes me able to come home and be mum. Not mum crying because something has happened at work.*

Instances where medical intervention is proving inappropriate or of no benefit also produces a sense of the macabre amongst the participants. One nurse suggests:

*don't get down in the doldrums because of something that we really can't change ... make the most of it.*



This notion is reinforced by one nurse who retells the tale of a 'code' which she attended in one of the wards. Her glib comments are not well received as she searches for some humour in the situation where there is only a negative outcome. She states:

*Excuse me, this man is 90. They all looked at me like I was some hard faced bitch. He's dying, let him.*

Whilst each participant approaches a 'code' or death and dying from a different perspective, it is clear from this common theme that the use of humour as a means for de-stressing and distancing from these episodes acts as a panacea in times of crises.

One nurse sums it up by reiterating:

*I would hate not to be able to crack up at a code.*

### **Recipient's Receptiveness to Humour**

Whilst humour is inherent to the Critical Care Unit during episodes of 'codes' or death and dying, it is also evident throughout the data that much of the comedy relief is dependent on those that provide this experience and those that are recipients of this event. Participants identify particular individuals who may be more receptive to humour and those with which they would never share a practical joke. This then provides insight into the next theme and is constructed due to the significant comments appearing within the data.

To a lesser extent, this theme reflects the use of humour within the Critical Care environment. This theme relates to the recipient's receptiveness to humour and is representative of the participants' descriptions of humour as they function within this specialist setting. From these significant comments it is evident that the participants choose particular individuals when sharing comical tales and practical jokes.

Nurses within this study identify two key components that contribute to their use of humour. Reciprocity is an important aspect of the use of humour within this environment, as the nurse gauges the recipient's 'comfort zone' when incorporating jocularity and practical jokes into everyday nursing practice. The crucial element becomes the respondent's ability and willingness to reply to this given situation and it is this that is tested by the nurse. Figure 4.1.3 provides a diagram of this relationship and demonstrates that humour is dependent on those who initiate the humour and those who respond.

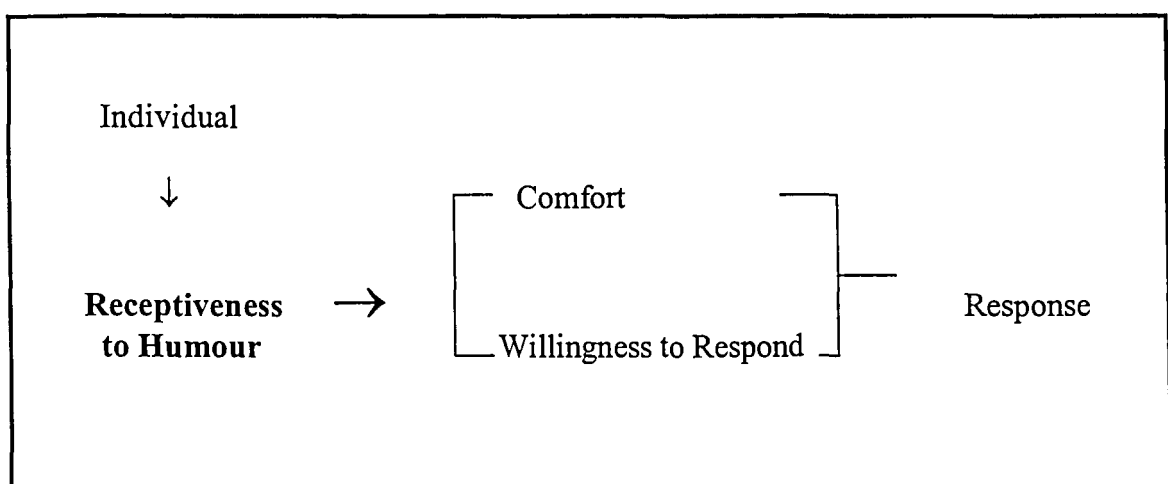


Figure 4.1.3 In Response to Recipient's Receptiveness to Humour

The data reflects this receptiveness to humour as participants describe their caution with and respect for those who choose not to incorporate humour into their working day. Comments are made in this way:

*I think it has got a lot to do with who is on with you. Some people just don't take jokes very well. If a certain co-worker was on with me, I wouldn't hesitate to say anything. Whereas if I had one of the even junior staff on with me I would be more cautious as to what I said. They tend to take things so literally.*

*It is comfortable. But sometimes you can notice that other people aren't comfortable with it. You soon learn who will and who won't be. You learn very quickly in the world. For some people it's very effective and for others it is not, it just backfires all the time, because you might make an inappropriate remark at an inappropriate time.*

One nurse goes on to comment on the significance of sharing a joke with another nurse during the recent death of a client. Whilst humour has been shared with co-workers on various occasions during these episodes, she describes the inappropriateness of incorporating humour when working with this particular nurse due to that nurse's value system.

*Well the person that I actually layed her out with was quite religious. Not the kind of person who would laugh over a dead body. I was respecting her as well. This nurse is also quite old and I guess I respect her age and wisdom as well. Looking back, it would have offended her.*

Participants not only comment on the use of humour with co-workers but they also describe clients' response to their use of humour. Those clients who see this environment as a traumatic period in their life do not always accept this sense of jocularity. Participants suggest that the nurse must ensure that clients comprehend the nature of the comedy. If this does not occur then the nurse should not incorporate this into his or her daily practice when caring for the client who does not understand the significance of the jocularity.

The participants describe:

*You've got to really feel whether the patient wants humour. You can't force it on a person. You've got to be able to gauge whether that person will accept that humour. Some people don't want to be humorous at all, so you've got to back off. Then sometimes if they see you doing it with someone else they will then join in. Sometimes they are frightened of letting go and having a bit of fun.*

*I guess it depends on the humour of the patient too. Sometimes you can have these real dour old ... but they're not a joy to be around at all. Then I have as little to do with them as I have to (laughing).*

The underpinning concepts that present within this theme relate to the individual's intuitiveness when playing the practical joker with co-workers and clients, and the recipient's vulnerability and receptiveness to these overtures of mirth. There is a fine

line between humour and insult, and it is this tightrope that these nurses have balanced on in their quest for rapport. One nurse contextualises this by suggesting:

*What I would say to some, I wouldn't say to others and it just depends upon that 'comfortability' that you have with those people. I guess you do play practical jokes on people that you are comfortable with.*

### **A Mechanism for Cheering Clients and Co-workers**

To continue the momentum and explicate the nature of the themes, the next topic generated from the data takes a step further to consider humour as a mechanism for cheering both the co-worker and the client within the Critical Care environment. This theme takes into consideration the environment, as well as the wellbeing of staff and visitors within this setting.

The importance of maintaining a cheerful environment continues to be the lynchpin for most themes within the data. However, there are notable comments concerning the importance of humour in sustaining this contented atmosphere which, when addressed, formulate substantial meaning and significance for both the client and co-workers. Participants comment on the benefits for clients who remain calm and content during their stay. This is important not only for the client's psychological wellbeing but also aids in their physical health. With this in mind, the nurse attempts to lighten the situation and disperse the fear associated with the technology of the Critical Care unit through the use of jokes and wit.

The flow chart depicted in Figure 4.1.4 identifies the concepts that are apparent within the data and illustrate the use of humour as a mechanism to cheer both the client and those staff members that the nurse works with during a shift. The comments found within the data are prominent and bear scrutinising as a separate theme, although there are those that may be seen as providing direct links to themes discussed previously. The importance of these comments, coupled with the use of comedy relief by the nurse, can then facilitate a more positive atmosphere, thereby promoting staff and client wellbeing within the Critical Care unit.

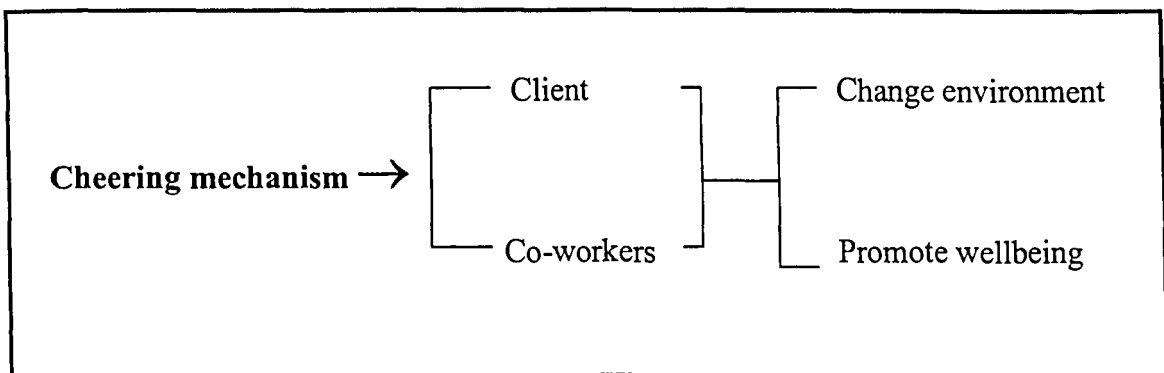


Figure 4.1.4 Humour as a Mechanism for Cheering Clients and Co-workers

Examples of this are seen within the data as one nurse comments:

*It is like with the cardiac patients when they come in and you see them looking at the monitor and I tell them "See this face, when it looks worried, you know you have got something to worry about. Otherwise, just ignore it up there."*

This use of humour to place the client at ease in a situation that may be fraught with stress and worry is described as a strategy often incorporated by these nurses. The common theme is to provide an environment that is conducive to the client's health

and wellbeing, whilst adding a mix of enjoyment to the everyday drudgery of daily ministrations. Comments emphasise this:

*I think the patients benefit from seeing people laugh and joke because maybe they feel that things aren't as bad as what they really think. One patient said to me once that it was nice to be in an environment where the people laughed and joked and were happy.*

*If they see that the staff are joking and happy and feel secure, they say that is important for them. They have that feeling that things can't be too bad. If they are doing that then I'm all right.*

*I think that they appreciate the stupidity. Like one morning I waltzed in coronary care with a man with a pacing wire in. He was mobilising around and we were just doing our morning's work. Six o'clock in the morning you are not really sane anyway.*

The participants not only use this as a release for the client's tension but also to retain their own harmonious working atmosphere. In response, clients view this humour as an opportunity to reciprocate in kind. As well, this allows them the chance to relax in this setting, knowing that if the nurse is playing the clown then there is no immediate problem or concern with regard to their health status.

One nurse describes this need to place the client at ease, suggesting that this is an important component of the day to day nursing care of the critically ill person.

*I probably use the excuse that patients aren't knowing what is going on, so they need to be cheered up as well.*

Cheering the client who may be experiencing a myriad of clinical procedures becomes the theme throughout the data, as participants describe the success achieved when using humour to promote a positive environment for the client, his or her family and the staff working on that shift. This positive environment is conducive to improved work relationships and patient compliance. Comments from the data support this notion:

*Even with the patients after having cardiac surgery, they are lying there in the special care unit feeling miserable. We had these spirometers with the balls. I would say "Come on fellas, lets blow your balls up". One of them would get the giggles and they would all start. They stop feeling sorry for themselves.*

*The patients are all tense, they're worried. You put a cartoon on and people will sit there and watch a cartoon and have a little giggle. They make light of everything. Life can be serious but it can be fun.*

### **Humour as a Method of Communication**

After considering the use of humour as a mechanism for cheering the client and co-worker, it becomes evident that the following theme serves as a vital component in this process. The next theme to emerge from the data addresses the concept of communication and how humour plays a key role in the development of this within the Critical Care environment.



Humour has long been recognised as a means for communication, often surfacing as one method for ‘getting one’s point across’. Significant comments from the data contribute to this notion and meld to shape the meaning of humour within the Critical Care environment. Participants describe their use of humour within this setting as a technique for building rapport with their clients and co-workers, as an aid in the education process often undertaken as part of the nurse’s role, as well as a style for incorporating life experiences when conversing with others.

These nurses also identify humour as an important aspect of their nursing practice, citing that humour as a communication strategy brings humanness to their every day exchange with the client. Finally, within this milieu, humour is outlined as a method for initiating power in times of dispute and clarifying messages between individual group members. Figure 4.1.5 represents this use of humour as a communication strategy, displaying the pertinent concepts which have evolved from the data.

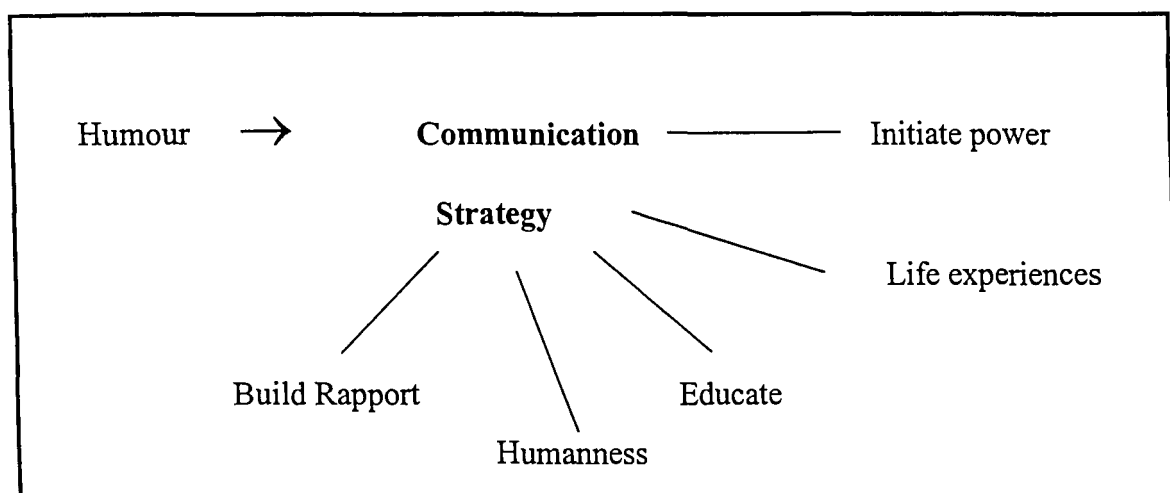


Figure 4.1.5 Humour as a Method of Communication

One participant comments on humour as a method for debriefing with staff members after traumatic events. She suggests that conversing with others in a comical way assists with informal discussion of these situations. The nurse describes it in this way:

*Even now I communicate with these people and often when we are sitting around talking we will remember things. I think on memories of things that happen and the further away they get the more comical they get.*

This ability to reflect on issues in hindsight provides the foundation for communication not only with co-workers but also with clients. Life experiences are used as a basis for discussion on future health care of the individual and can facilitate compliance with nursing and medical regimes. Data suggest that participants utilise humour, with good effect, as a communication strategy to initiate lifestyle changes.

One nurse explains:

*You use your own life experiences as well. I can laugh with people about losing weight, I mean that is a big thing. You know, we get a lot of people that are supposed to lose weight and having done it myself, you can laugh about it. So that's a good thing.*

Consequently, there evolves a sense of shared understanding that pervades the exchange, which, through the use of humour, generates a humanness and empathy that is encountered by both persons.

*You tell them in a funny way, like you've lost weight or how you did it. They see you more as a human being than as a person standing there telling them*

*they've got to do this. You bring it down to the level of what they are doing, I think that they accept it better.*

Humour also plays a vital part when educating co-workers, clients and their significant others. Participants describe jocularly and 'jestful' exchange as a useful strategy when undertaking teaching/learning sessions. This witty repartee promotes memory retention and breaks the monotony of learning difficult concepts. One nurse describes her use of this technique in this way:

*You've got to enjoy it and you can still learn. I tend to make jokes all the time. Make things funny but interesting. When teaching ECGs, talking about the pacemaker in the heart, I'll draw a little train and we knock off one train and make train noises and they are all laughing but they remember it. When teaching the ventilator the other day, I was showing this RN how the alarm silence is the most important button and how annoying it can be if it goes off all the time. By the end of it, she said it was very important, wasn't it. She said I was a good teacher. I don't know whether that is the teaching or whether that is the humour.*

Conveying a message through humour may dilute the substance of the conversation to number of manageable components that the recipient may find easier to digest. This is not to say that humour is essential to all educational sessions, however it does contribute to a more acceptable mode of learning.

This notion of humour as a communication strategy also takes on a new dimension when considering how one chooses to send messages to another individual. The data shows examples where participants use humour to communicate ‘wants and needs’ within this specialised environment. Often it is the urgent needs that are not being attended to and the nurse will use humour to ‘get the point across’ to co-workers. The nurses describe it thus:

*In my role I may have to come down on them but I also believe that by being fairly open and making jokes and things, that helps.*

*In times when you are really busy and you are getting patients in all the time and they can't find beds for you. I would think it is quite funny but they may not when you make a sarcastic remark about the needs of the unit. But it gets the message across. Its a power play isn't it? It's like saying, "Well I've come to the end, now you've got to give haven't you". It's like a game to see who can win the most.*

*I use humour to get what I want. People are more amiable if you are laughing and light rather than dishing out orders. I find it hard to criticise people and I use humour. I'll say "chop chop" if I want to hurry people.*

Evident within the data are examples of messages that border on sarcasm and wit. Participants describe how they use humour to converse with medical officers and clients in a bid to ‘soften the blow’ and clarify issues which may be called into question. Although this hidden agenda is often disguised beneath the cloak of a

practical joke or comical exchange, it comprises a tenet of sarcasm that reveals more about the relationship than does a superficial retort.

Significant comments from the data describe the use of humour to communicate these cryptic messages in this way:

*I think that patients are afraid of doctors. They feel that doctors are always in a hurry. Like this patient in Adelaide, he used to say to " he is always shooting past me" and I said " well you could always have a box of chocolates or the sports page, especially after Glenelg week ... so that he can stop long enough for you to ask questions".*

*If we are doing rounds and they are all talking over the patient, as an aside to the patient I will say " This is what they mean". We giggle about it but I am probably trying to get people to realise that that is a patient in the bed that wants to know some information, or that you are frightening them by talking about this sort of stuff. So I sort of joke about it in a way.*

As viewed from the data, the nurses' frustrations are communicated through the use of humour in an effort to make others aware of their inappropriate behaviour. Whilst a recipient's response to this may take various forms, this will be dependent on the individual's receptiveness to the humour.

## **The Nature and Practice of Nursing**

To conclude the findings from the data, one last theme must be described. This theme is derived from significant comments made by the participants and relates to the emergence of humour due to the nature of their nursing practice. Even though this use of humour is not unique to the Critical Care environment, it is important to understand the significance that this holds for these participants who often experience a very intimate relationship with their clients.

Although spoken about only briefly within the data, humour as a consequence of daily nursing care is noteworthy. In effect, it is necessary to describe these brief glimpses into the participant's experience when performing everyday tasks. Frequently, banter develops due to the mere circumstances in which an individual is placed, and the reliance that he or she must place on the nurse to provide daily care. During this time secrets are divulged and clients' most personal ministrations are shared, providing the perfect opportunity to break down barriers through comic relief.

Interactions with clients and co-workers when dealing with bodily functions and excrement form the basis of humour within this setting. Figure 4.1.6 identifies this final theme and illustrates, in diagrammatic form, humour within Critical Care as a consequence of the nature of nursing practice. This diagram also illustrates the relationship between the process of nursing and those interactions that occur with clients and staff whilst undertaking routine nursing care for the client. This then provides a feedback to the process as humour is generated through these events.

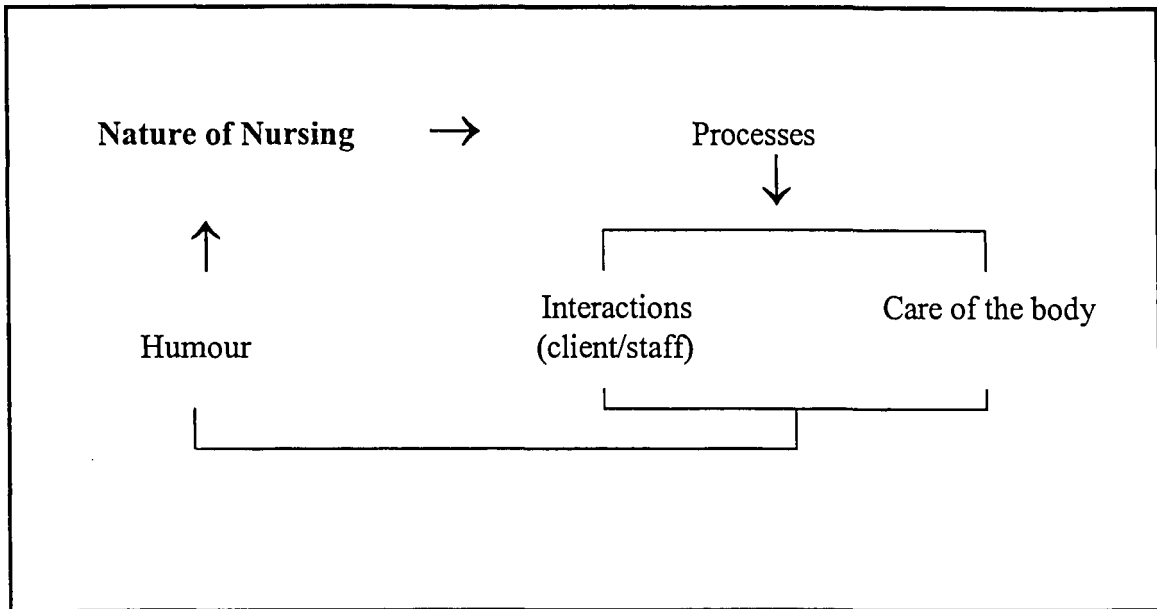


Figure 4.1.6 Humour in Response to the Nature and Practice of Nursing

The nurse performs a myriad of duties during any one day. It is the nature of these tasks that separate the nurse from other health professionals, and signify the nurse as unique in his/her ability to find the levity in the situation. The nurses describe the role that nursing has played in their use of humour thus:

*I think that nursing probably did it to me. I used to be sweet, naive and didn't know very much till I entered nursing.*

*It would be no point being a quiet, shy, withdrawn person becoming a nurse when your whole job is interacting with people day in and day out.*

Further to this, one nurse goes on to comment on his experience with the day to day care of bodily excrement, describing the need to see the funny side of performing tasks that can, at times, be quite abhorrent. This nurse tries to lighten the situation with the use of witty rejoinders as he tells:

*When things are just so bad that you just can't do anything else but laugh. Like you've got faeces from one end of the bed to the other, you just crack up about that and make a funny joke about it. Here you are trying to clean up all this mess and the person is down at the end of the bed making funny comments about what it looks like or what you are doing. Like, this is what we come to work for.*

Performing tasks when caring for the client and handling traumatic events within this environment have contributed greatly to the generation of jocularity and practical jokes. It is at this final point that the six themes merge to present a foundation model for the experience of humour within the Critical Care environment. However, this would not be complete without the closing quips from the participants. In fact, it is imperative that when these themes are considered, one can also visualise what humour means to the participants.

Whilst this has been described from the data, the final telling is in the closing reflections of humour. Therefore, to conclude the participants chose to describe their overarching personal impressions of humour. The comments are thus:

*It's life. Without it what would you be? What would I be without humour?*

*I'd be an absolute boring shell of a person.*

*I guess it is like looking at a glass. It's either half empty or half full. It's how you look at it and I guess humour is exactly the same way. It's how you look at life.*



*Humour reflects that positivism rather than negativism.*

*I think making the best of a situation, having fun, look for good things, look for positive things. We're not here that long, we've got to enjoy what we've got and sometimes that is very hard. If you can, make it a bit easier.*

*It's like a healing within.*

These comments, whilst not particular to any one theme, underpin the philosophy of humour taken from the data as it is experienced by the participants. This intangible thread that weaves itself through the experience of humour in the Critical Care environment is inherent throughout the data and contributes to the individual's experience of this in his or her daily nursing practice.

## **CHAPTER 5**

### **DISCUSSION OF THE FINDINGS**

#### **Introduction**

In response to the findings described in the previous chapter, this chapter will provide pertinent discussion of the themes previously identified and relate these to the concept of humour as it is framed within the current literature. Firstly it is important to review the focus of the study and remind the reader of the aim of the project. As proposed in Chapter 3, the aim of the study is to describe the experience of humour for the nurse working in the Critical Care environment. As a consequence, Chapter 4 identified six themes or formulated meanings from significant statements within the data and it is these themes with their related sub-themes that will be addressed in this chapter.

Each theme will be dealt with in sequence to develop and structure the discussion. To aid the reader's understanding of this chapter Figure 5.1 lists the themes and their related sub-themes.

THEME	SUB-THEMES
Humour in response to culture of CCU environment	Social structure Environment Teambuilding Friendship Maintain control Refocus and escape Reflection and deflection
Humour in the event of cardiac arrest or death/dying	Cheer and console Coping Distancing Decrease stress Isolate
Humour in response to recipient's receptiveness	Comfort Willingness to respond
Humour as a mechanism for cheering patients and co-workers	Change environment Client and staff wellbeing
Humour as a method for communication	Life experiences Build rapport Initiate power Humanness Educate
Humour in response to nature and practice of nursing	Process Interactions Embodiment

Figure 5.1 Formulated Themes from the Data

## **Culture of the Critical Care Environment**

Socialisation to and within an environment plays an important role in the identity of individuals and their commitment to work practice. The Critical Care setting is no different and as such, incorporates a myriad of norms and mores that are definitive in scope and nature. Bucknall and Thomas (1996) identify the uniqueness of the Critical Care facility, purporting this area to be a high stress, rapidly changing environment where nurses are confronted with complex, time dependent issues that require optimal clinical decision-making skills. In fact, the very nature of the environment lends itself to supporting comical interchange as a release from the day to day grind.

Participants recognised humour occurring as a consequence of working in this elite environment. Comments predominantly focused on specific comical behaviours displayed by group members which assisted them to experience a sense of 'being' in the team. Inevitably, it is via this notion that nurses sought to form an allegiance with members of the 'team' through sanctioning tomfoolery and play. Incorporation of humorous interludes, as a consequence of this, facilitate the development of friendships and rapport that provide support for, as well as sustain, group members during times of stress and crises.

As with most components of humour, there is much overlap as to where, how and why humour is incorporated into everyday life experiences. This theme emerging from the research data is no different and merely supports the notion that humour brings team members together, enhancing an awareness of role identification which in turn frames the social structure of the environment. In support of this, Gilligan (1993)

advocates humour as tantamount to bringing nurses together. Robinson (1993, p.8) agrees with this concept stating that "... we also initiate staff members into our group with our joking, practical jokes, and in-jokes".

Ferguson and Campinha-Bacote (1989) suggest that groups which laugh together at the same thing form a bond and develop a cohesiveness with other group members, decreasing social distancing and increasing the avenue of communication between all individuals. Pertinent comments from the results state that "... in Critical Care you can't run away ... (it) is usually a small unit and you can't go and hide anywhere, so you have to build team work ...". From the results, building this team depends greatly on the humorous interplay that takes place during the shift.

Further findings from the data support the idea of Critical Care being a cloistered environment and reflect this in the 'them and us' statements made throughout the data. This notion hinges on a separatist behaviour and individual identification from the rest of the institution. In turn, this demeanour instils in team members a sense of unity, develops trusting relationships and provides for control over the environment. This sense of control appears to be of importance and this is articulated within the data in terms of control over procedures and staffing issues. This form of control is then reinforced through the use of humour as a medium which provides recognition between group members during the course of the day.

Mastey (1992) espouses the idea of socialisation within the group and makes the point that nurses learn behaviour through role modelling and assimilation into a reference

group. In accord with the research results it might be suggested that assimilation into this Critical Care reference group occurs in conjunction with the new member's ability to incorporate humour into his/her everyday practice. Of significance within the results were comments which alluded to Christmas festivities and the relationship of this event to the group's identification as an entity.

These machinations provide the opportunity for group members to escape the 'humdrum' routine of the unit and add a jocular touch to the pristine clinical setting. Ackerman et al (1994), Booth (1993), Paquet (1993), Robinson (1993) and Strickland (1993) are only a number of authors who suggest means for utilising humorous strategies in the clinical area. Booth (1993) remains the only author found to date who focuses on the use of humour as a measure of the festive jubilation. He identifies this therapy as 'Yuleopathy' postulating on its benefits in enhancing the spirit by immersing one's self into 'the festive spirit'.

The value of this incident is intimated throughout the data as a means for escaping the daily grind of the unit. Due to the inclusion of Christmas festivities as a 'usual practice' in the Critical Care setting one might assume that this form of humour contributes to the identification of the reference group and, whilst providing an opportunity for escape and reflection, sparks the development of cohesive team functioning in this specialist environment.

## **Humour in the Event of Cardiac Arrest and Dying**

The research data also generated a multitude of tales as the participants reinforced the frequency and depth of jocularities in the even of a client experiencing a cardiac arrest or when the client was dying. This mirth was indiscriminately used, whether deemed to be appropriate by 'outsiders' or not, and encompassed situations where the client recovered from the cardiac arrest or died as a result of that or other health issues. Humour was frequently incorporated in nursing practice at those times when the situation was either a positive or a negative outcome for either the nurse or the client.

Consistent comments throughout the data focused on the use of humour during these times to allay anxiety and stress for the nurses and other members of the health care team. This humour often occurred as a result of medical procedures not proceeding according to plan or inevitable outcomes being less than acceptable to the nurse. At these times the nurse utilised his/her personal reserves of strength and endurance embracing humour in his/her practice as a coping mechanism to relieve the built up pressure associated with feelings of disillusionment and loss of control.

In support of the results the literature documents well the use of humour as an effective coping mechanism, a method for distancing one's self from events and a means for minimising stress in both the individual's personal and professional life. Although not specific to the area of Critical Care, two facets identified consistently relate to the physiological and psychological effectiveness (Ferguson & Campinha-Bacote, 1989; Knight, 1996) of using humour in one's day to day life. From these foundations a plethora of published work (Black, 1984; Ditlow, 1993; Groves, 1991;

Hague, 1994; Klein, 1995; Leiber, 1986; Snyder, 1992; Woodhouse, 1993; Wooten, 1996) reinforces the concept that the body employs a distinct physiological response as a result of humour in times of tension and anxiety.

Ditlow (1993), in support of the benefits of humour, identifies its life sustaining qualities in times of hardship and discord, providing a sense of sanity in a sometimes dysfunctional environment. Wooten (1996) concurs with this, reaffirming those comments made by participants within the data, stating that "... finding humor in a situation and laughing freely with others can be a powerful antidote to stress" (p.50). Participants confirmed this, reiterating that humour made them 'feel better' and more able to continue with what had to be done.

This sense of 'getting on with the job' is revisited throughout the data as the nurses utilise comical repartee to philosophically shrug off aspects of their nursing care that often do not 'sit' well with their own ideology. Descamp and Thomas (1993) purport that increased physical play decreases the strength of relationships between stress and the job, and workload dissatisfaction. This play enables nurses to "... express their frustration and stresses in ways less damaging and costly to the nurse and the hospital ..." (p.625). Similarly, the results reflect this concept as nurses share tales of play which becomes interwoven with everyday nursing practice.

Presently, however, there is minimal evidence within the literature that addresses those aspects of the data which consider the use of humour by Critical Care nurses during situations of death and dying. Although this is evidently of consequence to the



participants, it is not well defined within the literature. One might wonder at the paucity of research that broaches a topic which, for nurses, is a very real part of their daily practice. However, the subject of humour appears to be taboo, especially when associated with the client who is dying or has died.

As the Critical Care nurse deals with, on a regular basis, those clients who may be dying, it is quite appropriate to expect that the nurse may focus on this aspect of his or her nursing practice. If one then considers the occurrence of humour in this setting, it is logical to anticipate the links that will form between these two concepts. Crickmore (1987), Robinson (1986), and Schaefer and Peterson (1992) agree that the Critical Care environment is a stressful one and those working within this setting need to develop a sense of humour to relieve tension in response to events occurring during their day. This then provides the opportunity to practise in an environment that is more tolerable and workable.

Schaefer & Peterson (1992) go further to postulate that

Creating or responding to amusing or comical comments cultivates good feelings; draws people together; eliminates one-up-manship; makes everyone equal so true empathy exists; allows one to accept less than perfect behaviour or outcomes; helps dissipate anxiety, sadness, anger or frustration; relaxes smooth muscle; gives people the courage to move forward; and helps withdraw from unpleasant feelings (p. 32).

With this in mind, it is not surprising to see that the data contains significant evidence of humour during times when the nurse is attempting to relieve the tensions of the day. This is reflected in most comments from the data identifying humour as “a protective mechanism ... against allowing your feelings to come right through”.

However, as mentioned, there appears to be a paucity of documented literature that reflects the importance of humour during 'code' procedures. Page and Meerabeau (1996) discuss 'codes' as frightening to many nurses and suggest that it is "... widely acknowledged to be a highly stressful and 'most-dreaded' event for the majority of those who may be involved" (p.317). This event, therefore, generates a considerable amount of anxiety and tension within the team. Results from the data suggest that the research participants also experienced an increased level of anxiety during these episodes. These feelings were then tackled through the generation of jokes and play as a means for alleviating the stress. Significant in the data was the instance of laughter as a frequent entity amidst the nerve-racking, traumatic chaos that occurred during a 'code'.

Mastey (1992) purports that the main stressors associated with working in the Critical Care Unit, and those experienced by the nurse in this setting, continue to be death and dying, along with cardiac or cardiopulmonary arrest. Although there is minimal literature which links this known concept to the use of humour, one might suggest that these events facilitate the need to incorporate humour in the nurse's day to day existence, as death and dying play a key role in the function of the Critical Care environment.

The importance of comical discourse occurs in response to these situations and decreases individual and group stress, releasing the built up tension that is often present. As also mentioned in the data, humour provides a barrier from the hurt and

disillusionment as “... repeated exposure to death and dying promotes distancing or detachment to avoid the associated pain and sadness ...” (Mastey, 1992, p.210). The current study suggests that whilst pressure on nurses in the Critical Care setting remains high, it is clear that humour can provide a calming measure that contributes to a different outlook. Leiber (1986) sums this up when she suggests that “... when demands can be unrelenting, humor is often present, and is often found to make a positive difference” (p.162). One participant reflected this statement when she stated that humour did not solve the problem but did however “put things into perspective”.

### **Recipient’s Receptiveness to Humour**

The results from the data also addressed a key issue which relates to the individual’s response to humour and the importance of this response in the initiation of comical discourse. Cautionary measures were adopted with those co-workers who chose not to incorporate humour into their daily practice. Conversely, those team members who were receptive to humour reciprocated in kind ensuring a continuation of the witty play. McGhee (1993) suggests that although nurses’ attitudes toward humour are changing, there is still dissension amongst some co-workers who see humour and laughter as inappropriate and unprofessional.

In reply to this, the participants commented on respecting another’s choice not to joke and selecting the most appropriate audience with whom to share a funny moment. This was identified within the results, not only with staff, but as an important facet in the relational development with the client. Although data suggest that clients were receptive to the use of humour in the clinical area, there are those with whom the

nurse would not share a joke. Reasons vary from age and cultural considerations of the recipient, to the inappropriate timing of the joke in comparison to the client's health status.

McGhee (1993) goes on to postulate that one must remember "... to be vigilant to when humor is and is not appropriate in your contact with patients and their families" (p.40). Various authors (Balzer, 1993; Buckwalter et al, 1995; Forsyth, 1993; Gibson, 1994; Herth, 1993) discuss the importance of interpreting responses and gauging the receptiveness of humor when used in the clinical setting. Leiber (1986) invokes a three step program when undertaking humour with co-workers and clients. These three steps include: timing of the humorous intervention; receptivity to the exchange; and the nature of the content embedded in the discourse.

Similarly, results from the current research identified these three issues as important in the exchange undertaken between staff members and with their clients. Firstly, the participants commented on the 'comfortability' of the content which was necessary to ensure that the recipient was not insulted in any way. The participants then identified the recipient's willingness to respond to the jocularity as essential to the nature of the joke, and lastly results implied the need to provide an appropriate time and place for these jokes to occur.

Benner and Wrubel (1989 cited in Woodhouse, 1993) suggest that humor is often quite specific to the situation and might not be easily understood by those not involved in the experience. With this in mind, it is important to be aware of the nature

of the situation that generates the comical exchange and those who will be the recipients of the joke. Mindful of this, participants made constant reference to those persons with whom they felt comfortable about sharing the joke. In this way, humour has the potential to be "... both constructive or destructive, depending upon its application ..." (Buckwalter, 1991 cited in Buckwalter et al, 1995, p.14) and as such should be undertaken with the same care applied to any other nursing practice skill.

### **A Mechanism for Cheering Clients and Co-workers**

The most obvious of all uses for humour is that of cheering the giver and the receiver of the experience. This has been clearly identified within the current research study as the results depict examples whereby the humorous episode is employed with the express purpose of cheering the recipient. Once again, this theme becomes enmeshed in other areas of the data as the mechanism for cheering the recipient occurs due to the nature of the situation. These situations transpire as a consequence of two components. These relate to relationships which develop with the co-worker and those that develop with the client.

Utilising humour with both parties can not only alter the psychological perspective of the recipient but also enhance the clinical environment and promote wellbeing among those who experience the episode. In essence, the research results identified humour as conducive to a positive environment and important in the development of work relationships and client compliance in the clinical setting. This is supported by Hulatt (1993) who advocates the use of humour to enhance bonding within the group and, in turn, perpetuate a direct and substantial effect on those for whom he/she is caring.

Erdman (1991 cited in Harries, 1995) states that humour is more than merely retelling a joke, suggesting that "... a cheerful approach can go a long way to reassuring a patient" (p.985). Similar experiences have been identified within the results as the participants disclose tales whereby a simple gesture or witty comment has encouraged clients to cooperate with care or allay their fears over a required procedure. Victor Borge (Strickland, 1993, p.20) said that "The shortest distance between two people is laughter". Humour can consolidate relationships between co-workers and clients, and serve as a foundation for improved interpersonal relationships within the clinical setting.

Expressed within the results is the notion that participants employ humour as a nursing practice with these issues in mind. Sustaining the environment, which includes both the staff, clients and the relatives, often during arduous times, is achieved through the use of laughter and play. As purported by the participants and the literature one might suggest that this is a most appropriate nursing practice and conducive to positive outcomes within the Critical Care environment.

Kennedy (1995) reflects on this, stating

I find that I have often utilised humor, with the goal of encouraging laughter, while providing nursing care. Until recently I would not have labelled this action as a nursing intervention, with supportable rationale. Yet I have always realised, as so many of us do, that humor and laughter have positive effects on clients (p.25).

## **Humour as a Method of Communication**

Throughout time humour has emerged as a means for communicating stories in a pleasant form that will be both appealing and instructive to others. Recognised, is the importance of ensuring any response to this communication be positive and conducive to improved interpersonal relationships. The current study mimics this propensity for improved relationships as participants acknowledge within the data that humour is used frequently as a communication strategy with co-workers, clients and relatives.

Once again, the concept of humour as a communicator implies another separate entity or aspect of humour. However, this is not so, as it is impossible to segregate the totality of humour into small portions of the whole. As with previously mentioned areas of receptiveness and aspects of coping or stress release, humour's communication ability lends itself to incorporation in other sections of the text. Even so, for the purpose of the study this facet of humour has been 'teased out' as it reflects an element that is consistent within the current data.

Astedt-Kurki and Liukkonen (1994, p.186) discuss humour as a communication strategy stating that "... humour finds expression in verbal communication ...". Nursing practice involves significant exchange of information, thoughts and feelings. Conversing with clients and their relatives is a major part of the nurse's day. Including humour as a component of this verbal intercourse can bring about a more cheerful working environment. Whilst the appropriateness of the joke must be considered, this discourse can uncover relevant information through gestures, use of

metaphor and witty sarcasm. The nurse is then able to decipher and recognise the problems that are occurring for the client and family.

Humour as a communication technique was found within the data to bring about humanness and build rapport between individuals. This was often achieved by incorporating the nurse's own life experiences into the conversation. This self disclosure was twofold in that firstly it provided a humorous view of the nurse's own failings, allowing the listener to feel at ease with the storyteller, and secondly the listener was then placed in a position whereby he/she could self disclose without fear of retribution or ridicule.

Warner (1984 cited in Struthers, 1994) concedes that the value of humour is in its ability to be a means for self-disclosure and communication. He suggests that "... humour allows one to risk speaking of anxiety producing content in a safe, socially accepted way without fear of censure ..." (p.487). This then contributes to improved relations and builds a framework for the development of rapport between individuals. Forsyth (1993) expounds the therapeutic and communicative value of humour. She reiterates that humour is a 'two-way' street and includes both the joker and the listener into a new and exciting relationship.

Accordingly, the current study not only shows how humour has been integrated as a means for communication with others, the data goes further to suggest that this method can then be utilised to educate others within the clinical setting. Leidy (1992) has found that incorporating humour and laughter into educational sessions was one



method for reducing stress of the learners. This form of communication facilitates a supportive and nurturing environment for learning that encourages interaction amongst student and clients alike.

Participants within the current study recognise the advantages of incorporating humour within teaching sessions, as this strategy promotes memory retention and makes the session enjoyable. One participant states "... you've got to enjoy it and you can still learn ...". Pasquali (1990) supports this notion stating that humour facilitates learning through the enhancement of "... creativity, motivation, and learning retention by decreasing tension, anxiety, and social distance" (p.32). As the literature implies, the concept of humour remains interwoven with those previously mentioned facets of stress, anxiety, coping mechanisms and interpersonal relationships.

Interactions between the nurse and the client are based on meaningful exchange. This can have a positive or negative outcome for both, and may be dependant on the approach taken. The nurse performs a multitude of chores during his or her day. These often include nursing procedures which are little known or understood by the client. Astedt-Kurki and Liukkonen (1994) suggest that often these are carried out with humour utilised as a foundation for the nurse's practice. Humour has also been used to teach or instruct clients adding a sense of fun and nonsense to an often difficult or basic task. Correspondingly, the data outline episodes where the nurses used a humorous tact to address teaching sessions with staff, clients and relatives so as to bring about a change in behaviour, as well as to lighten the moment.

One aspect addressed within the data is the occurrence of humour as a weapon of power to communicate dissension or dissatisfaction. This concept, although brought to light within the current study, was employed more for its use as a power play than to cause conflict among team members. Within the literature there is minimal discussion of this aspect, however, what there is addresses the issue of using humour to aptly 'get the point across'. Davidhizar (1995), Herd et al (1995), Warner (1986) and Winters (1992) incorporate humour within text as a measure for achieving outcomes without the expenditure of insult or ridicule.

Whilst appropriate use of humour has been previously discussed, this issue goes further to identify this mechanism as a method for communicating wants and needs within the clinical environment. Davidhizar (1995) examines how humour may be applied to a negative discussion suggesting that "... humor can knock even the meanest people off their venomous trajectory" (p.56). Similarly, the current study displays examples where the participants soften the message using humour as a means for achieving their goal. Issues of staffing, workloads, client needs and administrative expectations are tempered by a jocularity that still achieves the same result but does so in a more amenable way.

Generally this facet of communication occurs via informal tales and metaphorical narrative as identified by Herd et al (1995) who vacillate on the demise of the 'wizard and the gatekeeper' within the health care system. This literature provides a prime example of witticism as a communication strategy. For those who understand the context, there is a pointed message to be gained, whilst others are not insulted by the

witty repartee. This form of tact utilised within the literature was also evidenced in the current study as participants applied this form of metaphorical mayhem to 'get their point across'.

### **The Nature and Practice of Nursing**

The very nature of nursing lends itself to the formation of humorous interplay and jocular exchange. Daily events within the Critical Care environment negate the usual confines of privacy and personal choice which is a basic commodity that is often taken for granted. Clients are subjected to bodily prodding and probing without the sanctity and boundary of their own environment. Diseases and procedures become part of the public domain as discussions are often undertaken in the hearing of at least six other people, some of whom may not be medical or nursing practitioners. It is within these confines that humour emerges as a basis on which the client and the nurse may cement the most intimate of relationships.

Excerpts from the data imply that this humorous relationship stems from the need to condone practices that may be embarrassing and ridiculing to the recipient. Humour then reshapes the status quo at a time when the sands may shift continuously beneath the individual. Robinson (1993) postulates that humour reduces the social conflict experienced when clients are compromised due to intimate and invasive procedures. This frequently occurs within the hospital system and more so in the Critical Care unit where every aspect of a person's health is monitored or linked to tubes and wiring.

Robinson (1993, p.8) goes on to state that "... humor gives a sense of mastery or control in a situation over which we have little or no control ..." (p.8). Although the nurse may be laughing at bodily excrement or mishaps occurring on the unit, it is these day to day happenings that provide the reaffirmation of one's nursing practice. Lawler (1991) identifies the 'dirty work' of nursing as a new experience for some who have not been schooled in the expectations of the practice.

Handling of urine, vomit and blood can often be a distressing way to spend the day for those who have not resolved this personal dilemma within their own minds. Humour then occurs in response to these gruesome tasks and the current study attests to the jocularity that has evolved as a consequence. Laughter at this time is not unusual and although considered inappropriate may prevent embarrassment in times when the nurse needs to 'get on with the job' of caring for the client. Consequently "Nurses often use humour ... in conjunction with other methods to help each other manage situations from the viewpoint of their own feelings and sometimes to protect the feelings of the patient" (Lawler, 1991, p.169).

Comments from the current study concur with this notion that one must laugh about the situation or one would cry. Data articulates the nurses' views of such duties, and although abhorrent at times, identified them as just part of the job. The humour enabled the nurses to continue on without being concerned about what they were doing. Jocularly and play enabled these tasks to be performed in minimal time and with a camaraderie that belied the nature of the work.

## **Conclusion**

In conclusion, this chapter has addressed and discussed, in conjunction with literature, the major themes outlined within Chapter 4. To isolate any one of the themes and separate it from the whole would be to do a great disservice to the data. The nature of the research is to describe the lived experience of humour for the nurse working within the Critical Care environment and as such incorporates all components of the six themes emergent within the study. Discussions undertaken in this chapter and the relationship of these to the literature has served to reinforce the concept of humour as a powerful entity which spans various pathways and reflects many aspects of nursing practice.

If one considers the mien of humour and how this relates to communication, responsiveness, coping, stress reduction, socialisation, friendship, rapport and interactions, are these not the foundations on which nursing practice excels? It would appear that the essence of humour is fundamental to much of the nurse's day to day nursing practice and as such has been described succinctly, in the current study, within the area of Critical Care.

## **CHAPTER 6**

### **CONCLUSION**

The value of the research project is in the journey travelled and reflection on what comes from the data. This may then provide the impetus for future projects and encourage new and innovative methods for nursing practice. Summarily, the project has come full circle and in its wake, generates a new set of questions that will, indeed, pave the way to new possibilities concerning the phenomenon of humour that is often taken for granted in one's daily life. At the close of the work it is probably fortuitous to return to the roots of the study and contemplate the path that has been followed and how the work evolved. In doing so, one needs to once again be prompted as to the research focus which was to describe the lived experience of humour for the Registered Nurse working within the Critical Care environment.

The Critical Care Unit as identified within the text, and those working within this area, may experience the full gamut of emotions during any one day. The 'highs and

lows' encountered by the nurse working within this environment may also bring about episodes of stress and tension for that person. These feelings of trepidation may occur as a result of the day to day functioning at the ward level, and it is often within this setting that one may be privy to the kind of humour amongst staff members that is not well understood in other areas of the hospital. This proclivity to include jocularity in times of increased tension as well as in quiet moments provides the foundations for the project as the researcher seeks to illuminate the essence of humour for the nurse and show description of this to the reader.

From these beginnings, the review of the literature concluded that humour is prevalent amongst nurses during times of stress and in situations when the nurse may wish to lighten the situation. Throughout the literature the common theme focused on humour's therapeutic worth and value as a communication strategy in the development of interpersonal relationships. However, as previously discussed, there has been minimal research which reflects the nurse working within Critical Care Unit and his/her use of humour. This notion of the Critical Care nurse's popular use of humour, coupled with the notion that this environment remains a stressful environment combined to motivate the project's inception and progression by the researcher.

Husserlian phenomenology provided the methodology on which the research was founded as the means for explicating rich description of the Registered Nurses' experience of humour when working in the Critical Care setting. True to the philosophical underpinnings it is important to remember that the results from this

research are not meant to be generalised to a larger population but guide the reader in a deeper understanding of what it is to be that nurse and experience the essence of humour within a particular milieu. The findings are grounded in the five participant's experience of humour and at no time does this imply a generalisation of this experience. However, this research does provide the reader with a glimpse of what becomes a plethora of experiences and provides the impetus to search further as nurses take part in this interesting and very individual phenomenon.

Once framed by the methodology, the research was undertaken utilising Colaizzi (1978), Bergum (1989) and Wolcott (1994) as sources for data analysis. This combination of literary methods was essential to the nature of the project and underscored the work to assist with the explication of the themes and aid in the description of the experience. True to Colaizzi (Beck, 1994) the researcher included even the most minute piece of data, believing that all information should be given equal recognition and importance.

From the research findings six significant themes emerged and these themes remained consistent with those identified within the literature that was reviewed for this project. Humour's physical and psychological benefits as a coping mechanism, to relieve stress and to alleviate tension are well documented within literature and the study identified these aspects of incorporating humour in one's daily schedule. It has been noted that there is however, little emphasis placed on humour experienced by the nurse within the Critical Care environment and the use of humour in the event of 'codes' (when the client is experiencing a cardiac arrest), or when the client is dying



or has died. Whilst this issue of humour specific to death and dying is not documented well within literature, it continuously surfaced as a recurrent theme in the findings, raising further questions and necessitating further research in this area.

The research maintained consistency with the literature as findings indicated that relationships were often developed and communicated through the use of humour as the humorist attempted to gauge the recipient's response to the experience. Research findings also implied that humour has both positive and negative attributes and plays a powerful role in the communication of 'wants and needs' within the Critical Care clinical environment. Discussions also focused on the culture of the environment as a contributing factor to the experience of humour for these nurses. The very nature of the nursing practice, as well as the day to day intricacies of very personal nursing procedures often provides the basis for the generation of humorous exchange.

At the completion of the thesis, it would appear that this research has only skimmed the surface, as the pool of humorous experiences stretches far and wide with interludes being dependent on the individual and the environment in which these situations occur. The nexus between the experience and the respondent forms the basis of new and fascinating understandings of this phenomenon. Moreover, this can also be said of the experience of humour within the milieu of the Critical Care Unit.

This initial research project generates a multitude of questions that remain unanswered for the researcher. Questions abound concerning humour's merits when caring for particular clients in this specialist area. How do others perceive this jocularly in the

inner sanctum of this 'techno-medical' environment? Do those nurses who use humour spontaneously as part of their every day life see this as a nursing practice? Can this then be taught as a strategy for improved team functioning and client care? There are no easy answers to these questions, however there is the opportunity to utilise understandings from this research project as the foundations for new and interesting projects.

Examples of innovative methods for improved nursing practice may evolve in answer to these future research questions as nurses embrace humour as a method for facilitating client interactions in times of noncompliance or when the client is experiencing extremes in emotion. This also has implications for improved interrelationship development with team members or co-workers, as humour has been found to facilitate positive working relationships among staff through the use of laughter and play. It would appear that there are unlimited paths on which future research may travel.

More questions that remain unanswered are: Why do some people use humour and others do not? Is this phenomenon linked to individual personalities or is this a learned experience that is initiated due to the culture of the environment? Do clients and relatives view humour in the Critical Care area as important to their health? Feedback from the participant findings would suggest that clients do view humour as significant in 'normalising' an otherwise traumatic experience. Viewing the experience from all angles is to build a three dimensional prism that will reflect the

understanding and entirety of the essence of humour illuminating the depth and scope of this extraordinary phenomenon

As one can see there is scope to continue with this theme within a broader context as answers to these and future questions will provide further insight into the phenomenon of humour as it is experienced for the individual within the Critical Care, as well as in other settings. Townsend (1994) states that “humor is found in all aspects of human development ... and is looked on as a positive aspect of being human (p.35). With this in mind, the nurse who incorporates humour in his/her nursing practice not only brings cheer to others but also facilitates the development of human relationships that are imperative to the functioning of, and also a key component in, the clinical environment.

This research study has sought to add to the current understandings of humour within literature by focusing on the Critical Care environment and acknowledging those experiences of humour for the Registered Nurse within this area. As mentioned, the use of humour within the Critical Care Unit is not well documented but lays claim to consistency with previous studies performed in specialist areas. It is evident that the Registered Nurse working within the Critical Care environment exercises a sense of humour that may not be well understood by others. This experience does, however, open up new doors and provide new paths for a deeper understanding of this phenomenon.

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**RESEARCH TIMEFRAME**

	Proposal and Ethics Approval	Literature Review	Initial Participant Interviews	Transcripts Returned (Refer Colaizzi's Data Analysis)	Data Analysis	Write Up
Oct 1996 - Jan 1997	Shaded	Shaded				
February 1997		Shaded				Shaded
March 1997			Shaded			Shaded
April 1997			Shaded			
May 1997			Shaded	Shaded		
June 1997				Shaded	Shaded	Shaded
July 1997				Shaded	Shaded	Shaded
August 1997						Shaded
September 1997						Shaded
October 1997						Shaded
November 1997						Shaded

## **COLAIZZI'S PHENOMENOLOGICAL METHOD**

### **FOR DATA ANALYSIS**

1. Read all of the subject's descriptions in order to acquire a feeling for them. Return to each protocol and extract significant statements. Spell out the meaning of each significant statement, known as formulating meanings. Organise the formulated meanings into clusters of themes
2. Refer these clusters of themes back to the original protocols in order to validate them. At this point, discrepancies may be noted among and/or between the various clusters. Researchers must refuse temptation of ignoring data or themes which do not fit. Results so far are integrated into an exhaustive description of phenomenon under study.
3. Formulate the exhaustive description of the investigated phenomenon in as unequivocal a statement of identification as possible. A final validating step can be achieved by returning to each subject asking about the findings so far.

(Beck, 1994, p.256-7)