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Therapeutic use of humor in occupational therapy

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THERAPEUTIC USE OF HUMOR IN OCCUPATIONAL THERAPY

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Abstract

THERAPEUTIC USE OF HUMOR IN OCCUPATIONAL THERAPY

by Gwen E. Vergeer

This thesis addressed the therapeutic use of humor by occupational therapists. Interviews with five occupational therapists who used humor within their practice were conducted and analyzed using the phenomenological method so that the lived experience of humor use could be examined to ascertain its true meaning to the subjects.

In-depth analysis of the data revealed the essential description of the phenomenon--the lived experience of the use of therapeutic humor in occupational therapy--as well as sixteen themes related to humor use by the occupational therapists in this study. These themes were compared with the literature and then analyzed to discover implications for occupational therapy practice; recommendations for further research were made.

Acknowledgements

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I especially thank the eleven occupational therapists who participated in this study and spoke so candidly and eloquently about their experiences with humor, in order that the information in this paper could be as richly descriptive and worthwhile as it has turned out to be.

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CHAPTER 1

INTRODUCTION

Purpose

The purpose of this study was to examine occupational therapists' experiences of using humor therapeutically in treatment.

Statement of the Problem

In recent years there has been an increased interest in studying the phenomenon of humor as it relates to health. A number of studies have documented various psychological and physiological benefits of humor (Averill, 1969; Fry, 1977, 1979; Gardner, 1981; Martin & Dobbin, 1988; Martin & Lefcourt, 1983; Robinson, 1977, 1991; Simon, 1988a; Williams, 1986). Others have delineated functions of humor or attempted to articulate the humor response (Bellert, 1989; Goodman, 1983; Haig, 1986; Pasquali, 1990; Siegel, 1986). Some studies have discussed the varied roles of humor between health care professionals or in the workplace (Duncan & Feisal, 1989; Robinson, 1991; Vinton, 1989). Still others have discussed the use of humor in therapeutic activities and relationships, as well as in overall approach to treatment, to aid the patient's adjustment or recovery

(Robinson, 1977, 1991; Ruxton & Hester, 1987; Simon, 1988b; Sullivan, 1988).

Humor is an intrinsic part of human interaction and experience, yet the idea of "therapeutic use of humor" is a recent conceptualization. Some health professionals have utilized therapeutic humor in their treatment for years, believing it to be helpful prior to any empirical studies on the subject provided evidence for this. Other health professionals are considering using humor in a therapeutic context for the first time, based on the recent research and current interest. Yet only one available article (Pasquali, 1990), from the nursing literature, discusses this therapeutic use of humor from the experience of a health professional, and no researchers have directly explored the experiences of the health practitioner who has used humor in his/her practice.

Given the documented health benefits of humor and its potential for application to activities and to the therapeutic relationship, it is important to investigate its use in occupational therapy. Very few articles on humor exist in the occupational therapy literature (Banning & Nelson, 1987; Southam & Cummings, 1990; Tooper, 1984). Each of these articles advocates the use and/or value of therapeutic humor based on literature or research from other

professions. However, they do not begin at the fundamental level (which is valuable for investigating a new or newly recognized aspect of treatment) of examining the meaning and practice of therapeutic humor as it is used in occupational therapy today. It is necessary to explore this phenomenon further if the use of therapeutic humor in occupational therapy is to be understood and developed. This study explores one aspect of the therapeutic use of humor--the experiences of occupational therapists who have used humor with their patients--in order to begin the process of clarifying the meaning of the phenomenon of therapeutic humor for and in occupational therapy.

Research Question

What is the occupational therapist's experience of using therapeutic humor in treatment?

Definitions

Due to the exploratory nature of this study, only technical terms are defined. Not only are terms such as humor difficult to define (Robinson, 1991), they may be artificially and too narrowly defined, influencing the researcher to adopt a limited perspective in choosing questions and evaluating the meanings of the data (A. MacRae, personal communication, April, 1991). The researcher must avoid potential for bias by allowing the

subjects to clarify their own perceptions and understandings of relevant concepts. "If we are to comprehend faithfully human (experience) as it is actually lived. . .we cannot resort to arbitrary preconceptions or definitions" (Fischer, 1989, p. 130).

For the sake of consistency and easier reading, throughout this study the recipients of occupational therapists' services are referred to as "patients." The reader is invited to mentally insert "clients" or another term that seems more relevant.

An occupational therapist is defined as one who has completed an occupational therapy education program, is registered to perform occupational therapy, and utilizes self-care, work, and play activities therapeutically to increase independent function, enhance development, and prevent disability (American Occupational Therapy Association, 1986).

Assumptions

General Assumptions

It has been assumed, in conducting this research, that therapeutic use of humor occurs in treatment with patients but that its use has not been well understood, especially within the field of occupational therapy. It has therefore been assumed that a phenomenological study exploring the

experiences of occupational therapists who use humor therapeutically would be valuable because it would clarify the meaning of therapeutic humor and its involvement in occupational therapy practice.

It has also been assumed that the information on occupational therapists' therapeutic use of humor collected in this study will have implications for the practice of and future research in occupational therapy.

Bracketing

Bracketing, or acknowledging and setting aside the researcher's beliefs and preconceptions to minimize the influence of these biases on the data collection and analysis, is an important part of phenomenological research (Smith, 1989).

Although bracketing is a continuous process during the course of a phenomenological study, this researcher recorded her bracketed beliefs on two occasions, prior to data collection and prior to data analysis. The results of the first bracketing were as follows:

The researcher believes that humor can be used therapeutically in a variety of ways within the therapeutic interaction. It can be formal or informal, planned or spontaneous. However, spontaneous "flow" of humor is often important for its goals to be achieved. The goals of humor

include increasing ease and comfort, improving rapport, seeing the absurd in the ordinary, decreasing tension (and achieving other physiological/psychological benefits as documented in the empirical literature), and asserting a positive outlook toward life. The researcher believes that humor can be a coping mechanism both for patients and for occupational therapists.

The researcher believes that the definition of therapeutic humor is very broad and that the term actually implies promoting a positive outlook on life and searching for aspects to enjoy instead of dwelling on that which is negative. The researcher holds that many occupational therapists use humor informally and frequently with their patients, while a few also use it more formally. She believes that more therapists would use humor deliberately if they considered not only the intuitively obvious benefits of humor but the scientifically discovered ones and were aware of more options for introducing humor into the patient-therapist interaction and environment.

The researcher believes that the expanded understanding and application of therapeutic humor is fundamentally important given the current interest in prevention of health dysfunction and society's realization that the medical model

alone falls short of meeting the needs of human beings in the health care system.

After collection of the research data, the researcher's perceptions had been colored by some of the comments made by the subjects which had not yet been analyzed. At this point the researcher bracketed her perceptions again, as follows:

The researcher believes that humor is difficult to talk about because it can change when observed, can lose its essential spontaneity when focused upon or even consciously attempted. Humor can be an ephemeral phenomenon, and there is a fine balance between trying to promote the use of humor and taking the essence of it away. The researcher nonetheless continues to affirm all that was stated in the first bracketing about the multi-faceted value of humor and thus believes that the difficulty of achieving this balance must be bridged.

The researcher holds that use of humor by occupational therapists with patients is part of therapeutic use of self. Like all forms of therapeutic use of self, there are times to use humor and times it is contraindicated, and there are different ways to use it with various patients or various patients' needs. Also, each therapist has distinct gifts to be used as part of therapeutic use of self, and if humor is not one of the gifts of a particular therapist, it would

probably not be effective for him or her to try to force it into interactions. On the other hand, all people have the potential to develop their innate humor--the playfulness of childhood or the ability to see absurd contradictions in life--even if they have not cultivated it before.

The researcher has become frustrated with fads that purport to cure all ills, and she fears that sometimes the focus on using humor therapeutically takes on the nature of this type of fad; at times, the workshops on therapeutic humor may convey this feeling. The researcher hopes that this study will find the use of humor to be a deeper, richer experience than a mere health fashion.

Despite the potential for misrepresentation by some of the workshops, however, and despite the fact that they may preach to those already converted, the researcher feels that such workshops can help people rediscover their innate humor, as mentioned above, and are valuable simply in the fact that they allow people to relax and have fun. As long as they portray humor as a means of adding quality to life and not as a panacea, the workshops can be constructive resources.

If this study could provide education about the use of humor to occupational therapists, the researcher predicts certain results. Occupational therapists who have never

used humor as part of their therapy may not be influenced to do so by this study, although it is possible that a few therapists who have not used humor could be so convinced of its usefulness and its enjoyable qualities that they would add it to their lives and their therapeutic interactions. Most occupational therapists have probably used humor occasionally, and such therapists may be moved by this study to consider humor more closely and to incorporate it more consciously into their therapy, their interactions with other staff members, and their internal coping mechanisms. The researcher feels that if she were to direct this study's recommendations to any group in particular, it would be to the latter group of therapists.

Limitations

This study had several limitations. The sample size was small, and while a small sample size is considered acceptable for phenomenological research, it is possible that greater variation in the lived experiences of occupational therapists who use humor would have been found if more interviews had been analyzed. Although generalizations from the data cannot be made, the depth of the interview analysis somewhat compensates for the small number of subjects, and data saturation in qualitative research can occur with a very small sample. Also,

phenomenological studies do not purport to provide data that are definitively generalizable; rather, they yield data which preserve the uniqueness of individual experience while allowing a general understanding of the phenomenon under question as it is collectively experienced (Banonis, 1989).

The sample in this study was not randomly selected, although the interviews actually analyzed were randomly selected from those conducted. The variables were not controlled. Although an attempt was made to select occupational therapists in different practice settings, not all practice settings were represented, and only a small geographical area was represented; again, generalizations about the results cannot be made. Nonetheless, this study is a valuable first step toward an understanding of the use of humor therapeutically in occupational therapy.

Because an interview was used as the method of data collection, it is possible that the recollections of the subjects were incomplete or that the method of collection altered the responses given. Studies have found that it can be difficult for therapists to articulate their thought processes (Barris, 1987; Rogers & Magasatani, 1982). To counter this limitation, the subjects were given an opportunity to think about the research question in advance

in order to maximize their ability to articulate their experiences.

Although every effort was made by the researcher to bracket preconceptions, it is still possible that experimenter bias affected the data collection and analysis. The experience gained by the researcher during the pilot study and the continual feedback received from therapists skilled in phenomenological research and/or the therapeutic use of humor helped minimize researcher bias and other difficulties in the research process.

Because of these limitations, further research that expands upon the findings from this study is recommended. Yet in spite of the limitations, this study provides valuable information in an area which has not been studied previously, that of the experiences of occupational therapists who use humor therapeutically within their work, in order to broaden the understanding in the field about occupational therapists' actual clinical practice and about possibilities for the use of humor in occupational therapy.

Significance of the Study

There has been no prior research on the experiences of occupational therapists who use humor therapeutically. Therefore, it has never been clarified what nature of humor is being used, why it is used, what happens during the

therapeutic encounter, what makes it therapeutic, and what the therapist thinks, feels, and experiences during this process. This study addressed these issues. Recent research in other health-related fields has indicated significant benefits from laughter and the use of therapeutic humor in patient care (Averill, 1969; Bellert, 1989; Cousins, 1979; Fry, 1977, 1979; Gardner, 1981; Goodman, 1983; Haig, 1988; Martin & Dobbin, 1988; Martin & Lefcourt, 1983; Pasquali, 1990; Peter & Dana, 1982; Prerost, 1989; Robinson, 1977, 1983, 1991; Ruxton, 1988; Ruxton & Hester, 1987; Salameh, 1983; Siegel, 1986; Simon, 1988a; Simon, 1988b; Sullivan & Deane, 1988; White, 1990; Williams, 1986; Ziv, 1988). It is imperative that research in occupational therapy keep abreast of current topics and issues in health care, such as humor, in order to maintain professional excellence and develop respect as an applied science (Gilfoyle & Christiansen, 1987).

This study involved analysis of the lived experiences of occupational therapists who use humor therapeutically. There is no literature on the experiences of occupational therapists who use humor therapeutically, yet it was apparent that there are therapists who do so. Therefore, it seemed worthwhile to probe some of these therapists for a detailed and rich description of their experiences in order

to discover what it means to use humor therapeutically within the occupational therapy setting.

This research has been conducted in the hope that it will fill in these gaps in the literature and articulate the experiences of occupational therapists who use humor therapeutically.

CHAPTER 2

REVIEW OF THE LITERATURE

Although for centuries humor has appeared in the writings of philosophers and theorists, and although humor is an intrinsic part of human interaction (Robinson, 1991), only recently has it become a subject of interest to medical and social researchers.

Theories of Humor

Many theories have been proposed to explain the meaning of humor, and a general knowledge of these theories forms an important framework for understanding the literature on humor. Robinson (1991) grouped the primary theories into two categories, those describing the nature of humor and those explaining the function of humor. In the first group are superiority theories, incongruity theories, and play theories. The superiority or disparagement theories view humor as a means for asserting one's superiority over others to compensate for feelings of inferiority (Morreall, 1987). Incongruity theories consider humor to result from surprise, ambivalence, incongruity, and conflict when two inconsistent ideas or emotions are absurdly juxtaposed (Morreall, 1987; Robinson, 1991). Play theories consider humor to be a necessary aspect of play and play a necessary aspect of humor; these include developmental theories that discuss the

mutually dependent development of humor and play (Robinson, 1991).

The second group of theories, which has been more thoroughly studied than the first, includes relief theories and biological theories. Relief theories consider humor to be a mechanism for the release of frustration and tension or for temporary escape from life's difficulties (Morreall, 1987; Robinson, 1991). The biological theories are those which emphasize the physiological benefits of humor and laughter (Robinson, 1991).

Robinson (1991) stated that most of the theories on humor have not yet been tested empirically and that no one theory fully explains the complex phenomenon of humor. One goal of this study is to provide more data from which to shape humor theories, and especially to explore the meaning of humor to those who use it, which has been assumed to be equivalent to the nature and/or the function of humor, an assumption that may or may not be valid.

Benefits of Humor

A number of researchers have reported that humor and laughter provide significant positive physiological benefits. Laughter has a similar effect on the body as exercise, increasing muscle tone, oxygen exchange, heart rate, respiratory activity, and circulation; it stimulates

both adrenalin and catecholamine production (Averill, 1969; Fry, 1977, 1979; Williams, 1986). Following this arousal state the body relaxes, and heart rate, respiration rate, muscle tension, and blood pressure return at least to previous levels, often stabilizing at levels below their pre-laughter state (Fry, 1979). The muscles exercised by laughter include those of the abdomen, diaphragm, back, chest, neck, throat, jaw, face, and sometimes even the arms and legs (Haig, 1988; Peter & Dana, 1982). The respiratory exercise generated by laughter can also aid expectoration of secretions from the lungs, thus preventing or remediating respiratory infections (Williams, 1986). A study by Martin and Dobbin (1988) showed that subjects who scored as having less sense of humor had a greater drop in immunoglobulin A (a substance thought to increase immune functioning) following stress than did subjects with a strong sense of humor. The limbic system, hypothalamus, and both hemispheres of the brain show coordinated activity during laughter and during the affect and cognitive appreciation associated with humor (Gardner, 1981; Haig, 1988). A classic non-empirical work describing an application of the physiological benefits of humor is Cousins' Anatomy of an Illness (1979), in which he recounted his use of laughter (in addition to large doses of vitamin C) to effectively

reduce his pain and blood sedimentation rate to help himself recover from ankylosing spondylitis.

Many psychological and social benefits of humor have also been discussed in recent literature. Robinson (1977, 1991) and Simon (1988a) considered humor to be a vital coping mechanism for relief of anxiety and tension. Martin and Lefcourt (1983) found by measuring connections between stress, mood, and sense of humor that humor served to decrease the impact of life's stress, and they stated that this occurs most effectively when individuals not only recognize the humorous side of a situation but when they place a high value on humor and actively produce humor themselves. Safranek and Schill (1982) reported contradictory findings; their study did not find that humor had a significant effect on life stress in general, but they allowed that humor may be effective in decreasing the experience of stress in some situations.

It is believed that the psychological and social benefits of humor can be of particular significance to hospitalized patients. Many rules of society, such as guidelines for privacy, are altered in hospitals, and humor can help patients cope with embarrassing situations, reduce the tension created by the unfamiliar regime, and quickly develop rapport with staff members (Robinson, 1977, 1991;

Simon, 1988b). Humor can convey empathy and a shared understanding of problems (Ruxton & Hester, 1987). It can also provide a constructive outlet for anger and frustration and can neutralize emotionally charged topics--such as serious illness--in order to help patients maintain hope and put themselves and others at ease (Robinson, 1983; Williams, 1986). Humor can allow people who feel powerless to regain control of their environment, at least momentarily (Prerost, 1989; Ruxton, 1988). Sullivan and Deane (1988) discussed the effectiveness of humor as a communication tool that promotes self-disclosure and leads to disclosure of more personal information than previously divulged, as well as prompting elderly patients to recall positive memories. Humor allows people to see new perspectives on situations (Goodman, 1983; Haig, 1986; Siegel, 1986; Williams, 1986). It can facilitate learning as well, in that by decreasing social distance and tension and by generating interest it enhances creativity, motivation, and retention (Bellert, 1989; Pasquali, 1990; White, 1990; Ziv, 1988). Salameh (1983) summarizes these psychosocial benefits by stating, "healthy humor can be considered as a creatively therapeutic problem-solving modality representing the human capacity for survival, continuity, and adaptation" (p. 81).

It is important to examine the distinction, discussed in some of the literature, between "healthy" and "unhealthy" humor. Concern has been expressed that despite the positive therapeutic potential of humor it could be destructive if used as a belittling, divisive, or self-serving mechanism. In fact, Kubie (1971) has condemned the use of humor in therapy as almost universally detrimental to the patient. Miller (1970), an occupational therapist, discussed evaluating patients' use of humor as a projective method of gaining information about them; he believed that patients who make sexual or aggressive jokes or puns are not coping well with reality and may either be pleading for help or escaping from life's problems. Like Kubie, he cautioned therapists to refrain from engaging in humor interchanges with patients. Other authors have refuted these claims (Mindess, 1976, 1981; Poland, 1971; Reynes & Allen, 1987; Robinson, 1983; Young, 1988), however, and have stated that humor used in a therapeutic context is unhealthy only if professionals use it in an abusive manner, putting their own needs before those of their patients. Given the more recent research showing benefits to patients from using humor, wholesale denunciation of therapeutic humor seems unreasonable. Pasquali (1990) and Robinson (1983) pointed out that it is each health professional's responsibility to

use humor judiciously, determining that it is being used for purposes that are healing to the patients.

The studies and articles describing the physiological, psychological, social, and cognitive benefits of humor provide interesting and potentially valuable information on different ways in which humor can be of benefit to human beings. Most of the research studies mentioned thus far focus on isolated aspects of humor and its cause or effect, but one can postulate, as many of the non-empirical articles do (Robinson, 1977, 1991; Siegel, 1986; Simon, 1988a) that altogether humor may facilitate restoration and maintenance of health and function. However, the studies and articles do not address humor from specific perspectives, such as the phenomenological viewpoint, which could provide more evidence in evaluating the truth of this conclusion. The available literature mostly derives its conclusions on the nature of humor and humor use by combining results from different studies or perspectives, reaching their conclusions by induction and often not by actual scientific examination. The multi-faceted and many-layered nature of humor seems clear from the numerous perspectives on it that have been advanced, but this has not been examined in a research study, nor has research attempted to find the

meaning of humor as it is experienced by those who are using it.

Humor in the Workplace

Humor is also noted to be an important component of staff relations in the workplace. Robinson (1991) discussed the various functions of humor for the health professional as discovered from her experiences and the research of others. She stated that the health professional's need for humor is as great as that of the patient. Sociologically, Robinson found humor to be used for increasing group solidarity and productivity, establishing and maintaining relationships, initiating new members into the health care team, creating change (including organizational change and change of values/images), diffusing resistance to change, and stimulating creativity. Vinton (1989) conducted a qualitative study which examined the use and types of humor in the workplace, in which he found that humor served the purposes of socialization, facilitating the completion of tasks, lessening status differences between employees, and creating bonds between co-workers. A study by Duncan and Feisal (1989) revealed that humor facilitates relationships, relieves frustrations, and improves group cohesiveness, which the authors postulated may indirectly improve group performance.

Psychologically, humor helps health professionals to cope with the stressful and emotionally challenging situations they face on the job; it serves as a means to reduce anxiety and as an outlet for frustration, fear, and anger (Robinson, 1991). Robinson pointed out that in situations of greatest stress (tragedies, crises, severe illness or injury, and death), macabre "gallows" humor emerges as a primary way of defending against the horror and reducing the feelings of hopelessness, pain, and despair which could otherwise incapacitate and overpower the professional, causing burnout. Although it may appear inappropriate to others, gallows humor is cathartic and restores a balance to those who use it (Robinson, 1991).

Humor in Occupational Therapy

A review of the occupational therapy literature yielded few articles on the use of humor. Tooper (1984) discussed the importance of therapists understanding their own attitudes toward humor and purposefully developing their own sense and style of humor. She stressed the importance of learning when and how humor is used most effectively with different patients. In the only published occupational therapy research on humor, Banning and Nelson (1987) found that including humor in a group activity increased group cohesion and the experience of affective meaning. They

discussed the positive benefits of using humor in activities. Southam and Cummings (1990) reported on the use of humor as a pain modulation technique and provided specific examples for using humor in the clinic.

Despite the dearth of occupational therapy literature on therapeutic use of humor, it seems that humor would be a modality well-suited to this field. The occupational therapists' conscious use of self is fundamental to the treatment process, especially in the initial establishment of trust and promotion of motivation in the patient (Tiffany, 1988). As mentioned, humor can be an effective communication tool to convey empathy and establish a bond rapidly between patient and therapist. The concept of helping patients regain control of their lives and develop adaptive coping strategies is also a central occupational therapy goal (Pedretti, 1990), and as stated, humor is a tool that can be used to these ends. Many authors have cited the value of humor-promoting activities (Banning & Nelson, 1987; Ewers, Jacobson, Powers & McConney, 1987; Pasquali, 1990; Ruxton & Hester, 1987; Simon, 1988; Southam & Cummings, 1990), and activity is a core concept in treating the occupational needs of individuals (Hopkins & Tiffany, 1988). Schmitt (1990) commented, "Laughter can create a comfortable environment for risk taking as patients

begin to try new ways to accomplish activities of daily living" (p. 145). Furthermore, the dictionary definition of occupational therapy, as established by the American Occupational Therapy Association's Representative Assembly (1986) begins, "(it is the) therapeutic use of self-care, work, and play activities to increase independent function, enhance development, and prevent disability" (p. 852). Humor can be seen as "a natural expressive accompaniment of play" (Southam & Cummings, 1990, p. 1), and play as an essential aspect of humor (Robinson, 1991). Due to its health benefits humor could be a useful component of self-care activities, and due to its psychosocial benefits, including social facilitation and stress relief, it could enhance work tasks and roles.

It seems appropriate to consider the conscious incorporation of therapeutic humor into occupational therapy practice. Tooper (1984) implied that humor has been utilized in practice by some occupational therapists for years, as it is a natural part of human life and interaction. She stated that "sense of humor" can mean a positive attitude, which is something therapists may desire to bring to the therapy session or to inspire within their patients.

Yet the idea of "therapeutic use of humor" is a newly recognized and little studied component of occupational therapy. Ottenbacher (1987) emphasized the need to integrate research with occupational therapy practice, using research to guide and direct practice. Before any treatment component is recommended it seems important to have an understanding, from research in occupational therapy, of what the phenomenon means and involves in occupational therapy practice. Only then will a profession-specific framework of understanding exist which can guide the educational approach to and the development, research, and practice of humor in occupational therapy. Parham (1987) pointed out that occupational therapists must move beyond primary emphasis on techniques to reflection on clinical problems and application of theory to treating these problems. Rogers (1983) also called upon occupational therapists to deepen their understanding of the process underlying assessment and treatment. No research has been conducted which would provide understanding of the underlying processes involved in the experience of using therapeutic humor in occupational therapy practice.

Summary

Much literature exists which discusses the theories, benefits, and uses of humor. However, certain aspects of

the experience of humor use, particularly in occupational therapy, remain to be studied. This study contributes to the literature on the meaning of the experience of therapeutic humor in occupational therapy.

CHAPTER 3

RESEARCH METHODOLOGY AND PROCEDURES

The Phenomenological Method of Research

This research has been conducted using phenomenological methodology for data collection and analysis, which is one form of qualitative research. Yerxa (1991) stated that the elements of qualitative research fit well with occupational therapy philosophy--these elements include observing in natural settings, dealing with participants' experience of meaning, and looking at the entire context of a situation, in all of its complexity. Yerxa (1988) also stated that qualitative research is important for occupational therapy at its current stage of theoretical and conceptual development as a profession; "researchers cannot begin to manipulate variables until the important variables have been clearly defined and described" (p. 174). Robinson (1991) stated that the study of humor in health care requires a qualitative research approach, since quantitative studies seeking to "validate theoretical constructs about humor are often questioned because there are not enough data from natural setting (sic) to provide a norm against which (such) studies can be judged" (p. 6).

Phenomenology has been called both the "science of pure phenomena" (Husserl, 1917/1981, p. 10) and the "science of

experience" (Ihde, 1977, p. 21). Phenomena, in this context, refers to the "content that intrinsically inhabits the intuitive consciousness in question and is the substrate for its actuality valuation" (Husserl, 1917/1981, p. 11). Such phenomena are both individually and universally experienced (Giorgi, 1985). The collective consciousness of the phenomena in question is made up of many people's intuitions together, each of which offers a slightly different perception of the phenomena so that the collective understanding is made richer (Husserl, 1917/1981). An attraction of the phenomenological method of research is that it both preserves the uniqueness of individually lived experiences and allows an understanding of the phenomena as experienced collectively (Banonis, 1989). This concept fits well with occupational therapy philosophy, which values both a humanistic respect for the individual and an integrated domain of concern or framework for occupational therapy practice (Llorens & Gillette, 1985). With phenomenology, there is also no need to discriminate between subjective and objective phenomena, since it is concerned with the living experience which interconnects them (Phillips, 1989). From a phenomenological perspective the affirmation of subjectivity, which is inevitable in any experience of reality, enriches the authenticity of the subjects'

perceptions and deepens the subsequent understanding of the phenomena (Munhall, 1989).

Phenomenological study involves returning to original entities (Husserl, 1900/1970) and examining personal descriptions of lived experiences so that these experiences might be better understood (Giorgi, 1985). Because the traditional natural sciences have been developed to deal more with phenomena of nature by means of verification than with experienced phenomena by means of discovery, the phenomenological method of research has emerged to bridge this gap and "do justice to the lived aspects of human phenomena. . .(by studying) how someone actually experienced what has been lived" (Giorgi, 1985, p. 1). MacRae (1991) has specifically advocated the use of the phenomenological method for research in occupational therapy because of the shared emphasis on seeking to understand the holistic complexity and richness of people's experiences. "Phenomenology offers to occupational therapy the means to further articulate its philosophical base and apply its principles to both practice and research" (MacRae, 1991, p. 14).

This study has been conducted using the phenomenological method of research described by Giorgi (1985), although from an occupational therapy perspective

rather than Giorgi's psychological perspective. Instead of examining the psychological meaning underlying an experience, the experience was examined in terms of variables which are important to occupational therapy theory and practice, such as the emphasis on attaining maximal function, the treatment setting as an environment promoting adaptation, and therapeutic use of self (Christiansen, 1991).

Rationale for Choice of Method

When the research question, "What are occupational therapists' experiences of using therapeutic humor in treatment?" was first formulated and the literature first reviewed, there was difficulty choosing the form of qualitative research which would most appropriately answer the question. Grounded theory was the first type of research considered, but it was eventually deemed unsuitable because of the difficulty of observing the effects of humor and of engaging in the requisite participant observation without biasing the results of the study. Researchers who have studied humor using this method have found that the patients' and health professionals' experience of humor changes if they know they are being observed (Buffum, 1989). Additionally, the nature of a grounded theory study is that the observations must continue until the categories formed

are saturated, with no new data appearing, and thus the data collection in these studies can take months or years, which was considered beyond the scope of master's thesis research.

The phenomenological method was chosen as the most appropriate method for studying this question in part because so little research had been conducted on humor in occupational therapy that it was important to start with a method that would provide a groundwork of understanding, articulating the meaning of humor use in occupational therapy as a basis from which further research could be conducted. Also, as mentioned above, this method shares an emphasis with occupational therapy philosophy in seeking to understand the holistic complexity of lived experience, and thus has been advocated for use in occupational therapy research (MacRae, 1991). Finally, this method was chosen because it was not apt to change the quality of an experience of humor as it occurred in the same way that observance of the actual experience--as the grounded theory method would involve--could. The data collection method chosen for this study was exploratory interviews of occupational therapists who have used humor in their practice.

Standards for Qualitative Research

It is important to establish the rigor of any research. It is especially important to establish standards for assessing the trustworthiness of qualitative research, which does not fit into the standard measures for critiquing rigor used with quantitative studies--reliability and validity (Burns, 1989; Krefting, 1991). Lincoln and Guba (1985) have proposed a model for assessing the trustworthiness of qualitative studies which is "comparatively well developed conceptually and has been used by qualitative researchers . . .for a number of years" (Krefting, 1991, p. 215). It judges the rigor of a study in terms of the following characteristics: truth value, applicability, consistency, and neutrality.

Truth Value

Truth value examines the confidence the researcher has established that the data gathered are true for the subjects and the context. It is loosely analogous to the issue of internal validity for quantitative studies. The truth value is subject-focused, not researcher-defined, and the duty of the investigator is to report what has been revealed as completely and accurately as possible (Krefting, 1991). In this study, a high truth value was pursued by audiotaping the interviews, collecting enough information so that data

saturation was achieved, and receiving feedback on the results of the data analysis from persons familiar with the therapeutic use of humor in occupational therapy.

Applicability

Applicability, the generalizability of the data to other people and settings (which bears some similarity to external validity in quantitative studies), is another consideration in the rigor of qualitative research. As Krefting (1991) discussed, from one perspective generalization is not relevant to most qualitative research, since the goal is to examine and describe unique experiences and phenomena, not to make inferences from the information gathered to other populations. Another perspective, though, is that a qualitative study has applicability if the findings can transfer to other situations in which the context exhibits a degree of similarity/goodness of fit (Krefting, 1991; Sandelowski, 1986). Lincoln and Guba (1985) stated that this criterion is met if the researcher provides enough descriptive data to allow others to make comparisons to similar situations. The fact that this research was conducted with several subjects and explored common themes in their lived experiences will contribute to the applicability of the study. The themes which were found

were also compared and contrasted with the literature, to add another dimension of applicability to the study.

Consistency

The third measure of rigor in qualitative research is consistency. This is partially comparable to the quantitative measure of reliability. Yet in this study, since the variety and the uniqueness of the experience of using therapeutic humor in occupational therapy are focused on and the researcher is learning from the subjects instead of controlling for them (Krefting, 1991), the traditional notion of reliability is irrelevant. Rather, auditability (Sandelowski, 1986) is the goal--that is, any variability that is noted ought to be traceable along a "decision trail" to identifiable causes, and similarly, further research should result in comparable, not contradictory, data. The researcher conferred with occupational therapists who were familiar with phenomenological research and/or the therapeutic use of humor throughout the data analysis to assure that this study had such consistency.

Neutrality

Finally, a qualitative study must have neutrality to attain trustworthiness; observer and procedural bias must be minimized. This is accomplished in phenomenological research by bracketing, recognizing beliefs and

preconceptions and then setting them aside during the data collection and analysis so that they do not color the meanings, themes, and essences expressed by the subjects (Smith, 1989). The researcher bracketed preconceptions while conducting the interviews and data analyses and took special care during the interviews not to lead the subjects to any particular responses in order to preserve as much neutrality as is possible.

Pilot Study

An informal pilot study was conducted with one occupational therapist prior to the collection of actual research data. These data were collected and analyzed in accordance with phenomenological method so that experience in interviewing and analyzing data with this method could be gained and so that unnecessary difficulties could be avoided during the study. This step was particularly instructive in helping the researcher to learn how to bracket biases and not influence the subject's responses during the interview. As Giorgi (1985) has said, in speaking of the importance of praxis in conducting phenomenological research, "Without a concrete 'working through' of the method one can imagine many difficulties, whereas the very 'working through' solves many of them before they become problems" (p. 21).

Subject Selection

Subjects for the study were located by contacting occupational therapists within the San Francisco Bay Area. An effort was made to obtain subjects who worked in a variety of occupational therapy practice areas with patients of different ages and disabilities; no additional control was exerted over variables in this study. Potential subjects were contacted, asked if they had the experience of using humor therapeutically in their practice of occupational therapy, and if so, asked whether they were interested in participating in this study. Twelve therapists from different communities in the Bay Area expressed interest in this study, and eleven of them were interviewed. Four of the subjects interviewed were currently working with pediatric patients, three with physical disability patients, two with geriatric patients, one with psychiatric patients, and one with hand rehabilitation patients, although their patient groups were not entirely discrete, and many subjects also discussed previous jobs or internships during which they had worked with other patient populations. Three of the subjects were currently working with inpatients and eight with outpatients; all were women.

The Interview

The purpose and structure of the interview was explained to each subject verbally and in writing at least two days before the interview (see Appendix II); the subjects were encouraged to prepare for the interviews by thinking about specific examples of their use of humor within their work as therapists.

The subjects were given an opportunity to ask questions of the researcher and were notified of their rights as research subjects (see Appendices II and III). After the consent forms had been read and signed by the subjects, the interviews were conducted. The subjects were asked to describe their experiences of using humor in their therapy in as much detail as possible; they were also asked about their thoughts on the concept of "therapeutic humor." No additional questions other than clarification questions were asked, and no explanation of the questions was made; the subjects were simply asked to respond as they thought appropriate. The interviews all took place either at the workplaces or the homes of the subjects. They lasted from twenty minutes to eighty minutes each and were audiotaped. The interviews were coded alphabetically to protect subject confidentiality.

Data Preparation

To organize the data for analysis, the researcher used a computer to transcribe the interviews. Words which had verbal emphasis were underlined. Gestures and other non-verbal cues (including smiling and laughing) were noted. Although there were small sections of three interviews which could not be used because they did not reflect the experience of the subject or would have jeopardized the subject's confidentiality, all of the interviews provided substantial usable data. As had been previously decided, it was only necessary to analyze five interviews; a small sample size is typical for a phenomenological study, since even samples of two to five subjects have been found to produce data saturation (Parse, Coyne, & Smith, 1985). Two groups of five interviews were randomly selected from among the eleven subjects, and the researcher chose the group which was more representative of different practice areas for analysis.

Data Analysis

The data from the interviews were analyzed as follows: First, the transcriptions were read thoroughly to gain a sense of the whole experience. Then the text was read again, more carefully, in order to derive meaning units (Giorgi, 1985). Meaning units are context-laden

constituents which are derived from the researcher's perception of a shift in the meaning of an experience for the subject (Giorgi, 1985).

The following example illustrates how meaning units were derived. Part of Subject A's interview proceeded as follows:

Researcher: Are there other things that you feel are going on for the patients, clients, while. . .that are connected to the humor?
Subject A: Yeah, yeah, it's a way of, kind of, you know, dealing with what's going on with them. Because what we deal with are head injuries and strokes and that, that kind of thing that are life changing, um, often very debilitating kinds of things, and it's not always easy to take it lightly. . .and to see, um, the humorous side of what's going on, that sort of thing. Um, that people know that their lives are never going to be the same. And that's a real difficult thing for them to deal with. . .in many cases. And it, sometimes there isn't any other way for them to even start to deal with it, other than to have some, to begin some kind of communication with someone,. . .whether it's the therapist or other patients or whatever. And often that's the way it works. They can't do it directly. You know, they can't talk about what's going on directly. . .
R: Yeah; how does humor work into that?
A: Uh, people can just relate, I think, more easily to it; it isn't, it isn't quite as personal, it isn't quite as, like, "Oh, this is really me we're talking about" (R chuckles) kind of stuff. You know, that. . .actually, I hadn't, until you asked the question I hadn't really thought about that. . .but I do think that that's what happens. . .

The interview was printed out so that it appeared in the left column of the pages. Then each point in the interview where the meaning of what Subject A was saying changed was marked as a new meaning unit. The essential meaning of what she was saying was then recorded in the right column. The

researcher performed this step two to three times for each meaning unit, rewriting them so that they most accurately reflected the subject's intention. The results were as follows:

A: Yeah, yeah, it's a way of, kind of, you know, dealing with what's going <u>on</u> with them. Because what we <u>deal</u> with are head injuries and strokes and that, that kind of thing that are <u>life</u> changing, um, often very debilitating kinds of things, and it's <u>not</u> always easy to take it lightly. . .and to see, um, the humorous side of what's going on, that sort of thing. Um, that people <u>know</u> that their lives are never going to be the same. And that's a <u>real</u> difficult thing for them to deal with. . .in many cases. And it, sometimes there isn't any other way for them to even <u>start</u> to deal with it, other than to have some, to <u>begin</u> some kind of communication with <u>someone</u>,. . .whether it's the therapist or other patients or whatever. And <u>often</u> that's the way it works.	The patients at A's clinic have had debilitating, life-changing injuries, which demand tremendous coping skills. They may find it very difficult to see humor and lightness in their lives. A finds that sometimes the only way they can begin to deal with their situations is by starting to engage in communication with someone (another patient, the therapist, etc.), and it is often humorous communication.
They can't do it directly. You know, they can't talk about what's going on directly. . . A: Uh, people can just <u>relate</u>, I think, more easily to it; it isn't, it isn't quite as <u>personal</u>, it isn't quite as, like, "Oh,	A's patients are not able to face their problems directly yet because of the gravity of them. Because humor is a less personal, more indirect way of approaching problems, the patients can relate to it more easily. Thus, they

this is really me we're talking about" (R chuckles) kind of stuff.	have one outlet with which to begin to deal with their difficulties, and this starts their emotional healing process.
You know, that. . . actually, I hadn't, until you asked the question I hadn't really <u>thought</u> about that. . .but I do think that that's what happens.	A had never previously thought about humor's success being due to its less personal quality, but this seems right to her. A's facilitation of humor use here, though therapeutic, is intuitive and spontaneous rather than planned.

The phenomenological method of data analysis can offer a rich, deep description of an experience and its meaning through the meticulous and deliberate examination of each unit of meaning. For example, on the first reading of the last meaning unit above, the researcher believed that the important point about this meaning unit, which did not seem as relevant as some of the other data, was that Subject A did indeed experience humor as effective because of its indirect quality, as had already been noted. A deeper reading of the unit, however, provided underlying information about Subject A's intuitive approach to humor, thus adding another dimension to the researcher's understanding of A's use of humor in therapy.

The next step in the data analysis process involved transforming the meaning units into themes which emphasized the therapeutic use of humor by occupational therapists yet

retained the substantive essence of the subjects' expressions, since the point of looking at the subjects' lived experiences is to see them as the subject perceived them (Giorgi, 1985). The themes express the essential aspects of each meaning unit, the central issue in each around which the therapeutic use of humor revolves. These themes were then combined into a situated structural situation (specific description) for each subject which summarized the meaning of the therapeutic use of humor to the therapist, as derived from the essence of lived experience in each meaning unit within the interview.

To continue the example of Subject A, each meaning unit was scrutinized for its most salient point, for its indication of the essential experience of the subject and its significance. Related meaning units were then combined into the specific description. The following excerpts from Subject A's Specific Description relate to the example provided above:

> Humor is a primary part of the milieu of A's facility, a natural, intuitively, and spontaneously included part of the majority of interpersonal interactions there. . . .The therapists' humorous responses to one another in clinic serve as a model for the patients, who begin to join into the joking process themselves. In doing so, the patients begin to interact with each other and with therapists--humor provides a vehicle for this therapeutic social interaction, which might not otherwise occur. These patients are struggling to find ways to cope with the devastating changes in their lives, and they are

> often too angry or depressed at first to see any positive aspects or hope in their lives. Their first step toward dealing with their difficulties is often to begin to communicate with others, which at A's facility generally involves humor.

The next step in the data analysis was to encapsulate each subject's situated structural situation into a general description (Santopinto, 1989) that encompassed the general meaning of the therapeutic use of humor for that subject and focused on the lived experience of therapeutic humor use. In Subject A's general description, the following findings which integrated lived experiences from the above data analysis were included:

> Spontaneous humorous interchange highlights the majority of the therapists' interactions. . . .The humor often has a profound effect on the patients at A's facility, helping advance their healing process and transforming their depression and hopelessness into a more positive, balanced outlook on life. This begins as the patients join into the therapists' jokes and start to interact and connect with them and with other patients. The indirect nature of humor allows the patients, at first, to ease into the task of facing their problems and the changes in their lives; later, it becomes a way of coping with and finding some enjoyment in life despite the problems and changes.

After several interviews had been analyzed through all three stages (meaning units, a specific description, and a general description), it became apparent to the researcher that in trying to remain authentic to the subjects' use of words, some of the subjects' layers of meanings and

underlying beliefs were being overlooked. The data analysis, therefore, began again, with closer attention paid to the deeper meanings of the subjects' stories; much richer descriptions emerged during this analysis. After six months the data analysis was complete, and the synthesis of the data began. The researcher searched for themes within the interviews, especially as related to the lived experience of therapeutic humor in occupational therapy, and compiled related information into categories. Each subject's general description was combined to produce a shared, descriptively rich characterization, from an occupational therapy perspective, to complete the process of phenomenological analysis.

CHAPTER 4

RESULTS

Five interviews were analyzed according to phenomenological method. For each interview, meaning units, a specific description, and a broader general description were obtained. The specific and general descriptions for each interview, as well as the essential description of the phenomenon, are included in this section. The interview data are reported in present tense as a reflection of the lived experiences of the subjects.

Subject A

Specific Description

Humor is a primary part of the milieu of A's facility, a natural, intuitively and spontaneously included part of the majority of interpersonal interactions there. A cannot imagine functioning in this environment without humor. A perceives the environment to be mutually enjoyable for both staff and patients.

It is A's experience that the therapists at this facility enjoy working there more than other places they have worked because of the unique centrality of humorous interchange as the humor helps them develop and sustain strong, enjoyable working relationships. The therapists' humor also helps them cope with stress by lessening the

impact of a difficult situation while it is occurring to enable them to continue working until they have a chance, later, to fully deal with the emotional impact of the situation. A finds that in their joking with each other, the therapists acknowledge one another's frustrations and stress and frame these difficulties in a humorous light, thus coping with their problems through laughter. A reports that the most rewarding aspect of humor for the therapists, however, is that they can witness the therapeutic benefits of the humor for their patients.

The therapists' humorous responses to one another in the clinic serve as a model for the patients, who begin to join into the joking process themselves. In doing so, A experiences the patients as beginning to interact with each other and with therapists--humor provides a vehicle for this therapeutic social interaction, which might not otherwise occur. These patients are struggling to find ways to cope with the devastating changes in their lives, and they are often too angry or depressed at first to see any positive aspects or hope in their lives. Their first step toward dealing with their difficulties is often to begin to communicate with others, which at A's facility generally involves humor.

A views humor as an excellent coping tool in the early process of emotional healing from debilitating injury/illness because it is an indirect way of dealing with one's problems. Patients who are not ready to talk about their problems can at least acknowledge them, through humor. Once the patients have begun to do this, the humor often has a transformative power for them; it can help them move from depression and hopelessness into an ability to see the lighter side of their predicament. At other times, patients may be able to express their feelings using humor but have difficulty moving beyond this point. For example, angry patients may deal with their situations with a sarcastic, caustic humor and not be able to use humor in a positive mode. In such cases, A would intervene, using the patients' humor as a catalyst for progressing their healing process--the patients' expression of angry humor would serve as an opportunity for A to confront them about their behaviors so that they might recognize and admit their anger and thus begin to face and discuss their feelings.

A also uses humor to frame a discussion about a patient's limitations in more tolerable terms to increase the patient's ability to listen to and accept the information. Confrontative situations are frequently avoided at A's facility because the therapists use humor to

take themselves out of the authoritative role and relate to patients on an equal, enjoyable level, often eliminating the patients' defensiveness and feelings of antagonism.

A experiences other uses of humor for the patients also, such as serving as a mechanism for initiating and maintaining relationships, helping them feel they are making a contribution, and providing a way in which they can fulfill their needs for recognition, status, and attention; this can be the only way some cognitively-impaired patients are able to feel acclaimed. In these ways, humor can uphold patients' sense of self-worth.

General Description

Humor is a core aspect of the therapeutic milieu at A's facility because of its unique and multifaceted benefits. A finds that spontaneous humorous interchange highlights the majority of the therapists' interactions, as they simultaneously use humor to cope with their personal stress; to develop and sustain strong, caring working relationships with one another; and to model a positive attitude and constructive coping skills for their patients. With patients, the therapists' humor establishes their role as friendly and non-authoritative, thus setting the expectation that therapy will be non-adversarial and enjoyable, and

builds rapport to facilitate successful communication between them.

Humor often has a profound effect on the patients at A's facility, helping advance their healing process and transforming their depression and hopelessness into a more positive, balanced outlook on life. This begins as the patients join into the therapists' jokes and start to interact and connect with them and with other patients. The indirect nature of humor allows the patients, at first, to ease into the task of facing their problems and the changes in their lives; later, it becomes a way of coping with and finding some enjoyment in life despite the problems and changes. The patients' humor provides information for the therapists on their level of coping and provides a context for the therapists to respond therapeutically to help their patients face and cope with their problems at a deeper level. Furthermore, by providing a vehicle for patients to achieve recognition, status, attention, connection with others, and a sense of making a contribution, humor can uphold these patients' sense of self-worth.

A's lived experience of using humor in treatment is of constructing a centrality of mutually enjoyable, humorous interchange which becomes integrated fundamentally and spontaneously into co-worker and patient/therapist

relationships for its unique effects, especially transforming lifeviews in a positive, hope-affirming direction; building and upholding self-worth; promoting passage through the healing process and ability to cope with stress; and non-authoritarian, caring supportiveness.

Subject B

Specific Description

Although B's primary patients are babies, to provide them with the best therapy she must also work with their parents by supporting them through their difficult emotions and in their needs; this lays the groundwork for successful therapy. In order to accomplish this, B deliberately watches for opportunities to use humor as they occur in actions and interactions, as she demonstrates during the interview itself, in order to create a relaxed and enjoyable atmosphere and to build trust and rapport by showing, through laughing at herself, her own humanness.

With the babies themselves, B uses various deliberate techniques appropriate to their developmental levels which elicit humor and laughter such as silly sounds, "peek-a-boo" games, incongruity, distraction, and funny accents. By these techniques, B endeavors to create an enjoyable relationship with the child and his/her parents and help the child maintain a sense of autonomy and dignity; the baby's

response to these techniques also provides evaluative information. B laughs at the baby's antics and tries to get the baby to laugh at her to show the parents that she and the child are comfortable with and enjoying one another. She uses humor to calm the parents by eliminating the possibility of their feeling failure at their baby's lack of cooperation. She also uses humor with the parents to create a jovial, trusting atmosphere so that when she has a serious point to make, it contrasts with her usual manner and is more likely to be taken seriously. B encourages the reciprocal use of humor to deepen the therapeutic relationship between herself and the parents.

A central theme for B is her belief in redefining the concept of professionalism from its traditional values to ones which she believes are more therapeutic, natural, and successful, and which include the use of humor. To B, traditional professionalism, which is tied to the medical model, is perceived as rigid and lacking in humor and supportiveness. It promotes the perception of the "expert" having great value and the patient being unworthy and ignorant. It values productivity and following procedures over creativity and individual needs. It creates an artificial and ineffective setting for therapy. B finds that in an atmosphere of traditional professionalism,

therapy is valued less than strictly medical treatments, and there is less teamwork between co-workers.

To B, the term "therapeutic humor" refers to the way traditionally oriented professionals might view the only valid use of humor in treatment; it implies codifying and formalizing humor, making it artificial. While B does consider humor a modality, it is one that is present naturally in life and part of being human, not one which could be successfully taught in a formal way.

Although B believes there is a trend toward recognizing the greater value of the non-traditional approach, many of her patients have relationships with other health and school professionals who still communicate the traditional professional approach. B sees her role with her patients as providing a balance to their other experiences through offering support, collaboration as equals, comfort, release of tension, honesty, and a patient-based approach to treatment. She uses humor as an instrument for creating this therapeutic environment and for establishing and sustaining her relationships with her patients, both parents and children. She also tries to promote her non-traditional approach with other professionals through using humor with them. B believes that she does not diminish her credibility by her approach.

B's approach not only works well with her patients, it heightens her enjoyment and success as a therapist. Her approach eliminates the impossible expectation of traditional professionalism that she, as the professional, be perfect. It also offers her the opportunity to relate to her patients in the style which is most comfortable for her and to be creative in meeting their needs.

B uses humor with her co-workers as well. She uses humor to promote solidarity among staff members and provide them with support during difficult times, such as by offering humorous awards that recognize and acknowledge the staff for their work. B defends the practice of staff members using macabre humor that makes fun of patients, considering it to be a coping mechanism for self-preservation; she believes this practice to be universal. She employs humor to help other staff feel less threatened in tense situations. B finds that her use of humorous banter with co-workers is a key factor in developing a strong working relationship with them that can, in effect, improve the care they provide together for the patients.

General Description

B describes a deliberate humor which she uses with parents as a means for changing the initially tense, scared, defensive atmosphere into a comfortable, trusting enjoyment

of and participation in treatment. In doing so, her humor helps build the collaborative rapport that is essential for occupational therapy to be successful. B encourages reciprocal laughter at "mistakes," which accepts the nature of being human in both herself and the parents, to deepen the therapeutic relationship.

B understands the development of humor and uses age-appropriate humor deliberately with babies, not only to build rapport but as a technique for evaluation and for helping them maintain their autonomy and dignity.

B views the effectiveness of occupational therapy as dependent upon a redefinition of professionalism and professional demeanor from their emphasis on rigid, productivity-oriented seriousness and lack of equality between therapist and patient, which devalues both the patient and the practice of occupational therapy, to patient-centered, enjoyable supportiveness which focuses on collaboration as equals. Humor is integral both to helping patients and professionals accept this non-traditional conception of professionalism and to employing the non-traditional approach itself. The genius of humor as a modality for achieving these ends lies in the fact that it is a natural, accessible coping mechanism for dealing with the human condition. B sees her role as pioneering this

non-traditional approach and as creating supportive relationships with patients which provide a balance for the many less comfortable relationships they have with professionals who still espouse the traditional approach.

B's use of humor increases her enjoyment, creativity, and success as a therapist. She also uses it to improve morale and interrelations between co-workers; B finds that humor develops stronger working relationships which ultimately improve the care provided to patients.

To B, the lived experience of using humor in therapy is wielding her natural humor to shape her interactions with patients, family members, and co-workers in a direction of creative, reciprocal, non-traditional collaboration, for nurturing, productive therapy in an enjoyable, supportive environment which recognizes the humanity of each individual and the unique, corresponding fitness of humor to deal with the human condition.

Subject C

Specific Description

C's experience is of using humor informally with her patients and with staff members. Although she had not consciously examined her use of humor, upon consideration she now finds that she uses it in many ways:

- to give patients a mechanism for coping with the changes, problems, fears, and disruption of daily life activities,
- to return some control to patients who have lost control over much of their life/body through helping them to objectify and laugh at their problems,
- to show empathy with patients' desires for control over their lives and acknowledge the difficulty of maintaining self-direction in a hospital setting and when ill or disabled,
- to convey acceptance and variety in people, thus improving rapport with patients and their significant others,
- to help patients connect with C and pay attention to their therapy,
- for improving the effectiveness and mutual enjoyment of a therapy session,
- as a cognitive/psychosocial evaluation tool,
- with patients who assume a passive sick role for catching them off guard so they respond more genuinely and increase their participation in therapy,
- for taking a light approach to managing difficult patient behaviors,

- to increase the awareness and participation, on some level, of patients in a coma,
- to distract or calm patients who are in much pain or are concentrating too hard for therapy to be successful,
- to help patients and their families realize the humanness and similarity to themselves of health care workers,
- for C's personal coping, stress reduction, and ability to view difficult situations calmly and professionally,
- as an approach which lightens the frustrations and conflicting needs and roles between different health professionals,
- to improve the cohesiveness of the health care team and deepen the relationships between its members, and
- to provide stress release for health professionals by allowing them to reenact stressful situations, giving themselves more enjoyment and control than they felt during the actual situations.

C finds the hospital system to be very disruptive to the normal, daily life of patients. One aspect of this is that many professionals within the system convey their own sense of stress and discomfort to the patients. C's use of humor with patients is partly to counteract their experiences with less supportive staff. Furthermore, C

feels that patients need to recognize and acknowledge the difficulties and contradictions of the hospital system, and that humor is the best way to cope with these because only humor directly faces the irony and absurdity in the system, thus allowing it to be managed.

C crafts her humor to the patients' needs, noting the sort of humor to which they respond, assessing the appropriateness of humor in a given situation, examining the patients' values/roles and the effect a humorous approach is apt to have, given those values/roles. Humor is individually experienced, even within cultural, gender, or age groups, so C approaches each patient individually to determine his/her current accessibility to humor. One positive aspect of humor is the immediate feedback of its successfulness which it provides to allow C to adapt her approach as needed.

Some patients do not respond to humor, and with these patients, C may take a more tough or straightforward approach that directly offers them control; thus, humor must be but one of many tools. Other factors that influence C in not using humor include her feelings of discomfort in a situation or shortness of time. She also has an ethical rule against using humor to make fun of other people.

Humor is intrinsically part of C's personality and thus comes naturally into her therapeutic interactions as therapeutic use of self. C reports that the success of her humor, though partly due to the intrinsic goodness of humor itself, lies also in the fact that she is being herself with her patients. She believes that when humor does not come naturally to a therapist--and she feels that there are many therapists for whom this is the case--the therapist will have difficulty using it effectively in therapy.

C is strongly opposed to the concept of "therapeutic humor," as it has been popularized, because in her experience this way of looking at humor destroys the natural, spontaneous, intuitive atmosphere necessary for humor to be successful. It causes therapists to try to quantify and formalize humor, becoming anxious that they are not using it properly. This approach is incompatible with the successful use of humor in therapy. C feels that a more successful way for therapists to learn about the benefits and uses of humor than therapeutic humor workshops would be through informal staff discussions, but she has not seen any interest in this among occupational therapy staff.

General Description

C uses humor informally, spontaneously, and intuitively to facilitate successful occupational therapy for her

patients and success for herself in her roles as therapist and health care team member.

C uses humor in therapy as a tool of empathy, rapport-building, distraction, calming, role-modeling, evaluation, behavior management, and encouragement. Most significantly, she uses humor to help patients cope with the role changes, problems, fears, loss of control, and disruption of daily life activities that occur during hospitalization. C uses humor to return some control to patients and help them participate fully in therapy. As a coping tool, humor has the unique advantage of allowing patients to manage the contradictions and difficulties of the hospital system by recognizing its irony and absurdity. Yet humor has to be one of many tools, used only when it meets the needs and values of the patient and of the therapist.

C also uses and experiences humor among staff members for stress reduction, coping with conflicting needs and roles in patient care, and strengthening the relationships and teamwork between co-workers.

In describing her use of humor, C alludes to feeling an estrangement from the attitudes of some other health professionals. She feels a need to use humor to counteract less supportive approaches used by some staff with patients, and she feels regret that therapists have accepted the

popular idea of "therapeutic humor," even though she believes strongly that this formalized approach is apt to be unsuccessful with patients because it destroys the natural, spontaneous, relaxed atmosphere necessary for humor to be therapeutic.

For C, the lived experience of using humor in therapy involves naturally crafting her intrinsic humor to meet a myriad of patient/staff/self needs raised by the high stress, role-changing environment of the hospital setting which is disruptive to daily life and often non-supportive. C finds humor to be an especially effective coping tool because of its unique, multifaceted sensing of absurdity, irony, and possibilities for play which helps disarm difficulties, tolerate contradictions, and manage role conflicts.

Subject D

Specific Description

D uses humor in therapy with patients who have psychiatric disorders as a natural extension of her intrinsically humorous view of life, as therapeutic use of self. Since her patients often take themselves very seriously, D models the ability to laugh at herself. She uses humorous exaggeration of their symptoms and situations, not by singling out individuals, but by collectively helping

patients see themselves more objectively and coaxing them out of their serious, self-imprisoning mindset. This use and elicitation of laughter has the goal of increasing the patients' abilities to function in personal and social capacities, which includes helping them to develop a protective outer layer, motivating them, and creating a sense of belonging and a connectedness between themselves and others.

Humor can also have the opposite effect, that of alienating patients who are vulnerable, sensitive, or overly serious. D stresses the importance of being watchful for this response in patients and being ready to deal with it when it occurs. D uses these reactions as part of patients' treatment. She talks with the patients about her intentions in using humor, acknowledges their sensitivity, and develops treatment goals with the patients involving their recognition and acceptance of humor. Other patients may have difficulty appreciating humor if the humor requires a cultural understanding unfamiliar to them or is too abstract for them to grasp, given their concrete thought processes. D feels strongly that it is important to use humor that is accessible to patients. She also eschews most joke-telling, which is generally not constructive for treatment as it tends to make fun of different groups of people.

Fortunately, D finds abundant humor in everyday life situations which can be used in treatment, especially within the psychiatric unit.

D once curbed her humor because she perceived some patients as being too fragile to handle it, but she has discovered that a part of the magic of the therapeutic process is that patients' coping skills will rise to the therapist's level of expectation, and that she is most effective as a therapist when she is being genuinely herself. D believes that humor fits naturally into occupational therapy, since humor is part of life and occupational therapy involves working on life skills to overcome disability. It also fits naturally into the casual, non-medical, home-like milieu within the mental health facility.

D finds that humor plays a major role among the staff. It is used as a stress releaser and as a defense for them to preserve their personal mental health in the face of their difficult and emotionally charged work. Laughter is closely akin to sadness for D; she deals with her sadness at patients' dysfunction by seeing humor in it. Sometimes the staff will laugh at the patients' behaviors or stories, when the patients are not present, in the spirit of release, enjoyment, or amazement; the craziness of the patients'

lives can make working in mental health very interesting. D also experiences acknowledgement and connection from the staff by their joking with her about her therapy modalities. She, herself, jokes about occupational therapy activities when talking to people who are not occupational therapists--and about mental illness when talking to people who have not worked in mental health--in order to connect with them, to educate them, and to demystify the unknown.

The concept of "therapeutic humor" seems calculated to D; it implies breaking humor down into steps and reducing it to a protocol, thus eliminating its naturalness and spontaneity. D feels strongly that therapists cannot successfully develop humor as a skill for use in therapy by studying it. Rather, she feels therapists can develop humor by living it, by relaxing and having fun, by developing their people skills in general, and by simply watching for opportunities to use humor in facilitating relationships with patients. To use humor successfully, therapists need to be self-confident and emotionally strong enough to make fun of themselves and handle their patients' teasing. D views humor conferences as offering valuable opportunities for having fun and relieving work stress, but she believes that due to funding issues the conferences are often misrepresented as classes providing specific instructions

for using humor in therapy, which they could not possibly do.

General Description

D naturally integrates her intrinsic humor into her therapy in a variety of ways, believing that since humor is part of life it fits naturally into occupational therapy's domain of working on life skills to overcome disability. Her therapeutic use of self includes using humor to model laughing at herself and not taking life too seriously. She uses activities involving humor and laughter to increase her patients' ability to function both personally, by increasing their motivation and coaxing them out of their self-imprisoning pain, and socially, by helping them feel connected to others. D remains watchful for patients who have difficulty accepting humor, which she views as an indication of their decreased coping skills. She then develops treatment goals which involve increasing such patients' receptivity to humor.

Humor is also part of D's interaction with other professionals, and it serves as a stress releaser, a defense mechanism, a way to increase enjoyment of their work, a means of acknowledgement and connection, and a tool for education and demystifying the unknown.

To D, the concept of "therapeutic humor" (as promoted by popular humor conferences) implies a calculated, reductionistic approach to developing humor which eliminates its essential spontaneity and naturalness and is thus bound to be unsuccessful. D believes therapists can more naturally develop humor by cultivating an attitude of relaxed enjoyment during their treatment, feeling self-confident, and allowing humor to naturally enter into their relationships with patients.

D's lived experience of using humor in therapy is integrating her intrinsic, spontaneous humor centrally into therapeutic use of self so that it becomes a natural, creative tool for building connections, increasing function and adaptive skills, and finding joy in her work, with the overall intent to facilitate emotional survival of pain and stress.

Subject E

Specific Description

Humor--an element that adds healing, spice, quality, and enjoyment to life--plays an important and complex role in all aspects of E's work. It is a major component of treatment within the hand therapy clinic where she works.

E espouses a holistic and broad view of humor--that it is a primary component in a positive attitude toward life

and that it is integrally connected with play. She believes that although humor is an innate resource for coping and healing, many people--both patients and health professionals--need to learn to use it more effectively to develop the ability to see humor in their difficulties and to move beyond a stress-dominated, serious mindset. E relates experiences in which people's attitudes directly affect their ability to heal.

With patients, E uses humor primarily to provide a release for their tension. She experiences this in various ways: Generally, the humor creates a relaxed, comfortable environment which increases patients' enjoyment of and participation/investment in therapy; it builds rapport and socialization, diminishes feelings of being intimidated or overwhelmed, and provides a greater sense of control. More specifically, laughter can provide both physical relaxation, which improves functional movement and releases muscle tension and physical stimulation, for many body tissues/organs. The re-direction provided by humor can diminish the experience of pain. Also, humor can help modulate a patients' emotional responses so that crying becomes laughing, which at times is a more socially comfortable release of stress, and sadness becomes balanced with lightness. For E, humor is the main way in which

patients can be redirected from their focus on their problems so that they can put more energy into achieving their treatment goals. E observes that patients' families who observe the use of humor in their family members' therapy feel a release of tension as well, and relief that there is still some joy in this person's life.

E finds humor to be used among staff members to help themselves cope with the high level of stress, gain perspective on their situations, and enjoy their jobs more fully. This self-preserving humor can arise from amusement at patient behaviors or joking between staff members. In the humor-affirming atmosphere that E creates for her patients, she has benefitted at times when patients have initiated humor to help her cope with stress. E believes that health professionals can survive personally and professionally only if they can develop their ability to see humor in situations. However, she comments that some staff members are irritated by humor and that she is concerned about the care that they provide for patients. She finds that staff members who dislike humor also tend to place technology above the individual needs of patients, which she believes alienates patients and jeopardizes their overall healing.

E's philosophy of patient care includes working with patients as individuals and providing treatment in a holistic way, taking all dimensions of their lives into account. E stresses her need to find a balance between letting patients grieve their losses and vent their frustrations, on one hand, and on the other hand, using humor to help them put their problems in perspective and to help them realize that in spite of their pain, life can include some joy. For E, therapeutic use of self includes using not just technical skills but her emotions to intuitively guide treatment, as she does whenever she uses humor. She sometimes models the ability to find humor in personal difficulties so that patients will realize that they have the ability to control their attitudes toward their problems, will feel less alone in their suffering, and will realize that they can survive their pain and find joy in life again.

General Description

E views humor holistically and broadly, considering it a central aspect in a positive attitude, integral to play, and an innate mechanism for coping with stress, healing, and finding enjoyment and quality in life. However, she finds that despite its intrinsic quality many people need to learn to use humor, need to develop and nurture the ability to see

humor in difficult situations, so that they can transcend their habitually serious, stress-dominated thinking.

E uses humor with her patients and their families, as well as with other staff members, for re-direction, increased enjoyment, release of tension, and gaining perspective on difficult situations. She believes that emotional survival of the high level of stress present in a hospital setting, personally and professionally, depends on developing the ability to view stressful situations in a humorous light. She expresses concern that health professionals who do not use humor to cope may not only deceive themselves but may actually shortchange their patients and jeopardize their healing.

Much of a therapeutic interaction, for E, centers around finding balance. As a therapist, she believes that she must come to a balanced view of her patients, taking all dimensions of their lives into account, and balance her interventions so that she allows patients opportunities to grieve their losses yet also to move on from the pain. One of her goals for patients is to help them find balance in their perspectives on life so that they can realize joy in spite of pain. Humor, as an intuitive part of her therapeutic use of self, is the medium through which E strives for balance.

For E, the lived experience of using humor in therapy is using her intuitive emotions to combine the complex, layered manifestations of humor to facilitate a holistic, balanced, enjoyable, maximally therapeutic treatment and mindset. E calls on her own and others' innate, healing resources of humor, especially its power for helping people to cope with stress, relieve tension, and promote a positive outlook in order to help people transcend stress and suffering by affirming joy and hope in their lives.

The Lived Experience of Humor Use in Occupational Therapy: The Essential Description of the Phenomenon

The following section describes the lived experience of humor use in occupational therapy as synthesized from all subjects' descriptions.

The lived experience of humor among the occupational therapists in this study was the application of the intrinsic, intuitive mechanism of humor both spontaneously and deliberately for improving quality of care and quality of life for patients, their significant others, therapists, and other staff members. Humor, in this capacity, was considered to be a continuum and multitude of concepts and acts, from jokes and silliness, playfulness and games, to a transformative healing agent, a positive, joy-affirming life

view, and a means for transcending stress and suffering. These occupational therapists used humor to facilitate balanced, holistic, patient-empowering, enjoyable, and maximally therapeutic treatment that attempted to encourage healing, improve function, build and sustain connections, and recognize individual humanity. Though humor may have limits and potential for misuse, it is a singularly valuable modality for coping with the human condition because of its ability to create appreciation of the irony, absurdity, and possibilities for play in all forms and degrees of difficulties so that pain can be endured, contradictions tolerated, self-worth upheld, and survival preserved.

CHAPTER 5

DISCUSSION

Significant Themes and Dialogue with the Literature

In the synthesis of data from all of the interviews, sixteen themes emerged which were common to some or all of the subjects and which carried particular significance for their experience and understanding of the use of humor. These themes are as follows: the concept of therapeutic use of humor; spontaneous versus deliberate humor; humor, the great equalizer; professionalism and humor; contraindications of humor; humor among co-workers; humor and play; humor and the environment; humor providing balance; the intrinsic quality of humor; the transformative power of humor; the effects of humor on the subjects themselves; humor as an evaluation and treatment tool; humor as therapeutic use of self; humor as a coping mechanism; and other uses of humor with patients. Each theme will be discussed first as a synthesis of the interview data; secondly, the findings will be compared and contrasted with information found in the literature.

The Concept of Therapeutic Use of Humor

One theme that emerged from this study relates to the subjects' perceptions of the concept of therapeutic use of humor. For most of the subjects, this topic aroused strong

emotions. Three of the five subjects reacted negatively to this concept. They viewed it as referring to an approach to developing humor for use in therapy which has been attempted by some therapists and promoted by the currently popular humor conferences. These subjects believed that this approach is bound to be unsuccessful because it destroys the essence of what is therapeutic about humor. This approach, it was said, formalizes and quantifies humor, which takes away its natural, intuitive, spontaneous quality and adds anxiety for therapists--now therapists must be concerned about whether they are "doing it right," whether if they lead a group they also need to have a recreation therapist involved so that professional role boundaries are not breached, and whether they ought to be following a humor protocol. These subjects all looked at "therapeutic use of humor" as something that therapists try to learn, particularly therapists who are insecure or not naturally inclined to view situations in a humorous light. The subjects felt strongly that these therapists could not learn humor by studying it or formalizing it. They offered suggestions regarding more effective ways for such a therapist to develop humor, such as by relaxing, developing people skills and self-confidence, having fun during treatment, and possibly discussing humor use in therapy

informally with other therapists. The therapists who disliked the concept of therapeutic use of humor objected to the format of most humor workshops, which they felt were misrepresented as specific lessons for becoming a funny therapist. They thought the workshops would be beneficial to therapists, however, if the workshops could just be opportunities to relax, have fun, and acknowledge the value of humor in their personal lives.

Of the other two subjects interviewed, one viewed the concept of therapeutic use of humor as referring to the psychological and physiological benefits of humor, some of which she had experienced with her patients and personally, and which provided an internal release for everything from pent up resentment to muscle tension to therapeutic chemicals. In summarizing and synthesizing all of the therapeutic aspects of humor she concluded that "God designed humor as a good thing." She conveyed her belief that human beings have a built-in mechanism for restorative and preventative healing, one major part of which is humor. The fifth subject, similarly, considered therapeutic use of humor to refer to humor as a coping and catalytic tool, fundamental to life survival, which helps to advance patients' healing processes by helping them deal with issues which they cannot face directly.

In summary, then, this study found that the therapeutic use of humor was perceived by some as referring to the current interest in developing humor through workshops and to learning humor techniques. The subjects who had this perception felt that such an approach to humor would destroy its essence.

In a review of the literature, nowhere was the potentially misleading message of humor workshops or the potential unsuccessfulness of technique-based humor directly discussed. Many articles did, however, advocate humor workshops and the use of techniques by health care providers to increase therapeutic humor use either with patients (Banning & Nelson, 1987; Ewers, Jacobson, Powers & McConney, 1987; Goodman, 1983; Lapierre & Padgett, 1991; Mindess, 1981; Murphy, 1988; Pasquali, 1990; Prerost, 1989; Raber, 1987; Ruxton & Hester, 1987; Schmitt, 1990; Simon, 1988; Southam & Cummings, 1990) or with co-workers (LaPierre & Padgett, 1991; Simon, 1989; Tooper, 1985). Murphy (1988), an occupational therapist, even told of attending a humor conference specifically to learn whether "a shy, serious therapist (can) run a humor group" (p. 1) and then reported success in leading such a group after her conference experience. Southam (personal communication, April, 1991) reported continued high success leading groups and using

humor which is partly technique-oriented with patients. Pasquali (1990) told of some initial failures at technique-oriented humor therapy with patients but reported eventual success after discovering how these techniques best met her patients' needs. Tooper (1985) told of leading humor workshops which she experienced as being quite beneficial to the professionals who attended. Clearly, there are different perceptions of the approaches to therapeutic humor which are likely to make the humor successful or not. Further research will be necessary to examine this variation of experiences in more depth.

Spontaneous Versus Deliberate Humor

Several of the subjects stressed spontaneity as being a critical element in the success of humor. One subject, in discussing the lack of spontaneity she perceived in the term "therapeutic use of humor," said, "That's kind of like. . . the therapeutic use of talk. . .therapy. . .or the therapeutic use of walking. It just is something that just comes, you know, very spontaneously, so I don't know how that (would work)." Furthermore, many of these subjects reported not generally giving humor considerable conscious consideration; "You know. . .until you asked the question, I hadn't really thought about that," said one subject. On the other hand, there were also therapists who used humor

deliberately. One subject described having specific objectives in mind and a specific direction she would want a therapy session to follow. She would look for opportunities to use humor to meet these ends.

Some subjects who had extolled the benefits of spontaneous humor used humor deliberately in certain situations, such as in giving a psychiatric patient an assignment to tell a joke each day to increase his socialization, or had certain topics about which they routinely joked with patients, such as the lack of hospital parking. In fact, those who most stressed spontaneity as a key element of humor seemed to be reacting to their opposition to using pre-planned techniques such as leading a humor group or reading from a joke book in the absence of spontaneous humor.

In synthesizing the interview findings, it appeared that all subjects used humor spontaneously at times and also used it deliberately in certain situations. The difference between the self-definitions of "spontaneous humor user" versus "deliberate humor user" appeared to lie in whether, as in the first case, using humor was a secondary objective, to be employed extemporaneously as the situation might allow, or whether, as in the second case, the use of humor was usually a primary objective, and the therapist actively

looked for opportunities to use humor for the benefits it offered.

In the literature, as in the experiences of the subjects, there was some dispute over the use of deliberate techniques versus the need for spontaneity in humor use. A qualitative research study of paramedics' use of humor (Rosenberg, 1991) concluded that "inherent in the ability to use humor as a mechanism for coping with stress is the ability to produce it spontaneously" (p. 201). On the other hand, as mentioned in the section "The Concept of Therapeutic Use of Humor," many practitioners advocated the use of deliberate humor and have experienced its benefits. Simon (1989) stated, "Although humor often occurs spontaneously, in many instances humorous activities may be consciously planned" (p. 669). In concurrence with this study, it appeared that both types of humor have their appropriate application and are not mutually exclusive.

Humor, The Great Equalizer

Several subjects mentioned the usefulness of humor in creating a relationship of equality and collaboration with patients. At first, it was said, patients might be tense and defensive, fearing that the therapist would appear impersonal and authoritarian, thus making them feel ignorant. Through a humorous approach, including

encouragement of reciprocal, supportive laughter between therapist and patient, the subjects endeavored to relieve these fears in their patients. One subject reported looking for opportunities to laugh at herself to show patients "I am frail, I am human, I am not the scary, imposing person that's coming to tell you what you've been doing wrong." Similarly, she encouraged patients to joke with her and point out her foibles to make the interactions "as collaborative as possible."

Another subject experienced few confrontative situations in her clinic and felt that these were avoided because the therapists used humor to change their perceived role from that of an authority figure to that of an equal with the patients. This eliminated the patients' perceptions that they and the therapists were in adversarial roles. With one of this subject's patients, "using a more humorous approach. . .took the defensiveness away for him. And he didn't feel like he needed to prove something to me; . . .he was able to hear, then, what I was saying to him." Another subject commented, "some people may react to (my use of humor to equalize the therapeutic relationship) and say . . .am I taking away my credibility if I do that? I don't think so, because I know what I'm talking about. . .and I make sure that. . .I do establish my credibility at the same

time, but what I'm trying to do is make myself human like they are. . .and the humor is a big part of that."

Although little was found in the literature about the therapist's role in using humor to create a sense of equality, Robinson (1991) spoke of the status-leveling, equalizing quality which humor can offer patients who are frustrated with the dependent role at the bottom of the status hierarchy which has been perfunctorily assigned to them in many medical settings. Coser (1960) spoke of the equalizing power of humor among health care staff members of different ranks, a factor that was not mentioned by the subjects in this study.

Professionalism and Humor

One theme that emerged for several of the subjects was a focus on what it meant to be a professional, how their role definitions as humor-using therapists differed from other health workers' role definitions, and how humor played a part in this process. Several subjects felt strongly that the traditional conception of professionalism and professional demeanor, still held by many of their colleagues, is not effective for meeting occupational therapy's goal of promoting healing through patient independence and empowerment. They described the traditional, "medical-model" view as one in which

professionals behave in an aloof, rigid, imposing, businesslike, authoritarian, and serious manner in which they do not use humor. In this mode, professionals give no credit to the patients for doing things right or solving their own problems. The subjects found that an approach which viewed the patient as an intelligent equal, which valued collaboration toward solving problems and meeting goals, and which provided an enjoyable, patient-centered, creative tone was much more therapeutic in meeting the patients' needs. Humor was integral to the practice of this non-traditional approach, as well as to the task of encouraging patients and other professionals to accept the approach. Certain of the subjects reported that they felt it was their task and role as occupational therapists and as health care team members to pioneer this non-traditional approach as an improved conception of what it meant to be a professional. They believed that in doing so they could counteract the less empowering, less supportive approach that many of their patients have experienced from other professionals.

As mentioned in the Review of the Literature, humor has been found to be an effective agent for creating change of images and values, as well as for reducing resistance to that change (Robinson, 1991). Occupational therapists,

furthermore, have been charged by Baum (1991) to bring about positive change within the health care system. These factors, while not directly sanctioning the subjects' perceived need to change the concept of professionalism in a more humanistic direction, generally support the role of the occupational therapist in changing attitudes and the usefulness of humor for doing so.

Simon (1989) was aware of the limiting traditional "rules" of professionalism, and she advocated that health care providers use humor in order to free themselves from "terminal professionalism" (p. 668). Simon's viewpoint does not seem as constructive as this study's subjects' desire to update and broaden the concept of professionalism; Simon's perspective relegated and devalued humor use and also implied that a health care worker's treatment modalities might not all be considered professional. Galewski (1990) pointed out that in her experience, some occupational therapy settings discouraged the use of humor, with occupational therapists at these settings tending to equate professionalism with seriousness and perfectionism, and humor with lessened professional credibility. She posited that these beliefs are rooted in insecurity and that occupational therapy settings which encourage humor use

actually provide many levels of therapeutic value to their patients, as the subjects in this study also experienced.

Contraindications of Humor

Subjects spoke of certain types of humor that they would not use with patients. Humor that "makes fun of" people or that "puts down" people based on race, sex, or other characteristics was mentioned by several to be strictly off limits. Humor which required abstract thought or a shared cultural understanding would be contraindicated for patients who were unable to share in such jokes. Furthermore, subjects said that patients' receptivity to humor and the type of humor to which they respond best needed to be individually assessed, since people vary widely in this respect.

No concrete rules about humor use with different populations appeared to exist for the subjects. One subject stressed that humor needs to be one of many therapeutic tools because there are some patients that do not respond to humor and certain times, such as when the therapy session is rushed, that humor would not be the ideal modality to use.

One subject stated that when she was a new therapist she had curbed her use of humor with patients in a psychiatric facility, believing that they would be too fragile to handle humor. She explained that she now uses

humor with these patients because she has learned that they will respond in one of two valuable ways. Some patients will rise to the level of expectation and reap the benefits of the humor. Patients who cannot tolerate the humor can work in occupational therapy toward improving their social and personal functioning through having a goal of decreased sensitivity to humor. Several subjects mentioned their use of "sick" humor, or laughing at patients' behaviors and predicaments among staff members, but each one was quick to add that they would never use this type of humor around their patients.

The literature opposing humor use in therapy because of its likely harmful effects (Kubie, 1971; Miller, 1970) was not borne out by this study. Rather, there seemed to be some professional guidelines for humor use which, when followed, can usually assure that the humor used is not detrimental to the patients (Pasquali, 1990; Robinson, 1983, 1991). Among these guidelines, confirmed by the literature as well as by the subjects in this study, is the importance of curbing the use of gallows humor and what could appear to be making fun of patients around the patients or their significant others (Robinson, 1991).

Humor Use Among Co-workers

Humor played a critical role for all subjects in their relations with co-workers and other health professionals. Humor was said to serve many functions in this capacity. It reportedly helped to improve team cohesiveness and to deepen and sustain interpersonal relations among staff, which improved both staff morale and patient care. Humor helped to increase staff members' overall enjoyment of their jobs. It furthermore lightened frustrations caused by conflicting needs and roles; one subject stated that the nurses at her facility used humor to let her know when they were frustrated by extra work they needed to do to prepare patients for therapy, yet by using humor they conveyed at the same time that they appreciated the subject's needs.

Humor among co-workers was viewed as playing a critical role in providing stress release and helping to preserve mental health. One subject stated, "If you really took this very seriously. . .you'd be right on the edge yourself." Sometimes this occurred when the therapists reenacted stressful situations, such as that of a patient requiring cardiopulmonary resuscitation or of a massive organizational restructuring, giving themselves more control and enjoyment of these events than they felt when the situations actually occurred, improving their perspectives on the situations so

that the absurd or amusing elements became more evident. Stress release through humor could also be seen when co-workers used humor to lessen the impact of a difficult situation as it occurred so that they could continue to function as therapists until they were able, later, to fully deal with the emotional impact of the situation. Several subjects mentioned techniques or gimmicks, such as cartoons and cardboard smiles, which have been used among staff members to lighten stressful situations.

Several subjects spoke of coping with the stress of dealing with the crises, tragedies, and high acuity levels of their patients by using "sick" or "gallows" humor with co-workers which "makes fun" of the patients or expresses amusement at patients' behaviors. Each subject who mentioned this considered it necessary for coping with the stress and emphasized that this type of humor is only used among staff members. Said one, "Sometimes a way. . .that I deal with my real sadness at seeing how dysfunctional people are is to laugh."

As mentioned in the Review of the Literature, the literature widely acknowledged the beneficial use of humor among staff for essentially the same advantages as were discussed by the subjects in this study (Duncan and Feisal, 1989; Robinson, 1991; Vinton, 1989). Coser (1960) spoke of

the use of humor to facilitate sharing and to decrease the social distance between staff members with different positions in the social structure. Simon (1989) described ways health care providers could incorporate humor into self care and stress management and advocated that they develop individualized, humor-oriented stress management programs. These potential uses of humor among co-workers were not mentioned by the subjects in this study.

Humor and Play

Two levels of play and the corresponding roles of humor were addressed by subjects in this study. The first was in reference to working with children, where humor was viewed as an attitude of playfulness, a means of creating an enjoyable rapport, and a way of allowing children to maintain autonomy and dignity. By using humor in the form of silly and playful distraction, it was possible to "avoid a battle of the wills," said one subject. Certain of aspects of humor were reported to be appreciated by babies from a very early age and could therefore be incorporated into play and therapy. One subject found the earliest development of humor to be babies' enjoyment of peek-a-boo games and silly sounds, followed by their responding to visual incongruities with a smile or laugh. By preschool age, the child's amusement at funny accents or funny

movements was apparent. This subject used playfulness "as a form of humor. . .for young children. . . .Being silly, laughing, you know, taking the tension away." Another said, "to make (therapy) fun. . .and get our goals met at the same time. . .we try to use play and have a lot of laughter and a little bit of teasing."

Play was also considered important and integrally related to humor by subjects who worked with adults and also, to a great degree, in humorous staff interactions. In analysis of the interviews, it appeared that when humorous interchange using props or gimmicks occurred, such as therapists wearing cardboard smiles, it readily fit the activity-based description of play as articulated by Christiansen and Baum (1991)--"choosing, performing, and engaging in activities for amusement, relaxation, enjoyment, and/or self-expression" (p. 856). Also, a general atmosphere of playfulness surrounded most of the humorous interchange mentioned by subjects with the possible exception of sarcastic, caustic humor used by patients, even when no props were used.

As has been stated in the literature review, play and humor were viewed as mutual accompaniments of one another, with each being considered a component of the other (Robinson, 1991; Southam & Cummings, 1990). No specific

mention was found in the literature regarding the relationship of props to the description of humor as play; further research would be useful to confirm or refute this hypothesis.

Humor and the Environment

Many of the subjects spoke of using humor to create a desired atmosphere at their workplace; it was a core aspect of the therapeutic environment. The humor created a comfortable, relaxed, friendly environment which increased patients' and therapists' enjoyment of treatment and was believed to improve patients' investment and participation in treatment as well. One subject said that the primary purpose of creating this environment was to decrease patients' anxiety "because not only is the trauma of the accident hard for them but I think for some of them. . .just coming to therapy is a big deal,. . .and (our job is) getting them to relax and getting them comfortable so they want to come back." Those subjects who primarily treated patients in one large room along with other therapists told of the important tone of the treatment room which was set by the light bantering and humorous interchange. One such subject took pride in the fact that a patient called her clinic "the laughing place" because she always thoroughly enjoyed the humor during her treatment sessions.

Little information on humor and the environment was found in the literature, but that which was found corroborated the data from this study. Schmitt (1990) and Sumners (1990) mentioned the use of humor in creating a therapeutic environment. Warner (1984) stated that a therapeutic milieu fostering humor may prevent regression in patients and added "laughter is good for (the) milieu as well as for the soul" (p. 21). Spencer (1991) mentioned the importance of the environment as a consideration in occupational therapy, noting that "environments play a fundamental role in shaping and directing activity. . .a central concern (for occupational therapy)" (p. 130).

Humor Providing Balance

Several ways were mentioned by different subjects in which humor was used to achieve balance of some kind. For patients who were focused on their illness, pain, or grief, humor was reported to provide a different focus, one which helped them move on or at least take a momentary break from their suffering. "What I tried to do is change the direction," said one subject, "of the seriousness of what we were talking about. . . .I just changed the subject and started to incorporate laughter and. . .joking around, and I know she was glad because then she started laughing, and it really eased the tension." For subjects who work with

physically disabled patients, their consideration of the patients' emotional status and needs, including their use and acceptance of humor and their ability to see the lighter sides of situations, was part of taking a balanced and holistic approach toward patient care. Another type of balance was that which subjects hoped their patients would develop in their attitudes and perspectives on life so that they could feel hope and joy despite their difficulties and pain. This, again, was sought by inclusion of humor in the therapy session and modeling of a positive outlook on difficult situations. Balance in patient care was also sought by subjects who used a supportive, patient-centered, humorous approach with their patients in part to counteract these patients' negative experiences with less supportive health professionals who did not attempt to collaborate with or empower the patients. "The point I am trying to make," said one subject, "is that a lot of (patients') experiences with professionals (are devoid of). . .humor; it's very serious: I'm here to. . .do a job, examine-the-child-tell-the-parent-what-to-do-prescribe-the-medication-they've-got-to-move-on-to-the-next-case. . .and so my relationship is very different than that. . . .I sort of try to make myself a balance to what they're experiencing the rest of the time, and humor helps a lot with that."

The multifaceted functions of humor as a way of creating balance were borne out by the literature. Lapierre and Padgett (1991), Robinson (1991), Rosenberg (1991), and Williams (1986) all spoke of the restoration of cognitive and emotional balance as offered by humor, and Haig (1986), Goodman (1983), Siegel (1986), and Williams (1986) discussed the function of humor in providing balance through opening people to new perspectives on their situations. Williams (1986) spoke of the balance that humor can provide by increasing patients' quality of life "by means of homeostasis in health" (p. 14). In discussing the role of occupational therapy, Levy (1988) pointed out that imbalance is the most salient characteristic of today's health care system and that occupational therapists must understand and work to correct this imbalance, as the subjects in this study were endeavoring, through humor, to do.

The Intrinsic Quality of Humor

Several subjects described humor as occurring intuitively and naturally in their interactions. "It's who I am," stated one subject, "And I couldn't leave it out." One subject "uses humor in everything that (she does)," and it "becomes a natural extension" to use it in occupational therapy. All of the subjects viewed humor as fundamental to their outlook on life and also as being innate, a built-in

resource for coping, healing, and enjoying life available to all human beings whether they chose to develop and use it or not. Therefore, it followed that all people have the potential to nurture and develop their sense and use of humor so that its effectiveness in their lives can increase. One subject believed that many people, patients and therapists alike, need to learn to use their humor more effectively in order for it to better effect their state of health, their attitudes, and their responses to stress.

The literature corroborated the findings of this study, noting humor to be a natural, intrinsic part of human life and interactions (Robinson, 1991; Tooper, 1984). Furman and Ahola (1988) saw a humorous outlook not as a talent or proclivity in certain individuals but rather as "the natural result of (a) constructivist therapeutic philosophy according to which there is no truth but infinitely alternative perspectives" (p. 20).

The Transformative Power of Humor

According to all of the subjects, humor had the unique ability to transform a negative, stress-dominated, problem-focused mindset to a more fundamentally positive attitude which observed the lighter side of difficult situations, which was playful, and which disarmed problems by recognizing absurd elements within them. Humor was also

able to transform a stressful, tense, defensive atmosphere into an enjoyable, comfortable, collaborative one; this quality was valued by several subjects who used it in their treatment to change an initially non-therapeutic atmosphere into one which enabled successful therapy to occur. Humor was also transformative as part of the healing process. Because it was an indirect method of facing one's problems, it was observed to be an excellent coping tool for patients in the early stages of emotional recovery--those who were not ready yet to face their losses directly. From there, humor was noted to transform the patients' hopelessness into hopefulness, as they regained the facility to see that life could still hold joy and that problems need not be overwhelming.

The literature, again, was basically in agreement with the data from this study; it was noted that humor influences people to see new perspectives on situations (Furman and Ahola, 1988; Goodman, 1983; Haig, 1986; Siegel, 1986; Williams, 1986) and to develop positive attitudes (Galewski, 1990; Tooper, 1984), and that it promotes restoration of health (Robinson, 1977, 1991; Siegel, 1986; Simon, 1988a). However, the literature did not emphasize the true transformation of experience, attitude, or environment that the subjects in this study believed to occur through humor

use. This study thus showed that the changes brought about by humor can be deeper and more profound than previously realized.

The Effect of Humor on the Subjects Themselves

All subjects found that the use of humor increased their enjoyment of their jobs and of their interactions with patients and co-workers. One subject remarked that using humor was professionally rewarding because she could witness its positive effects for her patients. One subject who felt that humor was part of her intrinsic style and mode of interaction remarked that using humor "makes my job easier . . .(because) I'm not comfortable being serious all the time." The subjects' humorous approach also created an atmosphere which promoted their creativity in meeting patients' needs. Some subjects also stated that humor increased their success as therapists, in part because a humorous, fun-filled approach to treatment eliminated the impossible expectation for the therapist to be perfect and have all of the answers. "I encourage (patients) to joke with me," said one subject, ". . .because I want them to feel as equal to me as they can. . .I don't want them to feel that I am up here and they are down here. . . .And (then) if I do something dumb like. . .mix up an

appointment. . .I don't (need to) try to cover up and act professional. . . .I will freely admit, 'I blew it!'"

Subjects also felt that humor improved their ability to cope, emotionally, with the stress in their work environments and that, at times, it allowed them to approach difficult situations in a more calm, professional manner than they might otherwise have. In the humor-affirming environment that one subject created for her patients, she found that the patient would sometimes switch roles with her and use humor to improve her state of mind if the patient sensed she was having a difficult time.

The available literature supported the findings of this study, although it did not describe all of the intrapersonal benefits that were mentioned by the subjects in this study. The literature focused primarily on the benefits to the health professional of increased resources for coping with stress (Robinson, 1991; Simon, 1989) and preventing burnout (Galewski, 1990), rather than on humor promoting the therapist's creativity or its quality of being professionally rewarding.

Humor as an Evaluation and Treatment Tool

Several subjects found that humor could be an important evaluative measure because it could provide a wealth of information about their patients' motivating factors,

cognitive and social skills, coping abilities, and some aspects of their developmental status. Most subjects considered humor to be a treatment tool or modality. One subject found that patients' occasional inability to accept her humor often indicated that these patients had decreased coping skills due to extreme sensitivity or over-personalization. The subject turned this situation into a goal of therapy by asking her patients "to tell me something that they've noticed on the unit that they felt was rather funny. . .and then it becomes a game. . .part of the treatment goals" to increase their ability to function. Another subject found that she could use her patients' defensive, sarcastic humor as an opportunity to confront them about their feelings when she felt they needed assistance in moving through the healing process.

Little literature was found which discussed the use of humor as an evaluation or overt treatment tool. However, Robinson (1991) discussed the developmental stages of humor use and appreciation in children, and Simon (1990) found that the most significant factor predicting positive morale in older adults was their use of coping humor; as with any developmental factors, these age-related experiences of humor could be utilized for the purposes of evaluation.

Humor as Therapeutic Use of Self

Humor was frequently mentioned as a component of therapeutic use of self, with subjects using humor to model coping responses, positive social interactions, and laughing at oneself, that is, not taking one's problems too seriously. Humor as therapeutic use of self was found to convey empathy and honesty to the patient. Humor served in this capacity to help patients see that, like themselves, therapists are human; therapists can be viewed as having needs, frailties, and strengths, and since neither the therapist nor the patient have all of the answers they must collaborate to reach solutions.

Another aspect of humor as therapeutic use of self was that therapists need to be themselves with their patients and use their personal talents and skills in order to use themselves most fully as therapeutic instruments. Some subjects reported that humor was such an important component of their self perception that it would be difficult and less than therapeutic to leave it out of therapy. One subject commented, though, that therapists whose strengths lie in other areas and who do not generally use humor in their lives would do better not to try to incorporate it into their therapeutic use of self, since it may not be an effective tool for them. One subject used humor to create a

light tone for her general interactions with patients in part so that when she had a critical point to make, calling their attention to something that was important or which could be dangerous, the change to seriousness in her tone was evident and the patients were more likely to realize the significance of her comments.

One subject stated that for her, "an important part of being a therapist, an important part of. . .use of therapeutic self. . .is to not only use the skills you learn but to use your own emotional centers for treatment," as she did when she sensed that a patient's situation could benefit from use of a certain dimension of humor at a certain time, and intuited the appropriate humor to use, discerning whether a tension-relieving joke or an attitude-changing positive philosophy would be more effective.

The literature supported the importance of therapeutic use of self as a component of occupational therapy (Tiffany, 1988), as well as the usefulness of humor as a component of this aspect of therapy (Robinson, 1991; Schmitt, 1990; Tooper, 1984). Tooper (1984) and Robinson (1991) also stressed the importance of therapists recognizing their own attitudes toward and style and sense of humor so that in developing their humorous therapeutic use of self they could choose the type of humor that came most naturally to them.

Humor as a Coping Mechanism

All subjects discussed the coping function of humor as being one of its most important uses. Humor helped patients cope with the gamut of difficulties they experienced, from general stress and pain to role changes and loss of control; from fears, anger, and grief to disruption of their daily schedule and activities. Humor did this, said the subjects, by reframing problems so that their absurd or lighter sides could become evident, by distraction, by physiological releases of tension, by allowing patients to regain some amount of control, by facilitating feelings of comfort and enjoyment, and by providing a less direct method of dealing with problems when a direct method seemed too threatening.

One subject said, "I think the hospital has got to be up there on the top ten places of. . .stress. . . .Any institution is stressful to people. . .where their daily life has been disrupted and. . .our daily life is being imposed on them. And I think that. . .if we're going to ask patients to be in that setting and staff to be in that setting, we need to give them a coping tool, and I think the best coping tool is humor." Several subjects conveyed that the unique advantage of humor over other coping tools was that it was a universally available tool for managing difficulties and contradictions, even when one had no direct

control over them; humor did this by allowing inevitable ironies and absurdities to surface and by aiding in the cultivation of a positive outlook in general so that life's pain could never completely obscure life's joy.

Just as the coping function of humor was mentioned as very important by all of the subjects in this study, much of the available literature also stressed this point (Cousins, 1979; Lapierre & Padgett, 1991; Martin & Dobbin, 1988; Martin & Lefcourt, 1983; Prerost, 1989; Robinson, 1977, 1991; Rosenberg, 1991; Schmitt, 1990; Simon, 1988a; Simon, 1988b; Williams, 1986). The literature also pointed out, as did certain of the subjects in this study, that humor was unique as a coping tool because of its ready availability and its ability to reframe almost any contradiction or difficulty by opening the user's perspective to the irony, playfulness, or absurdity present in the situation (Furman and Ahola, 1988; Robinson, 1991).

Other Uses of Humor with Patients

Besides the uses of humor which have been discussed in the separate sections of this chapter, many other uses of humor were mentioned by the subjects as valuable. Among them were the use of humor for building rapport, adding joy and enjoyment to therapy and to life, providing patients with the means for obtaining recognition and connection with

others, enabling the healing process to occur more freely, and allowing patients to see themselves more objectively and thus to break out of their self-imprisoning, stress-dominated mindsets. Humor was used for offering patients an opportunity to make a contribution; increasing patients' functioning in sensorimotor, cognitive, psychological, and social domains; calming and relaxing them; and freeing them from fear of failure or feelings of being overwhelmed. Humor was used to allow patients to regain some degree of control over their situations, to release tension, and to refocus patients' energy and attention from their sufferings to the task at hand or to a lighter perspective. Humor was used by some for its physiological benefits, for putting patients' significant others at ease, to help modulate patients' emotional responses, to convey empathy and support for patients' situations, to convey acceptance, to increase patients' levels of attention and interest, and to educate in a way which reinforces the information presented. Humor was also useful as a non-confrontative approach to behavior management. Humor was used as a pain management technique and as a method of distracting patients who were either concentrating too hard on a task or were not participating at the expected level in therapy.

The literature, again, was consistent with the findings of this study showing humor's various and many-layered meanings, though few studies showed as rich a complexity of humor uses as did this study. Some studies cited humor uses with patients which were not mentioned by the subjects in this study. For example, Coser (1960) found that humor created group consensus and closer group participation than most other forms of group behavior, and Ferguson and Campinha-Bacote (1989) mentioned the use of humor by patients to maintain a sense of spiritual well-being. Also not mentioned specifically by the subjects in this study, but very relevant to occupational therapy, was Sumner's (1990) practice of using humor with hospitalized patients to simulate social interactions as they would occur outside of the hospital, in order to improve patients' abilities to adapt socially after they were released.

Implications for Occupational Therapy

This study has shown a number of ways in which humor can be used in occupational therapy for purposes and processes which are characteristic of occupational therapy practice. These functions of humor are summarized below, as therapists may find it useful to have an understanding of how humor has been used as a guide to the practice and development of humor in occupational therapy or as a

framework for further research into this topic. Additionally, questions raised by this study about humor development are discussed.

Several subjects referred to humor as a tool or modality to be used, along with other tools and modalities, in treatment. Occupational therapy is concerned with daily living skills, and humor was said to fit well into this domain. The ability to see the humorous aspects of situations is a life skill which can be a focus of therapy, and the use and facilitation of humor in therapy fits into the common occupational therapy practice of using an activity to teach adaptive skills for daily living. Inclusion of humor in therapy can be spontaneous or deliberate, with humor taking a primary or secondary role in the treatment activity or plan.

Occupational therapy is concerned with the patient's ability to function, and subjects mentioned humor as useful for increasing performance or function in all components of occupational performance--sensorimotor, social, cognitive, and psychological. Occupational therapy's balanced and holistic view of human beings considers each component of patients' lives and how these come together to create function or dysfunction. Since humor can affect so many of these components it seems reasonable to include it as part

of a balanced, holistic approach to therapy. Humor was noted to be useful as a component of evaluation in the areas of social, cognitive, and psychological function.

Occupational therapy is furthermore concerned with providing an optimal therapeutic milieu, and it has been shown by this study that a humor-creating or humor-affirming environment can be integrated into occupational therapy. Occupational therapy is concerned also with creating a balance of work, self-care, and play. The subjects reported an interdependent relationship between humor and play, as well as humor's usefulness in emotional self-care and in the process of coping with work stressors and finding enjoyment in work activities.

The occupational therapists' use of humor with patients was often mentioned by subjects as being part of their therapeutic use of self. Therapeutic use of self is a fundamental component of occupational therapy; with humor use, it includes modeling and use of professional and intuitive judgment in choosing the type and timing of humor. Humor use was also mentioned in this capacity as part of a patient-empowering, mutually collaborative approach to patient care. Therapists' use of humor in treatment was noted to increase their personal enjoyment of therapy, sense of professional accomplishment, creativity in meeting

patient needs, and ability to cope with the difficulties and stress of their jobs as well, all of which are desirable factors in job success and satisfaction for occupational therapists.

Finally, humor was noted by the subjects to play a valuable role in building co-worker relationships and team cohesiveness, as well as in decreasing work tensions and frustrations caused by role conflicts, with the effect of improving staff morale and patient care. These issues affect most occupational therapists and must be dealt with in some way; humor was considered by the subjects to be a useful tool for handling them.

Most of the subjects spoke directly or indirectly about the developmental process occupational therapists engage in when learning to use humor therapeutically. Several issues were raised concerning this point. Many subjects recognized a need for humor use to be nurtured, developed, and/or learned by therapists; some of them told of their own process of development as humor-using therapists. Yet although there appeared to be agreement that humor use is developed, there was disagreement about the best way for this learning to take place. Two subjects implied that any constructive experience of humor use could be beneficial to therapists in developing their therapeutic humor use. The

other three subjects, however, felt strongly that any approach to humor development which was either reductionistic or technique-oriented would be unsuccessful and even detrimental. A concern of these therapists was that this approach would reduce humor to a calculated, protocol-based, formal exercise which could add anxiety to the attempt to use humor but take away the necessary natural spontaneity. These three subjects felt that humor workshops or conferences generally promoted this false sense of humor development. As has been discussed, this issue has not been raised in previous literature. In fact, many articles exist which support humor workshops and use of planned techniques for adding humor to therapy. Further research on this topic is essential to determine more accurately whether therapeutic humor use can be developed in a technique-oriented fashion or improved by attending a humor workshop. Understanding the lived experiences of therapists who have applied therapeutic humor as addressed in humor workshops would provide a fuller picture of the advantages, disadvantages, and role of these types of experiences for developing successful humor use.

The subjects in this study discussed certain ways which they believed occupational therapists could develop their therapeutic use of humor. They stated that this development

could be facilitated if the therapists simply endeavored to relax and enjoy their patients, strengthened their "people skills" in general, and developed greater professional self-confidence.

Recommendations for Future Research

Several topics for future research have been suggested by this study. One such topic, as discussed above, is the development of humor and the value of humor workshops and planned or technique-oriented usage of humor. It was noted in the data analysis that the boundaries set by therapists between spontaneous and deliberate humor use are not entirely clear, and it is possible that this is connected to therapists' feelings about planned or technique-oriented humor. Further study could elucidate this and examine the use and effects of different types of humor in treatment.

While this study examined occupational therapists' experiences of using humor in therapy, a valuable corollary would be a study of occupational therapy patients' experiences of humor in their therapy and healing, also utilizing the phenomenological method. These studies could complement each other and provide a more complete understanding of the experience of therapeutic humor in occupational therapy.

Another area in which further research would be worthwhile, as indicated by this study, is the use of humor as an agent of social change. Robinson (1991) has stated that humor "not only reflects the social structure. . .but can rebel against it, seek reform and become an agent for change" (p. 78), including change of values and images. This study revealed that humor was used to change aspects of the social structure, such as norms of professionalism, by occupational therapists, and further research could explore this issue in more depth.

Some of the subjects in this study indicated that their use of humor has changed over time as they have worked as therapists. Rosenberg (1991) found that the content of paramedics' humor is different during the training period, the post-training period, and after working for an interval of time. It would be interesting, through further research, to study more closely occupational therapists' use of humor as it changes over time and why this may happen.

One finding of this study was that staff members re-enact stressful situations, using humor, to gain more control and perspective on the situations. The phenomenon of re-enactment could be examined more specifically in future research to find out the details of why it occurs and to study what other factors besides humor enter into it.

Some subjects mentioned receiving the impression from their professors or supervisors that humor was not appropriate for use in therapy. Since the subjects in this study reported many benefits from humor use in therapy, it would be worthwhile to examine the impressions occupational therapy professors and supervisors today are conveying to their students/staff about humor use and how these impressions affect the subsequent humor use of the students and staff.

Additionally, none of the subjects in this study mentioned working in a supervisory position, so the use of humor from the standpoint of an occupational therapy supervisor or administrator was not discussed. A fuller understanding of the use of humor in occupational therapy would be gained by examining whether and how the use or lack of use of humor by an administrative or supervisory occupational therapist affects the experiences of the occupational therapy staff members and patients.

Other research questions were raised by this study as well. The precise relationship between humor and play has not been studied, and further research would be useful in defining this more clearly. Another research question is whether the use and appreciation of humor by patients can be indicative of their overall state of health and/or function.

Also, a quantitative study which examined the effect of the inclusion of humor in the therapy session on patients' performance, comprehension, or social interaction could provide increased understanding of the influence of humor in therapy.

Summary

This study explored the therapeutic use of humor in occupational therapy. The qualitative phenomenological method was chosen as the optimal process for data collection and analysis because it would elucidate the true, rich, descriptive meaning of the therapeutic use of humor to the subjects by examining their lived experience of using humor in therapy, providing a new perspective on humor use in occupational therapy.

Following a review of the literature, proposal preparation, and bracketing of preconceptions by the researcher, eleven subjects were located and interviewed. Five interviews were randomly selected for analysis. The researcher bracketed preconceptions again and then conducted a three-step process of data analysis, carefully determining the meaning units then preparing the specific descriptions, and the general descriptions for each interview.

When this process was complete, the researcher examined the findings of the five interviews as a whole, analyzing

the data to discover the lived experience of humor use in occupational therapy and to describe the themes which emerged from the interviews. For each theme the relevant literature was examined to determine whether similar or related themes had occurred in other studies or articles. The themes were then analyzed to discover implications for the practice of occupational therapy and for further research within this field.

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APPENDIX I

HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD APPROVAL

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San José, California 95192-0025 • 408/924-2480

To: Gwen Vergeer, Occupational Therapy
911 Fruitdale Place
San Jose, CA 95126

From: Charles R. Bolz
Office of Graduate Studies and Research

Date: May 21, 1991

Charles R Bolz

The Human Subjects Institutional Review Board has approved your request to use human subjects in the study entitled:

"Therapeutic Use of Humor in Occupational Therapy"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact Dr. Stanford or me at (408) 924-2480.

CC: Anne MacRae, M.S., O.T.R.

APPENDIX II

COVER LETTER FOR CONSENT FORM

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

School of Applied Arts and Sciences • Department of Occupational Therapy
One Washington Square • San José, California 95192-0059 • Main Office: 408/924-3070 • Fieldwork Office: 408/924-3078

Date:

Dear

Thank you for your interest in participating in my study on the use of therapeutic humor by occupational therapists. As we discussed, my chief area of interest in this study is the experience of occupational therapists who have either formally or informally used humor therapeutically in their practice. In accordance with the type of qualitative research I am conducting (using the phenomenological method), I will be asking you to describe your experiences from your perspective instead of asking questions that lead you to one particular answer or another.

Our interview is scheduled for _____. Due to the exploratory, open-ended nature of my study, the length of the interview is impossible to gauge, but in order to avoid scheduling difficulties we should allot at least an hour. I will be audio-taping the interview to assure that I collect accurate information.

In preparation for our interview, I would like you to give thought to your use of therapeutic humor in your practice. Think of ways in which you have used therapeutic humor and the outcomes of these situations.

Two copies of a consent form for participation in research are enclosed with this letter. Please read the form and sign both copies if you are in agreement. Bring these forms to the interview, at which time I will co-sign them and take one form for my records.

I look forward to meeting with you on _____. If you have any questions or need to contact me for any other reason, I can be reached at (408) 289-1013. Thank you.

Sincerely,

Gwen E. Vergeer, O.T.S.
Graduate Student

Enc: CONSENT OF AGREEMENT
TO PARTICIPATE (2 copies)

APPENDIX III

CONSENT OF AGREEMENT TO PARTICIPATE IN RESEARCH

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

School of Applied Arts and Sciences • Department of Occupational Therapy
One Washington Square • San José, California 95192-0059 • Main Office: 408/924-3070 • Fieldwork Office: 408/924-3078

CONSENT OF AGREEMENT TO PARTICIPATE IN RESEARCH
SAN JOSE STATE UNIVERSITY

RESPONSIBLE INVESTIGATOR: Gwen E. Vergeer, O.T.S.

TITLE OF PROTOCOL: Therapeutic Use of Humor in Occupational Therapy

I have been asked to participate in a research study that is investigating the therapeutic use of humor by occupational therapists. The results of this study should further understanding of the experiences of occupational therapists utilizing humor therapeutically in their practice.

I understand that:

1) I will be asked to think about my therapeutic use of humor and then participate in an interview. The interview will be audio-taped.

2) There are no anticipated risks from participation in this study.

3) The possible benefits to me from participation in this study are a deeper personal understanding of how I utilize therapeutic humor in my practice and knowledge that my contribution may be helping other occupational therapists better understand the use of humor as a therapeutic tool.

4) The results of this study may be published, but any information from this study that can be identified with me will remain confidential and will be disclosed only with my permission.

5) Any questions about my participation in this study will be answered by Gwen Vergeer, O.T.S. at (408) 289-1013. Complaints about the procedures may be presented to Anne MacRae, M.S., O.T.R., Professor, at (408) 924-3085 or Lela Llorens, Ph.D., O.T.R., Professor, Chair, and Graduate Coordinator, at (408) 924-3070. For questions or complaints about research subject's rights, or in the event of a research-related injury, contact Serena Stanford, Ph.D. (Associate Academic Vice President for Graduate Studies and Research) at (408) 924-2480.

6) My consent is given voluntarily without being coerced; I may refuse to participate in this study or in any part of this study, and I may withdraw at any time, without prejudice to my relations with San Jose State University.

7) I have received a copy of this consent form for my file. I HAVE MADE A DECISION WHETHER OR NOT TO PARTICIPATE. MY SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE.

Date:_____ Subject's Signature_____

Investigator's Signature_____