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The experiences of occupational therapists who have used humor therapeutically with elders

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THE EXPERIENCES OF OCCUPATIONAL THERAPISTS WHO HAVE USED HUMOR THERAPEUTICALLY WITH ELDERS

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ABSTRACT

THE EXPERIENCES OF OCCUPATIONAL THERAPISTS WHO HAVE USED HUMOR THERAPEUTICALLY WITH ELDERS

by Jennifer M. Chin

This thesis addresses the use of humor as therapy by occupational therapists who work with elders. Using the phenomenological method of research, five occupational therapists who use humor in their practice were interviewed. Descriptions of the subjects' lived experiences in the use of therapeutic humor were examined in order to uncover their true meaning.

Through an in-depth analysis of the data, the nature of the phenomenon, as humanly experienced, was revealed. Common themes related to the five occupational therapists' use of humor were determined and compared with the literature. From these themes, implications for occupational therapy were addressed and recommendations for future research on the therapeutic use of humor in occupational therapy were made.

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CHAPTER 1

INTRODUCTION

Purpose

The purpose of this study was to examine the experiences of occupational therapists who use therapeutic humor in the treatment of elders.

Statement of the Problem

Humor in therapeutic intervention has received increased attention in recent years. Humor as a healing force has been documented often. Four major functions of humor (physiological, psychological, sociological, and communicative) related to positive adaptation and health have been identified in various studies (Buxman, 1991; Davidhizar & Schearer, 1992; Dunn, 1993; Erdman, 1991; Fry, 1979, 1992; Goldstein, 1987; Herth, 1990; Mallett, 1993). However, these studies have basically given repeated descriptions of the beneficial effects of humor and laughter, although some have gone a step further in discussing humor's role in aiding a patient's adjustment or recovery (Herring, 1993; Mitchell, 1993; Tennant, 1990). Humor and laughter are potentially useful therapeutic tools but, as yet, little clinical research into their utilization has been conducted (Dunn, 1993).

Occupational therapy shares the same beliefs about humor that other health professions do although there is much less research conducted in this field. For instance, the association of humor and laughter with health and longevity and the belief that humor is necessary for human survival have been expressed by many authors in the fields of nursing and psychotherapy. In occupational therapy, as well as other helping professions, there has been an increased emphasis on a humanistic approach to the individual. Each patient is recognized as a psychosocial being with his own unique perceptions, motivations and behaviors. The patient is accepted as he is and where he is, with all of his problems, weaknesses, and deficiencies, as well as his strengths. Essentially, the health professional accepts the patient's humanness, that is, not only his potential for success, but his potential for failure, his potential for tragedy, and his potential for comedy (Robinson, 1977). Yet, there are limited articles on the experiences of health professionals who have used humor as therapy (Bader, 1993; Hunt, 1993; Pasquali, 1990; Vergeer, 1992; Vergeer & MacRae, 1993).

Literature on humor and occupational therapy is scarce (Banning & Nelson, 1986; Tooper, 1984; Vergeer & MacRae, 1993). Only one study has been conducted which explores the experiences of occupational therapists who use

humor in their practice (Vergeer & MacRae, 1993). Therefore, it is important that occupational therapists continue to investigate this phenomenon in order to further increase understanding of the concept of "therapeutic use of humor" and recognize its role in the therapeutic relationship.

Another variable to be explored in this study is the therapeutic use of humor in relation to the elderly population. In occupational therapy, literature regarding the effect of humor on the well-being of the older adult is nonexistent. But as the number of older adults continues to escalate, occupational therapists will play an increasingly active role in assessment, care, and health promotion of elderly patients. Humor is being used in nursing specialty areas, including oncology, with the terminally ill, in critical care, and in orthopedics, but in providing care for the growing number older adults, humor is sometimes forgotten (Davidhizar & Schearer, 1992). This study will explore the experiences, attitudes and observations of occupational therapists who use humor therapeutically with the elderly population.

Research Question

What are the experiences of occupational therapists who use therapeutic humor with elders?

Definitions

Operational definitions are not used in

phenomenological research because it is philosophically inconsistent with the method to pre-define what it is the researcher wants to learn about. Therefore, only technical terms are defined.

Finding a universal definition for humor is as difficult as finding a universal language or theory (Robinson, 1977). In order to avoid potential for bias, the researcher must allow the subjects to clarify their own perceptions and understandings of relevant concepts (Vergeer, 1992).

The "elderly" population, "aged" population, and "older" adults are defined as those people sixty years of age and older.

In this study, recipients of occupational therapy services are called "patients," although other relevant terms such as "clients" or "participants" may be substituted by the reader.

Assumptions

This study was conducted under the assumption that there are occupational therapists who use therapeutic humor with their elderly patients, but there has not been any research done on the subject with regard to the field of occupational therapy. It has also been assumed that occupational therapists may use therapeutic humor with different intentions and for different reasons when applied

to the elderly population as opposed to other populations. In conducting this research, it was also assumed that the therapeutic use of humor is not well understood in the field of occupational therapy and that any information obtained through this study will be of value in the future practice of occupational therapy.

Bracketing

The open-ended interview used with the qualitative phenomenological method of research enabled the five occupational therapists to disclose in depth their experiences with using humor therapeutically and therefore clarify its meaning and value.

One important technique used in phenomenological research is bracketing, a concept originated by Husserl (1981), which is a continuous process where the interviewer acknowledges and sets aside her beliefs in order to achieve a pre-theoretical state (MacRae, 1991; Vergeer, 1992). This procedure minimized the influence of biases during the data collection and prevented prior knowledge from biasing the analysis of the descriptive data.

During the course of this study, the researcher used bracketing in order to access the contents of experience as bias-free as possible (MacRae, 1991). The following are the researcher's beliefs brought to consciousness and then set aside during the analysis:

The researcher believes that humor is used therapeutically, whether consciously or unconsciously, by a majority of therapists. While different forms of humor exist, spontaneous humor will attain the best results and most occupational therapists use humor informally with their patients. The benefits of using humor are believed to be the same as those found in the review of literature--facilitating communication, promoting the building of positive interpersonal relationships between staff and patients, and promoting psychological and physiological healing. The researcher believes that humor can serve as a stress reliever and coping mechanism for both the patient and the therapist.

The researcher believes that while all patient populations can benefit from humor, humor is used differently and for different reasons with various populations. In the field of gerontology, the researcher believes that personal sense of humor is characteristic of those who have aged successfully and that even when the chronic disability of an elderly patient cannot be corrected, humor offers a way to make the unchangeable more tolerable.

The researcher believes that allowing humor into our communication with patients requires sensitivity. Sensitivity requires effort such as eliciting conversations

from the patients to determine their emotional condition before interjecting humor, carefully evaluating the patients' response to humor, and never using humor to make fun of others.

The researcher believes that humor is a disposition of mind or feeling to make life more tolerable and enjoyable and ranges all the way from pleasant feelings and spontaneous enjoyment to belly laughs. Humor adds to the quality of life for the patients.

The researcher believes that more occupational therapists need to become aware of the benefits of using humor as therapy. It is important that therapists further their understanding of therapeutic humor and learn to apply it towards a more positive patient-therapist relationship.

The researcher believes that there are contraindications to using humor in therapy, such as being patronizing or making fun of someone, and that humor should never be imposed on the patient. The researcher believes that a patient should not be forced to laugh if he/she does not want to. Occupational therapists must be flexible and must be able to vary their use of humor, using it differently with different patients. In this way, therapists will further develop their therapeutic use of self.

Limitations

One of the several limitations of this study was the

size of the sample. The sample size of five was quite small, although appropriate for phenomenological research. Small sample sizes are typical for phenomenological studies and samples of two to five subjects have been found to produce data saturation (Parse, Coyne, & Smith, 1985). Because the number was small, there was not as great a variation of experiences as there would have been if more subjects had been used. The sample chosen was confined to the San Francisco Bay Area only and they were not randomly selected. Therefore, generalizations about the results cannot be made. In addition, the sample did not represent occupational therapists working in various practice settings with elders. While an attempt was made to obtain a subject who worked with the geriatric-psychiatric population, unforeseen circumstances prevented this from being accomplished.

Although the subjects were advised to think about the research question in advance, it is possible that, during the interview, they may have given incomplete information about their experiences. Some of the subjects appeared to have difficulty giving examples of specific situations in which they used humor.

Significance of the Study

This study was designed to expand on Vergeer's (1992) study which explored the experiences of occupational therapists who use humor therapeutically with their

patients. Although it is apparent from clinical observations and discussions with numerous occupational therapists that therapeutic humor is utilized in treatment, only one known study has been conducted to clarify reasons why therapeutic humor is used in occupational therapy, why it is therapeutic and what the occupational therapist experiences throughout the process. This study addresses these issues as well, but with a focus specifically on the elderly population.

While recent research exists in other health professions on the benefits of humor and laughter in patient care, few have focused on its use with elders. There is a paucity of literature related to the use of humor in occupational therapy and no literature exists on the experiences of occupational therapists who use humor therapeutically with the elderly population. According to Gilfoyle and Christiansen (1987), it is imperative that research in occupational therapy keep abreast of current topics and issues in health care in order to maintain professional excellence and develop respect as an applied science. Therefore, it is necessary for the field of occupational therapy to contribute to the research on humor and laughter as therapeutic tools and to examine unexplored aspects of therapeutic humor in relation to other populations such as the elderly. The lack of qualitative documentation in the literature on humor with the elderly,

provided the impetus for this study.

The past two decades have seen an increasing emphasis within the health professions on a humanistic approach to the individual. Within this humanistic, holistic perspective, humor is an essential phenomenon. Paralleling the increase in the aged population has been an increase in gerontological research. Many studies describing psychosocial characteristics of this population reveal low self-esteem, low morale, depression, inactivity, and an impaired level of overall adjustment (Tennant, 1990). If occupational therapists can develop the use of humor as a therapeutic strategy that enhances well being, humor may then be recognized as an important ingredient in the delivery of treatment for aged persons.

Being able to resolve conflicts and incongruities through a humorous release of energy may give the aged person a feeling of accomplishment and satisfaction with life (Tennant, 1990). Patients at a California gerontology center became more sociable and more active when volunteers reawakened their sense of humor (Tennant, 1990). Skillful use of strategies such as humor appears to foster holistic health behaviors and enhance well-being in the elderly patient.

The lived experiences of occupational therapists who use humor as therapy with their elderly patients were

analyzed in this study. Their shared experiences provide a background that gives sharper definition to the uniqueness of individual experience. In occupational therapy, new understanding of the aging experience may enhance the patient-therapist relationship and lead to innovative ways of promoting health with older persons. This study hopes to substantiate the previous research on this phenomenon, expand occupational therapists' understanding of the use of humor in therapy, and enhance occupational therapy's knowledge base.

CHAPTER 2

REVIEW OF THE LITERATURE

Humor is essential to any smoothly functioning system of interaction, to any healthy person, and to any viable group (Goodman, 1983). Mulkay (1988) claims that humor is one of the few basic social phenomena that occur in all groups throughout human history. For many centuries, as far back as Plato and Aristotle, Western scholars have tried hard to make sense of the phenomenon, but there is remarkably little acknowledged agreement about the nature of humor.

Tooper (1984) stated that although humor and laughter have been a natural part of human life in all cultures as far back as recorded history can determine, the conscious use of humor as a therapeutic technique is comparatively recent. The therapeutic role of humor in health, illness, and adaptation received little attention until Norman Cousins wrote about how he used humor and laughter to effectively recover from a crippling disease. He described making the joyous discovery that ten minutes of genuine belly laughing had produced an anesthetic effect for at least two hours of pain-free sleep (Cousins, 1979). Although humor has always been thought of as being associated with positive adaptation in health and illness, scientific research on humor has been sparse (Moody, 1978).

Theories of Humor

Because humor is a multifaceted phenomenon, no one theory satisfactorily explains or predicts all aspects. The pragmatic stance is to apply several theories to cover all eventualities. Over 100 theories of humor exist and have been promulgated by philosophers, novelists, literary critics, psychologists, sociologists, artists and humorists themselves (Haig, 1988). Robinson (1991) focused on two categories of theories of humor. One category deals with the nature of humor and the other with the function of humor. The first group includes superiority theories, the oldest theory of humor, which basis lies in the assertion of one's own superiority by laughing at the inferiority, stupidity, or misfortunes of others (Robinson, 1991). Incongruity theories involve an element of surprise, a sudden shock or unexpectedness, an incongruity or conflict of ideas or emotions which produces the absurdity or ludicrousness resulting in a burst of laughter (Robinson, 1991). Play theories describe humor as an aspect of play and incorporate the aspect of play as a developmental factor in acquiring a sense of humor. Laughter prepares us for social life in a manner similar to play.

The second category includes relief theories and biological theories. Relief theories have as their base the concept of humor as a relief from tension, anxiety, and

frustration or a release from life's harsh realities (Robinson, 1991). Biological theories address the physiological benefits of humor and in some cases, compare the physiological component of laughter with physical exercise (MacHovec, 1991).

Most of the theories of humor have not been empirically tested; thus, the complexity of the phenomenon of humor is apparent. This study hopes to provide more information on the meaning of humor for those who use it as a therapeutic intervention.

Benefits of Humor

In the health-care setting, humor serves four main functions: physiological, communicative, social and psychological (Davidhizar & Schearer, 1992; Dunn, 1993). Modern medical science has begun to rediscover the physiologic benefits of laughter for patients. A majority of the literature cites identifiable medical benefits of using humor as therapy. Thirteenth century medical history depicts laughter as being used as an anesthetic for surgical procedures (Erdman, 1991). Five hundred years ago, laughter was known as a treatment for colds and depression (Lee, 1990). Much has been said of the positive effects of mirthful laughter on human physiology. One of the most vigorous proponents of this view has been Fry (1986), who for numerous years has studied its effects on heart rate,

oxygen saturation levels of peripheral blood, and respiratory phenomena. He found that both the arousal and cathartic effects of humor in psychological terms are duplicated in the physiological processes. In addition, laughter, in contrast to other emotions, involves extensive physical (motor) activity, and therefore the results are somewhat comparable to that of physical exercise.

According to Fry (1986), laboratory study has demonstrated that mirth and mirthful behavior affect most of the major physiological systems. For example, laughter has been found to raise the heart rate and increase muscle activity and oxygen exchange, and stimulate the cardiovascular system, the sympathetic nervous system, and the production of catecholamines. The exact effect of humor on the central nervous system is not fully known, but it is theorized that increased catecholamine levels are responsible for the beneficial effects humor has on mental functions, including increasing interpersonal responsiveness, alertness, and memory (Fry, 1992). Fry believes that further studies will demonstrate that all physiological systems of the body are affected.

Research has demonstrated that laughter is more than simple vocal and muscular behavior. Laughter, a motor reflex usually present by 4 months of age, requires the coordinated movement of 15 facial muscles, as well as changes in the

normal breathing pattern (Fry, 1992). Initial effects of laughter are stimulatory, with elevated pulse and respiratory rates; after the laughter subsides, a relatively brief relaxation phase ensues. In hearty, boisterous laughter, a large mass of muscle tissue participates, creating a total body response that is clinically useful because it may provide bed-ridden or wheelchair bound patients with some conditioning exercise. Laughter helps ease muscle tension in such areas as the abdomen, diaphragm, chest, back, neck, throat, jaw and face (Haig, 1988; Peter & Dana, 1982) and breaks the spasm-pain cycle seen in neuralgias and rheumatism (Fry, 1979). By aiding ventilation and clearing mucus plugs, laughter, which may cause coughing, also helps many patients with chronic respiratory conditions such as emphysema (Fry, 1992).

The psychological role of humor has received the most attention over the years. Early research By Vaillant (1977) identified humor as one of the five mature coping mechanisms available to a person for successfully dealing with difficult situations. The psychological benefits of humor are the release of pent-up tension, anxiety relief, and enhancement of problem-solving abilities which aid in coping with stress (Davidhizar & Schearer, 1992). Stuart and Sundeen (1987) see humor as a basic part of the personality which has a place within therapeutic relationships. It

resolves paradoxes, tempers aggression and is a socially acceptable form of sublimation. Robinson (1983) believes anxiety is one of the most common sources of discomfort that prompts the use of humor. The use of humor allows a patient to cognitively reframe a situation and to examine the problem from another perspective (Ruxton, 1988).

Humor and laughter are described as being among the most prevalent, yet one of the least studied or understood, forms of human social behavior. The identified sociological benefits of humor are: decreasing social distance, reducing communication barriers between individuals, conveying empathy, and increasing the ability to effectively cope with unfamiliar environments (Herth, 1990, Robinson, 1991; Ruxton & Hester, 1987). In a study of the social structure of a hospital ward, humor was found to reassure, convey information, release tension, and draw people more closely together (Buxman, 1991). Ruxton (1988) states that by sharing a simple humorous anecdote, nurses may reveal their own vulnerability and perhaps strengthen their relationship with patients. This helps to lessen the distance of the patient-staff hierarchy (Buxman, 1991).

Constructive humor helps communication by breaking down barriers, by making people feel good, and by bringing people closer together. According to Ruxton (1988), humor can help establish rapport and neutralize emotionally charged

interpersonal events. Through the use of humor, patients may be able to "jokingly" express feelings of fear or embarrassment. Humor can be an effective 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 (Sullivan & Deane, 1988).

It is important to note that a majority of the studies related to the functions of humor in health, illness, and adaptation have been conducted with young or middle-aged adults who are either well or experiencing a chronic illness. Only recently have studies involved the elderly and children. Researchers have agreed that there is a need for verification of the effectiveness of humor with specific populations.

Many of the studies mentioned have focused on specific aspects of humor but not from specific perspectives, such as the phenomenological viewpoint. Scientific examination of the use of therapeutic humor, employing the phenomenological method of research, could provide more evidence of humor's benefits to a patient's health and function. In this way, the meaning of humor as it is experienced by those who use it, will be revealed in-depth.

Humor and Occupational Therapy

Of the few articles which exist on humor and occupational therapy, only one explores the experiences of occupational therapists who use humor in treatment (Vergeer & MacRae, 1993). Tooper (1984) advocated the use of fun and laughter as a therapeutic tool and stressed the importance of developing humor, recognizing the individuality of humor and of therapists understanding their own attitudes toward humor in order to use it with others. Southam and Cummings (1990) discussed the use of humor in modulating pain. Because many authors have cited the value of humor-promoting activities (Banning & Nelson, 1986; Pasquali, 1990; Ruxton & Hester, 1987), and activity is a core concept in treating the occupational needs of individuals (Hopkins & Tiffany, 1988), it appears that humor would be an appropriate modality to use in occupational therapy.

Occupational therapy consistently involves four tools: therapeutic use of self, purposeful activity, activity analysis, and activity adaptation (Schwartzberg, 1993). The therapist's use of self is critical to engaging the patient in occupational therapy. Empathy is an essential ingredient to establishing a therapeutic relationship and is commonly viewed as a necessary condition to therapeutic rapport (Schwartzberg, 1993). Participation in such a humanistic relationship in occupational therapy brings the patient hope

in the potential for growth and change (Briggs, Duncombe, Howe, & Schwartzberg, 1979). As mentioned before, humor, as a communication tool, can convey empathy and help establish rapport. Therefore, the conscious use of humor as a therapeutic technique is one skill that occupational therapists can draw on to address the often complex and interrelated aspects of the elderly's health predicaments.

CHAPTER 3

RESEARCH METHODOLOGY AND PROCEDURES

The Phenomenological Method of Research

This research addressed the question: What are the experiences of occupational therapists who use therapeutic humor with elders?

This study was conducted using the qualitative phenomenological method of research for data collection and analysis. An increasing number of supporters within the occupational therapy profession have identified the value of qualitative research methodology in exploring relatively complex or unstudied phenomena such as humor (Kielhofner, 1982a, 1983; Merrill, 1985; Yerxa, 1983, 1988). Yerxa (1988) stated that "occupational therapy concepts generally are so non-specific that the profession needs to give far greater emphasis to descriptive research than to experimental research at this stage...Researchers cannot begin to manipulate variables until the important variables have been clearly defined and described" (p. 174). According to Yerxa (1991), "use of the natural setting as the direct source of data, concern with the process as well as the outcome, and having an essential interest in meaning from the participant's perspective" are components of qualitative research which correspond with occupational therapy (p. 200). Because qualitative research is contextualized,

its methods are compatible with occupational therapy's humanistic values and its focus on occupational performance (Kielhofner, 1982b; Yerxa, 1991). Kielhofner (1982b) maintained that a special harmony exists between the concerns of occupational therapy and the paradigms and methods of qualitative research. "Both focus on the realities of everyday life. Both appreciate the richness of mundane affairs" (p. 162).

The purpose of phenomenology is to do justice to the importance of the lived aspects of human phenomena, and to do so, one first has to know how someone actually experienced what has been lived (Giorgi, 1985). According to Husserl (1917/1981), the collective consciousness of the phenomenon in question is made up of many people's intuitions together, each of which offers a slightly different perception of the phenomenon so that the collective understanding is made richer. Giorgi (1975) asserts that the chief point to be remembered with phenomenological research is whether a reader, adopting the same viewpoint as articulated by the researcher, can also see what the researcher saw, whether or not he/she agrees with it. "That is the key criterion for qualitative research" (Giorgi, 1975, p. 96). Phenomenological study involves the examination of personal descriptions of lived experiences so that these experiences may be better

understood (Giorgi, 1985). Phenomenological investigators seek the essence of lived experiences (Parse, Coyne, & Smith, 1985) by returning to original entities. Knowledge about experience is expanded by allowing a phenomenon to show itself without application of the predictive prescriptions of the quantitative methodologies (Parse et al., 1985). An attraction of phenomenological research is that it preserves the uniqueness of individually lived experiences while allowing an understanding of the phenomena as experienced collectively (Banonis, 1989). MacRae (1991) discussed the philosophical similarities between occupational therapy and phenomenology in that "both disciplines recognize the complexity of the human realm" (p. 13). Both phenomenology and occupational therapy embrace a sense of wholeness which other dominant research and clinical traditions are lacking (MacRae, 1991).

The study method selected was Giorgi's (1985) phenomenological method of research, but from an occupational therapy perspective. Using this perspective, the researcher examined the occupational therapists' experiences in terms of the therapeutic use of self. Unlike Giorgi, who examined psychological meanings of experiences, this study examined experiences related to occupational therapy performance areas such as self-care and leisure and components such as social and cognitive in achieving maximum

independence and enhancing quality of life (Hopkins, 1993). MacRae (1991) stated that "phenomenology offers to occupational therapy the means to further articulate its philosophical base and apply its principles to both practice and research" (p. 14). This method was chosen because so little research has been done on humor and occupational therapy; therefore it was important to employ a method that would articulate the meaning of the therapeutic use of humor in occupational therapy as a basis from which further research could be conducted (Vergeer, 1992).

The phenomenological method of research was selected because of its shared emphasis with occupational therapy philosophy in seeking to comprehend the holistic complexity of lived experience (MacRae, 1991). Use of the phenomenological method enabled the researcher to collect and interpret narrative data obtained through exploratory interviews describing the experiences of five occupational therapists who use humor therapeutically with their elderly patients.

Rigor in Qualitative Research

Establishing rigor is important with qualitative research (Krefting, 1991). This relates to the credibility and dependability of the findings (Deitz, 1993). One of the greatest obstacles to the identification of excellence in qualitative studies is the lack of generally accepted

criteria (Burns, 1989). Several approaches have been advocated to help ensure the trustworthiness of qualitative findings which differs from the measures of reliability and validity used with quantitative research. Deitz (1993) stated that "achieving rigor in qualitative research is a complex and time-consuming process" (p. 413). Vergeer's (1992) chosen model of standards for qualitative research, based on the work of Lincoln and Guba (1985) as structured by Krefting (1991), judged the rigor of her study in terms of: truth value, applicability, consistency, and neutrality. These same characteristics are the basis by which this researcher has established rigor.

Truth Value

Truth value refers to the duty of the investigator to report what has been revealed as completely and accurately as possible according to the subjects (Krefting, 1991). Truth value was established in this study through audiotaping of the interviews to ensure accurate data and gathering enough information from the five subjects to yield data redundancy or saturation.

Applicability

The second characteristic in the rigor of qualitative research is applicability. Applicability is the generalizability of the data to other people and settings (Vergeer, 1992). According to Lincoln and Guba (1985),

applicability is attained if the researcher provides enough descriptive data to enable others to make comparisons to similar situations. Applicability of the study exists because this research explored the significant themes in the five subjects' lived experiences and compared and contrasted the common themes with the literature.

Consistency

Consistency is the next measure of rigor in qualitative studies. In this study consistency is measured through auditability, or "the development of a decision trail" (Miles & Huberman, 1984). To achieve this, the researcher must report all of the decisions involved in the transformation of data to the theoretical schema. This reporting should be in sufficient detail to allow other researchers, using the original data and tracing the decision trail, to arrive at conclusions similar to those of the original researcher (Burns, 1989). In assuring consistency with this study, the researcher consulted with persons adept in the phenomenological method and familiar with the therapeutic use of humor in occupational therapy throughout analysis of the data.

Neutrality

Neutrality is essential for ensuring the trustworthiness of qualitative research. Observer and procedural bias must be minimized (Krefting, 1991). In

phenomenological research, this is accomplished through the process of bracketing, a concept originally introduced by Husserl (1981). Bracketing is the researcher's conscious attempt to achieve a pre-theoretical state (MacRae, 1991). It is successfully accomplished when beliefs and preconceptions are purposely brought to consciousness, acknowledged, and then temporarily set aside during the data collection and data analysis. This process allows the data to present themselves without influence of bias so that the nature of the essences of the phenomenon can be uncovered. The researcher maintained neutrality by bracketing all notions throughout the interview and data analyses components of this study.

Subject Selection

Several occupational therapists who worked with elders in the San Francisco Bay Area were contacted by phone and in person and asked if they had used humor therapeutically in their practice. If so, a brief summary of the study was explained to them and they were then asked if they were interested in participating in the study. Five therapists volunteered to participate in this study and were interviewed. All of the subjects had been currently working with the elderly population and expressed an interest in the use of humor as therapy in occupational therapy. Two of the subjects were currently working at an adult day health

center for seniors with one of them also working part-time in home care, two were working at a skilled nursing facility and one was working in home health for seniors. While an effort was made to obtain a subject who worked in a geriatric psychiatric facility, the potential subject was unable to participate due to unforeseen circumstances. Only one subject had experience working with another population; the remaining four had worked with the elderly population exclusively. All subjects were women.

The Interview

The five chosen occupational therapists were interviewed and their experiences audiotaped. After verbally agreeing to participate in the study, the subjects were given or sent a cover letter for the consent form (see Appendix II) and two copies of the consent form (see Appendix III) which further explained the purpose and structure of the interview. They were also notified of their rights as research subjects in the consent forms. The forms were to be read and signed prior to the interview. The subjects were advised to prepare for the interview by thinking about the ways in which they use humor therapeutically in their practice and the outcomes.

The interviews were conducted at a place and time most convenient for the subjects. Some interviews were conducted at the homes or workplaces of the subjects and others were

conducted at cafes. The subjects' rights to anonymity and the right to withdraw from the study at any time were explained by the researcher. The subjects were again informed that the interviews would be tape recorded and that the audiotapes would be locked up in a safe when not being used by the researcher. The subjects were then asked to describe, in detail, their experiences in using humor as therapy with their elderly patients. A few additional questions were asked to clarify ambiguous responses. The subjects were allowed to respond to the question as they interpreted it and to speak as freely and as long about the topic as they wished. The interviews ranged from approximately twenty minutes to one hour. Each interview was coded alphabetically in order to maintain confidentiality.

In order to prepare the data for analysis, the researcher transcribed verbatim each audiotaped interview using a computer. Non-verbal cues, including laughing and pausing, were noted. Words which the subjects emphasized were typed in bold lettering. All of the interviews supplied an adequate amount of data for analysis. The small sample size, which is typical for phenomenological studies, yielded data redundancy or saturation. Giorgi (1985) explained that "adequacy of the sample is achieved when the researcher experiences redundancy in descriptions. Redundancy is repetition of statements regarding the phenomenon being

studied" (pp. 17-18).

Data Analysis

The data from the interviews were analyzed according to the phenomenological method of research in a format similar to Vergeer's (1992), which was derived from Giorgi (1985). The first step was to read through each transcribed interview to get a general sense of the whole experience (Giorgi, 1985). The next step of the analysis involved reading the text over again in order to determine the "meaning units" as expressed by the subjects. Giorgi (1985) defined meaning units as context-laden constituents, rather like words in a paragraph, which do not actually exist in the raw data, but are constituted perceptually by the researcher who actively searches for emerging meaning.

The following example from part of Subject C's interview illustrates how the meaning units were determined:
Researcher: I'm focusing on the elderly population. Do you think there's a difference in using humor with that population?
Subject C: I think it's **quite** important to use it, **especially** with the elderly population because there are a lot of elderly folks out there that are more lonely or seem more depressed um. . .especially when they're older and they get sick, they kind of start to feel **sorry** for themselves. So I think as a treating therapist going in to see the

patients, when you go in more lighthearted and **not** as structured, I think the patients actually um. . .gets **more** out of it and that's when I think the **therapeutic** aspect of humor comes in because. . .they actually look **forward** to therapy and not only do they get something out of treatment therapeutically, obviously, but on the side, the humor part can also be therapeutic because it **uplifts** them and kind of brightens their day.

Researcher: Is there anything else that humor does for the treatment session?

C: I think it kind of **flows** more easily. For **me** it does, anyway. I think it just creates a more **comfortable** atmosphere for the patients and puts them **more** at ease, too.

The meaning unit discriminations were noted directly on the description whenever the researcher became aware of shifts in meaning of the situation for Subject C. The interview was printed out again but on the left-hand column of the pages. The meaning units were then read over again, transformed into Subject C's essential meaning, and recorded on the right-hand column. This process was performed several times for each meaning unit in order to encapsulate the subject's intention. Continuing with the example of Subject C, the results were as follows:

C: I think it's **quite** important to use it, **especially** with the elderly	C feels that the use of humor is especially meaningful to the elderly

population because there are a lot of elderly folks out there that are more lonely or seem more depressed um. . .especially when they're older and they get sick, they kind of start to feel ***sorry*** for themselves.	population because they tend to be more lonely and depressed. Humor can often diminish the feelings of hopelessness and despair which arise when they become ill.
So I think as a treating therapist going in to see the patients, when you go in more lighthearted and not as structured, I think the patients actually um. . . get **more** out of it and that's when I think the **therapeutic** aspect of humor comes in because. . .they actually look forward to it and not only do they get something out of treatment therapeutically, obviously, but on the side, the humor part can also be therapeutic because it **uplifts** them and kind of brightens their day.	C takes a lighthearted, flexible approach when treating patients, which produces better results from them. Humor increases the patients' motivation for and participation in therapy and benefits them both physically and emotionally by brightening their day.
I think it just kind of **flows** more easily. For **me** it does, anyway. I think it just creates a more **comfortable** atmosphere for the patients and it puts them **more** at ease, too.	C's lighthearted approach to treatment as opposed to a more structured and aggressive approach, enables the treatment session to flow more easily by putting the patients at ease and creating a more comfortable environment. C's use of humor creates a cheerful, trusting atmosphere.

The next step of the analysis was to transform the meaning units into non-redundant themes related to the use of humor in occupational therapy. The subjects' perceptions

and intentions were converted to themes which expressed the integral aspects of each meaning unit, the central issue in each around which the therapeutic use of humor revolved (Vergeer, 1992). The essential themes were then synthesized as a situated structural description (specific description) which preserved the substance of the subjects' expressions while grasping the meaning of the therapeutic use of humor as lived by each subject (Santopinto, 1989).

Continuing with the previous example, the essence of Subject C's experience was extracted from each meaning unit. The corresponding meaning units were then tied together into the specific description. The following is a section from Subject C's specific description:

> Subject C believes that humor is essential in creating a positive environment for the elderly population, which tends to be more lonely and depressed. Her lighthearted and flexible approach to treatment results in an environment conducive to successful therapy. Humor provides a motivating force which keeps individuals involved and active in therapy. Subject C also uses humor to put her patients at ease, to release tension, and to create a pleasant, trusting, and mutually enjoyable atmosphere. For Subject C, the most important aspect of humor is its ability to benefit her patients both physically and emotionally.

The next step of the data analysis was to formulate general descriptions from each subject's specific description. The general description leaves out the particulars of the specific situation and tries to communicate the most general meaning of the therapeutic use of humor with elders (Giorgi, 1985). The following statements from Subject C's general description incorporate the lived experiences from the above data analysis:

> Subject C's lived experience in using humor as therapy is using her natural, spontaneous, lighthearted approach to diminish her patients' fears, tension, and hopelessness. Humor, as a treatment modality, creates a pleasant and trusting environment for elders who tend to be lonely and depressed. The therapist's lighthearted approach to treatment is uplifting for the patients, increases their motivation for and participation in therapy, and benefits them both physically and psychologically.

In the final step of the phenomenological analysis, the researcher compiled themes significant to the lived experience of therapeutic humor with elders in occupational therapy from each subject's descriptions. The insights were then synthesized and integrated (Giorgi, 1985) into an essential description of the phenomenon from an occupational therapy perspective.

CHAPTER 4

RESULTS

The five interviews were analyzed using the phenomenological method. Following the three stages of the method, meaning units, a specific description, and a general description for each interview were formed. A specific description and a general description of each interview are included in this chapter, followed by the essential description of the phenomenon.

Subject A - Specific Description

Subject A's informal use of humor comes naturally for her. However, working with the geriatric population has increased her awareness of the importance of humor in occupational therapy. As a result of the aging process, Subject A's patients have experienced great losses in terms of function and of deaths of spouses, family and friends. In order to help them cope with these losses, Subject A feels the need to inject humor into therapy in order for her patients to keep proper perspective, to increase their motivation, and to maintain a more positive outlook on life.

Humor plays a vital role in guiding Subject A's treatment. It changes what could be a negative situation into a more positive one and allows Subject A and her patients to look at situations in a broader, different perspective. It is Subject A's experience that humor

provides both psychological and physiological benefits to her patients. Therapeutically, laughter releases muscle tension, which often helps the patients rise above their pain. Overall, humor has helped Subject A to build rapport and create a more relaxed environment, which increases the enjoyment of and participation in therapy for her patients. Subject A tries to communicate to her patients the therapeutic importance of laughter. Because Subject A is fortunate to have patients in her program who possess a great sense of humor, she continually supports and encourages it. The informal facilitation of humor use among the staff in Subject A's facility also contributes to an enjoyable environment for all.

Subject A emphasizes the distinction between laughing with a patient and laughing at a patient and warns that one should never use humor to make fun of another person. She feels that there are times when humor may be inappropriate and because the hospital experience gives rise to various intensely felt emotions, there should be safe outlets for expressing all of them. Subject A feels that humor is not an emotion, but rather a vehicle for expressing emotions, therefore, Subject A's wish is not to impose humor on her patients, but rather to make it a viable option. The message Subject A tries to convey is not that her patients must laugh, but that it is acceptable to laugh. To Subject A,

humor is also a vehicle which enables many patients to maintain their dignity despite the insults of disability. In Subject A's opinion, her angry patients benefit through her discussions of how famous role models used humor to prevail over disability.

Subject A strongly advocates encouraging patients to laugh and acknowledges patients' courage to laugh in spite of fear and pain. Subject A believes that the more one laughs, the better one feels. She supports the use of humor if, for no other reason, than to facilitate a feeling of well-being.

A uses sensitivity when admitting humor into her communications with patients. By eliciting conversations from the patients, she tries to ascertain the patient's emotional status before interjecting humor. In this way, Subject A can craft her humor to the patients' needs. This sensitivity requires effort and even with a best effort, a patient may feel that his/her problem is being trivialized. While this occasion calls for an immediate apology to the patient, it does not merit a renouncing of humor.

Subject A also experiences humor as a means of bonding among people. It indicates inclusion rather than exclusion and can also communicate respect and caring. While Subject A is not able to build a rapport through conversations with non-English speaking patients, her attempts to elicit humor

in the form of smiling or laughing have resulted in a connection between patient and therapist and a mutual enjoyment of the treatment session. Subject A's natural and spontaneous use of humor involves knowing her patients and the sort of humor to which they respond so as not to upset them. Because laughing with her patients is based on empathy, caring and an inclusive approach, Subject A finds that it creates positive bonds. Subject A believes that smiling, whether real or forced can make a person feel better by providing both a physical and psychological boost. Therefore, Subject A feels that residents at long-term care facilities should be encouraged to laugh.

Subject A - General Description

Subject A's informal and natural use of humor helps her elderly patients cope with the many losses which have come about not only as a result of their disability, but due to the aging process as well. Injecting humor into therapy helps the patients keep proper perspective, improve their motivation, and maintain a more positive outlook on life.

Humor plays a vital role in guiding Subject A's treatment. It provides both psychological and physiological benefits, which enable the patients to rise above their pain. Humor is a primary component in creating a relaxed environment, which promotes effective therapy and results in mutual enjoyment of the treatment session.

The humor shared with others indicates inclusion. Humor reduces the perceived distance between people. Laughing with someone is based on empathy, caring, and an inclusive approach. It creates positive bonds. Humor is a disposition of mind or feeling, and when used appropriately with patients, the indirect nature of humor can make life more tolerable and enjoyable. Humor can be used as a vehicle to help patients maintain their dignity despite their disability. It drains the power from fear and gives patients a sense of self-worth.

Sensitivity is required when admitting humor into communications with patients. Eliciting conversations from patients allows therapists to ascertain their patients' emotional level, and therefore, adapt their humor in a way which will produce beneficial results. Humor is one modality in occupational therapy's repertoire of tools and should be made a viable option but never imposed on a patient.

To Subject A, the lived experience of using humor in treatment is employing its vitality in combination with her own natural and informal humor in order to provide a balance in her patients' lives through mutually enjoyable humorous interactions which produce a supportive, therapeutic environment for enhancing motivation and participation in treatment, a positive outlook on life, and the ability to cope with losses.

Subject B - Specific Description

Subject B's philosophy, as an occupational therapist, is that if she is serious all of the time, she will not get anything done. Subject B uses humor to create a comfortable atmosphere, which in turn, produces positive results during the treatment session. Such results include: increasing enjoyment of and participation in therapy, serving as a coping mechanism in order to help her patients deal with the problems, changes, and fears in their lives, increasing attention to therapy, and building a better rapport.

Because occupational therapists work on functional activities of daily living (ADL) such as bathing and dressing and get very close to and personal with their patients, Subject B feels that it is most important to build trust with them. It is Subject B's experience that if patients don't trust the therapist, the treatment will not be effective. Patients need to know that the therapist cares and that the therapist is human, too, and not some higher being. Subject B builds trust with her patients by laughing at her own mistakes and showing that people do make mistakes and things do go wrong. In this way, she helps them to realize the similarity between the patients and herself, and eliminates the environment of having the "authoritative" therapist and "passive" patient. The therapists at Subject B's facility encourage the use of humor and contribute to

the lighthearted atmosphere during treatment sessions by sharing in the laughter and also joking with one another over their treatment modalities and mistakes while patients are present. The therapists' humorous responses to one another allow the patients to hear and see that the therapists are relaxed and enjoying their work and therefore, the patients tend to relax as well.

Subject B's style of humor tends to be dry, which is an intrinsic part of her personality. Her use of humor as therapy comes naturally into her interactions with patients. Although some of her patients take some time to adapt to her style of humor, she believes she has the knack of getting the serious and difficult patients to work with her. Her therapeutic use of self has proven to be successful as there are few patients with whom she could not work. Subject B credits this success to the natural way in which she approaches her patients. Her effectiveness as a therapist is due to the fact that she is being herself and her patients know that she genuinely cares. Subject B believes that patients can perceive when a therapist is being unnatural, and humor does not work effectively in this case.

Subject B is most comfortable working with the elderly population and enjoys her job at a senior adult day health center. Subject B feels that the use of humor is especially important with this population because they are often not

treated as "normal" people. They often live alone and lack human contact. When they do have contact with others, they are often talked down to or ignored. Subject B communicates with everyone, whether patients, staff, or others, in the same way. She believes that the way a therapist approaches her patients will determine the success of the treatment. Subject B believes one's approach includes not only the way one speaks to a patient, but the affect and expression on a therapist's face when working with the patient.

Subject B experiences other therapeutic uses of humor for her patients, such as to minimize the tension during potential embarrassing situations which can occur during ADL training. By taking a light approach and putting her patients at ease, she finds that they are more willing to work with her again.

Subject B uses humor as an attention diversion technique to diminish her patients' concerns and fears of trying new activities. This distraction seems to calm her patients who focus too much on their pain to participate in therapy successfully. Humor is the primary treatment modality used to redirect Subject B's patients' focus from their problems to achieving their treatment goals.

Without the use of humor, she would become bored and her treatment would be adversely affected. Subject B believes that using therapeutic humor is necessary in order

to reduce burnout in therapists. Subject B uses humor to break up the monotony which often occurs in the structured environment of leading a weekly self-range of motion group. She uses what she perceives as harmless teasing to create a fun atmosphere. Using humor and eliciting laughter from patients produces results which one would not get in a more serious environment. Subject B believes laughter is contagious and by eliciting laughter from her group members, she is able to increase their participation, motivation, and sense of belonging.

Subject B - General Description

Subject B's philosophy in using humor is that a serious therapist is an ineffective therapist. Subject B's use of humor establishes her role as a genuine, non-authoritative, and trustworthy therapist to her patients. Her humanness is shown when she laughs at her own mistakes and is able to joke with other therapists over their own treatment modalities and foibles in the presence of patients, therefore conveying her view that life should not be taken so seriously. Humor creates a comfortable and enjoyable treatment setting, which deepens the therapeutic relationship by building a better rapport and promoting successful therapy. The elderly population benefits from Subject B's patient-centered approach which focuses on collaboration as equals.

Subject B witnesses the positive effects of humor on patients. In addition to increased enjoyment and participation in therapy, humor serves as a coping mechanism which helps patients deal with the problems, changes, and fears in their lives. Humor diminishes fears of trying new activities, redirects attention to treatment, minimizes tension, and puts the patients at ease during private and sometimes embarrassing situations.

Subject B finds that the repetition involved in some therapists' work can result in boredom and burnout, thus negatively affecting the treatment session. Humor has the power to mutually benefit both patient and therapist by reducing tension and creating a fun and enjoyable atmosphere.

Subject B's lived experience of using humor in therapy involves crafting her natural and intrinsic humor to her patients' needs in order to create an environment of equality, support, trust, comfort, and fun, which in turn, produce increased attention to and participation in the treatment session and a mutual enjoyment of therapy.

Subject C - Specific Description

Subject C uses humor naturally and spontaneously in working with the elderly population in home care. She has found humor to be a valuable tool in dealing with the difficulties of language barriers as she frequently works

with the mono-lingual Asian population. She uses humor, often accidentally as she attempts to converse with them, to convey acceptance of cultural differences, which results in a more relaxed atmosphere with her patients and their caregivers.

Subject C feels that it is especially important to use humor when working with the elderly population because they tend to be lonely and depressed. It is Subject C's experience that going in to see the patient more lighthearted produces better results from the patient. Humor provides a motivating force which keeps individuals involved and active. Patients actually look forward to therapy and not only benefit physically, but emotionally, as the humor seems to uplift them and brighten their day. Subject C feels that therapeutic humor has been more successful for her with the elderly population than with the pediatric population, with which she has also worked. She feels that with the pediatric population, therapy is more focused on play and there are more obstacles in terms of the child's behavioral problems. With the elderly population, Subject C is able to use humor in conversation and share life experiences with them in order to facilitate the bond necessary for an effective therapeutic relationship.

While Subject C uses humor as a modality, it is not planned into her treatment session, but comes out

spontaneously as a natural part of her life. Subject C views the use of humor as varying per therapist, and dependent on each therapist's own personality and treatment style. Subject C's own use of humor involves going into the treatment session with an open-mind in terms of talking with the patient and being able to share humorous incidents with the patient. By taking a lighthearted approach to treatment as opposed to a more structured and aggressive approach, Subject C enables the treatment session to flow more easily by putting the patient at ease and creating a more comfortable environment. Subject C uses humor with her patients primarily to release tension and create a cheerful, trusting, and mutually enjoyable atmosphere.

Subject C views workshops on therapeutic humor as being helpful in obtaining a theory base, but personally feels that humor cannot be taught formally if it is to be used successfully. Formalizing humor creates a more structured environment, which, for Subject C, would be incompatible with her treatment style, thus producing anxiety and pressure over whether or not she is performing this "act" properly. Subject C believes humor needs to flow naturally and spontaneously in order to be successful in therapy. To Subject C, the therapeutic use of humor is candid. It is instinctive and intuitive. Therapeutic humor cannot be practiced or taught and is therapist dependent. Humor is

individually experienced by both therapist and patient and is something that therapists can offer on an individual basis according to their comfort level.

Subject C's overall experience with using humor has been positive. She recalls numerous examples of how her use of humor has helped patients move from a state of depression and hopelessness into the ability to see the lighter side of their problems. She feels that the success of her humor is due to the fact that she can adapt her use of humor to her patients' personalities and predicaments. She yields herself on whether to be a little more candid in her use of humor or not and is flexible in allowing the treatment session to flow one way or the other, depending on the patient's response.

Subject C stresses the importance of using humor in occupational therapy. She sees her role with patients as helping them to maintain a balance in their lives through a patient-based approach to therapy. By utilizing this approach with humor, she is able to provide a comfortable, supportive and natural environment for her patients during treatment.

Subject C - General Description

Subject C uses humor naturally and spontaneously in home care with the elderly population to facilitate successful occupational therapy. Therapeutic humor can be

used to convey acceptance of cultural and language differences, therefore diminishing fear and tension, and creating a more supportive and comfortable environment for the patients and their caregivers. Subject C's use of humor as a treatment modality creates a pleasant and trusting atmosphere for elders who tend to be more lonely and depressed. Subject C's lighthearted approach to therapy is uplifting for the patients, increases their motivation to participate in therapy, and benefits them both physically and psychologically.

Humor is individually experienced for both therapists and patients. Therapists can contribute humor therapeutically if they take a lighthearted approach and use humor naturally in their relationships with their patients. Subject C's style of humor, as an extension of her personality, consists of being open-minded in terms of conversing with patients and flexible in allowing the treatment session to flow one way or the other.

Subject C views the concept of formal humor as being ineffective treatment because humor cannot successfully be taught in workshops or in other ways. Humor is instinctive and intuitive and needs to flow naturally and spontaneously to be successful in therapy. Formalized humor destroys spontaneity and eliminates the comfortable atmosphere necessary for humor to be therapeutic.

Subject C's lived experience in using humor as therapy is using her natural, spontaneous, lighthearted approach to overcome cultural differences, diminish fear, tension, and depression, and create a comfortable, supportive, and trusting environment. Subject C finds humor to be an effective treatment modality because of its adaptability, candidness, and uniqueness when dealing with a variety of patients.

Subject D - Specific Description

Subject D cannot imagine being a successful occupational therapist without using humor, as humor plays a major role in her interactions with her patients. She feels that most patients are distrustful of relationships and that therapists must earn their patients' trust.

Subject D's first goal in using humor is to find her patients' general area of humor. This is accomplished through informal conversations with her patients, usually during the evaluation. She notes their response and proceeds to examine the effect a humorous approach will have with regard to the patient's values and roles. Once she determines the sort of humor to which they respond, she uses this humor to gain their trust and enhance the treatment session.

Subject D views humor as a tool for "making therapy happen". Having her patients respond to her humor and being

coaxed out of their withdrawal is a precious reward for Subject D because they are enjoying their therapy; and for Subject D, that is what occupational therapy is all about. Humor has given depressed patients a more positive outlook on life and has provided a way for them to fulfill their need for attention and a sense of self-worth. Sometimes, because of language, it can be difficult to get a response from her patients. However, even with a language barrier, Subject D is able to generate laughter, often over their mutual unsuccessful attempts at communicating. Another positive aspect of humor for Subject D is the immediate feedback of its success. This allows Subject D to change her approach as necessary. Subject D's approach offers her the opportunity to be creative in meeting her patients' needs and she is able to adapt her humor according to her patients' needs. Fortunately, Subject D is able to find humor in everyday life situations, which she uses frequently in treatment.

Subject D finds that she often uses humor as a mechanism for initiating and maintaining relationships with her patients. The rapport that develops between patient and therapist from using humor helps the treatment session to run smoothly by creating a mutually enjoyable environment. Subject D also uses humor to help her patients deal with embarrassing or painful incidents.

Subject D believes that timing is crucial when using humor and advises therapists to try again and again if at first they do not succeed. Subject D feels that therapists can find ways of using humor with difficult and/or non-responsive patients by watching for opportunities--keeping eyes and ears open for clues as to what the patients might respond to. Subject D firmly believes that by simply watching for opportunities to use humor, therapists can find ways to cultivate the patient-therapist relationship. For those patients who need some encouragement to participate in therapy, Subject D uses simple, harmless teasing and cajoling.

While Subject D feels that humor is beneficial to any population, she believes it is especially important to use with the elderly because they may be more depressed and confused than the general population. Use of humor can often establish a therapeutic milieu where the patient and therapist can converse and laugh.

Participating in therapy is sometimes like starting a new social system for the patients since many of them live alone and are often confined to their homes. Subject D uses humor to help them learn personal relationships again, therefore increasing their functioning in the social domain. Humor provides a vehicle for therapeutic social interaction.

Subject D cautions that therapists must be sensitive in

their approach of humor with elders and not use it indiscriminately. Because their generation was brought up differently, elderly patients may have strong feelings about what is proper and what is not. Subject D feels that because she is older than most other therapists, it is easier for her to relate to her patients through reminiscing about humorous events from the past. This sharing of fond memories has proven to be successful with Subject D's patients.

Subject D's humor is automatic and an intrinsic part of her personality. She finds it difficult to describe specific situations because of the spontaneity of her humor. Subject D views humor as the primary component in having a positive attitude toward life. She feels fortunate to have come from a family who fostered her philosophy of humor. Subject D warns that humor must be natural and not contrived or patients will sense the artificiality of it. She believes that when a therapist does not use humor naturally, therapy will not be effective.

Showing her humanness is an important component of Subject D's approach in using humor. She feels fortunate to be able to work at a facility which allows her to be herself and which offers her the opportunity to relate to her patients in a manner which is most comfortable for her. Subject D finds that the traditional concept of professionalism is too rigid and creates an artificial and

ineffective treatment setting.

Subject D uses humor to show empathy with patients' concerns over decreased function, and at times, to acknowledge their criticisms of being in a hospital setting. What Subject D finds most rewarding, as an occupational therapist, is the transformation of a patient from arriving depressed, upset, and worried, to going home filled with hope. To Subject D, that is what therapy is all about and humor is the key. She believes that her patients' emotional level is as important, if not more, than what she does physically for them. She believes humor can enhance the physical rehabilitation part of treatment by changing a person's outlook or attitude into a more positive one, which is carried on after therapy.

Subject D also uses humor to help her patients put their problems in perspective, realize that they can survive their pain, and accept that they can still experience joy in their lives. She uses humor to instill in her patients her belief that people's attitudes can directly affect their ability to heal themselves. Humor helps her patients maintain their sense of dignity and develop a sense of autonomy.

Without humor, Subject D feels that health professionals would be limited in getting their jobs done. Without humor, there would be no emotional interplay between

patient and therapist and work would become monotonous and impersonal. Humor enables Subject D to work with patients who have similar diagnoses in an individual and enjoyable manner, often in order to obtain the same outcome.

Subject D - General Description

Humor plays a major role in Subject D's interactions with patients. It creates a feeling of connectedness with others, builds trust, increases participation in therapy, and increases overall quality of life for patients. Humor, as an intrinsic part of Subject D's life, offers her the opportunity to be creative in meeting her patients' needs. The immediate feedback of its successfulness allows therapists to change their approach and adapt their humor as necessary. By simply watching for opportunities to use humor, therapists can find way to cultivate a therapeutic relationship.

Subject D's role in using humor is to provide balance in her patients' lives. One of her main goals is to help them obtain a positive perspective on their lives so that they can experience hope and joy instead of pain and fear. Humor is the primary component in having a positive attitude toward life and helps patients maintain their autonomy and dignity.

Subject D uses humor with her patients to return some control to them and to increase their motivation for

therapy. Humor helps to develop a healthy rapport between patients and therapist, creates a mutually enjoyable environment, and increases success of treatment. Humor helps patients deal with embarrassing incidents and is used as a mechanism for coping with stress and pain. Humor has a transformative power and offers limitless opportunities for using creativity in therapy.

For Subject D, the lived experience of using humor as therapy is molding her humor to create mutually enjoyable interactions with patients in order to meet their needs for connectedness, attention, a sense of self-worth, a positive outlook on life, a sense of autonomy, a balanced life, and hope and joy in their lives.

Subject E - Specific Description

Subject E had never consciously examined her use of humor as therapy, but now realizes that she uses humor to benefit herself as much as she does for her patients. The advantage of using humor is that it helps Subject E to build a rapport with her patients. Her use of humor is spontaneous and comes about when she feels that a patient would appreciate it. Subject E uses humor to lighten depressing situations and keep her in a better mood. She tries to always keep a sense of humor for the mutual benefit of the patient and herself in creating a pleasant atmosphere for therapy.

Subject E experiences humor by taking a light approach in handling difficult patients, while still offering them some control. She also uses humor to empathize with patients who want some control over their lives. Humor frequently helps Subject E to make potentially unpleasant situations into ones that are mutually enjoyable.

Humor is a natural part of the majority of Subject E's interpersonal interactions. She uses humor spontaneously, but also applies her intuition and perception during the evaluation to determine whether humor would be appropriate for the particular patient. She often uses humor to alleviate uncomfortable and intrusive situations, such as when she's doing bathing training with modest male patients. She uses humor to release the tension and to create the therapeutic environment necessary for sustaining a relationship with her patients.

Subject E finds it easier to use humor with patients at the adult day health center where she also works. Subject E has longer term relationships with these patients, who are more comfortable and familiar with the staff and setting. Here, she is able to create a more fun and relaxed atmosphere and the reciprocal use of humor generally results in a mutual enjoyment of the therapy session.

There are some situations which Subject E feels are not appropriate to use humor. In those cases, she uses a more

straightforward approach. When a person has just had a stroke or has recently found out that he/she is extremely ill, Subject E feels that they will be more goal oriented in wanting to learn about their problems and how to resolve them and would not appreciate humor at that time. Subject E advises being cautious when using humor with patients who have major depression or anxiety. She avoids using humor with patients who are so anxious that they have difficulty focusing and also those patients with poor impulse control and poor attention. In these cases, Subject E feels that it is more important to stay focused on her treatment. With the depressed population, her use of humor is dependent on the degree of depression and whether or not she can elicit any type of response.

Another factor in Subject E not using humor is limited treatment time, especially when working in home care. However, she finds it helpful to relate stories to her patients when trying to make a point. She uses her actual life experiences to keep their attention and teach them certain principles or techniques, such as safety and dressing. The benefit of telling these humorous stories is that Subject E's patients tend to remember the point of her stories and apply it to themselves. Subject E finds herself tapping her inner resources when searching for humor. This includes identifying times she can laugh at herself by

finding that which is humorous even in difficult or embarrassing situations. She believes that even life's most embarrassing moments can be funny with the passage of time.

Subject E - General Description

Subject E's spontaneous, intuitive and perceptive use of humor facilitates successful therapy for her patients as well as herself. Humor can benefit therapists by lightening depressing situations, hence brightening their mood, and by creating a pleasant atmosphere in which to work.

Subject E uses humor with patients to offer them some control over their lives, create supportive relationships with them, build rapport, and keep them focused on the treatment session. Subject E naturally integrates her humor into therapy in various ways. In home care, humorous conversations are not convenient due to shortness of time, therefore, Subject E relates humorous personal stories to keep the patients' attention, but more importantly, to teach them techniques or principles about safety and/or dressing. This form of humor fits into occupational therapy's domain of learning life skills.

Subject E's therapeutic use of self with humor comes easier when applied to patients in the adult day health care setting. An increase in familiarity and comfort with one another arises out of the development of longer term relationships and establishes a more fun and relaxed

atmosphere. Reciprocal use of humor often takes place resulting in mutual enjoyment of the therapy session.

For Subject E, the lived experience of using humor as therapy is the integration of her intuitive, spontaneous, and creative humor as therapeutic use of self to increase function, decrease tension, redirect attention and teach life skills; this use of emotions to guide treatment effectively advances patients' healing processes, giving them a more positive outlook on life.

The Essential Description

The following is a description of the occupational therapists' lived experiences of using humor with elders as synthesized from the five subjects' interviews.

The lived experience of humor in occupational therapy with the elderly population involved the utilization of sensitivity, intuition, and creativity in order to provide the level of care essential to successful therapy. A personal satisfaction is experienced by the therapists who use humor. The natural and spontaneous attributes of humor equipped the occupational therapists with a tool to be applied in a variety of situations. Humor is the element used by these occupational therapists to create a pleasant, supportive, and mutually enjoyable atmosphere, and to build trust and rapport. The virtue of humor is the genuine, humane, and non-authoritative manner in which it contributes

to the maintenance of dignity and self-worth for patients and advancement of their healing processes. Humor is a means of facilitating balance as it increases participation in therapy and decreases pain and fear, increases motivation and decreases stress and tension, and increases overall quality of life while decreasing loneliness and depression for elders. Although humor with the elderly may have its limitations, it is the preferred treatment modality for helping patients to gain a positive perspective on life so as to experience hope and joy once again.

CHAPTER 5

DISCUSSION

Significant Themes and Dialogue with the Literature

The synthesized data from the five interviews resulted in 10 themes which were common to most or, in some cases, all of the subjects. These themes, which express the subjects' lived experiences of using humor with the elderly, are: humor with elders; humor as a trustbuilder; humor and the environment; spontaneous humor; the natural form of humor; limitations of humor; humor the connecter; humor as a coping mechanism; humor and rapport; and humor providing a positive outlook.

A second literature review was conducted as part of the process of phenomenological research. The findings of this study were then compared and contrasted with information found in the literature. A discussion of each theme as synthesized from the data is included in this section followed by a dialogue with the literature.

Humor with Elders

Four of the subjects expressed their feelings as to why the use of humor was important in treating the elderly population. Only one subject replied that she had not consciously thought about why humor with elders would be any different than with another population since this was the only population she had worked with.

Two of the subjects believed that the elderly were more lonely and depressed than the general population, as one stated, ". . . especially when they're older and they get sick, they start to feel sorry for themselves." Humor was used to "brighten their day" and as a way of helping them build personal relationships again. Another subject felt the need to inject humor in order to help her older patients deal with the many losses in their lives as a result of the aging process. Humor gave these patients the ability to keep proper perspective in their lives and helped to provide balance to their lives.

One subject believed that older adults were often neglected and not treated as "normal" human beings. She described, "When they're sick, they either get talked down to like they're a little kid, or people are afraid to touch them or talk to them." She explained that it was the genuineness of her approach with humor that resulted in effective therapy for her patients.

Several subjects stated that sensitivity was required when using humor with patients. One subject emphasized that humor should not be used indiscriminately because "particularly the elderly have some strong feelings about what is proper and what isn't since they were brought up differently." She felt that the elderly generation was more serious about taking things too lightly. Therefore, she felt

it was important to know the "lay of the land" before using humor.

The literature on humor and the elderly agreed with the subjects regarding increased depression and loneliness with this population (Erdman, 1991; Mitchell, 1993; Simon, 1988). The literature also pointed out that aged individuals suffered from chronic illnesses and inactivity and that a humorous approach could assist the elderly in facing some of the disappointments of old age (Adams & McGuire, 1986; Davidhizer & Schearer, 1992; Tennant, 1990). The literature did not mention the fact that the elderly had been brought up differently, therefore requiring sensitivity.

Humor as a Trustbuilder

Several subjects found humor to be a primary factor in building trust with their patients. One subject described a situation in which a quiet and complacent patient suddenly opened up and "gave all he could" in therapy after a humorous incident which displayed her humanness and resulted in his trust in her. "If they don't trust you, you're never going to be an effective therapist," she explained. Building trust was a necessary first step in developing a therapeutic relationship.

Many of the subjects mentioned the fact that occupational therapists work on functional activities of daily living, such as bathing and dressing, which often

involves getting close to the patients in order to help them perform personal and private tasks. One subject felt that most patients were distrustful of relationships and that therapists had to earn their trust. This trust was generally earned when therapists could relate to their patients and show that they genuinely care about them. Showing their humanness by laughing at their own mistakes is another way in which some of the subjects developed trust.

Little information on humor as a trustbuilder was found in the literature. However, the available literature supported the findings of this study, though not as in-depth as by these subjects. Schwartzberg (1993) stated that "Establishing and maintaining trust is preliminary to any therapeutic relationship" (p. 271). Bader (1993) described how his use of humor increased his patients' sense of safety and confidence in ways that built trust and enhanced the treatment. Other literature focused mainly on how humor could be used as an icebreaker, or for smoothing over embarrassing procedures and that humor could create a feeling of trust and friendship that eases events along (Herring, 1993; Strickland, 1993).

Humor and the Environment

All subjects found that their use of humor created an atmosphere conducive to successful therapy. The use of humor created a mutually enjoyable environment which also

increased patients' participation in the treatment session. One subject claimed that joking around with her patients loosened up the atmosphere and enabled her to attain the best results from them. Another subject felt that her group had a greater attendance and more success than another therapist who also led a group because her use of humor and laughter made it more fun for the patients. Two of the subjects reported that taking a lighthearted approach to therapy allowed the treatment session to flow more easily by creating a more comfortable atmosphere for the patients and putting them at ease.

Some of the subjects also mentioned how humor helped to "break up the tension" during uncomfortable or embarrassing situations which frequently occurred during ADL training. One subject gave an example of how she used humor to release the tension when she had to help an 80-year-old man bathe. She joked with him by saying such things as, "You know, my husband doesn't even get this kind of treatment. You're lucky." Comments such as these tended to produce a more relaxed environment for this subject.

Other examples of humor's effect on the therapeutic environment were expressed by subjects who treated patients in one room along with other therapists and patients. One subject described how the therapists would tease each other and laugh with one another in front of the patients. This

established a feeling of friendliness among those present in the room and enabled the patients to relax.

A few of the subjects also recounted lightening up situations in which language barriers created potential obstacles for successful therapy. Mutual laughter and smiling over mistakes and miscommunications established a sort of bond which brought about positive results. As one subject stated, "It worked out in the long run just because we saw the lightheartedness of the whole thing. . ." This lessened the stress of uncertainty for both the patient and therapist.

The literature supported the findings of this study. Numerous authors mentioned the use of humor in helping to establish a comfortable atmosphere (Audette, 1994; Ditlow, 1993; Dunn, 1993; Erdman, 1991; Mallett, 1993). According to Furman and Ahola (1988), "An atmosphere which is simultaneously respectful and humorous helps clients to talk about things more openly" (p. 5). Masagatani (1993) mentioned that it is occupational therapists' belief that humans can relate to human and nonhuman environments in a self-directed, purposeful, satisfying, and meaningful way and therefore, achieve and maintain a state of health.

Spontaneous Humor

Most of the subjects emphasized that the spontaneity of their humor enhanced the effectiveness of their treatment.

None of these subjects had ever gone into a treatment session with humor being formally planned into it. One subject felt that the use of humor was dependent on each therapist's personality and whether they were structured or flexible and open-minded in their approach. One of the subjects, in describing her use of humor commented that "It's automatic. I want to use it because that is part of me." Another subject had difficulty recounting specific examples of how she used humor because "it just happens." In addition, two of the subjects acknowledged that they had not actually consciously examined their use of humor in therapy; "I don't really feel like I'm using it as therapy because more or less, it just comes out when I find patients who seem like they would appreciate it," admitted one subject.

The literature had some support as well as some opposition over the use of humor spontaneously. Bader (1993) described one psychoanalyst's experience in using humor as "his own spontaneous use of humor and wit both reflected and strengthened the therapeutic alliance and promoted the analytic work" (p. 25). On the other hand, MacHovec (1991) claimed that because much humor occurred spontaneously, there was a lack of control over its direction and effect. Furthermore, Sumners (1990), in a study of the attitudes to humor of registered nurses, concluded that one of the problems with humor was its common use as a spontaneous

rather than as a planned intervention. She urged the expansion of nursing curricula to teach and assure the appropriate use of humor.

The Natural Form of Humor

One theme that emerged for most of the subjects was the natural and intuitive use of humor in their interactions. Some subjects believed that they were just fortunate to be born with or brought up with a sense of humor. One subject considered her style of humor with patients a natural extension of her personality. She described how it often took some time for her patients to get used to the dry humor she uses in therapy. However, in her opinion, this approach has proven to be effective as she feels she is able to get the really serious patients to work with her. Another subject mentioned how her intuition and instincts guided her use of humor with her patients. "You can usually get a sense of whether or not it would be appropriate to use humor," she stated. In synthesizing the findings, it appeared that the intrinsic quality of humor provided the subjects with an adaptable tool to be utilized in a variety of situations which promoted health and healing.

The literature was basically in agreement with this study. Dunn (1993) found that a majority of nurses mentioned intuition as being an important element in deciding when to use humor. Conboy-Hill (1990) defined intuition as a

"relatively untapped and unconscious process which allows us to meet other human beings at least half-way" (p. 15). Prerost (1985) stated, "In the absence of guiding principles and procedures for the inclusion of humor, the psychotherapist has been reported to insert humor during therapy on the basis of a personal intuitive sense when appropriate" (p. 67). According to Tooper (1984), humor has been a natural part of human life in all cultures.

Limitations of Humor

While the subjects believed that humor could be applied in almost any situation, they all agreed that certain circumstances and certain types of humor were contraindicated. Laughing with others as opposed to laughing at others was emphasized as an important factor. Timing was also mentioned as being crucial to the success of humor. Condescending humor or humor that "pokes fun" of others was stated by many subjects as being inappropriate. One subject said that if patients don't want to laugh, they shouldn't have to. "I don't wish to impose humor, but I do want to make it a viable option," she explained.

Humor was thought to be individually experienced and therefore, should not be "indiscriminately thrown around." The subjects felt it was necessary to determine the sort of humor to which the patients responded, or even if the patients responded at all, before using humor. Two of the

subjects stressed the role of empathy in determining whether or not to use humor. "It just depends on how the patient feels. If someone just had a stroke or just found out they were very ill, I don't think they're going to want to kid around," replied one subject.

While no specific rules guided the subjects' use of humor with elders, one subject stated that she was apprehensive about using humor with those who were very anxious or clinically depressed, depending on the degree of depression. "Some people are so anxious and have such poor impulse control that you need to stay really focused on your treatment. I don't think it's worthwhile to take a chance on using humor with them," she explained.

The literature was consistent with the findings of this study. Numerous authors stated precautions similar to this study and provided guidelines for the appropriate use of humor as an intervention (Erdman, 1991; Goodman, 1992; Hunt, 1993; Lippert, 1994; Pasquali, 1990; Robinson, 1991, 1993; Tennant, 1990). Experts cautioned that humor is destructive if used to ridicule and stated that sarcasm, put-downs, or racism were negative and untherapeutic and had no place in health care (Dunn, 1993; Hunt, 1993).

Another important factor, which was not specifically stated by the subjects, is to limit the use of humor in times when serious dialogue is initiated and at the height

of a crisis. For patients who do not value humor and who are not familiar with the use of humor as a way of coping with life, strategies that use humor are not likely to be beneficial (Davidhizer & Schearer, 1992).

Humor the Connecter

Several of the subjects maintained that laughing with someone is based on empathy, caring, and an inclusive approach. They explained how humor created positive bonds and described how shared laughter established a feeling of connectedness and belonging which enhanced the therapeutic relationship. As one subject stated, "The humor one shares with another can be very affirming. It indicates inclusion rather than exclusion and is a way of bonding among people." Another subject described how she, as an older therapist, was able to reminisce with her patients "so we had something to talk about that maybe no one else around us knew, but it's something we've shared and can laugh about." She felt lucky and fortunate that she and her patients could share their humorous memories together.

Better relationships with patients as a result of using humor were critical to the subjects' success in providing quality patient care. Humor also created group cohesiveness, which is important for the elderly who are gradually being stripped of meaningful relationships. As one subject stated, "Laughter is contagious. Even when someone in the group is

like a stuffed shirt, when the whole group laughs, that person will usually join in, too, and you'll have a more relaxed atmosphere and increased participation from the patients." Laughter and the personal closeness of group interaction reassures elders that they still have a sense of humor and that they belong and are appreciated. Two of the subjects mentioned that humor in the form of smiling or laughing helped to create a feeling of connectedness with their patients even though there were language barriers.

The literature supported the findings of this study. Much of the literature focused on laughter's ability to promote healthy relationships and an environment conducive to better health for everyone (Audette, 1994; Bader, 1993; Buxman, 1991; Davidhizar & Schearer, 1992; Erdman, 1991; Herth, 1990; Strickland, 1993). Banning and Nelson (1986) found that an activity structured for humor promoted group solidarity, and therefore concluded that humor can bring people together. Robinson (1993) explained how humor not only creates bonds, but strengthens existing bonds as well.

Humor as a Coping Mechanism

Most of the subjects found humor to be a coping mechanism in helping patients deal with a variety of problems and changes in their lives. Humor restored some control to patients and empowered them to cope better with pain, stress, fear, sorrow, and the losses which occur as a

result of the aging process. According to the subjects, humor enabled the patients to see the lighter side of their predicaments. Humorous conversations and anecdotal forms of humor helped to create a more fun, enjoyable, and comfortable atmosphere for the patients. Humor was also employed as an attention diversion technique, a tension reducer, and an uplifter.

One subject reported, "Humor just feels good. The physiological things that come along with laughing are very helpful. It just lifts your spirits and helps the patients rise above whatever pain they're in." Some subjects felt that it was also helpful to acknowledge their patients' courage to laugh in spite of fear and pain. Another subject believed that humor was a disposition of mind or feeling to make life more tolerable and enjoyable. She stated, "Smiling can make a person feel better by providing a physical and psychological boost. So, I think residents at long-term care facilities should be encouraged to smile."

One subject described her facility as a "gloomy and depressing" place for her patients and that humor was often the only element which brightened things up. Some subjects used humor to cope with potentially embarrassing situations. When the subjects responded to the situations lightly as opposed to seriously, the patients were more willing to work with them again. Other subjects used humor to divert

attention away from their patients' fears and toward the therapeutic activity.

One subject described a situation in which a combination of humor and occupational therapy gave a patient, who was grieving over the loss of her husband, "a reason to live when she was sure that she should die." Incorporating activities which were intrinsically rewarding to the patient brightened up her disposition and attitude and redirected her attention from her problems to the task at hand. The lighthearted atmosphere in the treatment room inspired her own laughter and encouraged socialization with others.

In general, it appeared that the subjects found humor to be a versatile coping tool which could be individually applied to each patient's unique situation and predicament. Humor appeared to promote both psychologic and physiologic healing. As one subject expressed, "I think what makes me feel the best is when I see somebody coming in who is really depressed, upset, and worried about themselves and seeing them go home in a couple of weeks with lots of hope, and to me, that's what therapy is all about. And I think humor really is the key."

The literature supported the importance of humor as a coping mechanism as conveyed by the subjects (Audette, 1994; Bennett, 1991; Cousins, 1979; Ditlow, 1993; Dunn, 1993;

Goodman, 1992; Hague, 1994; Mallett, 1993; Robinson, 1991, 1993; Saper, 1990; Strickland, 1993; Thorson & Powell, 1993). The literature also pointed out that "even when the chronic disability of an elderly patient cannot be corrected, humor offers a way to make the unchangeable more tolerable (Davidhizar & Schearer, 1992, p. 276). Humor was also described as a powerful coping mechanism which may play a role during terminal illness (Herth, 1990). Herth (1990) found that humor for the terminally ill provided a bridge, or connecting mechanism, that could lead to relaxation, hope, connectedness, perspective, and joy.

Humor and Rapport

Humor was a major factor for most of the subjects in building rapport with their patients. One subject defined humor as an "icebreaker" used to establish emotional contact with her patients. Some subjects explained that being genuine in their approach made a big difference in whether or not they could build a good rapport. "When I joke around with them, they know I'm being genuine about it and not putting on a show. . . and you get better results that way. If you're trying to be funny, they can catch on to that," stated one subject. Another subject found that going into the treatment session with an open-mind and sharing laughter over humorous incidents helped to build a rapport and create a relaxing atmosphere. In comparing the pediatric population

with the elderly population, one subject explained that humor worked better with elders because she could "have a conversation or share life experiences with them and try to build a rapport." Another subject used humor in order to be "on the same wavelength" as her patients. She believed that "building a rapport helped the treatment session go smoother by not making it all work." For these subjects, humor has initiated a positive therapeutic relationship with their patients.

The available literature supported the findings of this study, although in much less detail than the subjects in this study. The literature merely noted that humor helped to establish rapport (Buxman, 1991; Davidhizar & Schearer, 1992; Hunt, 1993; Lippert, 1994). One finding from the literature, which was not brought up by the subjects, was that a sense of rapport was necessary even before attempting to use humor with patients (Erdman, 1991).

Humor Providing a Positive Outlook

Several of the subjects found humor to enhance life, change perspectives, and foster joy. The subjects in this study used humor to help patients achieve some balance in their lives through development of a more positive attitude. A sense of humor, to these subjects, was a way of looking at the world and keeping a positive outlook on life. Many of the subjects used humor during the treatment session as a

way for patients to focus on the lighter side of situations rather than on their problems. One subject said, "We need to remind patients of how useful humor is, and to keep proper perspective, and to see how much there still is to do and to look forward to."

Some subjects believed that humor had the unique ability to change negative situations and attitudes into more positive ones which let patients look at situations in a broader different perspective. The subjects also found that humor enabled patients to experience hope and joy in their lives again instead of the pain and fear which seemed to have taken over. One subject emphasized that dealing with her patients' emotional levels was as important, if not more, than what she did physically for them. She stated that, "Humor can enhance the physical rehabilitation part to make it work much faster and can change a person's attitude so that they leave treatment with a more positive outlook than they had before treatment."

The literature corroborated the data from this study. It was noted that humor promoted a positive outlook and that humor could be utilized as an emotion-focused strategy to change perceptions of painful or stressful events (Lippert, 1994; MacHovec, 1991; Mitchell, 1993; Tennant, 1990; Tooper, 1984). In reference to the healing power of humor, when a positive attitude is present, patients feel better, take a

more active role, and focus outside the illness (Ditlow, 1993; Robinson, 1993). Haig (1988), Herth (1990), Pasquali (1990), and Strickland (1993) discussed the beneficial contribution of humor in providing balance in life through perspective.

Implications for Occupational Therapy

This study explored the ways in which humor could be used with elders in the field of occupational therapy. The following are implications for incorporating humor as a modality in occupational therapy. Implications for further research on this topic may also be drawn from these examples.

Many of the subjects in this study mentioned humor's ability to increase the patient's physical and psychological functioning in therapy. This is in keeping with occupational therapy's holistic approach to treatment, since the occupational therapy performance components of sensory motor, cognitive, psychological, and psychosocial skills must be taken into consideration whenever assessing and treating patients. In addition, humor was found to promote group cohesiveness and stimulate social interaction, therefore being a useful component in evaluating a person's social functioning, especially for elders who tend to be more isolated from society.

All of the subjects spoke of humor's influence in

establishing an atmosphere conducive to therapy. Included in occupational therapy is the adaptation of the environment in order to achieve maximum independence and enhance quality of life. The use of humor in occupational therapy created a safe and comfortable environment for elderly patients, who are often fearful of trying new activities, and increased their motivation and participation in therapy.

The occupational therapists' use of self is crucial to engaging the patient in occupational therapy. The subjects described how empathy and caring, which are essential to establishing a therapeutic relationship, were demonstrated through their use of humor. They applied their instincts and intuition for the appropriate use of humor, which increased their success in and mutual enjoyment of therapy. Humor, as a therapeutic use of self, was also used to build a therapeutic rapport with patients. Participation in this humanistic relationship returned hope, joy, dignity, and autonomy to the elderly patients' lives.

The major focus of occupational therapy intervention is the performance areas of self-care, work, and leisure. The subjects mentioned humor's role in promoting patients functioning in self-care. Humor facilitated learning as one subject utilized humorous stories, based on actual life experiences, to teach patients about safe transfers and proper dressing techniques. Using humor to minimize the

tension of uncomfortable situations during bathing and toileting inspired patients to work harder at mastering these skills. Humor was also a factor in influencing patients' emotional self-care.

Most of the subjects described how humor helped to provide a more positive outlook on life for their patients. There are times, when working with terminally ill elders, that improving or even maintaining function will not be appropriate goals in occupational therapy. Decreasing pain, providing choices as a means of increasing independence, and providing support and opportunities for expressing feelings are more appropriate goals for this population. In these cases, occupational therapists can incorporate humor in assisting patients to identify existing strengths and capabilities and fostering social competency in order to maintain some degree of participation in life roles and purposeful activities. Humor can be used in promoting a positive outlook toward the aging process, with a focus on quality of life rather than quantity. Humor also provides a sense of perspective which empowers patients and gives them a sense of self-worth.

Recommendations for Future Research

The paucity of literature on the use of humor in occupational therapy leaves the window of opportunity wide open for further research in this area. The results of this

study suggest a number of topics for future research. While this study concentrated on elders in particular, there did not appear to be much variation among the subjects in their use of humor with this population. One subject did report that there was a difference between using humor with elders versus the pediatric population. One implication for research from this study includes replication with different patient populations. Such populations could include different age groups (pediatrics), genders (male or female), or diagnostic groups (psychiatric). Further research would provide a more complete understanding of the use of humor from various occupational therapists' perspectives.

In a similar manner, replication of this study with a different subject population could prove worthwhile. One subject stated that it was easier for her to relate to her elderly patients since she was older as well. She felt lucky that she and her patients could share in the reminiscence of humorous events of long ago. Further research on the use of humor with elders from the perspective of older (50+ years old) practicing occupational therapists would be beneficial in explaining the significance of humor with elders in more depth.

While the nuances of cultural differences were not explored in this study, several subjects commented on language differences as being a potential barrier to using

humor. Different cultures may also have different understandings of what is funny and what is not. Therefore, a study on what humor means cross-culturally, from both the occupational therapists' and the patients' perspectives, would be worthwhile.

This researcher concurs with one of Vergeer's (1992) topics for future research which suggests examining the occupational therapy patients' experiences of humor in therapy, also applying the phenomenological method. Because this research and Vergeer's (1992) both studied the use of humor from the therapists' viewpoint, exploring the phenomenon from the patients' perspective is integral in providing a more thorough understanding of the therapeutic use of humor in occupational therapy.

All of the subjects in this study acknowledged their informal and spontaneous use of humor. None of the subjects had ever attended a humor workshop or applied planned humor to their practice. Some subjects maintained that therapeutic humor could not be used effectively if implemented formally. Further research should examine the outcomes of planned humor or the effectiveness of humor workshops using occupational therapists as control groups. An efficacy study would determine the value of formalized humor.

Another topic in which further research would be useful is whether the role of humor is included in the occupational

therapy curriculum and how it is conveyed to students. One subject revealed that she had become much more aware of the use of humor in therapy when a couple of her professors mentioned its benefits. She recalled feeling relieved that she could incorporate her intrinsic use of humor into occupational therapy while still being "professional." Therefore, it would be interesting to study the impressions that professors give their students regarding the use of humor in therapy.

This study raised other questions with respect to the use of therapeutic humor. Several subjects felt that it was necessary to use humor because the elderly tended to be depressed and humor appeared to uplift them. Further research would be valuable in defining the role of humor in decreasing depression. A similar topic which could be studied is humor's effect on stress, since many of the subjects reported humor's ability to release tension.

Summary

This study, which is an expansion of the only known study on the experiences of occupational therapists who use humor in their practice (Vergeer, 1992), examined the therapeutic use of humor in occupational therapy with the elderly population. Application of the qualitative phenomenological method of research enabled the researcher to explore the lived experiences of five occupational

therapists who use humor in their practice with elders so that these experiences could be better understood.

Common themes, which revealed the essence of the experiences, were established through examination of the data. These themes were then compared with the literature and analyzed to ascertain implications from the study for the field of occupational therapy. Lastly, recommendations for further occupational therapy research were made.

Results of this study add to the growing body of qualitative research by occupational therapists that attempts to understand phenomena such as humor from the individuals own, unique perspective. This study not only showed that humor and laughter are healthy therapeutic tools, but that humor is a part of life which needs to be valued, nurtured, and cultivated. It is this researcher's hope that this study will direct future, relevant occupational therapy research.

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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: Jennifer M. Chin
204 Ewing Terrace
San Francisco, CA 94118

FROM: Serena W. Stanford Serena W. Stanford
AAVP, Graduate Studies & Research

DATE: September 19, 1995

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

"The Experiences of Occupational Therapists Who Have used Humor Therapeutically with Elders"

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 Serena Stanford, Ph.D., 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 me at (408) 924-2480.

APPENDIX II

COVER LETTER FOR CONSENT FORM

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

College of Applied Sciences and Arts • *Department of Occupational Therapy*
One Washington Square • San José, California 95192-0059
Main Office: 408/924-3070 • Fieldwork Office: 408/924-3078 • FAX: 408/924-3088

CONSENT OF AGREEMENT TO PARTICIPATE IN RESEARCH
SAN JOSE STATE UNIVERSITY

Responsible Investigator: Jennifer M. Chin, O.T.S.

Title of Protocol: The Experiences of Occupational Therapists Who Use Humor Therapeutically with Elders

1) I have been asked to participate in a research study investigating the use of humor as therapy in occupational therapy with elders. The results of this study should further the understanding of the benefits of humor in the therapeutic relationship.

2) I will be asked to think about my utilization of therapeutic humor in my practice, followed by an audiotaped interview. The interview will take place at a time and place most convenient for me.

3) No risks are anticipated from participation in this study.

4) The benefits that may be gained from this study is increased insight into my use of therapeutic humor and how elderly patients respond to humor. From this study, occupational therapists and other health professionals who wish to use humor as a therapeutic tool, may increase their awareness of the issues and the continuums in the nature of humor.

5) The results of this study may be published, but no information that could identify me will be included without my permission.

6) Any questions concerning this research study will be answered by Jennifer Chin, O.T.S. at (415) 922-4581. Any complaints about the research may be presented to Gordon Burton, Ph.D., OTR, Graduate Coordinator at (408) 924-3074 or Amy Killingsworth, Interim Chair, Department of Occupational Therapy at (408) 924-3070. Questions or complaints about research subject's rights or research-related injury may be presented to Serena Stanford, Ph.D., Associate Vice President of Graduate Studies and Research, at (408) 924-2480.

7) My consent is given voluntarily. 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.

APPENDIX III

CONSENT OF AGREEMENT TO PARTICIPATE IN RESEARCH

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

College of Applied Sciences and Arts • *Department of Occupational Therapy*
One Washington Square • San José, California 95192-0059
Main Office: 408/924-3070 • Fieldwork Office: 408/924-3078 • FAX: 408/924-3088

Date:

Dear

Thank you for agreeing to participate in my study on the therapeutic use of humor by occupational therapists. As I mentioned in our discussion, my main focus for this study is the experience of occupational therapists who use therapeutic humor (either formally or informally) in their practice. My target patient population is older adults. In accordance with the phenomenological method of research I will be using, I will ask you to describe your experiences from your perspective only. No leading questions will be asked of you.

Our interview is scheduled for _____. Because it is difficult to estimate the length of the interview, due to the open-ended nature of this study, we should allot at least an hour. In addition, I will be audiotaping the interview.

As we discussed over the phone, I will be asking you to inform me of the ways in which you have used humor as therapy with the elderly population. In order to prepare for our interview, please give some thought to your use of humor in occupational therapy and the outcomes of these situations.

I have enclosed two copies of a consent form for participation in research. Please read and sign both copies if you are in agreement and bring them to the interview.

I look forward to our meeting on _____. Please contact me at (415) 922-4581 if you have any questions. Thank you.

Sincerely,

Jennifer M. Chin, O.T.S.
Graduate Student

Enc: CONSENT OF AGREEMENT
TO PARTICIPATE (2 copies)

8) I have received a signed and dated copy of this consent form. My signature indicates that I have read the information provided above and that I have decided to participate.

Subject's Signature_____ Date_____

Investigator's Signature_____ Date_____