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Susan Lutzke-Hoff
How Palliative Care
Professionals in Multicultural
or Monocultural Dyads
Incorporate Humor in Their
Work?

ABSTRACT

Some religions/people believe that a persons' core being, or spirit will cease to be at death, some believe in reincarnation, and others believe in eternal life. With the seriousness of one's spirit ending, transforming, or transitioning from this life to another, some believe it is a most solemn and serious time, where there is no room for humor. Others believe there are no boundaries to contain humor. It is part of life and death.

The objective of this qualitative study was to explore how palliative care professionals in multicultural or monocultural dyads incorporated humor in their work. The narratives in this study offered positive and negative experiences of thirteen palliative care professionals. The study utilized an interview questionnaire guide, a demographic information questionnaire, and the Multidimensional Sense of Humor Scale developed by Dr. James A. Thorson and F. C. Powell (1993).

A growing body of research is demonstrating that the use of humor in palliative care is both positive and normalizing for the client, allowing the client to continue to live while dying. Social workers are encouraged to be aware of cultural differences and actively to explore the diverse cultures of their clients.

HOW PALLIATIVE CARE PROFESSIONALS IN MULTICULTURAL OR
MONOCULTURAL DYADS INCORPORATE HUMOR IN THEIR WORK?

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2009

ACKNOWLEDGEMENTS

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged.

I wish to thank the compassionate staff of Providence Hospice / Seattle, specifically the Transitions program team; the thirteen empathic, giving and honest professional participants; my research advisor, Dr. Gael McCarthy for her patience, understanding, generous time and super woman efforts, my Smith College School of Social Work close friends: Sonnie and Jaeyoun; Liane Hartman the formatting guru; and my family for their ever-present support and encouragement.

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CHAPTER I

INTRODUCTION

"According to most studies, people's number one fear is public speaking. Number two is death; death is number two... . This means to the average person, if you go to a funeral you're better off in the casket than doing the eulogy," Jerry Seinfeld (2Spare, 2009). To aid us in managing our fears of death and dying we utilize a variety of adaptive coping mechanisms. According to Valliant's research throughout life we heal ourselves through involuntary (unconscious) coping mechanisms (2002). Humor is one of the mature coping mechanisms and has been found to be beneficial in many ways both physiologically and psychologically (McCreddie & Wiggins, 2007; Capp, 2006; Boyle & Joss-Reid, 2004; Adams, 1998; Martin, 2004; Franzini, 2001). It seems that one of the most efficacious situations in which to utilize humor would be in palliative care both by the patient and the clinician. There has been some past research investigating humor in palliative care settings (Adamle & Ludwick, 2005; Langley-Evans & Payne, 1997). This information about: humor being present in professional-based hospice visits and the humor initiated by the patient; the lighthearted and humorous nature of patient 'death talk' serves an important psychological function in allowing patients to distance themselves from their own deaths while simultaneously permitting an acknowledgement of their terminal condition may cause social workers to wonder how they may integrate humor into their work in order to support their end-of-life patients' needs in palliative care.

Social workers support clients who cover the entire spectrum of demographics: race/ethnicity, sexual orientation, religion, age, socioeconomics, gender, education and others. Given that death has no boundaries and that humor is beneficial using it would seem generally indicated: however are there multicultural or other barriers that would inhibit a clinician from utilizing humor with their end-of-life clients? The objective of this study is to explore how palliative care professionals in multicultural or monocultural dyads incorporate humor in their work in the hope that the information gathered may inspire further work and help social workers appreciate the benefits and challenges of incorporating humor in palliative care work.

Issues in End of Life Care

Curative care refers to those treatments and therapies provided to a person with the intent to improve symptoms and cure the person's medical problems. Chemotherapy, immunizations, and antibiotics treatments are all examples of curative care. The act of "doing" to fight the illness is the focus: ramping up the medications, going through another round of chemotherapy, or driving eight hours to the medical center in a neighboring state to participate in a new drug research study.

One of the most weighty and life changing decisions for a person or a person's family living with terminal illness is the decision to shift from the aim of curative care to palliative care. The departure is away from the quantity of life to not preferring years or months longer even if in pain or disability. The purpose then is the quality of life for the remaining time of living.

Palliative care is the comfort / supportive care that provides relief, but does not attempt to cure a person's terminal illness. Palliative care respects the goals and choices

of the person, mitigating the physiological and psychological pain and suffering, providing social and spiritual support to the person and family members, and helps gain access to needed health care providers and appropriate settings (Robert Wood Johnson Foundation, May 12, 2009). For some it may be a drastic change from actively "doing" to the act of "being": being with self, and with those close family and friends. This radical shift may almost seem foreign.

Many people have anxiety and some people with a terminal illness have both anxieties that are similar to those of us without an illness and other anxieties very specific to their situation in reference to their diagnoses, their demographics, and where they are in the span of their life. Their anxieties can be internal and external, insurmountable, dealing with fears of the unknown and the known. How do they cope with terminal illness and all of their anxieties? End of life care workers have seen people use denial to disavow their predicament: use prayer to stay connected with their spirituality, or seek out professionals to help cope and some use humor to make light of their situation.

Using humor can mean the ability to see that something is funny, or the enjoyment of things that are funny. In my palliative care internship it became very evident that people at the end of their lives are still very much alive. Being alive for some terminally ill people may mean finding humor even in the most macabre of situations as a way to cope. For some also to give normalcy to their lives they still need to laugh.

There are a plethora of professionals -- in many different environments -- who work with people at their end of lives. The palliative care team could consist of: social workers, nurses, nurses' aides, medical doctors, psychologists, psycho-oncologist, psychiatrists, chaplains, alternative therapists and many more. Each professional utilizes

specific skills to provide compassionate support and advocacy. This thesis is an attempt to bring forth much of what I wish I had known prior to beginning work in the field of palliative care -- with a special concern that my sense of humor might "get in the way" of the therapeutic relationship.

The field of palliative care has grown over the years, and there are many good books and professional journals dedicated to the subject matter. However, there is a scarcity in the literature of specific skills and techniques used by professionals to engage with, and support terminally ill clients through the use of humor, specifically in multicultural dyads.

Clinicians, with or without a sense of humor who are new to the palliative care field may be in need of this information, which in turn will hopefully benefit those vulnerable people facing their own death. This study includes information about stressors for end of life clients. It explores age appropriate coping mechanisms for people generally and those used by the terminally ill and dying. The project aims in particular to explore humor its benefits and detriments, the uses of a sense of humor, of possible therapeutic interventions with humor, and the importance of cultural competency for clinical professionals. This exploratory/descriptive study will investigate the personal sense of humor, knowledge, and skills of 13 experienced palliative care professionals. The study examined the clinicians' views about the impact of matching or not matching clients in terms of demographics when using humor: of multicultural and monocultural aspects of the use of humor in a palliative care settings. The research method is qualitative in nature and was carried out through semi-structured interviews.

This thesis is organized by an Introduction in which the rationale, problem, and purpose are presented. Next, the Literature Review will provide additional details of prior research concerning stressors and coping mechanisms in terminally ill clients. The clinicians' opinions about the benefits and risks of humor in their work are explored in depth. The Methodology chapter describes how participants were selected and how data were collected and analyzed. Following the Methodology chapter, a Findings chapter presents the narrative findings of the research organized by common and divergent themes in participants' responses. Finally, there is a Discussion chapter summarizing the findings, presenting my own opinions about significance of the findings and limitations of the study, and offering suggestions for further research on the topic.

It is my wish that this thesis be taken as the beginning and a continuation of an understanding about the many nuances, difficulties, and joys of humor in multi / mono-cultural dyads in palliative care. This thesis is not intended as a guide to palliative care with the use of humor, and does not seek to teach the correct or proper way to interact with people in end of life. It does, however, enlighten the reader about some of the practices and opinions of experienced palliative care professionals, especially in the area of humor – admittedly, so dear to my heart

CHAPTER II

LITERATURE REVIEW

Introduction

This chapter will survey research pertaining both to the roles and techniques that palliative care professionals use in their work with their dying patients and in particular will address what may pertain to the use of humor with culturally matched or not matched client-therapist pairs. Settings that address palliative care social work include hospitals, hospices, home care, nursing homes, senior centers, family service agencies, among other settings. While the field of palliative care social work has grown over the years, there continues to be a scarcity in the literature of research studies on specific techniques used by workers to engage with clients, assess their needs, and incorporate humor in their work with clients throughout end-of-life care, as well as clinicians' experiences and observations working in the field. As the National Association of Social Workers (NASW) notes: "Palliative and end of life care is a growing area of practice, and social workers may feel unprepared to deal with the complex issues it encompasses" (2005, p. 8). There are several texts dedicated to palliative care in social work. (Examples of texts include: *Living with Dying: A handbook for end-of-life healthcare practitioners; Palliative Care, Social Work and Service Users; and Social Work Practice With the Terminally*) and several professional journals (Journal of Social Work in End-of-Life and Palliative Care; Omega: Journal of Death and Dying; Journal of Palliative Medicine; Hospice Journal). These writings essentially focus on the stages a client passes through

during end-of-life care, the importance of a holistic approach and including family in the process, and options available, such as hospice care.

The literature on death and dying is quite broad. However, this chapter primarily focuses on the previous aspects of research regarding the use of humor in end-of-life care and the issues closely pertinent to use of humor. First, there is a general description of the stressors of the terminally ill, and then coping and defense mechanisms. Next there is a summary of humor research: the benefits and risks of using it, what a sense of humor comprises, therapeutic humor interventions, and possible resistances to it. A short discussion on ethnographic sensitivity then follows including a discussion of what it means to be culturally competent.

Stressors of the Terminally Ill

Here in this social community (the United States), there has been a history of denial and discomfort with thinking and talking about death. "For many years, society featured the strategy of ignoring death and practically everything connected with it, including the dying," (Kastenbaum, 2004, p. xvii). This is supported by Sulmasy's study reporting that seriously and terminally ill hospitalized patients spend almost all their time alone (2002). Perhaps to some people the dying, the terminally ill are already dead; this concept has been internalized in some of the terminally ill and they feel no self-worth or value. Singh concurred, "Some see the terminal prognosis sadly and bewilderingly as life's statement of their lack of unique value," (2000, p. 97). Kastenbaum added that for a person diagnosed with a terminal illness, "... [negative] self-evaluation can undermine one's sense of identity," (2004, p. 115).

“People with a potentially life-threatening disease are likely to feel overwhelmed emotionally,” (Sigal, Ouimet, Margolese, Panarello, Stibernik, & Bescec, 2008, p. 61). They face not only the daunting fact of their own mortality but a plethora of other stressors, whose accumulation may be just as disconcerting as the thought of death itself. Some of the issues people with a terminally illness were: change in activity level, reduced functionality, becoming more dependent on others, role changes, family member stressors, loss of control, being a financial burden, wanting and not wanting more information, changes in their disease status, what and when to tell family members, spirituality issues, fear of death, fear of the dying process, of pain, of suffering, or a prolonged dying process (Kutner, Steiner, Corbett, Jahnigen & Barton, 1999). In the McPherson, Wilson and Murray study (2007) evidence suggests that self-perceived burden is an important problem faced by many patients at the end of life. Many terminally ill clients fear that they will be "subjected to unnecessary and intrusive medical intervention when near death, with enduring and undesirable consequences for themselves and their loved ones," (Elliott & Olver, 2008, p. 178; McPherson, et. al, Kutner, et. al). They live with multiple hospitalizations, questions of insurance coverage or lack thereof, increasing medical bills, side effects of medications and treatment, nausea and weakness, bodily changes, loss of familiar routines, disruption of family life, separation from family, friends and pets, impaired cognitive abilities, unresolved conflicts, work obligations, loss of intimacy, decrease in the quality of life, leaving the family behind, no long-term future, unmet goals, questions about meaning of life, and leaving a legacy.

With all these stressors people with terminal illness have, it is not only important to be able to cope in a few ways, but to be able to draw from an arsenal of coping skills. We define coping as “efforts individuals make to master, reduce, or tolerate the demands created by stressful situations,” (Gadzella, Pierce, & Young, 2008, p. 2). Some of these coping skills we learn at a very early age.

Coping Strategies

Structural theory is named in reference to Freud's three structures that make up the human psyche: the id, ego, and superego. When we talk about coping strategies within structural theory we are referring to ego defenses. "Defense mechanisms are among the most important of the ego functions; they protect the self from both perceived and real dangers," (Berzoff, Melano, Flanagan & Hertz, 2002, p. 79). If the threat of death and dying is not mitigated it could result in anxiety or depression. Our coping / defense mechanisms help us restore our psychological balance. Defense mechanisms can provide mental respite to mitigate those changes in reality and self-image that cannot be immediately integrated such as the loss of a limb (Vaillant, 2000).

It has been widely theorized that there is a hierarchy of the defense mechanisms starting with those that we develop as children and those that evolve as we mature with age. Some developmental psychologists believe that these defense mechanisms, like other cognitive operations, are part of normal development. Each individual defense has a developmental history in that, "the defense is present in an early form at younger ages, becomes more prominent during its age-appropriate period, and then gradually declines in importance, while a new, more mature defense now becomes predominant," (Cramer & Brilliant, 2001, p. 298). This was supported in Vaillant's longitudinal study of Harvard

undergraduate sophomores over a more than 35 year period he found that with time, immature coping evolves into more adaptive coping strategies or mature defenses (2002).

The clients that we work with in palliative care span the chronological age continuum from infants to the "old" old. It is pertinent for social workers to understand the defense and coping mechanisms for each life stage.

Early Defense Mechanisms

Cramer describes a theory of defense mechanism development in which the life history of every defense begins in an innate reflex (1997). Cramer states that "denial the most primitive defense, begins in the innate blink reflex, which protects an infant from overwhelming visual stimulation"; the denial defense obstructs specific events or stimuli that are threatening to us, to our ego (1997, p. 234). The projection defense is a more mature defense than denial, and "... it requires the ability to differentiate between internal and external stimuli," (Cramer, 1987, p. 599). It allows us to propel unbearable impulses or anxieties onto someone else; then, we may then feel victimized by the other person and spare ourselves the anxiety of feeling our own responsibility by blaming them for our impulses or anxieties. The good versus evil and right versus wrong dichotomies fall into this category. The identification mechanism is a more mature defense than denial or projection, and it requires the ability of the child to differentiate self from others. "A child makes someone or an aspect of someone a part of themselves," (Mitchell & Black, 1995, p. 39); for example, a boy enjoys being in the woods like his mother. Considered an immature defense, acting out involves overtly expressing inappropriate wishes, impulses, and fantasies in behaviors rather than inhibiting them or expressing them in words.

Advancing Defense Mechanisms

In middle or latency age of childhood, the repression defense begins to appear. Repression implies completely forgetting: "... thoughts, memories and feelings protecting the self from unwanted knowledge, fears, or disappointments too difficult to bear," (Berzoff, et. al, 2002, p. 89). The reaction formation defense occurs when acknowledging an unacceptable impulse or emotion is avoided or transcended by emphasizing its complete opposite. For a child, reaction formation may be used, for example, to keep the child consciously unaware of the continuing, socially unacceptable pleasures involved in blowing the nose. A child is using the isolation defense when repressing the affect associated with a thought so that the thought has a "neutral" quality: for example a child describing the experience of a bone marrow transplant in a matter of fact tone and having trouble answering when asked how he felt about it (Davies, 2004). The doing and undoing defense is the expression of a negative impulse, immediately followed by the direct opposite; a child angry with her oncologist undoes the impulse by being over-anxious or remorseful (Davies, 2004,). The turning against self defense entails punishing oneself for having forbidden impulses - a child feels guilty and "beats herself up" -- criticizing herself due to the anger she may have towards her parents (Davies, 2004).

More Mature Defense Mechanisms

With time the immature coping evolves into more adaptive coping strategies. Berzoff mentions sublimation and humor as more mature coping strategies. The Vaillant longitudinal research found that the four mature coping strategies were sublimation, altruism, suppression, and humor (2002). The American Psychiatry Association (APA)

has assigned levels to the different defense mechanisms, the "high adaptive level" lists those most optimal in adaptation to handling stressors. They are: anticipation, affiliation, altruism, humor, self-assertion, self-observation, sublimation, and suppression (2000).

Altruism is considered to be the quality of unselfish concern and devotion to others. The Vaillant research states that it "... involves getting pleasure from giving to others what we ourselves would like to receive," (2002, p. 63). Suppression is the conscious decision to delay thinking about anxiety-producing things. "An individual uses suppression when faced with emotional conflict or internal / external stressors by intentionally avoiding thinking about disturbing problems, wishes, feelings or experiences," (APA, 2000, p. 813). Sublimation involves a process where "... the ego transforms asocial sexual and aggressive wishes into derivative behaviors that are socially acceptable," (Berzoff, et. al, 2002, p. 92).

Vaillant states that "humor permits the expression of emotion without individual discomfort and without unpleasant effects on others," (2000, p. 95). "Humor can be regarded as the highest of these defensive processes," for humor "scorns to withdraw the ideational content bearing the distressing affect from conscious attention, as repression does, and thus surmounts the automatism of defense," (Freud, 1905, p. 233). Vaillant adds that "mature humor allows people to look directly at what is painful, and transform the pain into the ridiculous," (2002, p. 63). Do people with chronic and terminal illness utilize the same or different coping / defense mechanisms?

Coping Strategies Used by the Chronic and Terminally Ill

It was reported that the participants in one study, all diagnosed with end-stage renal disease who were more inclined to use problem focused strategies "... relied on a

fighting spirit as an adjustment coping style,” (Gilbar, et al., 2004, p. 471). In another study in the UK, where patients in a palliative day care facility were observed for seven weeks, they, “... proposed that the light-hearted and humorous nature of patient ‘death-talk’ serves an important psychological function in allowing patients to distance themselves from their own deaths whilst simultaneously permitting an acknowledgement of their terminal condition,” (Langley-Evans, & Payne, 1997, p. 1091). In a study with patients in critical care, researchers found humor served to enable co-operation, relieve tensions, developed emotional flexibility and helped to humanize the healthcare experience for both the caregivers and the client (Kinsman & Major, 2008). Jones' (2008) study of patients' humor noted that it consisted of silliness, bodily function jokes and lightheartedness to reduce stress, enhance quality of life, and foster acceptance of death. In Minear's research about quality of life with the terminally ill, thirteen central themes emerged; humor was one of them (Minear, 1998). The Culver, Arena, Wimberly, Antoni, and Carver research study of minority women with breast cancer found that there were only two differences in their three groups compared to non-Hispanic White women: the African American and Hispanic groups both reported using humor-based coping less, and religion-based coping more (2004). Humor has been mentioned several times now as an effective coping strategy for some and maybe not as much for others. What is it about humor?

Humor

The late Norman Cousins wrote about his experience of laughing himself back to health after suffering a serious chronic disease. "I made a joyous discovery that ten minutes of genuine belly laughter had an anesthetic effect and would give me at least two

hours of pain-free sleep" (Cousins, 1979, p. 39). Freud wrote an entire volume on the subject in 1905. There has been an outpouring of humor research studies: Adamle, 2005; Adams, 1998; Berk, 2001; Boyle, 2004; Capps, 2006; Franzini, 2001; Jolley, 1982; Langley-Evans, 1997; Martin, 2004; McCreaddie, 2007; Mindess, 1998; Streat, 1994; Thorson and Powell, 1993; Valliant, 2000, and many others. Several text books at Smith College School of Social Work talk about the use of humor in therapeutic relationships. One in reference to cognitive behavior therapy states, "Humor can have positive effects on the patient's ability to recognize cognitive distortions, express healthy emotions, and experience pleasure," (Wright, Basco, & Thase, 2006, p. 34). Another text in reference to working with children and adolescents notes "Having a sense of humor in working with adolescents doesn't necessarily refer to the practitioner's ability to be funny in the comedic sense, although that might prove to be an asset if exercised with good judgment and timing," (Malekoff, 2004, p. 25). Taken together, this substantial literature suggests that there is some basis for credence in the cliché "laughter is the best medicine."

Psychological Benefits of Humor

Freud himself said, "Humor has the function of 'preserving the sense of self... . It is the healthy way of feeling a 'distance' between one's self and the problem, a way of standing off and looking at one's problem with perspective," (1959, p. 129). Capps's research provides a review of recent empirical studies of the psychological benefits of humor "Humor may help a person cope with negative life experiences and ... may counter the tendency to become depressed when one is in the throes of a painful life experience," (2006, p. 409). Berk's research presents a comprehensive synthesis of 30 years of research giving evidence of eight psychological benefits of humor and laughter.

The psychological benefits of humor and laughter are: it reduces anxiety, reduces tension, reduces stress, reduces depression, reduces loneliness, improves self-esteem, restores hope and energy and provides a sense of empowerment and control (2001).

In Martin and Lefcourt's (1986) research, the humor-health hypothesis states that there is a link between humor and health and the link is perceived to be a positive one which may occur by four separate processes, direct and indirect relationships: directly, "humor, in terms of laughter, creates accompanying physiological changes in the body which are positive and conducive to health. Humor and / or laughter may create a resultant 'positive emotional state' or mirth which confers health benefits" (reported in Martin, 2004, p. 4).

"Indirectly, humor and / or laughter may assist in moderating adverse effects stress via the individual's cognitive perception, thereby enhancing ability to cope and negating the known negative physical effects of stress," (Martin, 2004, p. 3). The psychological benefits of humor are numerous, but there are physiological benefits as well.

Physiological Benefits of Humor

Norman Cousins's successful self study created an explosion of other research exploring humor and its physiological benefits. The Berk study found that there are seven specific physiological benefits that involve the central nervous, muscular, respiratory, circulatory, endocrine, immune, and cardiovascular systems. Humor's direct physiological benefits are: "... improves mental functioning, exercises / relaxes the muscles, improves respiration, stimulates circulation, decreases stress hormones, increases the immune system's defenses and increases the production of endorphins,"

(Berk, 2001, pp.328-331). In the Rotton and Shats 1996 study, the researchers examined the use of minor analgesics amongst orthopedic patients and concluded that the humor group required fewer than the non-humor group (reported in McCraddie & Wiggins, 2007). In the Mahoney, Burroughs, and Hieatt study "both the positive and no impact groups had greater pain thresholds than the negative impact group," (reported in McCraddie & Wiggins, 2007, p. 587). The results in Booth and Pennebaker's (2000) study "... assert that there is a link between emotions and immunity or the brain-immune system communication and an association between pain, cardiovascular effects and humor," (reported in McCraddie & Wiggins, 2007, p. 587). Exposure to humorous comedy results in increases in pain threshold and tolerance; these effects are due to physiological changes affecting the sensory components of pain, rather than simply altering the cognitive-affective-motivational components of pain (Martin, 2004). Despite these many benefits -- as with any construct -- we need to examine the negative impacts, if any, of humor.

The Risks of Humor

Cousin saw a risk in that those other patients in the hospital were disturbed by all the commotion his belly laughter created (1979). On a more serious note certain cautions in the use of humor are appropriate. Clinicians need to be mindful that the intent of their humor may have a negative impact on a client.

In the Saper (1987) study it is suggested that "Improper humor is any humor that "humiliates, deprecates, or undermines the self-esteem, intelligence, or self-being of client," (reported in Franzini, 2001). Thomson in 1990 stated that humor or the use of "... should only be attempted after establishing a strong therapeutic relationship," (Franzini,

2001). "A few risks cautioned by Fry in his 1992 study relate to the central nervous, muscular, respiratory, circulatory, and cardiovascular systems," (reported in Berk 2001, p. 333). "A small number of people have experienced neurological reactions to laughter, including seizures and cataplectic and narcoleptic attacks," (Berk 2001, p. 333). "Large increases in abdominal and thoracic pressure are ill-advised following abdominal or pelvic surgery, after acute orthopedic distress, such as rib or shoulder girdle fractures, and acute respiratory diseases, such as asthma," (Berk 2001, p. 333). "The strong sudden increase in blood pressure of relatively brief duration can produce cerebrovascular accidents and even myocardial infarction," (Berk 2001, p. 333). Make note that Berk goes on and clarifies, "the benefits seem to provide overwhelming evidence in favor of laughing," (Berk 2001, p. 333).

It is very important *how* the palliative care professional reacts to the patient's humor. "The therapist could laugh genuinely with the patient, laugh falsely out of pity or sympathy, laugh disparagingly, attempt to top the patient with a better story or remark, or instantly attempt to "use" these humor data to interpret cracks or quirks in the patient's personality structure or to diagnose hidden psychopathological tendencies. All of these reactions, except the first would probably be therapeutically counterproductive," (Fanzini, 2001, p. 5).

The success of humor relies heavily on spontaneity; you cannot command spontaneity. You cannot order a therapist, a novice, or the inexperienced to be funny. "To force humor in a therapy session by a therapist uncomfortable or inexperienced in humor techniques would be unwise and counterproductive," (Franzini, 2001, p. 7). "The use of

exaggeration or the telling of a formal joke might create the impression that the therapist is insensitive or uncaring or excessively self-absorbed," (Franzini, 2001, p. 7).

"If we use humor to discharge some aspect of our own conflicts, we do not help the development of the patient's insight, mastery, and humor; in that circumstance, we seriously inhibit progress," (Strean, 1994, p. 20). "Humor is always double edged in its use; even seeming modesty, self-deprecating humor, runs the risk of the analyst's warding off emerging negative transference," (Strean, 1994, p. 21). Can clinicians' sense of humor or lack thereof impact their effectiveness and / or the therapeutic relationship?

Sense of Humor

Sense of humor as a personality trait, refers to a set of relatively stable humor-related personality traits or individual differences variables (Martin, 2004). No single dimension can adequately capture the concept of sense of humor (Martin, 2004). Mindess believes it is an inner condition, a stance, a point of view, or in the largest sense an attitude of life (2001). In Saper's (1987) research, sense of humor is "an affective, cognitive, or aesthetic aspect of a person; it's the personality trait that embraces at least two human capacities: appreciation, or the set to perceive things as being funny, and creativity, or the ability to say and do funny things, to be witty; it implies a readiness to find something to laugh about even in one's own adversity," (Franzini, 2001, p. 4). It may be conceived as a tendency to laugh frequently, to easily perceive humorous incongruities in the environment, to tell jokes and amuse others, to be generally cheerful, to maintain a humorous outlook in coping with stress, to deprecate oneself in a humorous way, and so on (Martin, 2004). If humor and laughter have positive effects on health, then one would expect that individuals who laugh and engage in humor more frequently in their daily

lives would show evidence of better general health, such as enhanced immunity, fewer illnesses, and greater longevity (Martin, 2004). Berk confirms this "... the psychophysiological benefits of humor are significant to the health and well-being of all humans, but especially to older adults" (2001, p. 335).

Cognitive-perceptual aspects of humor are more important than mere laughter, and the ability to maintain a humorous outlook during times of stress and adversity is particularly important (Martin, 2004). Certain styles of humor may be more adaptive and health enhancing than others e.g., excessively self-disparaging humor is probably not adaptive (Martin, 2004).

Thorson and Powell, when developing their Multidimensional Sense of Humor Scale determined that some elements that make up an individual's sense of humor are: recognition of oneself as a humorous person, recognition of others' humor, appreciation of humor, behavioral response by laughing, perspective, and coping with humor (1993).

Therapeutic Humor Intervention

The American Association for Therapeutic Humor (AATH) defines therapeutic humor as any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life's situation (Franzini, 2001). One of the primary roles of social workers or of palliative care professionals in general is to provide comfort and support to our clients with empathic attunement and mindfulness. This may be accomplished through a therapeutic humor intervention, and just through being genuine. These interventions may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual (Franzini, 2001). In Salameh's (1987)

research, he states that "Therapeutic humor should be well-timed, taking into account the patient's sensitivities and specific needs at the moment when a humorous intervention is considered; the judicious therapist is aware of when not to use humor, depending upon the therapeutic material under discussion and the patient's level of absorption," (reported in Franzini, 2001, p. 3). Salameh stressed that humor is the best gift we can offer our patients because it demonstrates constructively that with a newly acquired positive view, their problems become solvable (in Franzini, 2001, p. 3).

Therapeutic humor includes the intentional and spontaneous use of humor techniques by therapists and other health professionals, which can lead to improvements in the self understanding and behavior of clients and patients (Franzini, 2001). The humorous point should have a detectable relevance to the client's own conflict situation or personal characteristics (Franzini, 2001).

Mindess stated "deep, genuine humor -- the humor that deserves to be called therapeutic, that can be instrumental in our lives -- extends beyond jokes, beyond wit, beyond laughter itself to a peculiar frame of mind," (1971, p. 214).

The therapeutic humor intervention should be viewed as a component of stress management training, focusing on teaching individuals ways of using humor to cope with stress in their daily lives (Martin, 2004). Therapeutic humor intervention may be seen as an adjunct to social skills training, teaching individuals to develop a socially facilitative sense of humor (Martin, 2004). In humor interventions employed for pain reducing effects, individuals should be encouraged to enjoy themselves in an unrestrained manner, whereas forcing themselves to laugh artificially may actually be counter-therapeutic (Martin, 2004). Franzini states that humor helps to establish rapport, to illustrate the

client's illogical or irrational thinking, and to share a positive emotional experience with the client (Franzini, 2001). Ventis's (1987) study stated that humor can be used to compensate for inadequate levels of relaxation within systematic desensitization, it can promote self-efficacy in aiding the client in coping with previously difficult situations, and it can facilitate assertion training by reducing clients' fears while also teaching appropriate expressions of feelings in angry individuals (reported in Franzini, 2001). Saper, in 1987, confirmed the importance of establishing a strong relationship with the client and gauging whether the client can accept the therapist in a humorous role and even whether humor was a legitimate place in the therapy (Franzini, 2001).

Even with the stated benefits of many therapeutic humor interventions, some professionals may still be hesitant in utilizing humor or being comfortable being their genuine selves. Why the resistance?

Resistance to Therapeutic Humor Intervention

Therapists may see themselves and their work as very important and serious and themselves as very important and serious. As long as therapists are committed to the belief that their theories and techniques of therapy are cogent, valid, and beneficial, "... a deep and genuine sense of humor cannot be achieved and therefore promoted," (Mindess, 1971, p. 220). "Those therapists who are resistant to humor have difficulty with the issues of closeness and power, and that is a major reason why humor is not considered a 'legitimate' tool in some therapeutic societies," (Jolley, 1982, p. iii). "The real fear stems from how a therapist who uses humor will be seen through the eyes of his colleagues. A person who laughs with someone is sharing, and a therapist who does this is giving away some of his power, putting him more or less on an equal level," (Jolley, 1982, p. 21-22).

Many therapists may not have the humor skills to integrate humor into therapy. Yet most people, including therapists, can tolerate nearly any epithet about themselves except that they are humorless (Franzini, 2001, p.6). Classroom instructors and senior clinical supervisors of novice therapists historically have discouraged the use of humor as part of the psychotherapeutic process (Franzini, 2001, p. 6). Franzini asks "Does the role of ethnic humor by the client facilitate the therapy process when the ethnicity, age, sex, or religion of the clients and the therapist differ or are the same?" (2001, p. 11).

Ethnographic Sensitivity

Patients presenting with a variety of desires, beliefs, and cultural practices can be challenging. In attempting to provide culturally attuned support, social workers face the challenge of acquiring sufficient cultural literacy and competence to understand and to respect the cultural beliefs of their clients. It is striking that out of all the research studies mentioned in this paper, only one had minority participants. Another obstacle is that providers are limited in the treatments they offer by the very concepts and methods they use. The training is imbued with the constructs and ideologies of the White mainstream culture. What does it mean to be culturally competent for therapist then? Is it enough to read Dean's article on Native American humor; Milner's book on Asian humor, Beatty's book on African American humor or Flowers' book on queer humor?

Cultural Competency

The National Association of Social Workers' (NASW) standards for palliative and end of life care state in standard number nine "... cultural competence: social workers shall have, and shall continue to develop, specialized knowledge and understanding about history, traditions, values, and family systems as they relate to palliative and end of life

care within different groups. Social workers shall be knowledgeable about, and act in accordance with, the NASW Standards for Cultural Competence in Social Work Practice," (NASW, 2004, p. 5).

We can help by empowering ethnic minorities to be involved in the development of culturally safe practices in partnership with the majority community. Cultural competency needs to be part of the mainstream professional education, including insights from anthropology and cultural psychology. It requires the development of self-awareness, so that professionals can reflect on and examine their own beliefs, responses, and views. "It involves taking risks, trusting to intuition, and self monitoring, and welcoming feedback from colleagues, carers, and patients," (Oliviere & Monroe, 2004, p. 36-37).

It is far more valuable to view culture as being expansive or extensive; culture can include such things as developmental stage of life, profession, educational level, geographic region of the country, religion, spirituality, sexual orientation, political affiliation, gender, and socioeconomic status, to name a few (Katz & Johnson, 2006; Mazanac & Kitzes, 2003; Ayonrinde, 2003; Dyche & Zayaz, 2001). "This would indicate that individuals can easily affiliate with several cultures and that depending on where they are in the life cycle, they may lead with one or two of their distinct cultures," (Katz & Johnson, 2006, p. 93). "It should be noted that the process of identifying cultural affiliations can be quite challenging for the helping professional. It is valuable to learn about cultural values, beliefs, and practices through the simple conversations we have with patients," (Katz & Johnson, 2006, p. 94).

Cultural competency refers to a dynamic, fluid, continuous process of awareness, knowledge, skill, interaction, and sensitivity. It is more comprehensive than cultural sensitivity, implying not only awareness of cultural differences -- but also the ability to intervene appropriately and effectively. "Seeking to become more culturally competent requires learning in the affective attitudes, values, feeling, and beliefs, cognitive and intellectual and psychomotor behavioral domains, and assumes skill in critical thinking. Cultural competence is an ongoing process, not an end point," (Mazanac & Kitzes, 2003, p. 178).

CHAPTER III

METHODOLOGY

The purpose of this qualitative study was to examine how palliative care professionals in multicultural or mono-cultural dyads incorporate humor in their work. This study employed a qualitative or flexible method using mainly open-ended interview questions to explore palliative care clinicians' impressions of the effects of humor on people with terminal illness, as well as their views about the impact of multiculturalism and mono-culturalism on the use of humor in palliative care. That is, professionals were asked whether they believed the use of humor was impacted in any way by their being matched in a cultural way ("monocultural" dyad) with the client with whom they used humor, or not so matched ("multicultural" dyad). By using open-ended questions I hoped that the narratives gathered would provide some information to clinicians new to this area of social work and allow them to consider which skills could be useful in their practice with end of life clients and their families.

It is anticipated that readers will recognize the importance of incorporating cultural competency aspects of palliative care into their practice. Moreover, it is hoped that the reader will appreciate the feelings and wisdom conveyed through the narratives. Anastas states that the essential aspects of human behavior: feelings, meanings, and interpretations and memories of events from the past can be apprehended in words through interviewing (1999). This chapter presents the methods of research used in this

study and will describe the sample selection, data collection, data analysis and limitations and biases.

This research study used an exploratory/descriptive research design. The flexible / qualitative research method was used to collect and analyze data from professionals providing end of life care. The choice of an exploratory/descriptive study design was made so as to open up new insights into the topic.

Sample

This expert sample consisted of thirteen palliative professionals recruited from across the greater Seattle, Washington area. In order for the participants to qualify they needed to meet the following minimal criteria: 1. have a master's level professional license in a mental health related field (e.g., social work, clinical psychology); 2. have had three years or more end of life work experience; 3. be currently providing services to clients faced with end of life, and 4. have proficiency in the English language. I am aware of the dangers of oppression in research, and did not discriminate against a professional's participation based on race, ethnicity, class, gender, sexual orientation, religion, age, or disability. On the contrary, I had hoped to recruit as diverse a sample as possible.

The thirteen professionals were recruited through the Oncology Social Worker Network / Seattle listserv, Providence Senior and Community Services / Seattle listserv and Group Health Palliative Care / Seattle listserv. The individual managing the Oncology Social Worker Network / Seattle listserv, Siobhan Ginnane, MSW, LICSW, Social Work Department, University of Washington Medical Center, Seattle, WA, had been contacted and had offered to post the recruitment announcement on the listserv.

The listserv was visible to over 70 palliative care social workers in the area. The individual giving permission to use the Providence Senior and Community Services listserv and post the recruitment flyer at the facility was Robert Luck, MSW, LICSW, Interim Palliative Care Director. The listserv/facility was visible to over 100 palliative care social workers. The individual giving permission to use the Group Health Palliative Care listserv was Patricia Toddhunter, RN, Palliative Care Team Coordinator, who had been contacted and had offered to post the email on their listserv and post the recruitment flyer at her facility. Their listserv was visible to over 100 palliative care social workers. I decided to employ this sample due to the expertise I hoped and expected these clinicians would have after having worked in this particular area of social work for a significant amount of time.

In the instance of a lack of response from the Oncology Social Worker Network / Seattle listserv, Providence Senior and Community Services / Seattle listserv and Group Health Palliative Care / Seattle listserv, I intended to contact local professionals from the National Hospice and Palliative Care Organization website with a specialty in palliative care, also via a listserv. Fortunately that was not necessary.

Data Collection

Narrative data from open-ended questions facilitated through in-person interviews were gathered from a sample of thirteen volunteers who meet the selection criteria. Procedures to protect the rights and confidentiality of participants were outlined in a proposal and presented to the Human Subjects Review Committee at Smith College School of Social Work before the interviews began. Approval of the research project (see

Appendix A) assured that the research study was in accordance with the NASW *Code of Ethics* and the Federal regulations for the Protection of Human Research Subjects. Each participant contacted the researcher via an e-mail or telephone call expressing an interest in participating in the research study.

Once the participants had responded to the announcement on the listserv, they were requested to set up an initial telephone screening. At this time, they were asked to disclose their licensure status, the number of years they had worked in palliative care (a minimum of three years was required), verify that they were currently serving clients in palliative care, and whether they spoke English in order to conduct the in-person or telephone interview. They were informed of the length of the interview (60 minutes), and notified that it would be tape recorded. They were informed the interview would contain questions regarding their perspectives about the use of humor, countertransference / use of self, personal experiences, professional development, and therapeutic approach which they have felt to be helpful or unhelpful with their clients in regard to end-of-life care (see Appendix B for a copy of the Interview Guide).

The initial contact with the participants gave them the opportunity to inquire about the researcher, the study, their expectations as to how the data might be used, and any further questions they may have had. After the initial telephone contact, they were sent a copy of the letter of consent (see Appendix C), a Demographic Information Questionnaire (see Appendix D), as well a Multidimensional Sense of Humor Scale (see Appendix E). Once the letter of consent was signed, the Demographic Information Questionnaire and the Multidimensional Sense of Humor Scale were completed, another

phone contact was made in order to schedule a convenient time for the in-person interview. Because they were unable to attend in-person interviews, several participants requested that the narrative questionnaire be electronically forwarded to them. Interviews took place at a quiet location agreed upon by the participant and the researcher.

The narrative interviews, ranging from 30 minutes to 60 minutes, took place from March through April 2009. The in-person interviews were recorded by an Olympus Digital Voice Recorder WS-311M. The interviews were transcribed in their entirety to extract the maximum amount of detail. The data were maintained within Microsoft Word and Excel documents on a MacBook laptop. At the end of the research, the data were removed from the MacBook, transferred to a JumpDrive and stored in a locked safety deposit box.

The twenty-four open-ended interview questions were developed by this researcher. The questions were created based on previous research and information used in the area of palliative social work in regards to humor. The Smith College School of Social Work thesis advisor reviewed the questionnaire; her suggestions were incorporated into the questionnaire.

Two questionnaires were utilized in the research study, a demographic questionnaire and the Multidimensional Sense of Humor Scale (MSHS). The demographic questionnaire was used to investigate the multicultural / monocultural influences in the clinician / client relationship. The MSHS was used to rate the clinicians' sense of humor, exploring if there could be a correlation between the clinicians' sense of humor score and their use of humor or lack thereof with their clients. The MSHS developed by Dr. James Thorson and F. C. Powell (January, 1993), has been proven to be

both valid and reliable. The MSHS was developed through a series of factor analyses from a pool of 124 items. Thorson and Powell reported that the four factors remained stable across several large samples. They also reported a coefficient alpha of .92 for interrater reliability for the full MSHS.

Confidentiality was maintained throughout the research. No participant names appeared on any documents; specific numeric codes were assigned to each participant. Any quotes used to support my inferences did not include any identifying information. The information obtained in audio records and all research documentation are locked in a safety deposit box and will be retained for a period of three years, as required by Federal law. After the three years all audio records and documentation, if not needed for further research, will be destroyed. If they are needed beyond three years, they will remain secured in a locked location.

Participation in this study was voluntary. Participants could withdraw from the study, or choose not to answer certain questions, without penalty, nor will information regarding their participation be disclosed. Withdrawal could be done until the date of April 15th, 2009. Participants were asked to contact this researcher at the telephone number stated in the letter of consent if they choose to withdraw from the study, or if they had any questions regarding this process.

Data Analysis

The demographic data were analyzed manually and presented in Table 1 in the *Findings* chapter. The MSHS data were analyzed manually and presented in Table 2 in the *Findings* chapter. The taped narratives were transcribed into an electronic spreadsheet

and then analyzed for content using the grounded theory model as described by Anastas (1999). In this constant comparative method I analyzed data for similarities and differences across participants throughout the data analysis.

During the in-person interviews I took notes on any peculiarities or unusual aspects in themes or responses. When the narratives were transcribed these notes were added in a separate column. The transcribed data were first sorted by question number, and all participant responses to one question were gathered and printed as a separate document. That document was read and reread several times looking for and highlighting common themes, phrases and words, with different colors. Another document was created coding, tracking and sorting the common themes, phrases, words and peculiarities.

Limitations and Biases

The sample of self-selected participants was not a random sample. The sample size of thirteen is a small representation of end of life professionals and offered only a glimpse into the views of a few in the field of palliative care. I could not be sure if the sample would be diverse in reference to race, ethnicity, class, gender, sexual orientation, religion, age, or disability, though I had hoped to recruit for diversity in my sample. Table 4.1 in the Findings chapter presents the demographics of the participant sample.

Many interviews were facilitated in person, but not all participants were able to attend and requested to complete the narrative questionnaire on their own, which may have had an impact on the results. The in-person interview participants may have been influenced by my mannerisms, voice, laughter, and dress. In two of the in-person

interviews, I skipped over one question. My personal biases about the value of humor as a coping mechanism may have had an influence on the study. In the past I performed stand-up comedy and I use humor as a major coping strategy. There may be some subjectivity in my verbiage in the interview questions, as well.

CHAPTER IV

FINDINGS

Introduction

Although much has been written on palliative care, a review of the literature reveals less published on the use of humor by palliative care professionals. There is scarce documentation on the multicultural influences on the use of humor, specifically in palliative care. This exploratory study investigated the use of humor by thirteen palliative care professional in multicultural and / or mono-cultural dyads.

The interview questions were created to elicit information in reference to the professionals' experiences in palliative care, their style in the use of humor, the barriers they experienced and what the use of humor in care with terminally ill patients meant to them. Next a set of questions concentrated on transference, countertransference and use of self in reference to the professionals use of humor with their end-of-life clients. The study garnered patterns / themes of client anxiety and comfort from the participants' personal experiences. The final set of research questions focused on the professionals' development around cultural competency, the use of humor and supervisor and / or peer contributions. The questions closed by asking for the professionals' words of wisdom for those who would in the future be palliative care professionals.

Demographic Data

Participant Demographics

The geographical location of this research study was in the state of Washington. This study was comprised of thirteen palliative care professionals: nine females and four males. The professionals' ages ranged from 31 to 70. All participants (n= 13) identified as Caucasian. One participant did not respond to the socioeconomic status question, the majority (n= 7) described being in the middle and the remainder of the participants (n= 5) identified as being in the upper middle socioeconomic status. All participants had at least a master's level degree including six with a Masters in Social Work (MSW), three were Licensed Independent Clinical Social Workers (LICSW), one was a Licensed Mental Health Counselor, one had a Masters in Theology (M.Th.), one with a Doctorate in Psychology (Ph.D.) and one with a Doctorate in Psychiatry (M.D.). (See the following Table 4.1 for a summary of professionals' demographic information.)

Table 4.1

Professionals' Demographic Information

	Gender Female or Male	Age	Race	Socio- Economic	Credentials	
PARTICIPANTS	1	F	31	European American, White	Middle	MSW
	2	M	61	"	Middle	MSW
	3	M	--	"	Middle	MSW
	4	F	45	"	Middle	LICSW
	5	M	62	"	Upper Middle	M.Th.
	6	F	50	"	Upper Middle	LICSW
	7	F	53	"	Upper Middle	LMHC
	8	F	50	"	Upper Middle	Ph.D.
	9	F	35	"	--	LICSW
	10	F	58	"	Middle	MSW
	11	F	36	"	Middle	MSW
	12	F	32	"	Middle	MSW
	13	M	51	"	Upper Middle	M.D.

The following provides information in regards to the professionals' current care setting; therapy and palliative care experience, palliative and humor training. The participants worked in a variety of care settings: hospitals, a hospice facility, hospice outpatient, oncology clinic, and private practice. A number (n= 5) did outreach to the clients' residences: a private home, an adult family home, or different levels of skilled nursing facilities. The participants' years of experience in therapy ranged from 3 years to close to 30 years; several of the participants (n= 5) had more than 21 years of experience. The participants' years of experience in palliative care ranged from 3 years to more than 21 years, but the majority of participants (n= 7) had between 4 to 6 years of experience. Most of the participants (n= 10) received their palliative care training on the job; the remaining (n= 3) received their training within an academic setting. In reference to formal humor / humor therapy training the majority (n= 11) had no training, with the remaining (n= 2) receiving some form of formal training through professional seminars or an accredited university. One participant identified as a professional comedian.

Client Demographics

The age range of the clients was from young children to a 99-year-old client. One participant stated that 50% of her clients were children. Two participants reported that they worked with adolescents; these clinicians reported that adolescents comprised from 38 to 40% of their clients. Some professionals (n= 9) worked with young adults; these clinicians said young adults constituted from 1 to 34% of their clients. The majority of professionals (n= 12) worked with middle-aged adults; this age group represented from 10 to 85% of their clients. A majority of professionals also worked with older adults over

65 years of age; these older adults ranged from 4 to 92% of their clientele. One professional responded that the majority of her client base was evenly split between the middle aged and the older adults.

With respect to the ethnicity of the clients the professionals worked with, all the professionals (n= 13) worked predominantly with Caucasian clients. Two of the professionals worked solely with Caucasians, and six of the professionals reported 90% of their clients were Caucasian. However, almost all professionals (n= 10) worked with some African American, Asian, Spanish/Hispanic/Latino, Pacific Islanders, Native American / Alaska Natives, and Biracial race / ethnic clients. (See the following Table 4.2 for a summary of professionals' description of their clients' ethnicity.)

Table 4.2

Professionals' Description of Their Clients' Race / Ethnicity

		% of Clients Caucasian	% of Clients African American	% of Clients Asian	% of Clients Spanish, Hispanic Latino	% of Clients Pacific Islander	% of Clients Native Amer., Alaska Native	% of Clients Biracial/ Multi- Ethnicity
PARTICIPANTS	1	93	2	5	0	0	0	0
	2	95	5	0	0	0	0	0
	3	65	10	10	10	0	5	0
	4	90	3	2	2	2	1	0
	5	60	10	10	5	10	5	0
	6	90	2	2	2	2	0	2
	7	92	4	0	4	0	0	0
	8	100	0	0	0	0	0	0
	9	76	1	1	19	3	0	0
	10	92	3	5	0	0	0	0
	11	85	10	5	0	0	0	0
	12	100	0	0	0	0	0	0
	13	80	0	10	0	0	0	10

Within socioeconomic status of clients cared for, there was much overlapping. One participant did not respond to the question; the majority of others (n=11) stated that anywhere from 5 to 70% of their clients were middle class. A majority of participants (n=10) reported that anywhere from 3 to 90% of their clients were upper middle class. Also a majority (n=10) worked with some clients in the lower middle class, ranging from 10 to 40% of their clients. Some professionals (n= 8) worked with clients in the lower socioeconomic status, ranging from 5 to 75% of their clients. (See the following Table 4.3 for professionals' rankings of their clients' socioeconomic status.)

Table 4.3

Professionals' Rankings of Clients' Socioeconomic Status

		% of Clients Lower	% of Clients Lower Middle	% of Clients Middle	% of Clients Upper Middle	% of Clients Upper
P A R T I C I P A N T S	1	5	30	30	30	5
	2	20	25	40	10	5
	3	25	20	20	20	15
	4	15	10	70	5	0
	5	0	50	35	15	0
	6	75	15	5	3	2
	7	0	10	40	40	10
	8	0	0	9	90	1
	9	--	--	--	--	--
	10	10	40	50	0	0
	11	10	25	40	25	0
	12	20	20	20	20	20
	13	15	10	25	25	25

The majority of clients referenced in this study had been diagnosed with some type of cancer. All professionals (n= 13) had cared for clients diagnosed with cancer; the participants reported cancer diagnoses were present in from 10 to 100% of their clients. Two professionals worked solely with people diagnosed with cancer. Most other professionals had clients with a variety of diagnoses. It was noted that some clients had co-morbidity, living with two or more illnesses. Nine professionals worked with clients diagnosed with a cardiovascular illness, ranging from 4 to 38% of their clients. Nine professionals counseled clients with unknown debilities, ranging from 1 to 35% of their clients. Eight research participants worked with clients diagnosed with some form of dementia, ranging from 2 to 40% of their clients. Eight of the professionals had clients diagnosed with Parkinson's disease, ranging from 1 to 10% of their clients. Five of the participants had worked with clients diagnosed with Amyotrophic Lateral Sclerosis, ALS, ranging from 1 to 3% of their clients. Some clients had been diagnosed with Multiple Sclerosis, MS, and four research participants counseled them, ranging from 1 to 10% of their clients. Three professionals worked with clients diagnosed with the Acquired Immune Deficiency Syndrome, AIDS, ranging from 1 to 6% of their clients. Two professionals counseled clients with post-traumatic conditions, ranging from 12 to 60% of their clients. Two research participants cared for clients diagnosed with Endocrine illnesses, ranging from 5 to 15% of their clients. One professional working in pediatric palliative care revealed that 90% of her clients had been diagnosed with childhood diseases or disorders. See the following Table 4.4 for a visual display of the diagnoses reported for what percentages of their clients by participating professionals.)

Table 4.4

Diagnoses* Reported for What Percentages of Their Clients by Professionals

	Cancer	Cardiovascular Illness	Endocrine Illness	PTSD	AIDS	Dementia	ALS	MS	Parkinson's	Debility Unspecified	Other,*Child-hood Diseases	
PARTICIPANTS	1	40	4	0	0	40	1	0	5	10	--	
	2	10	10	0	0	35	0	5	5	35	--	
	3	50	20	15	0	2	35	3	10	5	20	--
	4	65	15	0	0	1	12	3	1	2	1	--
	5	30	30	0	0	0	30	0	0	0	10	--
	6	100	0	0	0	0	0	0	0	0	0	--
	7	30	5	5	60	0	0	0	0	0	0	--
	8	94	0	0	0	0	0	1	1	1	2	--
	9	10	0	0	0	0	0	0	0	0	0	90
	10	30	30	0	0	0	20	0	0	10	10	--
	11	50	38	0	0	0	5	1	0	1	5	--
	12	100	0	0	0	0	0	0	0	0	0	--
	13	50	12	11	12	6	2	0	0	2	5	--

* N.B.: Because clients often had more than one diagnosis, percentages may add to more than 100.

Participants and Client Demographic Similarities

On several survey questions about their similarity to their clients on demographic characteristics, the participants were asked to check all options that applied; therefore there was much overlapping. In fact, although some matching questions asked a yes/no query, some respondents answered both yes and no to the same item, with the result that the answers sometimes add to more than 13. The majority of professionals (n= 10) identified predominantly as being similar to their clients in ethnicity/race, socioeconomic level, education, and religious preferences categories. A smaller number of professionals (n= 2) reported they did not predominantly match their clients in the categories listed above. In the ethnicity/race category the majority (n= 10) matched their clients, but several (n= 5) did not match. In the socioeconomic level category, the majority (n= 9) matched their clients. However, a close number (n=6), did not match their clients on a socioeconomic level. In reference to their level of education, the majority of participants (n=8) did not match their clients, with a few professionals (n= 6) matching their clients. One participant did not respond yes or no matching their clients on an educational level. In the religious preference category, the majority of participants (n=8) did not match their clients, with only a few (n= 4) matching their clients. Two participants did not respond yes or no matching their clients in a religious preference. Two participants noted in the 'other' category, one a similarity with her clients in "spiritual depth," The other a difference in no extended family. (See the following Table 4.5 for a summary of professionals' matching/not matching their clients on demographics.)

Table 4.5

Professionals' Matching/not Matching Their Clients on Demographics

	Match Clients Yes or No	Match Ethnicity/ Race	Match Social Economic Status	Match Education level	Match Religious Preference	Match Other	
PARTICIPANTS	1	Yes	Yes	No	No	--	
	2	Yes	Yes	Yes	Yes	No	
	3	No	No	No	No	No	
	4	Yes	No	Yes & No	Yes & No	No	
	5	Yes	Yes	Yes	No	No	
	6	No	Yes	No	No	Yes	
	7	Yes	Yes	Yes	Yes	Yes	
	8	Yes	Yes & No	Yes	Yes	No	Similar Spiritual Depth
	9	Yes	Yes	Yes	--	No	
	10	Yes	Yes	Yes	No	--	No Extended Family
	11	Yes	Yes	No	No	No	
	12	Yes & No	Yes & No	Yes & No	Yes & No	Yes & No	
	13	Yes	No	Yes	Yes	Yes	

The Multidimensional Sense of Humor Scale

As stated in the previous Methodology chapter, the participants were requested to complete a Multidimensional Sense of Humor Scale survey. The scale questions were broken down into four distinct categories: creation and performance of humor, uses of humor for coping, social uses of humor, and attitudes towards humor and humorous people. In the creation and performance category the majority of participants (n= 7) scored the lowest. There was one tie of the lowest score in this category and there was one tie of the highest score. In the uses of humor for coping category some of the participants (n= 4) scored the highest, with others (n= 5) in a tie of the highest scores. The social uses of humor category had a few participants (n= 2) score the lowest; one participant scored the highest, and two others participants scored it with a tied high score. In the attitudes towards humor and humorous people, several participants (n= 3) scored it the lowest, the same number (n= 3) scored it the highest, two scored it as a tie highest score, and one scored it as a tie lowest score. (See the following Table 4.6 for a summary of professionals' Multidimensional Sense of Humor Scale scores).

Table 4.6

Summary of Professionals' Multidimensional Sense of Humor Scale Scores

	Creation and Performance	Uses of Humor for Coping	Social Uses of Humor	Attitudes Towards Humor & Humorous People	
P A R T I C I P A N T S	1	--	--	Lowest	Highest
	2	Lowest, tie*	Highest, tie	Highest, tie	Lowest, tie
	3	Lowest	Highest	--	--
	4	Lowest	--	--	Highest
	5	Highest, tie	Highest, tie	--	Lowest
	6	--	--	Highest	Lowest
	7	Lowest	Highest	--	--
	8	Lowest	Highest	--	--
	9	Lowest	Highest, tie	--	Highest, tie
	10	Lowest	Highest	--	--
	11	Lowest	Highest, tie	--	Highest, tie
	12	--	--	Lowest	Highest
	13	--	Highest, tie	Highest, tie	Lowest

* tie - signifies a "tied" or identical score

Use of Humor

Some religions / people believe that a person's core being, or spirit will cease to be at death, some believe in reincarnation, others believe in eternal life, and there are many other beliefs. With the seriousness of one's spirit ending, transforming, or transitioning from this life to another, some believe it is a most solemn and serious time, where there is no room for humor. Others believe there are no boundaries to contain humor. It is part of life and death.

The participants were asked if they introduce / initiate humor with their clients in end of life care? and if so, how? Most of the participants (n= 8) responded that they do introduce / initiate humor if they felt it would be appropriate for their clients depending upon: "the client's cognitive status and level of awareness," the client / clinician relationship, the number of prior visits, or where the client was in reference to the end-of-life continuum. Several of the participants (n= 3) indicated that they waited and took their lead from the client. One stated, "I generally wait for the patient or their family to initiate the use of humor." A few of the participants (n= 2) conveyed that they did introduce / initiate humor, neither dependent on nor taking their lead from the client. One of them responded, "Sometimes they need someone to lead into certain things...to know it's ok for them to do it (laugh), then I will purposefully take the lead." Another participant pointed out "if someone is actively dying, the family they don't always have to be solemn, that it's okay to laugh, that it's not sacrilegious." One participant stated that she was not sure as to whether or not she initiated humor with clients around end of life discussions.

There were common phrases used as to knowing if and when to use humor such as: "trust my gut feeling," "sort of feeling it out," and "if it feels right." Participants made

note of the need to be sensitive to the client, other family members, and caregivers.

Several participants insinuated something natural in the use of humor: "part of my personality," "comes up in me," and "integrated in my style." The following phrases were used by the participants to describe the motivations for, or the ways that they introduced / initiated humor: "lighten the mood," "bring a sense of levity to the situation," "point out humorous things," "ask funny things in their life," and "celebrate the life of the child."

It was evident that all participants took care when they did introduce / initiate humor. One participant pointed out a specific distinction:

I think that there is a distinction that is important to keep aware of by the way. It's the distinction between laughing at humor and laughter at irony, that there is a real important difference there. Sometimes when doing a mental status, it's important to note the range of somebody's affect, and sometimes what looks like someone has a full range of affect, she's smiling at something ironic. Well that's not funny. She's laughing, but it's not because it's funny. You know it's almost the opposite; it's sort of a sad ironic, wry laughter.

The second question in reference to the professionals' use of humor was, "Do you wait for the client to introduce / initiate humor? why or why not?" The majority of participants (n= 10) responded that they do wait for the client to introduce / initiate humor, some overlapping from question number one. The remainder of participants (n= 3) mentioned that they do not wait for the client to introduce / initiate humor. One of them stated, "It can be a useful tool to get at a subject matter that is otherwise, may be more difficult to get them to talk about."

The reasons why the majority of participants waited for the client were dependent on certain factors. Some stated earlier reasons mentioned in question number one and

additional ones: type of humor, client style, client diagnosis, age, medications and the environment or setting. One participant reported,

Humor is not the focus of my visit. It's lightheartedness when appropriate. As in I don't do it in Alzheimer units, and I won't wear my silly red nose that I wear if I was on a pediatric ward in the hospital just because those things could scare people. Just because those people could be on morphine or some other medication [which] doesn't mix and they [could] take what I do very wrong.

The professional who worked in pediatric palliative care stated, "I believe that it is important to respect where the client is at in their emotional journey." "Some people are not able to access humor as a coping tool." It was noted again by several participants that they were aware of the masking and or denial by the some of their clientele.

The participants were queried, "Do you think incorporating humor is helpful for the client in end-of-life care? why or why not?" Most professionals (n= 11) agreed that incorporating humor in end-of-life care is helpful for their clients. Only 2 participants voiced some concern with its helpfulness. One stated, "I'm cautious incorporating humor for fear of appearing too cavalier about death -- or of alienating the client." Most responses fell into one of three categories: humor being part of (their) life, humor as a tool, and what the client wants.

The first theme, humor being part of life was supported by these responses from the participants: "There is the serious part of life and the lighter side of life," "Humor is part of the human emotions," and "Humor is an important part of life." One participant mentioned, "Death and dying does not have to be all doom and gloom." Another stated, "It also reminds us that literally anything can be taken too serious, even death." When looking at the second category, humor as a tool, there were many examples, the most

common one was, humor was a tool to help the therapeutic relationship between the professional and client. The third theme carried over from responses to earlier questions, it is dependent on the client, for the multiple reasons stated earlier. One professional shared this:

It depends on the personality type. I believe a person dies the way that they live. If there has never been humor in their life and if they are a crotchety old person... I want to go with their personality, and if along the way there is an 'Ah ha!' moment and they get to look at themselves and they get to go deeper in their relationships and they find the healing that they have been looking for and they can laugh at some part of their life, that's great.

It bears mentioning that two professionals brought out two themes that evolved further in later research questions. They stated, "People will say, I want to make a joke," and it is better "the more genuine you can be."

To tease out more about humor and end-of-life care, question number four was similar to question three in that it asked the participants if they thought incorporating humor was *appropriate* for the client in end-of-life care? why or why not? Most participants (n= 8) agreed that it was appropriate with stipulations. The stipulations included: "dependent on the client," "where they are at in the end-of-life continuum," "being the right moment," "using clinical judgment," "it' can't be about me," "not about cheering them up," "only if I know the client will appreciate," "taking cues from the client," "how the conversation unfolds," and "appropriate whenever it's helpful." A few participants (n= 3) repeat the theme of humor as being natural, "part of life," and "humor is part of human emotions." The professional working in pediatric palliative care cited, "Working with children, it is their natural inclination to laugh and be joyful." "I think that it is absolutely appropriate for the client at end-of-life." One participant responded, "We

have to really demonstrate that we value quality of life, of which humor is a vital component." Another pointed out, "Any sort of therapy that will help a client tell their story is helpful."

Questions number five focused on multicultural similarities and differences that may have been influential in the professionals' use of humor with their clients. The participants were asked if they found it easier to use humor with those clients whom they do match on a multicultural level? why or why not? The responses were spread out on this question, some participants (n= 5) answered affirmatively, "yes" it was easier to use humor with those clients they identified as similar to themselves. Words and phrases used were: "automatically easier," "slightly easier," and "maybe false assumptions of some similarities." Other participants (n= 4) responded that they did not believe that multicultural similarities with their clients made it easier for them to use humor. Their responses varied greatly. One stated, "The universality of the human condition is dying." One observed, "It's more of what's going on with the person internally in terms of personality." Another mentioned, "I just try to be myself with people, no matter their culture or background," and one shared, "Cultural issues are sometimes deep and crucially important and some[times] they are just superficial issues where you connect on a deeper level." Two participants carried the previous theme were it was dependent on were the client was at. One participant had the following reply repeating the genuine theme:

I think that humor is sometimes easier when I do NOT match the person/family on a multicultural level. As long as the family can recognize that I am genuine in my effort to be culturally sensitive, it can generate a very organic sense of humor as we explore each other's differences and cultures.

One participant stated she had not really paid attention to the issue and didn't have a response. In reference to noted differences, the participants mentioned: religion, race/ethnicity, age, socioeconomic level, marital status, family of origin and education.

To determine if there were other facets beyond cultural ones, the participants were queried about those and if those made using humor more or less likely to occur? All participants (n= 12) that were asked replied with a variety of responses. One established theme was the family: "family culture," "family atmosphere," "client / family fear that the other will be hurt," and "just meeting the family for the first time." Another established theme concerned psychological aspects of the client: depression, defenses, grieving, or "freaking out." Make note that: "defenses," "the end-of-life continuum," and "start where the client is," were all mentioned in response to this question as in previous questions.

The following passage is one participant's viewpoint:

Yes. Well the very, very, very, near end of life, people are frail and moving on to letting go. More or less likely if they're in the middle of grieving and someone is crying it's not appropriate to crack a joke. That's sort of obvious, um... and if someone is on their deathbed I just don't, unless like I said, unless they initiate it. But I tend, I tend just like we're taught in Social Work 101. I tend to start where the patient, where the client is. So, I'm usually taking cues from them, and if they are sort of quiet and sort of solemn that's where I'm going to be. Now if the patient has started laughing about something we had talked about a few weeks before, you know, I could laugh with her. I could go with her, but I think it naturally happens anyway, the longer you are in the work the more, I think you unconsciously adjust how you are in the relationship to where that patient is, including whether they are in a heavy place or a lighter place, or a humorous place or a grieving place.

Novel responses to question six were: non-normative life experiences - "surviving a horrible car accident," or "a parent died when the client was two years old," "upbringing

in another part of the nation," "different stages of diagnosis in the client's illness," and environment - public or private.

Curious how the participants used humor, and what it meant to them, I posed the seventh question "What does incorporating humor into your work mean to you?" Three predominant themes presented themselves: humor as a tool, humor presented through the self, and self care. Some of the participants (n= 6) spoke about humor as a tool: "it's another tool in the tool bag," "to lighten the mood," "making funny analogies," "to make a lot more difficult things less threatening," and "to make me approachable." Another predominant theme was humor presented through the self. Other participants (n= 6) replied with: "It means being myself, using my creative force in my work," "I can be my real self with my patients and families," "It means that it is a simple human natural expression of need and desire," "It is a way of my being," "It means revealing myself as fully human," and "being authentic." One participant talked about possible excessive use of humor:

Part of it is a way of my being, so I think that is the most meaning. It's a way of my being. I've had to learn to temper it, based on where the client/patient is at. To me it is a very useful tool to put people at, to be more relaxed. I mean I have patients that call me 'XXXX XXXX.' Sometimes I think that "oh, I've gone overboard, I've gotten too much. But then well they tend to keep coming back so... it must be working.

Two participants mentioned the aspect of self-care and humor. One of them shared, "It means being able to sustain myself in this work." The other said, "It helps me reduce some stress."

Question number eight carried more weight in that the focus was on talking about death and dying with clients. The question was, "Are you able to discuss what will

happen to her/him at or approaching death in a humorous way with your client?" Some professionals (n= 5) were not able to discuss death and dying with their clients in a humorous way. There were no common themes in their responses. One participant noted there was a difference from supporting adults and children, "When I worked with adults this was a bit easier." "It is very difficult to approach the end of a child's life with humor." Another made note of using a certain type of humor, not with clients:

I've done it with funeral directors. Now that's different because we were sort of equals, and we were in a car together and because it was just us. I'm not sure gallows humor is appropriate at end of life. Some people might find it humorous that someone's kicking the bucket, it may be funny. This is not the time for that humor. It's not.

For other participants (n= 5) the general reply was that they would follow the client / family lead. Again participants produced phrases like: "go with the patients' flow," "follow their lead," "take my cue from the client," and "follow the client." The remainder of the participants (n= 3) communicated that they can and that they have discussed death and dying with their clients in a humorous way. One participant shared some of the death and dying analogies used at their facility:

Yes, and there are many analogies...some have asked ahead of time that we let them know when: TO GET THE SHOVEL, PACK THEIR BAGS, GET THE BUCKET, CALL THE UNDERTAKER, OR WHETHER THE ANGELS ARE SINGING, RALLY THE TROOPS; TO NAME A FEW. Other themes that may give rise to humor is the question posed to the Hospice staff: WHY ARE THEY BEING NICE TO ME? WHY ARE THEY WHISPERING?

Transference, Countertransference and Use of Self

Having a sense of humor has been recognized as a coping mechanism. The participants were asked if they believed that a clinician who works in palliative care has

to have a sense of humor? why or why not? All participants (n= 13) believed that having a sense of humor was helpful, but some (n= 3) didn't believe it was necessary. The common themes revealed were: self-care, client focused, and hiring. In reference to the self-care theme the majority of participants (n= 8) asserted it. One participant shared this:

You know why I'm laughing, what it is? If you don't have a sense of humor and I'm thinking about all that we do. What do they call it? Like the graveyard humor that you see. The GALLOWS HUMOR, yes that's it exactly! That you know there comes a point that you are soooo full of grief and loss that you're either going to laugh or cry! And so I think that people do that gallows humor kind of thing especially with their colleagues or something; it looks morbid from the outside. [But] it's a release of tension.

A clinician stated, "It is sometimes a darker sense of humor, but that is a coping mechanism." "Again used to sustain the clinician in this work." Other responses were: "lest we get depressed ourselves," "to blow off steam," "have to do something or it will kill them," Some of the participant (n= 5) replies were focused on the client. This is what one clinician shared:

When it comes to use of it (humor) in palliative care, because palliative care again is about allowing the natural to unfold in every level of one's being without too much direction. Another words, it's not just the natural unfolding in a physiological sense, but it's a natural unfolding in a psychological sense, and in a spiritual sense. You know I think that's what palliative care should be about. And so humor and sadness, joy and anger, all of those have a place. If you can't meet or at least allow for a natural unfolding of all emotions, which can sometimes move into humor, and use of humor, then I think that makes the whole process more difficult.

This is another clinician's perspective of having a sense of humor and working with clients:

I think knowing that humor can help and hinder is important. Between knowing that humor is a part of working with people and knowing how it can bring you a little closer to connect with people is important. How it can defuse a situation.

How it can reinvigorate a conversation. Or how the person can use it as a coping or defense mechanism. How sometimes people are using humor to not address what is going on. So, it's like anything else, it's something... that needs to be looked at and hopefully clinicians will sort of um... have some radar about that in their own work or if they [are to] use it or not to use it.

The clinician brings up another previous theme, that humor can be helpful and may hinder too, that it needs to be used judiciously.

The last common theme and an unexpected one was being mindful of someone's sense of humor when hiring future professionals. Two participants brought this up in their responses, the first had shared this:

You know, when I interviewed to hire social workers at the hospital in this program, I did take a look at their lightness and whether they could be light and smile during the interview. I appreciate the theory on this and some people come into the work to be at a peaceful state with the people. But I really, I think if I hire anybody, I would take a look first at how light they can be, and if they could be. But that's, it's pretty big for me. It's sometimes hard, NO, it's pretty easy to tell in an interview.

The other response in reference to having a sense of humor and hiring was:

It's helpful. It's certainly not in anyone's job description, but I would look for it if I were involved in interviewing prospective staff. We have such an intimate relationship and for our palliative care clients, we are in their homes and bedrooms, we meet family members and we may see them for over a year. If we can't find something to laugh about in that time, we're not doing our job.

Inquiring about transference and countertransference aspects, I asked the participants if they thought they might have influenced clients with their own sense of humor? The majority of professionals (n= 9) responded affirmatively that they did influence their clients with their sense of humor. A few participants (n= 3) replied that they didn't or were not sure if they did influence their clients. One participant responded

with a poignant statement, "I think that I can lighten their experience of what is happening to them without making light of their experience." There were two themes that carried throughout the replies, the professional's use of self and being cautious. One professional pointed this out about the positive and negative outcomes of use of self:

Yes, I think in a good way it can loosen them up. Like I said to get to things that you might not have otherwise. If I move into humor because I'm nervous about something, um.. I think that that can be used in a negative way, in a way that I'm not intending. Because if someone is in a more serious place for whatever reason and I'm anxious or whatever or nervous, or something is going on internally with me and I use humor as an outlet for my own anxiety and they're not there, that could stop conversation as well. So I guess humor could be used both ways. As a conversation stopper and it also could be an opening.

Others responded with: "It helps me join with them," "A client warms up and a small bit of humor gets interjected," "I try to bring the gift of themselves," "It's very allowing and allows them to have it," and "I have to teach coping strategies."

Some participants (n= 3) replies carried the cautious theme. Their responses were: "I try to be mindful that I can do that and be careful," "You kinda err on the side of caution," and "I have to be cautious."

With a focus on transference the participants were queried, "Do clients typically feel the need to have you be humorous with them, or not?" and "How do you address this issue?" The majority of participants (n= 7) stated that they did not believe that their clients typically needed the professional to be humorous with them. Some participants (n= 3) responded that yes they did believe that their clients typically needed the professional to be humorous with them. A few participants (n= 3) stated it was dependent on where the client was at. The major theme was the concern about the "need" of humor

from the professional (n= 4) by the client, raising more questions about the client's denial, defenses and masking. One participant shared a poignant lesson:

Rarely, I think most of my patients -- I don't really know if this is true -- but I think most of my patients probably experience me as warm, you know, and so I don't think they NEED to look for other stuff. You know: other manifestations of my liking them or being happy to see them, or you know be comfortable with them, that kind of thing. So I think, you know when people NEED you to be funny. You know, I have this one patient who is sort of a joker, um, he's an anxious guy and he is very creative and he is very, very smart. He has a bad prognosis of his illness, he is very functional still, you know he gets around, travels, raising a family, um. You know I think that one of the challenges in working with patients in all settings is that, um, you know, following someone's lead doesn't necessary mean doing what they are doing. So if someone makes a joke about dying, it's not necessarily asking you to make a joke about dying. It might just be asking you to help them to talk about dying. And it may be that the best response to their humor is a very, very serious discussion about dying. Um, so you know it's sort of like, it's sort of like, you know, if you're a WASP, and sitting with another WASP, the WASP can make a joke about being a WASP, you know. If you're sitting with a, you know, a Pentecostal, or a Jew, ha, ha, ha, and they're making a joke about WASP, you might be offended, you know, so, none of my patients have reason to believe that I have a risk of dying. So [in] that I'm not imminently dying, I'll let them make the jokes about dying, you know, and be very, very careful about making jokes about dying. Um, now I say making jokes, but there are lots and lots of ways of making humor. Um, sometimes what you're laughing about isn't so much about dying. What you're laughing about is ah... how frantically people cling to life.

Another theme that had evolved earlier and came out again was the need for a professional to be real and authentic. One participant responded, "They just want me to be real with them." In reference to those professionals who experienced clients needing them to be humorous was this reply:

I have a couple clients who come back that say "I love meeting with you and I love, and I just want to see you for a few minutes so that I can smile or feel light." There are a few -- whether it's, some of it is just my nature. I mean I have intent with my humor. But I also have this nature of mine.

One participant brought up an interesting point that speaks to our society's comfort / attitude with death and dying and how that may be internalized by some clients.

The respondent shared this:

I don't think it's typical. Um, I think, um, they usually anticipate the opposite from people. That they um, when if they are dying, people will come in and be all serious, crying and be met with doom and gloom. Um, I mean you hear it all the time. When people ask you what you do, and you tell them I work in hospice or you're a grief counselor. They'll go "oh, doesn't that make you sad all of the time." It's sort of a cultural anticipation. Um, so I think what happens is that when humor is used there is almost always some sense of a corresponding spark of an okay-ness, an allowance for it.

Another participant spoke about a professional's training and comfort with using humor. This person shared:

I haven't heard it, maybe it's because of it's my style, to move there at times, once I have that relationship. I think more and more experienced clinicians will go there more easily. [Not at first] the psychoanalytic oriented ones, because initially the training is so, can be so, seemingly rigid and less relational. I think the longer you're in the work and the more comfortable you are with your own style and your personality style and how you work, you're not trying to mold yourself into someone else's way of doing the work. Then it's easier to allow yourself to use [humor] if you have that little light-hearted piece to go there sometimes.

Probing about possible discord, the participants were asked if the client's humor was not in accordance with their own and what if there is a conflict / offense? Some participants (n= 6) replied that it's about the client not about the professional, and they would not join in. Several participants (n= 3) responded that they would not say anything and let the offense pass. One participant's focus was on the size of the offense. They stated that if the offense was small they might address it in a "sort of light way," if the offense was "egregious and would make me feel really icky, I would say something." Another participant's focus was on how well they knew the client. They stated, "If it's

somebody I don't know too well, I'm probably not going to say anything." "If it's someone I know pretty well, I'd probably use humor to confront them." Another "kind of a politically correct" participant focused on an opportunity to "do some inter-educational interjection" with any offense presented. One other participant took a diplomatic approach and stated that she would, "apologize and ask if there's another interpretation of what the professional misunderstood."

A few other themes were articulated, such as the importance of maintaining the client / professional relationship and a willingness of the professional to explore further when necessary or unclear. Other perspectives were: the awareness of the environment, private sessions versus group, and being in someone else's home. The client's offenses, biases or prejudices stated by the professionals in their responses were centered around: racism, socioeconomics, obesity, and homophobia. This is the response from one participant:

Um, I remember this one guy using the "Nigger" word A LOT, and I felt that I was in his home. It's just like smoking, I don't smoke, I may not want to be around people smoking, but I'm in their home serving them [so] I need to kind of tuck it away.

Wanting to explore the religious / spiritual influences on palliative professionals' approach to working with their end-of-life clients, I asked, "Do you believe there is an afterlife?" "Does this influence how you approach your work with clients, and [if so] in what ways?" The majority of the professionals (n= 6) responded to the first part of the question stating that they were not sure if there is an afterlife. Some participants (n= 5) replied that they do believe in some form of an afterlife or eternal life. The remaining two participants stated definitely that they do not believe in an afterlife.

To the second part of the question, "Does this influence how you approach your work and in what ways?" again, the majority of participants (n=10) responded "yes," it did influence how they approached their work with clients. The remaining three participants stated that no, their beliefs did not influence their work with their clients. The unfolding theme was that professionals would explore such an issue further with their clients. One participant shared this:

I will ask. I will often ask people what they are thinking, have they been visited by somebody. In bereavement you often hear about visits from loved ones in different ways, in dreams coming to them outside, and different places. I always ask, and I believe what they tell me. I take seriously what they say.

Another professional who believed in an afterlife shared this:

I do see death as a journey. I see and hear angels at times. This is beautiful, mystical and life altering for me, every time.

Other responses in reference to ways the professionals worked with clients were:

"work to support the patient and families wherever they are," "don't criticize my client's differing religious beliefs," and "find meaning in their belief."

Exploring further influences on palliative professionals' approaches to working with their end-of-life clients, I asked, "If clients do or do not have a belief in an afterlife, how does this influence your approach to care?" "Specifically, how does this influence your use of humor, if it does?" A number of participants (n= 6) responded that their client's belief or non-belief in an afterlife had no influence on their approach to care or use of humor. One of the professionals replied, "Well, it doesn't influence my approach to care at all, and it wouldn't influence my approach to my use of humor because I try to match my humor to what theirs is." Other participants (n= 5) stated that their client's

belief or non-belief in an afterlife did have an influence on their approach to care and / or use of humor. One participant's reply was ambiguous and one other participant passed on the question. Two themes were uncovered: the first was a professional's curiosity about what gives comfort to the clients, and the other, discussed earlier, matching the clients, specifically in their humor.

One of the professionals who stated that the client's belief or non-belief in an afterlife did have an influence on their approach to care and use of humor claimed:

Well, maybe if clients don't have a belief in the afterlife per se, you know, I'll ask folks what does or doesn't bring you comfort. You know, what helps you cope with your illness? What or how do you cope with your impending death? And for some that is humor for them. So that would definitely influence, you know, how we would interact, how I would work with them. You know so that is identified, as something that may be foreign to them.

Others responded with, "It gives you a possibility of greater subject material, if you believe in an afterlife you can use humor about the afterlife, ha, ha, ha." "It opens a conversation about what happens when a person dies and what that means or has meant for their life/legacy." "My use of humor in this area would depend on the relationship and rapport I have with the client."

To allow the participants an opportunity to reveal some of the major countertransference concerns, I queried, "What countertransference issues have been most challenging for you?" The major themes were: family parallels (with the client's circumstances), personally identifying with clients, and wanting to make things better for the client. The majority of the participants' responses (n= 7) were centered on family parallels and personally identifying with their clients. A few of the participants' responses

(n= 3) were centered on wanting to help improve the client's end of life journey. Three of the participants had very unusual responses.

One of the participants whose response was centered on family parallels and personally identifying with the client and her use of humor shared this:

I think after my father died, and I would meet other people with lung cancer who were dying it was very, very difficult to hold back. It talks about my experience with my father and wanting to influence, and this was unconscious until it became conscious, trying to influence family members to have a different experience. So I think that that was probably be, would be the most... you know when there is a very similar story and after my dad died, I think the first two years. After the first time it happened it was like when I walked away and got to my office I went, "Oh my god, what did I just do?" So I had more of an awareness, but I found myself still kind of 'eeking' things in and it took, I think it was just part of my own grief process. So, my story is my story, and I pretty much just keep there. The other challenging part is if any of the other people ask me if I had cancer or not. Um, I really wrestle with myself, if I tell them, if I do or not. When I first started I did, and ... because I thought it would be helpful for people. But then after a while I got to see that they started spending more time on me, their wanting to spend more time on me and my experience and I wasn't necessarily moving them into their own experience. So then I just totally just stopped telling people. Not necessary lie about it, but I do try to get around it. That's where humor comes in. HA, HA, HA! That's where I use my humor, it's really deflecting. Deflecting off myself.

One of the participants whose response was centered on wanting to help improve the client's end of life journey shared this:

I think I get really caught up in wanting some, wanting people to be at some peace. Like especially if there is a lot of family discord, you know. That's maybe not as hard as it used to be, you know, but it still pulls the heart strings. Really wanting to get things tied up in a bow. You know, clients are saying how they would love to reconcile with family members or this or that, whatever, you know, because I think it pulls you, you know, it's heart breaking and it makes you think about your own family and what if we were ... you know, what if something happens like that. So I think that's big. And a lot of countertransference comes I think inside of me when people don't have many folks, or none.

One participant had a unique response in reference to abusive and neglectful clients:

I have a client that I believe is verbally abusive towards his wife, and may be physically abusive towards his dog. I have to work harder to try and relate meaningfully and value this dying man as worthy of my respect – even if I don't like him. Some family members are neglectful of their dying parent's physical and emotional needs. Again, I work hard to respect them and listen empathetically – when they upset me.

Another participant had a unique response in reference to orthodox beliefs:

Probably the most difficult for me would be working with somebody who has a very orthodox, um, belief system that is punitive and exclusive in anyway. Oh for instance somebody who, let's say has a family member who is upset with the person who is dying because they have not accepted Jesus into their life, or the way in which the family member NEEDS to accept Jesus into their life. To believe that that person might actually have some possibility of a good afterlife and knowing that the grief process and bereavement processes of the person as well as the ongoing relationship with the person who is dying. All of that could cause great suffering because of a very punitive belief system.

A participant had a rich response in reference to specific clients, personal values, and insecurities:

Really, angry, accusatory patients that I feel they are like, unjustly accusing me of something I didn't do, those are hard, and it's usually displaced anger about what's going on with them and I have to do a lot of processing around that. I also have to look at if I did anything to cause this, and I hate to stir this up, but there are more borderline type patients where you can get a lot of crap, and that's just part of the transference stuff, and that doesn't change just because they're dealing with end-of-life, because it can just intensify it. Those are tough, but I usually do want to see someone before they die, for my own closure. Especially if it's someone I really cared about, and there is something about working with people at end-of-life for me. It's such an intimate work, you do. For me I do get very close to many of these patients and that's hard because you want to be there near the end, in some way, just to visit at least, put closure for myself. So that's a CT for me, I know that. You know I lost my whole family tree in the Holocaust. It's no accident that I'm working [with] dying people. It's no accident that I'm working with my grief every day, grieving survivors, so I know that I'm sensitive to those areas. Um, you just don't forget that stuff.

Part of it and the other sort of CT is for the reality piece, too. I think that goes in here, it's sometimes getting really clear what your values are. And one of the teachings of my own religion is you definitely do good deeds, period. It's commanded, it's not just altruistic, it's more than that. So for me making extra time for my patient or taking time out of my schedule to do that or whatever is a mitzvah. It's also what I'm supposed to, it's part of my value system. So keeping my own value system, the work I'm doing, from my own needs to put closure, those all get wrapped up together.

Well here are [what] some of the other top CTs are: when someone has children and they are dying. When I can't say good-bye to a patient for whatever reason, because it's too painful for them to see me again. Because I remind them again of their diagnosis or whatever, that's hard.

Another issue comes up that's very interesting, is when you are working with a patient and you have one set of recommendations for them, and but you know the social worker from "lalalala" said that we could do this, and I'm saying something totally opposite. So you're going "Hum, okay so tell me more about that, and so the CT piece there is, am I off? Did I say something wrong? Or, am I right?" And that's a really new social worker. What is that? And so it's mine, I'm calling up XXXX, "So this is it, lalala, this the patient, this is the social worker, this is what I said, what do you think?" So it's that insecurity even 30 years in the work! Oh did I do something wrong! So wrong! ... That comes up occasionally, which is interesting. And the other thing that I think is going to come up is and I don't know how exactly how all of that will manifest more in my own heart, heartstrings which is what I talked to about with mitzvah and being with people is with the new Death With Dignity Act. If I'm asked to be with someone, as they take the medication, that could be really hard. And I support choice, near the end-of-life, and I also support really good hospice pain-and-palliative care. So that would be hard. (In a soft voice), I think that could be really hard.

One professional summed up the response to the countertransference question with this perspective, "So, you could argue whenever you misread a patient it is a countertransference error, right? You know, reading people is instinctually, it's habitual, it's a learned behavior that is largely unconscious. Um, and whenever you react to anybody, you are reacting to everybody you have ever reacted to."

There was some controversy in that a few professionals believed that, with time, as they matured as professionals, and / or completed their grieving and bereavement that

the countertransference gets better or disappears; others conveyed that countertransference never goes away. A few professionals addressed self-care again, talking about the benefits of participating and seeking out supervision, consultations, and team support. Several mentioned the use of humor to deflect attention off themselves.

Personal Experiences

To learn more about how professionals have used humor, I asked the participants if they would share two stories where they felt humor made a significant difference for a client (one where humor was helpful, and one where it was not helpful). The major theme centered on relationships, with the stories where humor was helpful: "creating a deeper sense of community with the client," "family and the hospice team," "building a supportive relationship between a client's spouse and the clinician," and "reinforcing ties to the professional." A few solo ideas presented acknowledged a professional's own humanity and sense of humor, diffusing sensitive issues, and wisdom. A participant shared this unique experience:

I'll share one story where it probably was helpful...probably one in which I was probably the client, sort of, ... and [in] that situation I was with a friend of mine. I was with this friend of mine in his dying process and at the time of his death. We had called the funeral home to come, um, and they came, um, as they do, to put the body in a bag and take him out of the home, and most funeral homes, you know people are taught to have a certain demeanor when it comes to this kind of thing. So I recall when they came in, and I was truly grieving. The person who had died had been a hospice chaplain, and a bereavement person and also worked in organ procurement. So, you know he had his own sense of humor about these things. One of the things that he had when he left the organ procurement place was, everybody had signed a body bag and gave it to him as a gift. Everybody had signed this body bag. So in the midst of how sad this was, yet I saw these two guys and they were going to take out their body bag to put XXXX in the body bag and I said, "Wait, just a minute, he has his own! HA, HA, HA, HA!" I gave that to them and there were these signatures of all these people over it. Just, it, their

faces, it was just unbelievable! And what that did in terms of being helpful for me was that it, in that moment, was to remember how truly wonderful XXXX was in his humor as well as his serious side. How he could take anything really and bring the fullness of human experience into life.

Another participant gave this perspective on some of the rewards working with clients in end-of-life:

... and I think in this population, particularly, laughter is often a form of manifest wisdom. You know, it's a real sense of what it's all about and it comes across in their humor, and that makes the work very, very satisfying. I need all the wisdom I can get. So patients that are willing to share with me, I am grateful.

The major theme regarding the client's well-being arose in reference to the stories where humor was not helpful. Some of the stories revolved around family members becoming upset. One participant noted this story with a client focus:

Oh, about 7 years ago now, I was working in another health system as an intern and I wore my funny clown hair and my red nose on April Fools' Day, um, and two women in a particular room screamed. They had to be medicated heavily because they thought I was a demon. They had Alzheimer's and that's when I realized that one doesn't do that. Ha, ha, ha! It was inappropriate.

Another participant cited this example of a client's hindrance to care:

When I facilitate support groups I definitely bring humor into it, but I also think I overstep my bounds in support groups with humor. In that, it has stopped in a deeper level of discussion. I did have a patient and his wife meet with me after group a couple weeks after, saying that they were uncomfortable with that. So that they just felt that they were in such a crucial place in their life and to make light of it just... it was hurtful for them. So, I was probably trying to care of everyone in the group but them.

In reference to experiencing a situation where humor was not helpful, a professional offered this therapeutic perspective:

...but what you have to understand. Those that may appear to be unhelpful in the moment, I have always found that it is always grist for the mill, as the saying goes. It does something, it's part of the alchemy and so um.... possibly down the line it would be seen as maybe not helpful but part of what had to happen.

To recognize and to better understand any consistencies working with clients in end-of-life care the participants were asked, "Have you noticed any patterns or themes in your work with patients in end-of-life?" The themes focused on both the client and the professional. There were many client-focused patterns and themes: finding meaning, fears, anxiety, guilt, sadness, remorse, anger, grief, surprise, relationships, questions about the unknown, "struggling with hope," "still living while dying," "having to think positive," "can never let your guard down," "wanting to go to sleep and never wake up," "wanting to talk about their illness / death and dying," "not wanting to talk about it," faith and spirituality, and "the cultural and terminology of cancer." A professional shared this:

I think finding meaning, people finding meaning in the illness, finding meaning in their life, right, finding meaning in their current roles. You know sort of grieving loss [of] life... grieving the loss of the future, lost productivity, changes in relationships, you know real substantive stuff like that. Grieving loss of kinda of autonomy and control of your destiny, or the illusion of [it]. Ha, ha, ha. Our destiny, you know um... ha, ha, ha. That's big and you know ah... and still the importance of a relationship, regardless. Even for folks that are more solitary there is still that level, some kind of relationship can be important.

Another professional gave several perspectives: cultural, talking about it, and medical professionals:

There is a lot of this, you know, I have to be positive. I have to stay strong. Um... this sort of culture and terminology of cancer. We're going to fight this thing, we're going to beat this thing. So there's a lot around the militaristic language of fighting. I'm going to fight this thing. And when they realize that the battle is, [that] they're losing their battle, there is [this] set up, by that language. Then it's the permission to talk about it. You know what, I've had a lot of conversations with patients who have said, my family does not want to address that I am dying,

they just don't want to talk about it, and I want to talk about. How do I talk about it? That's a theme, especially in oncology; even amongst the physicians this is a constant um... sometimes the physicians don't want to talk about end of life care!

This participant concurred:

I'm filling a gap that would really painfully be unfilled if we didn't have everybody taking care of this person. People will broach topics with me that they won't broach with other people. I mean one that came up several times in a very short period of time this month, it was very striking. It was patients asking me, how am I going to die? And I said well it looks like you're going to die of metastasized cancer. "But what happens, how do I actually die?" I'm like "I'm the psychiatric; they don't want to ask the medical oncologist?" Actually on a few occasions people had asked the oncologist and felt that the oncologist had refused to tell them, that they hemmed and hawed. Or they go, "People die in different ways, or any number of things could happen, you know we won't know until we get there." That kind of stuff, and I said this is how it works, this is how it works, this is what is happening, the vulnerabilities that you have, these are the different ways that people die. Rather than saying, oh, people die in different ways. I say "Here they are: these are the ways that people die, these are some of the ways." And they'll say, "Well, what do you think will happen to me?" And I'll say "Wow, I don't know what will happen to you, but given the x y z's that have happened so far, the worst example of that seems like a reasonable answer." I give them books about dying, and that sort of stuff. They just don't get that at anywhere else. I think that maybe one or two of the social workers have substantial hospice experience and are better able to answer some of those questions but I feel that the patients don't ask them.

The words and phrases and themes that developed around clinicians were:

"having a sense of seriousness," "being quiet," "active listening," "supportive," "following the patient," "being there for them," "everything about them," "keeping myself out of it," "let people feel taken care of and safe," "teaching an allowance of just a normal condition," "making referrals," and "allowing them to talk about it." One professional talked about being client-focused and available, no matter what:

Following the patient, listening to them completely, being there for them. Having it to do with nothing about me, and everything about them. Keeping myself out of it makes it an entirely different outcome. Knowing that you can be there for

somebody or having somebody feel that you're there for them and that nobody can say nothing, that they can't do anything that will make you stop from coming back.

Wanting to know more about the concerns of clients in end-of-life care, I probed the participants with, "Have you observed any particular influences that have repeatedly caused anxiety and strife for clients in end-of-life care?" A plethora of anxiety causes were cited, the major themes were: physical pain (n= 5), family / relationships (n= 5), the medical team (n= 4), fear of death and dying (n= 3), the unknown (n= 3), and religion / spirituality (n= 2). This professional talked about the anxiety of pain:

The anxiety around pain comes up and hospice is very good with that, taking care a lot of that. But when it's not well managed in a hospital setting, or something like that, that is so... terrifying for them I think. It's often difficult for the family to watch, and you probably know that hospitals don't have the same regulations to up the morphine or whatever to relieve the pain, as does hospice.

Another professional shared an interesting perspective on family / relations:

Family conflict, it takes at least two different forms, one is being in conflict with a family member, the other is um.. feelings of guilt or regret over not behaving with other family members in a certain way. The other is, another is um... feeling responsible for unresolved conflict between other family members. And feeling like it's your job before you go, that kind of thing.

This professional addressed possible client anxiety brought on by the medical team:

Yes, when providers can not, um... have, um... open conversations. When they don't leave time and allowances for people to express what people are experiencing, without the provider jumping in from the very beginning and directing the whole thing. In the direction that they feel it should go! Then I think it makes for a hell of a lot of anxiety and strife.

Some of the other causes of anxiety and strife for the client were: being a burden and becoming dependent, unable to do things, psychological suffering, "prior traumas," not

being in control, "what I look like," "why me?" "regular check-ups," "care giver issues," "treatments," "being alone," and "hanging on or letting go." A few unexpected responses were: "computer glitches," "clinicians who try to normalize things," "comatose clients are challenging," "reactions and coping mechanisms of family and loved ones."

Wanting to know more about how to help mitigate the anxieties of clients and if clients turned to humor, the participants were asked, "Have you observed any particular influences that have repeatedly offered solace to clients in end-of-life care?" Again there was an abundant number of ideas with the major themes being: touching (n= 4), the hospice team (n= 3), music therapy (n= 3), pain management (n= 3), faith / prayer (n= 3), relationships (n= 3), being able to talk about it (n= 2), and being able to say good-bye (n= 2). The words and phrases from the participants in reference to touching were: "gentle touch," "touch," and "sex, massage, and snuggling." The responses in reference to the hospice team were: "having the hospice team," "their treatment team - hospice," "well hospice for sure, some of those great chaplains, some wonderful nurses, and wonderful social workers," and "hospice social workers." The words and phrases used in reference to pain management were: "resources to address pain," "having people's pain managed," and "ensuring that our clients are as comfortable as possible."

Humor was not one of the major themes, but it was mentioned by one participant, as offering solace to clients in end-of-life care. Several of the other influences mentioned were: "meaning making / finding," "keeping life as normal as possible," "having choices," "achieving last wishes," and "the promise of a better life." There were no surprise responses.

To better understand the influence of humor on the participants, they were asked, “What role does humor play for you in your personal life?” A copious number of replies, the major themes, words, and phrases were: the use of the word “love” in reference to humor (n= 12), participants partake in humor with others (n= 8), the significance of humor in the participants’ personal lives (n= 7), humor helps when things are not going well (n= 4), and humor is an important part of their marriage (n= 2). The professionals "love laughing and love to join in," "love a good laugh," "love creating puns, or humorous toasts," "love knock-knock [jokes]," "love to play with people," "love to tease," "love a good giggle," "love to be around all those people that stimulate that in me," "love those people," and "love slapstick, physical humor satire, and British humor." The professionals enjoy their humor with other people in their lives: “family,” “friends,” "grandsons," "my kids," "wife," "husband," “co-workers,” “peers,” and “clients.” Humor is significant in many of the professionals lives: "it's a pretty big part," "it's pretty big," "plays a large part," "very important part of my life," "important in my life," and "a very significant role." When things are not going well for some of the professionals they turn to humor: "I have a tendency to make jokes about stuff not going well... a way I let off steam," "I turn to humor when I have had a bad day, helps keep me de-stress," "I also use humor sarcastically when I'm angry" and "I seem to find irony in situations, the hard moments." Two participants shared how important it was in their marriages, one stated:

Well, it has to play a large part because I've been married for over 30 years to somebody who is my opposite. HA, HA, HA!!! And so if you don't have a sense of humor you're really S.O.L. Ha, ha, ha!

The other shared:

Just in the last, in the last month or two, my wife said to me that she thought that I had a good sense of humor, and she thought that was an important part of our marriage. That, that helped kind of thing, and it would never have occurred to me if she hadn't told me. So I think that I asked her to elaborate on it, and what she pointed out was something about, um, not letting stuff get to you, shit happens! Yeh! It's too bad. Wait around; it will happen again.

One participant talked about how he used humor as a child and the impact it had on him as a palliative care professional:

Very different now than when I was growing up. I was a very thin frail kid, afraid of my shadow. I'd had a brain injury that caused me to have limited motor responses in my hands and kids laughed at me, and it was an incredible painful experience for the first 15 /16 years of my life. Ah... going through Coast Guard boot camp, having some other training, ah... perhaps I became more of who I am because of that sort of rejection. I used humor back then to mask all the feelings I had and [was] unable to say. So I told jokes, half of which were inappropriate and I joked my way out of masking real sorrow and pain. Which is why it would be impossible to [be] doing that in a patient's pain.

Another clinician shared an earlier time in the person's life as a palliative care provider:

I try to laugh whenever possible. There was a time in my early life as a palliative care worker when I felt like I had lost my sense of humor. Everything felt very serious and I even found it somewhat difficult to relate to others. After taking a close look at that, I realized the increased need for self care in this line of work. I can't stress how important that is. I try to leave work type of things at work and not take them into my personal life.

Another professional closed with this in his response, "It's true, one of the greatest challenges of life is what to take seriously and what not to take too seriously. How to never take yourself too seriously, that kind of stuff is the difference of being miserable and being ready for the next day."

Professional Development

According to the Association for Multicultural Counseling and Development, culturally skilled counselors seek out educational, consultative and training experience to improve their understanding and effectiveness in working with culturally different

populations. (Murphy & Dillon, 2008). The questions in this portion of the interview focused on professional development, the first focused on cultural competency. The participants were asked, "As a professional, what does cultural competency mean for you?" The participants had a surfeit number of remarks, major themes were: professionals need to keep learning (n= 12); cultural differences were mentioned often (n= 8); professionals saw the value in learning from their diverse clients (n= 7); participants believed being aware / curious was beneficial (n= 5). A few participants did not believe that any of us could be culturally competent (n= 3); several believed every person should be approached as being different, even from the same culture (n= 3), and some reported that saying, "I don't know," is a good thing (n= 3).

All but one professional commented on being open to learning. The following phrases were used: "you can educate yourself," "better understand their culture," "find out about," "trying to understand somebody else's story," "try to be educated," "possibilities of exploration," and "so that you never stop learning." The participants pointed out differences, and only once mentioned similarities. Some of those stated differences were race, ethnicity, socio-economic status, religion, and generational.

The majority of professionals believed that their key way of being educated was by their clients. The following phrases were used to convey this: "inviting my client to help me understand," "my client is my teacher," "they'll teach me," "asking the family," "asking all the right questions," and "possibility of exploration and for that to be offered." Several participants voiced the perspective of always being culturally "aware," "curious," and "open." A few professionals stated that they don't believe that any of us can be culturally competent. One participant shared this:

Cultural competency, I don't think we are ever culturally competent, because every person is different, even from the same culture, is different. If I go to another Jewish daughter of a Holocaust survivor, their experience around that is going to be different than mine. I can't make any assumptions. Depending on when their parents were married, or if they were abroad. I can't make any assumptions.

A small number of participants consider that not knowing is okay. One professional had this comment: "I think, you know the three most important words for a clinician are, 'I don't know.' So I think the ground of cultural competence is not knowing."

One participant spoke regarding historical experiences and skepticism that bears mentioning.

...let's say you take a culturally competency class on working with African Americans, and Latino clients in a health care model, and learning about cultural context. Things like body language and eye contact, and um... you know how different cultures may, MAY BE, more influenced by this thing historically or whatever. It can come into, it can be barriers, BARRIERS to access to care. So sometimes people may be skeptical of the medical system. So when you're coming, being mindful of those things.

The majority of participants agreed incorporating humor was helpful for the client in end-of-life care. It seemed logical to ask in reference to professional development if they believed that clinicians could be taught on how to use humor with their clients, why? or why not? The majority of participants (n= 8) did believe that clinicians could be taught how to use humor with their clients. A few professionals (n= 2) qualified their affirmative response in that they agreed that professionals can be taught the freedom or permission to use humor. A couple of participants (n= 2) did not believe that humor could be taught. One participant's reply was ambiguous. Another, perhaps contradictory theme was that humor or one's sense of humor is inherent (n= 7). Words or phrases used were: "some

people are just more natural," "a person's nature," "style," "instinctual," and "it is intrinsically in you."

A few participants (n= 3) had ideas on how one could learn or be taught how to use humor through "observation," "role modeling," or "role playing" from other clinicians. Several participants (n= 3) considered the use of humor with their clients as another tool / skill. Two participants were concerned that professionals learn the appropriate use of humor, "if the timing is right and it's appropriate," and "how to do things appropriately, to use it or not to."

A participant, a supervisor, brought up this observation about previous students:

So I think there are people who have a humorous nature but don't know how to use it, they would be easier to teach how to use it and how it would be a good therapeutic intervention. I think about I look at the students I've had who um.. at YYYYYY. There are some that would never be able to pull it off, and then there are others. It's all about nature and how to use it therapeutically.

Another professional concurred, that it was all about nature:

Oh, I don't think so. Some things, I don't believe anyone can learn how to have a heart and soul. You either got it, you either got the gifts and graces or you don't. Education can teach you wonderful things in books. I've never had a course that taught you how to be fully human, ever taught me how to be a real person, ever told me what it took to have a heart and especially never told me even in seminary what it was like to have a soul. You can't be taught stuff that you can't see, touch or feel. Some people got it and some people don't.

The professional's perspective stated immediately above was refuted by the following participant's statement:

There is an enormous range of clinicians in appreciating what aspects of themselves are helpful with patients and what are not... . You know what the goal of the physician, or any clinician is to be, [to be] clinically effective. You know and that means that everything that you do should be oriented in that direction. Everything that you do should be oriented to clinical effectiveness. Especially in an era where value is so huge. We are so focused on making sure that we're doing the things that are evidence based, that are reasonable, that are efficient. That are

effective, [have] value you know, and... um.. I think that it's a great thing that has changed medical education in the last 10-15 years. More emphasis on the patient / doctor relationship, more and more emphasis on the quality of interactions clinicians have with their patients. Um, and I think it's something that you really have to work on it. And I think that it may be one of the things that appealed to me in psychiatry, is that that's what it's all about. That's what it is all about. But in psychiatry, it's EXPLICITLY what it's all about. Yah, you know. There is a great story about Freud, were Freud tells this story about were he needed to hire a nanny so he put an ad in the paper, and he would interview [the applicants] to see who he would hire to take care of his daughter and ah... one woman came in and he asked her "Who are you?" and she told him and he says, "Do you have any experience?" And she says "Well yes, I was once a child myself." And... I think a lot of clinicians approach their interactions with their patients the same way. They think just as long as they have been alive, interacting with people, as long as they have been interacting with people and they are essentially successful in their interactions with people, that they know what they are doing! And they don't, they don't! (Quietly). Because when I think about how much time and energy I have devoted to figuring out what the hell I'm doing. Ha, ha, ha! Over the last 30 years, I still don't know what the hell I'm doing. Ha, ha, ha! It's a lot of work. But it's teachable, it's learnable. It's not you either got it or you don't. Um... Having it helps, but it's not [all of] it. You can teach people this, if they are open to learning it.

To comprehend the teachable moments, and the communities' culture settings, the final question in the professional development section asked participants if they had talked with supervisors and peers about the use of humor in therapy and if so, what have been their opinions / perspectives. The majority of participants (n= 7) had talked with supervisor, peers or supervisees about the use of humor. Several of the participants in the study are supervisors. The remainder (n= 6) replied that they had not had any discussions about the use of humor with supervisors or peers. There were a wide variety of opinions given, there were no major themes identified. The following is a list of stated opinions:

1. "Humor can be a great tool if you have the knack."
2. "It can make people feel at ease and make it easier to join with them."
3. "Be who you are."
4. "If it isn't you, you don't do it."
5. "Knowing your limitations."

6. "Making sure that humor doesn't mask something else."
7. "It is valuable in large group settings."
8. "Using it as nurturing doesn't work."
9. "That humor is part of resiliency, being resilient as a human being is good, and the importance of promoting the resiliency in clients."
10. "Humor might be used with physicians."
11. "You have to laugh in this line of work."
12. "Need more dialog and education, think of Patch Adams, and clowning."

A participant had this comment about using humor and humor therapy:

I think the first thing people think of humor therapy [are people] like Patch Adams, or like someone who is sort of a clown, or someone who is coming into a medical environment who is bringing in FUNNY. To having someone, just a clinician, a practitioner who uses humor, who can use story, to use imagination to help heal, and to help honor where somebody is in their healing [is enough]. So that is the education piece, is to let people know that it can be used by anybody, because we do it anyway. But just to identify it, and it's not about. I think it's about educating, it's about educating people. Humor therapy isn't necessarily, it doesn't have to be systematic, like you have to be trained in humor therapy, or you don't have to be, it's not something formal, were you have to have someone come in and DO humor.

Additional Thoughts

Bringing closure to the interview the participants were given the opportunity to share anything else they wanted to with future social workers entering the palliative care field. The obvious five major themes were: 1) self awareness, 2) self-care, 3) putting aside your own agenda, 4) the patient / client tell us what they want, and 5) that we need to be authentic and genuine.

One participant recapped with "[the need to] be aware of, and counter your own countertransference," another added "the self awareness piece is critical." One professional shared how crucial self-awareness is:

Just about your own beliefs about palliative care, about end of life, not that you have figured out the meaning of life, or what happens to us when I die, but just that you are more aware about what your buttons are, what the hard things are,

what are the things you are pretty certain about, so you can separate what's yours and what's [the] client's stuff.

A clinician believed that palliative care can be both rewarding and challenging work. "As palliative care workers, we carry a lot of grief." "It's important to take care of ourselves." Another participant suggests the same but for a different reason, "Make sure you take good care of yourself as you do this work - you cannot be effective with your clients unless you practice good self care. One participant reiterated, "It's very rich work, it's very difficult work; I guess you get to find your place in it." "Remember, self care and all of those things that you need."

A few of the professionals had more reasons to put aside their own agendas. One clinician suggested, "checking your agenda at the door " because:

...sometimes people do enter this field, they see themselves as making it all better. Or um, whatever's ok, they have some belief in that, or value and that's their agenda. And it's always important to check your agenda at the door and figure out what it is that the patient and the client needs, because they may not want anything that is on your agenda. And if they don't know? Well, ask!

Another perspective on agendas:

Try to put aside your agenda and worry about doing the right thing. You'll find out from people what's going on in their head or about their worries and hopes. Because their world has lots of agendas, you know the curative, etcetera. But trying to sit back, take a deep breath, and relax, and you know [of] course that is the goal of all therapy.

The above quotes also pointed out that you will learn what your clients need from you. Here is another supporting response:

We are going into people's homes and it's their home, they have a right to throw us out. They have a right to tell us what they need. Most of the time people know

what they want, they just need us to encourage it. Ah... people don't need to be told what to do, and if there is a problem, it's probably our problem and not their.

A few of the participants' final responses reinforced being authentic and genuine.

Another was, "Start caring now!" One clinician shared these last words:

Don't be afraid to be humorous or to use humor, and again gauge how it is working with the person, or even ask them. I think it's one of those things we can give [them]. [We can ask, "Are there ways that you would like me to bring humor into your life?"] So don't be afraid to bring it up.

CHAPTER V

DISCUSSION

A primary objective of this qualitative study was to explore the skills and techniques that palliative care professionals use when working with clients in end-of-life care: the use of humor, multiculturalism and other facets in the therapeutic dyad were explored through the narratives of the seasoned professionals in the palliative care field. This chapter discusses the findings in the following order: 1) key findings, 2) implications, 3) limitations, and 4) conclusion.

Key Findings

The results are presented in detail in the FINDINGS chapter; therefore, they will be only briefly summarized here. The participants interviewed said that:

- They do initiate use of humor with terminally ill clients, but whether they use it is dependent on the client and on whether the professional feels it is appropriate -- "trusting [their guts], being sensitive to the client and it being natural."
- They will wait for the client to initiate humor, and follow the client's lead.
- They believe that incorporating humor is helpful and appropriate, but with stipulations. They find that multicultural similarities do have some positive

influence on the professionals' use of humor, tending to increase the use of humor when there is a cultural match between client and therapist.

- Other influences on participants' use of humor were: family participation and the clients' psychological well-being.
- Participants felt that incorporating humor meant the humor was used as a tool, and that it was presented through the use of self.
- That participants do talk about death and dying with their end-of-life clients, some waiting for the lead from the clients.
- These 13 professionals believe that having a sense of humor is helpful, but not always necessary.
- These professionals do believe that they do influence their clients with their sense of humor. They do not believe that their clients need them to be humorous, if such a need seems to be evident, the clinician should be concerned with denial, defenses and masking.
- If a client's humor was offensive to the therapists or in conflict with the palliative care professionals' own values, the participating clinicians would not join in with the client.
- These palliative care professionals are not sure about an afterlife.
- Their opinion is that a belief in an afterlife would impact their approach to working with their end-of-life clients; however, the client's belief in an afterlife would not influence the participating palliative care professionals' use of humor.

- Professionals identified three countertransference themes: family parallels, personally identifying with the client, and wanting to make life better for the client.
- The positive personal experiences that participants shared focused on creating a deeper relationship with the client and their family.
- The negative personal experiences that participants shared focused on creating a discourse with the client or their families.
- The professionals identified a plethora of patterns and themes working with people in end-of-life: finding meaning, fears, anxiety, guilt, sadness, remorse, anger, grief, questions of the unknown, struggles with hope, still living while dying, wanting to talk, and not wanting talk, faith and spirituality.
- The results indicated that there are also myriad influences that cause anxiety and strife: physical pain, family relationships, medical team conflicts or lack of skills, fear of death and dying, the unknown, and religion and spirituality.
- Factors that participants said mitigated their clients' anxieties and strife were: touch, the hospice team, music therapy, pain management, faith and prayer, relationships, being able to talk about it, and being able to say goodbye.
- One participant stated that humor lessened their clients' anxieties.
- Humor is loved by the responding palliative care professionals, who valued sharing it with others, its being significant in their lives, and its used as a coping strategy.

- These palliative care professionals believe that they need to keep learning about their clients' cultures and that the clients are their best teachers. Respondents stressed the need to be aware, open and curious.
- The respondents believed that clinicians can be taught how to use humor.
- These professionals do talk with supervisors and peers about using humor with clients and self care.
- Participants in this study wanted to pass on to novice palliative care social workers their hope that these workers would be self aware and pay attention to countertransference, self care, put aside their own agendas, know that the patient will tell them what they want, and know that they need to be genuine and authentic.

Implications

The group of palliative care professionals participating in this study may not have offered a representative sample that can generalize to the entire group of palliative care workers. Although these 13 professionals cannot be presumed to represent an all-inclusive group, their opinions may be useful in suggesting topics to include in future research with a larger and more representative group.

Palliative care professionals reported that incorporating humor is helpful for clients during end-of-life care the majority of the time. Their personal experiences illustrated that there could be times where incorporating humor is not appropriate, but that the negative experience could also be utilized as an opportunity to deepen the relationship when these dysregulations were used for repair. As a palliative care professional, workers will learn as they go, these participants said, and much learning

will come from the clients. It is in the clinicians' and the clients' best interest that the clinicians familiarize themselves with their clients' culture beliefs, practices pertaining to death and dying, as well as how -- within their cultures -- to interpret family dynamics and loss.

Time was a limiting factor and it is hoped that future research can be conducted with a larger sample. Future research might be done with a larger number, and particularly with representatives of diverse populations.

Limitations

The limitations were the lack of diversity in the racial and ethnic composition of the group. There may be geographical or cultural differences across the United States that are important to the understanding social workers' skills in providing end-of-life care. The clients referenced in the study by practitioners also lacked diversity in their racial and ethnic composition; again there may be geographical or cultural differences across the United States.

The sample of self-selected participants was not a random sample. The sample size of thirteen is a small representation of palliative care professionals which only offers a glimpse into the experiences of a few in the field of palliative care. Because some of the interviews were done in person, those participants may have been influenced by my mannerisms, voice, and dress. My biases may have influenced the study. I performed stand-up comedy and I use humor as a major coping strategy. There were some inconsistencies with collecting some of the data over the internet. I created the interview questions researching past research using my own subjective verbiage.

Conclusion

A growing body of research is demonstrating that the use of humor in palliative care is both positive and normalizing for the client, allowing the client to continue to live while dying. The narratives in this study offered positive and negative experiences of palliative care professionals while incorporating humor into their work. The purpose of this study was to determine if there were multicultural and / or other facets that would inhibit palliative care professionals from utilizing humor in a therapeutic relationship. Social workers are encouraged to be aware of cultural differences and actively to explore the diverse cultures of their clients.

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Appendix A

March 10, 2009

Susan Lutzke-Hoff

Dear Susan,

Your revised materials have been reviewed and all is now in order. We are happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your interesting project. It will be interesting to see if EOL professionals want to sign on to a study on humor. That alone will be a finding!

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

Appendix B

HOW PALLIATIVE CARE PROFESSIONALS IN MULTICULTURAL OR MONOCULTURAL DYADS INCORPORATE HUMOR IN THEIR WORK : RESEARCH STUDY NARRATIVE INTERVIEW QUESTIONS.

Use of Humor

1. Do you introduce / initiate humor with your clients in end of life care? If so how?
2. Do you wait for the client to introduce / initiate humor? Why or why not?
3. Do you think incorporating humor is helpful for the client in end-of-life care? Why or why not?
4. Do you think incorporating humor is appropriate for the client in end-of-life care? Why or why not?
5. Do you find it easier to use humor with those clients whom you do match on a multicultural level? Why or why not?
6. Are there aspects other than cultural ones that may make using humor more or less likely to occur? What are they?
7. What does incorporating humor into your work mean to you?
8. Are you able to discuss what will happen to her/him at or approaching death in a humorous way with your client?

Countertransference/ Use of Self

9. Do you believe that a clinician who works in palliative care has to have a sense of humor? Why or why not?
10. Do you think you may influence clients with your own sense of humor?
11. Do clients typically feel the need to have you be humorous with them, or not? How do you address this issue?
12. What if their humor is not in accordance with your own? What if there is a conflict/offense?
13. Do you believe there is an afterlife? Does this influence how you approach your work with clients? In what ways?
14. If clients do or do not have a belief in an afterlife, how does this influence your approach to care? Specifically, how does this influence your use of humor, if it does?
15. What countertransference issues have been most challenging for you?

Personal Experiences

16. Can you share two stories where you feel humor made a significant difference for a client (one where humor was helpful, and one where it was not helpful)?

17. Have you noticed any patterns or themes in your work with patients in end-of-life care?

18. Have you observed any particular influences that have repeatedly caused anxiety and strife for clients in end-of-life care?

19. Have you observed any particular influences that have repeatedly offered solace to clients in end-of-life care?

20. What role does humor play for you in your personal life?

Professional Development

21. As a clinician, what does cultural competency mean for you?

22. Do you believe that clinicians can be taught how to use humor with their clients? Why or why not?

23. Have you talked with supervisors and peers about the use of humor in therapy? If so, what have been their opinions?

Other

24. Is there anything else you would you like to share with future social workers who will be entering palliative care?

Appendix C

Informed Consent Form

March 9, 2009

Dear prospective research participant:

My name is Susan Lutzke-Hoff; I am a graduate student working on an independent research project as part of the work for my master's degree in social work through the Smith College School of Social Work. The data collected will be used for my thesis and other presentations and publications. In this study, I hope to learn about clinicians' perceptions of the benefits and effects of the use of humor in the therapeutic relationship between multicultural and monocultural clinicians and their clients with terminal illness.

Your participation is requested in this research study if you have, at a minimum, a master's level professional license in a mental health related field (e.g., social work, clinical psychology, psychiatry), have had three (3) years or more end of life (EOL) work experience and are currently providing services to clients faced with EOL.

If you decide to participate, I will:

- Call/e-mail and arrange an interview time/location to accommodate both of our schedules. I will gather your mailing address information to send you a demographic questionnaire and a Multidimensional Sense of Humor Scale (MSHS).
- I will follow-up with a reminder telephone call/e-mail two days prior to the interview.
- You will bring with you to the interview the demographic questionnaire and the MSHS. Completing both documents should not take you more than 10-15 minutes.
- The narrative interview, to be conducted in person with you, will require an estimated time of one (1) hour. A voice recorder will be utilized with the interviews.

Data collection for this research study will begin as soon as possible and conclude April 15th, 2009.

I do not see any foreseeable risks to you as a participant, though a few uncomfortable feelings may arise as you recall situations with your terminally ill clients.

There will be no financial compensation for participation in this project. This study is intended to contribute knowledge to those professionals who provide end of life care, which in turn will hopefully benefit those vulnerable people facing their own death. I hope this study's results may enhance your own expertise; I cannot guarantee, however that you will receive any professional benefits from this study.

Your identifying information in the study will be kept confidential, adhering to federal regulations and the mandates of the social work profession. Data will be stored securely and will be made available only to myself. My academic advisors will see the data only after identifying information is removed. If a data transcriber is utilized s/he will assure confidentiality of the research data by signing a confidentiality pledge. All data will be reported without connection to any identifying information. The data will be stored in a locked file for a minimum of three (3) years. After three (3) years all data will be destroyed unless I continue to use it, in which case it will remain in a secure, locked location. The data will be destroyed when they are no longer needed. Findings from this study may be published or presented in various forms beyond this master's thesis; if so, the data will be presented as a whole. However, if some illustrative quotes are used in the thesis or future presentations they will be carefully disguised. No reference will be made in oral or written reports which could identify participants in the study.

Your participation in this study is voluntary; you may decline to participate without penalty. You have the right to refuse to answer any question(s) in this survey without penalty. If you decide to

participate, you may withdraw from the study at anytime without penalty until April 15th, 2009, when the final report will be written. If you withdraw from the study before data collection is completed, all information pertaining to you will be destroyed. You may withdraw from the study by contacting the researcher via telephone. If you have questions at any time about the study or the procedures, (or if you experience adverse effects as a result of participating in this study,) you may contact the researcher, at telephone number 541.292.7205. If you have questions about your rights as a participant, you may also contact the Chair of the Research Sequence or the Chair of the Human Subjects Review Committee at Smith College School of Social Work, telephone number: 413.585.7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant's Signature

Date

Researcher's Signature

Date

PLEASE KEEP A COPY FOR YOUR RECORDS

Appendix D

HOW PALLIATIVE CARE PROFESSIONALS IN MULTICULTURAL OR MONOCULTURAL DYADS INCORPORATE HUMOR IN THEIR WORK : RESEARCH STUDY DEMOGRAPHIC INFORMATION.

The object of this study is to explore the impact of multiculturalism on the use of humor in palliative care. In order for me to gather information that will allow me to document the scope/diversity of my participant sample, I would be most appreciative if you would provide the following demographic information about yourself, your background, and clientele by answering the following questions. Please circle and/or fill in the blank with the appropriate answer.

Demographic Information of Therapist

1. Age in years:

- A. 21-30yrs.
- B. 31-40yrs.
- C. 41-50yrs.
- D. 51-60yrs.
- E. 61-70yrs.
- F. 71yrs. or over.

2. Gender:

- A. Female.
- B. Male.
- C. Transgender.
- D. Other. _____

3. Ethnicity/Race:

- A. European American/White.
- B. African American/Black.
- C. Asian.
- D. Pacific Islander.
- E. Native American or Alaska Native.
- F. Spanish/Hispanic/Latino.
- G. Biracial/Multicultural (please specify) _____
- H. Other (please specify) _____

4. Socioeconomic status:

- A. Lower
- B. Lower middle
- C. Middle
- D. Upper middle
- E. Upper

5. Geographic location:

City/Town _____

State _____

6. Palliative care setting:

- A. Hospital.
- B. Hospice facility.
- C. Client residency.
- D. Other (please specify) _____

7. Years experience in therapy:

- A. 1-3yrs.
- B. 4-6yrs.
- C. 7-10yrs.
- D. 11-15yrs.
- E. 16-20yrs.
- F. 21yrs. and more.

8. Years experience in palliative care:

- A. 1-3yrs.
- B. 4-6yrs.
- C. 7-10yrs.
- D. 11-15yrs.
- E. 16-20yrs.
- F. 21yrs. and more.

9. Where did you receive training in palliative care?

Institution _____

City/Town _____

State _____

10. Have you had formal training in humor therapy? YES / NO.

If so, what kind of training or degrees do you hold? _____

11. Do you primarily match your clients on a multicultural level? YES / NO

11.A. In what way(s) do you match your clients? (Please select ALL that apply)

- A. Ethnicity/race
- B. Social/economic status
- C. Education
- D. Religious preference
- E. Other (please specify) _____

11.B. In what way(s) DON'T you match your clients? (Please select ALL that apply)

- A. Ethnicity/race
- B. Social/economic status
- C. Education
- D. Religious preference
- E. Other (please specify) _____

Demographic Information re: Therapist's Clientele

12. Client age range percentages :

- _____ % children
- _____ % adolescents
- _____ % young adults 21- 45
- _____ % middle aged adults 45- 65
- _____ % adults over 65

13. Is there a predominant ethnicity/race?

- _____ % European American/White.
- _____ % African American/Black.
- _____ % Asian.
- _____ % Pacific Islander.
- _____ % Native American or Alaska Native.
- _____ % Spanish/Hispanic/Latino.
- _____ % Biracial/Multicultural (please specify) _____

- _____ % Other (please specify) _____

14. Socioeconomic status:

- _____ % Lower
- _____ % Lower middle
- _____ % Middle
- _____ % Upper middle
- _____ % Upper

15. Type of medical diagnosis most commonly seen:

- _____ % cancers
- _____ % cardiovascular illness
- _____ % endocrine illnesses (diabetes, etc.)
- _____ % post-traumatic conditions
- _____ % AIDS
- _____ % Dementia
- _____ % ALS
- _____ % MS
- _____ % Parkinson's
- _____ % Debility unspecified.

Appendix E

HOW PALLIATIVE CARE PROFESSIONALS IN MULTICULTURAL OR MONOCULTURAL DYADS INCORPORATE HUMOR IN THEIR WORK :

The Multidimensional Sense of Humor Scale

Developed by Dr. James A. Thorson & F.C. Powell

We are conducting a study of attitudes and would appreciate your help. If answering these items threatens you in any way, please just return a blank questionnaire. Please go through these items quickly, marking the response (with an X) that is appropriate for you going from left to right: "strongly disagree," "disagree," "neutral," "agree," or "strongly agree."

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Sometimes I think up jokes or funny stories.					
2. Uses of wit or humor help me master difficult situations.					
3. I'm confident that I can make other people laugh.					
4. I dislike comics.					
5. Other people tell me that I say funny things.					
6. I can use wit to help adapt to many situations.					
7. I can ease a tense situation by saying something funny.					
8. People who tell jokes are a pain in the neck.					
9. I can often crack people up with the things I say.					
10. I like a good joke.					
11. Calling somebody a "comedian" is a real insult.					
12. I can say things in such a way as to make people laugh					
13. Humor is a lousy coping mechanism.					
14. I appreciate those who generate humor.					
15. People look at me to say amusing things.					
16. Humor helps me cope.					
17. I'm uncomfortable when everyone is cracking jokes.					
18. I'm regarded as something of a wit by my friends.					
19. Coping by using humor is an elegant way of adapting.					
20. Trying to master situations through uses of humor is really dumb.					
21. I can actually have some control over a group by my uses of humor.					
22. Uses of humor help to put me at ease.					
23. I use humor to entertain my friends.					
24. My clever sayings amuse others.					

Thank you for answering these questions. Now, please indicate your age and gender.

Years: _____ Gender: _____