

2009

A priest, a rabbi, and a clinical social worker walk into an inpatient psychiatry unit : clinical social workers uses of humor on an inpatient psychiatry unit

Sarah Elizabeth Santoro

Follow this and additional works at: <https://scholarworks.smith.edu/theses>

 Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Santoro, Sarah Elizabeth, "A priest, a rabbi, and a clinical social worker walk into an inpatient psychiatry unit : clinical social workers uses of humor on an inpatient psychiatry unit" (2009). *Theses, Dissertations, and Projects*. 465.
<https://scholarworks.smith.edu/theses/465>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Sarah Santoro
Clinical Social Workers'
Uses of Humor as a Coping
Strategy on an Inpatient
Psychiatry Unit

ABSTRACT

The purpose of this research project was to explore clinical social workers' uses of humor as a coping strategy while working on an inpatient psychiatry unit. This mixed-methods study allowed for both a flexible, exploratory examination of clinicians' uses of work humor, along with fixed surveys to cross-correlate the collected data. Ten clinical social workers took part in a qualitative interview and completed the Professional Quality of Life Scale (ProQOL), Revision IV, and the Humor Styles Questionnaire (HSQ). Participants also provided demographic information, which included: level of education, level of licensure, job title, and number of months/years working on the unit.

Key findings from the data analysis are as follows: 1) types of work-related stressors and rewards; 2) individual worker coping methods; 3) the types and functions of work humor; and 4) how humor was addressed in social work education. There were no significant correlations between the two surveys; however, significant findings within each scale were noted.

The findings in this study have implications for clinical social work practice; predominantly in social work education on humor and coping. All participants in this study reported using humor to cope with work demands and these findings support that humor can be used to bolster work supports, relieve emotional distress, and manage stress that emerges as a result of work problems.

A PRIEST, A RABBI, AND A CLINICAL SOCIAL WORKER WALK ONTO AN
INPATIENT PSYCHIATRY UNIT: CLINICAL SOCIAL WORKERS' USES OF
HUMOR AS A COPING STRATEGY ON AN INPATIENT PSYCHIATRY UNIT

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

Sarah Santoro

Smith College School for Social Work
Northampton, MA 01063

2009

ACKNOWLEDGEMENTS

To my friends, fellow Smithies, family, and others; thank you for your support and encouragement throughout my journey into the world of Social Work. A special note of thanks to my Thesis Partner in Crime, Tara Slade, for hosting me for a week at her family's beautiful house on Lake Winnepesaukee. Your motivation and drive to finish this project was an inspiration to me and the serenity of the lake house provided the perfect environment to tackle what seemed like an impossible feat – getting the work done.

To Bruce McWhorter, the Yoda of Inpatient Psychiatry Social Work; thank you for teaching me that it is okay, even healthy, to laugh at oneself and at the absurdities of life when working on an inpatient psychiatry unit.

A special thank you to Shella Dennery, my personal Social Work Research Guru. Your ability to make research interesting, while also maintaining our core social work values, motivated me to take on a daunting and overwhelming project. I truly appreciated your accessibility, consistent words of encouragement, and thoughtful guidance.

To my participants; thank you for candidly sharing your stories about working on an inpatient psychiatry unit and discussing how you cope with the unique challenges and stressors that arise in this specialized clinical work. I greatly appreciated your interest in this project and your commitment to sharing your experience with other social workers.

To Maciej Wasiel; thank you for your encouragement and support in my quest to find a career that utilizes my strengths and inspires me to be a better person. While we are not finishing this journey together, I am grateful for all that you provided along the way.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION.....	4
II LITERATURE REVIEW.....	7
III METHODOLOGY.....	28
IV FINDINGS.....	36
V DISCUSSION.....	62
REFERENCES.....	75
APPENDICES	
Appendix A: Human Subjects Review Committee Approval Letter.....	78
Appendix B: Informed Consent.....	80
Appendix C: Interview Guide and Measures.....	83

CHAPTER I

INTRODUCTION

Clinical social workers have a large array of options when choosing their treatment specializations and work settings. While all clinical settings present their own unique challenges, clinicians working on inpatient psychiatry units are faced with specific and intensive job stressors that require the use of effective coping skills in order to manage the demands of the work. Such stressors can lead to job fatigue, and eventually, burnout, causing a high rate of worker turnover and impacting the continuity of care for patients on these units.

Little has been written about this specific worker population in the social work literature and even less about how they cope with job demands. In the available literature, forming strong social bonds at work has been cited as a significant buffer to stress and a means of managing it. Humor is minimally cited in the literature as an effective means of coping with job stress. Literature from business, medicine, and communication studies provides empirical research and anecdotal narratives describing the functions of humor in various workplace settings, as well as the general uses of humor in day-to-day communication. Some authors in the social work field have attempted to address social work humor and how it is used both clinically and in the workplace. Reviewing the available literature in all related fields, correlations can be made to address the unique demands of the social work profession. Important findings from these and other professional fields provide clinical social workers with information on how to manage the often overwhelming, stressful, and at times, hazardous nature of acute psychiatric work.

The purpose of this mixed-methods study is to address the gap in social work literature on psychiatric social workers, their means of coping, and their uses of humor as a coping strategy. Various humor styles will be explored in relation to participant's levels of reported compassion fatigue, compassion satisfaction, and burnout. Utilizing a flexible interview guide and two fixed quantitative measures, participants will discuss and rate their humor styles and current level of compassion fatigue, burnout, and compassion satisfaction. The Humor Styles Questionnaire (HSQ) will measure each participant's self-reported humor style based on four categories of humor: affiliative, self-enhancing, aggressive, and self-defeating. The Professional Quality of Life Scale, Revision IV (ProQOL) will measure each participant's self-reported levels of compassion fatigue, compassion satisfaction, and burnout. The working hypothesis of this study is that humor is a significant and effective coping strategy for job stress experienced on an inpatient psychiatry unit and participants who report using affiliative or self-enhancing humor styles will have lower levels of compassion fatigue and burnout, with higher levels of compassion satisfaction. Participants who report using aggressive or self-defeating humor will have higher levels of compassion fatigue and burnout, with lower levels of compassion satisfaction. Central to this study design is the use of both fixed and flexible data collection methods, which will be cross-correlated to explore participant's reported levels of stress, as well as their uses of humor.

The sample for this study was ten licensed clinical social workers who were working full-time on an inpatient psychiatry unit for a minimum of 3 months at the time of the interview. Each participant completed the HSQ, ProQOL, and an interview to

answer questions organized around the following major themes: a description of general work responsibilities; job role definition and work-related stressors and rewards; level of job satisfaction; methods of individual coping and the perception of how co-workers cope with job stress; and the perceived role, function, and uses of humor in the workplace.

There are two primary audiences for this study. First, the results of this study will be relevant to clinicians who work on hospital inpatient psychiatry units. Clinicians who work in these settings are exposed to homicidal, suicidal, and psychotic patients, among other serious presenting problems. Due to the intensity of the work, these social workers need effective methods of coping with work stress and may predominantly use humor to do so. Understanding the role of humor in the workplace may empower these workers to utilize it more often and more effectively as a result of the findings in this study. Furthermore, increasing awareness about compassion fatigue, including its symptoms and implications for burnout, will allow workers in acute care settings to identify the warning signs with the intention of preventing burnout. Second, clinical social work students will learn about humor, which will demystify its uses both clinically and in the workplace, and invite them to explore its positive applications in the work. Understanding the aggressive and ineffective uses of humor, as well as “inappropriate” work humor, will allow students to feel more confident about their uses of humor in the workplace and differentiate the types that can be harmful to the work.

CHAPTER II

LITERATURE REVIEW

In exploring how clinical social workers use humor as a coping mechanism on inpatient social work settings, there is a limited amount of scholarly literature on the coping methods utilized by clinical social workers while on the job. Much more has been written about the therapeutic uses of humor between clinician and client, but there is a significant lack of research on how humor functions as a coping mechanism for clinical workers. Research is particularly needed to explore how social workers in acute care settings, such as hospitals, manage work-related stress. While the available social work literature does not widely address this topic, literature from fields such as business and medicine explore the various functions of humor in the workplace. There is also a dearth of literature from the field of communication studies on humor, sense-making, and occupational identity management, which can inform research in social work. Particular to the social work field are the phenomena of compassion fatigue, compassion satisfaction, and burnout. In reviewing research on coping and humor, these variables must be addressed as a means of understanding the impact of chronic stress on workers. There is a wide range of literature on these topics and this paper will be limited to those that also address the influence of coping.

In the following sections, social work as a profession will be further defined, particularly in relation to global job demands and how these are viewed by society at large. The role of work-related stress will also be explored and how it affects compassion fatigue, compassion satisfaction, and burnout. Humor will be examined as a means of

coping and examples from a variety of disciplines will illuminate how existing research in this area is applicable to social work.

Social Work as Dirty Work

Social work can be considered a stressful and demanding occupation. Bennett, Evans & Tattersall (1993) cited that social workers often have to deal with difficult clients in difficult settings, frequently within the confines of public and professional limitations. Social workers may additionally experience conflicts between making autonomous decisions on behalf of clients while at the same time conforming to practices upheld by large organizations and legislative requirements. Such constraints place social workers in a paradigm that supports high demands with often a low sense of autonomy, which can produce a highly stressful situation in which to work. Moran & Hughes (2006) noted that working in the helping professions places people at a higher risk for experiencing occupational stress.

Bennett et al (1993) stated that relatively few studies have attempted to quantify the level of stress experienced by social workers. The authors quantified the stress experienced by three different groups of social workers: child, adult mental health, and elder care works. In their study, stress was defined stress as, “a process involving a number of distinct, but interacting stages: environmental demands, the perception of those demands, the coping resources available to the individual, and the outcome of these demands” (p. 33). Specific to social work, the authors cited that client-based work, client advocacy, work violence, and public scrutiny for agency-related failures as particular sources of stress. The authors also noted that social workers who focus their

specialization on client-based work have the additional responsibility of building relationships with clients who are in great need and potentially place a high level of demand on the worker. Client-based work often requires managing ambiguous or delicate situations, which was reported in this study to be the highest source of stress for workers. As a result of client needs and demands, workers may become overly involved in their clients' lives and become enmeshed in their problems, or distances themselves altogether. The authors found that there was a relatively high level of work-related anxiety and depression among all social workers surveyed, particularly child care workers, when compared workers in other professions.

Shinn, Rosario, Morch, & Chesnut (1984) studied the relationship between job stress and burnout in the human services sector. Unique to this study was an expanded assessment of the types of stressors experienced by human service workers, including measurement of the "potency" of each one in predicting psychological strain (p. 865). In this study the authors asserted that stress and strain can be defined as separate phenomena in the work experience. They defined stress as a negative feature of the work environment that impinges on the workers ability to be effective on the job, while strain is the psychological or physiological response to the stress by the individual. This is unlike Pearlin & Schooler (1978) who defined stress and strain as interchangeable in their landmark study. While stress and strain were measured as the same variable in their study, emotional stress was considered to be specific in two respects: 1) by being determined by particular strainful and threatening circumstances in the environment, and (2) by being a condition that has clear boundaries. For the purposes of this study, stress

and strain will be considered the same entity, with “stress” characterizing both phenomena, including emotional stress, which can be considered the type of stress most frequently experienced by social workers involved in direct client care. Shinn et al (1984) found that stressors associated with organizational climate, including measures of perceived job design, leadership, and relationships with co-workers were directly related to worker satisfaction and job performance. The emotional demands posed by clients and the unrealistic expectations supported by the agency, or the social work profession as a whole, were additionally found to be significant stressors for workers. Shin et al (1984) asserted these two areas are not typically covered by standard measurements of job stress and further research is needed in this area to determine how managing these unique demands impacts social workers job satisfaction.

Related to the stressful nature of social work is the concept of “dirty work” as discussed by Ashforth & Kreiner (1999). In their article dirty work was defined in the context of three different kinds of occupational taint: social, moral, and physical. Social work is considered to be socially tainted because of its regular contact with groups who are themselves stigmatized. While lower-level occupations, such as sanitation work, are generally more tainted, social work is shielded from overt forms of stigma due to its more prestigious social standing. The authors asserted that more research is needed in the area of higher-level socially stigmatized professions and how the principles of various occupational ideologies, such as reframing, recalibrating, and refocusing, effect the profession’s identity formation and management. Identity formation is an important aspect of occupational development. Tracy, Myers & Scott (2006) stated, “One of the

primary ways people define themselves is through their jobs” (p. 284). They conceptualized identity as a set of central, distinctive, and enduring characteristics that typify a person or his line of work. While forming a work identity is central to all occupations, it is not a fixed or stagnant process. Tracy et al (2006) stated that identity is constantly negotiated, re-negotiated, defined, and redefined.

As part of this fluid process, Ashforth & Kreiner (1999) discussed the phenomenon of social weighting as it relates to dirty work and occupational identity formation within these professions. Dirty workers are often concerned about their relationship with outsiders, which influences the formation of work subcultures and serves as protective measure by distancing the stigmatized group from outside groups. This idea may be applied to research in social work as it pertains to job roles that function within a hierarchical system and how subcultures provide social supports that mitigate high levels of stress.

Compassion Fatigue, Compassion Satisfaction, and Burnout

Related to stress are the concepts of compassion fatigue, compassion satisfaction, and burnout. Stress can be directly correlated with the phenomena of worker burnout. Shin et al (1984) defined burnout as the psychological strain experienced by individuals that is caused by the stress of the work, while Figely (2002) further added that burnout includes a state of “physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations” (p. 1436). Sprang & Clark (2007) found that burnout is a condition prevalent among healthcare professionals with mental health professionals demonstrating higher levels of burnout than primary health care

workers. This study attributed higher levels of burnout to workplace problems such as caseload size and agency demands, rather than because of reactions to traumatic client material. Shin et al (1984) echoed this sentiment and additionally found that burnout is not necessarily directly correlated to direct-care work, but is more closely related to agency-level problems. A comprehensive definition of burnout seems elusive, but may be best correlated to both workers' experiences with both clients and the agency at-large; separating one from the other does not address the holistic experience of the typical clinical social worker.

Supporting the negative effects of direct-client care on workers, Adams, Boscarino, & Figley (2006) stated that burnout is directly related to and caused by compassion fatigue, which can be defined as the caregiver's diminished capacity or interest in being empathic towards their client. Figley (2002) provided an etiological model for defining compassion fatigue, which is based on eleven variables that that may predict the causes of worker compassion fatigue as well as best practices for prevention. Among these variables, elongated exposure to particularly traumatized clients and the amount of empathic response required to reduce the suffering of a client were found to cause higher levels of compassion stress, leading to a more serious state of fatigue. Among fatigued responses, disengagement can be considered both a method of coping and a sign of greater problems. Bennett et al (1993) found the child care workers, who reported the highest levels of stress in their work in this study, were more likely to distance themselves from the needs of their clients. The authors asserted that this finding

supports that job burnout is influenced more by the job situation than the personalities of those engaged in the work.

A critique of Figley's (2002) etiological model of compassion fatigue is presented by Kanter (2007). The author stated, "Applying the diagnosis of 'compassion' fatigue to a distressed social worker is akin to applying the diagnosis of 'fatigue' to a medically ill patient. The symptom is identified, but there is, essentially, no differential diagnosis. And the 'treatment' for 'compassion fatigue' is as non-specific as the 'treatment' for 'fatigue'" (p. 291). In his critique, Kanter sought to outline the causes of compassion fatigue and possible universal methods of prevention. The author stated that each worker must continually assess his or her stress response and set reasonable job expectations.

Sprang & Clark (2007) noted that compassion fatigue is characterized by symptomology including increased anxiety, disconnection, isolation, depression, somatization and disrupted beliefs about self and others, among other debilitating symptoms, which can lead to a secondary traumatic stress disorder. Such a disorder in social workers, particularly those working with acute cases, can be debilitating and warrants attention by the field as a significant deterrent to job satisfaction and prolonged direct-care work with clients. Adams et al (2006) further examined the extent to which secondary trauma and burnout are related to and independent of one another, however a limitation of the study was a lack of positive items in the survey that analyzed compassion satisfaction. While results were relatively inconclusive, their work attempted to clarify the differences between secondary trauma, burnout, and compassion fatigue. A need to further investigate the influences of compassion satisfaction in relation to these

other variables is warranted. While those social workers who specialize in working with traumatized populations appear to experience higher levels of stress than their counterparts, they may also experience a positive aspect of their work which nourishes and sustains them. Bridge, Radley & Figley (2007) labeled the experience of being motivated by helping others as compassion satisfaction.

Coping

Aldwin & Revenson (1987) stated that the existence of stress for the individual may be less important to well-being than how an individual appraises and copes with perceived stress. This sentiment is echoed by authors in related fields (Figley 2002; Kanter 2007). Gellis (2002) stated, “The extent to which human service organizations and individual social workers learn to cope effectively with the stresses of work has important implications for their continued well-being and productivity” (p. 38). Pearlin & Schooler (1978) stated that coping is often used interchangeably with mastery, defense, and adaptation. In this study, the working definition for coping included any response to external life strains that serves to prevent, avoid, or control emotional distress. Vaillant (2000) distinguished between three classes of coping: seeking social support, utilizing conscious cognitive strategies, and involuntary mental mechanisms that distort our perception of reality to reduce distress. He stated that the first two classes of coping are superior to the third because they are under a person’s control and can affect real world outcomes.

The Transactional Stress Model, as utilized by Gellis (2002), Bennet et al (1993), Aldwin & Revenson (1987), and Meneghan & Merves (1984), examines the effects of

occupational stress on emotions and behavior and how they are moderated by various coping methods. This model defines two specific types of coping: problem-focused coping and emotion-focused coping. Problem-focused coping includes efforts used to manage or alter conditions that are perceived as a source of stress. Comparatively, emotion-focused coping includes the use of mechanisms that avoid direct confrontation with the source of stress. Within this coping style, workers may use problem-reappraisal or avoidance.

The debate surrounding whether problem-solving coping is more effective than emotion-focused coping is prevalent throughout the coping literature. Aldwin & Revenson (1987) stated that there is no clear consensus as to which coping strategies or modes of coping are most effective, evidenced by some studies that found problem-focused coping decreased emotional distress, whereas emotion-focused coping increased it, while other studies reported the opposite pattern. Meneghan (1982) found that problem-focused coping had little effect on emotional distress. Shin et al (1984) found no real evidence supporting whether emotion-focused coping or problem-focused coping were more effective at reducing stress. Gellis (2002) found that social workers were more likely to use problem-focused coping methods and as a result, had a lower level of reported stress, though the sample did not score higher in job satisfaction than their nursing counterparts. The author also reported that social workers on the whole used more positive coping methods to manage their stress, including emotion-focused coping through problem-reappraisal. The author stated that this finding is contrary to previous findings in other related studies and that more research is needed to further explore this

coping strategy in relation to stress and job satisfaction. Aldwin & Revenson (1987) stated that coping researchers are far from finding a “magic bullet” that can help workers “instantly solve problems and restore emotional equilibrium” (p. 338).

Subsequent to the two main type of coping, problem or emotion-focused, are the types of actual strategies that workers use to mitigate stress. Aldwin & Revenson (1987) outlined four main types of strategies, which include: instrumental strategies – those that take direct action towards a perceived threat; intrapsychic strategies – those that regulate or minimize emotional distress; inhibition of action – the ability to resist taking action if it is perceived to increase harm; and information seeking – gaining a basis for action through support mobilization. Related to these strategies, other authors, such as Pearlin & Schooler (1978) described a similar, but slightly different framework to describe coping. They identified two main resources workers may utilize when experiencing stress: social and psychological resources. Coping responses draw upon these resources at times of need and focus on what people *do* to mitigate stress based on what they *have*. In their research, the authors found that most workers have three main responses to stress: changing the situation, controlling the meaning of the stress after it emerges, or controlling the actual stressor. The response to the stress is often determined by what resources a worker perceives he has at his disposal. The authors cautioned against always taking direct action to change a stressful situation. They found that the efficacy of this response was low due to unforeseen additional stressors that arose as a result of directly changing an unwanted situation.

Measuring the efficacy of a particular coping strategy requires an assessment of its stress-buffering effects. The direct effects model holds that coping has uniform positive effects on well-being, regardless of the stressor; while the stress-buffering model maintains that coping serves to only moderate the impact of stressful episodes to different degrees, depending on the type of stressor faced. Aldwin & Revenson (1987) stated that studies testing these two models have yielded mixed results. Their own results showed that both models depend upon whether problem or emotion-focused modes of coping are examined. They cited that the strongest evidence for stress-buffering effects was presented by Martin & Lefcourt (1983) in their work on the use of humor as a coping strategy. This series of studies revealed that humor had a clear buffering effect on negative life events. Based on this finding, the Aldwin & Revenson recommended more studies on similar responses.

Beyond the type of coping employed, Aldwin & Revenson (1987) stated that there are a number of factors that influence how people cope, including personality characteristics, situational or role demands, cognitive appraisal of stress, and cultural practices and preferences. Further, the authors noted that the effectiveness of a coping strategy may depend on its efficacy in a particular situation. Pearlin & Schooler (1978) found that the type of problem faced was largely a predictor for the effectiveness of a coping strategy, while Meneghan (1982) argued that it was the degree of stress experienced that largely impacted outcomes. Pearlin and Schooler further stated, “The effectiveness of a coping behavior cannot be judged solely on how well it purges problems and hardships from our lives. It must be judged on how well it prevents these

hardships from resulting in emotional stress” (p. 8). Aldwin & Revenson argued against simplistic interpretations of the relation between coping and its effectiveness. In their study, the authors cited that those with poorer initial mental health may cope in maladaptive ways and the greater the severity of the problem, the more likely individuals are to use maladaptive coping, which further increases emotional stress.

The need for accurate problem appraisal and a worker’s perception of success at mitigating related stressors is necessary for effective coping. Aldwin & Revenson (1987) stated that coping and mental health outcomes are generally assessed without examining whether the coping efforts are successful in achieving the individual’s goals. Therefore, coping efficacy is the perception that the coping effort was successful in achieving the individuals’ goals in a particular situation. Further, the strategy must be seen as successful to reduce stress or else stress is increased, which particularly true for emotion-focused strategies. Pearlin & Schooler (1978) recommended that a person must first see a situation as a problem before applying efforts to modify it. Buffering-effects may be most effective based on the way a person responds to a stressor and the meaning that is attached to it. They stated that by cognitively neutralizing threats, it is possible to avoid related stress. Vaillant (2000) concurred that the use mature mental health mechanisms first begins with the recognition of the problem or stressor. Aldwin & Revenson (1987) further refined the advantageous effects of coping strategies by stating that responses may only be successful when stressors are highly threatening.

Across the coping literature was the examination of individual verses group efforts at coping. Various studies found that individual efforts at coping in the workplace

were met with limited results and a stronger buffer against stress was found in developing social supports (Aldwin & Revenson, 1987; Shin et al, 1984; Pines & Aronson, 1981; Meneghan, 1984). Aldwin & Revenson (1987) stated that garnering social support was found to be both a problem and emotion-focused strategy and was highly effective at both modifying the stressful situation as well as reducing emotional stress. Social supports can be found by creating sub-cultures of workers under the umbrella of the greater agency. These support systems aid members in mobilizing their resources, mastering strain, sharing tasks, and obtaining necessary information. Shin et al. (1984) noted that this level of mobilization can take place without the participation of the larger agency and may empower workers to come together on a related goal. In this particular study, group coping was negatively associated with strain in the areas of job dissatisfaction and alienation. Contrary to these findings, Pearlin & Schooler (1978) found that occupational problems were “immune” to all levels of coping strategies, but may be best responded to by utilizing psychological resources. Despite this finding, the authors recommended using a repertoire of strategies, including social resources, when mitigating work-related stress.

Specifically related to social work, particularly compassion fatigue and burnout, Figley (2002) and Kanter (2007) recommended drawing upon social supports at work as a significant method of coping, while Bennett et al. (1993) recommended increased agency support to help mitigate worker stress, including, stress management training, the encouragement of fostering work social supports, and better management of caseload demands.

Humor

Humor is a way of expressing various feelings including anger, hostility, frustration, and joy. It is a relational process that requires more than one person to illicit a response, thus reinforcing its inherent communicative function. Freud (1928) noted that there are two ways in which humor takes place as an interactional process between individuals. First, one person may adopt a humorous attitude, while a second person acts as spectator and derives enjoyment from it. Second, there may be two people interacting, one of whom is regarded by the other in a humorous light (p. 1). In the psychology literature, humor is considered to be an adaptive defense, which is essential to sound mental health and well-being. Vaillant (2000) noted that defense mechanisms reduce psychological conflicts and cognitive dissonance during sudden changes in reality. They can provide perspective to mitigate changes in reality and self image that cannot be immediately integrated. In summary, they shield a person from sudden changes in affect, reality, relationships, or consciousness.

In his landmark longitudinal study, Vaillant (2000) tested the five highest adaptive defenses: humor, altruism, sublimation, anticipation, and suppression across three large samples to examine how those with higher functioning defense mechanisms were impacted by stressors across the lifespan. He stated, "Each adaptive defense involves the ballet of keeping idea and affect, subject and object, clearly in mind while simultaneously attenuating the conflict" (p. 91). In his work, the author found that humor permitted the expression of emotion without discomfort or unpleasant effects on others. It allows for one to look directly at what is painful without being overcome by it.

O'Connell (1960) stated that humor is directly associated with empathy that is not overwhelmed by the misfortunes of others. It offers a flexibility of emotions and requires a tolerance for oneself as well as others. Humor is often used when a person has no other option in a conflicted situation – the fight or flight response will not suffice. As a result of its complexity, Freud (1905/1960) stated, “Humor can be regarded as the highest of these defensive processes” (290).

Freud's groundbreaking work on the processes of humor also sought to differentiate humor from wit. Humor is more sophisticated than wit, which O'Connell (1960), defined as, “a means of indirect expression for latent hostile urges.” (p. 263). The aim of wit is either to afford gratification or to provide an outlet for aggressive tendencies. He stated that Freud was never certain whether this mechanism was essentially pathological or adaptive. “Humor,” on the other hand, “is not resigned; it is rebellious. It signifies the triumph not only of the ego, but also of the pleasure-principle, which is strong enough to assert itself here in the face of the adverse real circumstances” (Freud, 1928, p. 2). While these pinnacle writings on humor sought to define and make sense of its adaptive functions, it remains a relatively elusive and difficult concept to study. Vaillant (2000) noted, “Humor, like a rainbow, is real, but forever evades our grasp” (p. 95).

Beyond its elusive nature, a number of authors point to humor as a social phenomenon, particularly in its ability to strengthen social supports and discharge unwanted hostility in a socially accepted manner (Vaillant, 2000; Nezu, Nezu, & Blissett, 1988; Romero & Cruithirds, 2006, Moran & Hughes, 2006; Tracy, Myers & Scott, 2006).

Nezu et al (1988) stated that the use of humor in stressful situations might serve to attract social reinforcement when compared with other forms of cathartic communication, which may engender negative reactions from others. Humorous reactions to stress tend to increase positive social reactions, whereas depressive responses cause social rejection. Meyer (2000) supported humor as a social phenomenon and highlights its “receiver-centered nature,” which suggests that humor can be used as a persuasive tactic when the audience is joined with the speaker (p.?). van Wormer & Boes (1997) expanded upon this notion, defining humor as a phenomenon that exists apart from laughter and requires the joint recognition of the “ridiculousness of life” (p. 88). These authors asserted that humor can provide insight and help during a crisis situation by serving as a coping mechanism that reduces tension in a socially accepted fashion. Siporin (1984) cited the psychoanalytic function of humor as a form of unconscious, unrepressed, but disguised aggression that is expressed in a way that is liberating and provides a pleasurable and socially acceptable outlet for hostility.

Meyer (2000) outlined the three main communication theories of humor origin, which include relief, incongruity, and superiority. Within each theory are four functions of humor: identification, clarification, enforcement, and differentiation, all of which fall along a continuum. Humor unites an audience through identification/clarification and divides through enforcement/differentiation. These functions are not mutually exclusive and humor can also simultaneously unite and divide within the same context. Implications of this phenomenon can be seen within individual interactions, groups, and larger systems. Siporin (1984) also pointed to how humor can, “establish control or

autonomy, intimacy or distance, and make for group cohesion, disunity, or disbandment” (p. 460). No other environment may provide the microcosm to study humor’s social functions than the workplace. Romero & Cruthirds (2006) defined organizational humor as “amusing communications that produce positive emotions and cognitions in the individual, group, or organization” (p. 59). The authors described four categories of workplace humor: affiliative, self-enhancing, aggressive, and self-defeating. Affiliative humor enhances social interactions through non-hostile and affirming joking, while self-enhancing humor is predominantly used as a coping mechanism when dealing with stress by helping to maintain a positive perspective. Aggressive and self-defeating humor encompass types of humor that are consistent with superiority theory and can cause disparagement, factions within groups, and miscommunication. When used effectively, humor can increase group cohesiveness through positive reinforcement and reduction of external threats, as well as getting members to conform to group norms. It can also promote open communication by creating positive emotions in group members and enhancing the listening, understanding and acceptance of a message. It additionally can reduce stress and enhance creativity.

Across the stress, coping, and humor literature a number of studies have presented conflicting findings. Of note, Martin & Lefcourt (1983) completed a series of cross-sectional studies which found that individuals must be able to use or produce humor in stressful situations for the humor to be stress-buffering. Nezu et al (1988) noted that this study was limited due to its cross-sectional framework and proposed that longitudinal studies are more effective at measuring the relationship between stress and coping

mechanisms, including humor. Moran & Hughes (2006) in their study of social work students supported Martin and Lefcourt's findings and additionally found that those in their sample who reported liking humor, but not producing it had increased stress levels. In their own prospective study, Nezu et al (1988) found that humor effected depression but not anxiety symptoms related to stress. Their findings garnered support for humor as stress-buffering and supported Martin & Lefcourt's original conclusions. Based on this research, the authors caution that relations between stress, humor, and distress appear to be complex and varied, depending on the study design and measures used. In this particular study, Nezu et al hypothesized that humor had little effect on anxiety symptoms because it may only serve as a coping strategy when used to manage an actual stressful event but not with the occurrence of anticipated negative consequences. In an earlier study, O'Connell (1960) found that stress and humor had no significant relationship and that stressed groups expressed no difference in preferences for humor use than non-stressed groups. Kuiper & Borowicz-Sibenik (2005) also cited a number of studies that do not support the buffering effect that humor may have against stress, including Kuiper & Martin (1998); Porterfield (1987); and Nezelek & Derks (2001). The authors proposed that additional research is needed in more refined and specific areas to mitigate these disparities. As in the coping literature, when researching how humor affects stress, it may be important to consider the study design as well as differentiate between the direct versus buffering effects of humor on stress.

Within the phenomena of humor, there are a variety of types, each performing various functions. van Wormer et al (1997) delineated five types including: tension-

relieving nonsense, play-on-words, sense of the incongruous, gallows humor, and foolish jest. Siporin (1984) also highlighted a variety of humor types including: comic, nonsense, burlesque, farce, satire, irony, wit, jokes, puns, or epigrams. Specific to what Kuhlman (1988) defined as a scaffold setting, gallows humor may also serve an important function in settings where there are “unremitting or inescapable stressors over which there is minimal control and a sense of existential incongruity” (p. 1086). In his commentary of the uses of humor on a maximum-security forensic psychiatry unit, the author defined gallows humor as similar to nonsense humor but also noted that it engenders a broader philosophical attitude which utilizes an illogical response to irresolvable dilemmas. A hallmark of this humor type is that it makes sane what is insane, particularly in “no-win” situations. The author asserted that in settings like psychiatric units, gallows humor allows workers to mitigate their inevitable stress by voluntarily taking on a temporary psychosis through the use of jokes and gags. Of all forms of humor, particularly in relation to a highly stressful environment, gallows humor offers the best form of humor coping. By recognizing and embracing the absurdities of the psychiatric unit, the staff can cope more effectively with the other-worldly aspects of the job. Obrdlik (1942) wrote on the sociological history and functions of gallows humor. The author defined this humor type as one that, “arises in connection with a precarious or dangerous situation” (p. 709). Gallows humor provides a necessary escape when all else fails through its use of irony and brings together generally oppressed groups that survive in difficult environments. It functions in two ways: by bolstering the resistance of the victims, while also undermining the morale of the oppressor.

While there are a wide variety of humor types available to workers, Siporin (1984) noted that there is a disparity within the field of social work since it is widely accepted that the use of humor denotes developmental maturity in clients, yet social workers are not well known for their humor. Workers are often portrayed in the media, and within the culture itself, as serious, cynical, burned-out, politically correct, and unlikely to make fun of themselves, their clients, or the larger institutions that influence their work. van Wormer (1997) suggested that social work does not support the use of humor due to its commitment to professionalism and ethics, which also serves as a means of legitimizing a stigmatized profession within the larger society. The authors state, “Sometimes self-discipline can be self-depleting” (p. 91). Contrary to the notion that social workers are not generally humorous, Moran & Hughes (2006) proposed that the use of humor is one of the most frequently relied upon coping mechanisms by social workers. Further, the authors asserted that the study of humor ties in well with the growing interest in strengths-based social work interventions. Siporin, van Wormer, and Moran & Hughes called for more research on the functions of humor within this field as well as its implications for education and clinical practice.

In summary, social work is a demanding and often stressful line of work that does not currently support the use of humor as a coping strategy due to its consistent need to be professionally and socially legitimized. Within this constraint social workers may have few outlets and supports to manage their stress, thus leading to higher rates of burnout than other helping professions. The application of literature on stress, coping, and humor to social work can enhance the profession’s collective occupational identity

development. Research in this area is needed to support the use of humor and to locate anecdotal, as well as statistical evidence, of its current use among social workers.

CHAPTER III

METHODOLOGY

Formulation

This study explores how humor functions for psychiatric social workers in a hospital setting, specifically examining its uses as a coping mechanism for work-related stress. The findings in this mixed-methods study are based on data collected through flexible qualitative and fixed quantitative means. A mixed-methods design allowed for both a flexible, exploratory examination of clinician's uses of humor on the job, along with the control of fixed surveys to cross-correlate data.

The qualitative interview allowed for the collection of direct narratives from participants, which highlighted their personal experiences of using humor in the workplace, humor's various functions in acute care settings, how humor may be understood as a coping mechanism, humor's affects on the individual clinician's work and workplace relations, and its influence on job identity development. A significant benefit to collecting narrative data is that few qualitative studies have focused on the uses of humor in social work, particularly in acute care settings. By recording individual experiences and analyzing themes that emerge from these narratives, conclusions can be drawn about how humor affects social worker productivity, job satisfaction, and role identification in a broad range of workplace settings.

Using two measures, the fixed quantitative data collection allowed for validity testing of the qualitative interview, specifically examining how clinician's verbalized perceptions of job stressors and their uses of humor on the job are compared to their answers on structured surveys. The fixed quantitative measures provided the concrete data necessary to understand significant findings on how social workers' perceptions of their sense of humor and job role correlate with their actual on-the-job experience.

Sample

Participants for this study were collected using snowball sampling. All participants were recruited through referrals made by hospital psychiatric social workers. Sampling in this study was purposive and non-random in that participants were required to meet defined criteria. While achieving diversity in the sample was a goal, due to the size of this study and convenience of the sample, it was not be feasible. Due to its relatively homogenous nature, one can draw the conclusion that findings may not be universal to all psychiatric social workers and a larger study may need to be conducted in order to further expand upon this research, particularly to explore how race, ethnicity, socioeconomic status, gender, and sexual orientation relate to work humor.

Inclusion criteria for this study required that workers had a Master's of Social Work degree, or higher, and were licensed as clinical social workers in Massachusetts (LCSW). They were required to have a minimum of three months full-time clinical experience on a hospital inpatient psychiatric unit. Potential candidates who had a Master's of Social Work degree, but who were not licensed clinicians in Massachusetts were not considered for this study due to their limited ability to engage in hospital

clinical work. Candidates with less than three months of experience on an inpatient psychiatric unit were not considered for this study due to their limited exposure to this setting.

The final sample for this study included 10 psychiatric social workers who are currently working on an inpatient psychiatric unit. All participants had a Master's of Social Work Degree and were licensed to practice clinical work in Massachusetts. Clinician's level of licensure included both LCSW (4) and LICSW (6). Workers experience on the unit ranged from 3 months to 10 years. Workers job titles included Clinical Social Worker (5) and Team Leader (5). The main difference between the two job groups was that Team Leaders had more administrative and supervisory responsibilities in addition to providing direct clinical care to psychiatric patients.

All participants worked at area hospitals on inpatient psychiatry units that serviced children through age 12 (1), adolescents from ages 13-18 (2), and adults from age 18 (7). Differences in the findings between the adult and adolescent inpatient workers are discussed in findings section of this study.

Data Collection

The design for this study was approved by the Smith College School for Social Work Human Subjects Review Committee (Appendix A). Informed Consent forms (Appendix B) were given to the participants at the time of the interviews. The Informed Consent outlined the risks and benefits of participation in this study, as well as the purpose of the study and its inclusion criteria. Data collection was accomplished through the use of in-person; semi-structured interviews of approximately 40 minutes in length, as

well as the completion of two structured and fixed surveys. Each of the ten psychiatric social workers who met selection criteria for this study and who signed the Informed Consent participated in both the quantitative and qualitative portions of the study. All Informed Consents were reviewed and signed by participants prior to data collection.

To begin the interview, each participant was asked to complete four demographic questions, which identified: level of education completed; level of Massachusetts clinical licensure, job title, and number of months/years working on the unit (Appendix C). Direct correlations between demographic data and the data findings are beyond the scope of this particular study. Following completion of the demographic information, each participant completed two fixed, descriptive surveys, which measured their general sense of humor, as well as work-related compassion fatigue, compassion satisfaction, and burnout. The descriptive surveys were selected as a method of data collection method for this type of study because they allowed for a better understanding of the function of humor in the workplace, as well as its stress-buffering effects, in detail (Anastas, 1999). These measures were available online and published by authors in the respective fields of humor and human services research. Permission to use each scale was obtained by emailing the authors. Subsequently, scoring guides were provided for the scales and used during the statistical analysis of the data.

The Humor Styles Questionnaire (HSQ), as developed by Martin, Pulik-Doris, Larsen, Gray, & Weir (2003) was used to measure each participant's general humor style, as it applies across life experiences. The survey contains 32 statements that each participant self-rated on a Likert-type scale from 1 = strongly disagree to 4 = strongly

agree (Appendix C). It weighted statement measures four dimensions relating to individual differences in uses of humor, which include the use of humor to: enhance the self (Self-enhancing); one's relationships with others (Affiliative); the self at the expense of others (Aggressive); and relationships at the expense of self (Self-defeating). Test-retest reliabilities for the Affiliative, Self-enhancing, Aggressive, and Self-defeating humor sub-scales, were respectively: .85, .81, .80, and .82 (all p 's < .001). The authors assert that all four sub-scales showed adequate internal consistencies, as demonstrated by Cronbach alphas ranging from .77 to .81 during validation testing. The intercorrelations among the four scales are generally quite low, indicating that they measure dimensions that are relatively distinct from one another. Additional validation data indicates that the four scales differentially relate in predicted ways to peer ratings of humor styles and to measures of mood, self-esteem, optimism, well-being, intimacy, and social support. The HSQ is useful for research on humor and psychological well-being in that it assesses forms of humor that may be detrimental to good psychological health as well as those that are beneficial. Based on its validation data, the HSQ is specifically designed to be integrated well into a study of job stress and particularly the type of stress experienced in the social work field.

The Professional Quality of Life Scale, Revision IV (ProQOL) (Stamm, 2005) was administered to measure each participant's level of compassion fatigue, compassion satisfaction, and burnout based on statements that describe the participant's work experience in the last 30 days (Appendix C). The measure included 30 statements that each participant self-ranked using a Likert-type scale from 0 = never to 5 = very often.

Each sub-scale for compassion-fatigue (10 items), compassion-satisfaction, (10 items), and burnout (10 items), were validated with Alpha scores of .80, .87, and .72, respectively, indicating adequate internal consistency. The authors assert that the scale demonstrated good construct validity and there is evidence that this version of the measure reduced the discrepancy between compassion fatigue and burnout. This measure is specific to the type of stress experienced by psychiatric clinicians and also measures the additionally important construct of compassion satisfaction, as noted by Adams, Boscarino, Figley, (2006).

Following the completion of the scales, each participant was interviewed for approximately 40 minutes to collect narrative data. The semi-structured interviews were an appropriate data collection method for this type of exploratory study because they allowed for the collection of rich, narrative data that contributed to a greater understanding of a relatively unknown phenomenon (Anastas, 1999). For the purposes of this study, the phenomenon of how humor functioned as a coping mechanism for psychiatric social workers in relation to their job stress was explored using an interview guide containing 20 questions. (Appendix C). Participants in the study were interviewed in-person, in order to allow for a personalized experience in which participants felt comfortable talking freely about their work experiences. The following themes were addressed in the interview: a description of general job responsibilities; a discussion on individual and co-worker coping styles; the functions and uses of humor in the workplace; the impact of humor on work relationships and clinical work with patients. The data gathered from the interview was unique to each clinician's work experience and

appropriate follow-up questions were asked in order to expand upon important themes that were particular to that individual. All interviews were recorded and transcribed into working text by this writer.

Data Analysis

The quantitative data collected included descriptive and inferential statistical analysis of the completed measures to capture how each variable is independently rated by participants and how these variables relate to one another, (i.e. total self-ranked level of compassion fatigue and humor style, based on the four sub-types. The descriptive and inferential nature of these findings provided a general overview of how to understand the sampled population in terms of the defined variables and how these may be related to data collected in the narrative interviews. Pearson's R Correlations were used to analyze the relationships between these two measures and their defined subscales. Relationships between each of the survey's subscales were also explored using this statistical test.

The qualitative data was comprehensively analyzed after each recorded interview was transcribed into working text. Written notes that were taken during each interview by the interviewer were also included in the themed analysis of the text. The data was systemically analyzed to differentiate specific themes by reviewing each transcription in-depth in order to locate specific themes that were further coded to develop the analytic framework. An issue that may affect theme analysis in this portion of the study is this writer's biases, including, how one defines an event or story as humorous. Biases will be discussed at length in the findings chapter and will be balanced by working definitions of humor, compassion fatigue, compassion satisfaction, and burnout. As themes were

established in the transcriptions, coding was completed with a line-by-line analysis of the text. A process of open coding allowed for first naming and categorizing the data, which will led to more specified methods of analysis. Conclusions that are drawn about the reduced and coded content will be discussed as significant findings.

This study has several limitations. Transferability or generalization of data may be limited by the small sample size and the constricted geographic area of the participants in this study. The data gleaned from this study reflects the in-depth experience of 10 psychiatric social workers who provide acute care in an urban hospital setting. As a result, the small sample size did not allow for diversity in a number of categories, including race, gender, age, or socioeconomic status. These variables were not analyzed as part of the final finalized findings. The quantitative measures chosen for this study are limiting in that they measure specific variable related to humor and the impacts of job-related stress. Though they are considered reliable measures in the research community, they may not comprehensively explain all variables of a psychiatric social worker's work experience.

CHAPTER IV

FINDINGS

This study was an attempt to answer the following question: How does humor function as a coping mechanism for clinical social workers working on a hospital inpatient psychiatry unit? This chapter will present data collected from two administered surveys and completed qualitative interviews with ten clinical social workers who currently work full-time on a hospital inpatient psychiatry unit. The first survey included the collection of basic demographic information, including each participant's level of education, level of clinical licensure, and number of year/months working on the unit; as well as a 32-item Humor Styles Questionnaire, which measured each participant's humor style based on four categories: self-enhancing, affiliative, aggressive, and self-defeating humor. Participants also completed a 30-item Professional Quality of Life Scale, which measured levels of compassion fatigue, compassion satisfaction, and burnout. Based on the fixed, quantitative data the hypothesis for this study is that those participants who have self-enhancing and affiliative humor styles will have lower levels of compassion fatigue and/or burnout, and higher levels of compassion satisfaction. Those who primarily have aggressive and self-defeating humor styles, or do not use humor at all, will have higher levels of compassion fatigue and burnout, and lower levels of compassion satisfaction.

After completing the surveys, each participant was interviewed for approximately 40 minutes. The interview guide included 20 questions organized around the following

major themes: a description of general work responsibilities; job role definition and work-related stressors and rewards; level of job satisfaction; methods of individual coping and the perception of how co-workers cope with job stress; and the perceived role, function, and uses of humor in the workplace. The ten interviews were transcribed and concepts from all responses were coded into eight themes. Some of these themes flowed directly from those related to the interview questions, while others emerged during the coding process.

Eight major findings were discovered in the transcribed interviews. The findings will be presented as follows: 1) basic participant demographic data; 2) a description of general job responsibilities, job role, and work-related stressors and rewards; 3) level of job satisfaction; 4) individual and group coping methods; 5) the types of humor used by workers on an inpatient psychiatry unit; 6) the functions of humor in the workplace; 7) the differentiation between appropriate and inappropriate work humor; 8) humor education: how the use of humor is addressed in social work education and in the workplace.

The quantitative data analysis of the two surveys revealed no significant correlations between the HSQ and ProQOL subscales, rendering the working hypothesis as unsupported, based on the small sample size. Significant findings within each survey's subscale will be presented at the end of this chapter.

Participant Demographics

The sample size for this study was ten clinical social workers. All participants had a Master's of Social Work degree and were licensed to practice clinical social work

in Massachusetts. Clinician's level of licensure included both LCSW (4) and LICSW (6). Worker's experience on the unit ranged from 3 months to 10 years. Worker's job titles included Clinical Social Worker (5) and Team Leader (5). Team Leaders had additional administrative and supervisory responsibilities, while also providing direct clinical care to psychiatric patients. All participants worked in urban hospitals on inpatient psychiatry units that serviced the following populations: children up to age 12 (1), adolescents from ages 13-19 (2), and adults from age 18 (7).

Job Responsibilities, Role Definition, Stressors and Rewards

This section explores how each social worker understood their specific job responsibilities. Based on these day-to-day tasks, participants discussed the aspects of their job that were unique compared to other disciplines, such as psychiatry, nursing, or occupational therapy. Participants also discuss work-related stressors and rewards based on responsibilities and defined job role.

Job Responsibilities

All ten participants identified direct-patient care to be their primary work responsibility. Each participant was required to work within a multidisciplinary team to determine a patient's treatment plan and also completed individual psychosocial assessments, provided individual and family therapy, contacted patient collaterals, completed discharge planning, and recorded patient medical record documentation. The participants who identified as Team Leaders had the additional responsibilities of clinical supervision and management of psychiatric social work staff, administrative work, and providing clinical training. Participants who worked in pediatric and adolescent

psychiatry had a maximum caseload of four patients, while those who worked with adults had a maximum of eight assigned cases. Team Leaders had a reduced caseload in order to fulfill their managerial and administrative responsibilities. All participants reported working with a multidisciplinary team, which included an attending psychiatrist, nursing staff, occupational therapists, the medical director, case managers, and other milieu staff. Participants who worked in teaching hospitals also reported working with psychiatry residents and medical, nursing, occupational therapy, and social work students. All participants reported being part of a social work staff, which included an average of three workers on each psychiatric unit.

Job Role

When asked how they define their job role in the context of the work environment many participants reported that they provide a “person-in-environment” perspective. One participant stated, “Often my role is to look at the person in the context of their life and the world around them. Their environment. I don’t think that psychiatry is taught that, or that it is emphasized as much. I think that I bring that perspective.” Another participant expanded upon this theme stating, “I think a big piece is bringing in the social work perspective and bringing in trauma-informed care. Otherwise kids’ presentations could be misdiagnosed at times.” Some participants reported on their accessibility to the patients and their ability to connect with them on a “more human level,” while others noted that they facilitate communication and collaboration with all the various people involved in a patient’s care. One person stated:

What I provide is a feeling that there isn't a problem that isn't so big we can't solve it. I think that's the biggest thing I provide for people. Because we're on a team and we collaborate and support each other. And making sure people do in fact collaborate and support each other has been the biggest challenge.

Participants who identified as a Team Leader reported that their job role was also focused on influencing different levels of hospital staff. One person stated, "Whether that's working with patients, their families, supporting staff in their work with patient, and also trying to encourage both myself and my staff to function as part of an multidisciplinary team, as opposed to being too identified with their role as a social worker."

Work Stress

When asked about the stressful aspects of the work, all participants reported that discharge planning was the most challenging responsibility of the job. One person stated, "There are more and more diminishing resources to refer people when they leave. So it makes it really hard to put a plan together for them that you can feel good about." Another person expanded upon this theme, "You just have to say to them [patients] sometimes, 'I'm sorry; this is the situation and there's nothing I can do about it. For me that's one of the most difficult aspects of the job.'" Many participants cited the pace of the work and the limited amount of time to get the work done as stressful. "The amount of time it takes to get the job done. Whether that's scheduling meetings or trying to find patients resources, it usually feels that there's never enough time to sort of get everything done." Related to the limited amount of time to "get the work done," one participant lamented about the lack of time to meet with patients individually, "That's the frustrating

thing about this work. You don't spend an equal amount of time with all of the patients. You just don't." Many participants, particularly those working with adults, also reported that quick patient turnover was stressful, while those working with children and adolescents reported longer patient length-of-stays due to diminishing community resources, which impacted discharge planning. Several participants reported that working with patients and their families can be stressful, as well as working with people who are chronically mentally ill. One person differentiated the challenges of working with children versus working with adults, stating, "The population is more stressful than with adults because you're working with multiple systems, multiple demands, multiple needs. So you have to define your boundaries as far as what you can and cannot do in a given day." One participant reported that working within a hierarchy can be stressful and Team Leaders reported that being understaffed and constant worker turnover, particularly with trainees, was stressful.

Work Rewards

Many participants reported that working with patients and families, while challenging at times, is also the most rewarding aspect of the work. "Family work is particularly rewarding for me. I like that people have the opportunity to come together in a time of crisis and we can help them to connect and gain a better understanding of what is going on." Another person stated, "I think there are times when the crisis of being in the hospital can really be a pivotal point for families and those moments are really rewarding. Usually it's my sense that I've done something to facilitate that transition." Expanding upon this idea, one worker talked about witnessing patient progress, "It's very

rewarding when there is progress made. When things come broken to you and you're able to help in a collaborative way to mend the pieces that feel broken." Participants also identified working with colleagues and in a team setting as rewarding. "I really enjoy the people that I work with. They make it fun and they are also supportive."

Job Satisfaction – "It Varies."

Seven participants reported feeling satisfied or very satisfied in their work. One person stated, "I'm pretty satisfied. In the system there is a lot of value placed on social workers on inpatient psychiatry units and I see my work as very necessary." Another participant commented, "For the most part I am very satisfied with my role...I think what influences my attitude about job satisfaction are two things, in terms of being less satisfied, if there are less resources and more pressure to turn patients around." One participant who works with children noted:

I like the fast pace of it. I really like getting to know the kids. One thing that is great about my job is that we work with kids who are so young and there is a chance that you get to do early intervention and potentially create some supports so that they will be more able to cope with stress later on in life.

Related to job dissatisfaction, three participants reported that they are not very satisfied with their current work. "Right now I'm not extremely satisfied. When I am more satisfied I feel like I'm more on top of my caseload and I'm helping people." Another participant, who was a Team Leader, stated, "I have a lot of conflicts with the hierarchical nature of the way the place runs. So I would have to say I am probably the least satisfied that I have ever been."

Individual and Group Coping

In this section, individual and group coping methods will be discussed. Participants reported the need for self care, social support, and humor as the main methods of coping with work stress. Participants also reported on the perceived methods of how co-workers cope, primarily through joking. One participant reported that those who did not use productive coping methods at work appeared to be more depressed.

Basic Self Care

Related to individual coping, many participants reported that utilizing basic self care was a way of managing stress. Basic self care included: exercising, taking breaks during the day by getting off of the unit, taking walks, meditating, reading to relax after work, and alternating work tasks throughout the day (i.e. doing paperwork, then going to meet with a patient, then calling collaterals). Some participants also reported the need to have structure in their daily work and set boundaries. In defining setting work boundaries, participants cited the need to manage time well at work, working only an eight-hour day on the unit, and setting limits with individual patients and their families.

One person stated:

I am really passionate about what I do, but sometimes that can backfire a little when it's difficult to create those boundaries and distance yourself from the work. And by that I mean boundaries around bringing work home with you and not being able to let go of certain things. Feeling really sad about certain patients. Or really angry at certain patients.

Perspective, Peer Support, and Joking

Participants also reported that getting perspective on the work is an important aspect of coping. One person stated, “The biggest thing is keeping perspective...My perspective is that everybody is doing the best that they can with what they have and it may come across in a different way.” All participants reported using their personal and work relationships for support by talking out problems with others, or asking for help at work when needed. One person said, “A major ingredient as far as me feeling satisfied is having those relationships that I feel are supportive.” Another participant stated, “I like to think I make use of the relationships with others that I work with.” Seven participants cited joking around with co-workers as a significant method of coping with stress. One person said, “I get a lot of support from the people who work here because people are all experiencing similar stressors so they know exactly what you’re going through. And we do a lot of joking around. A lot. I think it is kind of a stress relief.” Another participant stated, “I look to others for support, but probably do it in a humorous way, so as not to feel too vulnerable when I need that level of care, so to speak.” When discussing getting support from others at work, eight participants stated that they primarily sought out their social work colleagues for support, but two reported using co-workers from other disciplines as well, including psychiatrists and occupational therapists. One person summarized the general need for coping with work-related stress, “I think that a lot of the stressors I mentioned earlier are real and it’s important to develop ways to cope with those, because this is the kind of environment that can burn people out.”

Co-workers and Coping - "Joking is universal here"

When discussing their co-workers, participants identified coping methods that included taking breaks, exercising, setting limits and boundaries with the work, and using outside hobbies to relieve stress. One person stated, "The good copers have a full life outside of work. They have friends and activities. I know marathon runners. And Buddhists. Not feeling like you're job is everything. I think that's the key."

All participants reported that co-workers coped with work stress by joking around on the unit. One person stated, "I see tons of people joking around. So I'm imaging that's at least one part of the way they cope." Another participant stated, "I think a lot of people use humor – kind of a gallows sense of humor." Another participant noted that co-workers who do not use humor seem to release their stress through anger, while others seem to be "shut down" and depressed. "Sometimes people get angry at the patients and say, "Oh here comes another Borderline." Labeling and saying derogatory things about them."

Types of Work Humor

Four main types of humor were identified by participants as being used in the workplace. All participants reported that humor was used by workers. The types of humor identified included: irony, sarcasm, pranks, and gallows. One person reported that there was not enough humor used at work.

Irony, Sarcasm, and Laughing at Absurdity

Most of the participants stated that the humor used at work was sarcastic and ironic. One person stated, "Banter-y. There is a lot of give and take with it. I think it

would be really hard for someone to work here if they didn't understand sarcasm." Related to dry, sarcastic, and ironic humor was the notion of laughing at absurdity. One person stated, "There is probably a fine line when people who don't know me or my staff might misinterpret that we're making fun of patients, but it's really more emphasizing the absurdity of the situation. It's so pressing and it feels so heavy that it's like, wait a second, there's gotta be more to life than just whatever I, or this patient, or my staff are experiencing together right now." Another participant related a story about making fun of a patient with another co-worker:

I can think of an example from this morning! So one of our OTs [occupational therapists], one of the things that they do, they do what is called a sensory profile with patients where they ask them things like: What's calming for you; What music; What things do you like to do; Are there smells that calm you down? So one of my OT colleagues came up to me and said, 'I really need to tell you about this sensory profile. So-and-so said to relieve stress he likes to throw hand grenades. And he finds the smell of diesel fuel calming and his favorite taste is grease.' [laughing] 'So I really encourage you to join our sensory mod group today because I think I'm going to pump in some diesel fuel for some aroma in the room.' So it's just a nice joke to have in the day and probably his way of expressing, 'Wow, I'm working with someone who kind of freaks me out a little.'

Another person stated:

We have access to a lot of information when patients come in, so the patient said something and probably had paranoia or severe psychosis. And what the patient said is taken out of context and it sounds funny. I had a patient whose major concern on the admission paperwork is that he would run into a falafel truck. Or the patient was hit by someone with a piece of meat.

Silliness and Pulling Pranks

One participant reported that the humor is "silly" and four participants reported that there is a lot of "pulling pranks" among the staff. One person stated:

The humor is very childlike, especially in the backroom. The OTs [occupational therapists] and I joke a lot. They'll put funny pictures on my door. The other day a co-worker and I piled up half of my office onto the OTs' desk, so when they came back from a meeting, there were pictures, books, shoes, you name it. His desk was filled with objects.

Gallows Humor

Five participants identified the humor used at work as "gallows" humor. One person stated:

A lot of the humor is making fun of each other. I hate to say it, but sometimes making fun of the patients too; it's what would often be categorized as gallows humor; in the sense that you know that the folks you are joking around with are very dedicated to their work and they have a lot of compassion for the patients. So even when you're making fun of someone you know that's underneath...people who aren't in the field would think it's really offensive and cruel.

Another participant commented:

I think what it [gallows humor] means is that you're taking elements of the actual work and making fun of what you do and you're poking fun at it somehow. I used to do hospice work. So you would actually make jokes about death and dying, which would seem really contrary to what you'd expect. But it's a way of people just lightening the burden of whatever they're carrying. So here you might be carrying the burden of let's say, a very suicidal patient, who has done some very serious things to themselves. So you might be joking around and say, 'Well you know, they didn't try the antifreeze. Maybe that's the next step. It's known to be very effective.' [laughing] So that's an example of gallows humor. You would never say that to a patient. It's not really funny outside of the context of trying to help people relieve their stress.

"There isn't enough humor here"

One person reported that there was not enough joking around on the unit. "This is not a very humorous place. I've worked at places where I've laughed my head off every day. I think certain places can get too serious, too full of themselves, too self conscious."

Functions of Workplace Humor

Participants reported various functions of humor in the workplace. One person summarized humor functions, stating, “It [humor] has a supportive function. A function of release of emotional stress. A function of connection. We try to use a little humor with patients...clinically.” In this section the function of humor to reduce individual and group stress, increase social supports, resolve conflict and manage hierarchical workplace dynamics, and its impact on clinical work will be explored.

Stress Reduction

Related to release of emotional stress, three participants reported that they were able to release frustration or anger at patients by joking. One person stated, “When you’re getting yelled at by a patient in the middle of the milieu, obviously your reaction is some sort of defense. The thing that comes up for me is anger, and then trying to deflect it with joking.” Another participant stated, “I sometimes do get out my frustrations through joking and maybe it’s not the most appropriate thing, but that’s what happens.” All participants directly related humor and joking to relieving stress and to lightening the mood at work. One person stated:

It’s hard to imagine, especially after working here, working in an environment with other social workers where there wasn’t a lot of humor. To me it feels like part of the work, part of the way of coping with situations that are stressful; circumstances that we can’t change, relieving our stress so that we have more energy to go back to our day.

Another participant commented:

It serves as a stress reducer; as a way to connect to people, as a way of expressing one’s feelings about particular situations...People who use humor a lot have a certain philosophical view of life – not to take life too seriously because if you do, it can eat you up.

One person reported that he was more likely to joke when he was less stressed. “Sometimes when the stress is lower, I’m more vulnerable to using humor and maybe too much and going over the top. When the stress is higher, I still use humor, but one doesn’t have the time to sit and cavort with colleagues...” Another participant relayed a story about managing stress and difficult feelings with humor:

I’m thinking of one patient. I was sitting in the room as the supervisor. It was a big team room full of people, and I didn’t know many of them and I was there because I was training a new social worker. So I was sort of doing the job and she was watching me. And the patient came in and took one look at me and said, ‘Oh my God. I can’t believe there’s a really ugly fat woman in here.’ And I was like, ‘Oh my God.’ And she was acutely ill. She says mean things to people when she’s acutely ill and we know her. But I didn’t know her [at the time]. And I was like, ‘Whoa, am I going to laugh or cry about this?’ There was silence in the room and I got through it. But afterwards, in the backroom, I needed to process that and I processed it by making a joke out of it. Like, ‘Oh can you believe that happened? You’re not going to believe what happened to me today!’ So I was able to make a joke out of it – but she really hurt my feelings. And I everyone was like, ‘That’s a riot.’ I could have called her demeaning names, pick out her diagnosis and gone on a rant about that...but that wouldn’t have served any purpose. She’s acutely ill and I’m here to provide services.

Participants also reported that joking at work helps to put the work in perspective.

One participant stated, “Sometimes I have to take a step back and realize that this is just a fucking job. This isn’t my life.” Others pointed out that joking and humor help to prevent vicarious traumatization and burnout. One person commented:

I think it prevents burnout. We deal with some pretty horrible things that happen to people. I had a patient last week who came in because he was either able to pay for food or medication. It’s [the unit] a world in-and-of itself and I don’t think the general public would understand what happens here. People have these notions that it’s like *One Flew over the Cuckoo’s Nest*. You really need humor to stay sane and stay better connected to your co-workers and patients.

Social Supports

Eight participants talked about the use of humor to connect with other co-workers. One person stated, "I try to integrate humor into my relationships with colleagues. I try not to get too personal, but there is some humor in there and it's very benign. Laughing about how the system works and how sometimes it's difficult and doesn't make any sense." Another person concurred, "I think that it's used to be closer to colleagues. It creates more of a team environment." Another participant talked about joking with colleagues and lightening her mood, "I feel energized. I feel like somehow there's a little more adrenalin or something, or some feel-good hormones have gotten into my system. It's like a connection point during the day."

Many participants also noted that they have co-workers who do not use humor at work and stated that they seemed less integrated into the setting. "They do tend to be more silent players. They might try to do it a little bit, but they're just not comfortable with it for some reason. I don't think anyone looks down on them, or ostracizes them, but they naturally seem to be a little more on the outskirts." In relation to new workers on the unit, several participants noted that there was a period of transitional time that generally occurs before a person feels comfortable about joking with others. One person stated, "There is an adjustment period that I've noticed our trainees go through of going, 'Okay are these people just all assholes or what?'" Another person noted from first-hand experience what it was like to be new on the unit, "I'm pretty new and I actually remember when I walked in, I thought, 'Wow, this is a huge part of the culture here.' I

feel like it's almost expected that you participate...I think that it took me a little while to figure out how I fit into this culture.”

Laughing to Resolve Conflicts

Many participants also discussed the use of humor to resolve conflicts with co-workers and to manage the hierarchical nature of the work setting. One person reported that the attending psychiatrist on the team was most likely the first person to joke at a meeting, which made it acceptable for others to use humor because “he has a higher rank”. Others talked about how those with a higher rank need to be more careful about how they use humor because they are “role models,” while other stated that using humor can neutralize the hierarchical system on a unit. One person talked about using humor to assert her opinions with a higher ranking psychiatrist:

I think as far as the hierarchy goes, I can maybe come across as not as willing to defer to the doctor because maybe I'm joking about something to cope with it. I think it can come across as I'm annoyed with the situation, or I'm frustrated, or I don't agree necessarily, or I think something really differently and the way I'm expressing it is kind of passive-aggressive.

Another person identified using humor to resolve conflict with humor not as being passive-aggressive, but as productive. “I think overall we're pretty non-confrontational, not only in the workplace, but humans in general, so I think it's probably more comfortable in that sense. You can couch it as, ‘I was joking – it was just a joke.’”

Humor in Clinical Work

All participants discussed the role of humor in clinical work with patients and specifically commented on its impact on working with patients and families. Many noted

that using humor helps decrease anxiety for families, create equality between patients, families, and the social worker, and increase connectedness. One person stated:

It decreases anxiety if you do it right and you're greeting people and making some light humor. I find people will feel that you're more accessible. If it's a warm humor, I think it's a great way to create an alliance. Especially the families coming in who are usually just terrified. You know, the door locks behind them and they don't know what they're walking into. It creates equality because people look at you, and they laugh along with you, and they look you in the eye and they're like, 'We're all just human.'

Another participant commented:

It helps to open doors. When I use humor, there is something humble and authentic about it. Using the humor to talk about the things they are doing well. [Joking] helps make it not feel as heavy. It may help to have a little bit more hope in the meeting or space within myself to hold more of their angst or helplessness. The challenge of the job is that you're holding so much hopelessness.

Some participants noted that humor is used to label patients by the team, particularly those who are difficult. While these labels were never used clinically with patients, they were used by the team during meetings and in clinical conversations as a patient identifier. One participant told this story:

We come up with names or descriptions of a patient that immediately draws on certain associations. I can think of a recent patient and this was very difficult case, and the person was very intoxicated when they took an overdose and the overdose was nearly lethal and had done some major damage to the person's liver. And there was a question whether or not they would need a liver transplant. The after-effects of that were that the person looked jaundiced, so they had this yellowish look to them. So every time I would talk to different people on the staff, I would say something like, 'How is yellow woman doing?' [laughing] So it immediately draws upon who I am talking about and what the story was and the fact that I coined a term that would describe the whole case that seems funny to me and them, so it's almost like you don't have to go into as much detail about the person because they immediately know who I am referring to.

Another related story was reported as follows:

We had this kid – he was so great – he had a lot of psychosis. It centered around birds for him. He wound up with the affectionate name of “Birdman.” It was funny for us because he required so much intensive work that it was really hard for people. He was really elaborate in psychosis – I mean - he made himself a bird suit. It helped people because he was so sick. It helped to pull some of the weight out of that. It seemed to help people manage the moments when he was more aggressive. That he had this other part of him that was kind of cute and non-threatening.

Some participants stated that they did not feel that joking around about or with patients impacted their work. One person commented:

I would like to think it [humor] doesn't really affect my work. I would like to think it makes my work possible. When I'm with patients I don't feel like it makes me think any less of them or makes me any less compassionate. I'm sometimes kind of amazed by it because I think its something that actually happens when you are a therapist I'm at times really surprised how much I can distance myself from the joking and how much I can really come in with that completely objective viewpoint.

Another person stated, “I'm always aware of when I'm making a transition and informing myself of sort of what the next situation I'm going into is. If I've been having a raucous time five minutes earlier, I can turn that off and be very professional and serious.” This participant expanded upon the idea of mentally compartmentalizing the joking and stated:

It's more about situations that come up over and over again. I think that is one way that I do create boundaries between myself when I'm joking in the office and myself with the patient. I don't think when I'm joking I'm necessarily looking at – this person did this and this is a personal thing against them. I think it's a situation and I'm not really even thinking about my feeling towards the person. I think in my mind, that's how I naturally separate the two.

Another participant discussed the need to be aware of the humor when using it. “In general I want to be more mindful of how I'm coming across, that my fatigue and

frustration isn't coming out through humor. I don't think people are always aware of that. So self-awareness is very important to know what's behind the humor." A few participants expressed concern about joking with or about patients. One person said, "I find that it is hard for me to let go of some of the more negative connotations of the joke and be present with the patient." Another participant stated, "Sometimes it really helps, but sometimes I have a concern that maybe it was degrading for the patient. Or maybe I shouldn't have been involved in laughing about the patient. I sort of have a conflictual relationship to this."

Appropriate and Inappropriate Work Humor

One theme that emerged during the transcription process, which was not directly addressed in the formal interview guide, is the use of appropriate and inappropriate work humor. While a somewhat vague and subjective topic, each participant discussed the need to differentiate between the two types and monitor the type of humor that was used at work in relation to the setting and culture. Many of the responses reported in this section were prompted by questions about the perception of humor on the unit and the individual participant's comfort level in using humor.

Keeping Humor in the Back Room

All participants stated the need to control joking by keeping it contained to non-patient areas, such as a nurse's station, closed offices, or off the unit. One person stated:

I don't think we're yelling across the milieu but I do think at times I become self-conscious that maybe I shouldn't be saying this on the milieu, or maybe the patient overheard a side comment...The only thing I worry about is that because it is so accepted that there are times when people aren't saying, 'We really shouldn't be joking about this,' or 'Maybe that's not appropriate' ...because it's such a jokey environment.

A Culture of Humor and the Need for Trust

One person differentiated between cultures that use aggressive humor and those that use gallows as a means of creating “levity”. She stated:

It’s really easy for that stuff to become toxic. Yeah, it’s funny in the moment, but it’s not really the funny you want. And I think this is a morale issue too. Close-knit units have cultures. And they can be mean...and yeah everybody cracks up for the minute, but it leaves you feeling kind of gross...then there’s the unit that has a levity and maybe a little gallows humor – I think that’s appropriate in certain settings and a locked psych unit is one of them.

Related to the unit culture, some participants talked about the need to develop trust between co-workers in order for humor to be well received or interpreted in a positive way. When discussing what makes humor successful, one person stated, “If they are people you trust. If they are people who really know you and know that your intentions are good. People who share the same sense of humor.” Another participant noted, “[Joking] is based on trust and the relationship that people have with each other here.” Other participants talked about how the intention of the humor can be interpreted as positive or passive-aggressive. One person talked about the need to monitor the humor and to be aware of others, “That’s why you have to be careful. If you are capable of leading people along into a laugh, making sure that your humor isn’t hurting anyone and doesn’t leave anyone feeling badly for having laughed along with you.” One person noted that those who use humor passive-aggressively often do it as a means of addressing something that makes them feel uncomfortable, but that the communication is ineffective at resolving problems.

“They let me know when I’m not funny”

When making jokes that are not received well, many participants discussed picking up on social cues that let them know their joke was not appropriate. One person stated, “If I’m saying something in a humorous fashion that I want others to appreciate, even if they don’t laugh, I expect them to smile. If they look more the opposite, it will be obvious that I’m on a totally different channel. Other participants concurred that negative cues are mostly non-verbal and consists of others not laughing or smiling, or there may be a lack of another intended responses, such as joking back. Others stated that social corrections are also expressed with verbal cues. One person stated, “The other thing that happens here is there are a few people who will just say straight out – I don’t joke about that. And then you know.”

Inappropriate Content

Out of the discussions about the appropriate and inappropriate uses of work humor was the need to define inappropriate content. Topics such as politics, gender, race and ethnicity, sexual orientation or explicit sex jokes, health issues, and romantic relationships, and job performance, were noted by participants as content that is not appropriate in work humor. Some participants also reported that joking using physical contact, imitating a patient’s accent, and pathologizing a patient by joking as inappropriate. One person stated, “When humor is being used when someone really doesn’t like a patient. I think that’s unacceptable.”

Working with Adults verses Children

While each participant expressed the need for discretion when joking, those who worked with children and adolescents were more likely not to joke about patients, their families, or their presentations. One person stated, “I really don’t make fun of patients and their families. I really try not to. It’s different with kids – they are just so vulnerable.”

Humor and Seriousness

Related to the vulnerability of certain populations is the differentiation between the seriousness of the work and humor. One person stated, “I’ve definitely seen interactions that start out joking but then it veers into a more serious issue that’s going on. You can wonder if it’s joking or not. It is a fine line because of the work that we do – it is so serious, yet we have this kind of environment of humor that we’re working within, so when you put those two together, which are polar opposites, it’s bound to get confusing. Another participant commented, “The more I talk about this, I don’t want to give the impression that being on the job is one big joke...I want to emphasize the fact that when we have to talk about the work and the clinical care of patients, while there is still room for humor, I am very serious in those conversations.” Generally, all the participants agreed that some use of humor in the workplace is positive and does not interfere with the serious nature of the work. One person stated, “Tension is more harmful to the work than humor. Good humor that is polite and that is not damaging, and timely.”

Humor Education

Participants were directly asked about how humor was addressed in their social work education and how they learned to use it on the job. Only two participants stated that humor was addressed in their social work education, with one participant reporting that a class addressed the uses of humor to cope with work stress. The other participant reported that humor was discussed as a high defense mechanism, but little was discussed about how to use it clinically, or as a stress reducer. When asked how humor was addressed in her professional education one participant stated, “It wasn’t. I’m sure that’s not a rare answer. I had some professors who were humorous, so they would address situations that we’re talking about in class with jokes, but there was never any teaching about humor in the workplace, or how it can be an effective coping method, or how to use it clinically.”

“It happened organically”

Of those who reported that humor was not addressed in their social work education, all participants stated that they learned to use humor either from their family, or by observing cues in the work setting that indicated joking was acceptable. One person stated, “I grew up in a family where humor was used a lot...Just growing up with a certain family environment gave me a certain appreciation for the value of humor.” Another participant concurred, “I found out that my family uses humor to cope with difficult things. And it’s the very sarcastic humor. So humor was a way of bypassing talking about and actually dealing with difficult issues. That just carried over into the rest of my life, and naturally the workplace.” Other participants discussed how although

humor was not a part of their professional education, they learned to use it during graduate school internships. Others noted that observations made while in the workplace served as a cue that joking was accepted. One person stated, “Here I had a cue because the sarcastic humorous comments came out during my interview. So right off the bat, it was there.” Finally, one participant commented on her continued appraisal of workplace humor and her personal reflections on it, she stated, “What I’ve learned is that it really actually does work as a stress reliever for me. So I need to use it a little bit more.”

Quantitative Findings – The HSQ

The HSQ survey yielded one significant finding based on a Pearson’s R Correlation Test. This test found a significant relationship between aggressive and self-defeating humor ($r=.770$, $p=.009$, two-tailed). This strong positive correlation suggests that participants who reported using aggressive humor, also have a tendency towards self-defeating humor, suggesting that these humor styles are closely related.

Frequency analysis revealed that most participants identified their humor style to be affiliative and self-enhancing, with fewer scoring higher on the aggressive and self-defeating humor subscales. Using the four-point Likert scale, almost all participants scored between a 3 and a 4 for affiliative humor, indicating a stronger likelihood of using this humor style. Likewise, most participants scored very low on the aggressive humor scale, only ranking between a 1 and a 2 on the Likert scale. Mirroring these findings, most participants also ranked higher in the self-enhancing style versus the self-defeating style. As noted above, aggressive and self-defeating humor was closely correlated, indicating that these humor styles may be used by participants in a similar manner.

Quantitative Findings – The ProQOL

The ProQOL survey yielded two significant findings based on a Pearson's R Correlation Test. This statistical test found a significant relationship between compassion satisfaction and burnout ($r=-.770$, $p=.009$, two-tailed). This strong negative correlation suggests that those participants with a higher degree of compassion satisfaction had lower levels of burnout. The Pearson's R Correlation also yielded significant results for the relationship between compassion fatigue and burnout ($r=.780$, $p=.008$, two-tailed). This strong positive correlation suggests that the higher the level of compassion fatigue a participant reported, the higher the level of related burnout.

Frequency data for the three subscales revealed that most participants reported feeling compassion satisfaction in the last thirty days versus burnout. In the compassion satisfaction subscale, seven participants scored above the average of 37, indicating that they felt satisfied in their work. In the compassion fatigue subscale, only one participant scored a 20, which is three points above the average of 13, indicating a significant level of fatigue. Two participants scored a 16, indicating that they were somewhat fatigued and seven participants scored below the average, indicating low levels of compassion fatigue in their work. In the burnout subscale four participants scored at or below 18 indicating positive feelings towards their work and a sense of efficacy in the work. Three participants scored above the average of 22, with three others falling between 18 and 22, indicating that at least three participants were at risk for burnout, though to varying degrees.

The findings in this study were organized into ten categories and presented above. The next chapter will discuss the relevance of the findings to the literature previously reviewed. A discussion on the relevance of the findings to social work practice, theory and policy will also be included.

CHAPTER V

DISCUSSION

This study was an attempt to answer the following question: How does humor function as a coping mechanism for clinical social workers working on a hospital inpatient psychiatry unit? Key findings discovered in the data analysis are as follows: 1) work-related stressors and rewards; 2) individual worker coping methods; 3) the types and functions of workplace humor; 4) humor education: how humor is addressed in social work education and in the workplace. Additionally, there were no significant correlations between the two survey's subscales; however, significant findings within each scale were noted. Specifically, aggressive and self-enhancing humor were positively correlated, as well as compassion fatigue and burnout. Compassion satisfaction and burnout were negatively correlated.

This chapter will discuss key findings of the study as they relate to previously published studies in the humor, stress, and coping literature. Some of the key findings in this study supported the presented literature; others did not. Recommendations for further research in the area of humor as a coping mechanism for clinical social workers will be addressed in the later half of this chapter, as well as the limitations of this study and the implications of these findings in clinical social work practice.

Work-related Stressors and Rewards

Findings in this study generally supported previously published studies on stress and coping in human service work. Bennett, Evans & Tattersall (1993) and Moran &

Hughes (2006) both found that those working in the helping professions were at greater risk for occupational stress and burnout. In response to Bennett et al (1993), this study sought to quantify and qualify the stressors of a very specific worker population: psychiatric social workers. Examining the level of stress, compassion fatigue, and burnout experienced by this particular population is relevant to other specialties in clinical social work due to the potentially taxing nature of clinical work. Based on Figley's (2002) definition of compassion fatigue, psychiatric social workers are at high risk for burnout due to their long-term exposure to traumatized patients and their presenting problems. Evidence from this study supports this position in that all participants reported that work with patients and families could be stressful due to their acute medical and psychiatric needs. Often chronically mentally ill patients are oppressed and experience additional problems related to social isolation, poverty, substance abuse, violence, and limited access to needed social resources. These problems impact clinical social workers roles, particularly in relation to family work and discharge planning. In this study all participants reported that discharge planning was the most stressful aspect of the job, specifically due to the current national economic crisis, which has resulted in large state cuts to social services. Gellis (2002) also found that organizational constraints such as: agency-imposed pressure to discharge patients quickly, difficulties collaborating with other multidisciplinary staff, and limited community resources, all caused increased stress for hospital social workers.

The "absurd" nature of the work also impacts the felt stress experienced by psychiatric social workers. The consistent exposure to suicidal, homicidal, and psychotic

patients, among other acute presenting problems, can be exhausting and increase incidents of compassion fatigue, eventually leading to burnout. Shinn, Rosario, Morch & Chesnut (1984) found that the emotional demands posed by chronically mentally ill clients and the unrealistic expectations supported by the agency were significant stressors for clinical social workers. In this study, all participants reported that daily exposure to acutely ill patients had the potential to negatively impact job satisfaction. Several participants stated that they felt more satisfied in their work when they were “on top of my caseload” and making progress with patients.

In this study, three of the seven participants worked with either children or adolescents and reported that they perceived their job to be more intensive than adult work due to the multitude of demands placed on them by families and the larger social system. Bennett et al (1993) found that child care workers had increased levels of stress compared to social workers in other specialties, including those who work with adults.

While related studies found that work with clients and families can cause increased incidents of compassion fatigue and burnout in workers, participants in this study reported that clinical work can be a source of reward and pleasure. Adams, Boscarino, & Figley (2006) noted that a limitation of their study was a lack of positive items in their survey of compassion fatigue and burnout in human service workers. This study sought to fill that gap by including an analysis of compassion satisfaction. A significant number of participants stated that work with clients and families is rewarding, particularly when the worker has a sense of accomplishment. Participants also reported

that fostering supportive work relationships is a source of enjoyment and reward, which was extensively cited as a method of buffering stress in the reviewed literature.

Individual Worker Coping Methods

All participants in this study reported using social supports and cognitive strategies to manage work-related stress. This finding is supported by Vaillant's (2000) work on the positive impact of higher level defense mechanisms on quality of life. While Pearlin & Schooler (1978) did not find that coping strategies, including utilizing psychological or social resources, helped reduce occupational stress, this study found that increased social supports and problem reappraisal through the use of humor are effective methods of managing work stress. Based on these findings, social support and humor can be considered methods of coping that minimize and manage stress after it has emerged. These findings conflict those presented by O'Connell (1960), Kuiper & Martin (1998), Poterfield (1987), and Nezlek & Derks (2001).

The utilization of social supports and humor can be considered both problem and emotion-focused coping strategies in the Transactional Stress Model. Specific to emotion-focused coping, humor was used by participants in this study as a method of reappraising problems and the meaning attached to them, which is also supported in Martin and Lefcourt's (1984) work on humor. Pearlin and Schooler (1978) stated that productively managing the meaning attributed to the problem and the stress that arises from it are essential to successful coping. As a result of successful coping, seven participants reported that despite the emotionally demanding nature of their work, they were satisfied in their jobs.

Types and Functions of Work Humor

The types of humor used by participants included ironic or sarcastic humor, silly humor, and gallows humor. These humor types are supported in the humor literature by van Wormer & Boes (1997), Kuhlman (1988), and Obrdlik (1942) as types used by those working in scaffold settings, such as hospital emergency rooms and psychiatric units. van Wormer & Boes specifically defined humor as a phenomenon that exists apart from laughter and requires the joint recognition of the “ridiculousness of life” (p. 88). The need for participants to identify and joke about absurdities in the work was a significant finding in this study and is directly linked to incongruity and relief theory, as outlined by Meyer (2000). When faced with patient problems that are extreme, in conjunction with a lack of social resources to mitigate or eliminate them, workers often need to make sense of situations that appear to be hopeless. The incongruity that arises when a worker has limited means to resolve human suffering can result in feelings of ineffectiveness, which can increase incidents of compassion fatigue and lead to burnout. All participants in this study recognized the significance of managing feelings of hopelessness in the work and reported that relief through the use of humor and connecting with coworkers was essential to their work success.

Based on the humor framework used in this study, which was initially presented by Martin, Puhlik-Doris, Larsen & Weir (2003), participants mostly reported that they used affiliative humor, with fewer reporting the use of aggressive humor, as presented in the narrative descriptions of their respective humor styles. Affiliative and self-enhancing humor was reported to be more widely used because it is “benign” in nature and is more

effective at increasing social supports than aggressive humor, which has the potential to divide and create factions among social groups. Many participants reported that they used gallows humor at work and found it to be an effective humor type based on the acuity of their work. Due to its specificity of use, it is difficult to fit gallows humor into the four humor types presented in the framework. Depending on its use, gallows humor can be affiliative and aggressive in nature. Participants who reported using gallows humor stated that this humor type brought co-workers together and provided connection; in this usage, it can be considered affiliative.

The interactional nature of humor and its ability to increase social supports through joking directly impacts individual levels of work stress. All participants in this study reported that they, as well as their co-workers, joked on the job. Nezu, Nezu, & Blissett (1988) stated that the use of humor in stressful situations might serve to attract social support when compared to more negative forms of communication, such as complaining. Participants in this study confirmed this theory by relating stories about their uses of humor with co-workers and their observations that those who did not joke were more isolated in their work and seemed more depressed. Participants also reported that using affiliative or self-enhancing humor can help a worker navigate the hospital's hierarchical system and resolve conflicts by deflecting confrontation. Only one participant identified her humor style to be aggressive when used to resolve work conflicts, particularly with higher-ranking co-workers. Work conflicts may be easily resolved with the use of humor due to the expression of potentially hostile content in a form that is more socially acceptable. Freud (1905/1960) theorized that humor permitted

the expression of emotion without discomfort or unpleasant effects on others, which was later supported by Vaillant (2000) and O'Connell (1960).

Participants also reported that humor allowed them to work more effectively with patients and their families. They expressed that using humor, whether in a clinical meeting, or with co-workers to joke about a particular patient, provided an emotional release. One participant reported that joking about or with patients provided her with more "energy" and a sense that she could manage the task at-hand. Participants reported that the use of humor clinically promoted a sense of equality, connection, and alliance between worker and families. Participants also reported that clinical uses of humor helped not only the worker gain perspective on a patient's problems, but also helped patients to look at their problems through a more forgiving lens. The use of humor clinically fits into Meyer's (2000) frameworks of superiority and relief. Joking with patients reduces inequality in the working relationship and closes the status gap between the "sick" and the "well". Humor can also help de-stigmatize chronic mental illness by making light of less worrisome problems, or by providing perspective on those that seem unmanageable. The absurd aspects of life are no longer as threatening when one pokes fun at what cannot be controlled or eradicated.

When joking about patient's to other co-workers, humor provides a distancing from the often frightening and overwhelming aspects of chronic mental illness. In relation to superiority theory, the status gap widens with jokes that address a patient's symptoms, presenting problem, or life situation as it pertains to their illness. This type of humor, which often falls into the category of gallows humor, can also be creative and

lend perspective to the worst of situations. By releasing tension, hostility, and frustration through humor, workers can then come back to the responsibilities of the job refreshed and relieved. In its darker forms, this type of humor can also create a permanent divide between “us”, or those who are “well”, and “them”, or those who are “ill”. In these extreme cases, the humor can be counter-productive to the goals of effectively coping with the work, as well as maintaining the empathy required to help those in need.

Humor Education

One of the most significant findings in this study was the limited discussion of humor in professional social work education. This finding was corroborated by Moran & Hughes (2006) who noted that humor is not widely discussed in social work education as a clinical intervention, or as a coping mechanism. Siporin (1984) stated that there is limited support in the social work field for workers to use humor as a coping method. While humor was not widely addressed in social work education, all participants in this study noted that they learned to use humor either from their family or at work by first observing and taking note of the culture. An assessment of how humor was perceived in the work setting and used by veteran co-workers was reported to be an essential part of learning to use it at work and defining what types of joking were accepted by others. An unexpected finding in this study was the need for participants to differentiate between inappropriate and appropriate work humor. Many content areas were noted as unacceptable, including: race, gender, ethnicity, and sexual orientation, but most participants reported that the appropriate use of humor was largely defined by the unit culture.

The lack of humor education for social workers may be attributed to several factors, including a need for the profession to be legitimized by society and its widespread reputation as a serious and difficult line of work. Ashforth & Kreiner (1999) stated that social work is considered to be socially tainted because of its regular contact with groups who are themselves stigmatized. Due to its commitment to working with disadvantaged and vulnerable populations, it is possible that the profession does not place a high value on workers' uses of humor, due to the potential destructiveness of aggressive humor. In a field that values compassion, empathy, and connection, humor may have earned a negative reputation that precludes its use by workers in a breadth of settings.

Limitations of this Study

This study had several limitations. The small sample size and the specificity of an urban hospital psychiatric unit did not allow for transferability of the findings to a larger population of social workers who may work in rural geographic areas or in settings other than hospital psychiatric units. Additionally, the small sample size impacted the significance of the correlation between the two survey's subscales. A larger sample size may have yielded different results with more significant correlations. The participants in this study were racially homogenous and participant responses may have been biased towards the experience of Caucasian social workers. Nine out of ten participants were women, limiting the transferability of findings to male social workers. Other variables such as ethnicity, sexual orientation, and socioeconomic status were not measured in this study.

Attention was given to the issues of reliability and validity of the data collection process. The recorded interviews were transcribed verbatim and the transcripts compared to the original tapes to ensure accuracy. Potential researcher bias included interpreting data based on theories or concepts presented in the review of literature, as well as personal work experience on an inpatient psychiatry unit. Respondent bias may have included age, gender, ethnicity, sexual orientation, and work experience differences or similarities between the researcher and the participants. Measures were selected based on their validity testing with large samples and their relationship to the uses of humor and types job stressors that are specific to a social work population.

Implications

The findings in this study will have implications for clinical social work practice; predominantly in the area of social work education on humor and coping. As noted in the findings, all social workers in this study reported using humor to cope with the demands of working on an inpatient psychiatry unit with patients who are acutely mentally ill. Participants also reported that co-workers from other healthcare disciplines used humor at work and the “culture of humor” on these psychiatric units fostered supportive social networks among workers. A majority of participants reported that the uses of humor, both as an individual coping mechanism and clinical intervention, was not addressed in their social work education. The value placed on humor by these participants supports that humor research in the field of social work is important to both students and professional workers.

The findings in this study support that humor can be used to bolster work supports, relieve emotional distress, and manage stress that emerges as a result of work problems. Increased mastery over work stress may lead to better outcomes in compassion satisfaction and reduce worker burnout. As supported by the statistical analysis, increased compassion satisfaction was negatively correlated to burnout, suggesting that having a sense of satisfaction in the work reduces the likelihood of feeling burned out. Additionally, compassion fatigue and burnout had strong positive correlations, suggesting that prevention and early awareness about the signs and symptoms of compassion fatigue may reduce incidences of burnout. Education in this area is needed to help workers learn about options to reduce stress and cope with the demanding nature of the work. Understanding the implications of the use of humor, including its positive and negative functions, and promoting awareness about its effect on workers may help to legitimize its role in workplace culture.

Humor can be used clinically with patients, including with those who are acutely and chronically mentally ill. Education in this area can empower both new and seasoned workers to effectively utilize humor in their work and to better differentiate its impact on the dyadic relationship, as well as on the individual receiver. Humor can serve to lighten absurd, frightening, and difficult problems or situations, foster perspective by helping patients distance themselves from emotional pain and suffering, build clinical alliances, and neutralize the power dichotomy between worker and patient. Students and professionals should also have a better understanding of the negative impacts of humor. As revealed in the statistical analysis, self-defeating and aggressive humor were strongly

linked as having a positive correlation, suggesting that a distinction between the two types may be difficult to determine. In a clinical context, participants expressed concern regarding potentially degrading joking and how this humor type may promote a sense of worker superiority in comparison to patients and their problems. Aggressive humor is counterproductive and prevents social bonds from forming, promoting instead factions among workers and distancing from patients, their families, and their problems. In short, aggressive, superior humor supports an “us-versus-them” work philosophy. Understanding the difference between positive, productive humor and negative, aggressive humor will empower workers to differentiate between the two types and use humor in ways that are advantageous to their own professional development, as well as in creating a playful and congenial workplace culture.

Further studies should be done to gain knowledge in the area of baseline worker mental health, specifically to expand upon this study’s design and to measure for worker levels of depression and anxiety in relation to the effectiveness of their expressed coping strategies. Research in various clinical specialties, such as outpatient counseling, or community outreach work, with a larger, more robust sample of social workers, will provide important data on the more widespread uses of humor to cope with job demands. More research should be done on social worker’s perceptions of appropriate and inappropriate work humor to de-stigmatize the use of humor and to develop a workplace “code of ethics”. As cited across the stress and coping literature, an expanded, longitudinal study design will allow for a greater understanding across time of social worker’s levels of stress, how stress levels correlate to job satisfaction, and the

effectiveness of various coping strategies, including humor, to reduce or eliminate job stress. Finally, an assessment of agency demands on workers and their impact on job stress, job satisfaction, and coping may provide important information about the stressors experienced by workers in specific types of work settings and how those may be best mitigated.

Summary

In this study, humor was reported to be an important and effective coping mechanism for clinical social workers who work on an inpatient psychiatry unit. Given unique stressors experienced in their work, participants expressed a need to release stress through verbal interactions with other co-workers and cited joking as one of the most effective methods to make meaning out of their job roles, the absurd and often dark aspects of their work, and to remain motivated in the face of adversity. Participants discussed the clinical role of humor and how it can serve to humanize workers, equalize power dynamics with patients, and normalize the hospital experience for patients. Various types of humor were explored in this study, most notably gallows humor, and its relationship to the four humor styles measured on the Humor Styles Questionnaire. While it cannot be formally categorized, participant narratives supported that gallows humor can be both affiliative and aggressive. The need to differentiate appropriate work humor was also expressed as critical in developing a healthy and functional work environment. Finally, participants expressed a need for more formalized education on humor and its role in clinical work, as well as the workplace.

References

- Adams, R.E., Boscarino, J.A., & Figley, C.R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry*, 76(1), 103-108.
- Ashforth, B. & Kreiner, G. (1999). "How can you do it?": Dirty work and the challenge of constructing a positive identity. *The Academy of Management Review*, 24(3), 413-434.
- Aldwin, C.M. & Revenson, T.A. (1987). Does coping help? A reexamination of the relation between coping and mental health. *Journal of Personality and Social Psychology*, 53(2), 337-348.
- Anastas, J.W. (1999). *Research Design for Social Work and the Human Services*. Columbia University Press: New York.
- Bennett, P., Evans, R. & Tattersall, A. (1993). Stress and coping in social workers: A preliminary investigation. *British Journal of Social Work*, 23(1), 31-44.
- Bride, B.E., Radey, M., & Figley, C.R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, 35, 155-163.
- Figley, C.R. (2002). Compassion fatigue: Psychotherapist's chronic lack of self care. *Psychotherapy in Practice*, 58(11), 1433-1441.
- Freud, S. (1905/1960). *Jokes and Their Relation to the Unconscious*. Norton & Co: New York, 290.
- Freud, S. (1928). Humour. *International Journal of Psychoanalysis*, 9, 1-6.
- Gellis, D.Z. (2002). Coping with occupational stress in healthcare: A comparison of social workers and nurses. *Administration in Social Work*, 26(3), 37-51.
- Kanter, J. (2007). Compassion fatigue and secondary traumatization: A second look. *Clinical Social Work Journal*, 35, 289-293.
- Kuiper, N.A. & Borowicz-Sibenk, M. (2005). A good sense of humor doesn't always help: agency and communion as moderators of psychological well-being. *Personality and Individual Differences*, 38, 365-377.
- Kuiper, N., & Martin, R. (1988b). Laughter and stress in daily life: Relation to positive and negative affect. *Motivation and Emotion*, 22, 133-153.

- Kuhlman, T.I. (1988). Gallows humor for a scaffold setting: managing aggressive patients on a maximum-security forensic unit. *Hospital and Community Psychiatry, 39*(10), 1085-1089.
- Martin, R.A., & Lefcourt, H.M. (1983). Sense of humor as a moderator of the relation between stressors and moods. *Journal of Personality and Social Psychology, 45*, 1313-1324.
- Martin, R.A., Puhlik-Doris, P., Larsen, G., Gray, J., & Weir, K. (2003). Individual differences in uses of humor and their relation to psychological well-being: Development of the humor styles questionnaire. *Journal of Research in Personality, 37*, 48-75.
- Meneghan, E.G. (1982). Measuring coping effectiveness: A panel analysis of marital problems and coping efforts. *Journal of Health and Social Behavior, 23*, 220-234.
- Meneghan, E.G. & Merves, E.S. (1984). Coping with occupational problems: The limits of individual efforts. *Journal of Health and Social Behavior, 25*, 406-423.
- Meyer, J.C. (2000). Humor as a double-edged sword: Four functions of humor in communication. *Communication Theory, 10*(3), 310-331.
- Moran C.C. & Hughes L.P. (2006). Coping with stress: Social work students and humour. *Social Work Education, 25*(5), 501-517.
- Nezlek, J. & Derks, P. (2001). Use of humor as a coping mechanism, psychological adjustment, and social interaction. *Humor: International Journal of Humor Research, 14*, 395-413.
- Nezu, A.M., Nezu, C.M., & Blissett, S.E. (1988). Sense of humor as a moderator of the relation between stressful events and psychological distress: A prospective analysis. *Journal of Personality and Social Psychology, 54*(3), 520-525
- Obrdlik, A.J. (1942). Gallows humor: A sociological phenomenon. *The American Journal of Sociology, 47*(5), 709-716.
- O'Connell, W.E. (1960). The adaptive functions of wit and humor. *Journal of Abnormal and Social Psychology, 61*(2), 263-270.
- Pearlin, L.I. & Schooler, C. (1978). The structure of coping. *Journal of Health and Social Behavior, 19*, 2-21.
- Porterfield, A. (1987). Does sense of humor moderate the impact of life stress on psychological well-being? *Journal of Research in Personality, 21*, 306-317.
- Romero, E.J. & Cruthirds, K.W. (2006). The use of humor in the workplace. *Academy of Management Perspectives, 58*-69.

- Shinn, M., Rosario, M., Morch, H., & Chesnut, D. E. (1984). Coping with job stress and burnout in the human services. *Journal of Personality and Social Psychology*, 46(4), 864-876.
- Siporin, M. (1984). Have you heard the one about social work humor? *Social Casework: The Journal of Contemporary Social Work*, 65(8), 459-464.
- Sprang G. & Clark, J.J. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma*, 12, 259-280.
- Stamm, B.H. (2005). The professional quality of life scale: compassion satisfaction, burnout, and compassion fatigue/secondary trauma scales. Latherville, MD: Sidran Press.
- Tracy, S., Myers, K., & Scott, C. (2006). Cracking jokes and crafting selves: Sensemaking and identity management among human service workers. *Communication Monographs*, 73(3), 283-308.
- Vaillant, G.E. (2000). Adaptive mental mechanisms. *American Psychologist*, 55(1), 89-98.
- van Wormer, K. & Boes, M., (1997). Humor in the emergency room: A social work perspective. *Health & Social Work*, 22(2), 87-92.

Appendix A

Human Subjects Review Committee Approval Letter

December 12, 2009

Sarah Santoro
50 ½ Prescott Street
Somerville, MA 02143

Dear Sarah,

Your revised materials have been reviewed. You have done an excellent job and all is now in order. There is one small correction we would like you to make. In discussing the use of the materials, you go into more detail than necessary and also limit the possibilities of future use. Just say in both the Application and the Consent that it is for your thesis and for possible presentation and publication. That covers everything and doesn't limit you down the line.

We are happy to give final approval to your study and just request that you amend your materials and send the pages with the correction to Laurie Wyman so your file copy will be correct.

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 project. You may well get participants (usually the toughest part of this whole process) as I would think that people might be quite intrigued with the topic.

Sincerely,

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

CC: Shella Dennery, Research Advisor

Appendix B

Informed Consent

February 3, 2009

Dear Participant:

My name is Sarah Santoro and I am currently a candidate for a Masters of Social Work degree from the Smith College School for Social Work. In order to be awarded my degree, I am required to complete a master's thesis project. The purpose of this research study is to explore how clinical social workers use humor as a means of coping with an acutely intense work environment. This thesis project is for future publication by the School and for presentation.

Because you are a practicing clinical social worker who is currently working on an inpatient psychiatric unit, or acute care unit, your insights and work experience would be extremely valuable to this study. While there will be no financial benefit for participating in this study, your experience can contribute to the clinical and professional development of our field. In order to qualify for the study, you must be a licensed clinical social worker (LCSW or LICSW) currently working on a hospital inpatient psychiatric or other acute care unit in Massachusetts. You must have a minimum of three months of direct-care experience on the unit, a minimum of a Master's degree in Social Work, and have English language proficiency.

Your participation in this study will include providing certain demographic information in written form, as well as completing two surveys and a one-on-one interview. The demographic profile will include: number of months/years working on the unit, level of professional licensure, job title, and highest level of education completed. The surveys will measure how you use humor, as well as your current level of compassion fatigue, compassion satisfaction, and burnout. Each survey will take approximately 10 minutes to complete, for a total of 20 minutes. You will then complete a 40-minute interview which will be taped using a digital recorder. During the interview you will be asked open-ended questions about your job role, uses of humor in relation to your work, and job stressors.

Due to the nature of this study, it is possible that you may experience some emotional distress when reflecting upon past work experiences that were challenging or upsetting. You may decline to answer survey or interview questions that you find disturbing, or that are not applicable to your work experience. You may also withdraw from this study at any time and all contributed information will be promptly destroyed.

Your participation in this study will be on a volunteer basis and there will be no compensation awarded for completion of the research. Your participation will contribute

to expanding social work scholarship to include the impact and usefulness of humor in intense acute care clinical settings. In reflecting on your use of humor, you may find new strengths and a sense of resiliency in the face of acute stress. Measuring compassion fatigue, compassion satisfaction, and burnout may also provide useful information about your current stress level and how it can best be reduced.

Any identifiable information will be altered to protect your confidentiality in this study and the information that you provide will be assigned a code number as an identification marker. The collected survey data, recorded interview, and coded data analysis, will only be shared with this researcher's thesis advisor and the School's statistician after identifiable information has been removed. All transcription of the narrative data collected from the interview will be transcribed by this writer only. You will not be personally identified in any way in the final report of this research, which will include a written thesis and public presentation. Materials from this study will be stored in a secure locked/password protected location for three years as required by Federal regulations to ensure that confidentiality is maintained. After the three-year time period has lapsed, all materials that are no longer needed will be destroyed. Materials that are kept longer than three years will be kept secured and will be destroyed when no longer needed

Participation in this study is voluntary and if at any time you wish to withdraw from this study before, during, or after participation, you may do so until April 1, 2009 when the report will be written. Information you have contributed during the course of your participation in this study will be destroyed upon your withdrawal. In order to withdraw from this study, please contact this writer at the email and/or phone number provided to you.

If you have any questions regarding this research study, please contact me at the phone number or email address provided below. You may also contact Ann Hartman, Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974. Your participation in this study is greatly appreciated and the information you provide will be useful to the development of this thesis project.

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.

Signature of Participant: _____
Date: _____

Signature of Researcher: _____
Date: _____

Thank you for your time and willingness to participate in this study.

Sincerely,

Sarah Santoro
50 ½ Prescott Street
Somerville, MA 02143
Phone: 617-501-0563
Email: sully1019@hotmail.com

Please keep a copy of the Consent for your records.

Appendix C

Interview Guide and Measures

Demographic Information:

Highest level of formal education completed: _____

Level of Professional Licensure: _____

Job Title: _____

Number of months/years in work setting: _____ (circle one: Months/Years)

Interview Guide:

1. Please describe your typical responsibilities at work.
2. What are the most stressful aspects of your work?
3. What are the most rewarding aspects of your work?
4. How do you understand your job role in the context of this work environment?
5. How satisfied are you with your job role?
6. What methods do you use to cope with stress at work?
7. How do your co-workers manage stress at work?
8. How do you use humor at work?
9. How do your co-workers use humor at work?
10. How would you describe the type of humor that is used at work?
11. Among the different types of workers in this environment, who is the most likely to first use humor?
12. How is the use of humor perceived in the workplace?
13. How does humor impact your work with patients and their families?
14. How does humor impact your relations with co-workers?
15. How did you learn to use humor in the workplace?
16. How comfortable are you using humor in the workplace?
17. Describe an incident when humor was used in the workplace and how it was received by other workers.
18. What purpose does humor serve in this work environment?
19. What is unique about humor in social work?

20. How was humor addressed in your professional education?

Humor Styles Questionnaire

This questionnaire is concerned with the way you express and experience humor. Obviously there is a wide variation amongst individuals and therefore no right or wrong answers to these questions. Below you will find 32 states. In the space at the beginning of each statement, please indicate the degree to which you agree or disagree with that statement using the number scale below. Please be honest in your answers.

1=Strongly Disagree 2=Mildly Disagree 3=Mildly Agree 4=Strongly Agree

- ____ 1. I usually do not laugh or joke around much with other people.
- ____ 2. If I am feeling depressed, I can usually cheer myself up with humor.
- ____ 3. If someone makes a mistake, I will often tease them about it.
- ____ 4. I let people laugh at me or make fun at my expense more than I should.
- ____ 5. I don not have to work very hard at making other people laugh—I seem to be a naturally humorous person.
- ____ 6. Even when I am by myself, I am often amused by the absurdities of life.
- ____ 7. People are never offended or hurt by my sense of humor.
- ____ 8. I will often get carried away in putting myself down if it makes my family or friends laugh
- ____ 9. I rarely make other people laugh by telling funny stories about myself.
- ____ 10. If I am feeling upset or unhappy I usually try to think of something funny about the situation to make myself feel better.
- ____ 11. When telling jokes or saying funny things, I am usually not very concerned about how other people are taking it.
- ____ 12. I often try to make people like or accept me more by saying something funny about my own weaknesses, blunders, or faults.
- ____ 13. I laugh and joke a lot with my closest friends.

- _____14. My humorous outlook on life keeps me from getting overly upset or depressed about things.
- _____15. I do not like it when people use humor as a way of criticizing or putting someone down
- _____16. I do not often say funny things to put myself down.
- _____17. I usually do not like to tell jokes or amuse people.
- _____18. If I am by myself and I am feeling unhappy, I make an effort to think of something funny to cheer myself up.
- _____19. Sometimes I think of something that is so funny that I cannot stop myself from saying it, even if it is not appropriate for the situation.
- _____20. I often go overboard in putting myself down when I am making jokes or trying to be funny.
- _____21. I enjoy making people laugh.
- _____22. If I am feeling sad or upset, I usually lose my sense of humor.
- _____23. I never participate in laughing at others even if all my friends are doing it.
- _____24. When I am with friends or family, I often seem to be the one that other people make fun of or joke about.
- _____25. I do not often joke around with my friends.
- _____26. It is my experience that thinking about some amusing aspect of a situation is often a very effective way of coping with problems.
- _____27. If I do not like someone, I often use humor or teasing to put them down.
- _____28. If I am having problems or feeling unhappy, I often cover it up by joking around, so that even my closest friends don't know how I really feel.
- _____29. I usually cannot think of witty things to say when I'm with other people.
- _____30. I do not need to be with other people to feel amused – I can usually find things to laugh about even when I am alone.

- _____31. Even if something is really funny to me, I will not laugh or joke about it if someone will be offended.
- _____32. Letting others laugh at me is my way of keeping my friends and family in good spirits.

Professional Quality of Life Scale, Revision IV

Social Work puts you in direct contact with the lives of your patients. As you probably have experienced, your compassion for those you help has both positive and negative aspects. I would like to ask you questions about your experiences, both positive and negative, as a social worker. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

- ____ 1. I am happy.
- ____ 2. I am preoccupied with more than one of my patients.
- ____ 3. I get satisfaction from being able to help people.
- ____ 4. I feel connected to others.
- ____ 5. I jump or am startled by unexpected sounds.
- ____ 6. I feel invigorated after working with my patients.
- ____ 7. I find it difficult to separate my personal life from my life as a social worker.
- ____ 8. I am losing sleep over traumatic experiences of one or more of my patients.
- ____ 9. I think that I might have been “infected” by the traumatic stress of my patients.
- ____ 10. I feel trapped by my work as a social worker.
- ____ 11. Because of my work, I have felt “on edge” about various things.
- ____ 12. I like my work as social worker.
- ____ 13. I feel depressed as a result of my work as a social worker.
- ____ 14. I feel as though I am experiencing the trauma of one of my patients.
- ____ 15. I have beliefs that sustain me.

- _____16. I am pleased with how I am able to keep up with social work techniques and protocols.
- _____17. I am the person I always wanted to be.
- _____18. My work makes me feel satisfied.
- _____19. Because of my work as a social worker I feel exhausted.
- _____20. I have happy thoughts and feelings about my patients and how I could help them.
- _____21. I feel overwhelmed by the amount of work I have and/or the size of my caseload.
- _____22. I believe I can make a difference through my work.
- _____23. I avoid certain activities or situations because I am reminded of my patients' frightening experiences.
- _____24. I am proud of what I can do to help others.
- _____25. As a result of my work, I have intrusive, frightening thoughts.
- _____26. I feel "bogged down" by the system.
- _____27. I have thoughts that I am a "success" as a social worker.
- _____28. I cannot recall important parts of my work with trauma victims.
- _____29. I am a very sensitive person.
- _____30. I am happy that I chose to do this work.