

Critical Care Nurses Use of Humour: An Exploratory Study

BY
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**CRITICAL CARE NURSES USE OF HUMOUR:
AN EXPLORATORY STUDY**

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JOANNE E. MAJOR

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University
of Manitoba in partial fulfillment of the requirements of the degree
of
MASTER OF NURSING**

Joanne E. Major 1997 (c)

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LIST OF NURSE PARTICIPANTS

#1	Betty
#2	Claire
#3	Cindy
#4	Sara
#5	Bev
#6	Gloria
#7	Maxine
#8	Alice
#9	Nancy
#10	Susan
#11	Georgette
#12	Rhonda
#13	Ricki
#14	Wanda
#15	Stephanie

Note: The above names are pseudonyms to protect the anonymity of the participants.

ABSTRACT

An exploratory study of Critical Care Nurses Use of Humour was undertaken using an ethnographic approach. During Phase One, fieldwork involving direct observations of nurses and indirect observation of patients was carried out over a four week period. Sixteen semi-structured interviews were conducted during Phase Two. Morreall's Comprehensive Theory of Laughter was used as a conceptual framework. Humour was examined as a coping strategy, method of communication and a nursing intervention, as reflected in a review of the literature. Several questions regarding the nature of humour in a critical care setting were asked: 1) What factors promote or inhibit nurses use of humour? 2) How are nurses using humour when interacting with other health care team members and 3) How are nurses using humour with patients and family members?

Data were analyzed using thematic content analysis. Findings reveal that nurses value and use humour in their interactions with co-workers and patients. The context of humour includes those factors that enhance or inhibit the use of humour. Nurses identified specific cues and intuition in the assessment of their decision to use of humour. Humour may be interpreted at superficial and various levels of meaning. Humour helps to maintain a balance between patient-care needs and the self-care needs of the nurse. The use of humour represents an important communication strategy, means of coping and nursing intervention.

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CHAPTER I

STATEMENT OF THE RESEARCH AIMS AND OBJECTIVES

Introduction

This study explores Critical Care Nurses use of humour in relation to patients and family members, the maintenance of self (balance) and co-workers. A tertiary level Intensive Care Unit provided the setting for this research. The conceptual framework of Morreall's Comprehensive Theory of Laughter was used to guide this study. An ethnographic approach was employed to explore humour within the micro-culture of a Medical Intensive Care Unit.

Chapter one includes a description of the background of this research area. The significance of humour as a topic of research is discussed and an explanation of the conceptual framework provided. The problem statement and research questions are identified. Definitions applicable to this study are included.

Background Information

Humour, a universal phenomenon, is present to varying degrees in all humans. Laughter is often involuntary and therefore inescapable as a fact of everyday life. Embraced as an integral emotion by some, others value and initiate humour less. The essence of humour is difficult to define. Humour may represent a response to a situation or may be a part of the event itself. Humour may be fleeting and disappear as soon as the humorous moment has passed. One's chuckle at a joke is usually greatest when heard for the first time.

The context of a situation is crucial in determining the response of humour. In some cases the circumstances of a humorous moment are impossible to capture, with the

result that one is told that “you had to be there” in order to appreciate the joke. Indeed, the term “sense” of humour could be said to be reflective of this inability to put into words the message of humour that is interpreted by the other “senses”. The appreciation of humour is intensely personal, although humour in some situations has more universal meaning - testimony to the existence of professional comedienne.

Humour is seen as being vital to survival (Robinson, 1991). It is accepted that one cannot be alive without experiencing stress. Humour, as a universal human response, may also be associated with the act of living. Cohen (1990) described humour as a “powerful tool to lighten life, promote health, improve communication and interpersonal relationships, and enhance options, motivation, and creative problem-solving”(p. 10). The benefits of humour are multi-faceted, affecting many aspects of daily living.

Although historically recognized, humour has been described as “ a complex phenomenon only partially understood, which affects attitude, comprehension, mood, and interpersonal relationships” (Groves, 1991, p. 49). Biblical reference was made in the fifth century to the healing effects of humour. Florence Nightingale recognized the virtues of humour as a nursing intervention designed to distract the patient from his suffering (Groves, 1991). Nursing education has traditionally discouraged the incorporation of humour as a component of nursing practice. Indeed, nurses have been socialized not to use humour (Ruxton, 1988), equating laughing and joking with unprofessional behavior. The origin of this school of thought likely reflected the prevailing beliefs that laughter was immoral behavior for women. In Victorian England, women were permitted to smile and giggle, but not to laugh (Fry & Salameh, 1987).

The rise of consumerism and the increasing emphasis on holistic medicine have indirectly contributed to the acknowledgment of the healing and restorative powers of humour (Fry & Salameh, 1987). Traditional methods of physician-driven science have been challenged, as consumers have taken more responsibility for their own health. The rise of holism in health care has resulted in the incorporation of a larger body of knowledge that includes psychological and sociological aspects of an individual's care. The study of humour belongs within this realm.

Significance of the Problem

Humour, although universally present, is not unconditionally accepted by health care professionals. Humour, as a phenomenon, is not readily associated with Critical Care Nursing. This fact is reflected in the lack of scientific investigation of humour.

Numerous studies have described the stress associated with the practice of nursing (Boyle, Grap, Younger & Thornby, 1991; Cronin-Stubbs & Rooks, 1985; Foxall, Zimmerman, Standley & Bene Captain, 1990; Houston Acker, 1993; Keane, Ducette & Adler, 1985; Lewis & Robinson, 1992; McCranie, Lambert & Lambert, Jr., 1987; Moore Schaefer & Peterson, 1992; Stechmiller & Yarandi, 1993; Topf, 1989). Stressors of critical and non-critical care nurses have been contrasted (Anderson, Chiriboga & Bailey, 1988; Foxall et al., 1990; Keane et al., 1985). Results of studies comparing the stress of critical care and non-critical care nurses are, however, inconsistent. In a review of the literature, Bailey and Clarke (1989) found that conclusions of the larger studies, regarding the stresses of Intensive Care Nurses (ICU) nurses, should be considered tentative, given the methodological weakness associated with the studies. Agreement exists, however, about the inherently stressful nature of the profession of nursing (Keane

et al., 1985). The use of humour is one method of helping nurses to deal with the stress of their worklife.

Bartz (1994) identified personal, interpersonal and environmental sources of stress for nurses. Five types of stress, within the context of nursing, are consistently described: the environment, workload, patient acuity, interpersonal relationships and responsibility for life and death decisions (Thelan, Davie, Urden & Lough, 1994). These stressors may contribute to burnout (see Appendix A). Although stress is not unique to nursing, nurses are at higher risk than other professionals because of the nature of nursing practice, incorporating close contact with suffering individuals. Nurses are 30 to 100 times more likely than the general public to become chemically dependant (Wells-Federman, 1996). Environmental stresses imposed upon nurses are not likely to decline as staff shortages and health care deficit budgeting continue. A survey conducted by Manitoba nurses found “no significant improvement in the decision-making autonomy of nurses, while demands of nursing work increased, and de-skilling was evident” (Jones, 1997, p. 57). Hudak (1994) equated the rise of feminism with a tendency of nurses to leave their positions, rather than to continue to feel angry and frustrated with the prevailing conditions.

Ineffective coping skills have been associated with burnout in nursing (Thelan et al., 1994). Coping measures may be classified as adaptive or maladaptive. Adaptive coping measures decrease the severity of the response to stress, whereas maladaptive measures include responses that may be detrimental to the well being of the nurse and therefore are not effective in reducing the threat of the original stressor. Social support in the work setting and home environment has been correlated with decreased risk of

burnout. Improvement in one's sense of control, provision of feedback and a safe environment in which to express feelings of alienation are features of social support (Bryant, 1994; Powell, 1996). Wooten (1996 b) identified humour as a self-care tool that can help one to cope with stress. The physiological benefits of bolstering the immune system are additive to the psychological effects of replenishing "the spirit's energy level" and promoting feelings of optimism and "resilience to stress" (p. 53). Although humour as a coping mechanism is advocated in other areas of nursing, it has rarely been identified as being relevant to critical care nursing (Leiber, 1986). The use of humour as a method of coping, in this setting, has been virtually ignored. The implications of burnout for the profession of nursing include "absenteeism, serious on- the-job mistakes, and patient neglect" (Cronin-Stubbs, 1985, p. 31).

Humour as a communication strategy has implications for both the decrease of stress within interdisciplinary communication as well as decreased patient morbidity. The use of humour to enhance interpersonal communication has been identified as a successful strategy. Interdisciplinary collaboration, as facilitated through staff interaction and coordination, was found to be associated with positive outcomes for patients in a Medical Intensive Care Unit (Baggs, Ryan, Phelps, Richeson & Johnson, 1992). APACHE II scores were used to reflect severity of patient illness. This study found that as the amount of collaboration between nurses and physicians increased, the incidence of negative outcomes (readmission and /or death) decreased. Patient acuity was controlled for in this study. In 1991, the American Association of Critical Care Nurses (AACN) identified collaboration and communication among health care professionals as a priority research topic (Kinney, Rogers Packa & Byars Dunbar, 1993).

Although the physical and psychological benefits of humour are accepted, there is a lack of empirical evidence (Fry & Salameh, 1987). The physical advantages of laughter have generally been acknowledged, although the psychological effects are open to interpretation and thus to debate (Cousins, 1988). Fry (cited in Robinson, 1991) noted that laughter has been found to have an impact on most of the major body systems, concluding that future research will demonstrate this effect. The study of the physiology of humour is relatively recent as the tools to measure physiological and biochemical effects of laughter were only developed within the last few decades.

Humour as a subject of research has been regarded with some trepidation because of the perceived difficulties in collecting data in a natural setting, without altering the nature of the humorous interaction. A prevalent belief has been that laboratory studies “measure the response to humour rather than naturally created humour” (McGhee, 1979, p. 110). Robinson (cited in McGhee & Goldstein, 1983) noted the methodological constraints in researching humour - lack of reliable tools, insufficient data base in a clinical setting and the length of time required to engage in a participant-observer role. Literature about the use of humour in critical care areas is correspondingly sparse.

A review of the literature revealed agreement on the merits of the use of humour as a communication tool and nursing intervention, in a variety of settings other than critical care areas (Bellert, 1989; Hunt, 1993; Parkin, 1989; Simon, 1988b; Smith Lee, 1990; Struthers, 1994; Sullivan & Deane, 1988). However, much of the research on humour is anecdotal in nature.

A literature review does little to provide the reader with an appreciation of the thoughts and attitudes of critical care nurses toward humour, as well as the extent to

which humour is incorporated into their practice. The use of humour is largely undocumented in this setting. This potentially valuable communication strategy, method of coping and nursing intervention at present, may not be fully realized.

Conceptual Framework

Morreall (1983; 1987) developed a comprehensive theory that is used as the theoretical basis for this research. A description of the superiority, incongruity and relief theories precedes that of Morreall's theory, as these theories are combined to form the basis of Morreall's comprehensive theory of laughter.

1) Superiority Theory

The oldest of the theories, superiority theory, has also been called the theory of disparagement. The feeling or affect of the individuals involved is the focus of this theory. As the name would imply, negative connotations arise when the individual asserts his power by laughing at another person (Smith Lee, 1990). The person is said to be laughing "at", not "with", the other person. This theory may be viewed as a continuum: "from laughing at no one... to laughing at someone, specific people or groups, ...to laughing at oneself" (Robinson, 1991, p. 21). The ability to laugh at oneself is conceptualized as being the most healthy on this continuum, while the act of laughing is felt to represent an attempt to gain control over a situation, rather than as an act of "aggression" (p. 20). This theory does not account for laughter in situations which involve inanimate objects and ridicule of no one individual (Morreall, 1983).

2) Incongruity Theories

Incongruity theories emphasize the cognitive demands of humour (Ruxton, 1988). These theories have been explored in relation to the growth and development of

children. Two stages of humour are described: (a) the discovery that something is nonsense, or makes no sense and (b) the resolution of incongruity, making the information meaningful (Mc Ghee, 1979). Intellectual recognition of the incongruity increases with the maturing process of the child. The element of surprise is key, believed by many to be a necessary component of humour (Robinson, 1991). Configurational theory and incongruity theories, often included within this category, seek to provide a description of the nature of humour. The element of surprise is resolved in the catching of the joke; a consistent feature of this type of humour. According to incongruity theories, humour occurs when there is sudden understanding as the “pieces are fall [ing] into place” (Robinson, 1991, p.20). Humour in the Configurational theory may be a more subtle process, resulting in amusement, as opposed to outright laughter. The “gestalt” or appreciation of the whole results in a configuration or a picture representing the usual or expected (Robinson, 1991, p.20). Information that is not consistent with this picture may evoke a response of the ridiculous - amusement. The point is taken, however, that laughter is not a universal response to an incongruous situation (Morreall, 1983). Thus the incongruity theories are not suitable as a general theory of humour.

3) Relief Theory

Relief theory describes the release of pent-up emotion and tension, consequent to the “cathartic effect” of humour (Smith Lee, 1990,p. 86). Release of energy present, prior to laughing, or the release of energy generated by the act of laughing, provides relief. This theory acknowledges the physiological aspects of humour, which are involuntary (Morreall, 1983). Freud postulated that emotional energy may actually be conserved as tension is dissipated through laughter (Simon, 1988b). Freud saw humour as a method of

coping, believing that humour channeled both sexual and aggressive tendencies that had been repressed (Forsyth, 1993; Mc Ghee, 1979). Freud described different types of humour, each serving a different purpose. “Wit”, in the form of jokes, allowed the expression of repressed thoughts. The “comic” reflected the childlike thoughts, while “humour” permitted a distraction to more pleasant thoughts (Struthers, 1994, p. 487). The effects of humour were placed on a continuum from positive to negative, depending upon the intent and degree of “expression” of socially unacceptable thoughts (Mc Hale, 1989, p. 25). Freud’s concept of psychic energy release does not explain the humour of all situations, particularly those not evoking an emotional response (viewing a cartoon).

Morreall’s Comprehensive Theory of Laughter

Morreall’s theory of humour is comprehensive in that it combines the three traditional or classic theories of humour. The widened scope of this theory resides in its applicability to any humorous situation. The context of a humorous situation is crucial to the understanding of humour. A strength of this theory lies in its ability to explain humour in a variety of situations. Each of the traditional theories described is limited in the scope of understanding of humour. Given the complexity of the context of social situations, laughter can not be viewed solely from the perspective of a desire to prevail over another person, release of tension, or an unexpected disparity within an event. In this respect, Morreall’s theory would seem to promote a better understanding and a broader lens with which to approach an exploration of humour.

Three salient features distinguish Morreall’s theory. The first feature concerns a change in the psychological state of the individual, from a non-humorous or neutral to a humorous state. This change “can be cognitive/perceptual or affective/emotional”

(Robinson, 1991, p. 15). Cognitive changes are best captured by the incongruity theory. The affective aspects of a change are compatible with the release of pent-up emotions of the relief theory or the feeling of increased power of the superiority theory (Morreall, 1987).

The suddenness of an event, the second feature, is seen as being necessary to cause laughter. The term “shift” is used by Morreall to denote this aspect of laughter. An element of surprise is present in the form of a conceptual or psychological “shift” as the individual becomes acutely aware that the situation is unusual, or incongruous, based on previous experience (Morreall, 1983, p. 48). The suddenness of the change is related to the degree of change as well as to the speed with which the change occurs. An event that has been anticipated may lose its punch line and become contrived. Similarly, a joke is funniest when heard for the first time. This feature also explains the ability of the joke-teller to keep a straight face while telling the joke. Shifts may be described as “emotional”, “cognitive”, or “sensory”, depending upon the stimulus (Morreall, 1983, p.45).

The third feature of Morreall’s theory refers to the nature of the shift as being pleasant. A shift to a non-pleasant state does not induce genuine laughter. Laughter is the “natural expression of pleasure” (Morreall, 1983, p. 52). The act of laughter is described as a physical event, occurring in response to the feeling of amusement. Laughter may be perceived as being voluntary under circumstances in which the psychological shift is not pleasant. For example, conditions of embarrassment often result in laughter that is feigned and uncomfortable.

Certain conditions apply in order for the psychological shift to be perceived as pleasant. The element of security must be present either as a condition of, or as a result of the shift. One cannot find genuine humour in a situation resulting in a feeling of negative emotion (Morreall, 1983). The reaction to the shift reflects the degree of pleasure and security experienced.

Although laughter is the usual result of pleasurable feelings, embarrassment may also evoke “non-genuine” laughter. In this situation, the function of laughter may serve the social function of saving face by appearing not to be upset or by feigning laughter to be polite (sparing the feelings of another). In adults, this type of laughter may be an involuntary response as a result of learned behavior.

Although a shift does occur in each instance of humour, the type of shift varies. In the case of non-humorous laughter, the change is sensory, similar to a reflex. The act of being tickled evokes laughter of this type. An emotional shift is a component that boosts one’s enjoyment of a humorous event, often occurring simultaneous to the conceptual shift. The enjoyment of playing a joke on a friend rather than a stranger is enhanced. Crucial to any humorous situation is the presence of a cognitive shift, which is described as being “both sufficient and necessary for humour” (Morreall, 1983, p.47). Without the cognitive aspect, the incongruity of the situation cannot be appreciated and the humour cannot happen. The emotional shift merely accentuates the enjoyment of the event, while contributing to the context of the situation.

Summary of Conceptual Framework

Morreall’s comprehensive theory of laughter provides a framework to explore humour in a variety of situations. The inability of the previously described theories to

account for humour in all circumstances has been cited as the reason that their use as a framework for the study of humour has not occurred. Morreall (1983) has noted the need to research “general accounts of laughter and humour and how they fit into human life” rather than specific aspects (p. X). This approach recommended by Morreall is consistent with this research design. An exploratory study of Critical Care Nurses use of humour within the Critical Care work environment can provide such an account. The comprehensive scope of this framework is appropriate for use in this setting, where little has been documented about the use of humour. A broad lens with which to view and explore humour is essential, given the difficulty in describing the “essence” of humour (Morreall, 1983, p. 2). This framework combines the sum of that which has been explicated about humour and laughter, providing the language to describe findings without imposing a barrier to recognition of previously undocumented data.

Other models, less specific to the study of humour, were considered but abandoned because of their narrow scope in conceptualizing only certain aspects of the phenomenon of humour. Martineau’s Model of the social functions of humour incorporates the principle that humour functions in accordance with the perceptions of the audience (White & Howse, 1993). This model emphasizes humour as a vehicle of social support in the workplace, rather than as a method of communication. Simon (1988a) used the theoretical framework of stress and coping developed by Lazarus and Folkman to explore the use of humour in a geriatric population. This framework would be useful in exploring stress as a method of coping, but would not be helpful in viewing humour as a method of communication or nursing intervention. The Comprehensive Theory of

Laughter, as proposed by Morreall, facilitates the exploration of humour as a communication tool, method of coping and a nursing intervention.

Research Purpose

The purpose of this research was to explore the use of humour by Critical Care Nurses, in a Critical Care setting. A better understanding of nurses' use of humour is required, given the lack of empirical evidence, particularly in the area of critical care. The therapeutic use of humour has been successfully incorporated into nursing practice in a variety of settings, in the areas of oncology (Ackerman et al, 1994; Bellert, 1989), psychiatry (Dunn, 1993; Forsyth, 1993; McHale, 1989), and geriatric nursing (Davidhizar & Schearer, 1992; Simon, 1988a; Sullivan & Deane, 1988). An assumption was made that critical care nurses are presently using humour. The assumption was also made that the appropriate use of humour is beneficial to nurses and patients. A more in-depth exploration is required to understand the extent to which Critical Care Nurses are incorporating humour into their practice. Recognition of the use of humour may promote the legitimization of a practice deemed unprofessional by some. Improved quality of nursing care may occur secondarily, as a comparison of the use of humour in a critical care setting to other settings is invited. An enhanced understanding of the accurate assessment, timing and benefits of nurses' use of humour in a critical care setting may encourage reflection of current practice and provide direction for further study.

Problem Statement

The problem statement in the interrogative form can be stated as: What is the nature of critical care nurses' use of humour, in a critical care setting?

Research Questions

Several questions were posed regarding the nature of the nurse's use of humour in a critical care setting:

- 1) What is the nature of humour used by critical care nurses?
- 2) To what extent are nurses aware of their use of humour?
- 3) What factors promote or inhibit their use of humour?
- 4) What are their perceptions of the value of humour?
- 5) How are nurses using humour when interacting with patients?
- 6) How are nurses using humour when interacting with other health care team members?

Definition of Terms

Humour is elusive to define (Summers, 1990). White and Howse (1993) define humour as "a culturally universal means of communication" (p.84). The Merriam-Webster (1975) dictionary defines humour as "a state of mind or mood ... a comicality ... a quality that appeals to the sense of ludicrous or incongruous". Humour has variously been defined as a method of coping (Simon, 1988a, 1988b), a communication style/strategy (Struthers, 1994) and a nursing intervention (Robinson, 1991). Some researchers differentiate humour from laughter, referring to humour as an "attitude that allows one to take life less seriously" and laughter as the "response to humour" (Hunt, 1993, p. 35). Robinson (1991) referred to the futility of attempting to find "a single all-inclusive answer" (p.4). She conceptualized humour as being dependent upon the situation. The individual nature and perception of humour has been expressed (Simon, 1988b). This factor both confounds and challenges those studying humour.

For the purpose of this research, humour was defined within the context of the perception of the individual. Humour was viewed as comprising physiological, intellectual and emotional components. A Critical Care Nurse was defined as any Registered Nurse employed within this unit (subject to the process of informed consent). The terms Critical Care Nurse and Intensive Care Nurse were used interchangeably. Therapeutic communication was conceptualized as goal-directed, congruent with the desired aims of the participants (Boggs, 1995).

Laughter and humour were considered as a single concept, in keeping with the definitions within the conceptual framework. Laughter is defined as the “natural” behavioral manifestation and the expression of humour (Morreall, 1987, p. 136). The act of laughter may be voluntary in situations of non-humour, where laughter is feigned or calculated.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

A review of the literature begins with an overview of the concept of humour, from a historical perspective. The benefits of humour, both physiological and psychological, are briefly presented. Assessment of humour is described, as reflected in the emphasis of current research. Assessment is seen as being pivotal to the therapeutic use of humour. Current research and discussion papers are reviewed and presented according to the areas of educational, non-critical care and critical care settings. The literature review is confined to the field of nursing, although psychological and sociological philosophy is incorporated into the discussion of history and theory.

Historical Perspective

The origin of the term humour comes from the Latin word meaning “fluid” or “moisture” (Mc Ghee, 1979, p.4). Hippocrates described the presence of four humours thought to determine the mood or temperament. Choler, or yellow bile, was believed to result in anger if found in the body in excess. Black bile, or melancholy, was attributed to depression, if in abundance. An excess of sanguine, or blood, was associated with a cheerfulness of disposition. Apathy was seen as resulting from extra phlegm (Forsyth, 1993). A balance of the four humours was viewed as the cause of good humour. This school of thought later exerted great influence on scholars and scientists (Smith, 1983). The concept of “balance” in the study of humour has a physiological and a psychological basis. “Healing” results from an integration of the physical, mental, emotional and spiritual aspects of the person (Wells-Federman, 1996).

The evolutionary nature of humour changed has changed from a “baring of teeth” to smiling; humour has been substituted for an actual attack (Hayworth, cited in Robinson, 1991, p. 23). Plato and Aristotle emphasized the ethical implications of humour, “involving the elements of both pain and pleasure” (Mc Hale, 1989, p.25). Aristotle expressed caution regarding the potential for abuse in using humour to excess (Forsyth, 1993).

During the Middle Ages, court jesters were employed as a vehicle of communication and as a method of maintaining and /or restoring the health of the monarchs (Moody, 1978). The ability of court jesters to speak with impunity meant that unpleasant truths were sometimes imparted to royalty without punishment. Their disappearance from court society was associated with the belief that freedom of expression could lead to social liberty and immoral behavior (Doran, 1966). Emotions were felt to be located within specific organs of the body. Love was related to the heart. Laughter was connected with the spleen, presumably because of its connotation as a “low” form of behavior (Fry & Salameh, 1987, p.3). Reference is made to the curative powers of humour in post-operative recovery during the renaissance period (Moody, 1978).

The Bible makes reference to humour in Proverbs 17:22 “ A merry heart doeth good like a medicine: but a broken spirit drieth the bones” (Cohen, 1990, p. 2). However, the prevailing Christian attitudes were reflective of a more sober approach to living. Pilgrim settlers believed that laughter should be permitted only as it pertained to teaching a moral lesson (Fry & Salameh, 1987).

The earliest known textbook on psychiatry cites “mirth” as a cure for melancholy (Moody, 1978). The psychosomatic nature of humour arises from the philosophy of Emmanuel Kant, leading to the realization of the beneficial physiological effects of humour (Fry & Salameh, 1987). Florence Nightingale acknowledged this view as well (Groves, 1991).

Mistrust of the value of humour was prevalent during the conservatism of Victorian times, particularly for the female sex. Although encouraged to giggle or smile at any notion of impropriety, laughter was frowned upon (Fry & Salameh, 1987). Freudian philosophy mirrored this negative opinion, considering laughter to be an expression of latent hostility (Forsyth, 1993).

Robinson (1991) described the emergence of humour during the twentieth century, from the frontier style of exaggeration made famous in the folklore tales of Paul Bunyan and Davy Crockett, to the Midwestern style of the uncouth antics of Mark Twain. The “Roaring Twenties” and early thirties became the “Golden Age of Humour”, with the advent of Charlie Chaplin and the Marx Brothers (p. 34-5). The origin of the term “gallows” or morbid humour arose with accounts of Nazi prisoners joking in the face of fear and uncertainty. More recently, the “Polak” jokes of the 1960’s exemplified this same type of humour.

“Gallows” or morbid humour has been associated with the medical and nursing professions. Health care professionals are said to engage in this type of humour in order to alleviate some of the anxieties and feelings of vulnerability they face in dealing with unpleasant situations (Bellert, 1989). Gallows humour exemplifies the humour associated with being unprofessional. Robinson (1991) attributes the appearance of morbid humour

to the resurgence of the stresses placed on health professionals of this decade. Early studies (Coser, 1959; Emerson, 1963; Fox, 1959) revealed a relationship between humour and health, but were serendipitous in nature (cited in Mc Ghee, 1983). In studying the social structure of a hospital ward environment, Fox found humour to be a major mechanism used by health personnel and patients in dealing with stress (as cited in McGhee, 1983).

Psychological Benefits of Humour

Humour as a coping mechanism

The fact that “joy and stress pathways cannot operate simultaneously” (Cohen, 1990, p. 4) underscores the basis of humour as a method of alleviating stress. Adopting a humorous outlook can have the effect of allowing the person to “distance [the] self from the immediate threat...view it from a different perspective, and thereby, to reduce the feelings of anxiety” (Simon, 1988b, p.10). Martin and Lefcourt (1983) examined the relationship between negative life events, mood disturbances and the use of humour. These authors found a “significant moderating effect on the relation between life events and current levels of mood disturbance” (p. 1322). Significant differences were not noted between males and females. Thorson and Powell (1993) explored personality traits that were characteristic of individuals with a “high” or well developed sense of humour. These authors outlined the many aspects of humour, including appreciation of humour, creativity of humour use, coping through humour, tolerance of ambiguity and joie de vivre. Problem solving and creativity were potentially enhanced when the individual was required to reframe an event and examine possible alternatives (Ruxton, 1988; Sumners, 1990).

Martin and Lefcourt (cited in Bellert, 1989) found that the individual must value the use of humour as a coping strategy and must practice humour daily, in order to obtain relief from stress. Thorson, Powell, Sarmany-Schuller and Hampes (1997) examined humour using a Multidimensional Sense of Humor Scale. Scores on this scale were positively related to a number of factors of psychological health (optimism and positive self-esteem). Findings from this study supported these researchers assumptions that humour is multidimensional in nature. Fay (1983) also discovered that an appreciation of humour was a necessary prerequisite to the successful use of humour as coping (cited in Simon, 1988b). Ruxton (1988) commented that the research on the “laughter-stress relationship” was less “convincing than the link between physical exercise and stress” (p.58). Humour permits a temporary escape from problems, which promotes a degree of detachment healthier than the use of chemical or other substances (Dunn, 1993). Humour has been successfully used with cancer patients to “restore the hope and energy needed to survive and deal with the realities of the disease” (Bellert, 1989, p. 68). Play therapy with Pediatric patients has also been successfully to decrease anxiety (Frankenfield, 1996). Siegal, a surgeon, taught his cancer patients to place a higher value on the use of humour as a method of adapting to a changed lifestyle by adopting a change in perspective (Bellert, 1989).

Humour as a Communication Strategy

Humour as a communication strategy can function as a “social lubricant” (Moody, 1978). Laughter has been described as a “culturally universal means of communication” (White & Howse, 1993, p. 80). Laughter has the capacity to encourage cohesion, secondary to its infectious nature. In simple terms, laughter is described as decreasing

the distance between two people; an icebreaker that helps establish and build relationships (Davidhizar & Schearer, 1992). Similarly, humour is known to facilitate group rapport by encouraging feelings of equality among group members (Smith Lee, 1990). Davidhizar and Wysong (1992) described the merit of humour in establishing a relaxed atmosphere that promotes the exchange of ideas, making the receipt of criticism more palatable. Interpersonal conflicts can be changed from tension to laughter, promoting more effective relationships and defusing anger and hostility (Bellert, 1989). Smith Lee (1990) advocated the use of humour strategies to promote an improved work environment, noting that a humorous approach in delivering a message can make the information more palatable to the receiver.

A humorous comment made to an anxious patient, may relay the message that the nurse too is vulnerable, signifying empathy and thus creating a bond between nurse and patient (Ruxton, 1988). Warner (1984) related the value of humour as a means of self-disclosure, an “important contribution[s] to the therapeutic process” (p.17). Both humour and self-disclosure were thought to reduce tension and provide a catharsis (p.19). In contrast to gallows humour, humour may “act as an energizer for both clients and nurses and can help maintain their equilibrium” (Forsyth, 1993, p.959).

Physiological Benefits of Humour

The statement that “laughter is the best medicine” embodies the belief in the healing properties of humour and its association with a state of health (Davidhizar & Schearer, 1992, p. 277). The incorporation of humour into healthcare reflects a broader, more holistic approach (Moody, 1978). A renewed interest in the use of humour to promote healing is attributed to the work of Norman Cousins. Cousins reported that

laughter had been able to cure him of his ankylosing spondylitis and reduce his need for analgesia (Davidhizar & Scheerer, 1992). Despite increasing popularity and recognition of the benefits of humour in healing, some authors suggest that there is anecdotal, but little empirical evidence, to support its use (Groves, 1991). Others describe the physiological benefits as being “well documented” (Sullivan & Deane, 1988, p. 20) and “supported by numerous studies” (Cohen, 1990, p. 4). To date, the research on humour has centered primarily in the field of psychological rather than physical health (Simon, 1988b).

Humour has been characterized as “a catharsis which provides the body with a biological mechanism to release tension and rebalance its chemical state” (White & Howse, 1993, p. 84). Robinson (1991) stated that, unlike other emotions, laughter causes “extensive physical activity”, with the results being similar to physical exercise (p. 27). Potential benefits of humour can be examined in light of their effects on the various body systems. Humour can strengthen the connection between the physical and the psychological states of the body. The effect on the heart of twenty seconds of “guffawing has been equated with three minutes of hard rowing (Klein, 1989, p. 19). Cohen outlines, in schematic form, the relationship between the physical and psychological - the psychophysiology of humour (see Appendix B). Fry (1994) describes humor as a kind of “psychological fingerprint” (p. 112). The individual nature of humour is seen as a combination of factors that includes a genetic template as the foundation and an unfolding of life experiences. In summary, laughter decreases the effects of stress on the body and increases the ability of the immune system to prevent the appearance of disease and promote a healthy state.

Immune System

Numerous studies have been conducted on the relationship between stress and the immune processes of the body. Personality characteristics, including a sense of humour, were found in persons over one hundred years of age to influence longevity more than lifestyle. Longevity was attributed to a decrease in damage to the immune system and cardiovascular system (Groves, 1991). Although the effects of the two systems were not differentiated, other research supports the need to pursue this direction (Cousins, 1979; Robinson, 1991).

Laughter is purported to stimulate the thymus gland, the “master gland of the immune system”, to produce T-cell lymphocytes (Davidhizar & Bowen, 1992). Additionally, laughter decreases stress and associated neuroendocrine hormones, while increasing the production of immunoregulators that help to fight and prevent disease (Berk, 1996). Salivary immunoglobulin A (IgA) provides a first-line of defense against the entry of bacteria through the respiratory tract. Lower levels of IgA have been measured in association with negative moods and higher levels have been found with more positive moods. The effect of humour on the immune system, the mind-body connection, explains the basis of its healing qualities.

Central Nervous System

Laughter initially stimulates the catecholamines of the sympathetic nervous system. Increased parasympathetic tone and relaxation (Davidhizar & Bowen, 1992) follow this state of arousal. Release of endorphins, natural opiate substances, is thought to result in claims of pain relief (Astedt- Kurki & Liukkonen, 1994; Cousins, 1988). Laughter promotes a higher level of alertness by stimulating the left and right

hemispheres of the brain to function in a more coordinated fashion (Sveback cited in Green, 1994). Increased creativity is associated with this increased coordination of the senses.

The cathartic effects of humour are reflected in the work of Frey (cited in Robinson, 1991). He revealed that the chemical composition of tears of emotion (sadness and joy) is similar. Unlike the tearing seen with cutting onions, emotional tears remove chemicals associated with cellular waste products. A unique exocrine function is achieved by the removal of waste products of the body.

Cardiovascular System

Release of catecholamines causes an initial increase in blood pressure and heart rate in response to humour. This exerts an accelerated effect on the circulatory system, resulting in an increased supply of nutrients to meet metabolic demands (Bellert, 1989; Smith Lee, 1990). The subsequent relaxation effects of humour result in decreases in vital signs that are longer lived. These effects promote a decrease in oxygen demands on the heart.

Respiratory System

Major effects are seen in the respiratory system. Increased oxygen is taken in due to the increased tension of the respiratory muscles and cardiovascular changes (Bellert, 1989). Hearty “belly laughter” causes contraction of major muscle groups, particularly the diaphragm (Leiber, 1986, p. 164). This partially accounts for the relaxation following strong laughter.

Gastrointestinal System

Digestion is improved and muscle tension relieved secondary to the involvement of the abdominal muscles, creating the effect of “internal jogging” (Bellert, 1989, p. 67).

Theories of Humour

Over one hundred theories of humour have been identified. The complexity of humour is thought to be the reason that a “grand theory of humour” has never emerged (Smith Lee, 1990, p. 89). A single, more comprehensive view of humour, is considered by many, to be improbable, due to its complex nature of cognitive, social, motivational and physiological facets (McGhee, 1979). A brief chronology of humour theory is presented, in order to situate humour theories within the broader spectrum of the various disciplines.

Chronology of Humour Theory

Although humour is characteristic of all human beings, the study of humour has evolved through various disciplines. Bellert (1989) described three phases of theory development. The first, or pretheoretical phase, was postulated by ancient philosophers who viewed a balance of the four humours as determining the mood or temperament (Forsyth, 1993). The second, or Psychoanalytic phase, consisted mainly of the teachings of Freud. Freud focused on the spontaneous nature of humour, believing humour to be a vehicle for the expression of unacceptable thoughts (Simon, 1988b) and a source of momentary gratification of illicit desires (Bellert, 1989). The third and most current phase was referred to as the cognitive phase. This approach to understanding humour involved attempts to identify why people laugh and their attitudes toward humour. The response

to humour from a psychological and physiological basis was studied and the social context of humour considered (Bellert, 1989).

Humour Theory of Various Disciplines

The thoughts of early philosophers have been previously described in the discussion of the historical perspective of humour. According to Morreall (cited in Robinson, 1991) the work of early philosophers was largely negative, hindering the advancement of humour theory.

Sociologists approach humour with from the viewpoint of the group process. Their focus features humour: “as an index of intergroup conflict ... a means of control... and maintaining intimacy ... and as a joking relationship” (Mc Ghee, 1979, p. 28). The social functions of humour embody these principles, with the premise that humour can help “build and maintain relationships” (White & Howse, 1993, p. 83). According to Martineau’s Model of the Social Functions of Humour, humour is used to impart information, in any social system (McGhee, 1979). Effective humour, well received by a group, tends to promote cohesiveness. Humour that is perceived as disparaging is apt to disrupt the integrity of the group (White & Howse, 1993). The positive or negative effects of humour are therefore secondary to its interpretation by group members.

From a sociological perspective, social support provides a buffer to the psychosocial stresses imposed by negative interpersonal relationships in the workplace. As described by Smith Lee (1990), the benefits of humour can be used by nursing managers to reduce stress of the staff members and to promote a more productive work environment.

Nursing researchers have occasionally used this sociological approach as the framework of their studies. White and Howse (1993), through a questionnaire format, solicited twelve nurses' opinions on the value of specific humour strategies to reduce stress. A three point scale (agree, disagree, undecided) was used to rate the value of humour in each situation. Smith Lee's (1990) humour strategies for nurse managers formed the basis of the hypothetical situation questions asked of the participants. In this study, the highest level of agreement was found with humour as a relaxation technique and as a means of improving job retention. Moderate support existed for humour as a morale booster and means of increasing staff cohesiveness.

Compared to Smith Lee's (1990) research, White and Howse's (1993) study found a lower level of support for humour in the areas of work attendance and productivity. White and Howse attributed the difference in findings to limitations of their study. They felt that respondents in their study were more reticent regarding humour because some respondents associated laughter with increased noise levels on the nursing units, a lack of professionalism and potential negative effects of disparaging humour. The context of the situations presented and a lack of knowledge of the benefits of humour were also thought to be factors further influencing the response to humour and the resultant differences between the two studies.

Methodological problems were also apparent. The small sample size and the type of sampling utilized (convenience) were limiting factors. Use of the terms "highly" and "moderately" in White and Howse's (1993) data was non-specific and was based on 11 out of 12 respondents and 8 out of 12 respondents respectively. This difference was not of clinical or statistical significance. Respondents were required to choose between

three options, when, in fact, their opinions may have been better represented through use of Likert scales and open-ended questions. The researchers acknowledged that lack of awareness of the respondents' use of humour might have resulted in increased "disagree" and "undecided" responses. In examining humour as a mechanism of social support, White and Howse (1993) found that their results, though not generalizable in view of the limitations described, warranted further study.

Anthropologists have studied the effects of gender and culture on the appreciation and use of humour. Differences in humour are thought to be related to factors such as health beliefs, gender, socio-economic status and a minority group's status. North American culture regards death as the enemy, whereas other cultures view death and suffering as part of the cycle of life, with many cultures believing in the concept of life after death. Laughter is incorporated as a method of reducing pain and as a philosophy of not taking "anything in life too seriously" (Klein, 1989, p.183). It is recognized that just as the response to humour is individual and thus not always predictable, there is diversity within each culture. In order to avoid a stereotypical approach it is necessary to consider the cultural background while assessing the individual's stance within that culture (Robinson, 1991).

Assessment of Humour

Caution regarding the use of humour in nursing is evident when examining the literature. This may be attributed to a reticence to potentially inflict harm or emotional discomfort. Personality characteristics of the nurse will also impact upon the decision to incorporate humour into practice (Astedt-Kurki & Liukkonen, 1994). Assessment of humour arises from a desire to recognize or develop guidelines to facilitate the

appropriate initiation of humour and to avoid potentially deleterious effects of inappropriate humour. In any setting, the reason for using humour is an important variable. For example, when using humour within an educational setting, the intended purpose of humour must also be considered. Laughter as a means of gaining control over a situation needs to be differentiated from the use of humour indicating a “mask of denial” or an “area where an individual student requires further input” from the teacher (Struthers, 1994, p. 488).

The nursing process begins with assessment, which would occur prior to or concurrent with the use of humour as an intervention. The use of humor as a communication strategy or coping mechanism might be used at any stage of the nursing process. As will be described, there is a lack of consensus as to whether humour is spontaneous and intuitive in nature, or a planned event.

Deleterious Effects of Humour

Humour is said to be destructive when the laughter is “laughing at” rather than “laughing with” (McGhee & Goldstein, 1983, p. 11). There is widespread acknowledgment of the deleterious effects if humour is used inappropriately (Davidhizar & Bowen, 1992; Leiber, 1986; Smith Lee, 1990). As first described by Freud, the term “gallows humour” has been used to typify a kind of humour that is unprofessional and inappropriate in a given situation (Bellert, 1989; Ruxton, 1988). Robinson (1991) described humour on a “need continuum,” ranging from the health professional satisfying his/her own needs through the use of morbid or gallows humour, to the use of humour as a therapeutic intervention (p. 85-6). Cohen (1990) concurs, stating that one must be “clear as to whose needs are being met with the use of humour” (p. 4). The exclusion of

the patient from the relationship of the health professionals engaging in this type of humour is related to the “intimacy” and “equality of status” that are reflected in this exchange between the two health professionals (Ruxton, 1988, p. 55).

Several authors have identified criteria for determining the appropriateness of the use of humour. Pasquali noted three criteria: anxiety level, coping style and humour style as being relevant to a therapeutic relationship (cited in Forsyth, 1993). Humour was felt to be suitable when the level of anxiety was moderate. In the reduction of stress through humour, Simon (1988a) found that in order for stress to be moderated, the individual must value humour.

Successful use of humour may depend upon the type of humour used. Three forms of humour have been identified by Ruskin (cited in Sullivan & Deane, 1988). Cognitive-perceptual humour encompasses the telling of jokes, puns and humorous stories. This type of humour was most often seen when observing humour in a psychogeriatric setting (Sullivan & Deane, 1988). A disparaging form of humour was described as social-behavioral humour, initiated by the nurses or the patient himself. Humour of this description is compatible with the humour of the Superiority theory outlined in the discussion on humour theories. With this type of humour, one of the individuals involved in an interaction is degraded or subordinated (Chapman & Foot, 1987). The psychoanalytical displays of humour, in keeping with Freud’s beliefs, represented suppression, repression and the discussion of taboo themes. The most common theme involved sexual innuendo. The greatest factor limiting the appreciation of humour in this population was related to confusion and reduced cognitive abilities (Kuhlman, 1984).

Inappropriate laughter may be organically or emotionally based (Davidhizar & Bowen, 1992). Psychiatric conditions may precipitate uncontrollable laughter that has no obvious connection to the environment. Emotionally based laughter is viewed as laughter that occurs in response to a situation requiring a more solemn reaction. The similar biochemical response to laughter and tears is thought to be a mechanism for this reaction to two apparently diverse stimuli (Davidhizar & Bowen, 1992).

Guidelines for Humour Usage

Guidelines for the use of humour are required to avoid inflicting harm or discomfort. As well, it is acknowledged that nurses need to “be adept at using humour themselves” (Groves, 1991). Thus, guidelines are provided by some authors to assist the nurse in first assessing and then implementing humour as an intervention. Bellert (1989) emphasized the need for the nurse to develop an appreciation of the patient and families’ prior use of humour as well as their perception of the value of humour. Additionally, emotional status and current style of coping must be ascertained. To this end, specific questions asked of patients and their families are proposed by Bellert (1989) as a means of providing appropriate humorous nursing intervention (see Appendix C). This data can be used in planning nursing interventions on the oncology ward. Anecdotal evidence is presented in examining how oncology patients respond to humour. The need for further studies to investigate quality of life and disease survival is recognized

Forsyth (1993) concurred that the health practitioner’s style of humour must be congruent with the patient’s. Davidhizar and Schearer (1992) caution that in order for humour to be used effectively in a therapeutic relationship, there must be a feeling of

empathy and genuine caring. Otherwise, humour may be viewed as an obstacle, or a vehicle of ridicule.

Cohen (1990) also favoured the assessment of humour. She developed a 9-item "Humour Inventory" to determine one's humour style (see Appendix D). Similar to Bellert's (1989) questionnaire, hypothetical questions are posed to those who are interested in developing their ability to use humour as a strategy of everyday healthful living. These strategies are said to be adaptable to the work setting. It is crucial that the nurse first examine his/her own values and views toward humour before implementing humour as an intervention. One is asked to first determine what makes them laugh and then how they will be able to incorporate humour into their activities of daily living. Cohen (1990) acknowledges that the process of developing one's "laugh life" requires practice and involves initial discomfort in learning a new attitude (p. 8). Specific strategies are suggested. Methods of incorporating humour into daily living include laughing at least once a day, laughing at oneself and looking for the funny aspects of daily events. Cohen (1990) also recommends keeping a humour journal of funny anecdotes, stories and other humorous bits of data. The importance of sharing humour is noted as being beneficial for others in the workplace and also for the individual using humour.

Hunt (1993) provides additional guidelines to assess the advisability of including humour as a nursing intervention (see Appendix E). She cautions that humour that is sexual in nature or relating to a particular culture is disparaging. This type of humour is universally discouraged and recognized as being destructive. She advocates the use of

humour, particularly if problems with communication, anxiety, grieving, powerlessness, or social isolation were present.

Simon (1988b) viewed humour as a method of coping with a stressful event. She advocated the assessment of patient's usual coping strategies, prior to intervention. Simon (1988a) used the theoretical framework of psychological stress and coping developed used by Lazarus and Folkman, to examine the use of humour as coping. This theory states that in response to a stressor, the individual determines the threat to their well being through a cognitive appraisal of the situation. It is this cognitive appraisal that will determine their method of coping. Problem-focused coping strategies seek to address the source of the problem, in contrast to emotion-focused strategies which incorporate an emotional response to the problem. Simon (1988a, 1988b) viewed humour as an emotion-focused method of coping, in which the perception of a stressful event was altered to decrease anxiety. This information is helpful in assessing patients' perceptions of an event, as well as their usual methods of coping. She concurred with Martin and Lefcourt that humour was inappropriate with extreme anxiety. The importance of listening to the content of a humorous message is cited as a method of gaining information about what is being indirectly communicated. Indeed, the appearance of humour, in her opinion, may signify the beginning of the healing process.

Leiber (1986) described three criteria - timing, receptiveness and context - in her exploration of humour as a coping strategy for critical care nurses. Clinical examples were used to illustrate her discussion.

Timing

Leiber (1986) emphasized the relationship between the timing of humour and the height of crisis, believing that the usefulness of humour in relation to crisis is to help “balance difficult circumstances by revealing their less serious aspects” (p.167). Leiber (1986) and Bellert (1989) felt that humour was best timed after a crisis, when attention to a situation was less important and tension was abating. Bellert (1989) further described that humour may “assist with the adjustment to the crisis and may decrease tension”. Smith Lee (1990) felt that humour must be well-timed in order to be successful, while cautioning that ill-timed humour can be a detriment if the situation calls for a serious tone and full concentration. Davidhizar and Bowen (1992) relate the value of reframing to a less serious outlook, concluding that appropriateness of humour at times can only be determined retrospectively. They contend that anxiety is increased when concentration is being focused on solving a problem.

Receptiveness

Receptiveness of the patient needs to be assessed, as previously outlined. Simon (1988a, 1988b) elaborated on this point, stating that usual coping strategies and the possible message being delivered by a patient’s initiation of humour, must be addressed. Davidhizar and Bowen (1992) stress that successful use of humour is dependent upon factors such as the individual’s personal style, relationship of those involved, personality characteristics, culture and emotional status at the time. Smith Lee (1990) also noted the importance of humour in the presence of a “comfortable relationship with the listener” (p. 90). Bellert (1989) stressed the need to evaluate the receptiveness of families and patients to humour interventions to assess the impact on quality of life. She suggested

that further information on family dynamics might be revealed, leading to recognition of the need for further counseling. Additionally, it was felt that nursing staff receptivity could be assessed through their interactions with one another. Balzer (1993) noted that “some professionals choose to draw a clear distinction between the serious business of health care and the informality of their personal life, and these boundaries need to be honoured” (p. 34).

Content

The content of humour has received considerable attention. Caution urged regarding the use of humour is related to the highly personal nature of the perception of humour. Leiber (1986) and Davidhizar and Bowen (1992) referred to the vulnerability of intensive care patients, who are often within continuous earshot of personnel. Joking between nurses may be misinterpreted by the patient who believes that the joke is at his expense. Hunt (1993) provided specific guidelines regarding content of humour that would be destructive (see Appendix E). For example, humour that was sarcastic, racist or sexist in nature was deplored in any circumstance (Forsyth, 1993; Hunt, 1993).

Humour as a Spontaneous Event

Humour as a spontaneous event occurs in contrast to the planned interventions within the nursing process. Dunn’s (1993) research presented some conflicting findings regarding the necessity of assessment prior to humour as an intervention. The decision to use humour was described as a more spontaneous and intuitive process. Ten nurses in a psychiatric setting were interviewed in a semi-structured interview. An observational methodology was avoided in order to retain the spontaneity of a humorous event. Although detailed data were collected, the results reported were restricted by the

subject's memory and individual awareness of the use of humour. The context of nursing interactions within everyday practice was explored. Nurses described their use of intuition, rather than specific cues, in their decision to use humour.

Dunn (1993) concluded that there are "no definite cues which trigger the use of therapeutic humour" (p. 471). These findings are consistent with other researchers, who have related intuition as a component of decision-making. Benner (cited in Harbison, 1991) described five stages of nursing experience from novice to expert. Intuition was found to be characteristic of the final or expert stage. The formalized processes of assessment through to intervention are no longer explicated, but rather become automatic as nurses become more expert. However, the nurses in Dunn's study consisted of only two experienced nurses. Dunn does allude to the fact that cues may be present, in intangible form, during interaction with the patient. Different combinations of non-verbal cues, such as facial expression, were found by Kagan (1986) to correlate with the ability to recognize emotional states of patients and to facilitate the development of rapport (cited in Dunn, 1993).

Other researchers suggest that the use of cues to assess for the therapeutic intervention of humour is of limited value. Harbison (1991) noted the use of cues to develop and recognize patterns of decision-making, but also found that judgment was more than a formal or linear process. Experience eventually enabled a more informal or intuitive approach. Benner (1984) contends that not all knowledge of expert nursing decisions can be understood through identification and analysis of each element of the process. Dunn (1993) concluded that the four elements of knowledge, intuition, synchronicity and caring were necessary to produce therapeutic humour, with caring

being the most important. Burnard defined synchronicity as “being on the same wavelength” as the patient (cited in Dunn, 1993, p.471). However, the four elements were not further explained. Those who value a more scientific or objective process diminish the emphasis on the intuitive elements of humour as a method of decision-making.

Ruxton (1988) cited different findings in three phases of her research. The first phase involved the development of a humour assessment tool (HUMA) which was administered to assess the experience of humour via structured interviews. In the second phase, nurses were asked about their description, use of humour and humour interventions. Responses revealed that the nature of humour usage was more spontaneous than planned, was received favourably by patients and helped patients to better cope. Following a playshop to aid nurses in developing humour strategies, a further survey indicated that humour was more often planned than spontaneous. Although over five hundred nurses were surveyed, the response rate was only thirteen per cent for phase two surveys and thirty-nine per cent for phase three follow-up surveys. Thus, conclusions were tentative. Results of the phase one surveys were not reported.

Humour as Nursing Intervention in an Educational Setting

The value of humour in an educational setting is described in the literature. However, examination of this topic via empirical research is almost non-existent (Parkin, 1989; Watson, 1988). Watson, acknowledging the merit in educating students to incorporate humour into their style of communication, recommended developing the skill through role modeling and provision of clinical experiences. She advocated strategies to increase the awareness of nursing students about the value of humour.

Struthers (1994) examined the role of humour in the nursing student- nurse relationship, basing his conclusions on other discussion papers. Like Watson, he specified the need for teachers to be in tune with their own appreciation of humour, in order to “facilitate and recognize the students’ use of humour” (p. 486). The benefits of humour as a teaching strategy included stress relief, as students struggled with unfamiliar situations and humour as a means of self-disclosure. Self-disclosure was defined as a method of encouraging a safe environment for students - one that would promote learning through decreasing risk of censure upon making a taboo comment, allowing one to “rise above and gain a sense of control over a problem area through laughter” (p. 487).

Moses and Friedman (1986) utilized a quasi-experimental design to study the effects of deliberate use of humour by teachers on student anxiety and performance levels. Qualitative and quantitative data (pre and post test Spielberger’s State Anxiety Instrument scores) were collected. Humour was introduced twice during a laboratory demonstration. Several questions were asked of students, in an attempt to evaluate the effect of the humorous interactions. Results were inconclusive. No change in pre and posttest scores was found. Qualitative findings were briefly recorded as stating that humour “helped” 5 out of 9 students (p. 332). Methodological and design difficulties were acknowledged to have been a factor in the inconclusive findings. The planned nature of these interventions may have precluded the spontaneous emergence of laughter. As well, the individual meanings attributed to the humorous situation were possibly not consistent with the researchers.

Humour as Nursing Intervention in a Non-Critical Care Setting

Sullivan and Deane (1988) examined the incidence of humour in a psychogeriatric setting. Novice nursing students were asked to document their use of humour as planned interventions in a clinical experience. Observational data were analyzed using Raskin's framework for categorizing humour themes. Three forms of humour were identified: cognitive-perceptual, social-behavioral and psychoanalytical as previously defined. The joke telling form of cognitive-perceptual humour was most frequently seen, whereas the sexual innuendo style of the psychoanalytical form was least prevalent. Students noted that interaction, post humour, was more relaxed. Communication, on the part of the patient, was more open and self-disclosing after a humorous intervention. Students identified humour as a positive strategy. These findings are supportive of others in the use of humour as a method of facilitating communication (Davidhizar & Schearer, 1992). Limitations of this study included the use of secondary data of observations reported by the students. The sample size was not reported. Nonetheless, this study did provide information about the context and the individual meaning of humour to these elderly male participants.

Simon (1988b) studied humour in a group of 24 elderly persons at a senior's community centre. Humour was assessed in this group by administering three scales in a questionnaire format. The Situational Humour Response Questionnaire (SHRQ) was designed to assess humour in a variety of hypothetical situations. The Coping Humour Scale (CHS) assessed humour as a method of coping and the Current Health Subscale (CH) provided data on their perceptions of their health status. The individual's satisfaction with the social dimensions of his health was appraised by the Life

Satisfaction Index (LSI), while the Affect Balance Scale (ABS) measured the psychological components of health. Results indicated a significant positive between situational humour, perceived health and morale (ABS). A negative relationship was found between coping, humour and perceived health, indicating that those individuals who felt their health to be poor used more coping mechanisms. In this study, humour was not linked to improved satisfaction with life, a factor possibly related to lack of sensitivity to the LSI tool. Although not generalizable beyond the geriatric population, this study was thought to warrant further research, perhaps using different tools.

Sumners (1990) measured the attitudes of 204 nurses towards humour, in both professional and home settings, through random sampling. Two questions were examined: (a) What are the attitudes of nurses towards humour? (b) Are these attitudes different in the home versus the professional setting? The instrument used in this study was known as Sumners Attitude Toward Humour Semantic Differential. Construct validity of this scale was supported by factor analysis. Moderate to high internal consistency was reflected in the alpha coefficient of 0.85 in professional practice and 0.78 in the home setting. Attitudes of nurses towards humour, in both settings, were compared.

T-test results revealed a statistically significant more positive attitude toward humour in the home as compared to the workplace, although results for both areas were strongly positive. Older nurses and nurses with more years of work experience were found to have more positive attitudes towards humour. Written responses of respondents provided further insight. Comments of individuals provided the basis for Sumner's reflections that "approval of significant others" and "intended goals of one's behavior"

are important factors in one's attitudes towards humour (p.198). As noted by the researcher, other methodologies are required to provide insight into the phenomenon of humour.

The meaning of humour within the nursing process was examined by Astedt-Kurki and Liukkonen (1994) in an attempt to provide further insight into "humour as a phenomenon and as part of patient care" (p.185). Thirty-two nurses were selected, by convenience sampling, to answer open-ended questions in short essay form. Results were consistent with others who found that the context of humour was crucial to its success (Leiber, 1986). Humour was used in patient interaction by 50% of these nurses. A limitation of this study was remarked upon by some of the respondents, who had difficulty recounting humorous episodes because of their inability to remember and /or describe the subtleties and intricacies of the event.

Parse (1994) used a phenomenological approach to examine humour in 20 men and women over 65 years of age. Participants reflected on their experience with laughing and health in unstructured interviews. After repeated review of the videotaped interviews, three core concepts emerged. These included: "1) a potent buoyant vitality 2) mirthful engagements prompting an unburdening delight deflecting disheartenments 3) emerging {with} blissful contentment" (p.58). This data both supported and expanded Parse's theory of human becoming, which outlines the interconnectedness of laughing and health, from a nursing perspective.

Humour as Nursing Intervention in a Critical Care Setting

The use of humour in critical care settings has rarely been studied directly, but has been referred to in research about stress and coping. Humour, as an adaptive method of

coping was included in the data from Moore Schaefer and Peterson's (1992) descriptive study comparing critical and non-critical care nurses' coping strategies. The Jaloweic Coping Scale was administered to measure the effectiveness of strategies used to manage job-related stress. Sixty behaviors representing eight themes were rated using a four-point scale, ranging from "never used" to "often used" (p.30). Cronbach's alpha of the subscales varied from .90 to .80. However, the static nature of this tool may not have been sensitive to capture the "unfolding nature of the coping processes" (p.31).

Although limitations in the Jaloweic Tool as a measure of coping were expressed, the researchers felt that the use of humour should be encouraged. These researchers observed the need for more focused assessments of humour in order to further implement its use in the critical care setting.

Leiber (1986) advocated the use of humour in a critical care setting. She described humour as both a coping strategy and a nursing intervention. This view is consistent with the opinions of others (Bellert, 1989; Hunt, 1993; Robinson, 1991). Leiber's article, though published almost 10 years ago, provides the most recent analysis and summary of humour in a critical care setting. No primary sources relating to critical care were located.

Conclusion

As noted by Leiber "only a handful of studies" have explored the role of humour in this environment (p. 197). Empirically based research in the literature regarding humour is minimal, with data consisting mainly of unpublished theses or dissertations. These findings were supported in this review of the literature. The lack of empirical research was evident in the degree of referencing between researchers of the studies

reviewed. Research has explored specific aspects of humour, although data that provide in-depth insight into the nature of humour are lacking. This fact has been referred to as a methodological constraint (Sumners, 1990). Researchers are unanimous in their opinion that more research is required in order to illuminate and explore the phenomenon of humour.

Chapter III

RESEARCH DESIGN

Introduction

Humour is a phenomenon not readily associated with critical care nursing. Rapid advances in technology and demands associated with high patient acuity contribute to pressures felt by these nurses. A variety of nursing research has helped to define the specific stressors frequently encountered by critical care nurses. Communication difficulties have repeatedly been reported as a significant stressor within the context of the critical care setting (Lewis & Robinson, 1992; Moore Schaefer & Peterson, 1992). Leiber (1986) referred to the need for critical care nurses to use humour as a coping strategy to decrease stress and facilitate “cohesion among staff members” (p. 166). The use of humour as a nursing intervention has been widely documented in the areas of oncology (Bellert, 1989), psychiatry (Mc Hale, 1989), gerontology (Davidhizar & Schearer, 1992; Sullivan & Deane, 1988) and nursing education (Parkin, 1989; Watson, 1988).

The physical advantages of laughter are generally accepted, although the psychological effects are open to interpretation and thus to debate (Cousins, 1988). Theories of humour, although described, have rarely been tested. As noted by Simon (1988b), this may reflect, in part, their inability to actually explain humour. Two dominant themes in the literature concern the study of criteria surrounding the assessment, and appropriate versus inappropriate use, of humour. A theme of caution is evident to avoid “gallows humour” as first recorded by Freud. Acknowledgment of the

highly personal nature of humour requires that cues be taken from the patient prior to initiating humour.

The use of humour in critical care settings has rarely been studied directly, but has been referred to in research regarding stress and coping (Lewis & Robinson, 1992; Moore Schaefer & Peterson, 1992). Empirically based research about humour is limited. A literature review revealed that despite exploration of specific aspects of humour, data that provide in-depth understanding are lacking.

The thoughts and attitudes of critical care nurses toward the use of humour are poorly understood. Despite the merits of humour as a means of providing relief of stress and increased job satisfaction through improved communication, documented use in current critical care nursing practice is absent. A valuable strategy for the enhancement of quality of work life and advantage for patients may not be fully realized. Exploration of the concept of humour is required to understand the extent to which critical care nurses are incorporating humour into their practice.

Statement of the Problem

To gain further insight into the concept of humour and its use within the context of the critical care environment, further research is necessary. Several questions can be posited regarding the use of humour by nurses in a critical care setting. Are nurses aware of their use of humour? What factors promote or inhibit their use of humour? What are their perceptions of the value of humour? How are nurses incorporating humour into their interaction with patients? A broad question can be formulated: What is the nature of humour used by critical care nurses?

Qualitative Approach

Although both qualitative and quantitative approaches have a similar purpose in expanding the knowledge of a phenomenon, their assumptions and worldview are quite different (Haase & Myers, 1988). The goal of qualitative methodology is to promote an understanding of the topic or phenomenon that forms the basis of the research question (Sarter, 1988). As suggested by Brink and Wood (1989), qualitative methodology is indicated when little is known about the topic being studied. This is the case with humour usage in a critical care setting. A qualitative approach embodies a holistic belief that reality is based upon the perceptions of an individual within his/her environment (Burns & Grove, 1993). In exploring humour, each individual's view is interpreted within a framework that explores the wholeness of the person's experience, within his/her own environment. Qualitative methodology promotes an in-depth understanding of a phenomenon from each individual's perspective as well as the "collective" experience, enabling richness of data and a more comprehensive view. The premise is taken that the sum is greater than the total of its parts. A qualitative approach was indicated for this study to provide an understanding of humour in a setting where documentation is virtually non-existent.

Ethnography

Ethnography was chosen rather than phenomenology or grounded theory as the methodology for this study. The philosophy underlying phenomenology reflects a search "for a deeper understanding of the nature or meaning of everyday experiences" (Munhall & Oiler Boyd, 1993, p.17). A basic assumption of phenomenology concerns the interpretation of meaning of a lived experience through the examination of language.

Reality is seen as subjective and highly individual in nature, although “variations of meaning in shared experiences” are often described (Thorne, 1991, p.183). In describing reality, analysis and explanation are avoided, with emphasis placed on the description of the experience (Oiler, 1986). Phenomenology focuses on the "inner or subjective reality of the individual" (Rose, Beeby & Parker, 1995, p.1126). Given the need to examine the context of a humorous exchange, a phenomenological approach was seen as limited in its exclusion of the individual's environment.

Grounded theory emphasizes the social processes of a group. The aim of grounded theory is to “ understand how ... people define reality through their associations with one another and to communicate this in the form of theory ” (LoBiondo-Wood & Haber, 1990, p. 191). Specific to this approach is the simultaneous data collection and analysis through constant comparative analysis. (Polit & Hungler, 1995). Grounded theory is "designed primarily to generate theory" (Bowers, 1988 p.43). As described by Artinian (1988), the generation of theory is based on the "descriptive mode", which builds on a description from the viewpoint of a particular group of participants.

The purpose of this research was to develop an understanding of humour. In the process of exploring humour in a critical care setting, using an ethnographic methodology, the current theoretical understanding of humour was desired. This fact is reflected in the minimal testing of theory that was evident in the nursing literature. A second feature of this research distinguishes ethnography from grounded theory. A conceptual framework was used as a guide to the processes of data collection and analysis. This methodology is not consistent with grounded theory. In contrast to the

emphasis on process, seen with grounded theory, a salient feature of ethnography and of this research, was the goal of achieving a “thick description” of critical care nurses as they used humour in the course of their daily work. I anticipated that the description of some processual elements would, however, be a part of this description.

Fetterman (1989) defines ethnography “as the art and science of describing a culture”, with an emphasis on routine patterns of behavior” (p. 11). Ethnography is considered to be valuable in advancing nursing knowledge in view of the fact that insight is gained through an appreciation of the culture of nursing (Evaneshko & Kay, 1982). An exploration of humour usage by the critical care nurse, within the culture of a critical care environment was undertaken. Ethnography encompasses the attempts to uncover the ways in which people provide meaning to the everyday events of their lives (Morse, 1989). Ethnography is concerned with the rules that guide appropriate behavior within a particular culture (Aamodt, 1982). The use of ethnography is indicated when there is a wish to “understand... some health belief or practice, from a specific cultural or social perspective” (Omery, 1988, p.17).

Fieldwork is a salient feature of ethnography (Fetterman, 1989). This study incorporated fieldwork as a fundamental method of collecting data. Observations of the fieldwork phase of this research provided insight to guide the interview process. Ethnography is suited to an exploration of humour. The ability to understand humour in the critical care environment is contingent upon the ability to observe the context of situations in which humour is used. The ability to assess the effectiveness and to capture the essence of humour is dependent upon an appreciation of the circumstances in which

humour is used. Observational methods of conducting fieldwork are essential to collect this type of data.

Sample Selection

Sample selection is described separately for the two phases of this research. Convenience sampling determined the participation of Phase One. This method of sampling is analogous to the "big net approach" advocated by Fetterman (1989) as providing a "wide angle view of events before the microscopic study of interactions" (p. 42). This technique is commonly used with ethnography and permits a broader view of the setting, prior to narrowing the focus of study through interviews (Fetterman, 1989). Phase One involved the observation of nurses' interactions with patients and other nurses, through the process of participant observation.

The inclusion criteria for nurses were:

- 1) English speaking
- 2) Over eighteen years of age
- 3) Registered nurses employed within this Intensive Care Unit
- 4) Nurses willing to be interviewed.

The inclusion criteria for patient participants were:

- 1) English speaking
- 2) Over eighteen years of age
- 3) Patients willing to be observed
- 4) Patients who are conscious
- 5) Patients who are judged as being stable in the estimation of the Head Nurse or his/her designate i.e., Patients whose condition was not presently deteriorating

Phase Two, semi-structured interviews, were conducted with nurses who granted consent to be interviewed. Judgmental or theoretical sampling was used to select these nurses for Phase Two - following immersion in the field setting. Factors such as consent of the nurse and patient (or patient's family), acuity of patient condition, and timing (during a crisis) affected the feasibility of participation during Phase One.

Phase One consisted of direct observations of nurses. Indirect observations of patients, as they responded to and communicated with their nurse, were also observed, as appropriate. To introduce this study to the nurses, a letter of explanation was placed in the communication book on the unit (Appendix F). This letter was followed by a meeting with staff members on the unit, to provide explanations and answers to any questions. All General Duty Nurses working in this setting were provided with an explanation of the study, in writing, and asked to indicate to me if they were willing to be observed. A pre-arranged envelope, specifically for this purpose, was left on the unit. Information regarding participation of the nurses was held in confidence and thus not shared with administrative personnel. As is further outlined in the section of ethics, consent for Phase One was established by means of a disclaimer (see Appendix H).

Gaining consent from patients and family members proceeded in a slightly different fashion. Following consultation with staff members and my own assessment, I offered a brief explanation of the study to selected patients and their family members. I then enquired if they were interested in reading the disclaimer. A script was followed in talking with patients and their families (see Appendix I). The details of the research project were explained, if patients or family members expressed interest. I acknowledge

that the patient and family might have felt some degree of coercion in denying their consent, fearing that their refusal may in some way have jeopardized the care of their loved one. Careful assessment of patients and consultation with the nursing staff were observed, in recognition of this fact.

The disclaimer for patients and their families (Appendix J) specifically addressed this issue, reinforcing that no change in care would occur in the event that permission was denied. As with nurse participants, follow-up in the form of clarification was undertaken by me after consent, on an individual basis. Nurses, patients and family members appeared to be comfortable with this approach. All patients approached, with one exception, consented to my presence.

I found that my patient observations were limited to Coronary Care Unit (CCU) patients, as these patients clearly met the criteria I had established. Patients in the “main unit” of the Medical Intensive Care Unit were more acutely ill. The fact that they were intubated (with a breathing tube into their lungs) and therefore unable to speak made the issue of consent and the ability to assess their level of consciousness more difficult. Several patients appeared to be slightly confused (supported by the bedside nurse). One patient, although stable, was experiencing discomfort and thus was not asked to participate. Consequently, my observations were conducted with CCU patients. Data relating to other critically ill patients were obtained from participants during the interview process in Phase Two.

Setting

A Medical Intensive Care Unit in a large tertiary care hospital was chosen as the study setting for several reasons. The environment of this tertiary care hospital ICU is

similar to my background. Morse (1989) describes the desirability of conducting research in a familiar environment to the researcher's to bring a deeper understanding to the study. She does, however, caution that role confusion between the roles of nurse and researcher is more likely to occur in one's own setting. Morse also observed that the advantage of a more in-depth knowledge of an area might be diminished by difficulty seeing with fresh eyes what one already knows. Consequently, a decision was made to travel to another institution within the same city. A medical unit was chosen over a surgical unit because the patient population would be longer term, decreasing the number of patients involved in the study. A surgical unit would also involve more admissions both into the unit and to and from the operating room.

Access to this unit was not problematic (Appendix F). I anticipated that there would be a measure of interest in this topic, which carries a potentially positive message for critical care nurses. The effect of a third party has been described as a potential constraint (Morse, 1989). This factor is likely to be less pronounced with patients than nurses, who are apt to feel that their nursing care is being scrutinized. I found that the development of rapport and my presence on the unit over time helped to alleviate this concern, as nurses became increasingly desensitized to my presence.

On my first day in this unit a laughing comment by a staff member revealed her concern and confusion about my role. She commented, "Oh oh, she's likely taping us as we speak" (Fieldnotes, p.17). I quickly clarified, with a similar laugh, that I would only record the comments of participants – who have granted consent. I was often greeted with teasing remarks "Do you know that we call you the good humour lady?" Jokes were made that I was attempting to start a new humour journal – a rival to Nursing Jocular

(p. 145). I interpreted these remarks as small tests of my ability to laugh at myself. The sharing and connecting nature of these humorous comments lead me to believe that I was being accepted into this unit.

Data Collection

Data collection was accomplished through field study and semi-structured interviews.

Phase One

During the period of field research the role of participant observer was assumed. A continuum of modes of observation reflecting the amount of involvement between participant and researcher exists. Adler and Adler (1994) describe the three “membership roles ...complete-member-researcher, the active-member-researcher, and the peripheral-member-researcher” (p.370). The researcher role within this study represented the active-member-researcher. This is an intermediate role. I was with the participants for a period of 4 weeks. Observations - nurse to nurse and nurse to patient and family - took place for about six hours, for three days per week. Observations were undertaken on the day shift for two weeks, the evening shift for one week and the night shift for one week. The different routines of the evening and day shifts permitted a better understanding of nurses’ use of humour in a variety of situations.

By definition, this type of participant observation is known as observer - as - participant (Omery, 1988). Although almost any amount of involvement is deemed appropriate in ethnography (Aamodt 1982), as a fledgling researcher, I assessed this factor on a continuous basis, as a possible limitation to collecting and recording of detailed field notes.

Initially, all nurses (who consented) were observed using a participant observer method. Detailed information about the environment and basic organization of the unit was addressed within my fieldnotes. As I became more knowledgeable about the nature of critical care nurses humour, my observations became more focused.

Fieldnotes were handwritten, to facilitate continuous recording in the clinical setting. I strived for a balance between unobtrusive note-taking and openness about the reason for my presence. ICU staff (participants and non-participants) expressed interest in my progress. They enquired each day “Did you get anything today?” Therefore, I wrote where staff could see me, but away from direct patient care areas.

A notebook was used that was small enough to be carried in a pocket. This approach is consistent with that described by Hutchinson, while conducting her fieldwork in a Neonatal ICU (cited in Morse, 1989). Notes were written away from the bedside. I would engage in observations until I felt that I was saturated with information. I would then retire to an adjacent room, within earshot of the activities of the ICU. This partial seclusion provided an opportunity to quickly record and reflect upon events that had transpired, with minimal distraction. I appreciated a chance to collect my thoughts. I generated questions that I would consider after my fieldwork for that day. I would write for four to six hours each day following field work.

I circulated throughout the unit and spent time at each of the bedsides of the participating nurses. I felt that this approach was more unobtrusive, provided greater anonymity to the participants, and allowed me a greater diversity of observations. During patient rounds I had a “legitimate” purpose to “stand” in the middle of the unit for a large part of the morning. This afforded me an opportunity to see a variety of bedside scenes at

once, while capturing much of the nurse-physician interaction. I also found that admissions of patients facilitated many interesting scenarios. The mood of tension was heightened during the process of admission. The uncertainty of a new patient prevailed. As with rounds, the increased group size seemed to promote a need to perform. Humour was more evident at these times. This category “group size” emerged from my observations during my fieldwork. Meal breaks provided an opportunity to talk with the staff in a more relaxed atmosphere. The more casual atmosphere of the staff lounge revealed a more unrestrained type of humour. Participants often shared favorite stories in this setting. Although I never witnessed a 99 situation, nurses would often tell me about humour within 99 situations that had occurred.

My agreement with the institution stipulated that I would perform no direct nursing care. This arrangement worked to my advantage. I was not placed in a role conflict situation (ICU nurse versus researcher). I did at times participate in the provision of basic care such as turning patients. This afforded the opportunity for me to be at the bedside where many of the nursing interactions were taking place.

Informal interviewing took place in the observational setting, prior to semi-structured interviewing. As described by Fetterman (1989), an informal approach yields shared patterns that have meaning. Additionally, rapport is developed, setting the stage for further more in-depth discussion. I found that I had developed a level of comfort with my participants prior to the semi-structured interviews. Participants seemed at ease during the interviews and would sometimes refer to events that had taken place during Phase One.

Evening and night shifts provided a different perspective of this unit. On nights, however, there was less patient interaction and the unit was quieter. This provided me with more opportunity to sit and talk with the ICU staff. On the night shift I was first introduced to some of the “folklore” tales of this unit.

Phase Two

Phase Two of this study occurred after the completion of my fieldwork. Semi-structured interviews were undertaken with the goal of achieving a greater understanding of the interactions observed in the clinical setting (see consent - Critical Care Nurses Appendix K). I had planned to begin interviews (Phase Two) after the first two weeks of Phase One and concurrently with Phase One thereafter. I discovered that I needed to focus my thoughts on my fieldwork and observations, rather than incorporating further sources of data at that point in time. I therefore decided to begin interviews following completion of Phase One.

I approached each of the Phase One nurses to participate in semi-structured interviews. Not all Phase one participants were interviewed because of various scheduling constraints. I viewed the participation of these participants in Phase two as a type of closure with the participants. Each of the participants during Phase One had information to share that was germane to my increased understanding of humour. Participants consenting to Phase One also verbalized that they had expected to be included in the Phase Two interviews. A signed consent was obtained prior to Interviewing.

Sixteen semi-structured interviews were conducted (see interview guide Appendix L). Interviews ranged from forty-five minutes to two and one-half hours in

length. Semi-structured interviews involve the exploration of a topic, with the goal of developing understanding (Fontana, 1994). Interviews were tape-recorded and transcribed verbatim. One participant was male. Nurses with a variety of years of experience, from four months in an ICU to greater than twenty years nursing experience, were included. Semi-structured interviews provided an opportunity for triangulation of data. Comparison between stated and observed use of humour was also facilitated. This methodology of using more than one technique to permit “cross-checking” is referred to as triangulation (Adler & Adler, 1994, p.382). Additionally, information offered in the course of more casual previous conversations was, in some cases, expanded upon and clarified.

Knowing the participant, prior to interview, was sometimes of benefit. When approached for an interview, one participant told me that she appreciated humour but did not feel that she used humour in her daily worklife. This nurse stated that although she was willing to talk with me, she did not think that her input would be very helpful. I was able to discuss with her my observations of her use of humour (during my fieldwork). I described how I had witnessed the humour she created. She had generated an entire morning of laughter in the unit when she responded with witty comments to her patient’s self-extubation (removal of his breathing tube). Following this disclosure, she agreed with me and proceeded to engage in the interview with enthusiasm.

Interviews were conducted in a variety of locations, depending upon the preference of the participant. I expected that each participant would be interviewed once. This was the case. Phase Two interviews were contingent upon the convenience and availability of the participants and therefore continued for approximately 4 to 6 weeks

beyond immersion in the field setting. My goal was to complete these interviews as expediently as permitted by the participants, to permit clearer recollection of events occurring in the field setting.

Initially, demographic and grand-tour questions were used as ice-breaking techniques in order to relax the participants (Adler & Adler, 1994; Morse, 1989). Exploration with the participants about their philosophy of the value of humour progressed to the discussion of the more specific factors affecting their previous experiences in using humour. The open-ended nature of the questions and the limited guiding of answers given permitted greater flexibility in pursuing new themes which arose during the interviews.

At the end of the scheduled interview questions the interview became unstructured. Some participants responded by adding significant information during this time. Issues within the unit were often addressed when the conversation was not driven by questions. I believe that this chance to “vent” and to be heard was therapeutic for the participants. This added “context” was salient to my discovery of the “meaning” underlying the more superficial comments. The context of humour was more fully explored by moving beyond questions that encompassed “humour” per se. Field notes were also maintained during the interviews to provide a supplemental data base incorporating nonverbal aspects of the interview conversations.

Exploration with selected nurses regarding insight into their current use of humour surfaced during the interview process. I had expected to include nurses not exemplifying well-developed use of humour in the interview process, to gain a fuller appreciation of nurses' use of humour in this setting. This approach is in keeping with the

underlying assumptions of qualitative research that all data should be included in data collection and analysis (Omery, 1988). Credibility is also safeguarded by the inclusion of "negative cases" (Glaser & Strauss cited in Morse, 1989). This point is further elaborated upon in the section on trustworthiness. I found that each of the participants was supportive of the use of humour and sophisticated in its use. Their interest in the topic of humour prompted them to engage in this research project. Every participant expressed this sentiment at some point during the interview process. Thus, negative cases were sought but were not included within my participants.

An underlying assumption in ethnography is the belief that the researcher is the "primary tool" in the data collection process (Morse, 1989, p. 61). This subjective stance is integral to the process of seeing data and of then describing their meaning. Reflexivity refers to the researcher's immersion in the experience of data collection as a method of enhancing awareness of that which is being studied (Aamodt, 1983). Recognition of the beliefs that one brings to the research is crucial. Thoughts, feelings and impressions need to be recorded and organized. Throughout the observational phase of this study, field notes and a journal were maintained. Journal entries contained my personal reflections, hunches and beliefs concerning the process of conducting fieldwork. Extensive field notes were written in the clinical setting and following each field day experience.

Data Analysis Technique

Although described separately, aspects of data collection and analysis "often occur simultaneously" (Morse, 1989, p. 267). The process of reflecting, within a journal format and maintaining field notes, facilitated ongoing interpretation of findings. Categories of behavior gradually emerged, with increased exposure in the field. Data

analysis focuses on “extracting the meaning ... rebuilding and presenting the processed data” in a manner that enhances the understanding of the research (Knafl & Webster, 1988, p. 196). This principle of credibility is expanded upon in the discussion of trustworthiness.

The most exhaustive interpretation occurred following the data collection phase, via the process of thematic content analysis. Immersion in the data was accomplished through reading and rereading transcripts and listening to the taped interviews. Coding of all data was done as the first step of analysis. The process of coding raw data into meaningful units enables the recognition of emerging group patterns. Initial categories are broad but do not overlap (Burns & Grove, 1993). Codes were initially descriptive, but eventually become organized into interpretive and, finally, explanatory ideas, as the data were more fully understood. The process became one of progression from the concrete, literal account to a more abstract conceptualization. The themes of the “context” and “meaning” of humour became clear.

An open coding system was used, similar to that described by Burnard, (1991) in which categories or headings were first derived from the transcripts. The process of developing categories assumes that themes or commonalities are evident within the transcriptions of conversations. The categories represented at this point were literal reflections of the content expressed within the transcripts. For example, a single word or phrase was common to these initial categories. Examination of the literal “words” of the data facilitated articulation of the levels of meaning within categories as the symbolic nature was explicated. Categories were then derived from the underlying meaning of the words. Almost all of my data was accounted for within this process. Integration of

fieldnotes to support these categories was accomplished at this time. Comparisons were made between these two sources of data. Data not included in these categories mainly consisted of dross, or irrelevant information that did not enhance my understanding of humour in this setting.

The next step of coding was to collapse the existing categories into broader and more inclusive categories that contained similar information. Finally, transcripts and fieldnotes were reread and compared to the original categories and subsequent sub-categories derived, to ensure that data were appropriately accounted for within the coding system.

Throughout this process, the memoed notes and hunches contained within my fieldnotes were consulted to facilitate my conceptualization of the emerging categories. In addition to examination of patterns and categories seen within the transcripts, the notations included within the field notes enabled me to better appreciate the emergence of common themes. Analysis of fieldnotes proved beneficial to my understanding of the data. For example, an appreciation of the physical environment enabled me to recognize the sub-categories of environment as enabling and/or facilitating to the use of humour. Including fieldnotes in combination with interview excerpts facilitated triangulation of data. Additional categories (“group size” and “humour in code”) were facilitated by the inclusion of fieldwork data. Recognition of the rhetorical nature of humour was achieved during observations in Phase One (Fieldnotes, p.106). This fact was important to my conceptualization of the self-care aspects of humour. I also came to see that humour and laughter are not synonymous, a limitation of the theoretical framework for this research. The subtle nature of humour was more fully appreciated.

Following the coding and development of categories for the first four interview transcripts, my thesis chair examined and discussed with me the categories derived. This guidance served to validate my findings and provide assistance to articulate a framework to proceed with the completion of my analysis. I found this experience to be an excellent opportunity for enlightening dialogue, but also a means of increasing my confidence during the process of navigating this new and unfamiliar experience. My “quality of life” during the data analysis phase was also enhanced. The process of seeking the opinion of other researchers is important in establishing credibility of research findings.

This exploration of humour was situated within the context of the larger field of nursing knowledge through the examination of themes as they were interpreted in light of Morreall's (1983, 1987) Theory of Laughter. The comprehensive nature of this theory permitted its application in a variety of humorous situations. Morreall's incorporation of the cognitive, affective and psychological domains promoted an appreciation of humour that superseded the behavioral aspects of laughter. Interpretation of the meaning of a humorous interaction to all involved was invited. Because this humour theory accounts for humorous as well non-humorous situations, humour that was not effective could also be explored within this framework.

In keeping with the goal of ethnography, the use of humour within the cultural context of a critical care setting was described. Factors within the critical care environment relating to patient acuity, threat in some instances of imminent death, constant physical presence of nurses and patients, and the attitudes of Critical Care Nurses toward the use of humour, made examination of the cultural environment desirable. This methodology was crucial to understanding the context and the unique

qualities of humour within this setting. The “fun with” co-workers and instances of perpetuation of humour as a type of “folklore” were best appreciated through this lens.

Data management, or organization of stored information, is essential to facilitate retrieval of data in an expedient fashion. Memoing within the margins of my fieldnotes was used as a strategy to note impressions and record thoughts in an organized fashion (Burnard, 1991). This proved to be of benefit during my analysis as fieldnotes were arranged by date but were not indexed. The memos provided a more expedient manner of retrieval of data when searching through the extensive notations was undertaken. As a safeguard, an untouched copy of the transcripts and fieldnotes were kept in a secure location and used as a basis for comparison with the coded transcripts.

Ethical Considerations

Ethical convictions were observed for each step of the research process. Gaining research knowledge is always secondary to the rights of the individual. The principles of beneficence, respect for life and justice are not specific to any type of research and need to be universally regarded (Polit & Hungler, 1995). Ramos (1989) noted the obligation to assume greater responsibility to protect participants, in view of the decreased structure of the qualitative design. The formal process of observation of ethical standards was accomplished through submission of the research proposal to the Ethical Review Committee, Faculty of Nursing, University of Manitoba. This committee’s recommendations were incorporated accordingly. Subsequently, the access committee of the hospital was approached for permission to gain access to the Medical Intensive Care setting.

The principle of respect for human dignity requires that “ consent be informed and voluntary” (Medical Research Council of Canada, 1993, p. 21). Prior to entering the facility, an explanation of this research was provided to nursing staff at a staff meeting and by means of notices placed on the bulletin boards and in the communication book (see Appendix G). At this time, nurses were asked to consider granting consent by means of a disclaimer (see Appendix H). Nurses wishing to participate in this study placed their agreement in a pre-arranged envelope, to be examined only by me.

In recognition of their vulnerable emotional status in being admitted, or having a loved one admitted to an ICU, I anticipated that I would not approach patients directly to seek their consent. Staff nurses would be asked to approach patients and their families and seek their permission via a disclaimer (see Appendix J). A script was devised for nurses to guide them in their explanations to patients and families (Appendix I). This procedure was included in the explanation of the study to the nurses (Appendix G). Also with this factor in mind, the disclaimer for Phase One - Patients and Families - was phrased as clearly as possible, while still including essential information.

The procedure for gaining consent from patients was changed at the request of the committee granting access to this hospital. I was informed that a change in policy had been enacted, requiring that nurses not be asked to increase their workload to request consents from patients. This change in procedure meant that I would be approaching patients and family members directly (as per previous discussion under data collection). The Ethics Committee of the Nursing Faculty, University of Manitoba granted permission for this amendment. I reinforced the content and continuous nature of consent (right to withdraw at any time) when first meeting patient and nurse participants. At all

times I attempted to be as sensitive as possible regarding perceived position of power over patients, by virtue of my identity as a nurse.

Although the requirement to obtain consent for field observations is controversial, I felt that the consent of nurses, patients, and their families, if the patients were unable to make a decision, was prudent. Field observations were the basis of emerging themes and were recorded as part of the data analysis. Thus, informed and continuous consent was sought from all participating individuals.

Consent for Phase Two was of a different nature. Nurses previously selected (see sample selection) were asked to sign a consent for a face-to-face interview (see Appendix K).

In accordance with the principle of justice, it is essential that the right to privacy be guaranteed by ensuring confidentiality and anonymity. As described in the consents and disclaimers, all interviews were number coded only; no names of any participants were used. Participants were given pseudonyms. Although one participant was male, all pseudonyms were female, to protect the anonymity of this person. All original transcripts are being kept in a secure location. Descriptions of study findings were altered as necessary to reduce the occurrence of “tracing” any information to consultants.

The principle of beneficence states that the intent is “above all, do no harm” (Polit & Hungler, 1995, p. 134). Estimation of the risk / benefit ratio to participants was considered. In contrast to the more formal nature of the previously discussed principles, this assessment is less obvious and not always known in advance. In performing within the participant observation function, I anticipated that my roles of nurse and researcher might occasionally blur (Hutchinson & Wilson, 1992; Jackson, 1975). The fact that I

was not well known to the participants may have partially ameliorated role-tension. As described previously, my confinement to non-nursing tasks likely prevented role conflict. A degree of involvement in performing some patient care functions was a significant factor in “connecting”, “immersion” within the setting, and developing rapport with nurses and patients. Each situation was evaluated within its own context, with the implicit understanding that people are not to be treated as a means to an end (Munhall, 1988).

Methodological Rigor

The traditional standards of reliability and validity are derived from the viewpoint of quantitative research. “Quantitative and qualitative research are often distinguished by their variant concerns with objectivity and subjectivity” (Robinson & Thorne, 1988). The philosophy and goals of qualitative inquiry are in contrast to quantitative research. This can result in criticisms that are unfounded and irrelevant. Lincoln and Guba (1981) described four criteria that permit a more meaningful appraisal of qualitative work. Reliability and validity can be assessed through an examination of truth value, applicability, consistency and neutrality (Munhall, 1994). These “parallel criteria” provide an evaluation of the trustworthiness of the research (Guba & Lincoln, 1989, p.233).

Credibility

The truth value, or credibility, is judged by the degree to which the researcher is able to convey the reality of the participants. “Truth is subject-oriented rather than researcher-defined” (Sandelowski, 1986, p. 30). Credibility is a measure of the ability of qualitative research to yield an account that is readily identifiable to the reader from

his/her own experience. This study addressed this issue through its design of participant observation within the culture of an intensive care unit. I anticipated that this approach, in combination with the interview process, would promote a more indepth appreciation of the use of humour within this setting.

Ongoing interaction with my thesis chair, at every stage, provided a significant safeguard in this respect. During the fieldwork phase I discussed emerging themes and meaning of humour in relation to my observations. I was able to clarify potential “grey areas” as I proceeded. I was unsure of the ethical implications of approaching a non-participant in Phase One to consent to an interview in Phase Two. Following confirmation to proceed, I conducted an interview that was pivotal to my research findings. My “intuition” regarding this person’s non-participation was accurate. When asked about her lack of participation in Phase One, she replied that she was sure I would have been able to use the information that I had observed within the clinical setting, regardless of a lack of formal consent. I repeated the ethical guidelines that would have prohibited this course of action. I was left with the understanding that this point of view, occurring despite written (consents and disclaimers) and informal reinforcement of the nature of informed consent reflects the ambiguity of fieldwork. The “grey” zones of ethical decorum within a fieldwork setting, in part because of the informal and continuous presence of a researcher, are difficult for staff members to appreciate.

Negative case analysis was considered when interpreting findings. All accounts were regarded, not only those supportive of emerging themes. The inclusion of “negative cases” also adds a dimension of richness to the findings (Glaser & Strauss, 1967, p.118). As previously described, all participants were supportive of the use of humour, reflecting

their involvement with this research. I did, however, consider that the comments of Gloria were at times reflective of a “negative case”. Her perspective sometimes varied from the norm of the group. This enabled an opportunity to present two contrasting points of view. Progressive subjectivity refers to the process of monitoring the immersion of the researcher (Guba & Lincoln, 1989). This component was addressed through the continual process of reflection, journal entries and memoing, as described under data collection and analysis. Member checking involves validating the content of transcripts to determine whether the observations of the researcher are congruent with those of the participants. A potential disadvantage exists in the disparate aims of the researcher and the informant. Sandelowski (1993) disputes this requirement, stating that the ongoing clarification occurring within the interview accomplishes the same purpose. She further asserts that member checking can be detrimental to the research process, when the participant does not approve of data which may be accurate, but unflattering. In recognition of this fact, a collective member checking was solicited. Findings were shared with the hospital staff during a “Brown Bag Research” session, to provide an opportunity for feedback from the participants and response to the categories and themes derived from the data. Feedback from this presentation was positive and extremely supportive of my findings. No concerns were stated or apparent. Nurse participants were offered an executive summary of the completed study within the process of consent for Phase Two. This summary will be mailed to participants.

Fittingness

The applicability of research can be examined in light of its ability to “fit” into the broader context of nursing knowledge as well as the extent to which “its audience views

its findings as meaningful and applicable in terms of their own experiences” (Sandelowski, 1986, p. 32). Guba and Lincoln (1989) relate the use of “thick description” to enhance the reader’s appreciation and understanding of research findings (p. 241). In reporting findings, categories and themes were supported by the textual data and a vivid description of the environment. The research design and length of time spent in the field facilitated an improved understanding of the use of humour in an ICU setting and a rich description of the findings. Chapter five includes a comparison with the findings of this study and the current literature. The findings of this study are congruent with other similar research on humour, but also reveal different aspects of humour that in some cases are specific to an ICU setting.

Auditability

Auditability is analogous to the consistency found within the positivist paradigm. Qualitative research, with its emphasis on the experience of the individual, does not lend itself to exact replication, although a type of replication in other critical care settings is possible. Further examination of humour and themes derived from this research, would be invited through comparison of contextual variables present in another critical care setting. This study could be conducted within another setting to assess its replication. A different nursing setting such as a palliative care unit would allow comparison of this group’s use of humour.

A “decision trail” which can be easily followed by another researcher to yield similar results, is the hallmark of auditability (Sandelowski, 1986, p.33). Each step of the research process has been described within this chapter. Chapter four reveals a rich description supporting the themes and categories through the use of textual data. The

interpretation and explanation of jargon specific to nursing and the ICU setting has been carefully assessed and replaced in each scenario. The use of everyday language is designed to demystify the events occurring in the ICU and to facilitate an understanding of the salient issues and message being conveyed by ICU nurses, within the text. Increased clarity of understanding also facilitates the use of this research as a basis for comparison with other studies in a variety of settings.

Confirmability

Confirmability, or the neutrality described within a quantitative viewpoint, is dependent upon the presence of credibility, fittingness and auditability. Unlike the positivist paradigm, “the integrity of the findings are rooted in the data themselves” (Guba & Lincoln, 1989, p.243). This cumulative effect assumes that, in the final analysis, the reader will judge the quality of the research as it corresponds with their world view. If confirmability is attained they will be able to follow the approach taken, yet disagree with the results. My thesis chair was instrumental in auditing the data collection and analysis processes to ensure that findings of this study could be verified by the data within the transcripts.

Conclusion

This design reflects an ethnographic approach to a poorly understood phenomenon within the realm of critical care nursing. The combined methodology of participant observation and semi-structured interviews facilitated a richer appreciation with which to explore the use of humour by nurses in a critical care environment. Research findings have been interpreted within the broader context of Morreall’s (1983, 1987) Comprehensive Theory of Laughter.

CHAPTER IV

FINDINGS

Introduction

Chapter four includes a description of the findings of this study. The presentation of findings is organized under the themes of the context of humour and the meaning of humour. A visual representation of the data in the form of a “model of humour in an ICU environment”, as conceptualized through the findings, is included. The context and meaning of humour are explored from the various perspectives of the individuals participating in the scenarios. Levels of meaning, from the superficial to the underlying significance of the humorous dialogue, are described. Plurivocal messages contained within the data are revealed. The common threads of caring, courage and control are present throughout the presentation of findings.

Findings are presented and substantiated by means of verbatim quotations from fieldwork notes and interview transcripts. Pseudonyms for the participants are used throughout this chapter. All names are female in origin to protect the anonymity of the one male participant. Page and line numbers are included from the interview transcripts. Fieldnote page numbers are used in a similar fashion.

ICU ENVIRONMENT

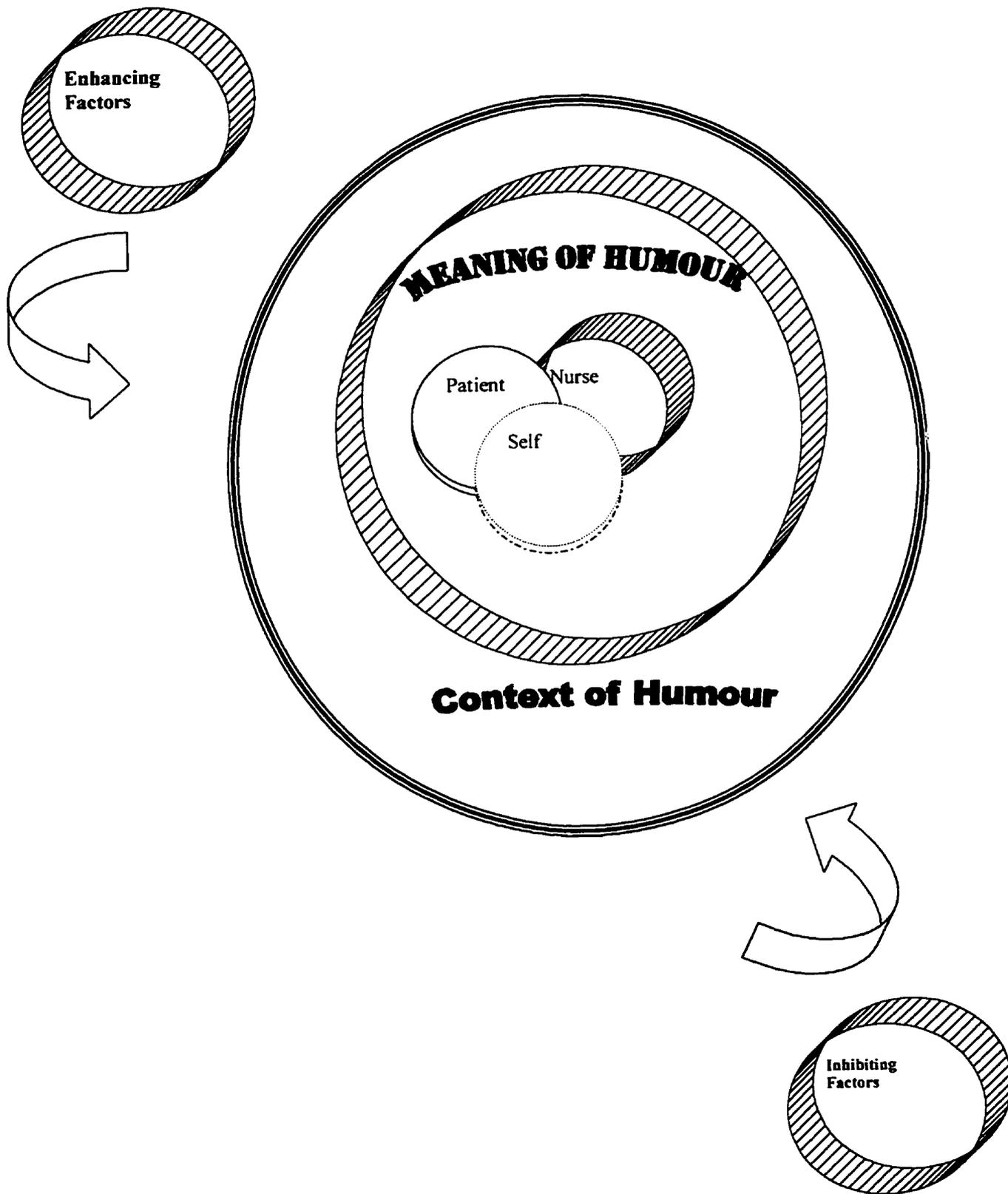


Table 1 Context of Humour - Enhancing and Inhibiting Factors

Physical Environment	Nurses/Workers	Patients/Family Members
Factors Enhancing the Use of Humour		
Close Quarters Time of Day	Knowing Co-workers Status Disrespectful Co-Workers Longevity in Nursing Group Size	Long Stay Patients CCU Patients (decreased acuity) Age Family Presence
Factors Inhibiting the Use of Humour		
Close Quarters <ul style="list-style-type: none"> ▪ Patient Initiated Inappropriate Sexuality ▪ Nurse Initiated Inappropriate Humour 	Co-worker Dynamics Longevity in Nursing Disrespectful Co-Workers Setting Personal Experience	Deteriorating Patient Condition Family Presence

The Context of Humour

Factors Enhancing the Use of Humour

Physical Environment

Close Quarters

Some elements of the ICU physical environment were conducive to the use of humour. A lack of privacy enabled close monitoring of patients and also allowed ICU nurses to pay close attention to co-workers and evaluate their response to events occurring at their bedside.

Betty: Perhaps in critical care we use [humour] a bit more because [we] work more closely with [our] co-workers, be it nurses, doctors, R.T.'s [respiratory therapists] ... just working in closer proximity ... you can see what's happening [with the other person] and you maybe can just lighten [up] their day by saying something to acknowledge that you're paying attention to what's happening in their corner... (#1 L. 78).

Proximity provided a closeness that promoted a stimulus for humour. A "view" of others in the environment enabled nurses to recognize and "acknowledge" a co-worker in need of a cheering gesture. This attunement allowed another nurse the opportunity to assess the situation and determine the timing of a humorous communication – verbally and non-verbally. Within the humorous message delivered, empathy and caring were conveyed that another person was sensitive to their colleague's situation.

Susan also offered her comment about the ICU, "It's small ...you're in small quarters ..." (# 10 L. 58). Her remark reflected a tone of making the best of a bad situation from which there was no escape "You can't go from room to room" (# 10 L. 59). There was no physical means of escape, leaving only the emotional or intellectual routes away from a negative or depressing scene. Humour represented one of the latter types of retreat.

Meal breaks did provide a legitimate reason to leave the ICU [briefly].

Cindy: ... but I think the lounge has a little bit to do with it too [use of humour]. Because we have our lounge that we can relax in for coffee, so, if we don't see each other even though you're busy at the bedside, you do basically have a coffee or a lunch ... (#3 L. 591).

The coffee room provided a haven, away from the bedside, for the nurses to "relax." The decreased physical proximity to ICU patients in this case promoted a tendency to "let loose" and engage in humorous exchanges in a more unrestrained manner with co-workers. In the atmosphere of the coffee room fellow ICU nurses, by virtue of their shared experiences, were less apt to misconstrue the meaning of an off-hand comment.

Humorous comments were specifically aimed at the physical aspects of this unit.

Maxine: The dirty and old environment doesn't get in the way of patient care and is an easy and safe thing to joke about ... sometimes patients are in ugly surroundings ... you might think it's an expression of the values of the people in the institutions ... I don't think it is, it's just health care cuts ... the patients themselves will compare ... and will talk about being in the more beautiful hospitals (# 7 L. 787).

The physical environment was treated as an inanimate object. The "ugly" surroundings were laughed at and distinguished from the values of the "people [who worked] in the institutions." Jokes were made about being in "the more beautiful hospitals," a fact that may have ignored the patient's acuity and reason for admission [to a tertiary care facility]. Patients' admissions to this tertiary hospital may have been necessitated by the severity of their condition. For the moment this was forgotten as "shots" were made by a "connoisseur of hospitals" [the patient] at the physical status of the institution they found themselves in.

Time of day

The time of day can be an enhancing or inhibiting factor in the use of humour.

The “night staff” consists of nurses who work a day /night eight-hour shift combination and other nurses who work twelve-hour days and nights. Additionally, a few nurses are hired to work permanent nights. The increased structure of the routine on the day shift - daily inter-disciplinary rounds on all ICU patients, numerous visits by consultants and the presence of administrative personnel - tended to decrease the inclination and the time available to plan and carry out more elaborate acts of humour. An underlying feature of increased available time on nights as compared to days also, at times, facilitated the use of humour.

Cindy: Days are too busy. You’re doing rounds, you’re doing consults. You’re doing [patient diagnostic] tests. So there’s not the time there ... but nights they’re always pulling something ... (#3 L. 762).

Ricki: there are more practical jokes played on nights, everyone is more relaxed (#13 L. 847).

Stephanie: We sit and do Monty Python skits on nights. We’ll sit down in the smoke room [the smoking lounge area – away from patient care areas] and do Monty Python. Oh no, its Monty Python night (#15 L. 1289).

Ricki recounted some of the “tricks” that the night staff played on the day staff.

Ricki: It wasn’t busy at all so we got a mannequin ...put all the IV [intravenous] lines and what not and covered the bed ...[we] made a bogus chart and assigned [this “patient”] to somebody [one of the day staff] (#13 L. 871).

Ricki: We had a patient who [was] always asking ...for the same [things], “Will you come here and give me this and give me that?” So we [the night staff] told him ... at seven or eight o’clock if you want something, say “Julie” [the nurse in charge] (#13 L. 881).

The night staff gained a reputation for playing jokes. Cindy explained “Nights are the notorious. Everything’s blamed on nights. It’s a night’s thing. Nights did it” (L. 751). She went on to summarize, “And nights complain, ‘Well, everybody says we did it because nobody sees us” (L. 754).

Nurses / Workers

Knowing Co-workers

Several participants stated that use of humour was enhanced when team members were more familiar with each other as persons.

Betty: ...In critical care you use [humour] more because you work more closely with your co-workers, be it nurses, physicians, R.T.’s, whatever ... I think you get to know them a bit better, plus they get to know you ... (#1 L. 73).

Nancy: There’s more teamwork in the unit. There’s more like a family, they’re closer knit [because of] the close proximity of working ... you need to rely on each other for lifting ... everything is teamwork, every admission ... when your patient starts to take a turn for the worse ... I don’t think it’s related to ICU. it’s related to the close knit staff (#9 L. 95).

Betty ... [Physician] Residents as well ... they’re [in ICU] for a long period of time. You get to know them. They get to know you ... I think you soon find out who you can say what to ... (#1 L. 174).

Sara: The longer you’re in a facility you become more comfortable with the people you work with and you know who will not appreciate it [humour] (#4 L. 573).

Getting to know team members occurs over a period of time. Betty and Sara both referred to the process of getting to know co-workers. Regardless of discipline, familiarity was a feature of working together closely. Trust between co-workers was nurtured when team members learned to help and rely on each other. Engaging in similar types of experiences together shaped a shared understanding and meaning of events. Peers were apt to have the greatest similarity of experiences in the workplace and thus a

more comparable worldview. Sara noted the individual “appreciation” of humour present amongst co-workers and peers. “Knowing the person” facilitated recognition of the personal nature of humour “Who you can say what to.” A “range of humour” - limits specific to the individual- was appreciated as staff members got to “know” each other.

Part of “knowing the person” encompassed an understanding of whether or not the individual on whom a joke is played will be receptive.

Cindy: [The difference in whom a joke is played on] ... I think it's the way they respond back ... like [a certain physician] he gets the most jokes played on him. He's a real favorite. You can kid around with him quite a bit... He's very witty... he'll think about it for a bit and [then] he can respond back ... [a certain other physician] ... is a little slower on the draw, but he will get it (#3 L. 1054).

A person receptive to a joke or a prank helped to perpetuate the comedy of a situation.

The person or persons initiating the joke may, in turn, be treated to a humorous remark or a return prank. A sense of reciprocity was seen. Responsiveness may have meant that a return prank was about to occur, or simply that the effort involved in playing the joke was acknowledged and appreciated.

Status

Wanda made the distinction that beyond knowing individuals a feeling of comfort and familiarity was facilitated between individuals who were peers. This feeling of familiarity lent itself to displays of humour. In the presence of this person, humour was safe to use. Familiarity, however, could be superceded by status.

Wanda: A couple of the doctors really intimidate me so I'm really professional with them ... I use humour more with residents and interns ... I guess I feel like I can be more of a peer with them (#14 L. 651).

An element of risk was present in many humorous interactions between physician and nurse. Challenging the status quo and advocating for patients in a humorous fashion

were facilitated if the nurse and physician had established rapport and enjoyed a relationship more as peers.

Gloria: With the residents and the interns it's usually a free for all in regards to humour ... Depending on the resident and depending on how much they like being where they are now [current rotation in ICU] or how much they hate being where they are..." (#6 L. 669).

Disrespectful Co-workers

Stephanie, however, described the use of a more disparaging type of humour with physicians the nurses did not enjoy rapport with. In contrast to the humour noted by Betty and Wanda, this type of humour was more openly hostile, reserved for physicians who demonstrated a lack of respect and collegiality to the nursing staff.

Stephanie: ... The ones you have respect for you don't tend to pick on as much ... but the ones that come in with that "I'm the godly physician" attitude and it's like oh, you spend a few weeks in here and we'll knock you're socks off, you know, because we're not as stupid as you think ... we had one group of guys [physicians] who went through people ... they were degrading us, they had people in tears and they would talk down to us ... we're used to having respect for our knowledge [but] they wouldn't. You'd ask them to do something ... and they would do totally the opposite because you suggested it ... I'd say something stupid like "I'm naturally brunette" ... stupid things come out. And they dismiss that and they laugh at you instead. I give them the royal giggle ... [I say to them] "The patient's done this and this." [The physician says] "You should do this. [The nurse says] "I've already done it. [The physician says] "Well, what do you want me to do?" (# 15 L. 1349).

In contrast to the humour that increased as the nurses and physicians became acquainted, this type of humour surfaced early in the relationship between nurse and physician. In the above scenario the "godlike attitude" of the physicians was evident in their degradation of nurses, putting them "Into tears and talk [ing] down" to them. This type of physician placed themselves in a "glass house", by virtue of their attitude. Nurses were more inclined to retaliate, with similar sentiment, to those physicians who had stimulated a "gloves off attitude." Camps between the physicians and nurses were

divided, as physicians would do “Totally the opposite” of what the nurses suggested. Stephanie’s account revealed the tendency of the physician to “Laugh at,” instead of “laughing with.” A shared understanding of humour with this group of physicians was limited. Teamwork suffered as nurses and physicians worked to outdo each other. Nurses would attempt to complete a task before it was asked for or suggested by a physician, in an effort to demonstrate the physician’s redundancy in this situation. Gloria described a different kind of humour that she used when she had “No respect at all for a physician.” In this type of situation she initiated humour that was “Very sarcastic ... meant to have an impact” or a more blunt message (# 6 L. 593).

An observer might witness laughter and a “giggle” or a joke, but animosity was not far beneath the surface of these interactions. The intent of the humour became transparent if the context of the situation was known [previous episodes demonstrating a lack of respect] and the meaning of the message [reference to being “brunette i.e. not “stupid”] were interpreted. Humour in this case represented a socially acceptable method of expressing frustration and an outlet for anger release.

Longevity in nursing

The majority of participants believed that their appreciation and use of humour had increased along with their years of nursing experience.

Maxine: I, comparatively speaking, would use humour more than I did a few years ago, or be more receptive ... I have a lighter attitude, a lighter heart ... I think that I’m more comfortable with myself and my nursing than I was a few years ago (#7 L. 477).

Claire: Absolutely [appreciation of humour increases with increased years of experience] and I think it goes with your personal security. As a new grad [graduate nurse] you’re not secure in what you’re doing so nothing’s funny ... but

after a while you become secure in what you do, you have time to lighten other people's lives and just have some fun along with the group (#2 L. 119).

Claire noted the focus on new graduate nurses in establishing a sense of credibility in their new role. As seen with self-disparagement types of humour, humour usage in this sense reflected a display of confidence by an individual nurse in his/her abilities. Initially, the recent graduate focused on provision of care. As time elapsed, nurses then became more familiar with their role. Eventually, there was more "time" to join in and engage in humour with other team members "the group." Increased time spent in nursing, with "the group" may have also enhanced the aspects of getting to "know" group members and also facilitated the use of humour by this means.

Another participant qualified the effect of experience on the use of humour, viewing humour usage as a combination of factors, including level of nursing experience and personal characteristics.

Betty: There is a lot to do with comfort level and/or experience, but I think that there still has to be something in a person to be able to [use humour]. Some people just can't (#1 L. 546).

Sara observed that the tendency to use humour was similar to any "learning process." "Just like anything else ...you have to stand back and watch and after you've been there a few times ...then you are more relaxed" (# 4 L. 466).

Longevity of the nurse within the ICU environment was also seen as an enhancing factor in the ease of humour usage.

Cindy: When you're a junior nurse there's a little hierarchy ... and same thing when you go to a new unit ... you get to know the environment ... what you can say and what you can get away with ... you've got to know where the line is ... I'm more relaxed around the docs a bit too ... in the last year (#4 L. 566).

Alice: As a new ICU nurse I am more cautious and I'm definitely not the one to initiate humour, but if somebody else does I might join in more easily. I'm

probably more serious at this point in my nursing [career] ... maybe down the road I'll lighten up a bit (#8 L. 437).

Cindy and Alice described their transfer to a new area, the ICU, as initially inhibiting their use of humour. Cindy recalled the need to "get to know the unit" before becoming comfortable in displaying humour. She compared the "hierarchy" of a junior staff member [playing by all the rules] to the development of seniority within the ICU environment, enabling her to "get away" with demonstrating humour. Sara also commented that "The longer you're in a facility you become more comfortable with the people ...and you know who will appreciate and who will not appreciate it [humour]" (#4 L. 573). This type of scenario resembles a small "rite de passage" of a new nurse in an ICU. Alice stated that she was "cautious" with humour in her role as a new ICU nurse. Although more apt to join in and respond to humour, she still does not initiate humour. She was able to foresee herself as "lightening up" in future, as she gains more seniority and experience.

Nancy contrasted her current ease in using humour under a particular circumstance from how she felt as a new ICU nurse.

Nancy: I know that when I first came to the unit some of the humour upset me ... and now I'm just that way ... my first body I wrapped I was with someone who was cracking jokes and I thought that it was a very respectful time [this made me uncomfortable]. Now I'm the very same way (# 9 L. 511).

Nancy explained how she learned to "psychologically separate" herself from the job of wrapping a body and engage in humour "Over top of the body ... [but still demonstrate] respect for the body." These humorous comments were about "Something totally unrelated" (#9 L. 527).

Rhonda and Wanda attributed their increased use of humour over time to an increase in personal and professional growth. They associated an increase in their use of humour with an increase in their skill in communication and self-confidence.

Rhonda: When I first got into nursing I was more concerned about the tasks that I had to do ... as time went in and I became more comfortable and confident ... I think my communication skills and my sense of humour sort of grew from there as well (# 12 L. 1069).

Wanda: [I use humour more now than I used to]. I used to be really serious. I learned that some of these patients are so wound up you just have to help them relax. And one of the things is with humour ... I make a little crack "I have to check your vital signs to see if you're still alive ... I don't think it has to do with my comfort level. I think it's related to my self-development (# 14 L. 129).

With increased experience in nursing, Rhonda and Wanda expanded their expertise from the more technical aspects of nursing to include humour as a communication skill. Wanda discovered humour as a technique effective with anxious patients. Maxine also reflected a personal growth in her statement "I'm more comfortable with myself than I was a few years ago" (#7 L. 479).

One participant felt that she did not use humour more now than when she started nursing. Gloria considered that her sense of humour was developed in a previous career, prior to entering nursing. She stated she has "Always had a sense of humour ... and brought that into nursing" (# 9 L. 342).

Patients and Family Members

Long Stay Patients

The tendency to use humour with patients increased when the patients had spent a longer period of time in the ICU.

Gloria: [I tend to use humour more the longer patients have been in the unit]...you get to know them ... we have a guy who's been with us for a month. He's up in his wheelchair and he bags himself [delivers oxygen through his endotracheal tube by pressing on an oxygen bag] and I keep saying, "Get a

bicycle at his bedside.” You know we’ll never get him off [the ventilator] if he doesn’t exercise. We told him that he should go over to the casino and ... win us some money (# 6 L. 961).

Georgette: With the long-term patients everybody knows their idiosyncrasies ... people will play on that... If you know something of the patient’s background [I may comment] on something related to their background that I saw in the [news]paper (#11L. 417).

The more long-term patient became a part of the social culture of the unit.

Gloria’s patient was included in social banter by the nursing staff. The nurses knew him well, (his) “idiosyncrasies,” enough to tease him about his need to exercise and build up his strength to get off the ventilator. Georgette recalled that humour with a patient who had been in the unit for two years was “almost like” the humour between staff members.

Maxine: [Humour is used more with] patients who have been around a long time. [The patients] are using humour themselves because it helps to get through their lying long hours (#7 L. 188).

Georgette: [We] tend to forget that [the patients] have eyes and ears and see everything that is going on in the unit. And often times they will joke around about something that was said between two staff members ... So they tend to almost become a little bit more like the staff’s humour in a way. We had a patient with multiple sclerosis that was here for two years ... He knew the ins and outs of everybody. So you kidded around with him like you did almost with each other.

Sara: If you have a patient for a long enough period of time, you start to become more, like more personal ... If I’m turning someone I’ll say, “Just grab a hold of me” ...just to lighten things up a bit. For the first two or three days that they’re in there, [ICU] it’s usually a more critical time and there isn’t a lot of [humour], but if they stay for a longer period of time than that, even if they can’t verbally communicate with you, I think that everyone gets so that it’s a little bit [more relaxed] ... like rolling someone too far [in the bed] and “Oops, trying to roll you out of bed” ... to lighten things up a little bit, and they usually respond ... They look at you, or they’ll roll their eyes... (#4 L.145).

The longer stay patients also were in more stable condition than those newly admitted. A new patient requires a period of assessment and stabilization. This assessment includes physiological status but also an opportunity to get to know the

patient as an individual. This process is similar to the process of nurses and physicians getting to know one another.

Claire noted that patient condition in and of itself was not a contraindication to the use of humour. She noted that “Some of the very sick patients on ventilators can laugh and be a part of it [ICU “social” atmosphere] too (#2 L. 243). The signs of humour in a patient on a ventilator are more subtle. As described by Sara, they may not initiate but can respond by “Facial expression” or “Roll[ing] their eyes.”

CCU (Coronary Care Unit) Patients (Decreased Acuity)

Several nurses agreed that they were more likely to engage in humour with CCU patients. A common feature of CCU patients was their decreased acuity. Patients who became unstable were transferred to the “main unit” of the ICU. CCU patients were never intubated [breathing tube placed into the windpipe]; they were able to respond verbally to comments made in jest. These types of patients also did not have a level of consciousness [alertness] that was compromised or they would have been transferred to the “main unit.”

Cindy: I probably [use humour] more frequently because you can talk [to the CCU patients] ...they can talk back and interact (#3 L. 397).

Sara: They’re never intubated so there has to be more conversation (# 4 L. 142).

Susan: ... Not that what CCU patients are going through is less than the [patients in the main ICU] but [admission to] ICU [main unit] is more serious ... Lots of times there is a good chance that they’re [main ICU patients] not going to make it (# 10 L. 124).

Maxine: Many times patients who’ve been in a Coronary Care room together for a while have developed a really interesting rapport and many times in CCU people who have gone through the same procedures [develop] a rapport. They’ll be laughing and being silly all the time and talk about staying up late at night and not wanting to go to bed and just kind of acting like kids at camp (#7 L. 198).

Patients in CCU were in a position to laugh with other patients as well as the ICU staff. Patients who had “gone through the same procedures” and were in close physical proximity have many shared experiences in common. Humour also provided emotional release as the patients temporarily “regressed” to more childlike behaviors and away from some of their health concerns and other responsibilities.

Age

Sara commented that an age difference between she and her patients at times facilitated use of humour.

Sara: Because there’s an age difference they comment on your age, or make some kind of remark that way, so that it’s usually an opening for something a little more personal and you get to know them a little bit better and you can make just quick comeback remarks (#4 L. 123).

It is possible that an age difference provides a buffer that makes the humorous comments of “a little more personal” nature seem more innocent or non-threatening.

Family Presence

Family presence was viewed by the participants as being both enhancing and inhibiting, in various circumstances. Inclusion of family members in the repartee of the unit staff members can make the family feel included as they spend time at their relative’s bedside.

Claire: Families will often sit by and watch [staff humorous episodes] and get the odd giggle and make a comment and come and talk to us (#2 L. 232).

Maxine: Where a patient is intubated I would very often direct humour more with the family than with the patient whereas with the patient [my approach] is more often supporting them and encouraging them and trying to be as gentle and understanding as I can ...I make jokes about them being all wired up or if they are looking at all the contraptions and gadgets as if they’re strange and mysterious I joke about them [the objects] being from another planet ... Sometimes I will make

light of things the staff are doing ... to sort of focus them away from the patient ... sharing silly things that are happening with the staff (#7L. 233).

Maxine: We're always eating cake ... and sometimes we joke with patients and families will talk about how we wish they could take a piece of chocolate cake and stuff it down the endotracheal tube (# 7 L. 277).

Maxine stated that, especially with patients who were intubated, she would direct her humour more to the family members. Family members were also indoctrinated into the people and the routines of the unit. Humour in this situation provided family members with vital information about the patient's condition and bedside equipment. A small gesture of humour may also ease family members' reactions to the sight of a loved one on a ward for the critically ill.

Group size

Incidences of humour may be more frequent with increases in the size of a group. During my fieldwork I observed an increased number of humorous incidences during rounds, admission of patients and at change of shift. Nurses would exchange bits of humour as they briefly meet at the desk area or the pharmacy counter [to mix medications] (Fieldnotes p. 104). These events had in common a larger number of persons congregating together. The stimulus for humour use may be enhanced in these circumstances. Additionally, a shared purpose [i.e. admission of a patient] and a sense of bonding may also facilitate humour. The need to perform in these instances may be heightened [along with a level of stress] as the actions of individual nurses are witnessed by others.

Factors Inhibiting the Use of Humour

Physical Environment

Close Quarters

The open physical environment can be facilitating to the use of humour as a function of the physical proximity of patients and other staff members. At a glance, a nurse can assess the circumstances of a near-by colleague. Intervention, in the form of a smile or comment to a colleague, can provide a simple gesture of support. This sense of intimacy can also present challenges in its lack of privacy. As described by the following nurse, an open environment can be “too revealing.” Nurses, cognizant of this fact, limit their use of humour when a humorous message would not be congruent for all those present in the vicinity.

Cindy: [The physical environment limits the use of humour] ...because the desk is in the centre, the beds are so close. You know, you're in earshot of everything. You always know what's kind of going on in the unit (#3 L. 570).

Sara: ... Because the unit is open ... it can make it hard to control, you know, what's going on around you ... (#4 L. 409).

Rhonda: You have to be aware of the surroundings because there's no walls in the unit. It's curtains and curtains aren't walls. And they're not sound barriers ... other people can hear ... (#12 L. 417)

Cindy referred to the intrinsically sombre mood of an ICU in her comments on the physical environment. The fact that “You're in earshot of everything” naturally inhibited the use of humour. Humour in the ICU is the exception to the rule, not the first inclination of its inhabitants who, for the most part, are in the midst of a life and death crisis. Nurses have a sense of the “gestalt of the vicinity” to guide their displays of humour.

From the viewpoint of the nurse and patient, the physical nature of the unit is another factor that decreases the sense of control. Sara commented on this fact. Patients are exposed to the discomforts of others in the same surroundings. Unpleasant events are often frightening in their significance as a potential occurrence to the patient watching. Rhonda noted that “Curtains aren’t walls.” The physical set-up of the unit prevailed. The risk of patients experiencing unpleasant circumstances of others in their vicinity is heightened. A sad event occurring in one part of the unit would thus exert an inhibiting effect on the use of humour in its vicinity.

Patient Initiated Inappropriate Sexuality

In recounting incidences of inappropriate patient-initiated humour Sara described a distinction between the intent of the message and the style of delivery. “It’s a humorous statement that comes out differently [accompanied by] a look that isn’t joking ... because someone else saying it with a different tone wouldn’t bother you in the least (#4 L. 304).

Sara: One man that had a “plasty” [angioplasty procedure of the coronary arteries that meant he had a dressing in his groin area, over the femoral artery, that had to be checked frequently] and was exposing himself every time... He made comments that were really inappropriate for any setting ... he had three different women visiting him while he was [in the unit] and he was a womanizer ... he made everybody feel uncomfortable ... it wasn’t a matter of [being] mixed up or confused. He just thought he had a right to do so (#4 L. 238).

In this type of situation Sara stated that she would not respond with humour, but would remain matter-of-fact. “If you were to be comical about it, it would only feed them, to continue it [the inappropriate behavior or comments] (#4 L. 230).

Nurse Initiated Inappropriate Humour

A style of humour delivery that was too loud was thought to be inappropriate. This fact is compounded by the close quarters that exist in this ICU environment.

Sara: Humour [that is] just very loud ... You're absorbed with what you're doing, not what's going on further down, [in the unit] so it can happen very easily that someone gets carried away, a little too loud and ... maybe there's a critical situation going on [in the vicinity – within earshot] (# 4 L. 394).

Nurses/workers

Co-worker Dynamics

“Knowing” co-workers contributes to the use of humour when a sense of familiarity engenders a feeling of trust and an appreciation of shared experiences. Humour can be used effectively when “knowing the person” allows the sender of humour to tailor remarks in recognition of the personal attributes of the receiver. On the other hand, this same “knowing” inhibited the use of humour when information became available to the sender of humour that caution was recommended because of the views of an individual.

Claire: Sometimes there can be an undertone, like a negative undertone and it could be certain working groups that have an undertone that their personalities are [not] particularly compatible, and I think people just avoid each other then, and you don't see as much laughter ... Those groups are not the majority, they're the minority (#2 L. 87).

Cindy: [Some groups of staff use humour more than others] [In reference to one group] They're very devote, [sic] very faithful people, so it's a bit more reserved when they're working, so you're a little bit more careful.

Rhonda: It depends on who you're working with ... there's some people I know where I hold back my humour, especially if it's dark [humour] (#12 L. 656).

In the above instances, use of humour was restricted as a result of “knowing” a co-worker and their beliefs. This act of limiting humour reflected an act of respect for the comfort and the values of others. Religious beliefs represented one such category of restraint.

Longevity in Nursing

One participant felt that longevity in nursing in some instances could result in an inhibiting effect on the use of humour.

Maxine: I think there are those people [nurses] who, perhaps because of their uneasiness, being new in a situation, will deliberately use more humour to cover their uneasiness ... others are so focused on their work that they don't have time for humour at the beginning, so they lighten up and other people maybe get less funny as time goes by, because they don't have to prove [themselves] (#7 L. 498).

Maxine contrasted the behavior of two individuals in their use of humour over time.

Humour may serve a different purpose in each of these cases. The individual with more years of seniority who engaged in more humour may have been feeling increasingly comfortable and a part of the "group." Increased skill expanded their focus to now indulge in more frivolous aspects in the workplace. The individual first described by Maxine may also have experienced a lack of comfort and a "need to prove." This person reacted in a different fashion, using humour in a self-disparaging manner – pointing out shortcomings before someone else did.

Not Knowing Co-workers

A lack of connection or bonding with other staff members tended to inhibit the use of humour that was genuine and not disparaging or sarcastic in nature.

Cindy: [One of the physicians] He doesn't even know who I am... I bought some treats for the unit and asked him to drop them off in the unit ... he told the staff, "The lady with the red hair told me to drop off these" ... The other [physicians] have taken the time to know our names whereas he hasn't [taken] ... the time and the effort to get to know the staff (#3 L. 1057).

This physician did not display interest in the individual staff members or the group process. He did not take "the time and effort" to get to know the staff in this unit. His

attitude, in contrast to physicians who displayed an overt lack of respect, was one of apathy. Sarcastic comments were not required to bring his behavior back into line. He was judged to have an apparent disregard for interpersonal details [staff member's names] and would not likely have responded to a joking comment. His behavior disconnected him from the group. Unlike the other physicians, "He wouldn't get it" and the joke would fall flat. He did not partake in the social milieu of this unit.

Setting (Work Versus Home)

Opinions of the participants varied as to whether they used more humour at work or in their home setting. Georgette and Wanda found their use of humour to be similar in the work and home setting. Wanda described how her attitude and consequently her use of humour at home and at work have become more alike.

Wanda: There's [sic] definitely more opportunities for humour at work ... but I think my attitude is the same ... I have the same wit and the same ability to see the humour in things [in either setting] ... I'm a different person than when I'm on breaks because I feel, or used to feel that I had to be quite professional and subsequently I was serious at work ... people were telling me to lighten up ... I decided that I'm just too serious at work and I can transfer what I'm like at home [to] work (#14 L. 435).

Sara felt that her use of humour was more apparent in her home setting, "I use humour more at home ... it's my lifestyle" (#4 L. 634). Georgette agreed, "Even as a new grad. [Graduate from a nursing program] [I used humour] it's always been a part of my life" (#11 L. 1448). Alice's comment also reflected this sentiment.

Alice: I'm probably a lot more serious in the workplace and I would say that I witness the use of humour more than I use it ... at home it's much easier, I'm with people I'm really close to (# 8 L. 937).

Betty, on the other hand, felt that her use of humour increased in the workplace. She attributed this to the fact that in the work setting she was exposed to a more adults (#1 L. 522).

Personal Experience

The personal experience of one nurse provided her with a higher degree of insight into the feelings of family members who were exposed to the sound of laughter when at the bedside of a sick relative.

Stephanie: I didn't realize until my grandfather was sick ... I would sit with my grandfather. And I would sit there and I could hear them laughing at the desk. And I'm thinking to myself, you know it isn't funny. But you don't realize that people can hear you. And sometimes [now] I have to go to the desk and tell them to tone it down (#15 L. 1034).

Patients/Family Members

Deteriorating Patient Condition

When a patient's condition was worsening, the mood was more serious. Deterioration in physical status was often associated with increased activity at the bedside as interventions designed to save the patient's life were initiated. The exception occurred when patients had been declared DNR [Do not resuscitate]. In this situation heroic measures were not undertaken and the patient was allowed to die with comfort measures providing the sole basis of interventions. The demeanor of the nursing staff reflected this reality. Emphasis was placed on getting the work done.

Betty: When a patient's not doing well ... you keep solemn ...it's a little more respectful (#1 L. 154).

Claire: When things are really bad and critical, people aren't laughing. They're responding appropriately (#2 L. 357).

Family Presence

Family presence was seen as an enhancing factor in the use of humour when family members could be incorporated into the humorous situation. Humour with family members provided a means for the nurse to connect with the family. In other circumstances, respect was displayed for the grieving of family members. Consequently, displays of humour were curtailed. Cindy noted, "If you're getting close to terminating treatment ...[we're] way more serious" (#3 L. 231).

Betty: When the patient's not doing well and the family's around, you try to keep a little bit more solemn mood into it because it's a kind of a little more respectful (#1 L. 154).

Nancy: It's hard to [to justify a display humour] when you have family in one side of the room that [are] emotionally upset with their loved one and there is a nurse in the room laughing about something (#9 L. 733).

The possibility of family members, who were not directly involved in a humorous conversation with a nurse, misconstruing comments overheard was also a factor in displays of humour. Humour is less likely to occur in the absence of trust and a degree of rapport between nurses and patients and their families. Maxine described a more extreme potential event of this nature.

Maxine: A patient had sued some doctors and nurses, not long ago at some other hospital [and was now a patient in this CCU] ... the family was taking notes of every single thing that went on ... I thought perhaps I wouldn't put myself at risk for being misunderstood (#7 L. 323).

In summary, factors can be both enhancing and inhibiting in the use of humour, depending upon the context of the situation and the shared meaning of the event to the individuals involved. The physical environment promoted a sense of intimacy that

enabled group members to be sensitive to the need for support of another member. Conversely, this atmosphere made it necessary for members of the immediate environment to respond to the same stimuli [demonstrate respect], despite the fact that circumstances [the context] of one bedside were often dissimilar.

The presence of shared experiences was more likely to be related to one's peer group. Shared understanding then promoted the use of humour within this group. Although rapport was not always prerequisite to the use of humour, the absence of rapport tended to limit humour other than disparaging humour. Likewise, humour tended to be inhibited in the absence of membership within the social structure of this unit.

Table 2 Context of Humour – Assessment, Timing and Consequences

<u>Assessment of the Appropriate Use of Humour</u>
<p>Knowing the Patient Cues Intuition Receptivity</p>
<u>Timing of the Use of Humour</u>
<p>After the Crisis Prolonged 99 Situation Busy States of the ICU</p>
<u>Inappropriate Humour</u>
<p>Content of the Humorous Message Intent of the Humorous Message</p> <ul style="list-style-type: none"> ▪ Fun "Of" versus "Fun With" ▪ Self-care needs of the Nurse versus Patient-care Needs
<u>Negative Consequences</u>

Assessment of the Appropriate Use of Humour

Knowing the Patient

As described under enhancing factors in the use of humour, patients experiencing a lengthier ICU stay were more apt to be engaged in humorous interaction. Participants described length of stay in ICU as a factor in their decision to use humour with a patient or their family members. During this time the nurse gets to know the patient as a person. Betty described using humour, “ In patients that you get to know” (#1 L. 129). Cindy agreed, “...Once you get to know them, you know where they’re at, then you kind of loosen up a little bit more” (#3 L. 213). More information was available to the nurse in assessing the advisability of introducing humour.

Gloria: [I decide to use humour based on] how well I know [the family] and how stressed I sense them to be (#6 L. 956).

Maxine: I like to wait [to initiate humour] until I get a feel for what kind of person it is. [I find out more about] the patient’s attitude and ...what I may have heard in report about family dynamics (#7 L. 371).

Wanda: [In giving information to family members] ... most of the time I’m really factual and uh, unless I’ve gotten to know them [family] really well. Then I start being light and humorous and stuff but I won’t make a really humorous comment right off the bat (#14 L. 207).

Susan: You get to know their history ... [you can tell by] how they respond when you first go into the room ... if they’re kind of stressed out humour may or may not work but if they’re really stressed out, it may not work (#10 L. 310).

Cues

Some participants told of more specific cues that they employed to assess the potential for use of humour in their patients. Bev noted that in a patient, “He’s [patient] got smiling eyes,” which provided a cue to use humour (# 5 L. 192).

Alice: I look at how focused the patient is ...if they’re so single track minded then probably for them I wouldn’t use humour ... but then there’s people coming in [to the ICU] ... they’re sick as a dog but they’re making jokes about how old they are

or whatever ... and there's the body language too ... if they look like they're just tightened and nervous and their blood pressure's high (# 8 L. 480).

Sara: Usually it's facial expression that makes you think [of using humour] ... patients in CCU will usually make a cute comment to you. Just a nice or an opening comment and you know that it's fine with them [to use humour] and so then you can sort of take it back and forth (#4 L. 620).

Rhonda: When I introduce myself to my patients ... my name is so and so, I'll be your nurse today and they say please don't call me that, call me [by their first name] ... And I think right away there's a stronger connection that they're wanting to be more personal (#6 L. 588).

Gloria also assessed the sense of humour of the physicians as an indicator of whether or not they would be easy to work with.

Gloria: I turn around and I say to one of them, "Look asshole." And if he turns around and has a fit or a convulsion and I figure, well you're a write-off (#6 L. 714).

Rhonda equated the assessment of humour with the performance of other nursing assessments.

Rhonda: You look at each of your patients and each of your situations differently and prioritize how you do things ... for me humour is a very strong part of my communication skills ... and with communication you need to prioritize how and when things are done as well as your other physical tasks (# 12 L. 538).

Intuition

Other participants felt that humour was used intuitively, or by mechanisms of assessment that were inexplicable.

Claire: I guess it's just a feel when you talk to someone and if they respond to you ...it's not something you're trained to do. It's something that happens (# 2 L. 254).

Maxine: Sometimes you can just tell by the way someone looks at you (#7 L. 161).

Gloria: It's just a gut feeling (#6 L. 179).

Georgette: Sometimes it's trial and error ... if [I've] said something light and having [the patient] just stare at me ... there's not too many patients in my

experience that haven't responded ...there is the occasional one and I've said, "I just can't click with that patient" (# 11 L. 713).

Cindy: Sometimes it's by instinct but you've got to really kind of know, or it just won't go over at all (#3 L. 173).

Betty: Often times it is used off the cuff (#1 L. 383).

Receptivity

Maxine noted a link between the attitudes of others to an individual and their response to humorous overtures by this person. A lack of rapport made others less receptive to the presence of humour used by this physician.

Maxine: There's a particular physician that I think is funny ... he will at times in rounds send me into fits of laughter, it can be a darkish humour that I don't usually laugh at but with him it was very funny. In the context of all his practice and all of the things he does, some people are very offended by his style, his way of practicing medicine ... sometimes I think some people are inclined to paint the entire person with the same colour brush ... if they are offended at that person in one area they just choose to be offended in all areas (# 7 L. 422).

On the other hand, the tone of an interaction can be set by the rapport between two persons, prior to a word being spoken. An air of expectation precedes a humorous interaction in this situation.

Claire: With certain co-workers ...they tease me and I tease them, and we just start. The mood is there...as soon as I see one of them ... as soon as he sees me he starts to laugh (#2 L. 158).

Timing of the Use of Humour

After the Crisis

Humour was often associated with unpleasant events and periods of stress and busy times in the ICU. Most participants agreed that humour was not likely to be used at the height of a crisis, but after the crisis had abated. During the crisis, energy was focused on dealing with the situation at hand. Humour then became apparent after this point as a sense of relief was felt and a semblance of control of events achieved or recaptured.

Betty: [Humour is used] probably more afterwards, [a 99 situation] during it there might be light things said as well ... probably more afterwards when things are under relative control. Like if you're working on a person and end up giving them umpteen milligrams of epi [drug – epinephrine used in 99 calls] ... once you figure out what's happening (#1 L. 189).

Sara: The stressful period comes, you deal with that, and as soon as the urgency is over with, someone usually makes a comical remark (#4 L. 86).

Cindy: You know where it's [the 99] is going to go [whether the outcome of the 99 will be successful or not] ...when it's at the end [of the 99] ... when the tension starts to drop a little bit and you start to relax a little bit (#3 L. 293).

Bev and Sara described the influence of nursing experience on the timing of humour. More experienced ICU nurses were more inclined to use humour during a 99 or other crisis. These nurses may not have perceived the same "height of a crisis" noted by other nurses and other health care workers. Their experience may have coloured their perception of a stressful event. This ability to laugh or initiate humour at a time, when others perceived only crisis, may be viewed as macabre humour.

Bev: I think that you see humour after, not during it [99 situation]. Immediately afterwards. You don't have time in a 99 situation ... maybe some of the more experienced ones [use humour more in the midst of a 99] (#5 L. 810).

Sara: I think it depends on how long you've worked in an area as to how you feel about the timing of humour. Initially in any situation you stabilize and then you go ... If you were newer to it and very tense, it may be very hard for you to deal with some of the remarks, but as you go along and do this, the more you realize somebody needs to say something to break the tension up and always working with different residents and at times they're own ease or tension plays into it (#4 L. 519).

Prolonged 99 Situations

Some of the participants noted that humour was more apt to be used when more time elapsed during a 99.

Gloria: [Humour is more pronounced] after the height of the crisis in a 99 – once the 99 is underway and the initial assessment has taken place and the situation is a

little more under control ... towards the later stages when the 99 is prolonged (#6 L. 718).

Maxine: It would be after or sometimes if a 99 has been going on for a long time and you kind of knew what the outcome would be at the outset, that it wouldn't be very good – then it's not such a situation where every person is straining to do all they can ... sometimes when you've used up all the drugs on the [99] cart ... I think it's to help us feel better about the death (#7 L. 825).

Alice: Once they [99 team] realize that this person isn't going to make it and they try a few more things, of course there's no family nearby (#8 L. 689).

A prolonged 99 allowed the staff members to regroup. The situation became more under control. Uncertainty was replaced, in part, by humour. The need for advocacy may at times spark humour as a vehicle for conveying a message to the physician in charge of the 99, as the futility of the efforts becomes more apparent to those nurses involved.

Busy States of the ICU

Participants described their use of humour when the unit became really busy. Elements of self-talk were present in an effort to alleviate a stressful situation – the potential loss of control and unpredictability that may have been associated with the increased pace of activity.

Maxine: I think that humour is more prevalent here when things are really busy and staff is stretched and there's more work to do than can get done ... and we like to laugh and have a good time and help one another and sometimes there's just lots to laugh at when there's chaos all around (# 7 L. 862).

Alice: I would say I use humour less when I am busy ... unless it's just that I'm so busy that all [I] can do is laugh at that point and say I'm so far behind and giving my ten o'clock meds at one o'clock (#8 L. 417).

Wanda: I'll use humour when we're kaka busy to relieve my own stress ... I'll just say, "Yahoo," sometimes or, "Here we go," you know, just to relax myself ... it gives me like a two second break and [a chance] to refocus so I can work a little better ... this may be on the way to a 99. And there [during a 99]. Because it's pretty crazy when you're there (# 14 L. 543).

Inappropriate Humour

Inappropriate humour can be a function of its content, intent or style of delivery.

The content of humour is often context-specific. Participants revealed a high degree of tolerance for the content of a humorous message. They deemed humour to be inappropriate most often on the basis of its intent, timing and style of delivery. During my fieldwork I noted that the content of jokes was often directed to one's own culture, a factor that provided much more leniency in terms of its acceptance (Personal Journal).

Content of the Humorous Message

The content of humour can be offensive when reference is made to minority groups or small segments of the population i.e. "Blonds."

Betty: I'm not into ... inferences made to various body parts [need to be] kept to a minimum ... off-colour jokes too ... (#1 L. 448).

Claire: Sexist humour isn't particularly funny and some people don't find it too funny (#2 L. 322).

The content of a humorous message is not a definite predictor as to how the message will be received. Other factors will be described that help to determine the response of an individual. Sara explained that comments not directed to her as an individual were not offensive to her.

Sara: I'm not really easily offended so I don't get too uptight about things like that. There's only been about, since I've worked here, two people that have been inappropriate in their mannerisms ... and they were [the same] with everyone ... I don't take it as directly towards me, and I don't really get flustered by things like that, so it wasn't appropriate, but [it's not a big deal] ... We have lots of people who call you cutie or call me the little blond one, I don't take offence to that at all ... (#4 L. 195).

Alice made the distinction between humour that was deliberate or accidental. Accidental humour that was directed at a characteristic or trait of an individual was more acceptable and therefore more easily tolerated.

Alice: Certain things regarding my religion I won't tolerate ... and sometimes stuff comes out of people's mouths and they don't even know they say it ... to me that's not a problem ... it's the attacking, deliberate kind of humour that I won't tolerate (#7 L. 925).

Sara: There's jokes about blondes, about ethnic origins and as long as it is random ... as long as there's not an onslaught ... I would find it offensive if someone was always gearing towards Native Canadians, [or] gearing towards Polish people (#4L. 352).

Intent of the Humorous Message

"Fun Of" versus "Fun With"

A message conveyed with an attitude of caring can transform the intent from "fun of" to "fun with." An aura of caring can transcend the content within a joke or a statement and thus perception of, from inappropriate to appropriate.

Claire: [the assignment of humour as inappropriate or appropriate] depends on the people ... I guess they have to feel each other out whether they're willing to accept [certain types of humour i.e. sexist] ... sometimes you'll get a group of residents that [have] worked together all their lives in medicine and they can be pretty risqué with some of the things they say, and tease and do what not (#2 L. 327).

In this situation, the benefits of "knowing" the person" as the recipient of humour decreased the risk that humour would be perceived as inappropriate. Humour that is not accompanied by caring may alter the intent of the message to "Jokes that attack or put down" (#6 L. 107).

Maxine: I think humour, if it's truly humour, ought to benefit the person or people involved ... I don't think it should be at the expense of someone ... I don't think humour should ever diminish people (#7 L. 519).

Stephanie described some of the rumours of the unit as “vicious.” She commented on the nature of some of the comments placed in the “Gentle Gossip” book. The personal nature of comments included crossed the line between humour and good taste and was inappropriate in her eyes.

Stephanie: [written in the book] Such a person is doing this and this and they don't realize that they're actually, you know, what they're writing in there could be demeaning to somebody ... it's nobody's business (#15 L. 186).

Self-care Needs of the Nurse Versus Patient-care Needs

This type of inappropriate humour, in contrast to the previous deliberate humour, was more reflective of a lack of or lapse in recognition of other's needs. Similar to the description of the needs of the nurse as self versus patient needs, the balance may be temporarily offset, with inappropriate humour as the result. An individual or a group may interpret humorous remarks in a different context. The shared meaning of humour to one group of nurses is deemed inappropriate to another group of nurses who attach a different significance to the comments.

Cindy: There's times when you kind of wonder where the priority is ... planning some social event while we've got a full unit ... there's a time and place for everything ... that's why we have coffee breaks (33 L. 1237).

Sara: They forget that there's more than just their patient. The people you're dealing with [assigned to] are all doing well but somebody else in the unit isn't ... I think if there's someone [nearby] who is very, very ill and there's family, I find that inappropriate ... I think it comes from the fact we're assigned one- on- one patients and you're dealing with them and it's very true that you might not necessarily know what's happening in the other room (#4 L. 396).

Alice acknowledged the dilemma when ICU personnel engage in humour during a 99 situation. Bystanders [ward staff] perceived the humour used by the ICU staff as uncaring and inappropriate.

Alice: When we're in a room [when a 99 team from ICU travels to the patient's room on a ward to resuscitate a patient] we don't necessarily think about bystanders ... and then our humour just flies. And I know it has been upsetting to some ... and understandably so. They know this person ... this may have been someone who's been there for several weeks that they know and have gotten to know the family ... you'll hear some of them as they're walking down the hall ... you'll hear some comments behind your back (#6 L. 223).

Cindy identified the need for caution in the pranks played by staff members on one another. A playful antic invites repercussions if equipment is toyed with or damaged. In this case, the joke results in a monetary expense to the unit if equipment is damaged, or an expense of time if personnel are required to clean up the aftermath "You don't do anything to play around with ... or damage the equipment" (#3 L. 740).

Negative Consequences of the Use of Humour

The risk of not responding or misinterpreting cues is always present. As previously described, some factors such as the open physical environment may be facilitating or inhibiting to the use of humour, depending upon the circumstances. Other factors are specific to individual patients. Assessment is crucial. The line between acceptable and unacceptable humour was sometimes evident only after it had been breached. Situations where factors inhibiting the use of humour were not heeded resulted in increased risk of negative consequences for patients and their family members.

Mixed Messages

The nature of many humorous comments is comical because of their double meanings. The expected effect is that the recipient of humour will view a subject or individual in a new or unexpected light. This double meaning can also be a source of misinterpretation if the recipient interprets the message in a manner not intended by the person delivering the humour. Humour is then modified from a therapeutic to a

nontherapeutic modality; driving a wedge rather than forming a bond between the parties involved. Susan noted the potential for the intent of a humorous message to be misconstrued.

Susan: [I feel comfortable using humour with the doctors] as long as it doesn't break with my professionalism ... humour in the sense that it may come across as flirting (# 10 L. 535).

Maxine expressed concern that family members would intercept humorous messages intended for ICU personnel. Unlike humorous comments, placement of cartoons and other written materials, by virtue of being tangible and more permanent, are not always within the control of nursing personnel when they are placed in an area accessible to visitors. The danger in this circumstance is that family members may attribute this information as reflecting a lack of respect and caring for ICU patients on the part of the nursing staff. The meaning of a joke is different for family members than ICU personnel. In this type of humorous communication the patient is often the "butt" of the joke.

Maxine: Pictures from a nursing magazine that were about certain types of doctors or nurses, certain types of patients in situations were placed in the nurses' washroom] ... it makes me uneasy ... it seems hurtful ... if that patient or doctor or nurse were right there and you were laughing at them, I wonder how they would feel ... it seems kind of cruel to me ... you're criticizing not one but a whole group of people ... what if a patient's family [member] were to walk into the bathroom by mistake, what would they think, looking at what we thought was funny ... I think they would be greatly offended, or think that we who seem to be so caring on the surface really weren't caring if we could laugh at stuff like that ... [information that is written and displayed on a wall, as opposed to a comment] is making a pretty strong statement about who we are and what we value and don't value (#7 L. 656).

In direct interaction with patients, nurses responding to the superficial content of a patient's comments are at risk of being viewed as not caring. Humour in this instance impedes meaningful communication and the opportunity for the nurse to acknowledge

the patient's difficult circumstances and perhaps the patient's attempts to carry on despite these challenges. Humour may also represent an attempt to prevent the patient from engaging in further exploration of troubling emotions. The incongruity in the patient's emotions and the circumstances present, may provide cues that need to be heeded in refraining from or responding to humorous discourse.

Claire: [In describing her interaction with a CCU patient] he's in a major denial stage and that's where he is so there's no point in pushing him, ... he might think that you're making light of his illness, and that's the last thing you want him to think ... the risk for them [is] to think that we don't care ... that we're belittling their illness ... if they took it the wrong way, they might think we think it's a big joke (#2 L. 263).

Susan: Sometimes patients will use humour if they [have] found out bad news and ... because it's their way of coping, whereas if you start going along with [them] and saying humorous things to them they may [think] she doesn't even care ... (#10 L. 458).

A seemingly innocent comment intended to relax a patient may have the opposite effect. A deficient piece of equipment may be interpreted as representing a facility and nursing staff that is unreliable.

Alice: If you're joking, "Oh, the equipment around here isn't that great ... if you're joking but they think you're serious they may take it the wrong way [and think] that this is an incompetent facility and equipment here is not [reliable] or that you don't know what you're doing and they won't have the confidence in you (#8 L. 564).

The need to monitor comments is important. The open nature of the ICU and the constant nurse-patient proximity are factors in conversations being witnessed by others than for those whom the message was intended.

Georgette: You have to make sure that no one is around to hear ... sometimes the walls have ears ... some people make comments in front of the patient. And granted, yes the patient may be comatose, but again we don't know what the patient hears and we also don't know who's listening around (# 11 L. 654).

Rhonda: ... Other patients might hear something that's not quite appropriate in the wording that you may have phrased it in and you have to be aware that there's

other people that may consider themselves this type of patient. And they may be thinking you're saying jokes about them (#12 L. 417).

Unintended or Undesirable Consequences of Humour

Participants recounted negative consequences that they had experienced or had witnessed in humour gone awry. The consequences ranged from mild annoyance and discomfort to devastation for family members already at the height of crisis.

Betty: I had a patient [a Nun] who ... was paralyzed ... I had her a lot and one day I was doing her nails and she couldn't open her eyes because she was paralyzed and I said, "I'm going to paint your toenails red." Well she, her heart rate [went] way [up] – woom (#1 L. 140).

Humour at the scene of a 99 can have disastrous consequences.

Cindy: They had a 99 on the ward a few years back and they [ICU staff] were cracking jokes in the room, but the family was actually standing out in the hall (#3 L. 272).

Stephanie: One year [the 99 team] got heck. They really got heck that they wore their Christmas hats, Santa hats and they called a 99 and no one [remembered], they forgot to take off their hats. So they went running to this 99 with the Santa hats on (# 15 L. 1577).

Three participants recalled suffering repercussions following humour that was not well received.

Betty: I've been told about my loud voice... When I haven't noticed that there is a sick family, or a sick person with family around and they'll [other nursing staff] tell you to shut up, and point and that kind of thing (#1L. 333).

Ricki: I thought I was trying to make him [the patient] smile and he says to me, "Why don't you go back to your own country?" So I said, "O.K." I just left him ... and from then on I tried to assess things before I start joking around (#13 L. 347).

Wanda: One time I was in the staff lounge and I made a comment about [a religious group] and I got booed down for that one. This one girl was really offended. It was just a joke (#14 L. 513).

In summary, the previously discussed features of the use of humour included those factors that were more or less likely to result in the use of humour. The decision to

use humour was based on assessment of the perceived risk / benefit of the results of using humour. Assessment of risk /benefit may involve a conscious evaluation or a more spontaneous outburst of humour in response to less specific stimuli. Some participants referred to an instinctual understanding guiding them in their use of humour. Others were more precise in their appraisal of a situation amenable to the introduction of humour. The context in which humour was used was multi-factorial. Factors surrounding the use of humour were at times inexplicable. The personal nature of humour was reflected both in the appraisal and the reception of the “initiator” and the “responder” to a humorous stimulus. As with any mode of communication, two-way messages occur. Identical circumstances may represent a source of enhancement of humour to one individual and of inhibition to another.

Aside from the factors encouraging or discouraging the use of humour, the element of timing was critical. In equivalent circumstances, an individual’s decision to use humour will be based on a sense of timing. All other factors being equal, timing can be a strong deterrent or facilitator of the use of humour. Inappropriate humour may be the result.

Participants alluded to negative consequences more than they were described. Two reasons are possible. Participants may have been reticent to share a less than optimal outcome of humour in an attempt to protect themselves or their co-workers. Another possibility may reflect the sophisticated and astute assessment skills of the participants. Given the caution expressed by individuals and the ability to discern many contextual and instinctual variables, the latter reason is plausible. Constant nursing

presence and rapport with patients may be instrumental in reducing the incidence of negative consequences.

The Meaning of Humour

The Intensive Care Unit (ICU) embodies an inherently stressful milieu. All patients admitted to this area are critically ill. In this tertiary [referral centre] hospital, ICU patients may be transferred from rural settings or other smaller ICU's not equipped to handle a patient with an extreme illness. There are no exclusion criteria related to severity of illness – no patient can be too sick for this place. The pace of the unit ranges from busy to chaotic as many patients simultaneously hover at the brink of death.

Nurses in this setting care for one or sometimes two [more stable] patients at a time. The line between the disciplines of medicine and nursing blurs as nurses make split-second decisions about critically ill patients. Collaborative practice is key. There is mutual admiration, trust and respect between physicians and nurses, as physicians come to recognize and rely on the judgement of the nursing staff. Physicians rely on the expert assessment of nurses to prevent or promptly recognize potential crises. Nurses, on the other hand, depend on the proximity of the physicians to manage the life-threatening events common to ICU patients. For example, nurses titrate [adjust] medications that continuously infuse into central veins [large veins entering the heart]. ICU nurses often treat a precipitous drop in blood pressure before, or during the process of alerting the physician. In a setting other than the ICU an emergency code would be initiated in a similar situation. Advanced educational background in the specialty of ICU nursing promotes a sense of pride and confidence in the nurses.

Evidence of humour in the ICU setting may be unexpected, given the life and death scenarios that are an integral and continuous presence in this environment. Yet, it is precisely because of the dramas that unfold in the ICU, whereby a very human dimension – humour – is found.

Table 3 Meaning of Humour –The Use of Humour by Nurses

CO-WORKERS	SELF-BALANCE	PATIENTS AND FAMILY MEMBERS
Humour and ICU Chaos: An Overview	Self-Care Versus Patient-Care <ul style="list-style-type: none"> ▪ Self-Talk: Controlling Uncertainty and Creating Competency ▪ Striving for Emotional Control ▪ Self-Caring ▪ Self-Preservation and Group Caring ▪ Humour as Avoidance Device: Anger and Denial 	Easing the Tension
Improving Co-worker Dynamics <ul style="list-style-type: none"> ▪ Getting Along: Increasing Group Cohesiveness <ul style="list-style-type: none"> ▪ Increasing Group Cohesiveness During Admission ▪ Floating 	Exposing Versus Disclosing <ul style="list-style-type: none"> ▪ Increasing the Distance: Humour as a Shield ▪ Decreasing the Distance: Self-disclosure <ul style="list-style-type: none"> ▪ Personal Self-disclosure ▪ Professional Self-disclosure 	Creating a Therapeutic Milieu During Admission
Humour in Code		Humour As a Nursing Intervention <ul style="list-style-type: none"> ▪ Nursing Presence ▪ Teaching of Patients and Family Members ▪ Distraction
Conveying a Difficult Message <ul style="list-style-type: none"> ▪ During a 99 ▪ Information Giving ▪ Challenging 		Conveying a Difficult Message: Empowering <ul style="list-style-type: none"> ▪ Information Giving: Empowering Patients ▪ Advocating for Patients and Family Members
Empowerment: Humour as a Decentering Device		
Fun with Co-workers		
Running Jokes – Perpetuation		
Retrospective – Reframing		

Use of Humour by Nurses in Relation to Co-workers

Humour and ICU Chaos: An Overview

Cindy: Sometimes when the unit is packed, and we're just flying, that's when it [humour] really starts coming out because ...it's your way of coping, to get through the shift (#3 Line 240).

Humour provides a means of de-escalating the chaos and helps nurses to survive an eight or twelve hour shift. Humour permits nurses to rise above situations as they "fly" around the patient bedsides. Nurses are greatly challenged to respond quickly to rapidly changing events in the ICU – especially in their quest to maintain "patient's physical integrity." Humour can improve the quality of the nurses' life as she/he not only gets through the day, but also "emotionally" integrates the experience. Humour can provide a boost of energy required to meet the physical challenges of a busy eight or twelve hour day.

Maxine alluded to the humanizing aspects of humour when she says "[Humour] makes you feel less like a rat on a treadmill (# 7 Line 890). The experience of being on a "treadmill" and going in circles is physically exhausting and potentially demoralizing. Humour provides a way off "the treadmill" – a different way of viewing the situation. The cup that was half empty is now half full. A sense of control can be regained and one's actions become more meaningful through the application of humour.

Maxine: When there's chaos all around it just really helps to share the laughter with one another and the festivities give it an unspoken way of saying, you know things aren't that bad, you know they're going to get better and you can get through this ... (#7 Line 875).

Humour facilitates reaching out and "sharing" through laughter. In the midst of technical and physiological chaos, human bonds are strengthened with the realization that

one is not alone, that others are sharing in the experience. A sense of survival is also promoted when humorous “festivities” suggest better times ahead.

Claire described the use of humour as a form of cleansing or catharsis, both emotionally and physically and as a means of decreasing tension.

Claire: Nurses...will sit and cry with a relative after a death...so I think they need the humour and need to laugh and let the old endorphins flow, and feel a little bit better afterwards (# 2 Line 507).

The nurse must first care for his/herself before caring for others. Nurses are able to impose a kind of control in a situation where many factors [patient related] are beyond their realm of control. Creating order out of chaos is achieved through acknowledging and emotional release. The sense of control, i.e., generating order, lies partly in timing the release of emotion. After the event [death] the nurse expressed her feelings and continued to nurse the family. The laughter and tears that helped to begin the healing process enhanced the sense of personal calm and professional competence after the death of a patient. This nurse was then able to move forward “emotionally and professionally.”

Under certain conditions, humour is used more frequently, as tensions more dramatically increase. These situations lend themselves to displays of humour when tensions build and team-members work in close proximity. The following exemplars illustrate the various aspects of humour involved in releasing such tension. The multi-faceted nature of the use of humour is also illustrated. Humour can simultaneously serve several purposes. Each instance of humour can be interpreted on more than one level. Although humour serves a variety of purposes, caring is always at its core. Those who use humour care enough to impart a message despite its potentially controversial nature.

A humorous comment can relay a sense of caring as a method of saving face, from a professional or a personal standpoint.

Improving Co-worker Dynamics

Getting Along : Increasing Group Cohesiveness

The use of humour was significant in the day-to-day functioning of the critical care unit. It served as a social lubricant enabling co-workers to work together in close proximity, under conditions that were sometimes tense.

The essence of humoring an individual is seen in the following situation. The use of humour may be required to coax a co-worker to perform his duties. Other means that were more confrontational were not effective with this individual. On one level humour is apparent, but on another level resentment can be present as the nurse recognizes that she will not receive assistance unless a joke is used. It is common knowledge among the ICU staff that this type of humour arises "out of necessity" to get the job done.

Cindy: [This co-worker] is very, very different [unusual and difficult to work with]... if you argue with him, he won't help you out...you're off the list... so if you can joke with him, he will be there to help you...so sometimes it's out of necessity to play around with your co-workers a little bit...I'd say probably 60% tease their co-workers...(#3 Line 340).

Potentially tense situations were averted through the use of humour.

Claire: [During rounds I was talking to some of the docs about my sore foot] we were looking at some intakes and outputs [sheets to tally fluid balance] and they're [the physicians] were looking at the totally wrong sheets [the wrong patient's] and they're studying and studying them and I'm trying to get away from them to give them the new sheets and I finally got them away from them and I gave them the new sheets and said, "You know, you guys memorized the numbers yesterday, work on this sheet." And the doctor said, "I think I know why her foot's sore. She's been kicking butt" (#2 Line 447).

The physicians were informed that they were looking at the wrong sheets without directly saying so. Their good intentions and hard work were acknowledged in the

reference to their memorization, although the term can also allude to lack of thought. The “give and take” atmosphere continued, as the nurse had to contend with teasing about her foot and her blunt statement. The physician, in his teasing comments, displayed his interpretation of the situation “She’s been kicking butt.” In a jovial manner he let the nurse know that he had picked up on the same information that she now had mentioned “studying the wrong sheets.” He also communicated the fact that he had taken note of the approach she has used in “giving the gears” to the physicians in rounds. Both parties – the nurse and the physicians saved face in this situation.

Beyond getting along, humour can be a powerful tool to increase the closeness of a group and promote teamwork. Two participants put it simply.

Maxine: [Humour] is a way of bonding together human relationships (# 7 Line 359).

Claire: They all tug together and work hard...(# 2 Line 66).

A connection is forged among co-workers who have common goals and who work hard together. A “we’re in this together” mentality emerges and individuals feel supported as part of the team.

Wanda: [Humour] helps the group to be more cohesive...because if they appreciated the humour they feel like they have a link with that person...so they work better as a team...I guess it’s part of getting along (# 14 Line 53).

Teamwork is enhanced as individuals work together not only as co-workers, but also as persons. In the previous situations, the unique characteristics of an individual were recognized – a co-worker who responds to jokes and a nurse with a sore foot from “kicking butt.” “Knowing the person” strengthened the emotional link between individual team members.

Increasing Group Cohesiveness During Admission

Admission to the Intensive Care Unit is a stressful time for nurse and patient alike. The nurse must quickly assess the condition of the patient. In cases of instability of patient condition, numerous lines must be set up and flushed through with solutions, while simultaneously administering treatments and medications. The ABC's [the basics – airway, breathing and circulation] of treatment frequently require that patients have tubes immediately inserted to facilitate breathing. Potent medications are administered to sustain a pulse or blood pressure. The family meanwhile awaits a visit with their loved one and explanation about the plans and prognosis.

Fieldnotes: When the patient arrived he was in extreme respiratory distress, requiring immediate intubation [insertion of a breathing tube]. The atmosphere was not really tense, but more tentative...it may have helped that [the nurses and physicians] knew this patient from before and that he was placed on no 99 status [would not be resuscitated in the event of a cardiac arrest]. After arrival, the physician was getting ready to intubate and the nurse was trying to find a site to give an intravenous medication [looking for a spot to start a fresh intravenous in a patient with many tubes can be difficult and time-consuming in a situation that required haste]... (p. 38).

I was able to witness the admission of several patients, in both stable and unstable condition. In each instance I noted a heightened tension, accompanied by an increased use of humour. The noise level escalated as more equipment was readied and people gathered around the bedside. The beds in ICU have no headboards and the side rails were not put up. During admission of a critically ill patient the bed is moved toward the centre of the cubicle, or often the middle of the unit, to allow personnel to completely encircle the newly arriving patient.

Although my presence may have created an added stimulus, awareness or a tendency to use humour, I noted its consistent use in every admission.

Fieldnotes: She [the nurse] couldn't get the medication to run in [to the vein] [a bit tense] and she didn't notice that the buretrol was empty [there was no fluid in the intravenous for the medication to be delivered in]. The staff man [physician in charge of the unit] standing behind her pointed it out to her [a little bit testy]. Realizing it was a bit of a put-down he made a comment about it being difficult to see from her vantagepoint [she was short]. This seemed to relax everybody (p. 40).

The physician in this case helped to diffuse a potentially tense situation. The professional integrity of this nurse was tested in a small but very public way. Several nurses and physicians were witnesses to her gaffe. The physician's humorous remark revealed a compassionate side as he displayed sensitivity to this fact and helped the nurse to save face. This nurse was acknowledged as a person [a short person] who made a little mistake for reasons that were beyond her control. The nurse's professional and personal integrity was restored. Integration among team members was promoted.

Other nurses at the bedside carried on with this [short people] theme.

Fieldnotes: Another nurse came to the bedside and made the comment that the bed was getting closer to the ceiling all the time and that soon a change of assignment was going to be needed [physicians putting in lines and performing procedures need the bed to be at their level and unfortunately this is not always an optimal height for the nurses] These comments seemed to energize the group (p. 41).

The focus shifted from the nurse to an inanimate object – the bed. This fact enabled the nurse herself to participate in making humorous comments and be a part of rather than the object of further comments. The inanimate status of the bed provided a safe outlet for jokes. A collective understanding was achieved when all persons involved knew the content of the humour. An understanding, on more than one level of meaning, was accomplished. The group at large shared these experiences, contributing to a sense of closeness. An underlying respect for co-workers as individuals and professionals was strengthened.

Floating to Another Unit

Being asked to fill-in on another unit [floating] is stressful to nurses who consistently work in one area, often stretching the limits of one's professional flexibility. The comforts of familiarity are lost, making even simple tasks difficult, in the search for the proper equipment. A sense of a supportive working environment is lost or diminished if one is not acquainted with co-workers on that shift. A nurse described one of her experiences while floating to another unit. Stephanie used humour in these instances to preserve her professional integrity in a setting where she was not known.

Stephanie: I went to get a urinal and I spilt it on the floor...So I just grabbed the mop and I'm mopping the floor when the charge nurse came by and said "What the hell are you up to?" I said, "Well, I had some down time so I'd thought I'd mop the floor" (# 15 Line 1157).

Her response to the questioning by another nurse was facetious, thus relegating the question to this same perspective. She effectively dismissed the notion that her action might attract a query and offered a response that exuded impeccable judgement and confidence.

She continued: [I couldn't find the tongue depressors so I just walked around] and said "If I was a tongue depressor where would I be?" They all put down their pens at the desk. They stop [ped] and look [ed] at me and then they point [ed] over to the thing (# 15 Line 1170).

The lack of comfort in this setting was evident in the "me/they" tone of this scenario. Stephanie demonstrated her intent to problem-solve independently. On one level, she was drawing attention to her small plight. The rhetorical nature of her comment was intended to send a message that she would not overtly ask "them" for assistance. This ploy was effective as "they" immediately stopped their work and provided the

answer. She became less an anonymous new face, forcing the onlookers to sit up and take note of this “float nurse.”

Humour in Code

Other nurses described more subtle means of displaying humour. These types of humour were less obvious to a bystander [patients and their families] and thus could be engaged in at the patient bedsides. This more subdued humour was safer to use. Risk of offending patients in the midst of agony or discomfort and families witnessing was reduced. A conversational tone could be used to make a comment, with or without accompanying laughter, while working in an uninterrupted fashion. The meaning of these “in” jokes would be understood by the ICU staff but not necessarily by onlookers.

Betty: I’d say [we use] deadpan stuff, you know. Saying one thing and meaning exactly the opposite (#1 Line 562).

Claire: We just tease each other (#2 Line 167).

Cindy: It gets a little bizarre and there’s all these little hidden jokes...patients have no idea what the hell you’re talking about (#3 Line 248).

This shared meaning was evident in some of the phrases coined that were specific to this unit. Cindy gave examples of “in jokes” shared among the staff. Some of these would have no significance to an “outsider,” without an explanation. “In jokes” often began with an experience in the unit that was referred to in later situations. In one case, the phrase “you can’t have a pulse without a rhythm,” occurred during a 99 when a nurse mistakenly thought she felt a pulse in a 99 when there was no heart rhythm on the monitor (#3 Line 260). This was referred to in subsequent situations. The significance of this statement would not be apparent without having been present at the 99 or having the story told by a staff member. A sense of belonging was enhanced when staff members

were informed and thus included in this joke. Furthermore, this “humour in code” provided a safe outlet for humour in the presence of patients, families or onlookers.

“Humour in code” was also evident during my fieldwork. A patient in unstable condition was “lifeflighted” into hospital by air ambulance in unstable condition.

On arrival the patient already had “many lines in situ”. While changing the patient over from the monitoring equipment of lifeflight to the ICU equipment a nurse commented on his heart rate of 142 [beats per minute] She said, “Nice heart rate” with a laugh. Other similar comments were made about the amount of medication the patient required ... When the oxygen saturation monitor [placed on the finger] would not pick up [the signal was not being relayed properly because the blood flow to the finger was so diminished] another nurse said “What do you expect with Dopamine running at 10 mcg/kg/min. [speed of infusion of the drug] (Fieldnotes p.93).

Those present understood the meaning of these statements. The powerful drug (Dopamine) caused the increased heart rate and worsened the peripheral perfusion. At 10 mcg/kg/min (a high dosage range) Dopamine diverted much of the body’s blood flow to the heart and vital organs. Thus the oxygen saturation monitor did not register on the surface of the skin. A tone of humour was used to impart this vital information, ensuring that personnel at the scene were aware of this fact. The nurse exposed this knowledge in a manner that reflected an air of calm recognition of the situation. The patient was subsequently changed to another more potent drug, Levophed (Norepinephrine) or “Leave’ em dead”, as it is commonly known.

On the surface, the words of the nurse may appear sarcastic in nature. A rhetorical vein is also apparent if one considers the fact that responses were not always expected (nor provided) to the comments. If an alternative inflection is considered - a “matter of fact” voice displaying no emotion - group dynamics are not altered – for better or for

worse. Another option, a voice displaying concern, might result in a mood of increasing alarm amongst the group at the bedside.

The patient was also a member of this scene. The nurse, in monitoring the tone of her comments, was likely aware that the patient may not comprehend the medical jargon of a conversation, but was apt to sense the existence of anxiety in his caregivers. The more jocular quality of this interaction served the purpose of imparting pertinent and vital information. Coincidentally, the impression was conveyed to the patient that the situation was under control and all was not lost. The need of the nurse to verbalize her underlying concerns may also have provided an emotional outlet during a potentially tense time.

Coined phrases such as the “Hershey Highway” (Fieldnotes, p. 58) are also part of the unique language of this unit. As the name suggests, although not immediately apparent, this phrase made reference to multiple or large bowel movements. Use of this term is obtuse to bystanders, while eliciting a flicker of humour to those who must do the unsavory job of clean-up.

Conveying a Difficult Message

Residents [physicians training to become specialists] rotate through the ICU, providing medical coverage on a 24 hour a day basis. Their level of knowledge and experience in a critical care unit is variable. In some instances the nurse will have more experience and comfort in the ICU than the resident. Nurses informally provide orientation to the unit to those residents who are receptive. Even the routines specific to ICU, the paperwork and technology, can serve to undermine the confidence of a resident, despite an in-depth knowledge of the principles of disease. The emotional impact of critically ill patients on the resident, coupled with the need to make instantaneous

decisions about life and death, is not lost on Critical Care nurses. Team-work is exemplified in comments by nurses designed to help a resident navigate through a new or unusual situation. Physicians or residents who do not “hear” the nurse are treated to varying degrees of wrath by nurses, depending upon the sense of danger that nurses perceive to themselves or their patients.

During a 99

As an emergency situation, a cardiac arrest [99 code] requiring resuscitation of a patient without a heartbeat or respirations presents many potentially stressful elements for a Critical Care Nurse. Immediate clinical expertise is required to bring this person “back from the dead.” An experienced ICU nurse does not necessarily find the 99 situation itself intrinsically stressful, but rather some of the events accompanying the 99. Participants universally expressed frustration at being involved in prolonged 99 situations, when all available treatments had been tried unsuccessfully and the chance of recovery [with a return to normal or previous brain function] was, in their view, virtually nonexistent. Tensions ran high when the opinions of the nurses and doctors varied as to whether or not a 99 should be initiated in some cases, or when it should be terminated.

During such a situation [prolonged 99] a nurse described her comments to the patient and personnel in the room at large. This type of comment is traditionally referred to as the macabre humour associated with a scenario that is not considered funny in a traditional sense.

Gloria: “George,[patient] make up your mind. Are you coming or going? ... We can only bring you back so many times. Make a decision”... I turn around and say to somebody [patients in prolonged cardiac arrest] “it’s okay to go”... some people don’t understand it, but I see it from a different angle... for many people they fight so hard until they’re given permission or until the last person they’re waiting to see arrives, they won’t give up (# 6 Line 255).

Although a 99 is not a humorous event, this nurse acknowledged the delicacy of the event in her twist of humour and in the direction of her comments to the patient himself. Aware that the physician could be offended at the suggestion that he/she make [up his/her mind] a decision, she directed her comments to the patient. She conveyed information [perhaps the time has come!] and also educated those present about the spiritual dimensions of this imminent death. The physician's lack of experience or expertise was not directly addressed, although there was tacit understanding. Given this understanding, this humour was not macabre but advisable and the sensitivity displayed commendable.

While I conducted my fieldwork I had opportunity to observe the caring this nurse exhibited to her patients and their families.

Fieldnotes: She sits close to her patient's bedside (p.141)... the family are camped out by the bedside on an overnight vigil [a patient in his 50's admitted following a large heart attack and a poor prognosis] (p. 138).

Her volunteer work is also a passion in her life as she expresses her interests in various organizations, sporting many pins on her shirt. I noted, "beneath a gruff exterior lies a very caring person" (p. 231).

Multi-dimensional aspects to the use of humour are present in these situations.

Humour not only serves a variety of purposes in each case, but also creates more than one level of meaning. The superficial or apparent statement of humour affords a degree of sophistication in delivering a more blunt underlying message. Humour always serves a purpose, although its meaning may not be immediately evident to the observer. Gallows humour exemplifies a type of humour so unique that its meaning is universally misinterpreted as macabre, to the uninitiated. The underlying meaning may be lost on the observer, who may be unaware of one or more levels of its significance. An element of

caring is evident in these situations. Humour serves to decrease tension, helping nurses to survive chaos, from a professional and a personal standpoint.

Humour was used to impart information in an expedient yet non-threatening manner in the following scenario. On a basic level, direction was offered.

Nancy: One time during a cardiac arrest they were just going and going and going. And they just didn't want to give up and there [reached] a point where we were just all standing there. And Bert [unit assistant] was continuing to do compressions [heart massage]. And I was watching him, watching him and it was almost intuitively he just started singing, "rolling, rolling" with the compressions...cause the doctor was stumped. We'd done everything that you can think of and he was thinking there had to be something else (# 9 Line 574).

The unit assistant in this case was able to say what the nurses involved in this 99 wanted to say. The comment he offered was less threatening, by virtue of the "para" medical nature of his position. His message was subtle but effective. The comment allowed those who were attuned to enjoy the flavour of the remark, thus providing relief of some of the tension related to the futility in continuing this resuscitation. The message to the physician was non-threatening on the surface. Nonetheless, a comment was made that it was time to consider terminating the resuscitation efforts. On another level, acknowledgement of the difficulty faced by this physician in discontinuing resuscitation was supportive. The physician was free to ignore the subtle message, respond to its superficial tone in a similar manner, or to heed its underlying plea. Courage and caring were evident if one considered the potential that an angry response from the physician might have occurred. This unit assistant felt strongly enough about the futility of the successful outcome to stick his neck out and make a comment, but caring enough to couch it in understated tones. This took place in an atmosphere of shared understanding.

Information Giving

At times, exchange of information within earshot of an angry patient was necessary. Information was provided in a straightforward manner, with a humorous bent, while demonstrating respect for the patient. In some cases humour was used to warn staff about a combative patient who posed a physical danger to those who were not aware.

Bev: One of my patients was combative that particular night...one of the others [staff] came over to help out, but he was fighting...he was going to grab the [oxygen] mask...[I] turned around and said, "Watch out for that left hook. It's a whopper"...by doing that you put a little smile on your face and you can really watch [his] hands and feet (# 5 Line 238).

Bev chose to display humour rather than anger or fear in her statements. Humour may mask the underlying emotional tone, which, in some instances sends two potentially conflicting messages. An important use of humour by nurses provides for exchange of information while simultaneously conveying an underlying emotional undercurrent. The understated humorous approach avoids or minimizes conflict while it softens the blow or the impact of the message. This approach also promoted a sense of emotional control, as the nurse decided upon the tone of her message and the extent of emotional disclosure. The physical proximity of the patient [a constant factor in the ICU] was acknowledged in her slightly veiled comments. Communication occurred on two levels.

Rhonda: Humour might bring out something beneath the surface. It might be funny on one level but if you examine it a bit closer you might realize that there's some serious issues that have to be dealt with. And the common thread is that it was funny to a group of people or to a single person. But maybe there's something deeper below, that can be shared and help you get through your day or your week and help you resolve some issues (#12 Line 46).

Challenging

A joke may be an effective method of communicating. The message in a joke is often symbolic in nature. The emotional undertone may closely reflect the feelings of the nurse, but the content is more obtuse. The answer was not as important to this participant as the question. In the following example, the relationship between the physicians and God became more apparent as a nurse described her frustration with the lack of respect displayed by some physicians to nurses. In directing her comments directly to the physicians, Bev conveyed information about her attitudes and perhaps her previous experiences to a physician new to the unit. Her remark also had the effect of educating and socializing the new physician to this unit. The social mores in this unit did not favour physicians who attempted to demean the nursing staff. Furthermore, the nurses in this unit - of which Bev was representative - were privy to this "attitude" and would not be tolerant. There was an element of threat in her message, delivered in a non-threatening yet assertive manner.

Bev: Sometimes you have a group [of physicians] that have come on that don't know how to be team members...they don't give credit to the nurses...they don't get credit for being intelligent...I'll just give them a joke. What's the difference between God and a doctor? (# 5 Line 365).

Susan also described the non-threatening quality of the use of jokes as an understated approach to convey a message. The physician can save face by responding to the message on the humorous level or its underlying meaning. Caring is reflected in the concern shown for the potential threat to the ego of the physician by the teller of the joke. A joke told in this setting can place nurse and physician on par – in a social sense. The nurse by virtue of his/her position imparts information. An underlying consideration of the "ego" of the physician is a part of such an exchange.

Susan: Sometimes if you use it as a joke, you don't hurt their ego...[if you joke] about something that is sort of a problem...that lets them take it or leave it. Whereas you're not saying...you really should do this and this for the patient (# 10 L 597).

During interviews, participants expressed a range of emotions when they related a light comment and further explored its context. Underlying frustration was apparent when nurses perceived that some physicians were less than competent - wielding power by virtue of their position, regardless of their degree of expertise.

Gloria: When a physician says to me after we've been there [in a 99 situation] for 45 minutes "Is there anything else we can do?"...I said "Well we can turn him on his head and see if it helps"...(# 6 Line 762).

Death had already occurred in this patient. This fact was apparent to the nurse but perhaps less apparent to the physician. The physician consulted the nurse about what she considered to be the obvious. On one level there was a sense of teamwork as this physician attempted to incorporate the views of the nurses. This nurse may have acknowledged the blurred line between nursing and medicine in her jocular response. She imparted information without directly stating that there was nothing more that could be accomplished – traditionally a medical decision. Her purpose in providing this comment was specific. Her goal was to persuade the physician to stop the resuscitation. Anger and sarcasm were often not far below the surface. The worldview of nurses and physicians differed in the continuum between life and death.

Georgette: I said to the doc that one night that we, uh, did all this stuff on a gentleman that we shouldn't have [I was concerned with the cost of calling staff in for overtime on a patient who should be allowed to die and whose prognosis was very poor] and that's when he [the doctor] threw back the comment that we can't think of money. I said being as tomorrow is my last shift in this unit because I've been bumped because of layoffs, I can. I was joking but I wasn't (#11 Line 1136).

This nurse offered a more pragmatic view of the ramifications involved in providing heroic measures to a patient she considered inappropriately managed. She remained undaunted at the suggestion that her view was less altruistic than that of the physician "Think of the money." Her words took courage as she confronted the physician and offered her perspective. In doing so, she also disclosed personal and painful information about herself, to emphasize her point.

In conclusion, in each of these situations the nurses gained voice through their skillful use of humour. Humour provided a vehicle to circumvent traditional levels of communication. The status quo was challenged in a less threatening and destructive manner. More formal means of communication, including raising concerns during rounds, were sometimes first attempted. An element of caring was evident in each exchange, as nurses conveyed a message in a manner that saved face for the doctor, but at the same time provided him/her with the necessary information to navigate new or difficult situations. Recognition of the emotional drain on the physicians was reflected in the light or jocular comments, which served to provide temporary relief from the gravity of a situation to all present. The physician in many instances was being included within the supportive network of staff members. Introduction to and inclusion within the culture of this ICU by the nurses was undertaken.

Courage was also a consistent feature of interactions. Nurses ventured beyond their domain of practice to instruct, educate, socialize, and offer suggestions. The nurses risked confrontation should an individual doctor have responded adversely to the underlying message. Although the basic intent of each message was to deliver

information, advocacy on the part of the patients and other nurses was present on one level of the message.

Empowerment: Humour as a Decentering Device

In the following scenario, the nurse used humour in an intellectual capacity as a decentering device. The physician was completely caught off-guard and responded with a “look of panic on his face.” While the physician struggled to compose himself, the balance of power shifted to the nurse who, “on bended knee,” had the upper hand. Only she could have predicted such an outrageous outburst. The physician’s energies were momentarily diverted to reconstructing the meaning of the scene before him. The magnitude of a “snapping” comment could not be lost on any bystander, as the nurse reacted with exaggerated fear to the tone of his voice. Her cowering body language and pleas “don’t beat me” exposed the unfairness of his comment.

Nancy: The doctor spun around and snapped at her...she dropped to her knees. cowered at his feet. She said, “Please don’t beat me now. All I ask for is a little grace. And the doctor was looking around. She [the nurse] had control over the situation. And he [the physician] said to her “ I didn’t mean to do it.” (# 9 Line 829).

This nurse, herself, described the same scenario to me.

Stephanie: He said something really snide to me and I just looked at him. I’d had enough that day. I got down on one knee and I said “Please don’t beat me, I’m just a humble slave working for you and the king...He [got] this look of panic on his face and he [leaned] over and said “I was just kidding.” I wasn’t...a little while later I had to get an albumin order...I said, “ Can I have some albumin?” He said, “Yes,” but the resident said, “Well you just have to phone me any time.” This was after I’d dropped to my knee. He looked at the resident, leaned over to the guy and said, “She’s pretty smart, I think you should just write the order” (# 15 Line 742).

This strategy would not have been as effective in the absence of caring. The physician responded to the underlying message that his behavior was unacceptable with an apology and a show of discomfort. A less caring individual might not have responded,

or simply reacted with a tone of impatience to the superficial absurdity of this display. Evidence that the nurse had successfully used humour as power occurred with this physician's comment to the resident "I think you should just write the order." The nurse was treated with due respect.

Fun With Co-workers

This kind of humour revealed itself in a variety of ways. In some cases, antics or pranks formed the basis of this type of fun. Creativity is manifest in many of these childlike escapades, as ICU staff struggled to find fun in an atmosphere that is not normally funny.

Stephanie: One of the doctors liked to sleep in the isolation room. We took plastic sheets ...cut it in half...it fit the isolation door perfectly...we stretched it and stretched it and put it over the door. So it was clear [and not obvious to the naked eye]...And we stood outside of the door and called 99 and the doc came winging out...Klunk against the plastic. And we're all standing in the hallway looking at him and laughing. And he just reaches up and grabs the plastic and rips it down. "Thanks a lot" [and] closes the door behind him (# 15 Line 1414).

Although in this case the physician did not appreciate the prank, staff had fun planning, carrying out and then recounting their part in this event. This type of scene provided humour on a more long-term basis. Individuals witnessing the prank received enjoyment from their participation in the joke. Being there was only part of the fun. Those present spread the word about what had happened. Others not present for the event were able to enjoy the story in its re-telling. A common bond was formed among those who shared the humour in the prank played on a physician and perhaps a certain pleasure that his response was not positive "thanks a lot." Stories such as this were treasured, retold and remembered. They became part of the folklore of this unit.

Another nurse talked about the fun that she and others had on their coffee breaks.

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Gloria: Coffee breaks are always full of humour...the smoking room is like our social room... it's different than the people who go on break upstairs...we find out all that is going on in the hospital...anybody who smokes is in the lounge... for those of us who work permanent nights, this is the only way we actually get information more than what's on the bulletin. (#6 Line 413).

The smoking room was the source of an informal network of information. A select group - those who work nights and who smoke – engaged in a more unrestrained type of fun. Away from the unit and out of earshot of patients and working staff members, insider “scuttlebutt” was exchanged. This group experienced their unique brand of humour. As this nurse described “There’s no holds barred. It’s a free for all...” (#6 Line 466).

I observed many instances of comedy breaks in the routine of the day when I was conducting my fieldwork. A new ventilator was introduced into the unit. The nurses verbalized their lack of ease with a new piece of technology, in a variety of joking comments. When I came on to the unit one morning the ventilator was sporting a new sign “the dragon.” Reference was made [by the nurses] about “the dragon guarding the bed” (Fieldnotes, p. 56). The use of the term “dragon” did symbolize, to some extent, the discomfort with change. Several staff members noted this fact. Staff were united in their sentiment as “each person who passed by the bedside made a comment on it” [the sign].

As nurses came on duty they were sometimes immediately exposed to a touch of humour. “Comments were occasionally made on the assignment book itself ...teasing words i.e., “out of mind” were often written on the assignment sheet beside a person’s name” (Fieldnotes, p. 165). Several nurses told me that no sign was safe from having comments written on it. Any paper left at the desk is not safe” ...when I look around at the signs on the desk many do have comments added to them ... (p. 52). Throughout the

day the nurses played little games – a “lotto is held ...to guess what time rounds will end” (Fieldnotes p. 173). The nurses clustered in the centre of the unit to ... probably to physically move away from the patients ... [they flipped a coin] ... heads or tails to see who got to go to the inservice and who got to relieve [stay behind and look after the patients] (Fieldnotes p.52-53).

Food was another means of relaxation for the nurses and other staff members. They referred to the many potluck dinners as “feasts ... as many as possible ... any excuse [to have one]” (Fieldnotes p. 95). These occasions of “feasting” both on and off the unit provided a medium for socializing. The food eaten in the unit had an air of the taboo – a hedonistic pleasure. The “forbidden fat” and “calories” were described. Food must not be eaten at the bedside. Nurses congregated, briefly or for longer periods depending upon assignment, at the desk or the pharmacy counter. A bite of food provided an opportunity for a quick chat or word with a person in the vicinity of the desk and perhaps a brief respite from their bedside. Food and fun were linked.

Running Jokes – Perpetuation

Humorous events were savoured and treasured in the unit. A 92 year old man admitted to the unit with a heart rate of 26 beats per minute provided laughter to all the staff, whether they were in direct contact with him or not. He endeared himself to all staff who met him. Staff members filed into his room to talk with him and see for themselves how spry he really was. His grin went from ear to ear, with one tooth left in the middle of his mouth (Fieldnotes, p. 70). The conversations became uproarious as one worker used a more risqué form of humour, “threatening” him by pretending that the pneumatic tube [used to send mail to other areas of the hospital via a tubing system - approximately

two feet long] was a suppository (p. 71). He had an effect even on those staff members who were not directly involved in his care. Stories about him were passed on from shift to shift and although he remained in the unit for less than two days the stories about him continued for several days after he had left the unit.

This tendency to perpetuate a humorous event was echoed by a participant.

Nancy: If something funny happens to a patient, people sort of pass it around... like the time there were two patients that had literally almost the same name and they'd call on the phone...and say can they visit so and so. And [the nurse] said, "Sure, come on in"[When the family came to the bedside] they said, "What happened to her...I was just in here two weeks ago and she didn't look like that"... the nurse explained "Well you know she's got this wrong." [The family continues] "Why I can't believe it, she looks awful." Of course the nurse took them to the wrong bedside. Stuff like that gets passed around as being real funny (#9 Line 1017).

A mistake had been made. The negative effect on the family was minimized [in the retelling] as the focus reflected the ongoing explanations given by the nurse as she tried to convince the family that nothing was amiss or unusual for this type of ICU patient. Although this situation had great impact on the staff members as evidenced by their emphasis on the telling of the story, there was an air of forgiveness. The reporting of this story implied that this was a mistake that anyone could make – after all the names were almost "literally the same." The outrageous nature of the story invited its telling and retelling. The facts of the story may be distorted over time, resulting in an even more outlandish version. Stories such as this are elevated into the realm of "classic hospital tales".

Beyond fun, some running jokes seemed to be initiated in response to the emotional needs of the unit. Humour can provide an outlet for feelings of distress that are felt by the nurses in relation to patient situations. In the following exemplar an inflatable

toy became a symbol for what some nurses considered outrageous over-treatment of a patient. Unable to impact upon the real situation, the nurses chose to parody the acts being perpetrated, on Dino. This display of emotion [humour] provided a safe outlet that all could participate in, without confrontation.

Cindy: [Dino was an inflatable dinosaur brought in to the unit by one of the nurses]...the next day we came in and somebody had put him in a bed and hooked it [Dino] up to a ventilator...[various equipment was added each day] EKG leads were attached and a Nitro [Nitroglycerine] bottle with milk in it to look like TPN...trached...somebody did abdominal surgery on it...this went on for two weeks...it just really got out of hand, and it was because we had this one patient that nobody would give up on. It was like flogging a dead horse. Literally everything that got done to this patient got done to Dino. And it was like a voodoo doll almost (#3 Line 1282).

Another nurse telling the same story gave a similar version of the significance of Dino on staff morale.

Stephanie: What we couldn't do to the patients we did to Dino...we literally made him into a patient...the docs even got into it...they wrote a 99 report on him...despite our best Dino didn't make it...sounds kind of sick but it makes us feel better...it's kind of like displacing anger on something you can't hurt (#15 Line 511).

Nurses and physicians alike participated in this scenario that went on for about two weeks. The physicians also "got into the game," writing orders. Cindy recalled "They actually wrote the progress notes to discontinue treatment." Closure was achieved with this patient who eventually underwent a peaceful death and was bestowed a tombstone. Teamwork and a sense of cohesiveness between nurses and physicians was achieved, with a fun undertone, as all of the unit staff participated in Dino's care. A pleasant work situation was fashioned, enabling close teamwork in fun circumstances. Participating in this scenario provided an adult version of "play therapy." The results were therapeutic for those involved in the re-enactment. In this situation, humour was also displayed in the form of a "coded message." Similar to the "coded comments" made

at the bedside this scene involved the enactment of a “coded display” of humour. The significance to a patient or family member would not be the same as the symbolic significance to the nurses and physicians. An element of emotional catharsis was present as participants enacted some of their underlying frustrations in real patient cases. The nursing staff, in initiating this joke, assumed control over Dino’s progress. A fantasy ICU patient, with a fantasy ICU course, was created. ICU personnel provided for Dino what was not always possible in the “real world.” The worldview of the nurses and physicians in their care of Dino [regarding extent of treatment and discontinuation of therapy] was remarkably congruent. Caring was also revealed in the attempts to provide Dino with the finest care and technology and eventually to achieve closure in providing him as peaceful death as possible. The complexity of humour was revealed in the variety of purposes served by the existence of Dino. Respect for Dino was ever present in this scenario.

Some of the more elaborate humorous events become part of the folklore of the unit. Many of the participants mentioned the “saga” (#3 Line 937) of “Theodore the Thermos” in their discussions. Although Theodore began as a more spontaneous prank, he quickly became an institution. His escapades became more frequent and long-lived. More staff members became privy to his existence.

Several elements are involved in the more elaborate “running jokes.” The first element of planning was evident in the statement of one of the nurses that a particular nurse had been planning to steal this thermos [belonging to another staff member] for six months (#3 Line 937). However, when the opportunity arose it came without warning. This thermos had been taken on a number of previous occasions and had been decorated

in various manners and the contents of the thermos [a special blend of hi protein food] replaced with hospital issue tube feed.

This time the thermos was taken to a number of locations and photographed with various personnel, accompanied by various props.

Cindy: We had to get these things...like a hat, Mr. Potato head things we tape on this thermos...we got a picture of the thermos in the car driving the car with a slurpee...so this started at one o'clock in the afternoon and at nine o'clock at night we were ... getting pictures developed (#3 Line 961).

The pictures were shared with all staff members of this and other units, promoting sharing and embellishment of the experience, as others not directly involved were included in the adventures of Theodore. The symbolism of this event may or may not have been lost, as the thermos belonged to an authority figure in the unit – one of the head physicians. This prank represented, on one level, a flouting of authority aimed at an individual of power and influence. Within the social domain, in this instance, the nurses prevailed. They had control of the events unfolding. “Theodore” developed a life of his own, dominated by the whims of the nurses who held him hostage for a number of days. The enormity of this event was evident in the numbers of staff members who enjoyed this saga. Its enduring nature and symbolic significance created a mythical quality to the humorous episode. This episode provided a safe outlet for humour in that an inanimate object was the target. The action took place outside of the unit, away from patients and family members, although the enjoyment of the re-telling and sharing of the story occurred in the work place. A more daring element of humour appeared in the removal and “desecration” of a personal object belonging to an authority figure.

Finally, the event was immortalized in the “Gentle Gossip” chronicle. This journal contained a collection of anecdotes and tidbits about staff members. Events in the work setting and at work functions were detailed and at times embellished, targeting various staff members (Fieldnotes, p. 121). The “gentle” nature of this book was seen in the affectionate and teasing comments, while the “gossip” was revealed in the personal nature of the details [some less than flattering] and the innuendoes. Meaningful events inducted into the “Gentle Gossip” were captured in an enduring fashion. These events became part of the physical environment of the unit and were preserved as part of its mini-culture. “Dino” and “Theodore” were not to be forgotten. Their stories will be passed to future nurses arriving in this unit, who will receive a full account from the more senior nurses, aware of the details surrounding their existence.

Another circumstance personified a more enduring type of humour. Although this situation had not occurred recently to the following nurse, it immediately came to her mind when she was asked to relate a humorous event. In this situation an unexpected urgency arose when the physician began to exhibit the kind of response one would expect from a patient in similar circumstances. A potentially serious breach of patient safety required rapid assessment and problem solving on the part of the nurse.

A resident from another service was “unable” to remove a sheath from this patient. A sheath consists of a large tube placed into the femoral artery during an angioplasty procedure and left in place until the patient stabilizes. This tube is removed usually by residents of a certain specialty because of the risk massive bleeding would occur from the femoral artery and also the danger of fainting [vagal] episodes, at times requiring medication. The patient can be prone to fainting when the doctor presses down

hard on the groin area to prevent bleeding, pressing in the vicinity of the vagus nerve that slows the heart.

Stephanie: I was in CCU (Coronary Care Unit) by myself. [The other resident could not remove the sheath] so as our gung ho resident says, "O.K. I'm going to take the sheath out." And I said, "Well, why?"... it's ticking me [off] that I'm the only one in CCU ... he didn't want it to be there so he took it out ... the guy's bleeding and bleeding and bleeding ... I said, "Just put your fist on the groin." So he says to me, "Get me a doctor." And I look at him and say, "Isn't that what you are?" He goes, "Oh, I mean another doctor." So I go walking out and I find another doctor reading the paper and say, "You look like a doctor, come with me." [The other doctor came to the room, reassured him about the bleeding, told him that things would be just fine and left the room]... he's looking a little pale and he [The physician] goes, "Oh, oh, I'm not feeling well, I feel a little "vagal"... I put the glove on and slam my fist into the guy's [the patient's] groin and the doc puts his head down between his knees (#15 Line 1199).

This nurse performed a dramatic account of the situation. It was obvious that the nurse had told this story before, knew it well and enjoyed it each time. Her actions and facial expressions reflected some of the emotions that she did not voice. She walked in an exaggerated fashion and her eyes rolled back as she dramatically reached for her groin. She continued, "All I could think to myself was, Doctor down, Doctor down. Nurse on groin. Patient bleeding. Doctor down" (# 15 Line 1222).

In the telling of this story, the position of the nurse is elevated. She achieves empowerment through her story telling. The nurse is in charge of the situation - the heroine - the only one that can handle the crisis. In the telling of the story the nurse made no mention of the anxiety she might have experienced, focussing on the instantaneous problem solving she engaged in. She did not describe the massive pressure that she would have needed to apply to stop bleeding from a femoral artery [normally requiring a minimum of 15 minutes without moving one's hand]. She also made no mention of the

amount of blood pumping rapidly out of a large artery that would have been present.[An uninterrupted bleeding from this major artery could cause the patient to bleed to death within a matter of minutes]. The physician attempted to preserve a measure of dignity as he admitted that he felt not faint, but “vagal.” His use of medical terminology, in his mind, may have set him apart from the individual who was merely “passing out.”

In the telling and re-telling of this story this nurse is myth making – a further significant event is incorporated into the history of this unit. Nurses hearing this story for the first time can marvel at the resourcefulness and calm displayed by a nurse in the midst of a stressful situation. Beyond the role modeling, this nurse perpetuated images of calm, competence and creativity under duress.

Other nurses were able to participate and capture some of the humour limelight in this situation as they reconstructed other possible solutions to the “vagal” episode suffered by this doctor. In each of these scenarios the physician, who was not useful, was removed from the scene.

Stephanie: “It would have been better if he [the doctor who was fainting] had put himself down on one of those chairs with the wheels, I could have kicked him into the hallway. Someone would have seen him. But with my luck he could have rolled [across the hall and into the other CCU room] and into CCU beds 5 and 6 and no one would have found him because there’s no patients in there...(# 15 Line1248).

There was an air of fantasy as nurses listened to and then participated in reconstructing possible solutions to this event. Many messages are conveyed here. The empowerment of nurses and the disempowerment of residents are evident. This provided an important sense of bonding as the nursing [and other staff] shared this experience. Staff morale, cohesiveness and a collective sense of empowerment were enhanced. The

excellence of one nurse was described and then extrapolated to all ICU nurses [particularly the ones in “this” unit]. This focus was positive, in contrast to the many sadder and bleaker events that are intrinsic to this ICU setting.

Retrospective Humour – Reframing

Many of the stories told by participants were seen to be funny in retrospect, after the crisis and the need for immediate action had abated. In the words of one of the nurses “Lots of the time situations are not funny [at the time] but later on [when] you think about them they are” (# 15 Line 1188). Another nurse commented that “At the time it’s not funny, but later when you look back and you think, oh, that’s the way I reacted in this situation, that’s kind of funny (# 8 Line 855).

In the midst of an event the nurse may be too involved in the performance of tasks to be able to consider the humorous aspects of a situation. Once the “rush” has subsided there may be more time to think and process the information. A sense of relief may be felt that a crisis has abated. At that point, the comical nature of the situation can be acknowledged. The mastery of a difficult experience and simply the passage of time may allow a problem to be minimized. Perspective on an event is achieved.

Rhonda: We had a patient [but] we only had one external pacemaker available in our unit. We had another patient that needed the external pacer immediately. It was a 99 situation. And I knew that this person’s underlying rhythm [without the pacemaker turned on] was complete heart block but there was still perfusion [he still had a pulse and blood pressure] even without the external pacemaker. So I immediately took the pacemaker off of him and went to run over to the other side of the room where the patient needed it urgently. And I ran with it, and it fell out of my hands. And what had happened, and I had no idea, was that the patient had grabbed on to all the cords and yanked as I was running with it... So it ended up on the floor. At the time it wasn’t all that funny. But shortly thereafter it was hilarious (# 12 Line 250).

This nurse reproduced the event in her mind, reviewing the circumstances and viewing this scenario, retrospectively, in a different light. This time in a humorous light. In the midst of the turmoil the nurse was too busy trying to ensure that a patient in a near cardiac arrest state was tended to promptly. After the fact, she was able to focus on the unexpected turn of events that had occurred. Patients, especially critical care patients, are not supposed to grab and hold on to the life-saving devices that are delivering electricity to them. The element of surprise in this situation made the management of this scene more stressful for the nurse to deal with at the time, but extremely funny afterwards. The narrating of this story allowed this nurse to regain the element of control that had not originally been possible. Balance was restored in the aftermath of a situation that had initially caught her off guard and thrown her off balance.

Georgette recounted a situation where aggressive treatment was instituted on an elderly female patient with a stroke, in an effort to confirm the diagnosis. Georgette felt that this woman's suffering had been prolonged by continuing treatment in a situation that Georgette felt was futile and would not alter the outcome [death]. In this instance, an elderly patient with Advanced Alzheimer's disease was treated for a ruptured aneurysm with emergency surgery in the middle of the night – only to die anyway.

Georgette: It's ironic...what are we going to tell him, [her husband] she stroked? [suffered a stroke] It's not really funny but it is ... it's anger over the situation...you're treating someone worse than you would treat an animal. And after all is said and done the inevitable did happen [the patient died] but in a less dignified and a less peaceful way for the family. This is going to sound sick but it's my way of dealing with it ... And I couldn't figure a good thing about it until I thought the only good thing about it is her husband's not going to miss her because he has Alzheimer's as well (# 11 Line 1093).

Achievement of perspective or resolution following an event can be difficult. This nurse struggled to make sense of the needless suffering that had occurred. The outcome

for the patient was not altered, despite the best care that could be provided. Powerless to change events, Georgette acknowledged, but did not wish to perpetuate her sadness at the death of this patient. She was able to find a ray of light in the fact that the patient's husband would never be privy to the details of his wife's death. He would be spared this knowledge because of his own disease – Alzheimer's. Although she could not have changed the events, she could alter their significance to herself and continue without emotional sequelae. Mentally reconstructing the event helped her to make sense of the incident. The retelling allowed her to impose a kind of understanding of the sequence of events. She "reframed" the tragedy – finding something "good" in the terrible details.

The resilience of critical care nurses is demonstrated in certain situations. A conflict situation between nurse and doctor was revisited in a humorous light, as a means of minimizing its negative impact and allowing more civil relationships to be regained. This required determination, creativity and ingenuity on the part of the nurses.

In the following situation one of the doctors had exposed nurses and other workers to physical danger during a 99 situation. Ordinarily, strict procedure must be followed in providing three verbal warnings, [I'm clear, you're clear, we're all clear] accompanied by a physical check to ensure that no one is touching the bed or the patient – prior to administering a shock [defibrillation of a patient]. Such a shock delivered to a bystander could cause a variety of consequences – from a shock to a part of the body to cardiac arrest [complete stoppage of the heart]. In the worst case scenario a 99 code would then be happening to not one but two persons in the room [patient and rescuer].

Bev: The nurses saw that he was about to defibrillate [administer an electric shock to the patient's chest]. [He] Did not call clear. She [the nurse] pulled her hands out really quickly. The respiratory tech saw what she was doing and pulled her

hands away really quickly. He defibrillated, didn't clear or anything. She [another nurse] even got the shock up her arm and she said something to him. And his response was basically, that it was her fault... So she did tell him how she felt (# 5 Line 424).

The nurses were outraged. They became intent on letting the other staff know of the impending danger, should they be involved in a 99 situation with this doctor "Don't give him the paddles because he'll kill you, you know" (#5 Line 470). Remarkably, a humorous tone was eventually included in discussion about this dilemma.

Bev: [We wondered] Well who are you going to defibrillate first? Who was more important? And [one nurse] says, "I'm younger so I should be defibrillated first." And I said, "That may be so but you may need the respiratory tech to intubate you. So who? You need an airway." (#5 Line 436).

Laughter was added to the feelings of anger. Determined not to feel further victimized, a spirit of wit emerged as nurses role-played potential tragic events with a "mad physician" in charge of the [defibrillation] paddles. Pecking order in the world they constructed followed different criteria. Youthfulness and utility prevailed. The nurses' sense of power and control over their environment was restored. Discussion focused on the solving of a problem. The physician was not a part of this scenario. Intellectualization predominated. The emotional response to a potentially devastating experience for ICU staff [injury of a worker] was not acknowledged.

In summary, a measure of healing was present in each of these situations of reframing. A negative emotion was replaced or dimmed through the use of humour in each case. Control was achieved during an event with a comment that was humorous on some level. Following an event, control was accomplished through reconstruction of its factual or emotional meaning. Caring weaved its way through the behaviors of the

individuals involved, an impetus for the application of humour that was always present. Courage was a factor when individuals, propelled by their sense of caring, challenged the status quo.

The Use of Humour in Relation to Self -Balance

The use of humour in this arena primarily benefited the nurse. In some instances the gain was for the patients and other workers as well. The needs of the nurse and the patient were occasionally in direct conflict. The needs of the nurse prevailed in these cases, when humour was directed toward the self. Provision of self-care as a pre-requisite for quality patient care was evident in these scenarios. The image of self was used as a tool to increase or decrease the distance between nurse and patient, in desirable (connecting) or less desirable ways. The nurse, in decreasing the distance, willingly and consciously shared something of her "person" with others. The effect of increasing the distance between the nurse and others also revealed, although more unwittingly, something of the nurse as a person.

Self Care Versus Patient Care

Self – Talk: Controlling Uncertainty and Creating Competency

Nurses may direct their humour inward to preserve a sense of emotional control in a situation they find potentially stressful or daunting. At times, expression of uncertainty is not appropriate and may be viewed by others as lack of competence. The nurse must convey an aura of composure to inspire the confidence of others in her abilities. Her actions are on display to both patients and co-workers. Humour as a kind of "self-talk" may be used in these circumstances.

Georgette: Admitting [the patient back from the operating room following open heart surgery] ... the big thing was admitting the heart...especially when you had to hook everything up [attach all the monitoring equipment]...you've got to be in a good place [feeling calm and confident]...even something as silly as calling [the tubing] spaghetti ...[makes it] a little bit easier... if you're really [feeling calm] the patient can sense it ... even if they're not awake sometimes I think they can sense it ... they're not going to have faith in you. They're going to be worrying about what kind of care am I getting from this person ... sometimes maybe things aren't coming out but you're thinking them to yourselves and they'll make you smile and away you go and things are a bit easier for you (# 11 Line 851).

Georgette described the use of humour as “self-talk” to simultaneously benefit both the patient and herself. On one level humour benefits the nurse and on another the patient. Georgette acknowledged the intended purposes of “being in a good place” through engaging in the “silly” talk of calling the monitor tubing “spaghetti”. The more unfamiliar “tubing” is given a more familiar and less threatening term – “spaghetti”. Use of this nonsensical term permitted Georgette to smile and appear calm and unruffled.

The need to “perform” was evident in Georgette’s statement “The big thing is admitting the heart.” Admitting a patient following open-heart surgery can seem like an onerous task to a more junior nurse. The need to recover the patient from anaesthetic following major surgery requires assessment of many details simultaneously, in a patient whose condition may be rapidly changing. All personnel in the vicinity can readily scrutinize the nurse as she, “Hook [s] everything up” [the lines from the operating room equipment to the Intensive Care monitoring equipment.]

The open physical environment enhances the ability to view this aspect of the performance of the nurse. “Self - talk” enables the nurse to exert an element of control in an uncomfortable situation, through the assignment of a common label “spaghetti.” A bond is established with her patient on another level, when both parties share an

understanding of the language used. Georgette attempted to achieve mastery over the equipment by diminishing the effect of its emotional impact. The calm demeanor she projected did not necessarily reflect her innermost feelings. However, lack of serenity is so pervasive that even a patient “not awake” can “sense it”. The resultant, “Worrying ... over what kind of care am I getting from this person” is a situation Georgette wanted to avoid for her patient. Her projected calm had the effect of instilling confidence in the patient and other onlookers.

During my fieldwork I noted the change in the conversational tone of a nurse as she set up her equipment in preparation for the arrival of a patient admission. Initially she described to me the history of the patient and some of the politics involved in out-of-hospital admissions. At some point I became aware that her comments were not addressed solely to me but also to the equipment being readied. As she flushed through the lines [tubing] the nurse became more intent on her task. I noted that many of the comments made prior and during the admission were “basically rhetorical comments ... in some ways a narration... in some cases I cannot tell [the humour] by the facial expression, but by the content” (Fieldnotes, p. 98). I considered this rhetorical quality to be a kind of self-talk, designed to benefit the nurse rather than others present, although in some cases [the previous scenario] others besides the nurse benefit. This also occurred when “humour in code” was used as a means of conveying delicate information regarding an increased heart rate and decreased perfusion in an unstable patient.

Striving for Emotional Control

The judicious use of humour, at times, enabled nurses to move from humour as a means of conveying information, to humour as a means of exerting control over one’s

emotional reaction to a situation. A nurse would respond as a person rather than in the professional capacity as a nurse in these cases.

Susan: Sometimes you'll use humour ...if you went to a code [99 situation] and it's a young person...cause if you don't laugh, you'd cry (# 10 Line 522).

During my fieldwork and in her interview one participant referred to humour as being the "flipside of anger" (# 6 L. 872). She referred to the fact that anger or sadness and humour can be used under identical circumstances. An individual choice is made to react in laughter or tears. This choice provides a degree of emotional control, when tears are avoided. In the midst of a 99 situation the nurse can perform her duties and carry on.

Alice: Some people use humour to cope and some people need to talk about a situation to cope with it and be able to cry or cope with it. So I think that in order not to cry using humour, maybe using humour would be a faster way of kind of dealing with it immediately...if you can use humour in a situation like that you can sort of get over it and it can help you move on until you have time to deal with it (#8 Line 1109).

Humour may provide a means of getting through a situation temporarily, until a more "socially acceptable" opportunity to display one's emotions occurs. The professional integrity of the nurse is maintained as he/she is able to perform a role competently. Personal integrity occurs with control over emotions.

Self-Caring

Georgette: Sometimes when it's really busy and it's hairy ...it's a lot easier to keep the mood a little bit lighter because ...myself I'm really uptight, I tend to, my body does the stress thing and that's just not conducive because I end up getting a headache and getting cranky and I don't work well...you know the patient gets pretty much the same type of care. But I feel like if I'm not feeling good, I'm not as much of a help to them (# 11 L 833).

The adverse physiological effects of "headache" were noted by Georgette in response to stress when it was "busy and hairy." The connotation of a "hairy" monster may refer to the potential danger to her physical and emotional health in dealing with

stresses in the workplace. The effect of “keeping the mood lighter” and thus less of a burden on her shoulders was positive. She noted that her ability to care for her patients was contingent upon her ability to care for herself “I don’t work well” [when too “uptight”]. She chose to display humour, rather than becoming physically ill with a headache, or “cranky” – a less socially acceptable alternative.

The stresses associated with caring for many critically ill patients experiencing high mortality rates can be cumulative. Nurses do not always have time to adjust from one death scene before they are confronted by another.

Stephanie: You have to use some humour, especially if someone dies. You don’t have time to turn yourself around. They’re saying, O.K. hurry up and get the body wrapped. You have another patient. So you don’t even have time to tone yourself down and you find that’s when you start cracking (# 15 L 1065).

A loss of control over events is evident in Stephanie’s words. “They,” say “Hurry up...you’ve got another patient.” She must struggle to race the clock in getting the body wrapped and also find the time to, “Tone [herself] down.” Humour in this instance forges a link between a previous dismal situation and a new and as yet indeterminate situation – a new patient arrival. Humour affords the flexibility to respond emotionally to now a very different set of circumstances. Humour is the emotion substituted for the sadness felt in the previous situation. The primary type of control that Stephanie can exercise in this situation is emotional. She is unable to change the events unfolding. Stephanie can, however, choose to take a momentary break from her grim environment by “using some humour.” She may initiate humour directed within herself or to another person. Others around her may reach out to Stephanie in a jesting manner – as a gesture of caring, acknowledgement of her difficulty, and concern. Stephanie will otherwise

arrive at her breaking point and start “cracking.” Her inner stress will leak through a fracture in her calm and competent exterior.

Self-Preservation and Group Caring

Participants described humour as a means of providing emotional support for each other. Several nurses explained that their families/friends could not truly understand the types of stresses they encountered in their everyday worklife. Nurses and other workers in this area best understand the unique nature of humour in a critical care setting. The vast majority of nurses interviewed felt that there was a brand of humour unique to Critical Care.

Bev: We’ll say things that nobody else would ever think of saying...Some people look at it as more warped...we’re different (# 5 Line 837).

Nancy: ...Intensive care nurses as a whole have more raw kind of humour...my friends back home who are not nurses do not appreciate the kind of humour I have (# 9 Line 172).

In this particular unit nurses pride themselves on their flexibility and problem-solving capabilities. This need is demonstrated in the admission and running of 99’s “You never know what you’re dealing with.” By contrast, admission of patients from the Operating room (OR) is less spontaneous with “everything in place” (Fieldnotes p. 209). Some of the nurses on this unit shared a joke that a nurse admitting a patient from the OR may say, “Here comes the heart,” but on this unit the nurses say “Here comes the heart ...oh no here comes the liver and the kidneys...” (Fieldnotes p. 209). Reference was made to the fact that this unit contained more long-term patients, many with multiple health problems and multiple system involvement. Several participants echoed this sentiment, adding that the more long-term patients enabled nurses to get to know their patients better, engendering a more relaxed atmosphere.

Another critical care nurse can not only empathize with their colleagues' experience, but can add a dimension of humour. This dimension engenders a caring approach extended to co-workers.

Claire: Even after a crisis sometimes we'll sit and ... talk about it jokingly...but I think it's done in a supportive, caring way, and not laughing at the situation but it's just a way of supporting each other (# 2 Line 514).

Several participants described the potential of stress in the workplace invading their personal life. Bev described the necessity of "Keeping their stress at work rather than taking it home with them" (Fieldnotes p. 221).

Georgette: If you've got to bring it home, ... try and put a twist on it ... a nicer spin [because] sometimes you have to discuss the bad parts...[but] if you bend it in a humorous way it doesn't sound so bad ... Family members may empathize more but they understand less" (# 11 L 1759).

An event may be "re-framed" by adding a humorous "twist" in its retelling. This reframing serves the purpose of "sanitizing" the situation to avoid unsettling an outsider (a non-Critical Care Nurse). For the nurse telling the story, humour may be an initial step in understanding the event in a context that is easier to assimilate. A workplace event may be so consequential that it cannot be "left" at work. Resolution of such an occurrence may be more long-term "if you [ve] got to bring it home." The impact of the "bad parts" is consciously reproduced for family consumption "Family members may empathize more but they understand less." This act serves at least two purposes – shielding family members from "gruesome" details and assisting the nurse to gain a different (broader) perspective (in the safety of home territory) on the information and its meaning. A negative event in the workplace may become less potent – more diluted in the face of many other stimuli occurring away from a work setting. When viewed in a

larger context [workplace and home] the effect may become more tolerable. A new perspective is gained.

Humour As An Avoidance Device: Anger and Denial

Not every participant viewed humour as a means of decreasing stress. Gloria disagreed with the premise of humour as a measure to alleviate stress. She described the need to acknowledge the emotion [anger] that resulted from an incident and deal with the “person responsible.” Gloria discounted the utility of humour as a stress releaser when the source of the stress was not addressed. She questioned whether individuals who “try” to be funny “instead of getting mad” are able to “feel satisfied afterwards.” In this instance humour can become a vehicle for denial.

Gloria: I don't so much use it [humour] for myself [to alleviate stress]. I don't see it as a stress releaser. It's just how it's fun... I know some people use it for a stress releaser, others force it as a stress releaser... Oh, it's like they try and find [humour]... instead of getting mad they try and be funny. As a coping mechanism they'd be better if they just got mad ...go talk to the person responsible or...you may not feel satisfied afterwards. Because you're still pissed off that it happened in the first place... so blow it off ... (# 6 L.778).

The individual nature and perception of humour was evident in Gloria's analysis of the unsuccessful gains for the nurse she observed using humour. She felt that humour, in this case, had accomplished little to defuse the underlying anger felt by the nurse who was “still pissed off that it happened in the first place.”

Alternatively, humour may have afforded the nurse involved the opportunity to “speak up” in a manner that was not challenging and therefore palatable to her. The outcome would not likely to have been altered, regardless of the approach taken. Thus, a humorous, understated approach may have conveyed a message, while maintaining collegial relationships, particularly when the interaction did not involve two peers, but

one person in a subordinate role. A contrast to previous examples of reframing is present. Negative emotions predominate following these attempts to be “funny.” Humour is used in this manner as a means of confronting in a non-threatening manner. The individual responsible is not affronted. A strong message of discontent was not delivered. The “incident” that Gloria referred to involved an interaction between a nurse and a person in an administrative role.

Gloria pointed out that humour is not a universal means of reducing stress. Nonetheless, she upheld the requirement of the nurse to “blow it off” and keep a handle on stress levels. The nurse must weigh his/her own needs against those of the patient - self-care versus patient-care.

There are occasions when the needs of the nurse are more overtly in conflict with those of the patient.

Rhonda: There might be instances where the type of people [who] don't appreciate my sense of humour were involved in a crisis situation where I will crack a joke... and you know its probably for my benefit more than anybody else's... just to give myself a laugh or make things a little bit easier for me. And I know they don't appreciate it, but yet I've done it. But that's too bad (#12 L. 724).

Rhonda's need to “crack a joke” was in contrast to the other health professionals present who did not “appreciate” this show of humour. In the midst of a crisis situation Rhonda was not at liberty to leave, but was required to stay and attend to the urgency of patient status. Stuck in this place, she attempted to “make things a bit easier” for herself. By necessity, this needed to coincide with the presence of the patient and other health care workers. The disdain of others was of secondary concern, “that's too bad.” A brief image of the personal side of this nurse, through a “crack” in the professional outer shell, was visible.

The element of balance is also apparent in the need of nurses to increase or decrease the distance between themselves and patients through the medium of humour. Too much or too little distance can affect the blending of nurse/personal/patient dynamics.

Exposing Versus Disclosing

Increasing the Distance: Humour as a Shield

Humour as a shield puts more distance between nurse and patient. Jokes and a tone of jocularity may subvert more serious issues from entering into the nurse-patient relationship. The nature of this type of humour is superficial to all parties. The interpretation of superficial humour is unidimensional and univocal. The sender (the nurse) of humorous messages is successful in deflecting questions or comments, conveying the impression that more serious topics are taboo.

Cindy: You don't want to use humour as a shield... [The impression is given] I just keep joking with them. I've got this shield going here. We don't have to talk. We just joke all evening. We don't have to talk about anything serious here. We don't have to discuss your fears, you know, we'll just joke all night (#3 L. 1202).

Georgette: Sometimes it's the staff's way of coping ... if a staff member is covering [relieving another staff member for a break] and they don't really have the time to invest into what the patient really needs [information] ... they might make a comment that kind of dismisses it for now, until the regular nurse gets back from break... (# 11 L. 628).

Cindy: ... If I'm joking with you I'm interacting with you. We're talking but I don't have to take the time to ask you what's bugging you...I'm not really finding out why you're upset... (#3 L. 1224).

Conflict between the desire of the nurse to avoid engaging in potentially challenging discussion and the requirement of the patient to be counseled was apparent. In this scenario, the needs of both parties' can not be simultaneously met. The patient may be entertained if the nurse chooses "to joke all evening." The need for information or support will not be realized however. The nurse may gain through avoidance of broaching delicate or awkward topics, but does not fulfill her obligation in relation to this patient's psychosocial domain.

This deflecting type of humour prevents the development of an authentic relationship between nurse and patient. The nurse exercises "topic control", deferring to fun or less difficult interaction that does not address patient needs. Humour used in this manner can be destructive and uncaring.

Increasing the distance between nurse and patient can in some cases benefit the nurse, without having a direct impact on the patient. The following nurse distanced herself from a hospital routine that made her uncomfortable. She also disengaged from her task of wrapping a body by participating in humorous conversation with a co-worker.

Nancy: There are things that I refuse to do [out of respect for the patient's body] I refuse to tie the ropes, you know, to tie a corpse with ropes. I refuse to do that. I just can't stand those strings cutting the flesh... So in that way I'm using humour over top of the body is out of respect for the body ... [comments made] wouldn't be about the body...it's just that the body is like a table ... Maybe it's a way of psychologically separating [myself] from the job [I'm] doing (# 9 L. 523).

Nancy paid homage to the body and treated it with respect "I refuse to tie the ropes." She then retreated to a safer distance when wrapping the body, by considering the body as an inanimate object "a table." Humorous comments exchanged between Nancy and other staff members provided a means of distraction. Comments "wouldn't be about the body." Their remarks also signified a return to normal business. In their view,

regard for the body was not diminished, yet they did not focus on the “job [they were] doing.”

Decreasing the Distance: Self-disclosure

Personal Self-disclosure

Humour directed to oneself is non-threatening. Barriers between patient and nurse are decreased as the nurse reveals something about his/herself to the patient. This knowledge can promote a sense of connecting and rapport. These remarks often involve a degree of self-disparagement. The nurse is seen as more “human” and less as a “professional” or a stranger.

Alice: [I make jokes about myself] If I fumbled doing something ...[or] “I guess I should learn how to drive” (#8 L. 184).

Susan: You put a thermometer in their mouth and then you start talking to them and so you’ll say, “Isn’t that typical, nurses always do something like that” (#10 L. 94).

Inanimate objects (driving abilities and thermometers) can be the butt of humorous comments. A non-human object is a safe one – a neutral target. Jokes about the environment or individual nurses can increase the bond between nurse and patient as they share a little joke, often at the expense of the nurse. Susan jokingly stereotyped nurses in their tendency to place patients in no-win situations by placing a thermometer in their mouth (requiring the mouth stay closed for the temperature to register) – and then asking them to open their mouth to respond to a question posed by that same nurse. On another level, this type of “bind” may parallel other discomforts faced by the patient in the ICU – those “discomforts” designed to diagnose and treat the patient’s critical illness. Susan’s comment, while self-disparaging, also had the quality of empathy for the plight of her patient caught in an untenable position.

Claire: Humour makes people more accepting. It shows them that they're a little bit more human and they're not so rigid that, you ... can't make a mistake (#2 L. 549).

Some nurses used their personal experiences as means of self-disclosure with patients and their families. This was effective in forging a personal connection beyond the professional relationship between nurse and patient.

Nancy: My Grandpa had bypass surgery [open heart] ...and when I prepare people for bypass I share with them ... all of a sudden it'd [be] my Grandpa lying there... I share this with them ... with my Grandpa I told him, with all the fluid you're wrinkles will be puffed out and you'll look 20 years younger...he was lying there [with an endotracheal tube in place] and telling me to get a little mirror, he wants to see what he looks like (#9 Line 237).

Nancy shared her Grandpa's experience with open-heart surgery. She was moved by the sight of a patient about to undergo a similar procedure "lying there." In the telling of this story Nancy revealed something of herself as a person. She ventured beyond the requirements of her professional role. Her humorous anecdote promoted a sense of confidence in patients' families when they realized that all must have gone well or the nurse would not be recounting a funny story. A person in dire distress following surgery surely would not be asking for a mirror "to see what he looks like."

Professional Self-disclosure

Sara: It's quite often [that I use humour] in equipment and beds, but more often than not, it's usually directed towards yourself ... people think, "Well, everyone's seen it, I better recognize it and call it for what it is first before someone else [does]" ... usually I find it more inward than towards someone else... (# 4 L. 585).

Humour was often initiated in response to a mistake that had been witnessed. The nurse "as a person" was exposed in her reaction to something "fumbled." Accountability for the error was evident within the humorous comments by the nurse. Admitting her

mistake did not necessarily diminish the credibility of the nurse. The fact that others, including the patient, were observers may have precipitated acknowledgement “before someone else [did].” The nurse’s ability to make fun of herself minimized the event as a little gaffe and projected an air of security and self-confidence in her skill. Humour directed “inward” toward oneself was safe. The mood was lightened – but not at the expense of another person.

I observed an instance during my fieldwork where a nurse acknowledged responsibility for an unfortunate incident. Her patient had pulled out his endotracheal tube during the process of taking an x-ray. Although not technically the nurse’s “fault”, this nurse assumed accountability for the patient under her care.

During the process of doing an x-ray his [endotracheal - breathing tube placed into the lungs] tube moved across the back of his mouth and became dislodged ... the situation was handled calmly and the patient remained extubated [without a tube]... a little while later jokes were made. One of the nurses commented that she had heard the patient would be “a difficult wean” [preparation to remove the tube would not be an easy process]. This nurse replied that she had given him “her own x-ray weaning technique” (Fieldnotes p.153-4).

This nurse’s comments spoke of her personal characteristics. She did not attempt to shift or deflect blame. Rather, she addressed the incident directly, taking charge of the scene in the retelling - “she had given him” this particular type of “weaning.” Those present knew that exactly the opposite scenario had transpired. Her humorous note [especially since the patient did well with his endotracheal tube removed] exuded an aura of confidence and control over her reaction to the event, in addition to her managing of the event itself (during and immediately post extubation). A minor incident was placed in its proper perspective and her “public face” saved.

This experience provided lots of ongoing amusement throughout the shift, when ongoing jokes were made about further x-rays that were performed. All of the staff in the immediate vicinity were entertained. On meal breaks the rest of the staff were “informed” and thus included. During the rest of the morning this patient had repeated x-rays performed (for reasons that were unrelated to the extubation). The nurse took the repeated interruptions (x-rays) in her stride and commented that the patient had “now had everything x-rayed except his sinuses” (Fieldnotes p. 158). A potential source of irritation had become a source of comedy.

The need to maintain a balance between a number of personal and professional forces is seen in these situations. The balance between self-care and patient care, closeness and remoteness, disclosure and exposure, personal and professional image, and catharsis and restraint, is precarious. A crack in the façade of the nurse may enable the patient a better view of their caregiver. This same crack may represent, to the nurse, an unintended exposure through a protective outer shell. The nurse must learn to handle this double-edged sword.

The Use of Humour in Relation to Patient and Family Members

The atmosphere in an Intensive Care Unit is not conducive to rest or relaxation. Patients lie in close proximity to one another, separated by curtains. Males and females share the same room – the criteria being not gender, but acuity of medical status. The other patients witness any visual, auditory or olfactory activity in the vicinity, if their level of consciousness permits. Extremely ill patients are not gowned but draped with small sheets across the thorax and groin. Easy access to the numbers of lines and tubes in their extremities, chest and groin areas is permitted, providing some sense of decorum. A

sheet will be spread over the patient when family is present. Each bedside or cubicle in the “main” unit consists of an arbitrary designation of physical space, its size determined by the varying amounts of equipment required to nurse that particular patient. Curtains provide a pliant and often insignificant boundary. Bedside curtains are ill fitting and do not reach the ground. Privacy is at a premium.

A bedside scene is often exposed as personnel repeatedly enter and re-enter a cubicle. A nurse at one bedside may need the visibility [curtains back] in order to safely monitor the progress of two [or three] patients while providing break relief. At best, patients hear the commotion of an unstable patient in crisis. At worst, they watch it too. They take comfort in the fact that help is nearby.

Easing the Tension

If a patient wished to deny or diminish the significance or potential threat to his life related to his need for ICU admission, this would be difficult. Alarms of every description and origin sound repeatedly. Movement of a single muscle on a patient’s chest, change in breathing or heart rate, or a slight cough, can cause alarms to sound.

Georgette: Some patients will get really tense when they hear an alarm [of a heart monitor] ring. “Oh, what’s wrong now.” ... I said to one gentleman, “Sometimes if you’re moving it’ll go off every time.” He said, “Don’t worry. If I can hear it I’m still alive.” I tell all my patients that (#11 Line 186).

This patient projected his concerns to the nurse in a light fashion “Don’t worry.” He conveyed an air of bravado in his joking statement, “If I can hear it, [the alarm] I’m still alive.” The dual meanings of the term “movement” - “artifact” [electrical interference] to the nurse and “life” to the patient - are a source of amusement. The patient has imparted important information about potential patient perceptions of alarms -

the threat of impending death. The ability to laugh in this “high tech” environment may decrease the patient’s anxiety. A “familiarity of feeling” was also enhanced when the patient was able to respond in a manner that was habitual (and thus familiar) for him/her. The patient was able to minimize the alarms in his/her mind as being “laughable.” He will assume the alarm to be “false” if he is alive and can still hear it. He laughed and suppressed the potential significance of the alarms and his own mortality. Sharing a joke also promoted a sense of bonding between patient and nurse, increasing the patient’s confidence and rapport with the caregiver.

Creating a Therapeutic Milieu During Admission

A time of peak anxiety occurs during the admission process. For patients experiencing a first admission everything is foreign and ominous. For those patients being re-admitted, the significance of a repeat event may also be terrifying. Nurses must keep a calm appearance at all times, to prevent a patient from sensing or misinterpreting the source of their anxiety. Humour provides an important means of restoring and maintaining a sense of calm [normalcy].

Alice: Even just joking about the equipment makes in their eyes the event seem less serious (# 8 L. 525).

Cindy: I think [humour] makes it a more friendlier unit...they [patients] can talk to more if they know you’re friendlier... makes you more approachable (#3 Line 1188).

Sara: You can let them know that they can fool around here ... what’s happened is serious but you’re supposed to have your stress relieved ... that’s one of the problems that have led to this, like just lighten it (#4 Line 130).

The above examples provided by Alice, Cindy and Sara reveal a quality of therapeutic intervention, in addition to their “ice-breaking” tendencies. An orientation to

the unit was contained within their comments. Although not stated, social mores were disclosed - the unit is "friendl[ier]" and "they can fool around here." The nurse was portrayed as being "more approachable" and viewed as "being there" for patients, willing to communicate on a serious or not so serious level.

Sara referred to the "problems that have led to this." Stress as a precursor to disease was acknowledged and dealt with [partly] through the use of humour. Patients with cardiovascular problems in particular are at risk of increasing the extent of the heart damage of a heart attack or inducing arrhythmias [irregular heart rhythms] when under stress. The Sympathetic Nervous System is stimulated and serves to increase the oxygen requirements of the body. The heart, already unable to supply sufficient oxygen, may be incapable of keeping pace with these increased demands (Riegel, Thomason & Carlson, 1997). Laughter, in promoting relaxation or reducing anxiety, can exert beneficial physiological effects by reducing arousal of the "fight or flight response" of the Sympathetic Nervous System stimulation.

In some instances the nurses attempted to project an aura of normalcy, particularly when a patient had an acute event (chest pain) that, from a medical standpoint, was now under control. During the admission of a CCU patient the nurse explained to her patient about letting her know if he should have any further chest pain. Her use of humour was subtle. She made colloquial types of comments when examining the patient's cold feet and taking his temperature, saying he was "frosty". There was an aura of relaxation (Fieldnotes, p. 67). An air of lightness in this situation was achieved through the use of non-medical jargon. Familiar words were spoken.

Cindy: When I'm coming in on a shift and the guy is really tense...I say, "Oh hi, I'm your nurse for today in this zoo," or something that just cracked the ice...and he just relaxed (#3 Line 167).

The nurse established the tone of the conversation through her remarks to a patient. In her use of the words "zoo" she acknowledged the busyness of the unit. Aside from the jesting nature of her comments she may have been affirming the patient's perception of the ICU environment, thus facilitating an immediate degree of rapport.

Sara: If you're too serious they're sure something is wrong (# 4 Line 57).

Sara exposed the patient's potential misinterpretation of a demeanor that is "too serious." The nurse, in expressing humorous comments, inspires confidence in his/her co-workers, as previously discussed in the section of "self." The patient also responded to the nurse in her deliberate attempt to use humour to display a calm competence.

Humour As a Nursing Intervention

Nursing Presence

Susan commented on the need of nurses to feel that they can make a difference. In a situation that is otherwise not hopeful from a medical standpoint, a smile or a laugh may provide a moment's respite from reality. Even a fleeting glimpse of a patient's humorous reaction can represent tangible evidence of the presence of the nurse.

Susan: I think it also gives [the nurse] a sense, it makes you feel a little better because every day you come on [shift] and you see patients who aren't doing well if there's no progress... it's hard for them but it's also hard for [the nurse] making them laugh or smile [makes you feel] that you've done something... if not medically maybe emotionally... (#10 L 189).

When the nurse can not make a physiological impact he/she attempts to make an emotional impact. The outcome [death] is not changed. The nurse benefits in the realization that he /she has "Done something." This knowledge may help the nurse to

resolve some of the more sordid details of caring for patients when “there’s no progress.” Gains are achieved for the sender [the nurse] as well as the recipient [the patient].

Teaching of Patients and Family Members

The onset of confusion is a very unsettling experience for patients and their families. ICU psychosis, a common cause, can be the result of myriad causes, including sleep deprivation, constant pain and anxiety, multiple stimuli affecting each sense, and countless physical reasons. Where possible, nurses seek to reassure families that its appearance is often temporary and beyond the control of the patient, so commonly seen in ICU that it is termed “ICU psychosis”.

Georgette: I’ve said to families, “You know, guess what, in two days when he’s fine he’s going to deny this”...when I saw the family after I said to them “Is he denying it?” and they said “Of course” (#11 Line 226).

The nurse reassured this family that the patient’s ICU psychosis was not a sign of further disease or complications. She referred to the way he will react “He’s going to deny this” following the event. The family was redirected from the current unpleasantness to the more positive future. “In two days,” the patient will be feeling so well that he won’t believe what happened and will “deny it.” The ability to joke about such a disturbing event allows the nurse to “speak the unspeakable” and educate the family at the same time. Information was provided in a tone that promoted a bond with the family, was truthful, and not condescending.

A humorous comment can be helpful in having a patient “save face”. During my fieldwork I observed a nurse respond to and alleviate the embarrassment of her patient with a humorous comment.

An elderly male patient was embarrassed in the morning because he had an “accident” following too many laxatives ... He was laughing and making

disparaging comments about himself. The nurse at first was very matter of fact in stating “no problem ... etc” Then she laughed more as he [the patient] continued to and told him a little story about a patient who had a similar experience after she had given him 2 prune juices. [The patient] at this point seemed much relieved and more relaxed. He smiled and stopped with his laughter (Fieldnotes p. 9-10).

In this situation the first inclination of the nurse was not to display humour. She attempted to listen and reassure the patient that there was “no problem.” When the patient continued to show his discomfort she then told him a story about another patient who had the same misfortune. He was not unique in his “accident.” This very problem had occurred in another patient receiving an overdose of laxatives. The patient in this scenario was then able to relax and desist from his self-disparaging comments. He knew that the nurse understood and accepted his behavior. The patient was spared further embarrassment when the nurse clarified that his problems were related to the medications he was taking and were therefore beyond his control. The humorous approach in this situation served to enhance the degree of rapport between this nurse and patient that already existed. This nurse did not display laughter at the onset of the conversation. Her laughter did not emerge until she had educated the patient about the potential cause of his problem and had reassured him that he was accepted and understood. She displayed her empathy for this patient throughout the conversation. Her sense of empathy guided her in her responses and interventions with this patient.

Wanda described humour as a tool to reduce anxiety and help make patients more amenable to teaching and explanations about their progress.

Wanda: [Coronary care patients] when they're really anxious, often in the first eight hours after admission ... when their pain is taken care of and they're still very anxious ... when you realize that they don't know what's going on ... you can assess when they're stressed out and not getting everything [too anxious to attend to detail] so then humour might help relax them (# 14 L. 343).

Stephanie and Georgette acknowledged the difficulty in providing information to a patient who was not ready to hear and using humour to reinforce a pattern of denial.

Georgette: It's harder when patients use humour back [when] you try to teach them and they're making comments and you're obviously not getting through... and that's when it is a defense mechanism for them...you play into it a bit and you keep trying to steer back to the seriousness...maybe on the ward they are ready to absorb the information...you go with it (# 11 Line 796).

Stephanie: Sometimes you'll find these older guys who are really nervous will sit and try to tell jokes. They're having nine out of ten (a pain scale of ten – with ten being the highest possible amount of pain) but they're trying to tell you jokes because you know that they're scared. I remember this guy sitting there trying to tell me jokes and his wife's [saying to him] just relax ... So you let him tell his joke and laugh and you say ... now we'll try to get rid of this pain and you can tell some [more] jokes later (# 15 L. 642).

Patients' use of humour post myocardial infarction [heart attack] may be used as a "defense mechanism" that permits the patient to suppress the reality of their myocardial infarct until they are "ready to absorb the information." Nurses' support of this denial may be therapeutic in some instances. A humorous comment can be used to provide a moment of relief. A funny comment can also promote a legitimate means of relating to the patient, at the same time creating an opportunity for the nurse to "steer" the conversation back to "serious business." As with any humorous statement, the patient is free to respond to a comment on any level – a superficial level or a deeper, in this case, more serious level. The nurse can assess this response as information to be used as a guideline for teaching purposes and patient coping responses to a significant life event.

Distraction

Humour can be therapeutic in large and small ways. The benefits can be fleeting or more enduring. Bev described the therapeutic effect of a smile on both patient and

nurse. A single comment can provide a moment of wellness in ICU patients and distract them briefly from their circumstances.

Bev: ...Patients that you know are never going to make it...you end up using a lot more humour...not that we expect our patients to have a pasted smile on. There's gotta be some kind of pleasure ... that basic quality of trying to get [the patient] away from [their] suffering. And sometimes you do that by ... using humour... he was the only one who was with it in that corner ... so basically when I said the comment it was because I knew he was looking... he was paying attention and he was bored out of his keister ... when I walked in I didn't have my glasses on. [I] had to go out and put them on and I looked around the room and said, "That's what you look like." And he just howled. He had a tube in his mouth but he was laughing, as much as he could ... [the patient] didn't expect [me] to do something so [silly]... (#5 Line 131).

Bev described the use of humour as a means of distraction "To get him away from his suffering" or to relieve boredom, "He was bored out of his keister." Her actions and words had a self-deprecating quality (I can't find my glasses and I can't see without them). Her humour was safe – directed at an inanimate object and her performance, but exuding an air of self-confidence. She acknowledged the patient's presence and his mood [boredom] in her comments. This man was the only patient in the vicinity capable of witnessing this scene. The nurse performed on this patient's behalf. She and a patient shared a joke that no one else had been privy to, permitting a moment's respite from the boredom and the uncertainty he faced. The nurse had injected something of herself into the situation. Her "act" was unexpected, accentuating the patient's enjoyment. The response of the patient "He just howled as much as he could" displayed his appreciation of this gesture of humour and his desire to share this moment with the nurse.

Rhonda: There's a common joke that I say to patients if I'm going to take their blood or start an intravenous and they say that they're scared to death of needles and hate the sight of blood and I'll say "Well you know what, so am I. So do what I do and close your eyes." And then I'll put in the intravenous or take their blood, or else make a comment like "I usually faint at the sight of blood myself.

And if I do please catch me.” And just to ease them up a little bit...if you can get them to even chuckle and then I do the poke at the same time (#12 Line 569).

This conversation disclosed several elements of humorous communication. The nurse used self-disclosure initially “Well you know what, so am I.” In a difficult situation, she and the patient shared the same emotion, they were both, “Scared to death of needles.” She included a joke, “If I faint ...please catch me.” This joke inferred a power that they [patient and nurse] both knew the patient did not have [the ability to “catch” her].

This implied ability empowered the patient embarking on an unpleasant experience. The technique of distraction was also employed. “At the same time,” that the patient chuckled, “the poke” was accomplished. In this manner, an unpleasant event served to potentially promote a closer bond between patient and nurse. The patient now knew a little more information about this nurse as a person. Patient and nurse shared and surmounted an experience by means of a “chuckle.”

Susan: I think they’re very anxious and stressed out about the fact that they’ve had a heart attack ... humour brings it into reality a little bit ... sort of, ... so they’re not focusing, focusing, focusing on the negative things ... humour makes them see a lighter side (#10 Line 130).

Susan also described humour as providing an effective means of distraction. In this situation emotions were substituted for the feelings of anxiety associated with suffering a heart attack. The nurse’s encouragement of the patient to laugh and not “focus, focus focus [ing],” was also encouragement to look at the bigger picture. This picture would include the “lighter side” – a more realistic view of resuming life after a heart attack. The patient was encouraged to move away from the overwhelming emotion of anxiety to incorporate another emotion, that of laughter.

Conveying a Difficult Message: Empowering

Information Giving: Empowering Patients

Humour can be used in a purposeful fashion, to present information. In this manner, communication is taking place on two levels - an outward jocular comment - and an underlying serious and perhaps unpleasant message. This type of delivery can serve to soften the blow, as a less negative connotation is accomplished. At the same time, a direct manner of communication is occurring.

Gloria: Humour with patients is more like a jocular kind of humour, more light easy flowing...when people say is it going to hurt? ... You can say it straightforward or you can say it in a joking kind of manner...it's a nicer way of letting them know the scoop (# 6 Line 475).

Use of a humorous bent to disclose certain information displayed the nurse's recognition of its unpleasant nature and also a measure of insight into the patient's position. A sense of caring was present as the nurse provided the information in as gentle manner as possible "it's a nicer way of letting them know the scoop." Gloria further differentiated the need to "soften the blow" via a humorous message, from the obligation, above all, to be truthful and avoid excessively minimizing the discomfort of a procedure. Recognition of and abiding by the need for gentleness and at the same time truth are a nurse's way of wielding power.

Gloria: You know it's going to hurt ... You can turn around and say [it in a] very frank, straightforward [manner] or you can say it in a joke...I don't lie to my patients...if someone says ...there's a mosquito bite. Excuse me. I've had IV's. I've had mosquito bites, they're not the same" (# 6 L 482).

This same nurse described a conversation with a patient who made a request that if granted would result in bodily harm to anyone in the vicinity.

Gloria: ... I have a fellow with COPD [chronic lung disease] up in a chair who's a three pack a day smoker and I say to him, "Can I get you anything?" And he says, "Coffee and a smoke will do right now." I said, "The coffee I can get you. The smoke will blow up your face right now" (# 6 Line 511).

The request for a cigarette would not be consented to in any area of the hospital. In the ICU setting this request is also life threatening. The presence of oxygen [this patient was likely wearing nasal prongs or an oxygen mask] would cause immediate combustion and "Blow up in [his] face." These comments were extremely direct in their graphic description of the consequences of such an action. The unexpected response of a reply of this nature was the source of a portion of its humour. To the uninitiated, this answer could seem humorous in its exaggeration of potential results, but in reality the answer was truthful.

In the midst of the foreign and often frightening atmosphere of the ICU the patients are able to exercise little control over their surroundings or over their own bodies. One nurse spoke of the patient in ICU as being " basically stripped of their dignity... while being exposed to multiple nurses and doctors" (# 8 Line 622). Some of the participants were sensitive to this loss of control and attempted to help the patient retain a measure of control whenever feasible. One participant contrasted the maternal approach of some nurses with her own style of relinquishing control.

Susan: Nurses can be ...very matter of fact...this is what you are going to do...It's more like telling a child what they're going to do...whereas I find...you go in there and sort of joke around and...it sort of puts them on the same level (#10 Line 484).

Both Susan and Gloria referred to the regression to childhood "telling a child" that can prevail, when patients are treated by caregivers who were not sensitive to their own power. The power of the nurse is magnified in the face of patient's circumstances.

Humour serves to minimize some of the imbalance and place nurse and patient “on the same level.”

The following nurse displayed empathy and a sense of her patient’s loss of “physical” control by using a light comment to impart rather unpleasant information.

Gloria: A patient says, “I don’t want to turn over... I say, “**You turn around**”. [This is stated in an obviously exaggerated fashion, much as one might talk to a naughty child or small pet] Am I going to stand there and scorn this person like a child and say” you have to or you’re going to die.” ... or do I just turn around and say, “Well, let’s look at the situation...” (# 6 Line 498).

The lack of power and control this patient retained over bodily function was seen in the need for discussion as to whether or not the patient would be turned. An element of futility was revealed in the underlying comment “You have to or you’re going to die.” The “nurse” [with her intact health] and “nature” assumed physical dominance in this situation. The nurse, however, attempted to deflect some of her power - the decision to turn - back to the patient “Let’s look at the situation.” The nurse’s discomfort at this patient’s loss of control was seen in her questioning and her use of the term “scorn” to reflect a patient’s opinion that potentially differed from her own [or the opinion of the medical community]. The nurse used exaggerated movements and compared the situation to dealing with a child, stating in a loud voice, “**You turn over.**” She mocked this type of scenario.

Advocating For Patients and Family Members

Nurses act as advocates for patients under many different circumstances. In all instances of advocacy, nurses attempt to represent the voice of the patient. When patients are partially or totally unconscious, or have an endotracheal tube in place, this may be true in the literal sense. An endotracheal tube is passed into the windpipe, [trachea]

through the vocal cords, to introduce oxygenated air into the lungs. Speech is not possible, because air bypasses the vocal cords in its direct passage to the lungs via the endotracheal tube. Nonverbal communication, mouthing of words, note-writing or pointing to letters and symbols on a board are methods of communication used in these circumstances. The need for advocacy on a minute-to-minute basis is real.

A nurse described her intervention on behalf of a patient by making a comment with a tone of jest to the son of a 40 year old female patient who decided that he would stay in the room while the EKG (electrocardiogram) was being performed on his Mother.

Bev: ... With an EKG [electrocardiogram] you have to have the body basically naked and we ... but we asked him to leave... keeping in mind that we work with intubated patients and we also have patients that most of the time it becomes a risk when [they are not able to express their wishes easily and clearly] ... I said, "My son ... he's never going to see me naked"... [then] I thought that it's the wrong thing to say because she's awake. I don't want to insult her...I wanted to protect her... and I guess it was my own feelings but to me [she seemed] almost, have some facial expression when he mentioned that he was going to stay. She responded to me well afterwards... (# 5 Line 58).

Provision of patient privacy is a concern of ICU nurses, given the physical setup of the unit and the proximity of other patients. Advocacy of this nature is within the domain of nursing as nurses maintain a constant presence at the bedside. This nurse empathized with the patient and attempted to "protect her" by affording her a degree of privacy in the midst of a physically exposing procedure. An EKG requires exposure of the chest to allow placement of twelve leads [pads attached across the chest wall]. She responded to "some facial expression" of the patient when her son announced he would stay. Her advocacy was based on an understanding of the procedure and an intuitive grasp of the patient's response. No words were necessary to convey this information. She initiated a humorous comment that revealed her understanding of the ramifications of

the situation. Her use of “I” statement was effective in its non-accusatory tone, yet her words were direct. This son would have no [further] confusion over the nature of the procedure. Her comments deflected attention and the decision from the patient [his mother] to herself. Although initially unsure of the appropriateness of her comment, this advocacy behavior was later reinforced by the response of the patient – a sense of gratitude. This woman’s son may have unwittingly benefited in this scene as well, if he was truly unaware of the intrusive nature of the procedure and was thus spared embarrassment caused by his presence during its performance.

A scenario the opposite of “over-exposure” of the previous patient is seen in the “under-exposure” of a patient covered for a procedure. The risk of forgetting the presence of this invisible patient, lost in the sheets, exists. Another nurse, Cindy, also described a time when she made an impact on an unfolding situation and changed its course. The doctors were in the process of putting in a Cordis [large intravenous] into a vein in the neck. Drapes, [cloths or special towels] needed to provide a sterile area for the procedure, were placed over the face and chest of the patient.

Cindy: I think sometimes they forget that there’s a patient underneath all these drapes ... there’s three of them standing at the bedside, and one of them goes, “Oh, be careful, you don’t want to hit the carotid [artery] like I did.” And uh, she goes, “Yeah, were you here the day that John put the Swan into the patient’s head? [a catheter that is normally inserted through the right side of the heart and into the lungs]. I had to say, “Hang on here. She’s not asleep. She’s under the covers here.” And the two of them apologized but the third one goes, “Well I’m not going to apologize for that.” (#3 Line 831).

These drapes provided for the physical safety of the patient, in protecting a sterile area. At the same time they exposed the patient, hidden beneath them, to comments that were open to misinterpretation and thus frightening. The physicians involved maintained a conversation, perhaps to relax a colleague in the midst of performing an unfamiliar or

difficult procedure. Their tone reflected concern with potential complications “You don’t want to hit the carotid [artery].” Their informal tone belied their underlying anxiety and perhaps a lack of experience. The patient listening to these remarks could possibly discern the fact that the physicians were referring to mistakes made on other patients. However, the extent, if any, or amount of suffering caused to these “Other patients” would not be clear to a non-medical person. The result could be far worse imagined consequences for the patient than would in reality occur. The fact that these “mistakes” occurred infrequently and were “usually” quickly assessed and rectified was not clear to the patient. The fact that, in the vast majority of patients, this procedure was safe may be of little comfort to a patient who may picture him / herself as part of the small percentage of patients in whom a complication could arise. The colloquial tone of the physicians in this case could be misconstrued by a patient as reflecting a lack of concern for patients suffering complications. In all likelihood, the more upbeat tone of the physicians represented a note of caring; colleagues in the process of supporting a peer through a procedure that was unfamiliar or difficult to perform. The nurse injected a note of caution. She reminded the physicians about the patient “She’s under the covers here.”

One nurse planned a strategy to deliver a message to a physician through the medium of humour. Unlike the previous situation, the opinions of the nurses regarding discontinuing therapy on this patient were not being solicited. When nurses voiced concerns they were dismissed. A more elaborate strategy, beyond a comment, was indicated, to ensure that the voice of the nurse was heard.

Bev: Who’s to say when enough is enough? But this particular patient was. We had every medication on him. He had multi, multi system shutdown...we were supporting every system of his body and they wouldn’t stop for this man. And he didn’t speak English. [Concerns were voiced in rounds] “What are we doing

here, have we made any gains?" They weren't listening to what we [the nurses] were saying [or] how we were feeling about the whole situation. The respiratory tech came by and I knew that the doctor was right behind me... I said "If you walked by this person on the ward ... what would you call out?" And she looked at me, because she could see the doctor behind me. And she didn't know what to say. I said, "You'd call 99." And she shook her head, yes. And she started to laugh and then she said, "The doctor is right behind you." And I said, "I know." She said, "You set me up." I said "yeah." Well she just laughed. But the message was gotten. The message was, take a look at the patient and stop looking at numbers and look at the patient ... the point was, if you walk by this person on the ward you would know [that he was near death] because he had that colour, the colour of death or the look of death ... And it didn't take much longer, maybe another 24 hours when they did discontinue treatment on him (# 5 Line 277).

Nurses were required to substitute their voice for this patient who not only did not speak English, but also was too critically ill to speak for himself. The nurse engaged in role-playing with a rather unwilling team-member, the respiratory technologist. The inter-disciplinary nature of this exchange may also have underscored the impact of the message to the doctor, i.e., This is obvious to everyone but you. Beyond the message that it was time to consider letting this patient continue his journey toward death, the nurse tried to educate the physician. This message was also intended for future patients. She underscored the importance of knowing the patient beyond his numbers on the monitoring screens. Her reference to patients on the ward [other than an ICU setting] encouraged the physician to think back to his /her previous experiences in other settings when the "benefit" of technology was not present.

Nurses often became dramatic in using a humorous approach to advocate for a patient. When recalling these stories their tone would fluctuate between laughter and frustration. In some instances the participant was close to tears. Nurses expressed their frustration at the lack of power or control in a situation that they did not want to be a part of. Decisions about discontinuation of therapy, or the need to press on with new

treatments until definitive diagnoses are made or confirmed, are the domain of the physician. Nurses, however, may not agree with these decisions. Despite their views, they must continue to provide minute-to-minute care for patients. They may perceive their only hope of influencing a situation is to voice their concern and attempt to affect the decision-making of the physician(s) involved.

Rhonda: In instances where you have given somebody over a vial of adrenaline over the course of a 99 [I say to the doctor] “Well do you want me to call Pharmacy and get another couple of bottles [of adrenaline] so we can keep going?” ... Those are smart ass kinds of comments that I have used to get the point across... I think you need to be a patient advocate ... for the patient and their family whether they're alive or dead... just because they're on their way out doesn't mean you stop caring for them (# 12 Line 926).

On the surface an innocuous comment is made. This nurse proposes a ludicrous solution to a potentially ludicrous scenario. Aware of the context and underlying meaning of the statement, the nurse described her comments as “smart-ass”. The physician was continuing resuscitation on a patient the nurses consider to be already dead. A vial of adrenaline can contain approximately 30 doses. The suggestion that another 60 doses of adrenaline be considered was immediately ridiculous to those present. At doses of 1 to 3 milligrams [a usual dose] spaced at three to five-minute intervals [the usual interval] the resuscitation would continue for many more hours. At the same time, this seemingly ridiculous comment conveyed intent to be an advocate for this patient and his family, who may have been anxiously awaiting word of the fate of their family member in the family room.

Stephanie: [In the middle of a prolonged 99] we had defibrillated this guy 9 times ... we asked the doctor, “You're the doctor, make the decision.” And she just hauls out this tissue [Kleenex] from her pocket. She just opened up the gauze and laid this tissue on top [of the bed]. That was the only comment she made through the whole 99. [No further input into the 99 was given by this doctor. Another doctor who was not presently doing a rotation through ICU ran the resuscitation]. “Good thing you had the right Kleenex with you,” we said. As the 99 situation

became more prolonged] ... I said, "He's [the patient] smoking, look at his chest" [referring to the multiple shocks given during the resuscitation]. I put the paddles literally underneath my armpits, you know and looked at her (# 15 Line 1505).

The inability of this physician to carry out her duties frustrated the nurses present.

Their first response was more gentle - a humorous comment made about an inanimate object [the Kleenex]. As the 99 continued, the nurses' impatience grew and their approach became more confrontational. Eye contact was made to attract the attention of the physician. Vivid body language [putting the paddles out of sight under the armpits while crossing the arms over each other in a classic closed style of nonverbal communication] was eventually employed.

The nurse at the bedside 24 hours a day must deal with the tangible reality of the minute-to-minute struggles of a patient in multi-system failure. A patient deemed incapable of making a clear decision about his/her future often is able to mouth words across an endotracheal tube, or fight to pull out all existing lines [tubes in place]. Some nurses talked at length about their views in this area. Their descriptions provided a context for the stresses associated with Critical Care Nursing and the need to develop coping mechanisms that were socially acceptable.

Rhonda: I think that nurses for the most part... reach an end point with patient care sooner than the physicians do...for stopping treatment for people that we think are futile ...I think in terms of being a patient advocate that we may be smart alecky towards the doctor in terms of what we may say when they're continuing with another new experimental drug or a treatment that they want to do. And they won't ever say it and you won't ever say it either but you're thinking that they're doing this in terms of research more than patient care...underneath the humour are undercurrents (# 12 Line 823).

Rhonda: I'm guilty of this. Of being sarcastic with physicians when they want to continue treatment ...And I know that I'm getting my point across without being too much of a jerk [for example] with asystolic patients ...[statistically] the survival rate is zero... if you give enough adrenaline you'll get a heart beat out of a stone (# 12 Line 879).

The tone of this nurse was almost apologetic as she described herself as “a bit of a smart-alec” and of “being guilty.” Nonetheless, patient needs took priority. Relationships with the physicians were nurtured where possible by the use of humour, with undercurrents of more serious meaning. Information must be conveyed in a manner without coming across as “being too much of a jerk”. The potential of treating patients as inanimate objects, by virtue of unremitting attempts to save their lives, was referred to in Rhonda’s statement that, after a certain point, “You’ll get a heart beat out of a stone.”

The plurivocal nature of the humorous messages included superficial jocular comments with underlying currents of caring and advocacy for patients. Varying degrees of frustration and anger on the part of the nurses were also part of these communications. In advocating for patients and their families, physicians were made to be accountable for their decisions. They were moved to make decisions that were often difficult. The gains made were gains not only for the patient, but also for the nurse. The voice of the nurse was heard, but also accepted in many instances as a part of the medical process of life and death decision-making.

CHAPTER V

DISCUSSION OF THE FINDINGS

In the concluding chapter I discuss the findings of my study. Documentation of humour as a method of coping, a communication strategy, and a nursing intervention within the literature, are compared with my findings. Discussion of the research objectives is organized under the themes “context of humour” and the “meaning of humour.” The meaning of humour is developed further under the categories of Critical Care Nurses “use of humour” in relation to their “co-workers,” the “self,” and “patients and family members.” Morreall’s Comprehensive Theory of Humour is examined in light of its ability to provide a framework for the examination of the use of humour by nurses in a Critical Care setting. Recommendations are included for future nursing practice in the areas of clinical practice, education, research and administration.

My journey as a researcher is examined through the processes of reflection and reflexivity. The personal experience of conducting research was clarified throughout the fieldwork and interview phases by means of journal writing and reflection. The process of exploring a critical care setting as a critical care nurse “with new eyes” is described. Areas of personal and professional growth throughout this qualitative research process are revealed.

Summary of Findings

Two themes, the *context of humour* and the *meaning of humour* were revealed in this study of Critical Care Nurses Use of Humour. Findings were presented under categories relating to each of these themes. The context of humour contained five

categories: 1) Factors enhancing and inhibiting humour 2) Assessment of humour 3) Timing of humour 4) Inappropriate humour and 5) Negative consequences of humour. The meaning of humour included three categories: 1) The use of humour by nurses in relation to co-workers 2) The use of humour in relation to self – balance and 3) The use of humour in relation to patients and family members. The six research questions that I posed were answered through examination of the context and the meaning of humour.

Exploring the uses of humour provided direction to the data analysis. Humour always serves a purpose, often a variety of purposes, although this purpose may vary for individuals in a group and may not be immediately obvious to an observer. Additionally, each instance of humour can be interpreted on more than one level.

The Context of Humour

The context of humour encompassed the external and more observable aspects of humour. These contextual factors were more likely to have a common meaning to those present in a situation. Enhancing and inhibiting factors were derived from three sources: the physical environment, nurses and co-workers, and patient and family members. Factors such as the close quarters of the ICU environment and family presence were enhancing or inhibiting, depending upon the circumstances.

Assessment of the use of appropriate humour involved both intuition and specific cues. Nurses used a combination of these techniques. “Knowing the patient” as a person enabled humour to be engaged in with less risk of offending the patient. “Cues” and “intuition” were seen as reflective of a combination of nursing experience and other nursing assessment skills, differing in the degree of specific identification and articulation.

The timing of humour was viewed as the culmination of all factors within the context of humour. Factors that were enhancing in one situation were modified to inhibiting factors in another situation, because of their timing. Optimal timing of humour most often occurred “after the crisis.” This finding found in the literature on the assessment and timing of humour (Leiber, 1986). The definition of “crisis” distinguishes an ICU setting from other areas of the hospital, making humour in the midst of critical events in an ICU more inexplicable to an observer. The “gallows humour” attributed to ICU and emergency personnel may arise from this viewpoint. In many instances, the faster the pace of the ICU, the more humour abounded.

Inappropriate humour was based on a judgement of the content and the intent of the message of humour. The content of humour was context-bound however. The content did not always define how the message would be perceived. The intent of the message was of greater significance. An aura of caring had the ability to transform the communication within a joke or statement from “fun of” to “fun with.” The perception was then altered from inappropriate to appropriate. Inappropriate humour was attributed by the recipient as lacking in caring.

Negative consequences of humour occurred when “mixed messages” were perceived and interpreted. Unintended negative consequences were seen when humour did not achieve the desired effect. Susan, a participant in this study, provided an example. A humorous message delivered to a physician could be misconstrued as “flirting” (#10 L. 535). Assessment was faulty, in the timing of humour or the lack of awareness of an inhibiting factor. In the case of family members, the results were potentially damaging. Escalation of an already existing crisis (admission of a family

member to ICU) was potentially compounded by a humorous comment that was perceived as uncaring.

The Meaning of Humour

The meaning of humour was created by the individual, but was often shared by others in a group as a means of increasing group cohesiveness and bonding. In addition, aspects of humour were specific to this particular ICU setting. The “folklore” and antics of the staff in this unit were savoured and preserved by formal and informal means. Positive memorable events and situations where nurses had prevailed were remembered. These stories formed the basis for part of the unique culture of this setting.

The use of humour in relation to co-workers was also multi-dimensional. Humour not only served a variety of purposes in each case, but also created more than one level of meaning to those who were attuned. A humorous comment allowed a message to be delivered in a sophisticated, yet socially acceptable manner. Additionally, the nurse was able to educate and sensitize a physician to some of the intricacies of the critical care environment and at the same time advocate for the patient through the use of humour.

Self-care needs of the nurse were sometimes in conflict with patient care needs. This fact was evident in the displays of inappropriate humour and the negative consequences that occasionally arose. The use of humour in relation to “self” required the maintenance of a balance between the needs of the nurse and the needs of the patient. Self-care as a prerequisite to patient care was recognized. Humour provided one means to increase or decrease the distance between nurse and patient.

The use of humour in relation to patients and family members involved skillful communication and nursing intervention strategies. Patients and family members were connected through the implementation of humour, as a means of providing truthful yet sensitive appraisals of information. Patients and family members were increasingly incorporated into the culture of this unit, as their ICU stay became more long-term. The plurivocal nature of humour was evident in the intended messages of advocacy, challenging, information giving, and empowering.

Common threads were seen in the exploration of the context of humour and the meaning of humour. Caring was common to all situations involving the therapeutic administration of humour. Inappropriate humour was perceived in light of its absence of caring. Courage, to challenge the status quo or to advocate for a patient, was often an underlying sentiment expressed through the use of humour. The voice of the nurse was exercised in a manner that was not openly confrontational, but nonetheless effective in its impact. Control was also a consistent feature of these interactions. Emotional or intellectual control was strived for, either during or after an event had taken place. This striving to control and “make sense of” reflected the resilience and creativity of these nurses.

Discussion of the Context of Humour

Discussion of the context of humour includes an examination of enhancing/inhibiting factors, assessment, timing, inappropriate humour and negative consequences.

Enhancing/Inhibiting Factors Influencing the Use of Humour

The close quarters of the Intensive Care Unit posed some challenges, but also provided a degree of facilitation in the use of humour. The proximity of staff members encouraged support from colleagues who were able to witness the trials and tribulations of a peer in the midst of a “bad day”. This feature of critical care environments also heightened the risk of humour. Leiber (1986) and Bowen (1992) comment on this fact. The context of one bedside differs from the next. Difficulty individualizing the use of humour with each patient in the vicinity can be the result. Both patient and nurse at one bedside may respond to the crisis at another bedside by decreasing their use of humour. In this respect, the inhibiting influence of the open atmosphere dominates. The discomfort of being a patient in an ICU may be further magnified, affecting those individuals who might otherwise benefit from a humorous exchange.

Humour was most apt to be exchanged between peers. Similarly, nurses were more inclined to engage in humour with the residents they worked more closely with and came to know as persons. Roberts (1990), in studying communication patterns between physicians and nurses, found that the impact of the “social context” and socialization of the physicians had the greatest impact on this communication (p. 68.) The social status of the health care provider was found to have a greater effect on the style of communication than gender (Taylor, Pickens, & Geden, cited in Roberts, 1990). The stresses of ICU nursing and contrasting worldviews of physician and nurses were evident in decisions to prolong or withdraw therapy. Every participant voiced concern and frustration regarding caring for patients when they considered the chance of survival was virtually non-existent. The nurses viewed this prolongation of suffering as unnecessary and cruel. Alice

was representative of the participant's views "We watch people suffer. And that's got to be the hardest thing ... You watch families suffer" (# 6 L. 1016.)

Shannon (1996) outlined the differences in interdisciplinary conflict around ethical issues. She regarded the difference in the perception of nurses and physicians as attributable to differences in socialization, education and the nature of the work of each discipline. Many comments made to physicians by participants in this study that were of a more disparaging nature reflected this undertone of conflict.

Simmond's (1996) research also supports this finding. Her interviews of nurses and physicians in an ICU revealed that "All interviewees acknowledged that overtreatment of dying patients makes working in ICU difficult" (p. 168.) The ambivalence and difficulty experienced by physicians in withdrawing treatment results in a wide variation in decisions made in different settings (community versus teaching hospitals) and with different populations of patients (Silverman, 1996.) The result is an increase in the stress levels of Critical Care Nurses who are charged with caring for these patients. Flippant comments of participants in this study often belied a sense of powerlessness and a need to achieve some kind of control over a situation. The underlying theme of control was present throughout the analysis of the context and the meaning of humour. Humour helped to provide emotional, and at times, intellectual gains. In this respect, humour in a critical care environment had the effect of serving as a powerful communication strategy.

Assessment of Humour

Attention to the assessment of "appropriate" nature of humour as an antecedent to its use was prevalent in a review of nursing literature (Bellert, 1988; Cohen, 1990;

Davidhizar & Bowen, 1992; Hunt, 1993; Leiber, 1986; Pasquali, cited in Forsyth, 1993; Simon, 1988a). Leiber (1986) identified the criteria of timing, receptiveness and content as determining inappropriate versus appropriate humour. Much of the literature, however, is anecdotal in nature.

Participants in this study disclosed that a combination of specific cues and intuition were instrumental in their decision to use humour. Seven of ten participants in Dunn's study (1993) described humour as a function of "intuition" during semi-structured interviews on the uses of humour in a psychiatric setting. Although Benner's (1984) levels of skill acquisition would indicate that intuition is a function of expert practice participants in this study using humour on the basis of intuition also included the more junior nurses in terms of years of ICU and nursing experience.

Similar to the findings of Dunn, (1993) "knowing the patient", was viewed as an instrumental means of assessment. Patients with longer stays in the ICU tended to be engaged in more humorous interaction with staff members, as they became a part of the culture of this ICU. Astedt-Kurki and Liukkonen (1994) reported that "not knowing" the patient represented a barrier to the use of humour within the plan of nursing care. "Synchronicity" or "being on the same wavelength" described by Dunn (1993) was reflected in the degree of rapport that existed between caregiver and patient within the category of "receptivity" in this study. Caring, the most important element leading to the therapeutic use of humour, (Dunn, 1993) was viewed as a thread underpinning all interaction in this study.

Inappropriate Humour

The literature is clear that the nature of inappropriate humour includes sexist or racist jokes, or comments made at the expense of another individual (Davidhizar & Bowen, 1992.) In this study, the determination of inappropriate humour was made on the basis of content and intent of the humorous message. The intent of a message was seen as being a more significant factor. Participants' perception of inappropriate sources of humour was congruent with the literature. However, each participant reported that the context of a remark could offset its potentially offensive effect. A high tolerance of "inappropriate humour" (by definition) within the nursing staff was found in the presence of a caring attitude in delivering a joke.

Participants in this study found their use of humor was enhanced with longer-stay patients and patients with decreased acuity. These types of patients most often included CCU type patients who were able to respond verbally to humorous messages. This ability to respond provided tangible and less ambiguous evidence of the effect of a humorous comment initiated by a nurse. The nature of humour as a communication technique incorporating feedback is underscored here. The ability of CCU patients to respond verbally was related to the absence of endotracheal tube (breathing tube placed into the lungs) in place and decreased severity of condition. CCU patients' receptivity to humour was increased in some cases because of their sense of relief associated "surviving" procedures such as angiograms.

Timing of Humour

The timing of humour was found to occur best after a crisis. This finding is in keeping with the predominate view of the literature (Bellert, 1989; Leiber, 1986; Smith

Lee, 1990). Humour in relation to alleviating moderate states of anxiety is best timed after energies are diverted from solving the crisis (Davidhizar & Bowen, 1992; Simon, 1989). Levels of anxiety were not measured in this study. The relationship between stress level and the benefits of humour in these studies has not been compared and in fact may differ for patient and nurses. The definition of “crisis” sets ICU nurses apart. The recognized tendency of Critical Care Nurses to use “gallows humour” may reflect a variation in their meaning of “crisis” from that of an onlooker.

From the perspective of the patient, Mallett and A’Hern found that patients undergoing hemodialysis used humour “at difficult times” (1996, p. 547). Emerson (cited in Mallett, 1996) also found that patients used humour before and during pelvic examinations at “the most delicate moments” (p. 547). This difference in timing for patient and nurse may reflect different meanings in the use of humour. For the nurse, the height of crisis signifies a signal that action is required, thus diverting the nurse’s energies to intervene in the management of the events unfolding. On the other hand, the patient undergoing this same crisis may need to engage in humour as a means of distraction to “survive the procedure.” Mallett and A’Hern (1996) also suggest that humour provides a means for the patient to reintroduce a topic that is causing the stress in a manner that reminds others, but is also more socially acceptable, when couched in humorous tones.

The timing of humour is regarded as the most significant factor in humour application. The element of timing, within the literature, was defined in relation to the height of a crisis (Davidhizar & Bowen, 1992; Leiber, 1986). More specific clarification of timing was not detailed. Timing in this study consisted of the culmination of all

factors that enhanced or inhibited the use of humour. This broader approach provided a view of the “context” of humour that encompassed many aspects, including assessment and timing. The crucial nature of the element of timing was further supported and articulated. The term “context” was obscured by the fact that enhancing factors became inhibiting factors under equivalent circumstances and vice versa.

In contrast to the literature emphasizing the need for assessment in preventing potential harmful effects of humour, participants in this study did not focus on assessment (Leiber, 1986). Negative consequences were alluded to more than they were described. Most participants had difficulty remembering a specific episode where the use of humour had not been well received. This may reflect the fact humour is often subtle, delivered in a manner that can be interpreted on more than one level. This effect of the ambiguity of humour may mean that a message that is not well received may also be less obvious to a bystander and thus underreported by these participants. The caution reflected in the literature may also reflect a desire to be conservative in advocating an area of nursing that is not well documented. It is possible that the literature, in its emphasis on “criteria” of assessment, undermines the assessment skills of the nurse, who also must deal with a variety of “sensitive” topics and experiences in the course of any workday. Criteria for using humour, as a communication strategy in the presence of rapport may be no more necessary than criteria for using silence. Criteria for the use of humour as a nursing intervention, however, may require a more formal assessment of the patient’s humour style.

Sumners (1990), in measuring nurses attitudes toward humour, revealed an “overall positive attitude,” with a “slightly more positive” attitude in the home versus

professional setting (p. 198). Participants in this study had a greater tendency to use humour in the workplace rather than home setting, in 5 cases out of the total of 15. Three participants reported using humour the same amount in both settings, while another three used humour more in their home. “Actual use” of humour was reported by the Critical Care Nurses of this study, in contrast to the “attitude” toward humour reported by Sumners. In keeping with the findings of Sumners (1990), participants in this study used more humour as their longevity in nursing and in the ICU setting increased. Sumners also found that the attitude toward humour became more favourable with increasing age.

Discussion of the Meaning of Humour

Use of Humour in Relation to Co-workers

The plurivocal nature of humour was present in the various uses of humour to different members of a group. Frecknall (1994) noted that humour was evident on a “number of levels,” each of which were “context-bound” (p. 19). Examination of humorous situations in a critical care setting often revealed superficial humorous comments with a basis of more serious underlying messages. Recognition that humour always serves a purpose encourages one to look beyond what is being stated.

Humour can be viewed as a “cognitive form of chaos” (Fry, 1992, p. 229.) Humour allows one to play with the chaos that arises through the use of humour (Fry, 1992). The creation of humour involves control via the manipulation of reality through play. This striving for a sense of control was a factor in much of the humour displayed in the ICU. Emotional control was achieved during an event, with a humorous quip, or following an event (reframing). ICU nurses often chose to display the emotion of laughter instead of anger, disparagement or sadness.

The element of play was present in many of the pranks and antics of the ICU staff in this study. Des Camp and Thomas (1993) identified two types of play in the work environment. "Play as goofing around" involves "physical, childlike play" such as squirting water with syringes whereas "play as a game" consisted of more intellectual challenges such as solving puzzles or engaging in contests (p. 620). Active play was found to correlate more closely than gaming play in reducing stress. These authors postulated that more physically active play had a cathartic effect, but also noted that more spontaneous forms of "play" might be a means of more consistent stress release. Critical Care Nurses in this study engaged in both types of play, from stretching plastic across a doorway to maintaining a "Gentle Gossip" book. The character of Dino was therapeutic for nurses and physicians as they "played" together and created their own reality of Dino's progress. They were able to act out their fantasy for this "patient." Although in this case the actual source of the stress was not addressed, this seemingly unrelated humour became a symbolic source of stress release (Morreall, 1991). The value of more spontaneous play would be well suited in an ICU setting, where the open physical environment can have a constraining effect on the use of humour.

Lefcourt (1996) noted an inverse relationship between humour and authoritarianism - "support of traditional values" (p. 61). An element of flouting of authority was seen in the design of some of the pranks concocted by the ICU staff. The physicians were often the butt of the practical jokes. "Theodore" (a thermos who was kidnapped by one of the nurses and taken "out on the town") was the property of one of the physicians in charge of the unit. Many of the humorous comments made in a teasing or sarcastic manner were directed at physicians. Though couched in more socially

acceptable tones, they often represented attempts to challenge authority or to point out the shortcomings of a physician struggling with the management of a patient. This ability to use humour was interpreted by Lefcourt as one means of attaining perspective on a situation, by distancing oneself from the stress involved.

The ability to laugh at oneself was another element in the relationship between nurses and physicians that reflected decreased credence of authority. Nurses valued this attribute. This characteristic influenced their decisions about which of the physicians would become their next “victims”. Similar to the increased use of humour with those patients who could respond to humorous overtures, nurses selected certain physicians. Those physicians who were responsive to jokes and who “played along” were most often chosen.

Koerner (1996) in studying congruence between job descriptions and the values of nurses found the least agreement for the skills of adaptability and flexibility. She advocated the use of play to encourage the development of divergent thinking and tolerance for ambiguity. In this study, the participation of nurses and physicians in the care of Dino and the rescue of Theodore provided similar opportunities.

Morreall (1991) recounted the value in the power of humour to encourage flexibility. The ability to engage in a different viewpoint - a less pragmatic one - promotes a more disengaged or objective vantage that may differ from one's own. “Amusement takes us out of the practical frame of mind in which we are only concerned with what to do next” (p. 364). ICU nurses demonstrated an ability to adapt from one death scene to the admission of a new patient through the use of humour, while in the

process of caring for the body after death. This perspective is valuable in the fast and changing atmosphere of the ICU.

The relationship between humour and creativity has been noted (Ditlow, 1993). A similar link was noted in this study. ICU nurses demonstrated creativity in the quality of their “play”, in-jokes and problem-solving abilities. When a physician disregarded their personal safety on more than one occasion, they reframed an unpleasant situation to one that involved humour. Thus, they were able to begin a healing process, first through a degree of detachment and a change of perspective afforded by their use of humour.

“Sharing” humour was seen in the “fun with” activities of the ICU staff. The bonding effect of humour was reflected in the telling and retelling of stories and in “humour in code”. This “humour in code” represented attempts by the nurses to achieve a measure of emotional distance from the situation at hand (an unstable patient transferred from the “north”). These comments had a “sanitizing” effect, changing the tone of the words from “emotion” to the more purely “scientific”.

Participants felt that they shared a brand of humour that was specific to Critical Care nursing and to this ICU. This unique type of humour is therapeutic in its capacity to “share secrets in a safe world” (London, 1995, p. 35). The folklore nature of humour was preserved in a vocal and written fashion. The “meaning” in folklore is always present, even if not articulated. Folklore themes represent symbolic communication and anxiety in the form of humour or the taboo (Buxman, 1995). Rosenberg (1991) also noted that nurses often felt that they could not share all stressful situations with family members. Rosenberg found that gallows humour in paramedics increased over time, with increased levels of experience. The inability to share all the details of worklife is apt to magnify the

feeling of uniqueness in a work environment and perhaps is a factor promoting the use of gallows humour to cope with stress. ICU nurses in this study experienced an increase in their use of humour with longer-term exposure to ICU nursing. Presumably the use of gallows humour was also more prominent over time, although this aspect of humour was not specifically explored.

Humour in Relation to Patients and Family Members

Humour has been recognized as a nursing intervention and defined as “facilitating the patient to perceive, appreciate, and express what is funny, amusing or ludicrous in order to establish relationships, relieve tension, release anger, facilitate learning, or cope with painful feelings” (cited in James, 1992, p. 297). Critical Care Nurses in this study implemented humour in the form of patient teaching, distraction and nursing presence. The literature outlines a plethora of humour “techniques,” including a variety of humour materials (Buxman & LeMoine, 1995; Wooten, 1996 a.) Humour used with patients and families rarely required “props,” in contrast to humour with co-workers. This fact may reflect the open nature of the Critical Care environment and the constraining effects of a “crisis” at one bedside affecting those in the vicinity. The spontaneous and informal use of humour may also be factors. The introduction of humour without physical evidence of its use (humour “gags”) is more unobtrusive and therefore more likely to be sanctioned. Lack of awareness of the availability of “humour” products, coupled with the unrecognized tendency to use humour as a nursing intervention in a critical care setting may also be considerations.

In his study Sheldon (1990), found that the parents of children reacted in a positive fashion to the humorous approach used by the nurses in their teaching. Ditlow

(1993) felt that the benefit of using humour in teaching were that the effects were “felt in the body as well as the mind” (p.68) Parents in Sheldon’s study felt that this humorous approach had lowered their anxiety levels. Nurses felt that these parents had more readily understood the information they were being taught. Sheldon (1996) found that nurses preferred humour that was initiated via facial expressions, laughter and tone of voice. These preferred styles of humour were used in teaching and communicating with parents and children. ICU nurses in this study often engaged in similar types of humour. This more “informal” humour is not only less elaborate and less time consuming, but also less performance anxiety producing.

Perry (1996) found that the top three characteristics of oncology nurses rated as experts by their peers included the effective use of silence, mutual touch and humour. These expert nurses were described as possessing the ability to see the best in all situations and to share this positive orientation in a way that benefited patients and other nurses. Astedt-Kurki and Haggman-Laitila (1992) noted that patients expected nurses to display warmth, an aura of familiarity and a sense of humour. Similar attitudes of family members of critically ill patients are not known. This study included patients and family members in their interactions with Critical Care Nurses, during Phase One. However, in-depth understanding of the perceptions of patients and family members was not the focus of this study. The smiles and positive comments of patients and family members in response to the gestures of the nurses were witnessed. During interviews, participants described positive comments they had received from patients and family members.

Jarrett and Payne (1995) decry the lack of verification of patient contribution to research on communication, noting that assumptions are made about patient perceptions

without the benefit of patient interview. The aim of this research was to explore the nurses' use of humour in relation to patients and co-workers, although the value of future research in this regard is acknowledged. This type of information is crucial and would be excellent for future research. The perceived risks in using humour, particularly in a Critical Care population, make this research even more advisable. In keeping with the mandate of nursing research to research patient outcomes, many future topics related to potential effects of the use of humour are possible.

Fosbinder's (1994) data on patient perceptions of nursing competence revealed patients' "personal sharing and kidding as central to the development of the nurse-patient relationship" (p. 1088.) Eight out of twelve nurses in that study used humour during many patient interactions. Reportedly, laughter and humour were often used when patients were in pain, as was the case with Mallett's (1996) hemodialysis patients. and in some instances of distraction noted in this study. The element of sharing personal information as a means of putting patients at ease was also found in this study (decreasing the distance between patient and nurse). Seed (1995) noted the tendency of nurses, with increasing maturity, to deal with intimate patient care through the use of humour. This observation was similar to Sumners (1990) data and this research with ICU nurses. One of the participants in this study, Bev, used the medium of humour to prevent the exposure of a patient during an EKG procedure.

Astedt-Kurki and Luikkonen (1992) revealed that about one-half of the 32 nurses they surveyed engaged in purposeful humour with their patients. Differences from this study in which all participants reported using humour (transcripts reveal purposefully) may be partly accounted for because of variations in the methodology. Astedt-Kurki and

Luikkonen used a retrospective methodology of study, requiring participants to recount episodes in writing versus interview format (discussion). The subtleties and context of humour might have been too challenging to capture in written short essay-type answers to questions. Varying definitions of humour and perhaps cultural variations (this study was conducted in Finland) were other potential sources of differences in findings. Comparison of use of humour by nurses in different cultural settings warrants further consideration. This study was not conducted in a Critical Care environment, a fact that may have affected findings. A constraint in the use of humour of “not knowing the patient enough” was an inhibiting factor cited in Astedt-Kurki and Luikkonen’s study. ICU nurses in my findings also noted this to be an inhibiting factor in the use of humour. The benefits of humour cited by nurses in both studies were similar in nature.

Similar to the findings of Warner (1984), nurses in this study used humour in delicate situations that involved potential conflict. In Warner’s study, humour was seen as enabling the client to decide upon the course and the direction of the conversation. This approach is congruent with the actions participants in this study demonstrated in empowering ICU patients by sharing knowledge. Gloria, a participant, told a patient requesting “coffee and a smoke” that the smoke “will blow up in your face right now” (#6 L. 511). This information was presented in a truthful, yet jocular manner.

A participant, Susan, described the act of being “present” when eliciting a smile in a dying patient. This nurse needed to “do something” in the midst of a situation that was medically futile. This act of “presence” was also an indication of empowerment of this nurse, when a definition of “power” is considered. Raatikainen (1994) defined power as the nurse’s ability to recognize his/her capacity to improve the quality of care.

Susan described this quality in her statement “Making them laugh or smile makes you feel that you’ve done something” (#10 L. 189). The quality of presence involves the use of “one’s whole self...in personal and professional dimensions ... the personal dimension affirms the uniqueness that each nurse brings to the situation” (McKivergin & Daubenmire, 1994, p. 67). The nurse, Susan, was able to connect with this patient through her use of self. The professional role was momentarily cast aside and the person, who was also a nurse, smiled. The individual nature of humour encouraged a sense of intimacy and connection, promoting the feedback of a smile. Caring was evident in the ability of this nurse to convey her caring as the human mode of being, “the basic element of being a person,” as defined by Simone Roach (cited in Keegan, 1996, p. 52.)

“Presence” as healing can be achieved through the provision of an atmosphere that promotes the self-regulating abilities of the individual. Warner (1984) saw humour as a type of self-disclosure that was beneficial in its ability to enrich a therapeutic milieu. Participants were able to share humour with patients at times through self-disclosing types of comments.

The Use of Humour in Relation to Self – Balance

Parse (1994) outlined the interrelatedness of laughing and health. Humour promotes healing in patients and the nurses caring for them. Laughter is viewed as a chosen way of “becoming” (p. 57). This view was exemplified in the reaction chosen when participants in this study responded with laughter (reframing) rather than another more negative emotion. Humour can help achieve a balance between connecting with patients (decreasing the distance) and shielding (increasing the distance). Warner (1984) described humour as one means of self-disclosure and reciprocity within communication.

This state of balance forms a basis of healing and a state of wellness. The word heal means to “make whole [by] bringing together the body, mind and spirit ” (Wooten, 1996a, p. 50). In order to facilitate the process of healing in others it is necessary to “awaken the healer” within the self (Wells-Federman, 1996, p. 13). This process requires a balanced perspective of self-care and self-awareness of the mind-body connection.

Wells-Federman makes the distinction that caring is not the cause, but rather the result, of burnout. A lack of caring can signify a lack of balance. A return to “health” parallels an ability to engage in caring. Caring was constantly present in the dialogue of participants in this study.

Humour may embody an aspect of spirituality in its tendency to “integrate” or “bring into harmonious interconnectedness” (Burkhardt, 1989, p. 73). The act of nurturing spirituality was not directly described, but was alluded to by participants. In the midst of a prolonged 99 a participant, Gloria, used an apparent gallows humour approach to educate those persons present about the spiritual dimensions of the experience (#6 L. 255).

Caregivers in this study tended to replenish their spirits through the use of humour. Humour permitted them to connect through “play”. A balance in meeting the nurse’s own needs and those of the patients was sought. Humour is often cited as a means to enable ICU nurses to distance themselves from their patients and protect themselves from the stress of working with dying patients (Mastey & Cole, 1992). However, closer examination of nurses joking with patients may also reveal a tendency to use humour to “connect” with patients. Nurses in this study shared jokes with patients for

many reasons. Inclusion of family members through sharing “in jokes”, and humour as distraction and as a means of decreasing boredom were “connecting” uses of humour.

Humour exerts positive effects on each of the body systems in addition to its effects of stress relief. A humorous exchange may promote increased “connectedness” through the involvement of many senses, including touch and eye contact. Humour is a natural substance and technique that is variable and individualized (Woodhouse, 1993). These factors enhance its applicability to both patients and nurses in a highly scrutinized Critical Care setting.

Higher occupational stress scores are significantly associated with higher scores indicating an external locus of control (Topf, 1989). Wooten (1996 a) found that following a humor training course significant decreases in external locus of control occurred. Hardiness and resilience are similar concepts that refer to an ability to respond to adversity (Dyer & McGuinness, 1996). Participants in this study displayed the characteristics of hardiness. Elements of control versus powerless, commitment versus alienation, challenge versus threat, and companionship versus alienation were among the struggles described (Hudak, Gallo & Morton, 1998). Humour, often displayed in response to one of these stressors, was instrumental in developing the characteristics of resilience that were displayed by these nurses. Participants in this study often achieved a sense of control, emotional or intellectual, in part through the use of humour techniques such as reframing. Humour was used as a socially acceptable means of challenging the status quo. Commitment was gained through the measures used to bridge the gap between patient and nurse. The “voice” of the nurse, an instrument of empowerment, was used to advocate for patients. Companionship or connectedness was attained through the social

network that was both common to nursing as a profession, and unique to this work environment. Consistent access to social support systems has been found to help nurses handle the stresses associated with a critical care environment (Chapman, 1993). Nurses in this ICU exemplified this type of social support.

Evaluation of Morreall's Comprehensive Theory of Laughter

A strength of this theory lay in its broad focus and application to humour in any setting. The combination of superiority, incongruity and relief theories enabled humour to be classified into one of these three areas. When approaching the study of humour within the fieldwork setting, this broad framework was helpful to provide a degree of organization and structure to an array of observations. This framework thus provided an excellent guideline that was flexible enough to be relevant for my initial observations of nurses, patients and family members. The cognitive, physiological and emotional components of humor were supported within the words and actions of the participants. Recognition of these aspects enabled an appreciation of the complexity of a humorous interaction.

The limitations of this theory were apparent as I became immersed in the data and began to ask more probing questions about the context and the meaning of the humorous interactions I was encountering. Morreall (1983) defined three salient features as “necessary” and “sufficient” for humour (p. 39). I did not find that these features were always present in humorous situations.

In keeping with Morreall's theory, I did note that the first feature, a change in psychological state (shift) from the non-humorous to a neutral or humorous state, occurred in the presence of humour. When the nurse engaged in self-talk, the change

from non-humorous (stressful) to neutral resulted. The act of self-talk calmed the nurse. Remarks, on the surface, were rhetorical in nature, serving the purpose of projecting an air of confidence while helping the nurse to prepare emotionally for an event. This neutral appearance of humour was effective and subtle, increasing its adaptability to an environment that was not always conducive to outright humour.

The second feature described by Morreall (1983) states that the “shift” in the psychological state accompanying humour must be a pleasant one. Morreall defined laughter as “the physical activity caused by, and which expresses the feeling caused by [the humorous event]” (p. 39). I did not find that laughter was present in all instances of humour. Humour encompasses a range of response, from laughter to a light moment, a smile or no change in expression may also accompany humour. Morreall used the terms laughter and humour synonymously, but did not account for those humorous situations that were not evidenced by laughter. This type of non-laughter humour was present in some of the displays of humour in front of patients. The nurse commenting on the “nice heart rate” of the critically ill, deteriorating patient did not display a smile. Only an understanding of the context and the meaning of the comment enabled one to appreciate an element of humour. Thus, the association between laughter and humour is not always apparent or present. Interpreting a similar situation solely on the basis of laughter would not be sensitive enough to capture that type of situation.

Morreall considers the third feature, the suddenness of an event, as being necessary to humour. This aspect of humour was also not evident in all occurrences of humour. The retrospective instances of humour, reframing, were not consistent with this element. In some cases, the ability to laugh and appreciate the humour arose after a

scenario had occurred. During the time of the event, the mood of crisis and the need of the nurse to “act” rather than “react” with laughter were inhibiting factors to humour. In some cases, when the element of surprise was removed, humour could surface. The “surprise” factor at the height of the crisis, with its potential for the loss of control, threatened the professional integrity of the nurse. Rhonda, a participant, described a scenario where the patient “yanked” the cables of the pacemaker as Rhonda was responding to the crisis of another patient (#12 L.250). Rhonda, in the midst of a critical event, needed to act quickly to avert further crisis. Following the event, she was then in a position to employ humour retrospectively. She reconstructed the meaning of the event and was able to assume a degree of control over the situation.

The sharing and connecting nature of humour were not always exemplified in the “sudden” nature of humour. Pranks of staff members contained a degree of surprise for the “victim”. However, the fact that the resident did not enjoy the plastic across the doorway did not alter the enjoyment of those watching. The nurses’ laughter and humour existed in the designing of the joke in a spirit of togetherness. Certain staff members were often engaged in humorous pranks precisely because of the lack of surprise. The individual’s reaction, participation and support of the prank were anticipated. Positive feedback was expected and required, to perpetuate the humour. Thus, the element of suddenness can be confining in examining the complexity and the meaning behind the use of humour in some situations.

In summary, the use of this theory provided a broad lens to view humour. Subsequent limitations in the ability to interpret findings in light of this theory may reside in a broader continuum of humour than that postulated by Morreall. The premise that

the presence of rapport and security must be present for an event to be perceived as pleasant was supported in this study. This fact was seen in the variation of tolerance displayed for “inappropriate humour.” Humour was viewed as inappropriate by virtue of its lack of caring. This theory of laughter is limiting in its attempt to account for all instances of humour through the study of laughter. Morreall (1983) concluded, “Our formula that laughter is the natural expression of amusement provides the key to understanding all cases of laughter” (p. 59.) However, understanding all cases of laughter will not be helpful in studying all cases of humour. The terms laughter and humour are used interchangeably by Morreall. This fact can be misleading in its inability to account for humour that is not manifested by laughter or even a smile.

Reflexivity

Reflexivity refers to the degree that the researcher becomes immersed in the setting being studied and is in turn affected by it (Boyle, cited in Morse, 1994.) This combination of the insider/outsider produces a new dimension that reflects an ethnographic picture. Warner (1984) noted the ability of humour to lead to an increase in self-awareness. This fact was reinforced to me during my fieldwork and throughout each “phase” of research.

The question most asked of me, “Why did you choose this topic?” carried with it the unspoken question, “What kind of person would make this choice?” I began to appreciate the “personal” nature of humour when I was scrutinized for my own evidence of humour. In the ICU setting, my willingness to “talk the talk” was assessed through the introduction of countless jokes and kidding remarks. I commented in my fieldnotes “I’ve never been told so many jokes in my life! ... I find that the jokes really do relax me and

seem to help me fit in a little better” (Fieldnotes, p. 60). My desire to be as unobtrusive as possible gradually was replaced by a tendency to “enter” the setting, with the aim of seeing a familiar setting with “new eyes.”

My assumptions about the use of humour in an ICU setting were largely supported. The “why” and “how” answers and further questions arising provided a constant source of direction in my learning. Prior to analyzing my data I considered the “context” of the situation as crucial in understanding the use of humour. As I explored the different layers of humour, the “meaning” of humour emerged as the crux of understanding. The actual words of the participants contained the answers to my questions.

After completing my fieldwork and interviews I dreamed that participants from my study came into my work setting as a group and carried out many of the pranks that they had recounted to me. In the dream the staff in my unit did respond with humour, creating a nightmarish situation. These acts, stripped of their context, created many problems. I came to see that the lack of “knowing” co-workers in this setting had not only dictated the negative responses, but also made it impossible for others to attach the same meaning to the “humorous” events taking place. This dream informed me of the energy that I was investing in the interpretation of my “data” as it related to my background; the blending of the “insider” with the “outsider”. The process of developing understanding occurred within the context of my experience as a Critical Care Nurse.

Reflection

The process of reflection involves a “bending or folding back, as a ray of light” that enables the focus of a lens on the self and the surrounding details that were

“previously difficult to see” (Lauterbach & Becker, 1996). Reflection was accomplished through the use of fieldnotes and a personal journal maintained throughout the research process. Initial notes revealed a sense of uncertainty and submersion in a new role and an unfamiliar setting. My journal entry reflected this state “I can’t tell if I am suffering from sensory overload or sensory underload with acute compensation” (p. 2). The “translation” of ICU nursing language into colloquial terms greatly enhanced my understanding of my findings, as I was required to put into words the layers of meaning that I had discovered. This was an unexpected but very significant aspect of learning for me.

Other early and lasting impressions I gained were of the kindness and caring of the ICU staff. Participants and non-participants welcomed me into their unit and ensured that I became orientated to my surroundings and was included in all of their conversations. I experienced their caring first-hand.

During my fieldwork I witnessed collegiality and camaraderie between the nursing and medical staff. Undercurrents of hostility became apparent only during interviews. When a participant described a resident physician’s careless defibrillation attempts and disregard for the personal safety of the nurses I became aware of another dimension of understanding that was not obvious during my observations. Upon hearing this story, I recall standing over the nurse in amazement, inquiring what action had been taken. It was difficult for me to hear and empathize with her account of the nurses’ reframing of this situation. This event had a significant effect on my understanding of the power of humour. At the time, the ability to laugh seemed unfathomable to me. I began to recognize the multidimensional nature of humour. With this increased understanding I was able to articulate the imbalance of power that was a “thread” weaving through much

of the humour in that unit. The elements of “challenge” and “humour as control” became apparent to me. My insight had increased by a measurable leap in the course of this one interview. I also learned something of the limits of my own humour.

The combination of reflection and reflexivity enabled me to navigate the uncertainty of the research process and emerge with an understanding that incorporated my beliefs as a Critical Care Nurse, a female and a feminist.

Recommendations

Recommendations in the areas of nursing practice, nursing education and nursing administration are included based on literature review and the implications of this study. Nursing research opportunities are incorporated into these areas of discussion.

Nursing Practice

The study of humour is valuable in the areas of patient communication, nursing intervention and patient education. Sheldon (1996) noted the benefits to parents of promoting relaxation and comfort. The advantages of the use of humour need to be documented in a variety of settings, from the perspective of nurses and patients. A feminist perspective as a conceptual framework may be promote an increased appreciation of the use of humour, given the underlying themes of power and control that were evident in this study. Conceptualization of humour as a form of caring is also an enlightening “lens” with which to analyze humour.

More information is needed to determine the efficacy and relevance of formal, planned humour versus informal, spontaneous humour in an ICU setting. Nurses in this study most often used the latter type of humour. Is this type of humour preferable in this

setting? Can other types of more formal humour be effectively incorporated into an ICU setting? These types of questions need to be answered.

A comparison of humour used by nurses in another ICU setting would invite comparison of themes discovered in this study. Generalizability of findings in a Critical Care environment needs to be assessed by conducting similar studies in other settings. The effect of gender on the use of humour was not possible in this study, as only one participant was male. The effect of gender on the interaction between physicians and nurses would also be beneficial to examine.

In the ICU, humour may be an important means of reducing stress to a level that allows patients to attend to information. Patient teaching can be enhanced through the introduction of humour. Following uncomplicated myocardial infarction, patients spend minimal time in hospital. The use of humour in cardiac teaching with stable patients within a CCU may be an avenue to facilitate improved retention of information. The time that patients do spend in hospital may be optimized in this respect.

As previously described, the perceptions of patients in relation to the effect of humorous communication and intervention need to be explored. A better understanding of patient perceptions of inappropriate humour may facilitate a more realistic appraisal of the risks of humour. This understanding may facilitate the introduction of humour into patient care with greater confidence.

The use of humour in relation to health promotion, for patients and nurses, is a strategy that needs to be further developed. The cost-savings benefits of humour as a stress reliever and promoter of well being for nurses and patients may be found in this area (McKivergin, Wimberly, Loversidge & Fortman, 1996). Nurses and patient

perceptions regarding effective means of incorporating humour into their work lives would be helpful in planning and evaluating these types of programs.

Social support has been cited as the most effective mediator of stress, both in the work and home setting. Lachman (1996) noted the requirement to shift the focus of research from assessment to interventions designed to promote self-caring practices. When one considers that a full-time nurse spends one-third to one-half of the day in a work setting this mandate becomes more imperative.

Nursing Education

Humour has significance in its application to the education of nurses. The awareness of and development of humour as a communication strategy and intervention should be included within nursing curricula. Students can experience humour as a method of self-care through the role modeling of their teachers and their own exposure to caring for patients through the modality of humour. The inclusion of humour as a method of evaluation (Moses & Friedman, 1986) and learning retention (Parrot, 1994) need to be further explored. Rosenberg (1989) advocates the benefits of humour in the professional role socialization of nursing students, stating that the message must be taught that “humour and professionalism are not mutually exclusive” (p. 7).

Nursing Administration

Implementation of many of the above strategies is incumbent on the individual nurse and also the administration. Institutional support is necessary to assist nurses and patients in their endeavors to incorporate humour into their worklife. McKivergin et al. (1996) noted that emphasis on a team approach is important as the complexity of care and demands increase and the resources decrease. Humour, as seen in this study’s findings,

provides an excellent medium to promote group cohesiveness, reduce tension and facilitate the imparting of information in a manner that defuses potential anger. Strategies that promoted cohesion in this study often centered on food and fun. Given the open nature of the ICU and the inhibiting nature of crisis at the bedsides, a space for nurses to release energy and relax, out of earshot of patients, is essential. The need for adequate staffing to ensure that nurses get breaks, in conjunction with other nurses, also facilitates group connectedness. In an ICU environment, where nurses are under greater scrutiny and thus in a more compromised position to defuse their emotions, this fact may be of greater significance than in other settings.

In the short term, financial assistance for wellness programs incorporating humour, continuing education and workshops for the purpose of learning about techniques of humour and the establishment of patient related humour programs will likely be offset by the more long-term gains in the health of employees. The act of self-care is also a path to empowerment for nurses (Lauterbach & Becker, 1996).

The underlying tension between nurses and physicians is a source of stress that needs to be addressed. The power imbalance seems to culminate in the area of ethics of patient care, especially in the area of prolongation of life and discontinuation of therapy. This is consistent with the literature on stress in ICU nursing. Interpersonal communication is consistently cited as a source of stress (Bartz, 1994). Shannon (1997) described the differing worldviews of disciplines as being a function of differences in their socialization and education. Lack of recognition of these differences results in lack of meaningful communication and understanding between disciplines. Nurses in this ICU perceived, at times, that their voices were not heard when they contributed their opinions.

... .

Their perceptions of patient suffering were distressing for the nurses to deal with. An avenue for interdisciplinary ethical discussion is needed. Education of disciplines regarding other perspectives of other disciplines may initiate greater insight and thus facilitate better communication. In the ICU setting, a time-limited discussion of one patient per day after rounds may begin this process of increased understanding between disciplines. Nurses have much to contribute to these decisions, as discontinuation of treatment is not based solely on physiology facts. Nurses need to be aware of the perspective of the physicians in reaching difficult decisions. Physicians need to be aware of the distress of nurses in caring for these patients on a minute-to-minute basis. Shannon reported that nurses' assessment of patient progress is based on experience with patients in an ICU setting. The physician's assessment is based on a larger population of cases in various settings. This knowledge colours the perception of the nurse and affects his/her view of patient suffering. Providing more information to nurses about the progress of patients before and after admission to ICU would be useful for nurses, perhaps alleviating some of their distress and tempering some of their views.

In the view of Woodhouse, (1993) nurses need to be supported in their release of energy through laughter and humour as much as their need to cry and grieve over patients. I support and advocate this position through examination and consideration of the previous recommendations.

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APPENDIX A

Bartz, G. (1994). Managing stress in critical care. In G. Wlody (Ed.), Managing clinical practice in critical care nursing. (pp. 297-311). St. Louis : Mosby.

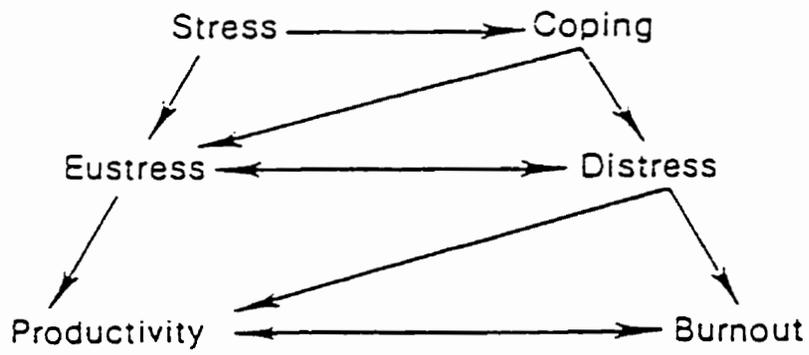


Figure 19-1. Stress management paradigm.

APPENDIX B

Cohen, M. (1990). Caring for ourselves can be funny
business. Holistic Nursing Practice,4 (4), p.5

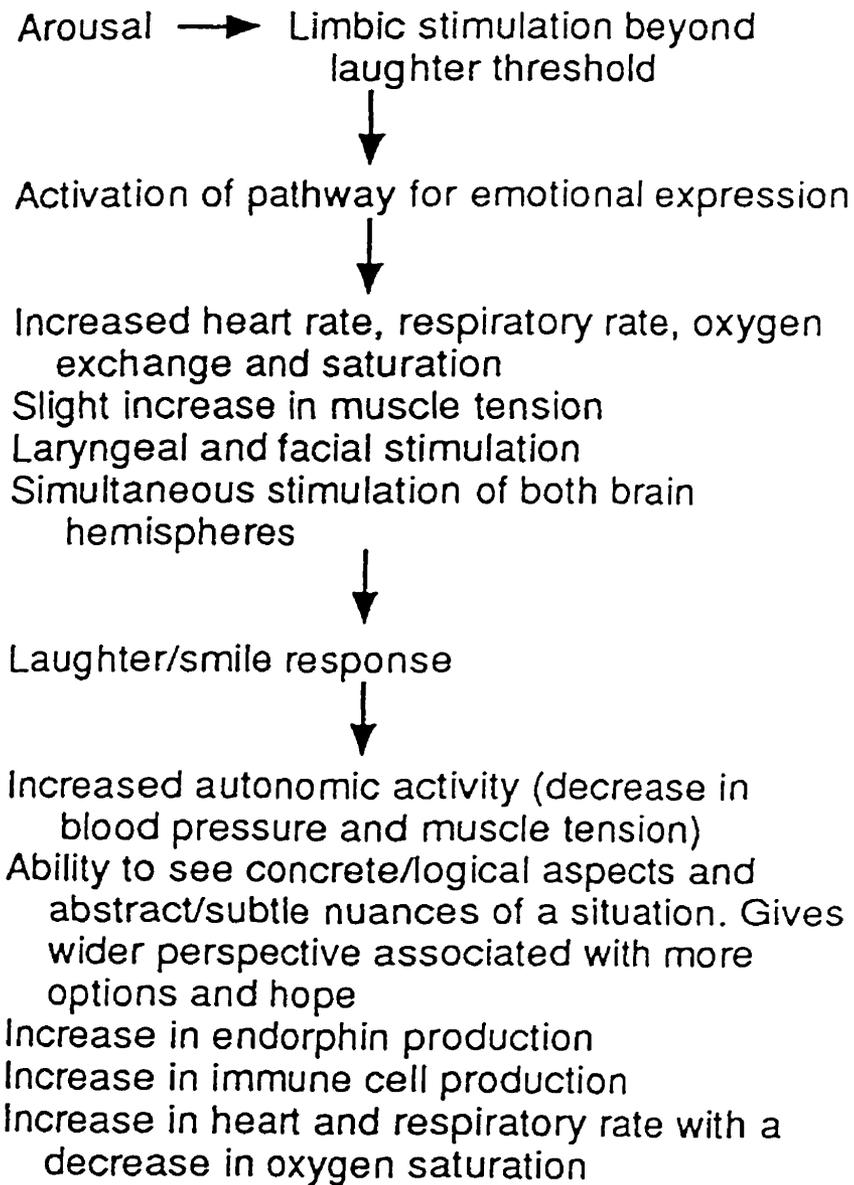


Fig 1. Psychophysiology of humor.

APPENDIX C

Bellert, J. (1989). Humour, a theoretic approach in oncologic nursing. Cancer Nursing, 12 (2), p.68.

1. Do you find yourself looking at the humorous side of a situation when dealing with everyday life problems?
 Never
 Rarely
 Sometimes
 Often
2. Since your diagnosis of cancer, do you find yourself using humor:
 More
 Less
 Same as prior to diagnosis
3. If you enjoy humor, check all the types of activities you find amusing or enjoyable.
 Comedy films Cartoons
 Joke books Joke telling
 Attending comedy clubs
 Being around a funny or lighthearted person
 Other (write in: _____)
4. Does it help if your nurse, doctor, or other health care professional has a sense of humor?
 Never
 Rarely
 Sometimes
 Often
5. Has humor ever made you feel better and assisted you in coping with your cancer?
 Never
 Rarely
 Sometimes
 Often
6. Do you enjoy telling jokes or humorous stories to others?
 Never
 Rarely
 Sometimes
 Often
7. When is humor and laughter an absolute "bad" or "negative" experience?

8. What do you think humor and laughter does for you?

FIG. 1. Questions to assist in assessing an individual's values and practices of humor.

APPENDIX D

Cohen, M. (1990). Caring for ourselves can be funny business.

Holistic Nursing Practice, 4 ,p. 8.

Humor Inventory

Identify five things you had fun doing as a child.

What do you love most about watching children?

Name five things which make you laugh.

Describe your own sense of humor.

Identify three people whose sense of humor you admire. What is it you admire?

Is your humor better around certain people? Why? How can you spend more time with these people and what can you transfer to other relationships?

Brainstorm to identify your 10 biggest frustrations with home, work, personal, and social life.

List 10 of the best qualities of yourself, your mate, children, mother, mother-in-law, boss, etc.

How is humor used and who uses it at work? At home?

How might your image change when you use more humor?

APPENDIX E

Hunt, A. (1993). Humour as a nursing intervention. Cancer Nursing, 16 (1), p.39.

TABLE 2. *Guidelines for use of humor as a nursing intervention*

Do's	Do not's
Laugh together	Ridicule
Laugh with	Laugh at
Lighten up	Laugh about tragedies
Avoid ethnic humor	Use sarcasm, racism, or put-down
Avoid sexist humor	Use sexist humor
Attend humor workshop	Use humor without preparation
Practice humor skills	Try humor without practice
Establish rapport	Ignore client humor styles
Assess	Omit assessment
Evaluate	Omit evaluation

APPENDIX F

Joanne Major
 46 Prairie View Road
 Winnipeg , Manitoba
 R3J1G9
 (Date)

Head Nurse
 Medical Intensive Care Unit
 St. Boniface General Hospital
 Winnipeg , Manitoba
 Postal Code

Dear Head Nurse:

I am writing to request permission to conduct my thesis research project entitled "Critical Care Nurses Use Of Humour: An Exploratory Study", in the Medical Intensive Care Unit of St. Boniface General Hospital. My research proposal has been approved by the Ethical Review Committee, Faculty of Nursing, University of Manitoba. A copy of the Ethical Review Committee acceptance is enclosed for your perusal.

The purpose of this study is to explore the use of humour by Critical Care Nurses. I would like to observe nurse-nurse and nurse-patient interactions over a four week period. Observations would take place on weekdays, evenings and nights, for approximately six hours per day, three days per week. In addition, I would like to interview between 10 and 15 nurses in order to further explore questions arising from my observations. Interviews would last approximately one hour in length and would be conducted during off-duty hours.

Participation in the study would be completely voluntary. Participants will be assured that all information will be kept strictly confidential. Anonymity will be maintained through coding of interview transcripts. At any time, participants would be free to discontinue their involvement. Informed consent will be sought from patients and nurses, prior to observations or interviews.

If desired, a summary of my study results will be presented to the Medical Intensive Care staff members, following completion of my thesis.

If you have any questions regarding this proposed research, please do not hesitate to contact me at 204 - 831-5935. You may wish to contact my Thesis Committee Chairperson, Dr. David Gregory, Associate Professor, Faculty of Nursing, at 204 - 474-6627.

Thank you for your consideration. I await your response.

Sincerely ,

Joanne Major RN BN
 Masters of Nursing Student
 University of Manitoba

APPENDIX G

Explanation of Study for Intensive Care Nurses

My name is Joanne Major. I am a student in the Master's of Nursing Program at the University of Manitoba. As part of my program I am conducting a study entitled "Critical Care Nurses Use of Humour: An Exploratory Study". This is an area that is not well understood in nursing. I intend to spend 4 weeks in this intensive care unit observing the daily routines of the unit.

Consent from nurses and patients will be sought through a disclaimer, prior to the initiation of any observations. Nurses will be given copies of a disclaimer, by means of interdepartmental mail, following a presentation by me at a staff meeting. Nurses can indicate their choice to participate by placing the tear-off section indicating a "yes" response in a sealed envelope in a pre-determined receptacle. This information will be kept in the strictest confidence and will not be shared with administrative personnel..

Consent of patients, through a disclaimer, to being observed, will be obtained by myself, after consultation with nursing staff. A word - for - word explanation will be used to approach patients.

I would like to interview between 10 and 15 critical care nurses about their experiences and thoughts on this topic, after I have been in the unit for at least two weeks. Should you agree to participate, one interview will be arranged at your convenience, at a location of your choice. In some instances a second interview may be arranged. At this time, nurses agreeing to be interviewed will be asked to sign a separate consent form. The interview(s) will last about one hour.

There is absolutely no obligation on your part to participate. If you do decide to become a part of this study, you are free to withdraw at any time, with no explanation required. Similarly, a decision not to participate carries no repercussions. Your name will never be used. No information will be shared in any manner that can be traced to your name.

I appreciate your support and trust that the process of giving consent will not be further stressful for patients or nurses. There is no known direct benefit to you should you agree to participate. However, indirect benefit may occur for Critical Care Nurses as more becomes known about this topic. Participating nurses will be able to provide input when results are compiled, before the study is completed.

If you have any questions regarding this proposed research, please do not hesitate to contact me at 204 - 831-5935. You may wish to contact my Thesis Committee Chairperson, Dr. David Gregory, at 204 - 474-6627.

APPENDIX H

Critical Care Nurses Use Of Humour: An Exploratory Study

PHASE ONE

Disclaimer (Critical Care Nurses)

You are being invited to participate in the above titled research project which will explore the use of humour by Critical Care Nurses. The intent of the study is to find out more about the nature of humour that Critical Care Nurses use in communicating with their patients and other nurses.

The study is being conducted as a Master's Thesis in Nursing at the University of Manitoba, by Joanne Major, a graduate student in Nursing. The study will take place on (date) for a period of four weeks, for six day shifts for two weeks, three evening shifts and three night shifts for one week each. Approval for this study has been obtained from the Ethical Review Committee of the Faculty of Nursing, University of Manitoba.

The study involves the observation of Critical Care Nurses in the course of their daily work. The researcher would like to be present at your patient's bedside to observe the interactions between nurses and patients and nurses and other nurses. During the course of these shifts the researcher will assist you with basic nursing care at times. With your permission, field notes will be taken to record events and interactions that may provide a context for understanding the use of humour by nurses. The researcher may also be recording her observations by means of a dictaphone. This would occur off the unit. The observation field notes and Dictaphone records will be typed out by a secretary. Only the nurse researcher (Joanne Major) and members of her thesis committee (Dr. David Gregory, Dr. Patricia Farrell, Dr. John Matthiasson and Ms Judith Kaprowy M.N.) will

have access to these notes. During and after the research, all data will be securely locked, kept from seven to ten years and then destroyed.

Your participation is voluntary and you may withdraw from the study at any time by simply telling the research nurse, who will then no longer record your interactions. Your head nurse, supervisor and director will not be provided with the names of nurses who choose to or not to participate in this study. The information gained from carrying out this study will not be used to evaluate your performance and the information you provide will not be shared with your colleagues, head nurse, supervisor or director in any way that can be traced to you.

The study offers no direct benefits to participants. However, the results of the study may indirectly be helpful to Critical Care nurses to further understand the nature of humour occurring between Critical Care Nurses, their patients and other Critical Care Nurses.

Your confidentiality will be protected because names will not be on the field notes. All participants will be assigned a code number and will be identified only by that number. Findings from this research may be published in journals or presented at conferences. A preliminary copy of the findings will also be made available to nurse participants. Your questions about the study can be answered at any time. The telephone number of Joanne Major is 204 - 831-5935. The Thesis Chairperson of this research study is Dr. David Gregory. His telephone number is 204 - 474-6627.

Nurse Participant

I would be interested in participating in this research project.

Yes. -----

Signature -----

Date -----

APPENDIX I

Recruitment Invitation To Patients - Observation

Hello (title and name). My name is Joanne Major. I am a student in the Master of Nursing program at the University of Manitoba. I am conducting a research study on this unit at this time. This study is about the nature of Critical Care Nurses use of humour as they communicate with patients and other nurses in their daily worklife. I would like to know if you are interested in hearing about the study to find out if you might want to take part?

ANSWER - NO - OK. Thank you very much (title and name) for your time.

ANSWER - YES - proceed with reading the disclaimer (Appendix D)

Following reading of the disclaimer (or presentation of disclaimer for those who wish to read it independently) and clarification of any questions:

I will leave you now to think about your decision. If you decide to participate you can sign your name on the form provided. The sealed envelope will be placed by your nurse in a specific location for me to collect. Thank you very much for your time.

APPENDIX J

Disclaimer (Patients)

I am a nurse taking my Master's degree in nursing at the University of Manitoba. Right now I am carrying out a study of the nature of Critical Care Nurses use of humour in communicating with their patients and other nurses. Approval for this study has been obtained from the Faculty of Nursing, University of Manitoba, Ethical Review Committee.

The study involves observing nurses as they interact with other nurses and patients. I am a registered nurse with a background in Critical Care Nursing. At times I will help your nurse with nursing care. I will be present on this unit for a four week period of six day shifts for two weeks and six evening and night shifts for another two weeks. Your participation involves being observed in relation to the care you receive and the interactions that take place. I will take notes, called field notes, to record events and conversations that may help me to understand the way that Critical Care Nurses use humour with their patients and each other. Your participation is completely voluntary. You may withdraw from the study at any time by simply telling me or your nurse. I will then not record interactions and / or events that involve you. Your decision to participate or not participate in the study will in no way affect the care that you receive.

Your name will not be used in the study and any comments you make will not be identifiable with you. Only a final report of the results will be shared with the nursing staff. The only persons having access to the field notes will be the nurse researcher (myself) and the members of my thesis committee (Dr. David Gregory, Dr. Patricia Farrell, Dr. John Matthiasson and Ms. Judith Kaprowy, M.N.). During and after the research, all data will be securely locked, kept from seven to ten years and then destroyed. Findings from this research may be published in journals or presented at conferences.

The study offers no direct benefit to you. However, the results of the study may be indirectly beneficial in helping Critical Care Nurses to further understand the nature of humour occurring between Critical Care Nurses, their patients and other Critical Care Nurses. Your questions about this research study can be answered at any time. My telephone number is 204 - 831 -5935. The Thesis Chairperson for this project is Dr. David Gregory. His telephone number is 204 - 474-6627.

Patient Participant

I would be interested in participating in this research project.

Yes. -----

Signature -----

Date -----

APPENDIX K

Phase Two

Consent Form for Study Participants

Critical Care Nurses

“Critical Care Nurses Use of Humour: An Exploratory Study”

You are invited to participate in a study on the use of humour by Critical Care Nurses. This study is being conducted by Joanne Major, a student in the Master’s of Nursing Program at the University of Manitoba. You have been asked to take part in this research because you are a critical care nurse. Approval for this study has been obtained from the Ethical Review Committee of the Faculty of Nursing, University of Manitoba.

Your decision to participate is entirely voluntary. Should you agree to take part in this study, the following may be asked of you:

Being interviewed about your use of humour with patients and with other nurses, for approximately one hour, on off-duty hours. A second interview might possibly be requested, subject to your agreement. This interview (s) would be tape-recorded and later typed word for word, with your permission. The location and timing of the interview (s) would be your choice.

Confidentiality

Any information obtained through interviews or observations will be kept anonymous at all times. Your name will not appear on any records, documents, or in any publications. Each participant in the study will be assigned a code number; no names will be used.

No information will be shared in any manner that can be traced to your name. The only persons having access to the interview transcripts will be the members of my thesis committee and a typist. These transcripts will be identifiable by a code number.

All documents - tapes , transcripts and consent forms will be locked in a safe place for seven to ten years and then will be destroyed.

Voluntary Participation

Agreement to take part is strictly voluntary. You are free to withdraw from this study at any time, without question or any other untoward effect.

During the interview, any question can be refused and / or the interview terminated, at any time.

During the interview, you are free to request that no tape-recorder be used, or that the tape-recorder be turned off at any time.

Benefits and Risks

There are no known direct benefits to you for taking part in this study. It is possible that the research findings will indirectly affect current practice through expanded knowledge of critical care nursing.

There are no known direct risks for participating in this study. It is acknowledged that you may experience inconvenience in being interviewed for one or possibly two hours, in total.

Your signature on this form will indicate that you have:

Read and understand the purpose of this study and your role as a participant.

Had questions or concerns answered to your satisfaction by Joanne Major.

Agreed to participate.

A copy of this form will be provided for you to keep. You are still free to withdraw from this study even after signing this form. Should you need to contact me I can be reached at 204 - 831-5935. If you have further questions or concerns you may wish to call my Thesis Committee Chairperson, Dr. David Gregory, Faculty of Nursing, University of Manitoba, at 204 - 474-6627.

Date: _____ Participant's Signature: _____

Date: _____ Researcher's Signature: _____

If you wish to receive a summary of the study results, please write your name and permanent address below. A copy will then be forwarded to you upon completion of the study.

Name: _____

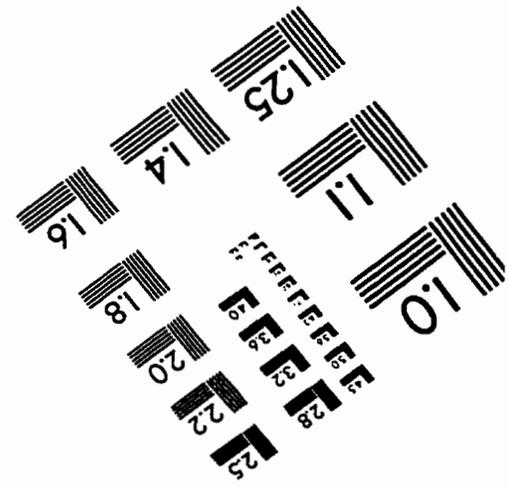
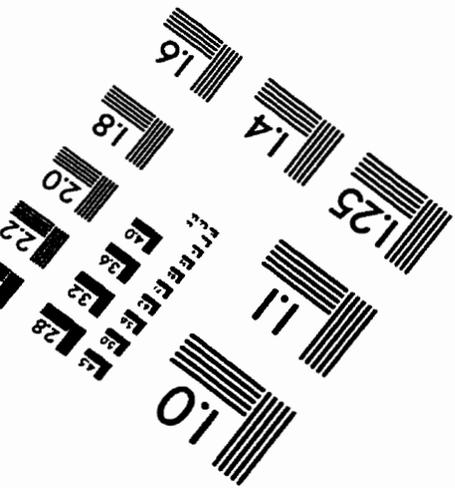
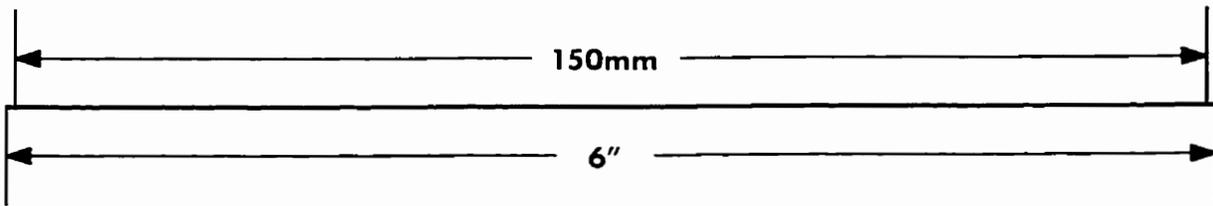
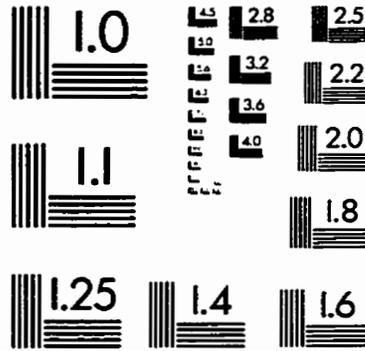
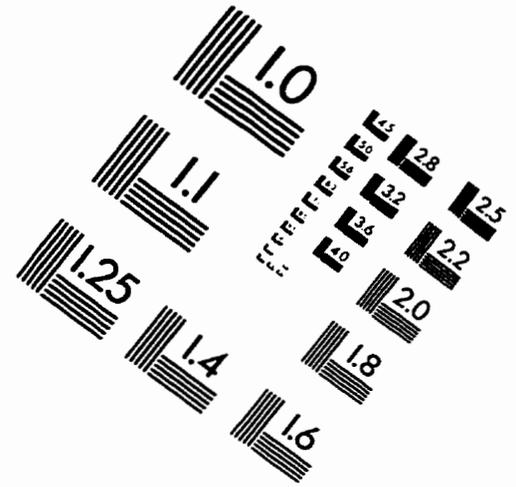
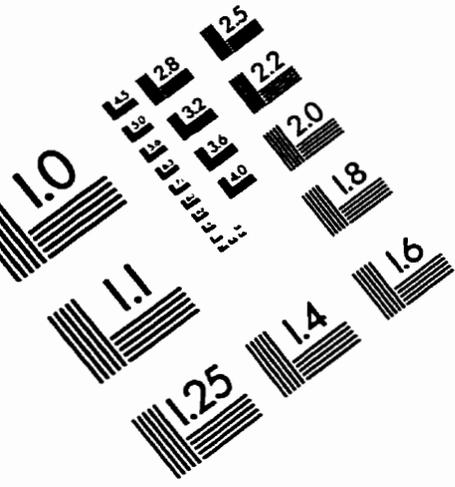
Address: _____

APPENDIX L

INTERVIEW GUIDE

1. How long have you been in nursing? In critical care? In this unit?
2. If you had to give a definition of humour, what would you say?
3. Do you believe that humour has a place in nursing? In critical care?
4. If so ...why? If not ...why not?
5. Do you feel that you tend to use humour with your patients?
6. Can you think of any factors that help you to use humour? Or which do not?
7. Can you think of any circumstances when you would definitely use humour? Or definitely not?
8. Are you aware of any benefits of humour to patients? Any risks?
9. Are you familiar with any benefits to nurses?
10. Can you give me an example of a time when you found that humour worked well for you in the critical care setting? Did not work well?
11. Do you feel that your appreciation or use of humour is different in your work life than in your home life?
12. What do you think constitutes “appropriate” humour in nursing?
13. What do you think constitutes “unacceptable” humour in nursing?
14. Do you have a funny story that you would like to share?
15. Is there anything else that you would like to say?

IMAGE EVALUATION TEST TARGET (QA-3)



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