An exploratory study of the humor advantage: clinicians self-report on use of humor in therapy

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This study explored social workers' use of humor with clients in therapy. The main objective of this study was to ascertain whether clinicians initiate humor in therapy. If, indeed humor was initiated, why, to what extent and how facilitative is the clinician's use of humor in regards to the working-relationship, which includes the therapeutic process. This study adopted Lazarus's Cognitive Appraisal Theory in order to determine if the use of humor aids the client in the appraisal process. The sample included 11 members from the National Association of Black Social Workers and 19 members from the Clinical Social Workers and Social Work Private Practice Yahoo! Groups Listservs. A frequency distribution and a content analysis were used for research purposes. Findings suggest that humor is indeed initiated by social workers, yet for varied reasons.
AN EXPLORATORY STUDY OF THE HUMOR ADVANTAGE:
CLINICIANS SELF-REPORT ON USE OF HUMOR
IN THERAPY

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF
MASTER OF SOCIAL WORK

BY
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To the most high who makes all things possible when there is no light in sight, thank you. To the greatest parents on earth, Brenda and Freddie Williams, thank you for your unconditional love. To my family and friends who understood the one-line emails and one-minute phone calls of me saying, “I was just thinking about you,” thank you. To my professors and classmates who were always right on time with a word of encouragement and a pat on the back, thank you. To Professor Ward for your unrelenting guidance, thank you. Finally, I give thanks to myself for finishing what I began.
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CHAPTER I
INTRODUCTION

"If I had no sense of humor, I would long ago have committed suicide."
Mahatma Gandhi' (2003, ¶ 1)

Are there times in therapy when the use of constructive humor would prove fruitful for the client’s development (Foster, 1978)? Does this experience need to be intense and draining (Dewane, 1978)? Dewane believes the occasional use of humor can abolish a possible “sterile interaction” between the clinician and the client. Humor, he says, can smooth painful insights into a pleasant experience (p. 510). Buckman (1994) in The Handbook of Humor: Clinical Applications in Psychotherapy states that, “humor connects us with others” by supplying “closeness and warmth” (p. 73). He expounds on how humor allows individuals to not take everything so seriously and that humor is the antidote to the stresses and hardships of life.

The following question was asked: Should Social Work, the scholarly publication, “be a laugh-free zone” (Witkin, 1999, p. 101)? The social work profession and the Social Work journal are “serious, but they need not be somber” (p. 104). Witkin suspects that social workers mistake the two words, serious and somber, to have similar meanings. He says it is this confusion that attributes to lack of humor. “To be serious is to be
determined, intent, and thoughtful, whereas to be somber is to be gloomy, sullen, and grim” (p. 104). Witkin concludes by declaring that humor and seriousness can coexist, while humor and somber can not.

In those moments when individuals are in the midst of hopelessness and despair and least receptive to humor, it is then when it is most needed. Humor, in these situations, is able to provide these persons with a perspective that otherwise would not be seen. It “enables us to distinguish the annoying from the intolerable, the unfortunate from the disastrous, and the unpleasant from the awful. Social work is a serious profession; it need not be a humorless one” (Witkin, 1999, p. 104).

Statement of the Problem

The clinician’s lack of the use of humor in working with clients can be traced back to social work training. Dewane (1978) asserts that social workers have been trained, thus, taught, to keep a fair distance between themselves and the client. He continues with, social workers who reach out for closeness really desire to be accepted, those who “joke with a client” are really trivializing the client’s experience and are revealing their own uncomfortability with the dynamics of the situation (p. 508).

Bloomfield (1980 [as cited in Reynes & Allen, 1987]) corroborates Dewane and further acknowledges that much of this distance between the clinician and client derives from psychoanalytic writing. This writing permeates the idea that to be a “good” clinician one must feel nothing during sessions and exude a “uniform and mild benevolence,”
particularly in moments of perceived shared feelings or where laughter could occur (p. 261).

Social work training and psychoanalytic scholarly writings have contributed to the fact that, "many of those involved in psychotherapy with patients are often reluctant to take advantage of a valuable device in their armamentarium, specifically the use of humor" (Reynes & Allen, 1987, p. 261). The paradox is that working with clients has evolved into heart to heart relationships. There are several ways to work with clients, one being with the use of humor. The prevalence of this knowledge and the possible benefits are limited in social work literature. This study seeks to address this issue and add to the developing body of social work scholarship.

Purpose

This study is designed to enhance the social work knowledge base concerning the use of purposeful humor throughout the clinician-client working relationship, which focuses on the therapeutic process. The purpose of this study is to explore if this purposeful humor is practiced and if so, what influence, if any, does this have on the clinician-client working relationship. In addition to this, the study seeks to determine how, when and to what extent this purposeful humor is employed spontaneously.

Significance of the Study

The distance that speaks to aiding the client is not that of clinician and client, but that of the client and the client's problems. Clinicians have an opportunity, with the use of
purposeful humor, to offer insight whereby the client is able to step back and look at their
issues from a different perspective (May, 1953 [as cited in Rutherford, 1994, p. 218]).
Humor teaches clients, at the appropriate time, to take their problems and themselves less
seriously (Mosak, 1987 [as cited in Rutherford, p. 218]). O’Connell and Cowgill (1970
[as cited in Rutherford, 1994, p. 218]) state that not only clients, but people in general,
who are void of healthy humor run the risk of becoming caught in a spiral of self-
inhibition. Prerost (1989 [as cited in Rutherford, 1994, p. 217]) upholds this view that
people who are chastised for sustaining a humorous attitude towards life find themselves
in a confined life of functioning and psychological health. Rutherford (1994) agrees and
adds that this restriction steals peoples’ spontaneity and flexible behavior, which results in
an impediment in their psychological growth.

This study is important because it speaks to, not only, how social work
professionals, a group whose scholastic literature on humor is scant, can better engage
their clients, but it also gives new and experienced social workers an opportunity to
explore the use of self differently in their profession. Moreover, this study seeks to offer a
new way of looking at how humor can possibly facilitate the clinician-client working
relationship, thus therapeutic process.
CHAPTER II

REVIEW OF LITERATURE

The following literature review provides a brief, yet captive picture of the thought processes of the use of humor between the clinician and client in the working relationship, thus the therapeutic process. The review will include diverse authors and their varied understandings of humor, in and of itself, and in association with therapy. In addition, an elaboration on the variety of functions used within the therapeutic process and an overview of ideological conflicts on the clinician’s use of humor will be presented. Empirical research, identifiable limitations of the literature and the proposed study will conclude this chapter.

Overview of the Literature

Reynes and Allen (1987), in “Humor in Psychotherapy: A View,” note that the controversy surrounding the role of humor in psychotherapy is “ambivalently” held by those who are based in techniques and practice. Reynes and Allen continue with how the views have ranged from traditional concern of transference and counter-transference to contemporary considerations as to how humor can be employed as a “vehicle for bypassing emotional roadblocks and unblocking the door to creative growth” (p. 260).
Witkin (1991) underscores the fact that the nature of the clinician-client relationship influences the way clients express their issues.

Rutherford (1994) believes that therapists who are able to laugh at themselves and accept their own weaknesses all the while expressing enjoyment of life, are able to provide their client with a healthy sense of humor to model. Similarly, Osterlund (1983) believes that there are a large number of professionals who may in fact have a good sense of humor, yet feeling it is not professional to use humor, are hesitant in expressing themselves humorously. Robin Haig, M.D. (1986) in “Therapeutic Uses of Humor” says that from personal observations the best therapists “possess a good sense of humor,” have ready wit and enjoy the art of storytelling (p. 546).

Foster (1999) supports Osterlund in that those professionals who overlook the potential of humor in counseling may indeed lean towards their “sense of professionalism.” The result, however, is that the counselor takes herself or himself seriously as to avoid “cognitive dissonance” or to be “a response generalization.” He strongly expresses that mistaking professionalism with always being serious could possibly “weaken” the clinician-client relationship. The counselor, thus becomes “mechanical, one-dimensional and lacking in a quality that seems to be altogether human” (p. 47).

Foster (1999) believes that there is a way to train and educate counselors on humor and reverse the “deadly seriousness of training” without lowering the current standards (p. 48). Humor, according to Osterlund (1983) is “part of a process” that when combined with loving care enables us to create healing relationships with our clients. It, inevitably, “extends our humanity” (p. 47).
Witkin (1999) says that humor, while previously, thrown to the side as “serious scholarship” is surfacing. He states that there are several scholarly books and academic conferences on humor (p. 101). Young (2001 [as cited in Franzini, 1994]), asserts that clinicians are being prodded to employ humor in their practices with clients by favored and professional references. In addition, students in the helping profession have texts where humor, now appears as a “technique to facilitate clients’ new learning and the rethinking of their own problematic situations” (p. 13). Even Epstein (1987 [as cited in Witkin, 1999, p. 101]) has advised social work research faculty to seek people who can appreciate and express humor, revealing, “Funny colleagues are worth cultivating whether or not you like their work. Funny students are to be cherished” (p. 88).

There is survival value in humor. As a result, it continues to exist and develop (Lowis & Nieuwoudt, 1993, p. 419). “Therapists who cultivate and refine their capacity to use humor will find that they have a powerful ally in their quest to help their patients” (Buckman, 1994, p. 73). There is reward in hearing a client battling with neurotic depression say, “You’ve helped me to laugh again!” (Dewane, 1978, 510). Clients are faced with an archive of ills, such as unemployment, poverty, homelessness, physical and mental illnesses. Foster (1978) asks, how do counselors laugh in the face of such problems? His response, “We laugh because we realize we have to, because humor of the best kind always holds a measure of hope” (p. 49)

In summary, the overview of literature represents diverse thoughts from several authors on the controversy of clinician initiated humor in therapy. Some authors express that professionals who indeed have a sense of humor yet withhold it in therapy – hold a
strong allegiance to professionalism. The authors state that professionals oftentimes confuse this professionalism with a lack of sense of humor. This confusion, inadvertently, not only renders a stoic professional, but a less than healthy sense of humor model for the client. Other authors believe that professionals with a sense of humor are valuable not only to the client, but the profession.

Understanding Humor

For the purpose of this study, the clinicians' use of purposeful humor is defined as the clinicians' ability to spontaneously offer a humorous remark, gesture or action that induces laughter, a smile or a new way of thinking from the client during the clinician-client working relationship, thus process for some purpose related to achieving the client's goals. Unlike this study, the field of social work does not have an established definition of humor. Foster (1978) warns that “anyone searching for an abiding, precise definition of humor will probably be disappointed” (p. 46).

Haig (1986) attests that a “definition of humor is singularly absent from the somewhat scant literature on the place of humor in psychotherapy” (p. 543). She concludes by declaring that a therapist who is open to humor, not intimidated by it and who understands the implications, will be able to utilize humor constructively when it arises in therapy. Since, according to Gladding (1995), “humor naturally” arises “in some counseling situations” (¶ 1).

Corey (1986, p. 380) says that therapists need to be able to understand the difference between humor that enhances an experience and humor that detracts from an
experience ([as cited in Rutherford, 1994, p. 214]). Adler, (1927/1946, p. 252) clearly states that laughter can make or break connections. Humor and laughter can be both useful and useless ([as cited in Rutherford, 1994, p. 214]).

According to Mindess (1971, p. 214 [as cited in Franzini, 2001]), therapeutic humor, is defined as deep, genuine humor – the humor that deserves to be called therapeutic, that can be instrumental in our lives — extends beyond jokes, beyond wit, beyond laughter itself to a peculiar frame of mind. It is an inner condition, a stance, a point of view, or in the largest sense an attitude to life. (p. 3)

Saper (1987, p. 364 [as cited in Franzini, 2001]) understands humor to be: an affective, cognitive, or aesthetic aspect of a person, stimulus, or event that evokes such indications of amusement, joy, or mirth as the laughing, smiling or giggling response. (p. 3)

Foster (1999) emphasizes that humor is spontaneous, a “creative effort,” that lacks planning (p. 48). While Lowis and Nieuwoudt (1993) warn that “just as beauty is regarded as being in the eye of the beholder, so humor is in the perception and cognition of the observer” (p. 418).

Functions of Purposeful Humor

Good taste and good timing are the main ingredients to using humor properly. “Just as the experienced surgeon need not be reminded of the difference between an appendectomy and evisceration so the counselor learns the nuances of humor” (Foster,
Popular media has oftentimes depicted analysts as stoic, straightforward, distant and humorless individuals, who while their patients seek guidance, respond with “uh-huh” perpetually. So, when psychoanalysts express their sense of humor, their “humanness,” fond memories begin for the patient. These moments of sharing humor “become markers for the patient of the alliance and sense of partnership that were enjoyed” (Bader, 1993, 52).

Kuhlman (1984 [cited in Rutherford, 1994, p. 209-210]) sustained that, like all other human relationships, there is a place for humor in the psychotherapeutic relationship. He states that humor acts as a catalyst for change. Mindess (1961 [as cited in Rutherford, 1994]) saw humor as “facilitating insight and as a helpmate for catharsis, self-acceptance, and openness in therapy” (p. 212). The use of humor is able to detach clients from their negative views about their thoughts and behaviors. Kuhlman (1984) also supported this view of detachment; for while clients are “off the track” for a moment, they are able to perceive their situation in a different light (p. 212). Prerost (1989, 361 [cited in Rutherford, 1994, p. 209]) had two suggestions for the functions of humor. Firstly, he suggests, humor acts as a tension reducer and mood depressor. Secondly, humor functions to aid the process of resolving conflictual, thus stressful situations.

Buckman (1994) declares that humor is an “integral part” of the treatment relationship from the first initial visit to the last:

Used skillfully and with sensitivity humor can help the therapist: (1) make an assessment, (2) build the therapeutic relationship by creating a hopeful, non-threatening climate, which encourages communication about difficult subjects,
(3) facilitate the acting out of conflictual material and the working through of these themes and (4) provide insight into conflictual material. (p. 34).

Soliciting a favorite joke from your client can prove advantageous during the initial assessment. It can offer insight into central conflicts (Reynes & Allen, 1987). According to Nussbaum and Michaux (1963 [as cited in Goldin & Bordan, 1999, p. 405]), humor has long been acknowledged as a diagnostic aid for "measuring the level of a client's depression, predicting patient adjustment after hospital discharge (Starer, 1961 [as cited in Goldin & Bordan, 1999, p. 405]), assessing schizophrenic patients (Send Huston & Cohen, 1956 [as cited in Goldin & Bordan, 1999]) and difficulties into socialization" (p. 405). In addition, humor has the ability to "expedite a variety of therapeutic functions," such as dissolving tension, resistances and providing the client with a healthy identification with the therapist (Reynes & Allen, 1987, p. 268). Rosenheim (1974) cites Greenson's (1967) resolve that "the best therapists possess a good sense of humor, and that the ability to use this sense of humor requires relative freedom from defensiveness and a relatively secure ego, as well as readiness for mutuality with the patient" ([as cited in Buckman, 1994, p. 33]).

*The Nature and Potential of Therapeutic Humor,* Burbridge's 1978 dissertation, stresses humor as a "reframing" method. He discussed humor as being a "powerful tool" that can liberate patients in developing "new cognitive and affective freedom" (Reynes and Allen, 1987, p. 265). This reframing method is seen as offering clients the authority to choose and promoting the ability to choose. Kubie (1971 [as cited in Reynolds and Allen, 1987]), despite his reservations, refers to the "humanizing influence of humor"
and Heuscher (1980 [as cited in Reynes & Allen, 1987]) makes reference to its value in producing a “different world design” (p. 265).

Lastly, but certainly not least, for the sake of the mental health of the counselor, humor acts a buffer against stress. It can prove worthy in “overcoming the hurdles of working in the health profession” where compassion fatigue and burn-out is common (Shulman & Haugo, 2003, p. 4). Unfortunately, counselors, akin to other mental health specialists, “tend to be prone to much stress that can turn into distress if not properly addressed” (Guy, 1987 [as cited in Gladding, 1995, p. 6]). Through the use of humor, therapists can release “defenses and pressures of everyday life and work.” Humor may be the tool for relief in a profession where the day is spent working with client concerns. Most therapists value ending therapy sessions with a client on a humorous note. It enhances the client and therapists’ sense of hope (Rutherford, 1994, p. 210).

In summary, in understanding humor, it is imperative to also understand its functions. Purposeful humor is laden with powerful functions ranging from offering the client a different view on the circumstance to an opportunity to simply laugh and feel human. Humor also affords the clinician a range of opportunities from strengthening the therapeutic working relationship to assessing the client throughout the therapeutic process. The authors are suggestive to say that therapists who are able to use humor skillfully in therapy are at an advantage than those who opt not to.

“The use of humor in selected situations presents itself as a viable and often invaluable technique in social work practice” (Dewane, 1978, p. 510). However, it is most appropriate to address the risks associated with the use of humor in therapy.
One author, Gladding (1995), outlines "cautions and limitations" of the use of humor. He discusses humor as being seen as a put-down of the client, overused and consequently ineffective. He says when practiced with clients who lack a sense of humor, there is a possibility of digression in therapy (p. 7). The following section includes like-minded authors who warn against the harmful possibilities of the use of humor in therapy.

Ideological Conflicts

Although Maslow (1954) saw a sense of humor as an "indication of a person's being self-actualized" (Goldin & Bordan, 1999, p. 405), humor as a psychotherapeutic technique has offered a wide and controversial debate (Rutherford, 1994, p. 207). Bader (1993) says, "many psychoanalysts view humor with suspicion" (¶ 2). Kuhlman (1984) discovered that his colleagues viewed his enthusiasm for humor with skepticism, as though "humor may taste good but has little nutritional value" (Rutherford, 1994, p. 207).

One view is that, humor most definitively can be dangerous. It "can be disrespectful and self-serving if improperly used" (Foster, 1978, p. 47). Philosophers like Plato, Aristotle, Hobbes, Hartley, and Rousseau all understood humor and laughter to represent "manifestations of man's baser qualities, indices of hurt anger, envy, spite, derision and ridicule" (Kieth-Spiegel 1972, p. 25; Chapman & Foot 1976, p.1 [as cited in Foster, 1978, p. 47]). Freud understood all humor to be a defensive mechanism and that all jokes were either "obscene or hostile in nature" (Foster, 1978, p. 47).

Kubie Lawrence maintained a firm posture as the most out-spoken opponent on the clinicians' use of humor in therapy. In his article, "The Destructive Potential of
Humor in Psychotherapy" (1971), from the outset he exclaims, "humor has a high potential destructiveness." He calls humor a dangerous weapon and that the clinician should not confuse pleasant feelings and amusement with progress towards change with credit to the use of humor (p. 861).

Kubie (1971) catalogs several drawbacks to using humor. He states that the client will realize the ease in masking hostility and not know if the therapist is serious or joking. In addition, this gives the therapist an opportunity to disguise his or her anxieties while subtly coercing the patient for acceptance. Dewane (1978), in contrast, voices the normalizing effects of humor and its unquestionable role in therapy, in spite of the cautions surrounding its use.

Jolley (1982 [cited in Franzini, 2001]) speaks of the weight placed on therapist standards and professional role expectations. Jolley believes that the "real fear" of the therapist who uses humor in therapy is rooted in how they will be read by their colleagues (p. 7). Kubie (1971) agrees in a similar tone. He states that therapists who advocate on behalf of the use of humor in therapy feel "secret guilt." In reporting cases, the therapist somehow forgets and hides it, only to report "seriously what he actually presented to the patient with humor" (p. 865). According to Dewane (1978), some therapists, however, simply do not have the proper humor skills insofar as to integrate into therapy.

The research visibly presents humor as profitable or profitless. Killinger (1987 [as cited in Franzini, 2001]) discovered that the key variable in using humor effectively dwelled in the therapist's level of maturity (¶ 36). Strean (1994 [as cited in Franzini, 2001]) agreed and believed that in order to be successful, the therapist, in addition to
possessing maturity, needed that of flexibility (¶ 36). Buckman (1994) asserts that if therapists are unable to articulate the reason for humor, it ought not to be used.

In summary, just as there is a clear group of proponents for the clinicians' use of humor in therapy there is also a group of opponents. The authors agree that the clinicians' use of humor can be distracting, destructive and self-serving. These authors also note that colleagues of the clinician play a significant role in the reasons for not discussing and reporting humor in cases, if used in therapy. Authors refer again to the clinician's understanding of professionalism and standards of the profession. The following section discusses how clinicians' use of humor has been researched and the findings of such studies.

Empirical Research

Research on humor is presented in J.I. Megdell's 1984 study on the relationship between counselor-initiated humor and client's self-perceived attraction in the counseling interview. In the study, she was able to resolve that when the therapist initiated humor and it was perceived by the client to be humorous, the frequency and magnitude of the attraction ratings increased significantly. The results uphold theories that support the potentially positive role of therapist-expressed humor (O'Connell, 1976; Mindess, 1976 ([as cited in Rutherford, 1994, p. 210]) and "upholds the contention that humor in therapy can facilitate mutuality and strengthen the therapist-client relationship" (Rancoli, 1974 ([as cited in Rutherford, 1994, p. 210]).
There are also studies that speak to the cognitive-shift influenced by humor. In 1995, Kuiper et al. found that individuals with a high sense of humor were able to cope with the stresses of life by viewing these events more positively than those with a low sense of humor. Consequently, he proposed that “an increased sense of humor does help the individual deal in a more positive and growth-oriented fashion with a variety of life circumstances and situations” (Abel, 2002, p. 367).

Dixon (1980) and Martin et al. (1993 [as cited in Abel, 2002, p. 366]) state that humor has been described as a cognitive-affective shift generator that creates less threatening situations. Abel (2002) adds that the cognitive-affective shift “is related to the transactional model of stress proposed by Lazarus and his colleagues” (p. 366). Humor, Abel (2002) continues, provides an opportunity to explore “cognitive alternatives in response to stressful situations and reducing the negative affective consequences of a real or perceived threat” (p. 366). Bippus (2002) believes that with the adoption of the appraisal theory, research focusing on humor in comforting interactions “may shed light on the process by which interpersonal humor is able to induce certain outcomes for distressed persons” (p. 380).

In short, research on humor has revealed that the clinician’s use of humor can offer the client an opportunity for a cognitive-affective shift. This opportunity allows the client to gain insight and view the situation from a different perspective. Humor, in essence affords the client an avenue for coping with the presenting problem. The cognitive-affective shift is then defined as the Appraisal Theory. Clinicians who take advantage of this theory can present the client with alternative ways of perceiving and
dealing with the immediate issue, inside and outside of therapy.

The information presented thus far depicts how humor is perceived by the profession and dissenting authors. The proponents for the clinician’s use of purposeful humor in therapy state that humor is a powerful tool that can benefit not only the client, but the clinician as well. Opponents are firm in their position in that humor can be destructive and too risky at the client’s expense. Authors note that the code of professionalism has played a strong role in clinicians who have a sense of humor, yet yield its presentation during reporting cases. Humor was discussed as a natural and integral part of treatment and that clinicians, if open, will be able to skillfully utilize humor in therapy. Dissenting authors do agree that humor is able to humanize relationships, yet the clinician’s use of humor in therapy is where difference of opinion occurs. Research has shown that individuals with a sense of humor are able to cope with the pressures of life. In addition, clinicians who engage clients with humor by utilizing the Appraisal Theory will be able to teach clients new ways of coping and viewing trying situations. The next section discusses the limitations of the literature and the proposed study.

Limitations of the Literature

Dewane in 1978 claimed that “unfortunately” literature regarding the use of humor in social work practice was scarce (p. 508). Franzini (2001) says that although the call for the use of humor in therapy is steadily growing, “salubrious claims” are still empirically untested. Saper (1987 [as cited in Franzini, 2001]) believed that to accomplish such research would be “formidable, if not impossible” (¶ 4). Even Witkin in 1999 continues to
echo Dewane in that “humor is rare in social work literature” (p. 101). Due to the scant social work literature, it was necessary for the researcher to draw from additional scholarly fields of study, such as psychology and human communication. This study seeks to add to its own field of research by adding empirical data to the body of social work in hopes of educating and furthering the discussion regarding the clinician’s use of humor in therapy.

Proposed Study

This study will gather information on how, why and to what extent clinicians’ use humor in therapy with their clients. The researcher will seek to understand how the clinicians’ use of humor actually influences the process of therapy. Frequency distribution and content analysis will determine if the clinicians’ use of humor has any facilitative influence on the clinician-client working relationship, thus therapeutic process.
CHAPTER III
CONCEPTUAL FRAMEWORK

This study adopted Richard S. Lazarus’ Cognitive Appraisal Transactional Theory of Stress. This theory emphasizes the significance of the process of appraisal. Bippus (2000), Assistant Professor in the Department of Communication Studies at California State University, Long Beach, believes that this theory is able to shed light on the influence humor has on “comforting” a client (p. 380). As in the literature review, this is similar to Burleson and Goldsmith (1998 [as cited in Bippus, 2000]) who offer that the real measure in the effectiveness of comforting lies in its “ability to promote problem-focused coping for distressed persons causing them to reappraise their problems as somehow more manageable” (p. 379).

Lazarus identifies two types of appraisal processes that clients experience: primary appraisal and secondary appraisal. Primary appraisal refers to a client’s “estimate of the severity of a stressor.” The stressor is then thought of as a harm or a challenge. Secondary appraisal “refers to a person’s estimate of his or her resources to cope with the stressor.” These two appraisals are usually concurrent (Schmitz, 2002, Theory, ¶27).

This makes clear that the perception of a stressor is a highly subjective process. It implies that people differ in their appraisals of stressors. A patient having
undergone a bypass operation, for example, might perceive the rehabilitation demands, shortly after surgery as a threat, because he or she does not have the idea to dispose of the physical resources, or the stamina to be able to comply with the demands, but he or she might as well perceive them as a challenge to prove one's own stamina, and physical resources. Those different appraisals will consequently lead to different actions -- and, of course, to different emotions, and to a different level of stress (Schmitz, 2002, Theory, ¶30).

The rationale for adopting the Cognitive Appraisal Transactional Theory of Stress for this study lies in the potential of the social worker as a clinician to encourage the appraisal process through the use of purposeful humor. Yielding to feelings of depression or helplessness can be aided by the ability to laugh at our problems. This ability induces a sense of power, authority. In the words of Bill Cosby, "If you can laugh at it, you can survive it" (Shulman & Haugo, 2003, p. 6).

Definition of Terms

Appraisal Method – the process in which a client comes to understand their situation from a different viewpoint

Advantage – the leverage that provides an opportunity to enhance circumstances

Clinician – an individual skilled, trained and employed in social work, psychology or other helping profession

Clinician’s Use of Humor – the clinician’s ability to spontaneously offer a humorous remark, gesture or action that induces laughter, a smile or a new way of thinking from
the client during the clinician-client working relationship for some purpose related to achieving client goals

**Humor Advantage** – the use of humor as a leverage in an attempt to provide an opportunity to enhance circumstances

**Purposeful Humor** – the spontaneous offering of a humorous remark, gesture or action that induces laughter, a smile or a new way of thinking from the client during the clinician-client working relationship, thus process for some purpose related to achieving the client’s goals

**Self-Report** – an individual’s assessment of self via narrative accounts

**Therapeutic Process** – the method by which the clinician and client operate to achieve prescribed goals

**Working-Relationship** – the relationship that exists between the clinician and client throughout the therapeutic process

**Statement of Research Question/Hypotheses**

What facilitative influence does the clinician’s use of humor have on the clinician-client working relationship, thus therapeutic process?

**HA:** The clinician’s use of humor in therapy has a facilitative influence on the clinician-client relationship, thus therapeutic process.

**HO:** The clinician’s use of humor in therapy has no facilitative influence on the clinician-client relationship, thus the therapeutic process.
CHAPTER IV

METHODODOLOGY

This section reviews the methods that were applied to conduct the study. The design, setting, sample, measure, procedures and statistical analysis are discussed.

Design

The design adopted for this study was the non-experimental exploratory research design. Design notation is: \( X \circ \), where \( X \) is the clinician's use of humor and \( \circ \) is the measure, The Clinicians Assessment Questionnaire.

Setting

This study took place on December 8, 2003 and via email between January 19 and January 28, 2004 in Atlanta, Georgia. On December 8, 2003, the researcher met with The National Association of Black Social Workers, (NABSW) Atlanta Chapter. The meeting was held at the Auburn Research Library in Atlanta, Georgia in an upstairs conference suite. NABSW, a national and non-profit organization, was formed May 1, 1968. It consists of African-American Social Workers and workers in related fields of human services. The organization provides a forum whereby ideas, services and programs
are designed "in the interest of the African-American community and the community-at-large" (Ellis, 2000, ¶1).

Due to the exploratory nature of the study and in order to broaden the scope of the study, between January 19 and January 28, 2004, the researcher collected data, via email, from The Clinical Social Work and Social Work Private Practice Yahoo! Groups Listservs. The clinicalsw@yahoogroups.com listserv was founded October 28, 1998 and has 282 members. The web-site maintains that the list is intended for clinical social workers and those interested in clinical social work. Members share ideas, viewpoints and concerns that range from client-specific issues, professional practice to the larger socio-economic environment (Yahoo!, 2004, ¶1). The accompanying listserv, swprivpratice@yahoogroups.com was founded on December 31, 2002 and has 337 members. The web-site maintains that it is "intended to provide a forum for mental health professionals to exchange ideas, have case presentations, share information and expertise." Discussions range from clinical, political to policy and managed care (Yahoo!, 2004, ¶1).

Sample

The convenience sample consisted of NABSW members who attended the meeting in Atlanta and members of the listservs who received the researcher’s email and decided to participate. The sample from NABSW, after receiving permission from the President, was selected based on those willing to participate. The study consisted of 11 members from NABSW and 19 members from the Clinical Social Work Yahoo! Groups and Social Workers in Private Practice Listserv. The total sample size consisted of 30 participants.
Measure

The outcomes of this study were assessed with two distinct measures: The Clinicians Assessment Questionnaire and The Clinicians Self-Report Questionnaire. Both questionnaires were designed specifically for this study. The Clinicians Assessment Questionnaire is a 25-item questionnaire that evaluated facilitative factors, such as, establishing rapport and assessing treatment needs. Some questions were constructed around the “Interview Guide” designed by Deborah Jean Katz (1989) in *Humor as a Treatment Tool: An Exploration of Psychotherapists’ Differential Use of Humor*.

The 25-item, self-report, questionnaire is divided into two sections: Section I and Section II. Section I consisted of eight questions, 1 through 8 pertained to clinician demographics. This section requested the clinician’s gender, age, highest degree earned, years of practicing, practice setting, target population, primary responsibility and daily number of seen clients. This section was strictly multiple choice with “other” as an option.

Section II was comprised mostly of questions asking for narrative accounts. It was designed as “yes or no,” multiple choice and short answer. It began with the study’s definition of “the clinician’s use of purposeful humor.” The remaining 25 questions dealt with the clinician’s use of humor based on the study’s definition: The clinician’s ability to spontaneously offer a humorous remark, gesture or action that induces laughter, a smile or a new way of thinking from the client during the clinician-client working relationship for some purpose related to achieving the client’s goals. Questions categorically asked about initiating laughter, a smile. There were questions where examples were requested of when the clinician initiated said affects. Further questions inquired about the clinician’s personal
and professional definition of their use of humor and how humor has helped or hurt the working relationship, thus therapeutic process with the client. These questions also solicited brief, yet clear examples that demonstrated the said questions.

In addition, three questions were refined in order to polish the questionnaire: The first question, “Do you think the use of purposeful humor (refer to definition above, p. 24) is helpful in working with clients?” now reads “Do you think the use of purposeful humor (refer to definition above, p. 24) aids you in reaching the goals outlined for your clients?”

The second question, “Does your use of humor facilitate the working-relationship, process with a client?” now reads “Does your use of humor facilitate the therapeutic process with a client?”

Lastly, the third question, “Has your use of humor ever influenced the way your client viewed their situation?” now reads “Does your use of humor influence the way your clients appraise or view their situation?”

The Clinicians Assessment Questionnaire was pre-tested before the actual administration to the study’s sample. It was pre-tested on 5 individuals - all employed in the human service field. Volunteers included two LMSW’s (licensed master social worker), one LPC (licensed professional counselor), one LCSW (licensed clinical social worker) and one MSW (master of social work) student. One participant expressed difficulty in answering the question related to the number of clients seen daily. This question was re-worded for clarity.
Procedures

The researcher gained approval from the President of the National Association of Black Social Workers, Atlanta Chapter to collect data from the current body of members. Once approval was secured, the researcher attended the October monthly meeting. The researcher briefly informed all attending members of the researcher's study, purpose and participant confidentiality rights. In addition, desired participation at the December monthly meeting was expressed. On December 8, 2003 the researcher met with NABSW to administer The Clinicians Assessment Questionnaire. The researcher, again, briefly introduced self, the purpose of the study and confidentiality rights. The researcher answered all questions and thereafter administered the questionnaire. All members participated and were thanked for their time and support.

In broadening the scope, the researcher emailed two listservs, clinicalsw@yahoogroups.com and swprivpractice@yahoogroups.com on January 19, 2004. The email briefly informed members of the researcher’s educational status, the purpose of the email, the study’s topic and an invitation for participation. The researcher made mention of an abstract being supplied to the participant upon request and where the thesis would be filed upon completion. The email also included the number of participants needed, the deadline to return completed questionnaires and contact information. The researcher emailed the group publicly every two days for ten days with updates on the number of completed questionnaires and the number of remaining participants needed. The researcher, also, followed-up with individuals personally via email who had received a questionnaire but who had yet returned it via email, after a three-day wait.
Once the researcher received an email from a participant, gratitude was extended, an informed consent form, acknowledging the participants confidentiality rights and the questionnaire was emailed to the participant as an attachment. Participants were asked to use the study’s definition to complete the questionnaire, for consistency, and to supply at least two to three sentences for narrative questions. Participants were also asked to complete and return questionnaires, either by fax, as an attachment or in email form, by Wednesday, January 28, 2004 and to call or email the researcher with any questions.

Once the participant returned the completed questionnaire via email to the researcher, the researcher reviewed the questionnaire for delivery errors or unidentifiable data. The researcher emailed the volunteer back with questions regarding the error or data, in hopes of securing a completed questionnaire in return. All participants were thanked for their time and participation.

Statistical Analysis

Data collected from the NABSW members and the two listservs were analyzed in an appropriate collapse for analysis. This data were analyzed by the Statistical Package for the Social Sciences (SPSS) and through a content analysis. A descriptive statistics utilizing a frequency distribution table was used to examine Section I and II, the demographics of each participant, the yes or no and multiple choice questions. Content analysis was used to examine the variations and similarities of the narrative examples supplied by each participant. The content analysis was divided into seven category themes. The first two categories were the clinician’s professional and personal definition
of humor and narrative accounts of initiation of a smile and laughter from the client. The following two categories consisted of the clinician’s professional standpoint of the use of humor and when the clinician was most and least comfortable using humor. The next two categories consisted of how the clinician has seen the use of humor help and hurt the working relationship, thus the therapeutic process and if the use of humor assisted the client in the appraisal process. The last three categories spoke to the helpfulness and the facilitative factors of the use of humor and the clinician’s main reason for not initiating humor.
CHAPTER V

FINDINGS

This chapter presents the findings of this study. The findings were meant to add to the current body of literature. The researcher sought to determine if clinicians initiate humor with their clients. In addition, if humor was used, how influential was it with respect to the clinician-client working relationship, thus the therapeutic process. A total of thirty clinicians participated in the study.

Demographic Tables

The responses to Section I consisted of demographic data. The demographics of the clinicians are shown below. Tables 1 – 16 represent individual variables represented by frequency and percentage.

Table 1

Gender of Participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>11</td>
<td>36.7</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>63.3</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The majority (63.3%) of the participants was female, while 36.7% were male.
Table 2

Age Range of Participants

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - 29</td>
<td>2</td>
<td>6.70</td>
</tr>
<tr>
<td>30 - 34</td>
<td>2</td>
<td>6.70</td>
</tr>
<tr>
<td>35 - 39</td>
<td>2</td>
<td>6.70</td>
</tr>
<tr>
<td>40 or above</td>
<td>24</td>
<td>80.00</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (80%) of the participants were 40 years or older. The remaining sample (20%) aged between 25 and 39 years old.

Table 3

Highest Degree Earned by Participants

<table>
<thead>
<tr>
<th>Highest Degree</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor</td>
<td>3</td>
<td>10.00</td>
</tr>
<tr>
<td>Master</td>
<td>26</td>
<td>86.70</td>
</tr>
<tr>
<td>Doctorate</td>
<td>1</td>
<td>3.30</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (86.7%) of the participants hold a Master degree and 10% hold a Bachelor degree.
Table 4

Number of Years Practiced by Participants

<table>
<thead>
<tr>
<th>Years Practicing</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Years or Less</td>
<td>2</td>
<td>6.70</td>
</tr>
<tr>
<td>3 – 5 Years</td>
<td>3</td>
<td>10.00</td>
</tr>
<tr>
<td>6 – 8 Years</td>
<td>3</td>
<td>10.00</td>
</tr>
<tr>
<td>9 Years or More</td>
<td>22</td>
<td>73.30</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (73.3%) of the participants have been practicing as clinicians for 9 or more years and 26.7% have practiced for 2 years or less to 8 years.

Table 5

Practice Setting of Participants

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>2</td>
<td>6.70</td>
</tr>
<tr>
<td>School</td>
<td>3</td>
<td>10.00</td>
</tr>
<tr>
<td>Clinic</td>
<td>3</td>
<td>10.00</td>
</tr>
<tr>
<td>Community</td>
<td>7</td>
<td>23.30</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>50.00</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Exactly half (50%) of the participants’ practice settings include the hospital, school, clinic or community. The remaining 50% of the participants noted that their practice setting was in private practice.
### Table 6
Target Population of Participants

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse</td>
<td>2</td>
<td>6.70</td>
</tr>
<tr>
<td>Senior Citizens</td>
<td>4</td>
<td>13.30</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
<td>80.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The majority (80%) of the participants’ target population is outside of Substance Abuse and Senior Citizens. These participants’ target population ranged from families, students and the mentally ill.

### Table 7
Primary Responsibility of Participants

<table>
<thead>
<tr>
<th>Primary Responsibility</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>16</td>
<td>53.30</td>
</tr>
<tr>
<td>Intake/Assessments</td>
<td>1</td>
<td>3.30</td>
</tr>
<tr>
<td>Administration</td>
<td>2</td>
<td>6.70</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>36.70</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The majority (53.3%) of the participants’ primary responsibility is individual therapy, while 36.7% noted responsibilities outside of therapy, assessments and administration.
Table 8
Average Daily Number of Clients Seen By Participants

<table>
<thead>
<tr>
<th>Average Daily Number of Clients Seen</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 5 Clients</td>
<td>20</td>
<td>66.70</td>
</tr>
<tr>
<td>6 - 10 Clients</td>
<td>4</td>
<td>13.30</td>
</tr>
<tr>
<td>11 – 15 Clients</td>
<td>2</td>
<td>6.70</td>
</tr>
<tr>
<td>16 or more Clients</td>
<td>3</td>
<td>10.00</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>1</td>
<td>3.30</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (66.7%) of the participants see, on average, 1 – 5 clients a day and 13.3% see 6 – 10 clients a day.

Table 9
Frequency of Participants Initiating Laughter with Clients

<table>
<thead>
<tr>
<th>Initiate Laughter</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1</td>
<td>3.30</td>
</tr>
<tr>
<td>Sometimes</td>
<td>10</td>
<td>33.30</td>
</tr>
<tr>
<td>Often</td>
<td>14</td>
<td>46.70</td>
</tr>
<tr>
<td>Always</td>
<td>5</td>
<td>16.70</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (46.7%) of the participants initiates laughter with clients “often” and 33.3% initiates laughter “sometimes” with clients.
### Table 10
Frequency of Participants Initiating a Smile with Clients

<table>
<thead>
<tr>
<th>Initiate A Smile</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1</td>
<td>3.30</td>
</tr>
<tr>
<td>Sometimes</td>
<td>3</td>
<td>10.00</td>
</tr>
<tr>
<td>Often</td>
<td>18</td>
<td>60.00</td>
</tr>
<tr>
<td>Always</td>
<td>8</td>
<td>26.70</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (60%) of the participants initiates a smile with the clients “often”, while 26.7% initiates a smile “always.”

### Table 11
Frequency of Participants and Clients Laughing Together

<table>
<thead>
<tr>
<th>Laugh Together</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes</td>
<td>14</td>
<td>46.70</td>
</tr>
<tr>
<td>Often</td>
<td>12</td>
<td>40.00</td>
</tr>
<tr>
<td>Always</td>
<td>4</td>
<td>13.30</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (46.7%) of the participants notes laughter with the client “sometimes” and 40% notes laughing with the client “often.”
Table 12
Participants’ Belief Humor is Helpful

<table>
<thead>
<tr>
<th>Humor Helpful</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1</td>
<td>3.30</td>
</tr>
<tr>
<td>Sometimes</td>
<td>9</td>
<td>30.00</td>
</tr>
<tr>
<td>Often</td>
<td>13</td>
<td>43.30</td>
</tr>
<tr>
<td>Always</td>
<td>7</td>
<td>23.30</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (43.3%) of the participants believes that the humor is helpful “often.” Thirty percent believes that humor is helpful “sometimes.”

Table 13
Participants’ Belief Humor is Facilitative

<table>
<thead>
<tr>
<th>Humor Facilitative</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>29</td>
<td>96.70</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>3.30</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (96.7%) of the participants believes that purposeful humor is facilitative and 3.3% believes that humor is not facilitative.
Table 14
Participants' Belief Clients Receive Humor Positively

<table>
<thead>
<tr>
<th>Clients Receive Humor</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rarely</td>
<td>1</td>
<td>3.30</td>
</tr>
<tr>
<td>Sometimes</td>
<td>5</td>
<td>16.70</td>
</tr>
<tr>
<td>Often</td>
<td>16</td>
<td>53.30</td>
</tr>
<tr>
<td>Always</td>
<td>8</td>
<td>26.70</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (53.3%) of the participants believes that the client oftentimes receives the use of humor positively, while 26.7% believes the client always receives the use of humor positively.

Table 15
Participants' Belief Humor is Influential

<table>
<thead>
<tr>
<th>Humor Influential</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>27</td>
<td>90.00</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>10.00</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (90%) of the participants believes that the use of purposeful humor is influential, while 10% believes that humor is not influential.
Table 16
Participants' Main Reason for Initiating Humor

<table>
<thead>
<tr>
<th>Main Reason</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish Rapport</td>
<td>16</td>
<td>53.30</td>
</tr>
<tr>
<td>Assess Client Needs</td>
<td>1</td>
<td>3.30</td>
</tr>
<tr>
<td>Offer Insight</td>
<td>4</td>
<td>13.30</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>30.00</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The majority (53.3%) of the participants' main reason for initiating humor is to establish rapport, while 30% employ the use of humor for reasons outside of establishing rapport, assessing client needs and offering insight.

Variables

There were a total of 30 participants. All data from the 30 participants were analyzed. Among the 30 clinicians, 14 participants (46.7%) stated that they “often” initiate laughter with their clients in therapy. Ten participants (33.3%) noted that they initiate laughter “sometimes,” five clinicians (16.7%) indicated “always” and one person (3.3%) indicated that humor is “never” initiated. The following is Figure 1.

![Figure 1. Initiate Laughter](image)
In response to the question, “How often do you initiate a smile from your clients in your work with them?” 18 of the 30 participants (60%) stated that they “often” initiate a smile with their clients in therapy. Eight participants (26.7%) noted that they initiate a smile “always,” three clinicians (10%) indicated “sometimes” and one person (3.3%) indicated that a smile is “never” initiated. This information is presented in Figure 2.

![Figure 2. Initiate Smile](image)

Among the 30 participants, 13 clinicians (43.3%), stated that they think the use of purposeful humor is helpful in working with clients in therapy. Nine participants (30%) think it is “sometimes” helpful. Seven clinicians (23.3%) indicated “always” and one person (3.3%) indicated that purposeful humor in therapy is “never” helpful. Figure 3 presents this information.
The majority of the clinicians, 29 out of 30 (96.7%), believe that their use of humor facilitates the therapeutic process. One participant does not believe that their use of humor facilitates the therapeutic process. Figure 4 presents this information.

In response to the question, “Do your clients positively receive your use of humor?” 16 participants (53.3%), stated that clients positively receive their use of humor “often.” Eight clinicians (26.7%) noted “always,” while five clinicians (16.7%) indicated “sometimes.” One participant (3.3%) indicated that their use of humor is
“never” positively received by their clients. The following is Figure 5.

![Figure 5](image)

**Figure 5. Clients Receive Humor**

The majority (90%) of the clinicians in this study believe that their use of humor influences the way their clients view their situation. Twenty-seven out of 30 participants (90%) answered yes to this question. Three participants (10%) do not believe their use of humor influences their client's view. Figure 6 presents this information.

![Figure 6](image)

**Figure 6. Humor Influenced Clients View**
More than half of the clinicians in the study stated that their main reason for initiating purposeful humor is to establish rapport. The remaining sample, nine participants (30%) noted the choice “other,” while four clinicians (13.3%) initiated humor in order to offer insight and one clinician employs humor to assess client needs. Five out of the nine participants who answered “other” on the questionnaire noted that they use all of the given choices: to establish rapport, offer insight and assess client needs. Two clinicians noted that they use humor to relax and comfort the client. One participant stated that their main reason is to establish rapport and offer insight. The remaining participant claimed that their main reason is to impart that humor is human in order to make a connection.

Figure 7 presents this information.

![Chart showing the main reasons for initiating humor](chart.png)

Figure 7. Main Reason for Initiating Humor

Content Analysis

The significance of utilizing content analysis as a form of investigation is so that the researcher can determine the degrees of thought from clinicians that operate in different practice settings. The conceptual framework seems applicable to this study as
found in the empirical research section of the literature review. Therefore, this content analysis will pull from the Cognitive Appraisal Theory. There were a total of 14 questions asking for narrative accounts on the use of humor. All responses were reviewed with great inquiry. There were a variety of responses. Summarized below are responses from each question and the arching reference.

**Category One**

Category One is comprised of the clinician’s professional and personal definition of humor and examples of when the clinician initiated laughter and a smile.

Question numbers 14 (NABSW Questionnaire) and 6 (Listserv Questionnaire):

**What is your professional definition of humor?**

The responses from 33.3% of the participants are reflected below, in which the replies were in accordance with the question. The material not selected was either general or already captured as a major theme. Two participants did not have a professional definition.

**Arching References: Laughing and Smiling**

Able to laugh at self regardless of self, using language or actions that help someone smile or laugh about a situation, the soul’s weapon against the absurdity and unfairness in life, a re-framed lighthearted mode of seeing another view, use of non-threatening jokes to relieve stress, appreciating the irony and light-hearted aspects of a situation, which usually offers an increase in energy and new insights or solutions, the ability to transform lemon into lemonade, the ability to appreciate the absurd in a situation, laughter and smiling, thinking outside of themselves and not taking life or self so seriously.
Question numbers 19 and 11: **What is your personal definition of humor?**

This question was asked to see if clinicians operate under two separate definitions.

Only two clinicians (6.66%) noted the fact that their personal definition was the same as their professional definition of humor. This suggests that clinicians employ humor differently in and outside of the therapeutic setting.

Question numbers 10 and 2: **Please provide an example of when you initiated laughter in your work with clients.**

The responses from 16.65% of the participants are reflected below, in which the replies were in accordance with the question. The material not selected was either general or already captured as a major theme.

**Gesturing:** When working with children that don’t open up, I sometimes try to make the same face that they are doing, generating some laughter.

**Absurd:** While working with a compulsive stealer who was telling me about stealing a terrific daily schedule book, and nothing had worked so far, I asked, “Wow. Can you get me one?” We both knew I was kidding and laughed our heads off.

**Exaggeration:** Used exaggeration when client was putting self down.

**Word Play:** To diffuse the anxiety of a 21 year-old ADHD man who was feeling cognitive dissonance between his actions and his stated conservative Christian beliefs, I joked with him about his different heads.

**Self-Disclosure:** Elderly client did not want to use her cane to ambulate because it made her look like an old lady. While the nurse did her part of the geriatric assessment, I went to get my cane to show her that I use one too. I demonstrated my use of the cane --- well,
this client roared with laughter because she said, "You are too young to walk with a cane like me!" I told her that I would rather be safe than sorry and wanted to live to see my grandchildren grow up. Well, she laughed again and remained in a positive mood (depression is part of her diagnosis).

Question numbers 13 and 5: If yes, please provide an example of when you initiated a smile from your clients in your work with them.

The responses from 16.65% of the participants are reflected below, in which the replies were in accordance with the question. The material not selected was either general or already captured as a major theme.

**School Social Worker**: Today, I went to visit a student in the hospital and when he saw me, I said, "I bet you are happy to see me."

**School Social Worker**: I smile a lot. I greet with a smile regardless of the situation and she or he usually responds with a smile.

**Family Crisis Social Worker**: Reassure them that I am there to assist with their needs and that I do not work for the Department of Family and Children Services.

**LCSW in Private Practice**: Often imitating myself or making fun of how or what I said.

**CSW in Hospital Setting**: A registrant came to me for help with her housing application. She was wearing a hot pink sweatshirt and sweatpants and I commented, "Mrs. __, that hot pink color looks very attractive." Mrs. __ responded with a big smile.

**Category Two**

Category Two consisted of the clinician’s professional standpoint on their use of humor and moments in which the clinician was most - least comfortable initiating humor.
Question numbers 21 and 14: **From a professional standpoint, why do you use humor?**

The responses from 43.29% of the participants are reflected below, in which the replies were in accordance with the question. The material not selected was either general or already captured as a major theme.

**Arching References: To Establish Rapport and to Ease Tension**

For therapeutic rapport, to ease the mood, to engage clients and help them to relax, to add levity to a serious situation and to help me get through the day, to enhance the relationship with the client, to open up communication, it has been proven that laughter in health is good for us, so the client can relax and not see me as the enemy, it helps most of my patients achieve their goals in a comfortable way - that’s my strong skill and it works and it allows the client to discuss important issues with comfort, can alter the mindset and consequently the view of the problem, hence opening up more possibilities, to ease stress, create rapport and to join and make a connection, to help the client to not take self too seriously - if engaging in self-pity.

Question numbers 21A and 15: **From a professional standpoint, why don’t you use humor?**

This question was asked to those participants who, from a professional standpoint, do not use humor. Twenty-nine (96.57%) out of thirty participants from a professional standpoint do employ humor. There was one participant whose answer noted that laughter is never initiated nor is a smile from the clients in working with them. The participant also answered this question saying that it can be distracting, especially in individual work.
Question numbers 20 and 12: In what moments do you feel most comfortable in using humor?

The responses of 36.63% of the participants are reflected below, in which the replies were in accordance with the question. The material not selected was either general or already captured as a major theme.

Arching References: Breaking the Ice and When Rapport Has Been Established

Breaking the ice or before sessions begin, breaking the ice with family, when talking about an awkward situation, when relationship has been established with the family, almost always, with patients who have established flexibility, when easing a client’s distress, depends on gut reaction that has been developed over 30 years of experience, after relationship has been built, when stress is so thick you could cut it with a knife and when I have someone in the right mood, as an icebreaker to relax clients.

Question numbers 20A and 13: In what moments do you feel least comfortable in using humor?

The responses from 39.96% of the participants are reflected below, in which the replies were in accordance with the question. The material not selected was either general or already captured as a major theme.

Arching References: Grief and Crisis Situations

Crisis or grief situations, when issues are related to grief, loss or abuse, tragic situations, death and serious illness, if the client is angry, when I am depressed, with rigid and fragile patients, with a new client, death or loss, discussion around trauma, someone in incredible pain.
Category Three

Category Three inquires on the clinician’s personal experience in their use of humor helping and hurting the working relationship, thus process. This category also speaks to the clinician’s use of humor influencing the client’s view of his or her situation.

Question numbers 17 and 9: In what ways have you seen the use of humor help the working relationship, thus process between you and your clients?

The responses from 53.28% of the participants are reflected below, in which the replies were in accordance with the question. The material not selected was either general or already captured as a major theme.

Arching References: Strengthens Rapport and Opens Communication

Builds rapport, lightens the mood, communication is better, clients see their issues as not the worst in the world, they focus on issues differently, opens up communication and develops insight, enhances communication and helps client open up, helps person relax, makes situation less threatening, able to get more information, builds trust, gives hopes and removes judgements, conveys warmth and compassion which stabilizes the therapeutic alliance, helps client want to return to therapy - rather than dread, sees me as human. One participant states that the use of humor may interfere with the therapeutic process.

Question numbers 18 and 10: In what ways have you seen the use of humor hurt the working relationship, thus process between you and your clients?

Nine participants (29.97%) state that they haven’t experienced the use of humor hurting the working relationship, thus process with the client. Other participants noted:
humor at the wrong time, when client is extremely defensive, not aware of youth’s sensitivity to perceived belief about being teased.

Question numbers 24A and 21: If yes, how did your use of humor influence the way your client viewed their situation? and If yes, how did your use of humor influence the way your client appraised or viewed their situation?

The responses from 43.29% of the participants are reflected below, in which the replies were in accordance with the question. The material not selected was either general or already captured as a major theme.

Arching Reference: Saw Situation in More Positive View

Saw that their situation wasn’t that bad, focused on issues differently, youth began to understand that his behavior led him in the system and his behavior will get him out, understood it to be not as bad as they thought, client saw that it wasn’t as bad as it seemed, restored hope, they don’t feel alone in the struggle, they become more reflective, reduced self-defeating behavior, helped them to see the lighter side, saw situation as less dire, able to get out of stuck position, saw situation as more manageable.

Category Four

Category Four is comprised of the clinician’s view on humor being helpful and facilitative. It also addresses the clinician’s main reason for not initiating humor.

Question numbers 16A and 8: Why do you think the use of purposeful humor (refer to definition above) is helpful in working with clients? and Do you think the use of purposeful humor (refer to definition above) aids you in reaching the goals outlined for your clients?
The responses from 53.28% of the participants are reflected below, in which the replies were in accordance with the question. The material not selected was either general or already captured as a major theme.

Arching References: Shows Clinician Genuineness, Humanity/Builds Therapeutic Alliance

Opens up therapeutic relationship, puts client at ease and builds trust, it allows the family to perceive the worker as able to relate to their issue at hand and allows the worker to show concern for the family’s well-being beyond the court matter, opportunity to get more information, helps to ease a troubled mind, enables a client to gain back a sense of control – I am bigger than what is happening to me, breaks up cognitive sets, allows us to view things differently, does something neurochemically to make life easier, allows us to distance ourselves from ourselves, let’s them see I’m human, it increases participation, builds trust, makes the most painful topics reachable and bearable, provides an attitudinal shift, seen as a human being rather than a stern or stiff professional who is superior.

Question numbers 22A and 17: If yes, please provide a past example on how the use of humor facilitated the working-relationship, process with a client? and If yes, please provide a past example on how the use of humor facilitated the process with a client?

The responses from 9.99% of the participants are reflected below, in which the replies were in accordance with the question. The material not selected was either general or nonspecific.

It helped with relationship building – the client wanted to come back to therapy and eventually reached his counseling goals. After the use of humor - a client informed me of several concerns he had. These concerns were not listed during our previous
sessions and his affect thereafter was changed for the better. Specifically, his involvement in treatment, once the client saw that he still had the ability to teach and hit the ball he was able to process his physical losses in a more realistic manner and he eventually went home and still is involved in golf.

Four (13.32%) participants did not note a narrative. One participant stated that therapeutic neutrality is preferred and humor is not employed.

Question numbers 25A and 24: What is your main reason for not initiating purposeful humor?

Out of 30 participants, 29 (95.7%) state that they use humor in therapy. One participant stated it distracts from the process. This participant added as a parting note that it is self-serving for the therapist to initiate humor suggesting it functions to satisfy own needs.

Summary of Findings

According to the data, the majority of the participants (63.3%) were female, while the remaining sample (36.7%) was male. Eighty-percent of the sample were 40 years or older and 86.7% had a master degree as their highest earned degree. Twenty-four clinicians hold a master degree in social work, three hold a bachelor degree in social work and one person has a doctorate degree in social work. Two participants have a master degree in clinical counseling psychology and the other participant - marriage and family therapy. Twenty-two clinicians (73.35%) have been practicing social workers for nine years or more and 50%, 15 clinicians, work in “other” practice settings.
Eight (26.7%) participants who stated "other" noted their practice setting as private practice. The remaining seven clinicians noted: government agency, juvenile court, nursing homes, in-home, outpatient clinic, clubhouse community and family service agency.

Eighty-percent (24 clinicians) of the participants noted that their target population was "other." Four participants who stated "other" noted that their target population was mental health/illness, three stated families and two noted grades 1-12 and the other participant, K-8. The remaining sample noted their target population as people with employment problems, the handicapped, juveniles, youth/families involved in court, adults, adults/couples/families and children and families and adults. Other responses included cancer patients, loss/grief, adults/couples/adolescents, adolescent issues and individual/couples. One participant noted "general."

A little more than half (53.3%) of the sample’s primary responsibility is individual therapy and 66.7% (20 clinicians) of the sample see between "1-5" clients on average a day. Fourteen (46.7%) clinicians initiate laughter often with their clients in therapy, while 33.3% (ten participants) of the clinicians stated that they sometimes initiate humor with their clients in therapy. While 60% of the participants initiate a smile often, 40% of the clinicians noted that they sometimes laugh with their client. Forty-three percent (43.3%) of the participants think that humor is often helpful, while 30% think it is helpful sometimes. Ninety-seven percent (96.7%) of the sample believes their use of humor facilitates the therapeutic process, while one person (3.3%) does not.
Of the total sample, 53.3% believe that their clients positively receive their use of humor and 90% believe it influences their client’s view of their situation. The main reason why 53.3% (16 participants) initiate humor, according to the data, is to establish rapport. Thirty-percent (9 participants) of the sample noted “other” as an option other than the given choices. Five out of the nine participants who answered “other” on the questionnaire noted that all of the given choices: to establish rapport, offer insight and assess client needs were all reasons they initiate humor in therapy. Two clinicians noted that they initiate humor in order to relax and comfort the client. One participant stated that their main reason is to establish rapport and offer insight. The remaining participant claimed that their main reason is to impart that humor is human in order to make a connection.
CHAPTER VI
DISCUSSION AND PRACTICE IMPLICATIONS OF FINDINGS

Limitations of the Study

The main limitation of this study is its small sample size. Thus, this study cannot be generalized to social workers and other clinicians as a whole. A larger sample would afford for a wider scope of social workers’ beliefs and utility of humor in therapy with their clients. In addition, a self-report was used to analyze narrative accounts of the social workers’ experience. “Self-report might possibly constitute a valid measure, although the question of conformity to social desirability will always be raised” (Babad, 1973, p. 619).

Conclusions Based on Findings

The conclusions based on the findings suggest that humor is indeed being initiated by social workers. The facilitative factors, according to the data, are quite varied, which indicate that clinicians are aware and able to create opportunities for the client with the various uses of humor. Although social workers are not operating under one shared and recognized definition of humor, these social workers are relying on experience, timing and the client’s responsiveness to their humor. Social workers also indicated that their use of
humor is practiced based on the client’s unique situation. This suggests that clinicians are adherent to the client’s situation before their own. Social workers did note that humor can be dual beneficial. Not only does the use of humor facilitate the therapeutic process, but based on the findings it lessens burnout.

This study speaks to the fact that clinicians who use humor, use it deliberately and with therapeutic intention. Some oft-cited comments spoke to humor being the clinician’s nature and their mode of operation. These comments addressed the researcher stating that it not only works, where results are visible with the clients, it prevents burnout.

The conclusions that can be drawn from this study include the fact that social workers are using humor, differently, yet with the same intent. The ultimate goal of any therapy is to alleviate distress, whether that comes in the form of physical, emotional, psychological or spiritual. Humor, based on the findings is used differently, for different purposes throughout the working relationship, thus therapeutic process. However, ultimately, social workers are seeking to better the conditions of the client and through the use of humor, participants have stated - this is being achieved.

Implications for Social Work Practice

The Cognitive Appraisal Theory was the fundamental basis for the analysis of this study. Social workers note that their use of humor provides insight for their clients, that it gives their clients a new perspective. Hopefully, social workers will, if not already, look towards humor as an ally in working with clients in therapy. The benefits are profitable
not only for the client, but for the clinician as well. However, as the overview of literature states, and this study supports, it is a matter of timing and knowing the client and his or her situation that contributes to client receptiveness. Furthermore, this study speaks to the humor advantage, the social worker’s humor advantage. The clinician’s use of humor allows for, as the study indicates, quick rapport and the strengthening of the therapeutic alliance. Subsequently, the clinician is able to facilitate the therapeutic process. Future research can look at a similar study as this and compare it to the variance of actual client responsiveness to the clinician’s use of humor.

This knowledge is important to social workers and social work practice because humor is readily available. In the words of one of the participants of this study, “We need research such as this for our discipline. Other disciplines are eager about this topic, including physicians. Humor is not only a good tool, but it works FAST. Today, social services face crisis in some areas, being ‘cut back’ or even eliminated (e.g., home health). We have even less time to work with clients, and humor offers us one way to get the mostest the fastest.”
APPENDIX A

Site Approval Letter

We, National Association of Black Social Workers Atlanta Chapter, give Crystal Williams permission to conduct research with our NABSW Atlanta Chapter members for the sole purpose of completing the degree requirements of Master of Social Work at Clark Atlanta University. It has been explained by the researcher that the participants will not be at risk and will not suffer from any stresses or discomforts. The participants are volunteers and may remove their data at any point to the extent that it can be identified.

Signature: ____________________________

Print Name: _______________________________

Title: _________________________________

Date: __________________________

Questions: Crystal Williams, 404-808-3532
APPENDIX B

Informed Consent Form

My name is Crystal Williams, a graduate student at The Whitney M. Young Jr., School of Social Work at Clark Atlanta University. I will be conducting research with the objective of learning more about the clinician’s use of humor in working with clients. Results will be used to further the existing social work knowledge about how humor is employed as a facilitative tool.

The study is being administered to qualified members of the National Association of Black Social Workers Atlanta Chapter. Participation is voluntary and confidential. Participation can discontinue at any time without prejudice.

If you agree to these terms, please complete information below and return to researcher.

Signature: ________________________

Print Name: ________________________

Title: ______________________________

Date: ______________________________

Questions: Crystal Williams, 404-808-3532
APPENDIX C

The Clinicians Assessment Questionnaire

SECTION I

1. What is your gender?
   a. Male
   b. Female

2. What is your age range?
   a. 24 or younger
   b. 25 - 29
   c. 30 - 34
   d. 35 - 39
   e. 40 or above

3. What is your highest degree earned? Please specify major.
   a. Associate _____________
   b. Bachelor ______________
   c. Master ________________
   d. Doctorate ______________
   e. Other (Specify) __________

4. How long have you been a practicing social worker?
   a. 2 years or less
   b. 3 - 5 years
   c. 6 - 8 years
   d. 9 years or more

5. What is your practice setting?
   a. Hospital
   b. School
   c. Clinic
   d. Community
   e. Other (Specify) __________
APPENDIX C (CONTINUED)

6. What is your target population?
   a. Substance Abuse
   b. HIV/AIDS
   c. Teenage Pregnancy
   d. Senior Citizens
   e. Other (Specify) ______________________

7. What is your primary responsibility in direct practice?
   a. Discharge Planning
   b. Individual Therapy
   c. Intake/Assessments
   d. Administration
   e. Other (Specify) ______________________

8. How many clients, on average, do you see daily?
   a. 1 - 5
   b. 6 - 10
   c. 11 - 15
   d. 16 or more
   e. Other (Specify)

SECTION II

Assessment

The clinician’s use of purposeful humor is defined, for the purpose of this study, as the clinician’s ability to spontaneously offer a humorous remark, gesture or action that induces laughter, a smile or a new way of thinking from the client during the clinician-client working relationship for some purpose related to achieving the client’s goals.

9. Do you initiate laughter in your work with clients?
   a. Yes
   b. No

10. How often do you initiate laughter in your work with clients?
    a. Never
    b. Rarely
APPENDIX C (CONTINUED)

c. Sometimes
d. Often
e. Always

11. Please provide an example of when you initiated laughter in your work with clients?

12. How often do you initiate a smile from your clients in your work with them?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Always

13. If yes, please provide an example of when you initiated a smile from your clients in your work with them?

14. What is your professional definition of humor?

15. How often do you and your clients laugh together?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Always

16. Do you think the use of purposeful humor (refer to definition above) is helpful in working with clients?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Always

16A. Why?

17. In what ways have you seen the use of your humor help the working relationship, thus process between you and your clients?
APPENDIX C (CONTINUED)

18. In what ways have you seen the use of humor hurt the working relationship, thus process between you and your clients?

19. What is your personal definition of humor?

20. In what moments do you feel most comfortable in using humor?

20A. In what moments do you feel least comfortable in using humor?

21. From a professional standpoint, why do you use humor?

21A. From a professional standpoint, why don’t you use humor?

22. Does your use of humor facilitate the working-relationship, process with a client?
   a. Yes
   b. No

22A. If yes, please provide a past example on how humor facilitated the process with a client?

22B. If no, why not?

23. Do your clients positively receive your use of humor?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Always

24. Has your use of humor ever influenced the way your client viewed their situation?
   a. Yes
   b. No

24A. If yes, how did your use of humor influence the way your client viewed their situation?
APPENDIX C (CONTINUED)

25. What is your main reason for initiating purposeful humor? Please choose one.

   a. To establish rapport
   b. To assess client’s needs
   c. To offer insight
   d. Other (Please Specify):

25A. What is your main reason for not initiating purposeful humor?

   Thank you for your time!
APPENDIX D

Informed Consent Form

My name is Crystal Williams, a graduate student at The Whitney M. Young Jr., School of Social Work at Clark Atlanta University. This project is in partial fulfillment of the requirements for the degree of Master of Social Work. I am conducting research with the objective of exploring the influence of the clinician’s use of humor in therapy. Results will be used to further the existing social work knowledge about why and how humor is employed in therapy with clients.

This study is being administered to members of the Clinical Social Work Yahoo! Groups and Social Work Private Practice Listserv. Participation is voluntary and confidential. This participation can discontinue at any time without prejudice.

If you agree to these terms, please complete the information below and email to researcher.

Print Name: __________________________

Title: __________________________

Date: __________________________

Questions: Crystal Williams, 404-808-3532
APPENDIX E

The Clinicians Self-Report Questionnaire

SECTION I

1. What is your gender?
   a. Male
   b. Female

2. What is your age?

3. What is your race?

4. What is your highest degree earned? Please specify major.
   a. Associate _____________
   b. Bachelor ______________
   c. Master ________________
   d. Doctorate ______________
   e. Other (Specify) __________

5. How long have you been a practicing social worker?
   a. 2 years or less
   b. 3 - 5 years
   c. 6 - 8 years
   d. 9 years or more

6. What is your practice setting?
   a. Hospital
   b. School
   c. Clinic
   d. Community
   e. Other (Specify) __________

7. What is your target population?
   a. Substance Abuse
   b. HIV/AIDS
   c. Teenage Pregnancy
   d. Senior Citizens
APPENDIX E (CONTINUED)

8. What is your primary responsibility in direct practice?
   a. Discharge Planning
   b. Individual Therapy
   c. Intake/Assessments
   d. Administration
   e. Other (Specify) ______________________

9. How many clients, on average, do you see daily?
   a. 1 - 5
   b. 6 - 10
   c. 11 - 15
   d. 16 or more

10. If any, which school of thought/model/theory do you subscribe to?

SECTION II

Self-Report

The clinician’s use of purposeful humor is defined, for the purpose of this study, as the clinicians’ ability to spontaneously offer a humorous remark, gesture or action that induces laughter, a smile or a new way of thinking from the client during the clinician-client working relationship for some purpose related to achieving the client’s goals.

1. How often do you initiate laughter in your work with clients?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Always

2. Please provide an example of when you initiated laughter in your work with clients?

3. How often do you and your clients laugh together?
   a. Never
APPENDIX E (CONTINUED)

b. Rarely
c. Sometimes
d. Often
e. Always

4. How often do you initiate a smile from your clients in your work with them?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Always

5. If yes, please provide an example of when you initiated a smile from your clients in your work with them?

6. What is your professional definition of humor?

7. Do you think the use of purposeful humor (refer to definition above) aids you in reaching the goals outlined for your clients?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Always

8. How?

9. In what ways have YOU seen the use of your humor help the working relationship, thus process between you and your clients?

10. In what ways have YOU seen the use of humor hurt the working relationship, thus process between you and your clients?

11. What is your personal definition of humor?

12. In what moments do you feel most comfortable in using humor?

13. In what moments do you feel least comfortable in using humor?
APPENDIX E (CONTINUED)

14. From a professional standpoint, why do you use humor?

15. From a professional standpoint, why don’t you use humor?

15A. How do your colleagues feel about the clinicians’ use of humor in therapy with clients?

16. Does your use of humor facilitate the therapeutic process with a client?
   a. Yes
   b. No

17. If yes, please provide a past example on HOW humor facilitated the process with a client?

18. If no, why not?

19. Do your clients positively receive your use of humor?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Always

19A. Please explain your reasoning, from #19.

20. Does your use of humor influence the way your clients appraise or view their situation?
   a. Yes
   b. No

21. If yes, how did your use of humor influence the way your client appraised or viewed their situation?

21A. How would you describe your type of humor?

22. Could you be equally effective without initiating your use of humor?
   a. Yes
   b. No
APPENDIX E (CONTINUED)

23. What is YOUR main reason for initiating purposeful humor? Please choose one.

   a. To establish rapport
   b. To assess client's needs
   c. To offer insight
   d. Other (Please Specify):

24. What is your main reason for not initiating purposeful humor?

25. What were you taught formally, in your academic program, about initiating humor with clients and humor in general?

Any parting comments?

Thank you for your time!
APPENDIX F

INVITATION FOR PARTICIPATION

Hello,

My name is Crystal Williams, a master-level social work student. I am required to complete a thesis as partial fulfillment of the requirements for the degree of Master of Social Work. I am conducting a study exploring the clinician’s use of humor in therapy. I am inviting you to participate as part of my sample. Upon your request, an abstract of the study will be furnished to you. The complete thesis will be filed at the Robert W. Woodruff Library, 223 James P. Brawley Drive, Atlanta, GA 30314.

I am seeking to secure 50 professionals from this listserv to complete a 25-item questionnaire via email. I currently have 10 completed questionnaires. I am asking that completed questionnaires be returned no later than Wednesday, January 28, 2004. I can be reached at cdelight@acninc.net.

I look forward to your participation.

Thank you,

Crystal Williams
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