CE

Professional Case Management
Vol. 14, No. 1, 18–29


# Hitch up Your Humor Suspenders, Case Managers

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**ABSTRACT**

**Purpose/Objectives:** Although case managers must project professionalism, a dash of healing humor can accomplish a lot of trust in a little space of time. To show how case managers can incorporate humor into case management (CM), the article explores beneficial humor-based interventions and sources of unhealthy humor. Suspending the garment of good humor are 2 main straps: (1) increasing the theoretical knowledge base about healthcare humor for case managers and (2) encouraging knowledge transfer through appropriate humorous exchanges up and down the care continuum bucket brigade.

**Implications for Case Management Practice:** With backgrounds in social work, nursing, therapy, and even doctoring, CM practitioners see the soft underbellies of people's lives. From evidence-based research, case managers can garner tips for humor tact and identify ways to incorporate them into CM practice. Recommendations are elaborated to achieve positive outcomes of authentic communication and improving the quality of healthcare experiences. Examples include recognizing boundaries of unfunny and funny, dignifying and humanizing interactions through levity, responding to age groups appropriately, and drawing from client-preference tidbits like inspirational songs and humorous stories. Avoiding negative outcomes is discussed, especially harming with humor. Five common displays of the humor coin's flip side and ethical erosion are presented.

**Findings/Conclusions:** To aid case managers, caregivers, and clients in fortifying their coping mechanisms, research findings showcase not only the good but also the bad and the ugly such as interventions to avoid. Findings spotlight appropriate uses of humorous antics, bells and whistles signaling low humor and high risk, and simple takeaways case managers can tuck in their satchels. The article's multipronged conclusion is that respectful humor used judiciously can buoy clients' spirits, bring spoonfuls of levity to a sea of seriousness, show humility that softens the stiff authoritarian semblance of control, and increase clients' confidence that their proverbial exposed underbellies are in safe hands. Pile in the little red research vehicle with the author on this purposeful journey of jocularity. As the slogan goes, many true things are said in jest. *Hitch up Your Humor Suspenders* is one of them.

**Key words:** *case management interventions, communication, coping mechanisms, evidence-based guidelines, humanistic care, humor*

## INTRODUCTION: HUMOR IN ACTION

Humor can be a welcome means of communication in client—case manager relationships. Of the humorous case management (CM) routines I employ, the most fun one is Sheriff Craig. I found my Sheriff Craig badge in the dollar store during the 16th annual CM Society of America (CMSA) symposium in Texas in 2006. What better thing to come home from Texas with but a sheriff's badge?

While entering clients' homes in my community CM practice to conduct detailed assessments, I sometimes need to count on a few reliable chuckles to break the ice. I follow protocol and display the regulation name tag that identifies me as a *bona fide* case manager. But, under that id, I wear the tin star.

During the assessment, if I discover that the client is resistant to getting out of bed or to taking medication or food without grumbling, I advise the client and caregiver that "Not only am I here as the nurse case manager, I'm here as…Sheriff Craig." Like the *CSI* guy on TV, I flip that play badge up with a snap of the wrist and say, "Part of my job is to (pregnant pause) deputize the primary caregiver." As they take in the toy badge, jaws drop, eyes twinkle, and, if just for a moment, a chuckle erupts.

The author has no conflict of interest.

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*During the ubiquitous assessment phase and therapeutic relationship establishment interval, perhaps case managers should include an exploration of the things, people, songs, or movies a client finds humorous. Adding these tidbits to the knowledge base about the client's likes and preferences may provide appropriate and meaningful resources for levity or inspiration in the glum hours.*

I tell client and caregiver, "This deputy is my appointed sidewinder who has to be listened to and minded." I continue, "The deputy has the authority to say 'take your medicine,' 'eat your greens,' or 'get up and shake a leg.' And, this deputy has the right to pick up the phone and give the sheriff a dingle[1] if the deputy isn't being listened to."

Facial tension dissolves. The caregiver, grinning, joins in with "Yeah, that's right. Now maybe you'll listen to me, partner." If she[2] does not join in right away, I take up her part and say in my best John Wayne imitation, "Now you better start listenin' to me, partner!" to get the "Yeah, that's right" response. I conclude in a thick southern drawl, "Ya'll remember. There's a new sheriff in town and there won't be no lolly-gaggin' allowed."

## 1000 Islands Window Dressing

This technique served its good purpose during a home visit to assess a client's need for nursing relating to a serious surgical neck wound that was not healing well in a gentleman who lived in my town by the shores of Lake Ontario. In fact, a few of the 1,000 Islands were visible out of the front window as Bernard ("Just Bernie"), Grace Rayburn,[3] and I sat on the edges of our seats in their tiny but tidy living room.

Mr. Rayburn's health had been good and reliable for the majority of his 75 years until devastatingly last year he discovered the lump at his neck and underwent a whirlwind of tests, radiation treatments, chemotherapy regimens, and this radical surgery to his neck, jaw, and face. For 3 months, his progress appeared sound and on course; then, Bernie's wound seemed to stop healing. His voice was raspy and his spirits seemed just as raw. But he sat close by his wife of 51 years, their legs in slight contact for the reassurance that light touch provided them. As Grace sat with her head bent ever so slightly toward Bernie, she listened with fixed attention to each word I was saying. Worry was evident on her face and in her tense posture. She insisted that I call her Grace, but Bernie called her Gracie, like George Burns and Gracie Allen from the early days of television comedy.

I had entered their home in a dire and frightening time and they did not know what to expect. Someone had told them that I was there to cut back his nurses' visits and the coverage for the cans of liquid nutrition he had been receiving for several months. Bernie had been refusing these liquids he was supposed to take regularly, had lost too much weight off his already thin frame, and had not felt like his normally jolly self in more than a year. Although he continued to try to take in "normal people's food" and Grace strived at each request to prepare any food whim that Bernie imaged might taste good, Bernie's diet, weight, and reluctance to take liquid food were sources of failure and discord that punctuated the conversation for the first half hour I was there.

It was time for a little levity. I put down the pencil and pad, pushed the portable computer to the side, and poised the situation for what I knew was coming. Enduring their worried looks, I began my soliloquy. "Now, Mr. Rayburn, Bernie," I said, "Your wife is one of the most important people in the job you have to do, which is to get better." He nodded slightly yes and looked softly at Grace. "And, to that end, I'm here not only as your Case Manager," as their facial expressions went slightly glum in anticipation of whatever might be following this unusual turn of conversation, I continued, "I'm also here as Sheriff Craig." Both sets of brows went alternately more and less wrinkled while they tried to take in these quirky words. As I flipped up the badge, I said, "I'm here to deputize Grace…as Primary Caregiver." At this, both Bernie and Grace looked at me in surprised bewilderment for just a second or two before the smiles broke across their faces and they leaned back on the sofa almost in unison. For a moment, we all joined in a stolen sliver of merriment and talked about what being

[1]Dingle, a derivative of the phrase by Lily Tomlin as Ernestine, the telephone trunk line operator, and Ernestine's inevitable countdown: "1 ringy dingy, 2 ringy dingys…" (Tomlin, 1960).

[2]Usually, the caregiver is a wife or daughter, but this gig is gender neutral.

[3]Names are blinkered to protect the innocent. For optimal effect, clients may be composites of characters or characteristics.

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Sheriff and Deputy on his particular case meant, where the badge came from, and a favorite friend of his in the law enforcement business he had not thought of in years.

### Humor as Psychodrama and Tension-Breaker

The sheriff's badge is this case manager's version of the sock puppet. I learned in psychodrama sessions at Appalachian Hall, a psychiatric facility in Asheville (North Carolina), that it is easier to ask for something when the sock puppet does the talking. When someone feels powerless or vulnerable, a substitute character or voice can open up the flow of communication.

But do not be fooled about the Sheriff Craig tension-breaker. Deputizing the primary caregiver serves the serious purpose of respecting and legitimizing the person's importance to my client's welfare and stability. (If I had "real" deputy badges, I would give them out like awards.) People have approached me afterward, after I have revealed the Sheriff Craig persona, in squeaky, cheeky voices to request something they were reluctant to ask for before. Moreover, an assumed persona can help caregivers or clients reveal something they had been holding back by using the guise of a silly character. Without the guise, they would not have been brave enough to divulge the secreted information.

Found in countless physicians' office waiting rooms, magazines such as *Stitches* and *Reader's Digest* serve as testaments to the calming influences a bit of humor can infuse in moments of tension and trepidation. The magazine *Stitches* contains amusing anecdotes, medical verses, parodies, and spoofs about delivering medical, nursing, and healthcare to treat the maladies of daily living. Even mainstream medical journals such as *Chest* run "tongue-in-cheek" articles containing humorous prescriptions like "500 ml of chicken soup q4h."

Many healthcare practitioners use humor and some study the use of humor as the following research reports demonstrate.

## Humor Research

### Southern Comfort

In 2003, Dr. H. J. Bennett from the George Washington University Medical Center (Washington, DC) published his article "Humor in Medicine" (Bennett, 2003) and confirmed that the funny business of humor and laughter can have a positive role in medical education and stress reduction. His article in *Southern Medical Journal* discussed experimental studies showing that "exposure to humorous movies" (p. 1257) and comedy videotapes enhance the ability to tolerate pain. Field research found that patients need to take active parts in their postoperative courses—patients need to select and watch the movies that were funny to *them*. Other people's versions of funny just could not cut it. Through this brand of active participation, patients were able to reduce minor analgesic use by about 39%. Dr. Bennett related that, indeed, clinicians were able to help patients reduce their postoperative need for analgesics by almost 61%. That is cutting it.

Moreover, Dr. Bennett relayed the work of family physician Dr. Wender who uses gaffs, quips, and other sorts of humor to narrow interpersonal communication gaps, to communicate a caring attitude, and to relieve anxiety—his patients' and his. Bennett (2003) recommended that medical and nursing personnel should "pay attention to (a patient's humorous) overtones and use them as jumping-off points to discuss a patient's deeper concerns" (p. 1259).

During the ubiquitous assessment phase and therapeutic relationship establishment interval, perhaps case managers should include an exploration of the things, people, songs, or movies a client finds humorous. Adding these tidbits to the knowledge base about the client's likes and preferences may provide appropriate and meaningful resources for levity or inspiration in the glum hours. Providing a quote, incorporating a song lyric, or recalling a scene that involves a favorite character may offer a moment of escape from discomfort or provide a ray of optimism from a preferred source registered in the individual's humor profile. Furthermore, practitioners could catalog humor and song preferences, build evidence-based joke profile libraries, analyze joke performance by diagnosis codes, and run retrospective joke-to-code reports and prospective song-to-code reports, predictive yodeling.

### Nurses Know Best

Wisely, Bennett (2003) acknowledges that "Nurses have traditionally played a more active role than physicians in bringing humor to patients" (p. 1259). Because they are around more often during the

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course of a patient's in-hospital day and have longer interactive nonhospital sessions with patients, nurses are more likely to witness the oddball things that happen or to catch the unusual in their patients' experiences. Nurses then use the odd mundane events to introduce banter and twists to improve a patient's mood and quality of experience. Furthermore, Dr. Bennett's research found that nurses are more likely to allow patients to "horse around," play, and laugh. In conjunction with their senses of humor, nursing care professionals display simultaneous senses of comfort, connection, and commitment.

In some hospitals, formal humor programs, humor carts, humor resource centers, humor videotapes, and humor paraphernalia are made available for use by both the more humor-challenged and the more humor-adventurous to distract patients and to brighten their moods. Observational studies of inpatient cohorts revealed that fellow patients often exchange "jocular griping" to let off frustration and amuse each other by trading complaints, experiences, and tales. The sites in which the jocular griping most often occurred were in locations of waiting—rooms, corridors, and clinics. The link reaffirmed the positive association between waiting and griping.

According to Dr. Bennett's report in the *Southern Medical Journal*, even the famous Canadian physician and Johns Hopkins educator, Dr. William Osler, used humor in his teaching. Although Dr. Bennett's point may have been that fame does not preclude familiarity via good-natured fun, no fitting formula for fame-to-fun was formulated for baseline and comparison purposes. However, Bennett (2003) concluded by emphasizing that when they "share humor with patients," healthcare providers "create lines of communication that encourage patients to discuss difficult issues" (p. 1260).

For practical application, as mentioned previously, case managers can build humor libraries just like they build professional libraries. Although they may no longer be engaged in bedside practice, rest assured case managers are still witness to the oddball or two. Be sure to have your humor receptivity radar out and tuned in to pick up the banter and twists of our plain, mundane, and odd interactions arising from the extraordinary reasons for being in people's lives. By improving the mood, case managers have concrete opportunities to contribute to the positive outcomes of authentic communication and improve the quality of healthcare experiences for their clients.

## Humor in Higher Education

### Nurses Learn Funny

To show that humor-challenged nurse educators can acquire humor, nurses in four nursing facilities' nursing faculties ($N = 4$; 2 in United States, 1 in Northern Ireland, 1 in Taiwan) were polled to study humor as a therapeutic intervention in learned faculty bodies, especially old ones (Adamle, Chiang-Hanisko, Ludwick, & Zel, 2007). Older and more experienced nurse faculty members with higher levels of education reported using less humor in their classroom curricula; yet, this amount of humor was more humor than they used in clinical settings. Apparently, younger faculty members felt freer to forge students' humor facilities in classrooms and to expose their own humor faculties in clinical fields, figuratively speaking. However, the researchers retained hope that older educators could (1) demonstrate new tricks they learn and (2) thereby improve each faculty's humor faculties.

In another study involving three nursing faculties (Ulloth, 2003), different types of humor were used, but unpredictably. Faculty varied their humor presentations from simple cartoons to jokes and stories to song and dance routines. The faculty continuously searched for new material to expand their repertoire, but each member was careful not to overuse humor. They gradually increased their uses and brands of classroom humor. The researchers' concluding remarks indicated that successful humor in nursing education depends on infusing the right type of humor under the right delivery conditions to rightly receptive students at the right time and to the right degree. For example, a certain percentage of teachers were found not to be good singers and dancers. For them, this type of humor would be ill advised except for specific purposes at the most specific of times and only with students who would be highly receptive to bad singing and dancing.

*It's true that case managers must always project professionalism. But a dash of healing humor can accomplish a lot of trust in a little space of time. Humor used judiciously can be a buoyant life vest of levity in an ocean of seriousness. Respectful humor shows humility on the part of the professional and decreases the authoritative stiffness of command and power.*

Although not all types of humor are enjoyable, teaching with humor was shown to be something all involved potentially could enjoy to a positive degree.

### Small Doses of Humor in Statistics

During a 14-week statistics course, a clinical study that Dr. Bennett describes breaking students up into experimental and control groups that did include and did not include humor, respectively. On the final examinations, performance was better from the humor-privileged versus the humorless (also labeled humor-deprived or humor-starved) classroom recipients. However, it was found that humor "works best in small doses, usually four or five jokes or cartoons per lecture" (Bennett, 2003, p. 1958).

These studies show that there is a place for humor in higher education. Dr. Bennett reported that just a spoonful of 'coMEDy' made students' compliance go up, such that humor by the spoonful made the statistics go down easier. Overall, students did report that small doses of humor made statistics easier to take. However, following the Case Management Adherence Guideline pundits' leadership, Dr. Bennett should replace compliance with adherence because CMSA case managers worth their margarita salt know: while people comply with the law, they adhere to a plan. To summarize, a spoonful of higher education comedy's going down—small doses of four or five jokes or cartoons per lecture—can make students' statistical course adherence go up. Moreover, if humor dosages work for students in statistics classrooms, it is likely that humor may work for normal people in the real world.

## Humor Location Research

Some researchers boasted "Location of Sense of Humor Discovered" in Chicago, Illinois (MedscapeNews StaffWriter, 2000). However, others speculated that sight gags and language-based humor coevolved in frontal, amygdalar, and cingulated cortical lobes in the great apes (Watson, Matthews, & Allman, 2007). In the absence of any apparent adaptive value, sight gags and language-based humor seemed to have helped humans "navigate through a shifting and complex social space" (Watson et al., 2007, p. 316). Moreover, this correlated positively with other researchers who showed that although left amgydalae were activated during subjective amusement, amygdalectomies are no laughing matter (Adamle & Ludwick, 2005; Bartolo, Benuzzi, Nocetti, Baraldi, & Nichel, 2006).

Putting aside the great ape debate until later, sight gags and funny phrases, indeed, may have increased adaptive value by helping the majority of humans who are researchers still alive today better inhabit their subjective shifting social spaces. For themselves, all questioned stated in the affirmative that they prefer a sight gag or language-based humor to an amygdalectomy.

### Funny Versus Unfunny, Nonfunny, and Almost-Funny

Through their empirical perspectives of patients' subjective amusement while viewing funny versus nonfunny cartoon pairs, the humor psychology theory of Bartolo et al. (2006) postulated a two-stage funny model for first detecting and then resolving incongruity in jokes and cartoons. Incongruity results when a prediction is not confirmed in the final part of a situation or story. My husband's jokes often fall into the nonfunny category with a few almost-funny. He models his favorite joke on the work of Henny Youngman, a Catskills borsht-belt comedian from the vaudeville era, about a businessman with briefcase in his hand and a banana in his ear who is standing at the bus stop when another well-meaning, suited citizen walks up and says, "You know you have a banana in your ear?" The first man replies, "I'm sorry I can't hear you. I have a banana in my ear."

In such an instance, incongruity hangs in the air like a fog in the brain. A main method to achieve resolution requires a few seconds of mild head-shaking to relive the mental *incongruity residue*, encapsulated in the terminology *incongruidue*. Although incongruidue from a banana in the ear can gum one's mind like an unwelcome wad on the sole of a shoe, some (at least one spouse-type) find it funny.

To take one more step with incongruidue, cartoons achieve and display the congruity-incongruity transformations with differing degrees of humoristic

skill. The best cartoon humorists are able visually to transform a congruous nonfunny or unfunny story or situation into a funny incongruity. Regarding television cartoon characters, researchers might agree that *The Simpsons* cartoon patriarch Homer serves as a prime specimen of odd congruity situations that turn into funny incongruities. Indeed, both researcher and nonresearcher types have shaken their heads at the countless residues of incongruidue Homer Simpson leaves behind.

Perhaps these funny, nonfunny, unfunny, and almost-funny incongruity resolutions match the oddball that nursing professionals including case managers often glimpse in their caretaking interactions with patients and clients. It may be found that the humor-privileged case managers who successfully incorporate humor into their practices are the best transformers of congruity into incongruity or perhaps just capitalize well on incongruity as its pure, unadulterated incongruency.

For example, one case manager with whom the author worked in Pennsylvania used an almost-funny phrase rather frequently. She would pronounce this whenever she got off the phone with a particularly tangled problem she was in the middle of trying to resolve with more or less success at the time. Dianne would say, "The only logical conclusion is to get up off your assumption and dance." Moreover, she would, right there in the aisle for just long enough to "loosen the monkey off her back and dive back into the fray for another go at the gorilla," another one of her incongruent and almost-funny sayings. She was full of them but a superb case manager. Her tenacity tinged with good humor helped her excel at the herding cats conundrum case managers often face when working with physicians, surgeons, supervisors, and other Homer-like characters in healthcare who generate incongruidue at the drop of a hat.

As an avenue of future research, the congruity and incongruity paradox could be coaxed through performance hurdles and hoops. Or, along with the congruity/incongruity paradox, the many other shapes and forms of funny could be packed all together into one little tiny red research vehicle and taken for a spin around the halls of academic investigation.

### Humor in Study Subjects: Laugh Tracks and Humor Themes

In fact, using *The Simpsons* and *Seinfeld* television episodes as known sources of funny, Moran, Wig, Adams, Janata, and Kelley (2004) studied specific humor moments. To the Moran group, a humor detection moment culminates in "getting it" and the humor appreciation moment has its expression via a "mirth" burst (Moran et al., 2004, p. 1056). During full-length viewings of episodes of *The Simpsons* and *Seinfeld*, study subjects had their humor detection moments and humor appreciation moments time-locked to brain activities. In the Moran research pool, humor remained an enigmatic substrate. But these researchers did find evidence that humor critically involves two events: (1) humor detection, as a neural system incongruity resolution and (2) humor appreciation, as a bilateral affective brain mirth expression.

Therefore, if neural systems detect humor incongruity and both sides of the brain engage in mirth appreciation, it can be postulated, and hoped, that these phenomena will help case managers put on their happy faces and persevere at work when people who control the purse strings (for example) talk out one side of their mouths and then the other. Albeit, such a moving and shaking earthquake maker can get on a case manager's last bilateral affective nerve.

With training, resourceful case managers could exercise the learned response to have a Moran moment of mirth burst (discretely, researchers recommend) just like watching an episode of *The Simpsons* or *Seinfeld* unfolds before them in their workplaces. Or, case managers could recognize that they are experiencing what life would be like inside one of the cubicles in a *Dilbert* comedy strip. Under either scenario, when appreciating the incongruities of the supervised work life, a properly trained case manager might assess, "I get it: My brain detects the welling up before a Moran mirth moment" and express—"Beware all who dare. A mirth burst is upon me."

Adding to incongruity, Gervais and Wilson (2005) concentrated on "the hominid biobehavioral repertoire" (p. 395). In their research, Gervais and Wilson identified two types of laughter: Duchenne and non-Duchenne. These researchers reported finding that the two real-life laugh tracks correlated with nonserious social incongruity demonstrated in fleeting periods of safety in playful emotional-contagion laughter and the "dark side" of laughter, respectively (Gervais & Wilson, 2005, p. 396).

## Doing Harm With Humor

### Medical Students: Five Harmful Humors

Concerning the dark side of humor, medical students as healthcare workers were shown capable of doing harm with humor. Wear, Aultman, Variley, and Zarconi (2006) studied the exhibitions of "ethical erosion" (p. 454) or derogatory and cynical humor that medical students direct at patients over time. Via videotaped interviews of medical students

with patients, five unranked categories of harmful humor usage emerged.

- Humor-cloaked derision also called disparagement humor directed toward patients as "fair game" objects such as the fat and other profiles considered self-inflicted and preventable.
- Not-funny humor displayed as sarcastic mordacity, caustic mordancy, or acrimonious scorn.
- "Humor game" initiation rituals, meaning those inflicted as cynical rite-of-passage interactions perpetuated from persons of dominance (such as exalted although often humor-challenged faculty or residents) to subordinate positions (such as interns) and from interns to the more subordinate initiates (such as lowly medical students and externs) and from all to patients, the lowest healthcare participants.
- Harmful-humor—permissive locales or safe havens where sarcasm, derision, disparagement, belittlement, cynicism, and other maladaptive stress-relieving behaviors were seen as permissible to express with impunity from judgment or reprimand due to the guarantee of insularity because of higher status, superiority, and dominance.
- Humor motives including instant stress relief and maladaptive coping habits expressed in derogatory comments, white-coat attitudes, and flippant behaviors.

One example of the "fair game" mentality of acceptable or tolerated bad behavior among medical student peers and tolerated by faculty can be seen in the cartoon openly posted in the examination room of a urology clinic. The cartoon pictures people in medical garb gathered around the phone snickering as one of the group answers the phone at a location labeled Urology Clinic. The phone-answerer says into the phone receiver, "Urology Clinic, can you hold?" Erectile dysfunction medication cartoons and jokes in urology office waiting rooms were another example of a fair-game group prone to harmful-humor toleration. These and other examples of maladaptive abusive humor were comments made at the expense of another's self-esteem displayed by more dominant members of a group of medical peers that come to be tolerated as acceptable, diffuse through the peer group, and eventually are modeled as appropriate or accepted conduct. However, seen in hindsight or in oversight, what they were was humor that harms.

### Other Peer-Pressured Groups: Norm-Regulated Disparagement Humor

Disparagement humor such as that displayed by the medical students and exposure to acts of disparagement humor serve to increase the peer-pressured tolerance of discrimination against members of groups targeted by the humor, according to Ford and Ferguson (2004). These researchers explained that in the prejudiced norm theory, norm-regulated disparagement humor means that individuals who witness derogatory humor are more likely not only to tolerate subsequent discriminatory events but also to emulate disparaging humor as the norm. In other words, medical students experience peer pressure or they emulate their trainers', the interns', and residents' bad psychosocial behavior. If the intern cannot stifle a giggle at the fat person with body odor or an older man with a leaky bladder, the extern is more likely to tolerate and model these Hippocratic oath breaches. Next thing, according to the prejudiced norm theory, medical students tend to descend that slippery slope slide from Hippocratic to hypocrite.

Instead of the medical faculty's adage to "see 1, do 1, teach 1," according to the prejudiced norm theory, displays of ethical erosion induce the tolerance of a medical student's culture to "hear 1 bad one, okay to do 1 bad one, okay to do 1 more bad one" with no negative consequence. Wear et al. (2006) concluded that medical students and faculty need better humor development, better sensitivity training, plus periodic and vigorous critique of what too often passes as the norm.

The message to case managers from this research in ethical erosion and harming with humor is to remember that humor has the potential to do harm. Therefore, CM practitioners of all walks are behooved to bear witness not only to the oddball occurrences of patients' daily lives but also to the five harmful-humor forms of ethically eroded, humor-cloaked derision to which patients may be subjected. Ethical practitioners must intervene not only to add dignity and quality but also to stop harm done through bad humors. Caution and care must be exercised not to give in the force from this non-Duchenne dark side of laughter.

## Hospice Humor

### Going Toward the Light (Side)

Across hospice settings, Adamle and Ludwick (2005) found that 85% ($n$ = 112) of 132 hospice nurse intervention instances involved humor and 15% ($n$ = 20) did not. In the 112 intervention instances with humor that were studied, 70% (78.4) were patient-initiated humor and 15% ($n$ = 16.8) were humorless. (Another 15% [$n$ = 16.8] were undeterminable.) As a prevalent part of everyday hospice work, humor was frequent, spontaneous, and an intrinsic

social phenomenon. Furthermore, humor interventions were enacted to increase feelings of well-being and to relay tidings of comfort and joy.

In the care of dying patients in Manitoba (Canada), palliative care nurse researchers found that use of humor had "3 overarching themes: building relationships, contending with circumstances, and expressing sensibility" (Dean & Gregory, 2004, p. 144). As well as relieving tensions, protecting dignities, and preserving senses of worth, humanizing communications supplied clinical proof for the significance of interpersonal humor and laughter in ethnographic evidence-based practice.

To summarize, Dean and Gregory advised that in Canada, humor is powerful—it should not be trivialized nor taken lightly. The ability to preserve dignity and humanize the impending and transfiguring decent to the outcome of inevitable demise with an evidence-based intervention of light, spontaneous humor was powerful and humbling. The power to dignify and humanize with humor formed the coin whose flip side was seen previously as the potential to do harm with humor. The outcome of unwisely spending this coin and thereby squandering this potential power, whether inside or outside of Canada, should not be taken lightly or treated flippantly.

## Humor Research Toward Interventions

### Bottoms Up and Back Again: Reflected Humanity

One form of evidence of the beneficial effects of humor as interventions in healthcare settings focused not on humor initiated by caregivers but by patients. As in the Adamle and Ludwick study of patient-initiated humor in hospice settings, Adamle and Turkoski (2006) found that humor arising from patients that is directed toward their caregivers relates to the patients' efforts to relieve stresses of uncertainty, embarrassment, and dehumanization in association with their caregivers' seeming certainty and control. Patients observe caregivers' responses for signals of acceptance (openness) or isolation (flatness, nullness, or negative response). From these observations, Adamle and Turkoski developed patient-initiated humor guidelines concerning the practices to recognize, interpret, and respond to patients' humor. The outcomes were to achieve not only support but the creation of humanistic patient-care atmospheres.

Applying evidence-based protocols such as Adamle's and Turkoski's patient-initiated humor guidelines may aid case managers in their pursuits to assist patients to de-stress the awkward positions in which they may find themselves with their caregivers. Indeed, these pursuits may help case managers dress down the stiff attire of white-coat aloofness, loosen the yoke of professional distance that collars both practitioner and patient, and help ensure that one's emotions are not so tightly pinned to the vest or that embarrassing issues are not skirted. According to these researchers, patients saw themselves as accepted, negated, or repulsed in the facial, behavioral, and verbal reflections of their carers (caregivers). Therefore, professional and lay carers alike must remain mindful of their reactions to clients' self-deprecating and stress-deflecting humorous jabs and overtones. Accurately recognizing, correctly interpreting, and appropriately responding to a client's signals for the need for humor should be evidence well worth incorporating into every case manager's practice.

### Measuring Humor Orientation

Wanzer and the two Booths-Butterfields (Wanzer, Booth-Butterfield, & Booth-Butterfield, 2005) used Folkman–Lazarus transactional influences to resurrect the emotion-coping theory. Transactional emotion coping was used to correlate healthcare providers' job satisfaction with measures of humor. More specifically, humor orientation (HO) was measured for job tension relief. Coping efficacy was also measured. In eight types of work situations, nine different categories of HO were produced from 142 nurses. The most common physical demonstration of HO was by 21.4% (30.4 nurses) in patient care such as moving patients and giving medicines; however, the most common HO, "word-play" (Wanzer et al., 2005, p. 127), was reported to be used by 38.66% (54.9 nurses). In direct correlation, higher HO yielded higher ratings of humor effectivity, emotional expressivity, and self-coping efficacy perceptivity. Recommendations included that researchers should explore gender-based HO and years of professional experience-based HO. The seminal work of Wanzer and both Booth-Butterfields began the measurement of outcomes associated with successful HO and humor utilization.

Indeed, the current author recommends that HO and its companion experiences humor effectiveness (HE) and humor appreciation (HA) be scheduled for studies via trial effectiveness (TE) to further elucidate humor utilization habits (HUH) versus deficient utilization humor (DUH). It is postulated by this writer that HO will far surpass HE and HA but, more importantly, or just as important, the studies of the TE of HE, HA, and HO will show no DUH while all practitioners will demonstrate exceptional HUH. Case management students, researchers, and practitioners could secure grant awards to pursue a properly formulated null hypothesis ($H_o$) of HO using the aforementioned suite of humorous transactions.

## Humor by Age Groups

### Humor and Youth: Infection Deflection

Once again, Folkman and Lazarus breathed life into a study about children's senses of humor and their very serious associated cancer-stressors. Children's adjustment to cancer, infection, and immune function was appraised with respect to the Folkman–Lazarus stress-appraisal coping theory. Dowling, Hockenberry, and Gregory (2003) demonstrated that senses of humor and adjustment were directly related such that a high sense of humor had a moderating effect on the incidence of infection. Children with lower coping scores who had the coincidental factors of being children were reported to display more incidences of infection. But, even as cancer stressors increased, high coping scorers who also displayed this youngness-of-age characteristic were reported by the researchers to have fewer incidences of infection. Although they were young, or perhaps because they were young, children who scored high on stress-relieving cancer-coping humor tests were seen in this study to incur fewer infections, whereas children with lower scores in the stress-relieving cancer-coping humor tests appeared to have more infections. Thus, the researcher trio intimated that biobehavioral humor can provide biological armor.

In another Dowling article concerning humor and youth, Dowling (2002) posited humor as one strategy for pediatric nurses to help children deal with illness and hospitalization. In theory, Dowling made links from McGhee's developmental stages of humor to Piaget's stages of cognitive development. In the theoretically linked humor interventions, Dowling postulated connections between human and cognitive developmental stages and humor interventions for different age groups. Like Dowling, Bennett found that cognitive development correlated to humor preferences. The researchers reckoned that numerous activities existed to implement humor in pediatric clinical settings related to diagnoses, assessments, and outcomes. Dowling recommended researching this.

In his *Southern Medical Journal* article, Bennett (2003) says that, in caring for children, laughter therapy can increase a child's sense of mastery over the surroundings and relieve tension by increasing curiosity. In Bennett's report, young children liked sharing a game of tickle, peekaboo, and play-toy; older children preferred jokes, riddles, and office-based slapstick. Although it has been known for a long time that some physicians are better at slapstick and tickle tasks than others, it may be presumptuous to presume that pediatricians have grown up with advanced juvenile humors. Nonetheless, all practitioners including case managers can add to their knowledge bases the preferences by developmental age groups for implementing tickle and peekaboo interventions in younger children versus jokes, riddles, and job-related slapstick interventions for slightly older children.

### Old People Humor

In Florida, to study what older adults find humorous, 130 hospital auxiliary personnel aged 50 years and older were asked, "What makes U laugh?" (Kruse & Prazak, 2006). Content analysis revealed nine themes in two major categories: (1) people or animals and (2) situations or events. The largest people category was laughing at children (30%) and the largest category of events was jokes (51%). One Kruse–Prazak conclusion was that if their sources are appropriate, older adults can be humored by nurses.

Furthermore, humor has been found to reflect healthy aging in the elderly (Shammi & Stuss, 2003). Unlike more youthful patients with focal frontal lesions and elderly persons with frontal lobe degeneration who have maladaptive affective responses, the "elderly able" were defined as those able at the age of 50 years and greater to get a punch line (Shammi & Stuss, 2003, p. 856). The elderly able still able to get a punch line at 50 years and greater have been shown to have three important humor faculties that function: working memories, mental flexibilities, and verbal abstraction abilities. Results indicated, however, that most of these elderly demonstrate scores indicating relative deficits in cartoon testing and punch line detecting. Despite this, 50-plus elderly were able to comprehend humor with significance; therefore, Shammi and Stuss felt confident that humor may be used as a coping mechanism in the 50-plus elderly able.

### Assisted Living Facility Laugh

Humor coping, health status, and life satisfaction among the older old in assisted living facility (ALF) residents yielded a structured equation model with direct and indirect associations and latent variables (Celso, Ebener, & Burkhead, 2003). The researchers expected to find that health status directly (D) affected both humor coping and life satisfaction. When these direct associations occurred, humor coping was believed to affect the relationship between health status and life satisfaction indirectly (I) (see Fig 1, depicting cognitively peculiar reality or perhaps real peculiarity of research). After having ALF older-old residents complete these

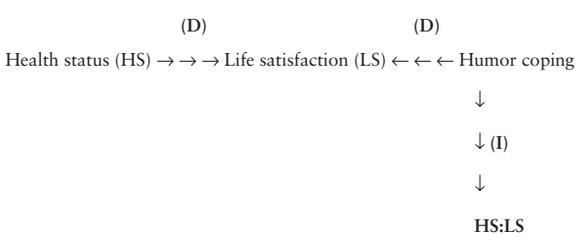


**FIGURE 1**
The structured equation model represents the postulated relatedness among health status (HS), life satisfaction (LS), and humor coping in older-old assisted living facility (ALF) residents. From "Humor Coping, Health Status, and Life Satisfaction Among Older Adults Residing in Assisted Living Facilities," by B. Celso, D. Ebener, and E. Burkhead, 2003, *Aging & Mental Health, 7* (6), p. 444. Adapted with permission.

tests—Multidimensional Functional Assessment Questionnaire ("the Multi-Fun"), life satisfaction index-A ("the life-sat index"), and the Coping Humor Scale ("the Coping Humor Scale")—the researchers found that some of their expectations, hypotheses, and relatednesses were supported and others were not. Despite disappointments in interdirectional relatedness of the theoretical $H_o$, it was found that, for the most part, overall in older-old ALF, better humor signified better health.

The researches postulated that both humor coping (upper right fringe) and health status (upper left fringe) directly (D) affected life satisfaction (LS; upper center) to a statistically significant degree. Yet, surprisingly, humor coping indirectly (I) affected the intersection between health status and life satisfaction (HS:LS). However, in this study, both the direct association of humor coping on LS and the indirect association of humor coping on the intersected HS:LS roles were not found to be supported by the researchers. Despite the findings' peculiar inter- and intrarelated directionalities, researchers discovered older-old ALF laugh to cope with their humor.

## Recommendations for Case Management

Meanwhile, back at the 1000 Islands bunk house, Sheriff Craig reiterates what some of these studies reveal: a fine line exists between healing and harmful humor. Therefore, levity in CM should be painted with a light brush. Let Sheriff Craig issue a few summons.

- Always be aware of the "audience" before launching into playfulness. Watch where and how the playful message is delivered. For example, once, the shiny, fake badge was visible when I entered Street Health, an inner-city clinic for walk-in clients. The young woman in the waiting room saw me enter with a purposeful stride and thought that I was there to arrest someone…her!
- Always be mindful of the residual effect. Like this example—do not say "lolly-gagging" to someone with a swallowing problem. If there is doubt, play it straight.
- Although it works for Rodney Dangerfield, avoid self-deprecating humor. A self-deprecating comment about the case manager by the case manager puts the client and caregiver in an uncomfortable position. Save your self-deprecation for the office.
- Patients may use jocular griping but from the professional, jocular griping sounds like griping.
- Never let levity have overtones of superiority or undertones of sarcasm. Remember the medical students' learned norm for doing harm with derisive humor as an example of what not to do.
- Sarcasm can be seductive because of its ease. But, in the long-term, sarcasm is as corrosive as the medical students' "ethical erosion." In the short-term, sarcasm cuts both the user and receiver with its jagged double edge. Sarcasm should be renamed scar-chasm because a relationship cut by sarcastic humor may never heal well.
- Do not be sucked into participating in sarcastic put-downs about a physician, therapist, caregiver, or client. This splitting technique (a throwback to psych nursing days) drives a wedge of mistrust between the deliverer and you. The person is left with the residue, "If you'd say this about them, you'd say something just as bad about me."
- Always end the visit, interaction, or conversation on a professional note. Never, after any silly bit, exit stage right (like Lippy the Lion and Hardy Har Har do in Cartoon Land). Open and close with professionalism.
- Return the client–case manager exchange to a serious tone by asking whether there is anything that was missed. I like to ask, "What did I *not* talk about that you will wish you had asked me about once I walk out the door?" This backward phrasing hits pay dirt every time.

It is true that case managers must always project professionalism. But a dash of healing humor can accomplish a lot of trust in a little space of time. Humor used judiciously can be a buoyant life vest of levity in an ocean of seriousness. Respectful humor shows humility on the part of the professional and decreases the authoritative stiffness of command and power. You may not see *yourself* as powerful, but you exercise control in clients' lives, liberties, and pursuits of happy acquisitions if not happiness itself.

## Summary

So, hitch up your humor suspenders, case managers, and heed the article's ethnographic evidence-based

practice guidelines summarized here. By adding the sensitive and age-adjusted humor activities to your interventions portfolio, the reality of value-proposition outcomes realization is within sight. Outcomes include protecting dignity; preserving sense-of-worth; humanizing communications; recognizing and rewarding patient-initiated, humanity-reflecting, pain-reducing, infection-deflecting, self-coping humor receptivity; promoting efficacious perceptivity, emotional expressivity, and human effectivity; and providing tension relief from tensions of uncertainty, embarrassment, and dehumanization. Good taste gaffs, quips, gags, cartoons, and jokes are permissible—but in small doses—with songs and dances even smaller if you are one prone to get up off your assumption and dance like this article reports some case managers and nursing faculty have been shown to do.

Pay attention to patients' humorous overtones, witness the oddball, catch the unusual, and introduce mood-improving banter and quality-enhancing twists. Besides riddles and on-the-job slapstick, engage in a game of tickle, peekaboo, or play-toy for the right age groups. For future reference or current reference if applicable, evidence shows that even the 50-plus able-old can still get a punch line with 30% liking kids and other animal stories. Trying a game of wordplay with non–brain-injured ALF residents of the ALF 50-plus elderly old-age group can tickle a fancy or hit pay dirt with ALF laughter. On the dark side of laughter, there are things to remember. Remember, no matter how popular Dr. House gets on TV, humor-cloaked dominance rituals, fair-game fun-poking, sarcastic mordacity, caustic mordancy, and acrimonious scorn are just not funny. Remember to avoid sarcasm, derision, disparagement, belittlement, cynicism, and the maladaptive coping habits of derogatory comments, white-coat aloofness, and flippant behaviors. If you find these funny, you need a humor tune-up speedily. For the more studious, there remains the opportunity for a TE–HE of HO $H_o$ for HA and HUH; but no DUH (see page 8 for DUH details).

Sheriff Craig says that if you think you are too smart to use humor effectively, think again. Give affectionate humor a try but, until the tender bounds of funny/not-funny are found, tread gingerly and curb the sass. It is easy to agree with the anonymous writer who observed, "A smile is the light in the window of a face that shows that the heart is at home."

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