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The Use of Humor With Families During Pediatric Trauma Intake Assessments

Letitia Batton
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Walden University

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Letitia Batton

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Walden University

2017

Abstract

The Use of Humor With Families During Pediatric Trauma Intake Assessments

by

Letitia Batton

MA, Temple University, 2004

BS, West Chester University, 1994

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Human Services

Walden University

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Abstract

Traditionally from a positive psychological view, humor is regarded as an adaptive force, a vital aspect of healing, and possibly a beneficial coping tool when faced with traumatic circumstances. Despite these beliefs, little is known about how humor relieves stress with parents in the initial intake assessment when their child has been traumatically injured. The purpose of this phenomenological study was to explore social workers' use of humor during pediatric trauma assessments. A sample of 6 parents were from pediatric parent trauma support groups to participate in this study, which employed a subject-intensive theoretical framework. Face-to-face interviews and participant observation were used to analyze the experience of the parents with the social worker that used some form of humor consisting of jokes, laughter, smiles, and verbal or nonverbal body language during their intake process. All encounters were audio taped and the data were manually transcribed. Theming was used to analyze the data of the study, and 9 themes emerged with a set of subthemes. The findings provided narratives from the parents regarding their initial perceptions of the social worker, forms of humor used, parenting skills, and factors that either support or oppose the social workers' intake assessment using humor. The study also reaffirms the benefits of the use of some form of humor in the pediatric medical field, revealing that humor benefits not only help the children, but parents and clinicians as well. These findings provide an outlook on how social workers make connections with parents at the onset of the hospital experience to create better lines of communication and improve relationships for all parties. The findings have implications for training and raise awareness around social workers use of humor in pediatric trauma assessments.

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Dedication

“The race is not given to the swift not to the strong, but to the one who endure to the end." *Ecclesiastes 9:11*

Mothers, Fathers, Grandparents, Legal Guardians, Social Workers,
Clinicians, Support Systems.....

These works are dedicated to parents who have found strength to care for their child in the midst of their traumatic situation. To parents who were able to hide their fears and allow medical staff and clinicians to take control. Your children, biological and non-biological, are blessed beyond measure.... You! Giving unconditionally of your love, time, and strength, making whatever sacrifices necessary to ensure your child's comfort and healthy healing. You have opened up about your parenting ability to let others into your world to provide suggestions, support and resources. You were honest about your experiences during the hospital intake process and if it helped, hurt or had no effect at all. To each of the 6 parents who with a commitment and interest in this study, have laid a foundation for discussion around the pediatric trauma intake process. I am thankful for your participation and assistance with my study; I have been blessed by your strength and resilience. I applaud you as a parent as it is not an easy job. Continue to be the role models you are for your children, and having consistent morals and values. I have achieved a level of education that many do not consider and I cannot express my gratitude enough for you being a part of my journey..

Acknowledgment

First, I want to thank GOD whom made this possible. God walked me through this process and showed patience and resilience that I did not think I had. This has been a long road full of bumps and detours but eventually helped me reach my destination. I realized the true meaning of "All things are possible" especially pertaining to me. The road blocks may have been signs to turn back and quit but as the GPS, I was shown another route. I never would have imagined that I would have ever sought a PhD, but I said the same about my Master's Degree. This process has taught me so much more about myself and trusting in God that he will do things in his time. There have been days that I have felt all alone but remembered a scripture my grandmom used to say "Seek God first!" I too have learned to laugh a little more because life is a gift and we must cherish every moment. I always say we never know what someone is going through or has been through so this is my chance to make their day. I have learned from others mistakes as well as my own to dare to be different and foster change. Both my parents worked hard but my mom always said go to school and get an education. Mom probably never imagined that I would have achieved this milestone. If only she knew that I did more so she would be proud. I have so many to thank for help, support and inspiration. First, thanks to Danielle Massey who felt it not robbery to rescue me when I could not rescue myself. To my family, Frank, Jaylen, and Leonique my rocks that listened, laughed and complained. My editors and math magician, Elizabeth Stein and Darius Williams, I thank you for lending your time to help make a difference. I pray that the tenacity you have witnessed on my journey will serve as an inspiration to let you know that with GOD all things are possible. Last but not least, my true Face Book family and friends that had words of encouragement that kept me going. To my Walden Committee, Dr. Phillips, Dr. Bold, and Dr. Hickman thank you being a part of my "Team", this journey that has taken me to heights I would have never fathomed. I cannot thank you enough for your

patience and dedication to this process and myself, I will be forever grateful to each and every one of you. I plan to continue to laugh and spread the knowledge obtained to make a difference in lives of families and clinicians.

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Chapter 1

Introduction

Many children are exposed to traumatic life events. A traumatic event is one that threatens injury, death, or the physical integrity of self or others (LaCapra, 2014). Caffo, Forresi, and Lievers (2005) defined traumatic events as “sexual abuse, physical abuse, domestic violence, community and school violence, medical trauma, motor vehicle accidents, suicides, and other life threatening experiences" (p.422). When a child suffers a traumatic injury, it is a stressful event for all involved. Hospital staff are often the first people the patient and their family encounter. The initial encounter between families of children with traumatic injury and hospital staff may be a critical part of the child’s recovery (Marsac, Kassam-Adams, Hildenbrand, Kohser, & Winston, 2011). After a preliminary review of the literature, I have found no research on the use of humor during the pediatric trauma intake process helping to lighten the mood. This gap in the literature has been consistent across my access of multiple databases. In this study I examined the humor used in the intake process with families and how this process contributes to mitigating stress.

A significant amount of research describes how humor can be a helpful coping tool for individuals who have experienced some certain types of trauma (Figley & Kiser, 2013; Levine, 2013). Also, researchers have described how the ability to use humor as a coping tool could be taught to clinicians, but there is a lack of research on how clinicians should or do react to client acceptance of humor during the intake process (Levine, 2013). Ruch (1998) suggested that humor is connected with feelings of freedom, control, and

heightened self-esteem, and can be a characteristic of mental health. The initial intake process with families whose children have suffered a trauma can increase rather than mitigate the family's stress (Figley & Kiser, 2013). If the initial intake process is flawed, the entire hospital stay can be taxing on the family and present challenges for ongoing patient care (Figley & Kiser, 2013). However, some techniques for connecting with parents play a positive role in assisting families during their hospital stay, therefore promoting better patient care (Scholl, 2007). One such technique could be humor. The use of humor by clinicians in pediatric trauma intake may provide a significant breakthrough to help the patient and family relieve stress and cope (Levine, 2013). Humor may also assist clinicians in controlling their cognition and understanding of the families, which may reduce stress during the hospital admission, but no specific study related to pediatric trauma admissions (Amaya-Jackson & DeRosa, 2001).

Establishing a sense of humor about life's difficulties is a productive coping method that can lead to greater well-being and can be a basic stress minimizer (Amaya-Jackson & DeRosa, 2007). Apart from the healing benefits of laughter, having a sense of humor about life's challenges can afford the individual a way to connect with others, look at things differently, normalize experiences, and diminish fear (Bennet & Lengacher, 2006). Rosenberg (2008) argued that if a clinician promotes the use of humor, it can help strengthen their relationships with their clients families. However, after a preliminary search, I have been unable to find any specific research that addresses clinician's use of humor during the pediatric intake process and how humor mitigates stress with these families (Bennet & Lengacher, 2006, Martin, 2007). In this research study I examined the

humor used in the intake process with families and how this process contributes to mitigating stress.

The idea that humor can relieve stress has been debated through the years among clinicians (Amaya-Jackson & DeRosa, 2007; Bennett & Lengacher, 2006). Some researchers do not think that humor heals patients who are experiencing trauma and tension (Amaya-Jackson & DeRosa, 2007). However, Vettin and Todd (2004) found that having a sense of humor when dealing with traumatic circumstances could assist individuals in lessening the intensity of their traumatic stress reactions. While humor may not minimize the significance of the trauma, it may allow the families and patients to cope and thrive in their present situation (Force, 2011). Force (2011) proposed that even though physicians and clinicians have the experience to fix and heal, humor may be used as a segue during their assessments to making coping more manageable. When using various forms of humor during intake with parents of pediatric trauma patients, Spitzer (2001) concluded that momentary emotional relief is obtained, yet there is little current research to this claim. A common problem in research addressing trauma on the parents is the presence of many limitations: studies are often retrospective, use self-report surveys, and the results may be generalized (i.e., they are not trauma assessment specific) (Caffo et al., 2005). The question that remains, then, is whether humor used during the intake process can mitigate stress with families during the pediatric trauma (Rosenberg, 2008).

Wanzer et al. (2005) stated that it is unclear if humor used by clinicians in pediatric trauma intake with families relieves their stress. However, MacDonald and

Attardo (2006) suggested that humor helps to connect families and clinicians and can be used to amuse and educate families of all ages because it encourages laughter. However, they do not make a specific connection with pediatric trauma. Some clinicians are not humorous, or they cannot interpret humor because they are too concrete in their thinking (Gordon, 2007a). Scholl (2007) argued that families believe that the intake process completed by clinicians is mechanical, and they speak in a robotic manner that limits any connections.

Considering the ongoing debate about how humor relieves stress during the pediatric trauma intake, it is necessary to examine how families perceive the use of clinician's humor and whether it helps their coping experience (Amaya-Jackson & DeRosa, 2007). Amaya-Jackson and DeRosa (2007) proposed that for humor to be beneficial in relieving stress, clinicians must develop a connection to the patients and families. Although the aforementioned research regarding the use of humor as a healing or coping mechanism illuminates important findings that is critical for this research. However, I have found no research that examines use of humor during intake process through the lens of the experiences of parents. This void in knowledge in this particular area warrants further examination and research in the use of humor used in the initial pediatric trauma assessments as a tool to mitigate stress. O'Connell (1976) argued that people with a strong sense of humor can detour their thoughts on a specific situation. With this in mind, it allows individuals to distance themselves from the current threat of a traumatic situation and in turn lessens the paralyzing feelings of stress and weakness. The main focus is how humor is experienced by the family's ability to cope with the trauma

and if the humor relieves stress while in the hospital. To address this, I conducted interviews of families surrounding their initial intake experience when humor was used, after their child was injured and taken to the hospital. I have accessed several databases and detected this gap in the literature that does not examine the use of humor in the intake process with families and how this process contributes to mitigating stress.

Significance

The purpose of this qualitative study is to allow for exploration of the use of humor phenomenon, providing an opportunity for participants to tell of their experiences during the intake process with families whose children experienced a traumatic injury and were taken to the hospital. The researcher examined the lived experiences with the use of humor as a stress reliever with families during the intake process. Results from this study may help clinicians improve their intake techniques in order to better assist families in coping with traumatic events. Because traumas experienced by children can be emotionally draining on the patient and parents or caregivers, the initial intake process should be comforting and help to relieve stress (Balluffi et al., 2004).

Clinicians may struggle with working with and helping trauma families because they lack appropriate communication skills (Scholl, 2007). The researcher examined how families view the intake process used by clinicians in pediatric trauma. A potential social change may emerge from a clinician's enhanced skill set to improve the intake techniques; so that families become more receptive to the intake process (Cohen & Mannarino, 2011). Training can be implemented for clinicians to target their intake process so that connections can be made with the families. By connecting with families

and putting them at ease, clinicians will be able to obtain vital family information (Cohen & Mannarino, 2011).

Madsen (2007) suggested that if clinicians change their approach, this may restore positive relationships with families that have not had successful experiences with conventional advances. However, there has been little research found that focuses on the clinician's initial intake process being used as a stress reliever with pediatric families (Bennet & Lengacher, 2006). This study is aimed at exploring the lived experiences of families where humor was used to relieve stress when their child suffered a traumatic injury.

Background

Force (2011) stated that during the intake process, humor can be mutual. If families laugh during the process, and, in turn, the clinician laughs, it shows that humor improves the clinician's spirits as well. In this study I explored the use of humor by clinicians during the intake process with families that have experienced pediatric trauma. Research indicates that humor enhances communication, facilitates cognitive reframing, offers social support, and has possible physical benefits (Morreall, 2011).

Humor is not easy to define. Martin (2007) defined humor as the feature or essence of something like a story, action, or joke that brings out entertainment and laughter. Understanding what humor is may be important when determining how detrimental or beneficial it can be to lighten the mood. Force (2011) suggested that the influence of humor on many issues, such as anxiety, tension, and public opinion, have been studied thoroughly by initial research and for that reason frequently accepted.

Defining Humor

Martin (2007) presented a basic definition of humor; however, there is more to humor than just the ability to make people laugh or to be able to laugh at something funny. Smiling and laughing can be a normal response to humor as an emotional reaction. Laughter can also be an emotional reaction to pain, fear, or shame (Bennet & Lengacher, 2006). Humor is an emotional response to comedy that includes both characteristic emotional responses and positive mental shifts (Martin, 2007). The sense of humor is a psychological trait that varies significantly and allows persons to react to multiple types of humorous encouragement (Force, 2011).

Not only is humor displayed in multiple fashions, but it also differs among cultures. Humor differs from culture to culture regarding what is humorous and what is not, when humor is appropriate, and the purposes humor serves (Smith, 2008). Smith (2008) said that humor is also profoundly distinctive and very much a subject of personal taste and choice. It is argued that humor is a cultural construct (Martin, 2007). Smith observed that sense of humor not only differs between cultures, but it may also differ within the same culture. Kuipers (2008) concluded that humor is an appropriate intervention for ethnically varied clients when used tactfully in the advising method. Even though the use of humor may be global, there is some research that cultural differences exist in the use of humor and how this is expressed (Levin, 2013). Morreall (2011) indicated that the difference depends on the degree to which humor is understood, the way humor is shown, the appreciation of humor, and the tendency to use humor as a coping mechanism. As individuals, they all respond differently to humor and trauma, but

researchers have indicated that different cultures express it in multiple ways especially when it relates to children (Cox, 2013).

Humor and Health

Humor is a natural pressure reducer and problem reliever that can be associated with better wellness, expanded life probability, and general good health (Bennet & Lengacher, 2006). Although Bennet and Lengacher (2006) argued that humor can have positive effects on health; however, they did not directly associate it with traumatic situations. Humor used as a mitigator of stress is customarily both integrative and accepted medicine (Amaya-Jackson & DeRosa, 2007). Bennet and Lengacher (2006) stated that humor is therapeutic for easing stress and anxiety but not necessarily as a tool used during assessments. Stress has been associated with mental tension, and humor appears to safeguard individuals against these negative influences if utilized properly (Amaya-Jackson & DeRosa, 2007).

Researchers have found that an affirmative mental state has beneficial effects on the body (Godfrey, 2004; Leber & Vanoli, 2001). More recently, researchers have found that the use of humor improves the immune system, associating humor with reduced pain and an ongoing effort benefiting the health systems (Bennet & Lengacher, 2006). The use of humor has also been perceived by clinicians as a valuable tool for regulating the mind, body, and spirit, thereby decreasing stress and providing a viewpoint of control (Godfrey, 2004). MacDonald (2004) defined therapeutic as a feeling of treatment, healing, or a cure. Humor may reduce hospital stays and assist with providing the patient and family with a better prognosis (MacDonald, 2004). Appreciation of humor refers to the ability to

see the humor in the environment, whereas generation of humor is the tendency to make humorous comments or act in a humorous manner in a situation (Levine, 2013).

Accordingly, this study involved a qualitative analysis of the use of humor with families whose children have experienced a traumatic injury.

Theoretical Framework

The theories used in this research are cognitive behavioral theory (CBT) and unconscious thought theory. CBT in association with humor may be the learning methods and what is viewed by society as humorous healing. Conscious and unconscious thoughts greatly influence our decision-making process (Dijksterhuis & Nordgen, 2008). Many times, individuals find themselves smiling or laughing and not realizing it, especially in traumatic situations. Conscious thoughts are the emotional state that embraces an individual's logical reasoning realization, while unconscious thoughts are a fundamental focus that people are normally unmindful and can change an individual's behavior (Dijksterhuis & Nordgen, 2008). Dijksterhuis and Nordgen (2008) suggested that CBT and UTT reinforce each other as their intentions are to learn and improve positive outcomes; however, I have found no current research to support this specifically with pediatric trauma assessments.

Although humor is almost universal, not all societies develop, respond to or appreciate it. Therefore, it is unclear what the positive or negative effects are (Smith, 2008). Humor is about an underlying emotion identified as "the feeling of not being serious" (Oring, 2011). Humor can appear in the form of a joke, a facial expression, body language, and laughter. It can also be relayed through a comment or a connection made

with another person (Force, 2011). Based on the types of humor mentioned, one or more may be used in the intake process; however, the dilemma is in the benefit factors (Force, 2011; Oring, 2011). Chafe (2007) stated that jokes are a subset of humor using a punch-line to gain a surprised reaction.

Facial expressions can tell a story without saying a word (Scholl, 2007).

Individuals can have a sense of humor in traumatic situations, but a smile or specific eye movement can be viewed as humorous and provide mental relief (Scholl, 2007). The delicate use of body language can also deliver a more powerful message than words especially when it is funny movement. The way one stands or moves around the room may be considered humorous. Wanzer, Booth-Butterfield, and Booth-Butterfield (2005) proposed that laughter is a distinctive coping tool to assist individuals with handling life's struggles.

Dr. Patch Adams has devoted his life's work to the thought that healing should be a loving human interchange, not a business transaction (Spitzer, 2001). Dr. Adams is a medical doctor who wears several hats as an educator, healer, clown, and performer. The movie "Patch Adams" displayed this clinician's work by exploring the association between humor and therapy using his exclusive combination of understanding drama and "hands on" teaching methods (Spitzer, 2001). Currently, The Humour Foundation which was established in Australia gained inspiration from the work of Patch Adams and the Clown Care Unit in New York. The mission of the Foundation is to introduce and promote the well-being to patients, their families and clinicians through the use of humor (Ford, Tesch, & Carter, 2011). The Foundation uses acting, humor, empathy and

sensitivity to assist individuals to deal with complicated life events. Seminal research by Dr. Albert Ellis (1977) believed early on that humor was therapeutic; however, he was disliked by many for his research. Ellis (1977) stated that making fun of someone's problems would allow them to assess the insanity of their flawed thinking. Ellis mocked his client's thinking, cautiously explaining to them he was not making fun of them but their thought process.

Research Questions

RQ1: How do families respond to clinicians' use of humor during the initial intake process?

RQ2: How would families describe the clinician's use of humor as a way to relieve stress during the intake process?

Nature of the Study

This phenomenological qualitative study consisted of interviewing families of children who were hospitalized through the trauma department of a pediatric hospital, but have since been discharged. The study connected patterns and themes of the families' experience and their reactions to the styles of engagement by clinician's and the improved relationships developed with patients while hospitalized. Specifically, the responses from the interviews created the patterns used for this research. The researcher examined the parent's hospital intake experience and what it meant to them.

The participants consisted of 6 families whose children between the ages of 2 and 15, suffered a traumatic injury and were hospitalized in Philadelphia or surrounding counties within the last 2 years. The families were selected from a trauma support group

that is facilitated by parents and meets twice a month. The support groups are advertised between the two major children's hospitals in Philadelphia and word of mouth among the parents. The groups are not sanctioned by the hospitals. The families were informed through a flyer that was distributed at the meeting about the nature and purpose of the research, and their participation will be requested. The interviews conducted were a naturalistic inquiry at a designated location.

Chapter 2

Literature Review

Each year in the United States, emergency departments treat more than 200,000 children ages 14 years and younger as a result of a traumatic injury (Marsac, Kassam-Adams, Hildenbrand, Kohser, & Winston, 2011). The first impressions made on families when entering the hospital after a child's traumatic event may be a determining factor in the child's welfare (Rutchick, 2013). The hospital experience can be stressful. Social workers and other personnel are the frontline staff who take care of the child and support the family. In this chapter I explore the current research on the use of humor by social workers during the pediatric trauma intake process. The present research involved a qualitative study on families whose children have experienced a physical trauma and the effects of the intake process on the hospital stay.

An exhaustive search was done utilizing several sites including, but not limited, to psychological, medical, nursing, social work, etc. journals. The initial literature search strategy consisted of a general library database search using the Walden University Library EbscoHost to locate documents related to pediatric trauma and humor. The literature obtained from this site consisted of full-text, scholarly peer-reviewed journal articles contained in databases such as PsycINFO, PsycARTICLES, and Academic Search Complete. The literature search strategy was expanded to several online Internet sites including Google Scholar and SAGE Journals. In an attempt to move beyond the limited research on the subject, literature was also obtained from various reference books. Some of the journals most used were: International Journal of Humor Research, Journal

of Traumatic Stress, and Journal of Child Health Care. The searches consisted of using the following keywords such as Humor, Trauma, Pediatric Trauma, and Intake Process, as well as many others. The literature review begins with a discussion of trauma and then goes on to discuss the use of humor in the hospital intake process. Research findings on the functions and types of humor, as a managing mechanism in the face of stressors, were then assessed. Lastly, the researcher discussed humor and the intake process with families whose child experienced physical trauma. The chapter concludes with a representation of the intention of the study and research questions.

The Diagnosis and Effects of Trauma

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013), “Trauma- and Stressor Related Disorders,” for diagnostic purposes in the identification of PTSD or Acute Stress Disorder, must meet the following criteria:

1. Directly experiences the traumatic event;
2. Observes the traumatic event in person;
3. Has knowledge that the traumatic event happened to a close family member or close friend experienced multiple first-hand substantial exposure to unemotional specifics of the traumatic event (not through any form of media).
4. The circumstance, regardless of its initiation, causes clinically major hardships or impairment in the individual’s relationships, ability to work or other important areas of daily living. It is not the physiological result of another medical condition, medication, drugs or alcohol. (pp. 36-37)

The diagnostic criterion for the DSM-V draws a fine distinction when detailing what makes up a traumatic event. The DSM-V focuses on the behavioral conditions that are associated with PTSD and suggests four specific demonstrative groups instead of three (Kilpatrick, Resnick, Milanak, Miller, Keyes, & Friedman, 2013). According to the American Psychological Association (APA, 2013), they are portrayed as (a) re-experiencing, (b) avoidance, (c) negative understanding and emotions, (d) and arousal. Re-experiencing involves impromptu memories of the traumatic experience, repetitive dreams related to it, past thoughts or other piercing or extended psychological adversity. Avoidance refers to upsetting flashbacks, intellect, emotions or external notice of the experience. Negative understandings and mood symbolize countless feelings, from a constant and skewed sense of responsibility of self or others to alienation from others or considerably decreased regard for activities, to being incapable to remember important facts about the experience. Lastly, arousal is pointed out by hostile, negligent or self-harming activity; sleep disruption, intense behavior or associated issues. Rutchick (2013) argued that one of the biggest experiences following a traumatic injury and the hospital intake process is the negative blame as assessed in the DSM-V.

Effects of Trauma

Following a traumatic experience, there are several reactionary patterns in response to the traumatic circumstances, better known as trajectories (Catherall, 2013). These include a severe interruption in functioning, slow recovery, and added stress over time to the entire family. Current research with children hospitalized for serious physical injury following one traumatic experience found support for four post-traumatic reactions

(chronic, delayed, recovery, and resilience) in the first six months of recovery from injury (deRoon-Cassini, Mancini, Rusch, & Bonanno, 2010; Quale & Schanke, 2010).

Additionally, they discovered that contact with simultaneous or varied stressors lessens the amount of resilience, although exposure to one traumatic event concluded in critical injury raised rates of resilience (deRoon-Cassini et al., 2010).

For individuals who have survived trauma, the ability to find intent and significance in the midst of adversity highlights the importance of discovering ways to promote personal growth and positive adjustments during the intake process (Joseph, Alex Linley & Harris, 2005). In similarity to Erickson's (2010) attention to client strengths, Orner (2010) offered that clinicians view responses brought about by trauma as adaptive signs that should be acknowledged and applied during and after the trauma. Tedeschi and Calhoun (2010) supported a client's knowledge of their life experiences and being in tuned to patterns or progress and positive changes (e.g., empathy, courage). Clinicians should realize the ramifications of trauma and be inclined to create personal interventions that target the clients understanding of health and infirmity (Morrison, 2010). Research on coping has concluded that it is not only the essence and seriousness of a traumatic experience that effects the response of individuals, but also one's strength to deal with the process (Kiser, Donohue, Hodgkinson, Medoff, & Black, 2010). Coping normally applies to most attempts to resolve issues and regulate stressors, but specific attempts are swayed by both personality characteristics and social aspects (Carver & Connor-Smith, 2010).

Kiser et al. (2010) suggested that it is important that clinicians learn and create a

support system for their clients during the intake process since this has been shown to improve hospital stays. This may involve teaching and includes family, friends, and neighbors. It is also important that clinicians be open to converse about subjects that they normally avoid in order for trauma recovery to be productive (Kiser et al., 2010). Kiser et al. insisted that combining and creating the family's coping plan of action in the healing process is important. Kiser et al. asserted that this can be achieved through a poetic form (writing, music, or art), or in a haven where they feel comfortable talking about the trauma and how they have adjusted. Emotional healing should encompass efforts to face feelings of guilt and embarrassment and promote personal courage and feelings of self-worth. Treatment should also include efforts to counter feelings of shame and blame and foster individual strengths and feelings of self-worth (Kiser et al., 2010). The effects of a trauma mentally or physically can be devastating, especially for a child. The initial contact made by a social worker with the family can provide momentary relief (Kiser et al., 2010).

Trauma in Families

When families experience trauma, the entire family reacts and responds (Catherall, 2013). Individual immediate family members, as well as the extended family, can be affected. Becvar and Becvar (2012) suggested that in order to appreciate the significance of families in the context of individual circumstances of trauma and recovery, it is important that clinicians understand how individuals respond to trauma. The nature of the injury and the family dynamics determine how individuals will respond. Families come together to show support and to be a resource when a child has suffered an

injury and is hospitalized. The result of trauma spreads through families whether it is a household member or a distant relative. Other family members may incur their trauma symptoms. Kiser et al. (2010) found that the dynamic of the whole family may be affected and, often, the effects of the traumatization are so dynamic that they are transmitted across generations. Some family members internalize the injury and place blame on themselves or suffer guilt (Becvar & Becvar, 2012). When confronted with pediatric trauma experiences, the intake process is just as vital as the care the child receives. The family is the support system for the child as the child looks to them for comfort. When a clinician greets, assesses and begins the support process that can dictate the comfort level of the family (Catherall, 2013).

Pediatric Trauma

Injury is the leading cause of death and disability among children (Marsac et al., 2011). Each year, almost one in six children in the United States require emergency department (ED) care for the treatment of injuries, and more than 10,000 children die from their injuries (MacFadyen et al., 2012). Pediatric trauma is defined as injuries that happen to children ranging from infant to 17 years of age that require immediate medical treatment or care (MacFadyen, Ramaiah & Bhananker, 2012). Pediatric trauma care provides injured children with life and limb saving treatment (Stelfox, Bobranska-Artiuch, Nathens, & Straus, 2010). The relief of pain and psychological healing are important parts of the treatment of an injured child (Stelfox et al., 2010). Children often look to their parents for relief when hospitalized (MacFadyen et al., 2012). Pediatric trauma can be a result of abuse, sports injuries, falls, or tragic accidents

(MacFadyen et al., 2012). Regardless of the mechanism of how the injury is caused, the medical care does not change. The only thing that is altered is how the clinicians respond in providing support and resources (Smith, 2013). When it pertains to pediatrics, families often feel helpless and wish they could take their child's pain away (Smith, 2013).

Importance of the Intake Process in Trauma

Trauma is the number one killer of children and the most common cause of hospital admissions (Sluys, 2012). How a patient or family is treated when they enter a trauma center can determine how the rest of the care rendered and relationships built will be determined. Once trust is established, families can become calmer, and medical staff is more able to obtain patient information and provide the best possible care (Davenport et al., 2010). During the intake process, the social worker should maintain consistency including, but not limited to, having a positive attitude and a sense of humor (Valentine & Gabbard, 2014). Gallow suggested that humor happens when we hear the truth in a way that we have never been told; particularly from someone we do not know (Watson, 2011). Social Workers should be visualized as human beings; therefore, laughing and caring for others are both sources of fulfillment (Watson, 2011).

When a patient enters the emergency department at the hospital, the intake process begins. Not only are they met by a team of doctors, but they are also met by social workers that not only assist the medical team but support the family. Based on the nature of the injury, family members are often highly emotionally attached to each word they hear that may offer the possibility of a positive outcome (Valentine & Gabbard, 2014). A genuine engagement could provide a sense of relief and resource showing the

family that they are not alone. If a connection is made based on words, a smile, or maybe even a hug, this could mitigate the traumatic experience (Watson, 2011).

Emergency Room Strategy to the Intake Process

Many hospitals have different policies and procedures that must be followed once a patient enters. Specifically, addressing the emergency room policy, each patient must be assessed to determine the level of their illness (Wiler et al., 2010). Once that is specified, that patient will be seen in the order of the severity of their sickness. There is a specific protocol for Level 1 trauma hospitals that are guided by federal regulation. If a patient is brought in through the emergency room as a result of a traumatic injury they are usually taken straight to the trauma room for care. A series of doctors and nurses respond to the trauma for assessment and to determine a course of care (Wiler et al., 2010). If the injury is severe, or life threatening, specific support teams are notified. Besides the medical staff, the support team can be comprised of social workers, therapists, child life specialist, and possibly a chaplain (Love, Murphy, Lietz, & Jordan, 2012). These individuals are the first voices heard when entering the hospital (Love et al., 2012).

Definition of Humor

Based on the Merriam-Webster dictionary, humor can be described as “that quality which appeals to a sense of the ludicrous or absurdly incongruous;” “The mental faculty of discovering, expressing, or appreciating the ludicrous or absurdly incongruous”; or “something that is or is designed to be comical or amusing” (Webster, 2015). From an emotional perspective, humor is a broad and versatile approach that has been both functionally and theoretically described in a series of ways, often including

emotional, intellectual, psychological, behavioral, and social features (Martin, 2007). Based on Martin (2007), the paramount elements of humor involve an “emotional response,” a “social context,” an “intellectual process,” and “the vocal behavioral expression of laughter” (p. 5). Cann, Stilwell, and Taku (2010) recognized the following to be personal aspects of humor: individual belief that he or she is humorous, an acknowledgment of others’ humor, laughing, outlook, and stress-relieving humor (i.e. coping). Therefore, an array of descriptions can be used to explain these different aspects of humor. A few definitions center on the actions of others. For example, Martin defined humor as “the frequency with which a person smiles, laughs, and otherwise displays mirth in a wide variety of life situations” (p. 253). Cann et al. (2010) also attributed intellectual and interpersonal perspectives of humor in their definition, stating that humor is “a way of looking at the world...a style, a means of self-protection and getting along” (p. 13). The authors in this description are referencing humor's protective role.

When humor is used as a coping tool in the midst of trauma, it may include emotional (e.g., good feelings), intellectual (e.g., knowledge), social (e.g., relationship), and mental behavioral (e.g., laughter and smiling) components. One dispute in humor studies has to do with the different styles, many definitions of similar terms, and cultural differences in key meanings and elements (Galloway, 2010). For example, an individual defined as being in a silly or playful mood is thought to be in a humorous mindset that is restricted by time and circumstantially confined (Cann et al., 2010). Kuiper (2012) suggested that humor can be looked at as an intellectual skill, a beautiful reaction, a constant behavioral model; an emotion attached personality trait, demeanor, a coping

plan or defense method. Humor can be used to cover or avoid stressful circumstances by laughing and not crying (Kuiper, 2012) For example, a person who has an exceptional talent to create humor also probably finds joy in making others laugh, although they may not always utilize humor as a daily coping mechanism. Lefcourt and Martin believed that humor is used as a tool, instead of an attribute, that is greatly altered by environmental and cultural elements. Therefore, Lefcourt and Martin suggested that there cannot be one complete definition of humor. Also, within the scope of psychology, researchers in various areas of the field may take a somewhat different focus on the discussion of humor.

Humor has been specifically recognized in the past as an important factor to one's mental welfare and has also been found to be a facet of resiliency (Ripoll, 2010). In past research, according to Peterson and Seligman (2004), humor was universally used as a personal strength for several reasons. Peterson and Seligman suggested a few reasons as self-gratification, the ability to unite individuals (through a joke) where the individual display of harmless humor does not belittle others, the reverse of humor (e.g., dull, sad) is offensive, etc. In general, humor has been recognized as a positive mental characteristic and an individual strength that has the potential to assist people to cope with life's stressors.

Researchers have indicated that people who are resilient seek out ways to generate positive feelings when confronted with stress (Lefcourt et al., 2012; McGhee, 2010). McGhee (2010) suggested that individuals recoup faster from stressful occurrences, avoid depression, and mainly prosper. In turn, the positive feelings frequently constructed by

humor can assist to further one's resilience. Similarly, Hutchinson and Lema (2009) examined relevant research which suggested that incorporating laughter, fun, and positive feelings into any hospital assessment can help individuals who suffered trauma to build resilience, as it symbolizes a "small way to withstand even the most violent of circumstances" (p. 9). Despite the fact that there has been researching on the use of humor in trauma in general and humor use in managing stress and misfortune, I have been unable to find research on the use and functions of humor during the pediatric intake process with families whose children have suffered a traumatic injury.

Studies on this topic are further complicated by the reality that both humor and traumatic experiences are explained, clarified, and valued differently (Levine, 2013; Morreall, 2011). Also, researchers and clinicians must take cultural variances into consideration into account when using humor when working with clients who have experienced trauma (Kuiper, 2012). Many cultures view humor differently, and clinicians must be careful not to be offensive. If clinicians are not knowledgeable on a certain culture, it would be important for them to research before incorporating any form of humor in the intake process (Kuiper, 2012).

Psychoanalytic Theories of Humor

This entire section is made up of seminal research that assesses the various types of humor from a psychodynamic, developmental, and multifaceted view, and is based on the different features they include and roles they serve. It summarizes an analysis of other familiar features mentioned in the literature, consisting of the style, recognition, and presentation of humor. Early on, Freud (1928) made a clarification among three different

forms of amusing experiences; consisting of jokes, the comic, and humor (Martin, 1998). Based on psychoanalytic theory, “paraphrase each of these involves a saving or economizing of psychic energy which, having become unnecessary for its normal purposes, is dissipated in the form of laughter” (Martin, 1998, p. 18).

Primarily, Freud upheld that excess nervous energy can be released through laughter. According to Freud, humor allows an individual to express unconscious aggressive and sexual stimulus that would alternately be curbed. The individual displaying humor may include nonverbal essentials (e.g., clowns) and often results in childish actions and healing laughter. Freud (1916) also described gallows humor as a form of humor in which an individual is capable of grasping the true definition of a problem, but instead he contains it by using humor as a coping technique.

Garrick (2005) defined the use of gallows humor among police officers, paramedics, and other workers who face traumas on a daily basis and use dark humor as a way to make it through their jobs. A significant amount of literature and research also involves the use of such humor within different cultural groups, often as a means to cope with injustice and/or oppression. In fact, humor may be a common language that is essential to the way of life in societies exposed to social injustice by assisting individuals in a minority group to gain perspective on their adversity, maintain a sense of identity, and reaffirm their way of life (Martin, 2007). Vaillant (1992), stated that humor allows an individual to clearly display feelings without personal discomfort or unpleasant effects on others. Like Freud, Vaillant (1977) stated that “humor can be regarded as the highest of these defensive processes. It scorns to withdraw the ideational content bearing the

distressing affect from conscious attention as repression does, and thus surmounts the automatism of defense” (p. 233). Vaillant (1977), however, believed humor to be a mature protection and not a form of repression. This perception of humor as a healthy or mature defense technique is not limited to the psychoanalytic field, however, and continues to hold credibility within the field of psychology (Martin, 2007).

Yet, Freud also made a specific clarification between humor, which he regarded as favorable and typically beneficial, and fun, which he referred to as more aggressive and possibly harmful. Hence, the most important distinction between types of humor continues to be with whether humor is progressive or damaging. Psychoanalytic theories of humor also helped to attract awareness to certain elements of humor, including the hostile and sexual themes in various jokes, the mental pleasure created by humor use, and the generally effective motivation to engage in humor (Martin, 2007). In general, however, psychoanalytic theories of humor have received conflicting and very limited empirical support, and a major disadvantage of Freud’s theory is that he focused specifically on intrapersonal dynamics and failed to consider the social and interpersonal framework of humor.

Dr. Patch Adams has spent his career advocating that healing should be a compassionate interaction, not a just a job (Spitzer, 2001). Dr. Adams is a physician who is characterized as many things ranging from a professor, researcher, healer, clown, and actor (Clark, 2013). He founded the Gesundheit! Institute and currently is heading their 31st Annual Russia Clown Tour to Moscow and St. Petersburg to clown in medical facilities, orphanages, nursing homes, and anywhere they can spread humor and love.

Their phenomenal journey is filled with participants from cultures all over the world that will gather to explore and exchange healing, playfulness, compassion, and performance (Clark, 2013). Dr. Adams encourages future doctors to develop compassionate relationships with their patients (Clark, 2013). His remedy for this kind of care relies on humor and play, which he views as beneficial to physical and emotional health (Clark, 2013).

For several years it has been claimed that laughter has medical benefits; also over the last decade many humor and laughter focused benefits have gained recognition (Mora-Ripoll, 2010). Laughter has shown mental, physical, and emotional well-being benefits. Therapeutic effects of laughter comes from spontaneous laughter and self-induced laughter (Watson, 2011). Although there is not information to demonstrate that laughter is a healing component, there is enough evidence to support that laughter has some positive effects on health (Mora-Ripoll, 2010). Although there are many clinical programs designed to bring humor into pediatric hospitals, there has been very little research with children concerning the particular use of humor for children dealing with stressful situations. Humor may assist a child in looking at a traumatic event from a different perspective and view because it was less threatening and more of an opportunity or challenge (Stuber et al., 2009). Also, humor may lessen related feelings of anger, frustration, stress, and pain. Humorous distraction is useful to help children and adolescents deal with stressful and painful situation. Pediatric nurses believed that humor carefully and appropriately used helped children lessen their fears of being treated and being hospitalized (Stuber et al., 2009). Watson (2011) noted that humor and laughter

helped to relax, build relationships, and encourage cooperation between medical staff, patients, and families.

In summary, the difficulties in accurately capturing the multifaceted dimensions of a sense of humor and, in particular, differences between beneficial and maladaptive uses, pose significant challenges in humor research (Cann & Etzel, 2008). As Martin (2007) suggested humor “has taken on many positive connotations over the years, while becoming increasingly vague and ill-defined” (p. 225). Accordingly, this dissertation will focus on a variety of elements and types of humor that may serve different functions within the therapeutic framework.

Types of Humor

Although Martin’s (2007) research can assist in better comprehending what humor is, and its function in people’s lives, it fails to account for the structure of humor. Humor has also been analyzed according to various types that individuals tend to value most (Warren & McGraw, 2015). These types include discrepancy resolution humor (i.e., humor in which there is some discrepancy that can be resolved by information offered somewhere in the joke), absurd humor (i.e., jokes in which the discrepancy is not necessarily resolved, but the discrepancy itself is enjoyed for its bizarre elements), and sexual humor (i.e., jokes containing sexual content themes). The first two factors relate more to the structure of humorous stimuli, while the latter is related to content themes. Humor recognition only accounts for a small portion of the different styles of humor that individuals use or face in their daily lives, there are several more to be discussed further in this literature (Warren & McGraw, 2015).

Another common difference between types of humor in the literature is between reactive versus productive humor (Morrison, 2012). Reactive humor can be described as the ability to acknowledge and respond to humorous stimuli in the environment, whereas productive humor is an individual's ability to frame and use humor in situations that do not seem to be inherently humorous (Rutchick, 2013). Morrison (2012) found that many of the studies done on the advantages of humor fail to make a distinction between these types of humor, which leads to equivocal findings. However, even research which did make such a distinction produced different responses. Morrison and Rutchick (2012, 2013) were consistent with other studies suggesting that production of humor can be facilitated for use during stressful situations.

Benefits of Humor

As previously discussed, theorists such as Freud (1983) and Valliant (1992) acknowledged the positive effects of certain types of humor (Kuiper et al., 1993; Martin, 2007). Humor has long been associated with holistic healing, as it is purported to contribute to healthy physical and psychological functioning (Martin, 2007). Physiological benefits of laughter include an increase in certain antibodies, along with a decrease in stress hormones (Kuiper, 2012). That is, laughter can strengthen the physical immune system. In addition, Lefcourt et al. (2012) suggested that humor can also help to maintain the mental immune system by changing how we act. Hasan and Hasan (2009) found that the health benefits of laughter can be dependent upon the level of laughter exhibited as well as the culture in which it is used. Isen (2003) reviewed a number of studies that found that individuals who experienced positive emotions (including humor

or fun) exhibit improved social behaviors and cognitive abilities, including greater cognitive flexibility, more efficient memory organization and integration, improved planning, thinking, and judgment, and increased levels of social responsibility and associated helpful and/or generous behaviors.

Researchers suggested that positive humor may involve reappraisals of a situation, whereas negative humor may serve to create emotional distance from negative events. It does not necessarily allow an individual to create a more positive view of the events. However, in the past, experimental laboratory research only appears to support the short-term mood effects of humor and laughter. There is minimal evidence for more long-term psychological benefits (Martin, 2007). When it pertains to pediatric trauma, the window for humor to be effective is very limited based on the severity of the injury (Catherall, 2013).

Research has also generally supported the notion that humor can enhance interpersonal closeness and bonding, strengthen social supports, and reduce stress (Levine, 2013). Humor is considered to be an important mode of social communication and beneficial to improving relationships. For example, humorous exchanges may be motivated by a desire to impress others, gain attention, or convey messages in a more implicit manner (Kuiper, 2012; Levine, 2013).

Negative Effects of Humor

Peterson and Seligman (2004) suggested that humor seems to have such positive implications that its darker side (e.g., ridicule or sarcasm) is often neglected. In support of this view, the researchers observed that the distinction between wit (a cognitive ability

that is hurtful) and humor (which is benevolent and “comes from the heart”) developed in the nineteenth century, was not reflected in research. However, researchers now recognize that there are both adaptive and maladaptive components of humor (Dozois, Martin, & Bieling, 2009). Indeed, humor studies would benefit from a more in depth examination of its possible negative aspects (Dozois et al., 2009). Kuiper (2012) suggested that individuals using self-disparaging humor in an attempt to gain the approval of others are likely hiding social and personal anxieties. In summary, it seems “simply having a well-developed sense of humor is not enough to obtain the mental health benefits humor offers,” as a well developed by negative sense of humor can potentially interfere with psychological health and social relationships or interactions (McGhee, 2010, "p. 43"). Distinctive forms of humor such as avoidant, sarcastic, or disparaging that could possibly be harmful to one’s psychological welfare, depending on culture, are often not taken into account in self-report measures (Martin et al., 2003).

Assessment of Humor

Along with these different components of humor comes a range of instruments and techniques aimed at measuring those (Lefcourt & Martin, 2012). For example, different assessment methods have been used to measure comprehension of humor, ways in which humor is expressed, the ability to create humor, humor appreciation, the tendency to use humor to cope with stress, and the degree to which individuals seek out sources they find humorous (Martin, 1998). Many assessment instruments have been developed and used on adults, rather than children. Again, additional research on the assessment of humor is needed, as most studies are over 10 years old.

Until about the 1980s, humor assessment methods focused primarily on humor appreciation and examined individual differences in the content of jokes that individuals preferred and found funny by having individuals simply respond to presented material (Peterson & Seligman, 2004). Joke tests also measured humor creation by confronting an individual with a joke and asking them to develop as many funny captions as possible (Lefcourt & Martin, 2012). Although previous research attempted to measure one domain of humor, this study suggested that a sense of humor is not one-dimensional. Seligman and Peterson (2004) noted that other early attempts to measure a person's sense of humor or related states and characteristics also included humor diaries, peer reports, behavioral observations, experimental tasks, interviews, and surveys, although these methods were significantly less common (Lefcourt & Martin, 2012).

Because of the biases inherent in self-report methods, Martin (2007) argued that humor research should seek to utilize behavioral observation methods, particularly since they can offer important insight into the behaviors that people perform related to humor. One dimension captured by behavioral observations concerns genuine or fake humor. The presence or absence of a genuine Duchenne smile (which is characterized by raised mouth corners and cheeks along and wrinkles along the outer edges of the eyes) can be used to establish whether a person's display of laughter or smiling is genuine and an expression of impulsive amusement or if is being used to fake enjoyment (Martin, 2007). The research found suggests that perceivers of smiles are sensitive to smile form and react differently to genuine versus false smiles (Johnston, Miles, & Macrae, 2010).

The relationship between smiling and laughter has been assessed (Morreal, 2011).

Smiling is almost universally acknowledged as a signal or communication of a positive emotional experience (Johnston et al., 2010) and is sometimes accompanied by the expressive behavior of laughter (Martin, 2007). Although some people consider laughter to be a form of exaggerated smiling, the literature suggests that smiles are more likely to demonstrate feelings of satisfaction, whereas laughter responds from a surprise or a perceived incongruity (Morreal, 2011). However, an expression of humor or amusement is not always accompanied by the expressive behavior of laughter or smiling. Conversely, laughter and smiling can also be caused by non-humorous stimuli (e.g., tickling, embarrassment, modeling) (Ambadar, Cohn, & Reed, 2009). Other researchers have noted that laughter can often serve only as a function of social communication and that the majority of laughter in everyday occurrences results from comments that appear to be ordinary or otherwise not humorous to observers (Ambadar et al., 2009; Morreal, 2011).

Research on Humor, Stress, and Coping

In addition to the general benefits discussed earlier, humor can also help individuals to cope with difficulties they encounter, especially in trauma (Jacobs, 2009). Ambadar et al. (2009), for example, found a sense of humor to be associated with a more positive judgment of negative life situations. Kuiper (2012) also found evidence to suggest that individuals with a well-developed sense of humor cope in a proactive manner, have a more positive view of self, are more satisfied with their interpersonal relationships, and have a greater sense of control over their environment. Key studies in this area, utilizing varying methodologies, are discussed below. In experimental investigations of humor as a stress moderator, participants are typically either asked to

create or accept humor during mildly stressful experiences or are exposed to humorous stimuli (e.g. comedy) (Force, 2011; Levine, 2013), before facing a stressful event. Humor is a model of a versatile coping method or strategy that can be useful in judging possible stressful events. Even though researchers sometimes fall short in definitively classifying the use of humor as a coping technique into one of the several prior mentioned types, humor is normally considered as a coping method that may promote coping and modifying (Kuiper, 2015; Levine, 2013). The research will impart a more exhaustive discussion of humor, its ability to serve both modifying (e.g., by increasing positive feelings) and non-modifying (e.g., by use of antagonistic or offensive humor) as a coping technique in the midst of trauma, and the detailed methods by which it may serve these actions. From a positive and emotional mindset, humor can be viewed as a flexible advantage and a significant feature of holistic well-being (Wilkins, & Eisenbraun, 2009). Undoubtedly, there is compelling diverseness within and limited methodical understanding about humor (Cann et al., 2010). This portion discusses different descriptions and forms of humor examined in the literature, the effects of humor (i.e., possible benefits and negative ramifications), and techniques that have been created to evaluate humor.

Specific attention to this study is humor's role in pediatric trauma intake assessments in relieving tension and coping with adversity and life stress (Lefcourt & Martin, 2012). Many individuals appear to be able to manage stressful situations and events that pose a threat to their wellbeing by turning them into something that can be laughed at. In fact, the DSM-V has identified humor as a highly adaptive defense

mechanism or coping style that can facilitate ideal adaptation in the management of stressors (American Psychiatric Association, 2013). The use of humor, as a coping mechanism, differs greatly and does not appear to represent any one specific coping style. This is not necessarily surprising given its multifaceted and blurred nature (Kuiper, 2013). In fact, researchers have conceptualized humor as representing several different coping techniques. Humor as a problem-solving strategy could, for example, involve the use of (nonhostile) humor to diminish interpersonal conflicts and tension (Kuiper, 2012; Martin, 2007). Conversely, Lefcourt and Rutchick (2013) regarded humor as an emotion-focused coping response in which negative or unsettling emotions are avoided by resorting to laughter.

For many of these reasons, some clinicians and researchers feel strongly that their use of humor in the pediatric trauma assessment may be limited based on the injury. Jacobs (2009) noted that novice clinicians, specifically, should use caution when applying humor in the initial assessment, as it can often be used as the clinicians' inadequate defense against anxiety and/or viewed by the client as hidden hostility (Jacobs, 2009). Okun and Kantrowitz (2014) also noted that the effectiveness of humor in intake assessments also depends on personal qualities of the clinician (e.g., maturity, flexibility). In summary, humor can be beneficial in the initial assessments, although it requires the clinician to be culturally sensitive and to understand the historical and cultural meaning of humor for specific groups and individuals. In addition, factors such as the timing of humor use, the client's receptiveness to humor during the traumatic experience, and the nature of the therapeutic relationship can affect the benefits of humor

in the assessment with a diverse population of clients. Overall, there is also an increasing need for research to support the theoretical writings on the use of humor in pediatric trauma intake assessments.

Theoretical Framework

The following sections present various theories regarding the effects of humor in traumatic situations. Specifically, the following are discussed as they relate to theories of stress, aggressive forms of humor, arousal theories, liberation and social enhancement aspects of humor, and the broaden and build theory concerning positive emotions (Freedy & Hobfoll, 2013). Contextual examples and research findings that support or fail to support such theories are also discussed as they relate to these different perspectives.

Further research has emphasized the significance of context (i.e., the situation involved) as it relates to the benefits of humor used during the intake process (Cann et al., 2010). That is, the benefits of humor may be related to a fit between the particular demands of the traumatic injury and the intake process employed (Cann et al., 2010). Thus, the ability to identify and adapt to changing demands of a situation by using various intake processes may be an important aspect of a successful hospital experience. Riolli and Savicki (2010) suggested that “psychological adjustment may be less related to any specific coping strategy than to the individual’s ability to draw upon a diverse set of effective strategies and to apply them flexibly” (p. 99). The researchers defined coping diversity as an individual’s ability to adjust to situations when typical intake processes prove to be useless. Researchers suggests that using any one intake process exclusively may be problematic (Catherall, 2013). Similarly, Capuzzi and Gross (2014) maintained

that the ability to be flexible (e.g., in terms of assessments) when dealing with potentially traumatic injuries is more important to a trajectory of resilience than using or relying on any one particular intake process. The researchers argued that individual differences may account for such variations in responses to potential trauma.

Carver and Connor-Smith (2010) also advocated for a contextual approach to the intake process, but noted that this methodology makes it difficult to assess an individual's baseline coping style. Cohen and Mannarino (2011) argued based on different approaches, there are no universally bad or good intake processes. Thus, definitions of what is a successful intake process may be is also variable. Davenport et al. (2010) suggested respecting and understanding the families state of mind at the time on the traumatic injury once they enter the hospital can help make the intake process more relevant (and thus appealing) to this population as well as more beneficial in facilitating the hospital stay. For example, Figley and Kiser (2013) asserted that assessing external factors (i.e. religion, support) in family dynamics may be helpful in the engagement part of the intake process. This research provided important information about the hospital intake process, but further research is needed in incorporating humor pediatric trauma intake.

Phenomenology Methodology

The goal of this qualitative phenomenological research was to recount a real life experience of a phenomenon. Phenomenology is the thought process that focuses on individuals biased experiences and understanding of the world (Merriam, 2014). Phenomenology highlights the study of experiences from the participant's perspective,

surmised expectations and normal ways of observing (Merriam, 2014).

Summary of humor and coping with stressors or trauma

Humor is a complex phenomenon involving emotional, cognitive, physiological, and interpersonal elements, especially when it pertains to pediatric trauma (Kuiper, 2013). Empirical research on the benefits of humor in dealing with stress, in particular, is mixed and has a number of limitations, one of which is the failure of researchers to differentiate between the different uses of humor. Also, there may be limits to the adaption of the use of humor by clinicians in the intake process. Although the literature generally supports the view that humor can assist with emotional regulation and in coping with stress, its benefit depends on contextual factors and the specific types of humor that are used (Lefcourt & Martin, 2012). Thus, it is far too simplistic to assume that humor is solely a beneficial method of coping with stress and trauma. Additionally, no single theory can fully explain the techniques by which humor can possibly help in coping with stressors or trauma; rather it appears that cognitive, emotional, social, and physiological elements of humor together may account for humor's healing potential. The next section discusses the use of humor specifically by clinicians including risks, benefits and training.

Clinician Training Programs

Because of the possible advantages of the use of humor as well as the significance of clinicians' reactions to expressions of humor from clients, it is important that mental health professionals receive appropriate training on humor use. Martin (2007) suggested that "the ability to use humor appropriately with clients may be viewed as an engagement

skill that clinicians need to practice and refine, just as they need to develop a number of other communication skills” (p. 341). Thus, in addition to the creation and assessment of programs geared at improving the ability of individuals to effectively use humor in coping with adversity, there is also a need for programs (e.g., graduate training, continuing education) that educate clinicians to respond to clients appropriately.

Several authors have suggested formal humor training for clinicians (Valentine & Gabbard, 2014). Franzini (2001) for example, offered a specific humor training program be created for clinicians with different levels of experience (e.g., supervisors, trainees). He suggested that the following components be included in course of study (a) the designing and reinforcement of clinician humor behaviors by clinical supervisors, (b) specific training in the variety of humor methods, and (c) sensitivity to any humor attempts by their clients, which can become critical transition points in the therapeutic process (p. 179). Salameh’s (1994) Humor Immersion Training is an example of a formal program for clinicians that included training on humor development, advantages of humor, limits to humor use, and differences between possible helpful and harmful types of humor. Additionally, the program includes several exercises and role-plays to assist mental health professionals with practice using humor mechanisms. Yearly conferences and continuing education credit classes offer opportunities for clinicians to learn about the benefits of using humor in assessments. Continued creation and assessment of this type of training will help to ensure the beneficial use of humor between clinicians and families.

Training for Humor Use in Coping and In the Context of Pediatric Trauma Intake.

Initial researchers have suggested that humor can, in fact, be taught and facilitated. Lehman et al. (2001), for example, found that brief preparation on the development and use of productive humor leads to greater humor production, suggesting that an individual's humor production can be facilitated for use during stressful situations. Other research has found that most people already know the rules for developing humor (Lefcourt & Martin, 2012) and that humor use increases with positive reinforcement (Kuiper, 2012). Together, these findings have implications for the potential benefit of programs aimed at developing humor for use by people coping with stressful situations as well as training programs for clinicians who would like to integrate humor techniques or effectively respond to client humor in their clinical work. What many may not know is the use of humor is medicinal for clinicians as well (Dormann, 2015).

Conclusion

Overall, research supports that humor can be a helpful coping technique or mechanism for families/children who have experienced trauma or are facing adversity. In addition, the thought that the ability to use humor as a coping technique could be promoted or taught to clients has been encouraged, although there is a lack of research on how clinicians should or do react to client expressions of humor in the intake process. As a result, the purpose of this study was to assess the use of humor during the intake process with families whose children experienced a trauma. The researcher examined if the use humor relieves stress with families during the intake process.

Chapter 3

Research Method

This study was a qualitative, phenomenological analysis of the intake experiences of families whose children have suffered a traumatic injury. By understanding these experiences, clinicians and researchers will gain a better understanding of the hospital intake process of families where humor was used by the clinician, which could inform intake assessments and future research. There is a gap in the literature specifically with the use of humor used by clinicians in the pediatric trauma intake process. This research study specifically will examine the humor used in the intake process with families and how this process contributes to mitigating stress.

Parents often display resilience when their child has been injured, but many times fall apart when the injury is serious, and the child is hospitalized (Kiser, Baumgardner, & Dorado, 2010). The researcher examined the humor used in the intake process with families and how this process contributes to mitigating stress.

The lived experiences of humor in the initial intake process as a stress reliever will be examined during this research project. The purpose of this study was to gain an understanding of the lived experiences of families, and how the intake assessment has relieved stress while in the hospital. This chapter details the qualitative methods used to gather and assess data. In order to ensure this study adheres to ethical standards and practices, approval from the Walden University Institutional Review Board (IRB) was obtained before conducting research with participants.

Research Design and Rationale

Research Questions

The two research questions which guided this study were:

RQ1: How do families respond to clinicians' use of humor during the initial intake process?

RQ2: How would families describe the clinician's use of humor as a way to relieve stress during the intake process?

Qualitative methods

This chapter is composed of four fundamental areas. These areas include research design and rationale, the role of the researcher, the methodology, and the issues of ethics surrounding the research. The research project employed a qualitative research method. In the first area I discussed the Qualitative research design which allowed for the exploration and increased knowledge regarding the lived experience of a family's pediatric hospital intake assessment, from their perspective. In the second section I provided a detailed analysis regarding the researcher within the study. The third section covers the methodology and provides an explicit detail description of the method used to conduct the study. Lastly, the credibility and dependability are explored in section four covering ethics.

The purpose of Qualitative research is to acquire an enhanced knowledge of activities based on the actions of the participants (Maxwell, 2012). The data gathered and analyzed is non-quantitative in character, consisting of contextual material and visual materials that tell the stories of human experiences (Saldana, 2011). Phenomenological

Qualitative research allows for the examination of a phenomenon and allows an opportunity for participants to tell of their lived experiences (Denzin & Lincoln, 2005). Phenomenology is one of the approaches used to conduct qualitative studies. This study examines the phenomena of the family experiences during pediatric trauma intake process, illuminating the issues faced by families and providing a foundation for generating discussions related to the phenomenon. This was conducted using a qualitative phenomenology research method. It provided a forum and opportunity to the families to tell their own story as it relates to their intake process.

Sample Selection

A sampling using between 6 and 10 participants has been found to produce credible and trustworthy findings (Saldana, 2011). Trauma groups created by parents are advertised in the Philadelphia neighborhood pediatric hospitals, but are not hospital organized or sanctioned. The group's leader was contacted and, informed about the study. The researcher requested permission to come to the group and leave flyers about the study for potential participants. The groups are held at a designated family's home or community center. Once the researcher was contacted, she notified the families further about the nature of the study. The selection criteria consisted of families whose children have suffered a traumatic injury and were hospitalized. They must have been discharged within the last 2 years, and their crisis phase must have already passed. Once 6 to 10 families are identified, the researcher sent each of them a letter detailing the intended study and asking for their participation. One week later, the researcher contacted each of the families by telephone to determine their interest and agreement in participating. For

the traveling convenience of all involved, participants for this study will reside within Philadelphia County, Pennsylvania. The participants were biological parents or legal guardians of the child that suffered the traumatic injury.

Participants

Participants for this study were parents/guardians whose children have suffered a traumatic injury, were hospitalized and the parent was present for the intake. The parents participating in this research project were also either biological parents or legal guardians that have raised the children. The study did not include parents that were not involved in the child's rearing, restrained by law from having any contact, or lost custodial rights for various reasons. There are no issues specific to single parenting, two parent households or ethnic groups. In short, participants for this study were parents/guardians who have primary responsibility of raising their children.

Role of the Researcher

In a qualitative research study, the researcher's role is that not only of an active learner, but the main instrument of data collection (Maxwell, 2012). As it pertains to this research project, the researcher was an observer-participant. Analysis began during the first interview and information gathered in early interviews were compared for verification in subsequent interviews. Analysis continued through the transcription process and coding. The interviews were analyzed at least twice and coded for content and themes present. Themes present in one interview were reviewed in all other interviews. Coding began after all interviews have been transcribed and assessed various times. The researcher searched for patterns in the transcripts, sorted and identified them,

then looked for familiar themes bridging the interviews (Wheeldon & Faubert, 2009).

While engaging the participants in the data collection processes, the Researcher observed their reactions (verbal and nonverbal) as well. The researcher considered the level of sensitivity raised by the issues of the trauma. Demonstration and use of strong interpersonal and communication skills were important in this study. The data was assessed for merging, patterns, discrepancies, and review of all the information collected in the interviews (Wheeldon & Faubert, 2009).

The study was limited to families whose children suffered a trauma and were hospitalized. Due to the fact that the researcher was previously a hospital Social Worker; there was an awareness of her own personal biases. Therefore, a peer reviewer (credentialed clinician) sat in and monitored the interviews in order to avoid counter transference and bias. It was crucial that subjectivity and objectivity be maintained throughout the study.

Ethical Protection of Participants

Written Informed consent (participant consent letter). To ensure ethical protection of members and to be in compliance with IRB, each participant was provided with a consent form (see Appendix B), and initials were used to ensure anonymity. The form was a detailed outline of the purpose, description, data collection methods and other important information related to the study. Identification and contact information for the researcher and designated individuals of Walden University were provided. The consent form was distributed during the interview for review and signatures. Each participant was given two copies of the consent; one for them to sign and return to the researcher, the

other for them to keep. The form was constructed using the sample provided by the Walden University Research Center. The researcher provided families with resources if requested for further support.

Confidentiality Agreement (licensed clinician). To ensure credibility of the findings from the study, the researcher recruited a licensed clinician to assist with corroborating the findings, reduce bias, and ensure objectivity. This individual was required to sign a confidentiality agreement, prior to their involvement with the study (see Appendix F). The licensed clinician agreement was specific to keeping information confidential and families anonymous. The families met the clinician and were aware of their role and signed agreement.

Data Collection

Methods of data collection. This qualitative study consisted of interviewing parents and/or guardians that were present at the hospital at the time their child was hospitalized as a result of suffering a traumatic injury, but are no longer hospitalized. The participants consisted of 6 parents or caregivers whose children are between the ages of 2 and 16, and were injured and hospitalized in Philadelphia, Pennsylvania within the last 2 years. The families were from different trauma support groups that are facilitated by parents and gather twice a month in a non-hospital setting. A brief screening was conducted via telephone to all interested participants in order to validate participation criteria consisting of being the biological parent of a child that suffered a traumatic injury, hospitalized, and humor was used by the clinician.

Once interested individuals contacted the researcher, the researcher followed up

with that individual to discuss the nature of study and determine if they meet the qualifications to participate. If the individuals met the specific criteria, the researcher set up a date and time to meet the participants in person to complete the consent form, participant data collection sheet, and the interview protocol questionnaire.

During the meeting between the researcher and the candidate, the letter of consent was reviewed and signed. If the candidate signs the consent form, they were identified as a participant. A copy of the consent form is kept for the researchers records and the participant will also receive a copy of the letter of consent. Next, the researcher completed the participant data collection sheet and the interview protocol questionnaire with participant during their meeting. Once all of the participants completed the interviewing process, all data collected during the study is obtained and stored using paper, electronic, and audio equipment. The data obtained during the study is managed by the researcher in a secure locked file only accessible to researcher and licensed clinician. Researcher only used the parent's initials as identifiers.

Open-ended interview questions (interview protocol questionnaire). The researcher conducted semistructured, in-person interviews with each parent/guardian individually, using open-ended questions. The researcher developed the interview questions (see Appendix D). The interview lasted no more than 2 hours. The interviews were conducted in a private room at the Penn Wynne Library that was easily accessible and at an agreed upon time. The researcher informed the participants that the interview is only for the parent/guardian and that no other family members should be present. Interviews followed the interview protocol created, but were semi-structured. This

allowed the discussion to be open but specific to the participants; while focusing on issues of trauma and humor. The interviews were recorded then transcribed by the researcher.

Transcription. The audio recordings were fully transcribed verbatim as a way of ensuring that there would be little opportunity for inaccurate documentation (Saldana, 2011). Patterns and themes were filtered through a circular process of analysis to obtain a greater knowledge of the data results from the overlapping process of analysis; reflection on the findings and discussion with the participants (Saldana, 2011). Participants were offered an opportunity to review and respond to preliminary and final findings.

Once the interview and transcription was complete, the researcher gathered personal notes taken during the process of the interview to use as a data basis. Reflective notes were recorded to document personal thoughts, ideas and impressions (Marshall & Rossman, 2014). The researcher created and offered an evaluation feedback form for each participant to share on their experience of participating in the research project. Researcher observation, interviews and the data from the questionnaire were used for purposes of reliability (Methods Triangulation). Peer debriefing were used for this research project in order to ensure credibility of the findings from the study. In order to corroborate the findings, reduce bias, and ensure objectivity, the researcher recruited a licensed clinician. The clinician served as the peer reviewer and signed a letter of confidentiality. There were no monetary compensations for participation in this research project.

Tools for Data Collection

The tools used for data collection included the criteria qualifier form, participant data collection sheet, interview protocol, participant study evaluation, and participant feedback form. The models for this research project were used in order to establish validity and reliability. The researcher ensured necessary accommodations (e.g. reading support, clarity on any areas of ambiguity, writing assistance) were provided to the participants. The researcher was the main instrument for data collection involved in the study of this phenomenon.

Criteria qualifier form. The researcher designed this document in order to obtain preliminary information during a brief screening to affirm the individuals meet the criteria for participation in this research (see Appendix A). The form was completed via the telephone in a conversation between the researcher and the interested participants. If an individual was found to meet the criteria for participation in the study, the researcher made arrangements to meet in-person to assess and determine if the candidate would like to consent for participation in the study.

Demographic Questionnaire

Once the individual had consented to participating in the study, they were then identified as a participant. Each participant completed a participant data collection sheet, which was used to gather demographic information (name, contact information with an assigned number) (Appendix C). This questionnaire was used solely to provide a view of the diverse population being interviewed along with the qualifying criteria.

Interview protocol form. The researcher created and utilized a questionnaire

containing twenty open-ended questions during the face-to-face interviews (see Appendix D). Open-ended questions allowed participants to contribute as much detailed information as they desire, and to express their viewpoints and experiences in full (Turner, 2010).

Participant feedback form. The researcher also developed a form consisting of 13 questions that use a rating scale: NA – *not applicable*, 1 – *strongly disagree*; 2 – *disagree*; 3 – *neither agree nor disagree*; 4 – *agree*; 5 – *strongly agree*. This allowed the participants to give feedback to the researcher only, on their participation experience. (see Appendix E).

Conclusion

The purpose of this study was to utilize a phenomenological method to highlight the experiences of families during the hospital intake process after their child has suffered a traumatic injury. This method allowed the researcher to explore and understand how critical the initial intake process is with families, and how those experiences might relieve stress if humor was used. The researcher was aware that there may not be any similarities in this study due to different social workers completing the intake, and they may or may not have used humor. This chapter provided a full explanation of the research as it relates to the research design, the researcher, instruments to be used, and ethical considerations. Included also in this chapter was a detailed account of the informed consent. This chapter also gives detailed information regarding all aspects of data collection.

Chapter 4

Results

Although the present literature suggests that humor can be a useful management tool in the face of stressful or traumatic circumstances, I have been unable to find any research on the use of humor with families during pediatric trauma intake, and in particular the assessment process. The current study sought to explore the intake assessment experiences of parents and the social worker's attempt to use expressions of humor to relieve stress. The majority of the current research and literature available on this topic have focused on humor and healing but are not specific to the pediatric intake assessment. This study was conducted to examine the current intake process and the effect that humor has on the experience of the parents of pediatric trauma victims.

The research questions that formed this study were:

RQ1: How do families respond to clinicians' use of humor during the initial intake process?

RQ2: How would families describe the clinician's use of humor as a way to relieve stress during the intake process?

Chapter 4 highlights the following: data associated with the demographics of the participants, sampling, the information gathered, and the assessment process. Strategies used to ensure credibility, confirmability, dependability, and transferability are described. Finally, the findings of the research are provided, followed by a summary, with attention specifically to the research question responses.

Settings

The interviews were scheduled and held in a private room inside of the public library. All interviews were taped using a digital voice recorder. Possible participants for the research were recruited by developing and circulating posters at parental trauma support groups. Those interested in participating in the study contacted the Researcher at the number provided on the flyer. While speaking with the individual by phone, the intention of the study was discussed, and the criteria qualifier (see Appendix A) administered. Of the 10 participants who had a desire to participate in research, 4 were not appropriate based on data gathered using the criteria qualifier. The 4 participants were not eligible due to child's injury not being traumatic or the child was not their biological child. After the remaining 6 participants had been considered qualified, a date and time that was convenient was determined. During the interviews participants read, signed, and were provided with a copy of the consent letter (see Appendix B). The Participant Data Collection Sheet (see Appendix C) was completed, and using the Interview Protocol (see Appendix D), the interview was administered.

Demographics

The main focus of phenomenological studies is to make voices heard (Lester, 1999). Lester (1999) suggested that the number of participants depends on many factors, including the quality of data, the scope of the study, the nature of the topic, and the design of the study. Overall, there were 6 research participants that were deemed eligible for the study based on the criteria qualifier They were parents/legal guardians who live in the home with the child, have the main responsibility of rearing their child or children,

experienced humor by the social worker, and were present at the hospital when the child was admitted on the trauma service. Initials were used instead of the participant's names to ensure confidentiality. I completed and interpreted the interviews.

The Participant Data Collection Sheet was used to gather demographic information (name, contact information, ethnic background), information about the children (their ages), and the completed education level of each participant. Responses were provided by each participant on the following: marital status, educational level, and employment status. The age range of the participants was age 23 to 38 years ($M=30.5$). The participant pool consisted of all women. Four of the participants were married, and two of participants were single, never married. All of the participants raised their biological children. Three of the participants have Bachelor's degrees, one has her Master's degree, one is currently in college, and the other has her GED. All of the participants were currently working at the time of the research. A demonstration of the social statistics of the participants in the research is displayed in Appendix H.

Phenomenological Characterizations

When preparing to introduce the themes/patterns, phrases, experiences, and observed reactions, a phenomenological characterization for each participant was developed. From the information gathered during the interviews, using the Interview Protocol form (see Appendix D), I interpreted these phenomenological accounts. Again, initials were used to safeguard the anonymity of the participants. Each description contains the logistics of the interview.

J.F. (007). J.F. is a 38 year-old mother with two children (ages 8 and 6). She has

been married for 10 years. She holds a master's degree in Communication and currently works as a communications instructor. J.F. shared that her husband and immediate family are her support systems. During this interview, J.F. became emotional as she remembered the experience and watching her son 6-year-old son fall to the ground after being hit. J.F. is of the Jewish religion and relies heavily on the Jewish community. J.F. shared that her son was injured in June 2015 while playing soccer and colliding with another player head first and hospitalized for 5 days. The child was transported to the hospital by an ambulance and the J.F. rode with them. When she arrived, she was met by the social worker who was very nice, kept J.F. calm, and appeared very understanding asking questions about what happened. J.F.'s initial perception of the social worker was she was educated, but she wanted to speak with the doctor and wondered what the social worker could do for her. The social worker impacted J.F. because she was very knowledgeable about trauma and the injury. The social worker assured that child was in the best place medically, and she offered hospital resources. Per J.F., the social worker's demeanor was calm, and she kept redirecting her to remain focused. J.F. shared that her initial view of the assessment was why I am being questioned now. J.F. shared she knew she was being impatient and probably acting crazy as she worried about her son, but realized social worker was there to help. J.F. reported that the social worker was very jovial, by laughing and touching her arm as to empathize with her. J.F. felt all of this calmed her down and made her feel like they had a connection. Social worker lightened the mood even further when she started talking about her soccer skills, which were far from reality. The social worker was influential in helping relieve stress because she was able to joke and make

light of the injury, answer the questions, as well as keep parents abreast of the child's care plan. Because the social worker was very knowledgeable about trauma, she was able to discuss the injury with everyone (including her son), and explain what to do when they are discharged and how to follow-up. J.F. felt relieved by this because she wanted to make sure she was caring for the child properly. J.F. shared that this helped more than the doctors, because the social worker talked in understandable words and not medical terms. The most difficult part of her experience did not know how badly the concussion was and if her son would be normal again. J.F. managed by relying on their faith and support from staff and family. J.F. felt her son was courageous and less afraid than her. Overall, J.F. believed that for such a traumatic experience they all recovered well and it was an eye opener to sports injuries. Even though J.F. felt the social worker did an excellent job, she wished she had more written information on concussions so she could read and process on her own. J.F. is a big fan of the use of humor and she welcomed it as a stress reliever. The interview with J.F. took place on July 18, 2016, and lasted for approximately 1 hour and 43 minutes.

J.T. (009). J.T. is a 33 year-old mother who has a daughter aged 7 years. She is single, has her G.E.D., and works as a dispatcher for a security company. J.T. resides with her mother, who is her main support system although dad is involved. J.T. was nervous to answer questions about the incident but eventually calmed down and wanted to continue. J.T. is Baptist regularly attends with her mom and other family members. J.T. shared that her daughter was injured in August 2014 when she fell back on a boxing ring corner spoke that injured her tailbone. Initially, child's mother thought their child

was going to be okay, she only saw a little blood and cleaned child up. Before putting the child to bed, she gave her some Tylenol as she said her butt hurt a little. When J.T. checked on before going to bed, there was blood all over. J.T. rushed the child to the nearest ED. After the child had been checked over relatively quickly, according to the mother, they said she needed to be transferred to a pediatric hospital. The doctor that was working at the hospital has visiting rights at the pediatric hospital, so she came along and informed J.T. that her child needed surgery and she was doing it. J.T. said they were not met by a social worker at the first hospital. The child was transported by ambulance to the pediatric hospital which was about 30 minutes away. J.T. and her mom followed the ambulance, and they arrive at the same time. J.T. shared that when they arrived, her daughter was taken directly to the operating room and she was told to wait in the waiting area. J.T. reported that before they could reach the elevator they were greeted by a social worker at 1 am. J.T. could not believe that social workers were available 24 hours a day. The social worker showed them where the waiting room was, asked if they needed anything, and told them to get comfortable she would be back. The social worker appeared wide awake and assured J.T. that child would be fine, and she would get an update. J.T. felt that just the fact that a social worker was working and was there for them were a relief in itself. The social worker stayed with the family the entire time which was about 5 hours. J.T. believed the social was also glad for the company to help the shift go by faster. J. T's. initial perception of the social worker was she was just doing her job at 1 am, when they are probably doing nothing. The social worker impacted J.T. because she kept talking and that took her mind off of the surgery at the time. J.T. felt like it was her

fault and injury might have gotten worse because she did not take child immediately to the doctors. Social worker reminded J.T. that she was not a doctor, and her child seemed ok at the time. Per J.T., the social worker's demeanor was hilarious by the ways she carried herself, walking around the room talking with her hands. The social worker was very understanding and nonjudgmental, which is what she felt she needed. J.T. shared that the social worker was a "Godsend" because she asked what happened, helped her not take the blame, as well as assured daughter would be just fine. The issue J.T. had was with the doctor that was accusing that someone hurt her daughter and not that she fell on the boxing ring. J.T. reported that the social worker was upbeat and happy for people who are usually sleeping at this time of morning. The social worker's entire attitude made J.T. laugh and cry at the same time. J.T. felt the social worker could relate to her daughter when she hears the story from her view as the social worker has been to Disney several times. J.T. shared that the social worker repeatedly hugged her and brightened the mood. J.T. felt the social worker remained positive by smiling, singing and moving around telling her to keep herself together, which was funny. Even though the ordeal was stressful, the social worker was influential in helping mitigate stress, because she kept talking about everything but the injury. J.T. shared that social worker kept her calm and motivated to see the child, and begin caring for her so she could get better. The most difficult part of her experience was dealing with the doctor that kept wanting to insinuate that someone hurt her daughter and not believing the true story. The social worker kept reassuring J.T. that the doctor was just being sure and covering all bases. J.T. managed by relying on her faith, focusing on her daughter, and caring for her. J.T. felt because of the

social worker, her daughter was a trooper. J.T. reported that her daughter looked for the social worker daily as she was hospitalized for almost two weeks. Overall, J.T. believed it was a great experience because of the social worker and her animation. J.T. shared that the social worker kept her calm, and she believed that she went above and beyond her job. J.T. felt the social worker was great at her job and there is nothing she could have done differently. Until this incident with her daughter and even more so this interview, J.T. did not realize how much she laughed and cried. J.T. believes that humor is a must in the hospital because she would not have been able to handle this experience without the smiles, talking, funny body language and anything else the social worker did that she enjoyed. J.T. shared that the social worker, through the humor helped her realize things are not as bad as they seem. J.T. admitted that she is an outgoing and funny person, so humor works with her and her family. The interview with J.F. took place on July 18, 2016, and lasted for approximately 2 hours.

E.E. (011). E.E. is a 38 year-old mother with three children (ages 16, 12, and 4). She is married, has her bachelor's degree in communications, and is currently employed as an administrative assistant. E.E. shared that her family is her biggest support system. E.E. reported that her daughter was injured in October 2015, when hot water burned her on her lower trunk area, thighs, and tailbone. E.E. reported that child's skin immediately turned red, and they took her straight to the emergency room. E.E. solicited support from the medical team and her family because she did not know the severity of the burn. Her child was hospitalized for over three weeks due to the nature of the burn. E.E. shared that once they reached the emergency room, her child was taken from them quickly into the

trauma room. E.E. was informed that she had to wait, and the social worker was coming to speak with her. Her initial perception of the social worker before she even arrived, was apprehensive, and they were taking her child. E.E. was not clear on why she had to talk with the social worker before seeing her child. Once the social worker arrived and introduced herself, she began asking questions about the injury and getting clarity to make sure it was an accident. The social worker impacted the experience by remaining professional and stuck to her role. The social worker's demeanor was serious, especially because the tension was high, as well as apprehensive, not knowing what response she would get. After things had somewhat calmed down, and the social worker heard the chain of events leading up to the injury, she smiled which provided relief. The social worker also tripped while leaving, and laughed at herself stating this is how accidents happen. E.E. shared that the social worker's humorous attitude after tripping lightened the mood with her and her entire family. The social worker was influential with relieving stress by reassuring the family that the child was going to be fine, and referring to her tripping. The most difficult part of her experience was being separated from her daughter, crying, and waiting to hear the unknown. E.E. was being supported by her husband and mom who came to the emergency room. Overall, E.E. believed that the three-week experience was better than she thought it would be. E.E. believes humor allowed for her stressed to be reduced, even if for a moment, brought hours of relief. E.E. shared that smiling and laughing provided a calming spirit. E.E. admitted that as the assessment and days went by, the social worker put herself in their shoes, and allowed us to see her as a person. The interview with E.E. took place on July 23, 2016, and lasted for approximately

2 hours.

B.H. (001). B.H. is 23 year-old and the mother of a 2 year-old daughter which is her only child. She is a single parent raising her daughter with support from her mother. She has a relationship with her daughter's father and they coparent. She is currently in college and employed as a sales associate for a department store. Along with support from her mother she has two older sisters that help care for her daughter while working and attending class. B.H. reported that her daughter was injured last year, May 2015 by falling off the bed and suffering a skull fracture. Her child was initially unresponsive, but after calling her name and taping her back, she screamed. B.H. called 911 immediately, and the ambulance arrived and transported them to the hospital. When they arrived, B.H. and child were taken straight to the trauma room, and they began to care for child medically. B.H. stated she stood back while the doctors assessed her daughter and she provided history to staff. B.H. shared that the doctors updated her on child's status and said they were taking her for an x-ray of her head, and she could accompany them. While waiting outside the x-ray room, she stated that she was greeted by a woman who identified herself as the social worker. B.H.'s initial perception of the social worker was that she was there to take her daughter and did not know what to say. According to B.H., the social worker was straight forward in her questions when asking about how the fall occurred. B.H. shared that she answered all the questions as she remembered, and as honestly as she could. B.H. described the social worker's demeanor as calm, but friendlier after her daughter came out of the x-ray room. Once the doctor reported on their findings, and that the injury was consistent with the story, pressure was relieved, and the social

worker gave me a hug. B.H. offered that the social worker began to explain the hospital process and smiled throughout the discussion. Even though the social worker shared smiles, B.H. did not feel it relieved the stress, the anxiety, or change the care of her child. B.H. felt that the most difficult part of her experience was the fear of losing her child based on how the social worker initially presented herself. B.H. managed by asking questions and being supported by her family. B.H. shared that her daughter was sedated for the for the assessment, and would not have realized what was happening. Her child was hospitalized for approximately two weeks, and they both loved the services provided by child life staff. B.H. shared that if the social worker were more comforting in the beginning and not as serious, the smiles would have mitigated the stress substantially. Overall, B.H. felt that the social worker tried very hard to be humorous, but the initial fear placed by the first contact made it hard for the humor to improve the mood. The interview with B.H. occurred on September 14, 2016, and lasted for approximately 1 hour.

B.S. (002). B.S. is a 28 year-old mother with a 4 year-old son. She is married, possesses a bachelor's degree in computer science and is employed as an analyst. B.S. and her husband's parents are both loving and supportive. During this interview, B.S. was relaxed and shared the traumatic experience vividly. B.S. shared that she is a Christian, and relies heavily on her faith. B.S. reported that her 4 year-old child was injured in August 2015 by falling while at the daycare and hitting her head. B.S. stated the daycare notified her immediately and told her to meet them at the hospital. Her child was transported from the daycare by ambulance to the hospital accompanied by the daycare

director. B.S. contacted her husband and met them at the hospital within 30 minutes of getting the call. When they arrived at the emergency room, the hospital staff took them to a waiting area until they could locate their daughter. B.S. expressed that what seemed like forever waiting, was only about five minutes when a nurse took them back to the trauma room. B.S. stated that after being greeted by the nurse and told their daughter had a concussion but should be fine, the doctor provided them with an update. B.S. shared that their daughter was lying on the table not moving, but they explained that they gave her medicine to calm her down. B.S. stated the nurse informed her that the next person they would speak with was a social worker. The social worker was very pleasant and assured her that this injury was common. B.S. explained that her initial thought was this injury is not common to her or her daughter. B.S. shared that the social worker continued to share that the daycare director was present and explained what happened as she was told. The social worker assured us that our daughter would be fine, they just needed to run a few more tests and monitor her for a couple of days. B.S. felt the more the social worker talked her; anxiety began to decrease. B.S. stated the social worker stayed with them the entire time answering all of our questions and providing them the opportunity to talk with the daycare director. B.S. reported that social worker was hilarious from the beginning when they entered the trauma room. The social worker shared that this injury happens all the time, and she was making jokes about other stories, as well as other families. B.S. believed the social worker was trying to lighten the mood, but this was their only child, and they did not find much of anything funny. B.S. said the social worker was regularly checking in on them, and telling her to remain calm. B.S. shared that even though they

were assured that their daughter was going to be fine, they were concerned about her brain and long term effects. According to B.S., the medicine did not wear off for almost two days, but they were told this was an effect of the concussion. Their daughter stayed in the hospital for over a week, and the social worker was extremely helpful and comforting, as well as the child life specialist who brought smiles to their daughter's face. B.S. shared that she had been to this particular hospital in the past when their daughter was a baby, but not for anything serious or when they needed a social worker. B.S. reported that the social worker smiled and laughed from their initial meeting, and it helped more towards the middle of the stay than in the beginning. Overall, B.S. felt the humor used was appropriate, but at the wrong time. B.S. felt the social worker should have taken more time to get to know them, instead of joking as soon as they entered the trauma room facing the unknown. B.S. expressed that her husband and she love to laugh, but at a time like this the humor did not mitigate the stress. The interview with B.S. took place on September 15, 2016, and lasted for approximately 1 hour and 5 minutes.

K.W. (003). K.W. is a 31 year-old mother of two children (ages 8 and 10). K.W. is married, and is a college graduate with a bachelor's degree in criminal justice and is currently a police officer. During this interview, K.W. was straightforward, but anxious about sharing her experience. K.W. reported that she has a huge family and support system from work. K.W. shared that her 8 year-old son was injured in a car accident while riding with her sister in November 2015. K.W. stated she and her husband were at work at the time of the accident. K.W. shared that she received a call to return to the barracks, which was not unusual. When she arrived at barracks, she was informed about

the accident and another officer transported her to the hospital. K.W. expressed that she did not know what to think, as nobody knew any details about the accident. While being transported to the hospital, K.W.'s husband called and stated he heard about the accident and was meeting her there. K.W. stated her husband's conversation was short, and she began to worry. K.W. and her husband pulled up to the hospital at the same time. K.W. shared that everything at that point appeared to be moving in slow motion, but people were running around in front of her. K.W. stated she snapped out of it when someone said follow me. K.W. and her husband were escorted to the trauma room where the medical team was working on their son. K.W. was informed that her sister and nephew were taken to another hospital. By the time K.W. and her husband reached the hospital, their son had been sedated and had many tubes coming from his body. K.W. and her husband were informed that their son suffered fractured ribs, a broken leg, has some internal bleeding and a brain injury from hitting his head. K.W. felt her legs about to come from under her, and her husband had to grab her. At that point, K.W. and her husband were taken to the family room so the doctor could explain all the injuries and the plan of care for their son. The next person that greeted them was a social worker. K.W. stated she had been to this hospital a thousand times transporting children and families but never thought it would be her. K.W. shared that the social worker was very nice and spoke in a calming tone, almost scary it was so calm. K.W. stated the social worker explained her role with the trauma team and that she would provide whatever we needed. K.W. felt that the social worker was maybe nice because she was in her police uniform. K.W. shared that after the introductions and updates, she was ready to see her son again,

and they took them back to the trauma room. K.W. shared that she was not up for talking with the social worker at that time, she was worried and focused on her son. After returning to the trauma room, another officer arrived and filled them in on the information surrounding the accident. K.W. told her husband to call family and contact the other hospital to check on her sister and nephew. K.W. admitted that the social worker was present the entire time and informed her that she was not leaving, and she said that sarcastically. K.W. felt that was funny because she did not need her right now, but nice to know that she was available. Also, while K.W. and her husband were in the family room, they had already taken their son for x-ray and MRI and were preparing to transport him to the ICU. K.W. did not feel moved by the assessment because she was so focused on her son. K.W. reported there was some humor used in the form of smiles and body language, but it did not lighten the mood or change the care of her child. K.W. shared that the anxiety of knowing and seeing their child's injuries clouded anything the social worker said or attempted to do. K.W. felt the most difficult part of her experience was the whole experience and realizing the tables were turned, and this was now her son in the hospital. K.W. reported that she was surrounded by family and her fellow officers, which drowned out the social worker entirely. K.W. believed as the days went on and their son began to wake up, the social worker developed a better relationship with him. K.W. shared that the social worker played games with her son and made him laugh, and that was a blessing. K.W. admits that humor can influence healing, especially with the children. Overall, K.W. believes that the humor shared by the social worker did not move her or her husband because they were concerned about their son and the humor went

unnoticed. The interview with K.W. took place on September 15, 2016, and lasted for approximately 1 hour and 12 minutes.

Data Collection

Approval for this study (#06-22-16-0273054) was acknowledged by the Institutional Review Board (IRB) for the period of June 21, 2016 – June 21, 2017. If individuals have a desire to participate they could contact me by email or telephone, and acknowledge their willingness to participate in the research. During the first telephone contact, the intention of the study was discussed and the criteria qualifier (see Appendix A) was reviewed to make sure the candidate qualified for participation. If individuals were interested in participating and were deemed qualified for the research, times and dates were agreed upon for when to complete the interview. The interviews were scheduled and held in a private room inside of the library. All interviews were taped using a digital voice recorder. The participation consent form (see Appendix B) was read, agreed upon, and signed before the gathering of data for the research. The participant data collection form (see Appendix C) was used to compile social statistics (name, contact information, ethnic background), information about the children (their ages) and their level of education completed. Questions referencing employment and marital status also were asked of each participant. These interviews were completed between the dates of June 9, 2016, thru September 15, 2016, with each interview lasting between an hour or two.

After finishing the interviews and compiling the data, each of the 6 participants was given a copy of their participant description and feedback form. These forms were

sent through email, along with a thank you letter of appreciation for their participation along with contributing their feedback that consisted of 15 questions about their experience in completing the study (see Appendix F). Information gathered during the study was compiled and stored using paper and computer devices. All of the information gathered during the study will be handled by me and in my care until it is disposed of. All written information and computer drives will be locked in a safe for a period after the study has been completed (June, 2019).

Data Analysis

Phenomenology is often a study target whose focal point is on things as they present, with an up close view (Saldana, 2011). A phenomenological study determined that what will be researched are the essentials of a self-awareness phenomenon in a story like format (Saldana, 2011). The goal of this research was to attain knowledge of the phenomena regarding the use of humor with families during pediatric trauma intake. During this research, I used the information gathered from the participant's interviews and participant cognition, to capture the essentials of the exact experiences of the 6 participants in this study. The examination of the data collected during this study allowed me an opportunity for a clearer knowledge of the phenomena as I conversed with each participant, watched their reactions (verbal/nonverbal) to the questions being presented and paid close attention as they responded.

Interview Protocol Document

The interview protocol form was developed to gather the essence of the connection between humor and pediatric trauma intake assessments by social workers.

This document consisted of 19 questions and a review of strength based characteristics. The questions were created as a chance for the participants to share their experience as a parent of a child who suffered a traumatic injury, hospitalized, and was interviewed as a part of the trauma intake assessment. After each interview was completed, I reviewed and attentively monitored the taping of the interview. After reviewing the interviews again of the participants, I analyzed the data from each interview protocol form as well as the transcriptions the researcher had noted in reflecting diary. The researcher went on to draw out words, phrases, and statements that were repeated during the participant's individual's interview, to develop particular themes and subthemes. Direct quotes were used as well to exemplify the exact experience of the participants.

A phenomenological description was designed for each participant. The participants were given a copy of the phenomenological description to review. Participants were classified by their initials and a number to protect anonymity. The questions asked in the Interview Protocol Document were designed to examine if certain elements were found to be true of the use of humor with parents during the trauma intake assessment. These elements would include initial perception, assessment, and the use of humor, and social work actions that relieved stress.

Humor can be viewed as a verbal or nonverbal action. Attardo (2006) believed that due to various forms of humor and levels of trauma it might be complicated to determine if and when stress could be mitigated. Abel (2002) identified several factors that were common to participants in past studies relating to humor and healing. One prevalent component was that humor is to one's interpretation. Some of the following

factors suggested by Abel (2002), used most frequently when faced with trauma, and their use of these factors when it pertains to their child and making connections with clinical staff are: relationships, perceptiveness, independence, positive view of personal future, flexibility, self-motivation, competence, self-worth, spirituality, and perseverance. These factors were asked of the 6 participants included in this study. The participants classified themselves as having most, if not all the elements. Knowing a little about the participants' personal values can be components in how humor plays a part in traumatic situations.

There are two principle theories which guided this study, cognitive behavioral theory, and the unconscious thought theory. The cognitive behavioral theory examines the approach to human behavior that looks at how we think, with the thought process that it will affect the manner in which we act (Dozois et al., 2009). Our behavior can be described as a series of responses to external stimuli. Behavior is regulated by our own thought processes, as opposed to hereditary elements. As with the unconscious thought theory, Dziegielewski et al. (2003) describe it as a thought or reasoning that takes place when conscious attention is directed elsewhere. Many experiments have proven that considerable unconscious thought can improve one's decisions. For example, if you laugh in the midst of a traumatic situation without realizing you are laughing, in turn, stress could be mitigated. Theming was the method I chose to interpret the data for this research study. Nine themes were created, along with a set of subthemes based on the information acquired from the interview completed with the participants and notes from my diary. Six of these themes were found to about cognitive-behavioral theory, while the

other three related to the unconscious theory.

Individual Interpretations

Theme 1: Initial Perception or Behavior of Social Worker. Many of the participants were able to make direct correlations to having some of the same feelings, the social worker just doing their job, apprehensive, defensive, and loss of custody. As I reviewed and themed the data gathered during the face-to-face interviews, several examples of the participant's initial view of the social workers stood out. It was evident from the research that most of the participants referenced from their experiences that their initial perception was frightening. These participants were able to take their specific and individual circumstances and share factors that guided their experience with the social worker.

Part of job description. Three of the participants reported that they felt the social worker was just doing their job.

K.W. stated that: "I was very exhausted, nervous and scared about my child's condition, and then hearing a social worker was coming added to the anxiety. I tried to rationalize and realized they had a job to do, and it was not personal."

J.T. stated "It was 1 am in the morning, and I did not know that social workers were available at that time of morning. I also thought she might be mad that she had to be disturbed to."

E.E. stated: "My mind was focused on my child and what was going on, since they immediately took him from me, then said a social worker would be in to talk with me. My initial thought was this is part of their job when a child suffers this

type of injury."

Loss of custody of the child. Two of the participants reported that they believed that based on how the social worker conducted her assessment; they could lose custody of their child. Many felt this way because some injuries were so severe that they felt the social worker would not believe it was an accident, and still call social services.

B.H.- "My child had suffered a skull fracture, and I thought the hospital notified the social worker to report me for not watching my child. The social worker was very straight forward and initially cold showing no emotion. All I could think about was them removing my child from me, and telling me they had to investigate."

E.E.-"I was very concerned about what was going on when they took my child from me and said I could not go in the trauma room with him. I waited in a family room, and the next person I saw was the social worker. I immediately thought are taking my child because he was severely burned at home and probably nobody was watching him. I thought for sure they had already called social services because they took my son and told me to wait."

Defensive/apprehensive. Three of the participants stressed feeling defensive and apprehensive at just the thought of having to see or speak with a social worker. Many felt they had no need for a social worker, so their guards immediately went up.

B.H.-"Not only did I fear to lose my child, but my defenses were also heightened because I did not know what to expect. The fact that my child fell off the bed while I was a few feet away and could not stop the fall, caused the

apprehensiveness and the need to be believed."

B.S.-"Hearing that a social worker was coming to talk with me, made me apprehensive because I did not request to talk with one. I had already told the doctor and nurse what I knew, why did I need a social worker."

E.E.- " Again, since they whisked my child away from us and made us go wait for the social worker, I automatically thought negative and was defensive and apprehensive. I did not know whether to be angry or just answer the social worker's questions and get her out of my face."

Theme 2: Assessment Influential. Based on the interviews, four of the participants expressed that the initial intake assessment was beneficial and for several reasons. The benefits ranged from explaining the hospital policies to reassurance.

E.E.-"The social worker reassured me and provided me with the hope that my child was going to be ok because they were in good hands. She explained that this injury was common, and she has seen it many times."

K.W.-"The social worker helped me understand hospital terms as well as provided me with options and resources. She talked to me, and not at me, and she spoke to everyone. She remembered their names, and addressed everyone personally."

J.F.-"The social worker was able to get answers for us, as well as respond to questions when we felt lost. She was able to calm and clear up our frustrations when we were trying to understand the plan. She understood the sport my son played as well as the coaches in the league so she could relate."

J.T.-"Even though ordeal was stressful, the social worker did not give me enough

time to allow for stress to set in or get the best of me. She stayed positive, smiled, was singing and moving around telling me to get myself together."

Did not lighten the mood- Two of the six participants expressed that the social worker did not lighten the mood or make the hospital stay better. They felt the social worker's added some humor, but their child's injury overshadowed her attempts.

K.W.- "I have been coming to this hospital for many years and had to talk with social workers. I never thought it would be me in the trauma room with my child. The social worker was funny, but it did not make the feeling better."

B.H.-"After hearing the words skull fracture, I blamed myself. The social worker made attempts to be funny, but that could not change those words or how I felt."

Did not help with the care of the child. Four of the participants did not express any connection between the intake assessments making a difference in the care of their child.

K.W.-" The social worker did as much as we allowed, and we were grateful. Nothing the social worker said or did assist with the care of their child. We needed to hear from the doctors and nurses which took attention away from the social worker."

B.H.-"I could not let my guard down constantly thinking someone was coming to take my child. The social worker did her job, kept me informed, and was as supportive as she could be. I stayed close to my child, kept my guard up, and nothing the social worker did change how I cared for my daughter."

B.S.-"As much humor as the social worker used, it did not help us care for our

child any different."

E.E.-"Since I am hands on, and was only able to hear some things as I was worried about my son, the assessment did not change how I cared for my child. As a mother, my instincts kicked in, and I took care of my son."

Theme 3: Social Worker Greeting. Not only can an initial perception set the tone, but how one is greeted can determine the outcome of the rest of the hospital stay, and if a relationship can be formed.

Interrogation. Three of the participants felt that they were under investigation based on how the social worker presented herself, and the line of questioning.

E.E.-"I was already nervous that I was being judged due to the nature of my child's burn, and then I was told the social worker was coming. The social worker began her introduction asking many questions that made me feel I was under investigation."

B.H.-"Due to the age of my child, and the seriousness of her injury, it felt like everyone was interrogating me. The social worker was very stern when talking to me, and I did not know what to say, or how to say it out of fear."

K.W.-"As a police officer, anytime I am being questioned it feels like an interrogation."

Calming, nice, but serious. Four of the participants felt either one or more of these describes social worker's style of greeting.

E.E.-"The social worker introduced herself, provided support, and then clarified what was taking place with my son."

K.W.-"The social worker introduced herself in a calm, but firm tone."

J.F.-"The social worker was nice, and she seemed understanding. The social worker spoke slowly and she appeared calm."

J.T.-"It was 1 am and the social worker met me when we arrived at the hospital. She explained to me what was going to happen, and what they were doing with my daughter. She was very nice, calm, and stayed with me until my child came out of recovery."

Theme 4: Manage Traumatic Situation. Everyone handles trauma differently but when it comes to our children our rationale may be altered (Cohen & Mannarino, 2011). At times like these, even when help is offered, we tend to be hesitant to accept. Based on the interviews, most of the participant's offered strong skill sets to help them manage during their stressful times.

Focus on child. Three of the participants shared that they put all their focus on their child, no matter what was going on around them.

E.E.-"Once I was reunited with my son, and given updates, I could not hear or see anything but him. I would not leave his side the entire time in the hospital."

K.W.-"Based on many trips to the emergency room as a police officer, I felt I knew the drill. The most I could do was listen, but I was focused on my child."

B.H.-"Focus was on my child for several reasons, especially since I thought I was losing custody."

Understanding the trauma process. Three of the participants expressed that even though they were aware of all the things that were taking place and why they also

realized that the intake assessment was a part of the process, and it had to be done.

B.H.-"Even though my defenses were up, the social worker assured and explained the process. This helped calm some of my anxiety, but I did not leave my child."

J.F.-"Not knowing what the outcome was going to be, I told myself that I was not being singled out by the social worker, this was not personal, and this is normal hospital procedure."

K.W.-"I know the process, just difficult hearing it as it pertains to my child."

Theme 5: Avoidance. Because traumas can range from a broken arm to death, people go through a host of emotions especially when it pertains to their child (Cohen & Mannarino, 2011). The last thing some individuals want to do is talk to anyone, except whoever is treating or providing healing to their child. Three of the participants felt there was no need for social work at all.

K.W.-"Because this process is so familiar to me, I did not need or want to talk to a social worker. There was nothing the social worker could tell me or help me with."

E.E.-"As distraught as I was over my child being burned, the last thing I could think of was dealing with a social worker. My nerves were shot, and all I could do was think about my child and what could I have done to avoid this. At this point, there was nothing I wanted to talk about with a social worker."

B.H.-" Just hearing skull fracture scared me and I wanted all the support I needed, but not from a social worker."

Theme 6: Use of Humor. Multiple studies connect humor and healing.

Momentary use of any form of humor can reduce stress and relieve anxiety. Just as several participants had a negative view of the initial perceptions of social workers, several believed that even though the humor was used, it did not make for a positive hospital stay, mentally or physically.

E.E.-"Looking back at the moment, the humor used did not relieve my stress or reduce my anxiety of worrying about my child."

J.F.-"I am a big fan of humor and comedy. I could have used some extra humor to reduce my stress in the hospital."

B.S.-"The social worker came in telling jokes, it was at the wrong time. That was a horrible introduction."

K.W.-"The humor used did not affect me or my husband, because we were concerned about our son."

Theme 7: Awareness of surroundings in traumatic circumstances. It was clear that the participant's child had suffered a traumatic injury and was hospitalized. Many participants shared that they knew they were at the hospital, but was not aware of everything that was said or done. Some of the participant's admitted that they know people were talking, and they were responding, but the experience was cloudy.

E.E.-"When they took my child from me and told me to wait in this small room, the walls felt like they were closing in. I know a couple of people came in, but I do not know who they were or what they said. My husband said I answered all their questions, but I blocked out everything until I heard someone say they were the doctor."

K.W.-"I was so caught up in the fact that I was at the hospital for my child, I blocked out much of what was being said."

B.H.-"After they had said the words skull fracture, I was in a daze, and I became numb. I saw people's' lips moving in the trauma room, and all I could focus on was looking at my daughter on the table not moving."

Theme 8: Humor-Verbal/Non-Verbal.

Smiles and body language. All of the participants shared how their social worker showed some form of humor; great or small during their hospital experience.

E.E-"Once I calmed down, and the social worker had heard what happened, the social worker started to smile. The social worker at one point had tripped over a chair, and we could not help but laugh, but she was ok. The social worker also laughed at herself and said accidents happen. That laughter took my mind off my son briefly, but it was needed. The social worker probably did not know the effect that had on us."

J.T.- "The social worker was upbeat from the first time we met. She made me smile and laugh when talking about my child's injury and her travels to Disney World. She hugged me several times, and this brightened our day, relieving tons of stress. I found myself laughing while my daughter was in surgery."

B.H.-"My social worker smiled from the time we met until we were discharged. Even though I feared to lose my child, the smiles relieved the anxiety."

B.S.-"The social worker told jokes about other families and children that have had the same injury. I do not think she was making fun of them, just letting me know I

am not alone."

K.W.- "My facial expression was probably no nonsense, but the social worker put her hands on her hips and said she was not leaving. That was hilarious, and I almost asked her who she was talking to."

Theme 3: Interpretation of Humor in Trauma. The fact that people can find some humor in the midst of a traumatic experience suggests there is nothing we cannot find to be humorous, at least when it is presented right (Attardo, 2006). They were able to define points when the social worker provided humor, and they found themselves laughing.

Realizing humor was used. Even though most of the participants expressed that they realized the social worker was trying her best to be funny, they just could not accept it in the spirit it was presented at such a traumatic time.

B.S-"Even though the social worker was telling jokes from the beginning, they were more concerned about their child's health. If it were under different circumstances, I would have engaged the social worker more, but this was not the right time."

E.E.-"Even though we eventually got past the apprehension and defensiveness, only her tripping incident was funny."

K.W.-"The social worker tried to be funny and share smiles, I am not sure how genuine they were. I wondered to myself was the smiles part of her job."

Integrity

There were many approaches utilized to protect the integrity of the data in this

research study. Saldana (2011) stated that credibility and integrity are elements of the researchers' honesty and trust. Employing and transcribing with clarity helps attain credibility and integrity. My hope and ultimate intention were to guarantee that plausibility, flexibility, devotion and consistency were at the center of this research.

Credibility

Credibility is the assurance of the truth of the findings (Lincoln & Guba, 1985). Being a previous hospital social worker, I worked tirelessly to abstain from counter transference and partiality. I also am mindful that the subjectivity and objectivity should be maintained throughout the study. A master-level licensed clinician was asked to participate in the study as a peer evaluator, to confirm the findings, reduce bias, and assure impartiality.

Member checking also was used throughout the research. Angen (2000) stated that member checking is viewed as a tool for establishing the validity of a participant's account. I reviewed the information gathered from the different aspects of the research. Member checking includes the criteria qualifier form, participant data collection sheet, and interview protocol forms. The data (written documentation and voice recordings) were transcribed and drafted into a document identified as the individual phenomenological participant descriptions. A copy was shared with the participants with the summary for their analysis and feedback. Participant evaluations were used to gather feedback also.

Transferability

Thick description is defined by Lincoln and Guba (1985) as detailed

representations of the participant's experiences, going past a depiction of the external phenomenon to their interpretations, revealing feelings and the meanings behind their behaviors. The thick description method was used in this study to report the interpretation of data collected from the participant's, study results and findings. The participants in this research shared their exact experiences to offer an understanding of the effects of the pediatric trauma intake assessment.

Dependability

Triangulation was the tool I used during the review process to ensure dependability. It is a method used for substantiating results and as a test for validity, and ensuring the truthfulness of the research (Creswell & Miller, 2000). I triangulated the information from the questionnaire, the evaluator, participant evaluations and theories. Dependability was established by the participants' feedback and my observations, which found an extensive amount of commonalities.

In this study, it was important to me as the researcher, that the spirit of the participants was captured. The thick description was used to specifically share the participant's personal detailed account, in turn, ensuring transferability. Direct statements from the participants, peer assessment, a diary and digital verbal recording were used as means of ensuring dependability.

Confirmability

Confirmability is the extent to which the results of a study are formed by the participants and not researcher bias, inspiration, or regard (Lincoln & Guba, 1985). In establishing confirmability of this phenomenological research study, the participants were

provided with the opportunity to review the individual phenomenological descriptions to ensure accuracy in the analysis. Furthermore, I was able to think about my experience as a trauma social worker in an attempt to reduce bias and examine the phenomenon as shared by the participants. Corroborating the information from the theories relating to cognitive behavior and unconscious thought in conjunction with humor was used throughout the research.

Results

This study analyzed the exact circumstances of 6 participants whose child has suffered a traumatic injury, was hospitalized with humor being used. The participants all reside in the tristate area (Pennsylvania, New Jersey, and Delaware) and willingly participated in the study. A phenomenological, subject intensive, qualitative descriptive research method was used to complete this study. Face-to-face, semi-structured in-depth interviews with open-ended questions were used to inspire the participants to describe their personal experiences concerning the pediatric trauma assessment. The interviews were translated using the raw data that included verbatim quotations of the participant's responses. All interviews were voice recorded and translated word for word. I used a reflexive diary to remember statements and responses that may not be clear on the recorded audio and to include any specific behaviors/expressions that the participants displayed during the interviews. The data was assessed identifying major themes shared by all of the participants in the study. Two research questions guided this research study. They are:

RQ1: How do families respond to clinicians' use of humor during the initial

intake process?

RQ2: How would families describe the clinician's use of humor as a way to relieve stress during the intake process?

These research questions were devised concerning the cognitive behavior theory and unconscious thought theory. The cognitive behavior theory focuses on exploring connections among a person's thoughts, feelings, and behaviors (Dozois et al., 2009). This theory examines the mindset that attempts to explain human behavior by understanding your thought processes. Risk aspects can be summed up to be those negative encounters of life (disrespect, cultural bias, abuse, etc.). The participant's experiences during the pediatric trauma intake assessment displayed behaviors as a result of the social work interaction. The factors that were analyzed were the social worker's demeanor, influence, use of humor, and stress mitigated. This theory helps to understand why people conduct themselves the way they do. The Cognitive Behavioral Theory believes that individuals tend to form self-concepts that affect the behavior they display (Dozois et al., 2009). These concepts can be positive or negative and can be affected by a person's environment.

Dziegielewska et al. (2003) defined UTT as the mind being capable of performing tasks beyond an individual's knowledge. Ironically, decisions about complex matters can be better approached with unconscious thought, as experienced in traumatic situations. This theory is pertinent to decision making, forming impressions, changing perceptions, problem-solving, and creativity.

When analyzing the responses from the participants in this study, I recognized an

extensive relationship between the existing theories and the exact personal account of the participants. Concerning the first research question: How do families respond to clinicians' use of humor during the intake process when their child is admitted for a traumatic injury? As reiterated by the findings of this study, a large number of the participant's initial perception of the social worker was negative which in turn interfered with humor being influential or accepted. Also, some of the humor was not beneficial because the participants were too distraught to notice. On the other hand, many participants admitted some form of humor was used, and they found themselves laughing or smiling unconsciously.

Almost all the participants shared humor used appropriately and at the right times could relieve stress and provide some form of healing whether emotional or physical, even if for a moment. They all provided examples of things that the social worker did that may have lightened the mood such as: smiled, laughed, touched their shoulder, told jokes, tripped, or moved their body in funny ways. There was a consensus that many of the social workers were friendly and calm but serious which caused them to be apprehensive. Some of the participants could not understand the need for a social worker, and they were defensive. As stated in earlier chapters, at certified children Level 1 trauma centers/hospitals; a social work consult is needed for all trauma patients and families. As parents are not aware of this policy, they cannot understand the need for social work. Because the initial contact or perception is not viewed positively, the relationship starts off disconnected. Attempting to implement humor by either the social worker or the parent is already flawed. There were some participants that after getting past their initial

perception understood the social work assessment was required. According to some of the participants, the assessment even though required; did not have any bearing on the care of their child.

The participants in this study agreed that any initial meeting of hospital staff could have made a difference either in the traumatic experience or the future of their hospital stay. Several mentioned that if specifically, the social workers greeting were different, maybe their tone or demeanor would have opened up a smoother line of communication. Sometimes the way you are greeted can set the tone for future interaction. Many shared that their top priority was their child, and in the essence of the moment would have accepted any help that seemed genuine. Some explained that their trust level was low due to prior experiences, or based on things they had heard. One specific participant spoke of a particular hospital's social work department being known for calling social services, whenever a child is admitted for a traumatic injury. This also was a common view of social workers; that they would call social services, and the participants' child would be taken. Since this was an initial perception or how the social worker presented during the assessment many participants feared leaving their child alone. However, a few of the participants felt the questioning and determining if social services should be called as a part of the job.

Years of research studies show that there is a connection between humor and healing of all ages. In a strong consensus in this study, the participants agreed that humor was used. Unfortunately, based on several factors may not have changed their hospital stay or lessened their anxiety. While some of the participants seemed to manage during

this traumatic time, they credited it to remaining positive and not due to the social work assessment or humor. Of the participants, many would have avoided any social work interaction if they could. Out of the six participants, many were married, but their husbands did not participate in the interview. Also, out of all the participants, their social work experience was with a female.

Another factor identified by many of the participants in the group was they were not aware of their surroundings which are also associated with Unconscious Thought Theory. Participants shared that they knew they were at the hospital but admitted they do not know what people said or who said it. Some of these same participants shared that humor was used and they found themselves laughing in the midst of their trauma. Forms of humor that might seem funny to one person may be harmful to another. While humor can promote pain, it can also bring joy, happiness and a needed sense of empowerment (Ambadar et al., 2009). When used appropriately, it sets the tone for a positive conclusion. This stands to verify that cognitive behavior learned and experienced unconsciously can have an affirmative outcome especially with the use of humor.

The second research question investigated how families would describe the clinician's use of humor as relieving stress during the intake process. Individuals faced with negative situations are often told to reassess them and reinterpret the situations in a way that makes them positive (Cann et al., 2010, Hasan & Hasan, 2009,). All of the participants admitted that some form of humor was used, but many said it was not effective in helping them cope during the hospital stay. During the interviews with the three of the participants, they wondered if the humor, jokes or smiles were genuine.

Many responded that they laughed, and some cried from the humor, because it was so funny, not realizing they were laughing. They felt bad later because they felt they should be more serious at traumatic times. This goes to Unconscious Thought again because they all admitted that they smiled back or laughed. One behavior brought about another. One question was: How do individuals view what humor is or how it is interpreted? The participants shared that humor was used, but it was obvious that some viewed it as not being influential or appropriate for traumatic experiences.

In addition to reaffirming that humor was used, the humor the initial perception or greeting set a negative tone. A few participants also humbly admitted that when it comes to your children you never know how you would react or respond when faced with this dilemma. When asked about their overall experience, many said it was okay, but their main concern was their child. Even though many could recall that horrible day that their child was injured, they never critiqued how the initial intake assessment improved the hospital experience. Despite their experience with the social worker, all the participants expressed how they were still able to care for and support their child. The data provided by the participants, afforded insight into the use of humor by the social worker during the intake assessment.

With prior research findings (Hasan & Hasan, 2009), there are overwhelming studies around humor and healing and humor used in adverse situations. I was not able to find any surrounding humor being used in pediatric trauma assessments. In all of the interviews conducted, the participants admitted they never thought about the use of humor. Once the discussion about humor began, the participants started thinking about

what humor is and whether it used. The interview gave them an opportunity to share about their assessment experience. Descriptive words such as *apprehensive*, *negative*, *serious*, and *child-focused*, were commonly used to describe the participant's experiences. All six of the participants in this study pinpointed other elements that helped them specifically relieve stress other than the social worker's direct assessment. There were a few that shared that the social worker was influential in the hospital stay, but they did not connect it with humor or as a stress reliever. These participants discussed how the social worker answered questions and provided resources. Others recognized after the interview that humor was used but not enough that it lightened the mood, because of other reasons. These other reasons include: getting past initial perceptions, severity of the injury, and having the ability to engage and be receptive. Again, this ties into CT and UTT, as our behaviors are learned but some we do without realizing we are doing. Some of these participants may have smiled without realizing, then feeling bad like they should not be smiling at such a serious time. Two of the participants were adamant that nothing was funny during this time, so they struggled to accept the humorous gestures.

After completing the interview questions, I asked the participants about strength based elements that may apply to them. The reason for these questions, were that they could help determine how individuals deal with adversity, other individuals, themselves, and views on life. Most of the participants believed they possessed most if not all the strength based factors. One participant admitted that she struggled with having positive relationships due to past disappointments. She shared during the interview that she was one that was apprehensive and had her guard was up when she heard the social worker

was coming and after she arrived. Another participant felt that in their everyday life they are flexible, but when it came to her children, there was no room for error. All the participants agreed that they shared in the perseverance factor. No matter what was going on, or being said, they had to fight for their child and be strong through the process. Although the social work experience was not as expected, they did what they had to do to get past it. This initial intake assessment alone weighed heavily on the participants. In other instances, some of the participants utilized it for other purposes such as getting what was needed for their child. Whereas others realized it was part of the social worker's job and they had to go through it. Overall, a social worker should be an added resource and support for families in most cases despite initial perceptions. The culture of parents in general displays the ability for us to do what is needed to raise and care for our children no matter what.

The findings from this research exhibited that even though all the participants reported that humor was used, most of them felt it was not beneficial in helping to lighten the mood. They reported that they did what they needed to do to care for their child and get out the hospital. All of the participants had some support from family or friends, but also relied on the hospital staff. Everything done in a hospital is important and can be critical long term. So if the initial perception was negative followed by a negative interaction, the stress, and anxiety level was always high. On the other hand, the one participant that was a police officer who had been at the hospital many times did not let anything affect her or how she cared for her child. She admitted to tuning a lot out, except what the doctors and physical therapist said.

The participants in this study displayed their abilities to achieve favorable results during their hospital stay, despite the humor not being beneficial in relieving stress. Two particular participants' experiences stood out for me as they shared their intake interaction with the social worker. One participant could not get past the thought of her child possibly being taken, so humor was not making it any easier for her to cope. She was able to talk about the experience, but did not remember everyone she came in contact with. This participant admitted she was apprehensive about talking with the social worker for several reasons, but realized she had no choice. She also realized that she smiled at the social worker thinking she was polite, not realizing she was doing it. The other participant was the police officer who had been to this hospital with other children and thought she knew the process. She shared that she was apprehensive because she has heard and witnessed other assessments and felt she did not need or want a social worker. Even though the social worker was cordial, and her body language was hilarious, she wanted nothing to do with her. It was interesting to hear and view how different and alike minded the participants were based on age and educational level.

In general, many of the participants referred to their faith or beliefs in a higher power as their stress reliever. They did not want to credit just a single person or action as the reason that helped them manage through this traumatic situation. Quite a few of these participants expressed using prayer to help them cope and get through the hospital experience. Many of the participants made reference to their relationships with their spouses or significant others as their support system, even though they did not participate in the study.

Based on the information written in the reflexive diary, during the face-to-face interviews, it was evident that the women felt they had to put on a facade when it came to caring for their injured child. Many of the women shared that they were adamantly active in their child's care while in the hospital. It appeared that maintaining a calm image to their children was helpful in them remaining calm so they could heal.

Summary

This study was conducted to explore the use of humor in pediatric trauma assessments. I used a phenomenological approach to examine the exact personal account of the eleven participants. The factors around cognitive behavior and unconscious thought during their hospital intake assessment were explored, giving each participant an opportunity to share their experience. Following the cognitive behavior theory, the participants in this study showed that they possessed a variety of strength protective factors, which allowed them to be still present and care for their child in the midst of the trauma. The participants' feelings and emotions guided how they interacted with the social worker. Many shared that the beginning of the assessment had a negative connotation, but as the evaluation went on their perception had taken on a lighter view. As the assessment took a turn for the positive, the participants admitted they were unconsciously receptive. They were so worried about their child that they interacted in search of good news or updated information. Information from these interviews was reviewed and presented in this chapter.

The research questions which guided this study were formulated around the need to analyze:

RQ1: How do families respond to clinicians' use of humor during the initial intake process?

RQ2: How would families describe the clinician's use of humor as a way to relieve stress during the intake process?

The themes were developed from the responses shared by the participants. Concerning the cognitive behavior factors that allow these participants to have preconceived notions about the social workers, which in turn made them defensive and apprehensive to interact with them. The findings from this study demonstrate initial perceptions played a major part in humor or non-humor being incorporated in the assessment. The participants shared that the social worker used some form of humor, but many did not respond to it or found it to be beneficial.

The participants believed that, despite the fact the interaction with the social worker was not as pleasant as they would have liked, they were respectful enough to do what was needed for favorable odds with their children. A few participants in the study did admit the presence of unfavorable patterns on certain hospitals, promoted by the media and past experience; they reported these to be major reasons for how they interacted with the social worker before they even arrived. One of the participants specifically stated she felt the social worker was trying to lighten the mood simply because she was a police officer. Because she had this thought process, nothing said or done by the social worker may have made the experience positive. The other participant felt she might be accused of intentionally hurt her child or not supervising her appropriately. Nevertheless, both these participants shared that humor was not enough, or

used at the wrong time.

There was definitive agreement that the initial perception was negative, the greetings set the tone, and overall humor being used could have relieved their stress during the hospital experience. Descriptions were provided for what kinds of humor could have been most influential, one being a smile. The participants credited themselves with remaining mature and even professional while in the hospital no matter what the relationship was with the social worker. In Chapter 5, the results from this study will provide a summarized interpretation of the findings, limitations, recommendations and implications for positive social change.

Chapter 5

Discussion, Conclusions, and Recommendations

Introduction

Historically, there has been an abundance of research conducted that examines humor and healing in relationship to children and traumatic experiences (Cafe et al., 2005). Many of the studies done up until now have focused on humor as a stress litigator, an anxiety reliever, thought diverter, and overall healing and coping mechanism (LaCapra, 2014). The researcher examined how the use of humor with families during the pediatric trauma intake assessment relieved stress, improved the hospital experience or the care of their child.

The purpose of this phenomenological study was to provide an opportunity for the participants to share how the social worker's initial assessment with the use humor affected their hospital experience. Six participants shared their stories and explained how their hospital experience was changed by the pediatric trauma assessment. It is anticipated that the results from this study will prompt favorable social change or discussion around the initial trauma assessment by expanding the knowledge of and thought into the creation of pertinent perceptions and relationships. The staple findings from this study can be utilized by educators, community-based organizations, human service professionals, clinicians, and medical facilities to create positive and enriching services for all families.

In the summer of 2016, a sample of 6 participants was enlisted to participate in this study. These participants confirmed that they were parents or legal guardians of a

child that suffered a severe injury, admitted into the hospital, and humor was used. Study participants' criteria were that their child's injury happened within the last two years, and they were currently not in crisis. The participants zealously agreed to share their experiences. Based on information collected in individual interviews, results offered affirmation of various characteristics of cognitive behavior and unconscious thought theories. Nine themes were derived from the data: (a) initial perception, (b) assessment influential, (c) social worker greeting, (d) manage traumatic situation, (e) avoidance, (f) humor heals, (g) individual awareness, (h) humor-verbal/nonverbal, (i) interpretation of humor in trauma. The following discussion section will expand upon on these themes with support from the literature reviewed in Chapter 2.

Interpretation of the Findings

Phenomenological research design provided the participants a chance to share their exact personal account from their perspective. The conceptual framework for this study consisted of two theories: the cognitive behavioral theory (Dozois et al., 2009), and unconscious thought theory (Dijksterhuis & Nordgen, 2006). There were several commonalities identified between past research and this study as it pertains to humor and healing.

Findings Implicated by the Cognitive Behavioral Theory

Cognitive Behavior has been described as your thoughts defining your actions or behavior (Rutter, 1999). When individuals learn to assess their thinking in a more realistic and accepting manner, they experience improvement in their mental state and their behavior. If the participant's initial perception of the social worker were positive, the

interaction would have started out on a positive note. Then leading into the assessment, humor could have been used by the social worker if the participant was receptive. On the other hand, the social worker's initial greeting could end the negative perception which paves the way for a positive hospital interaction including humor. The first six themes were consistent with the cognitive behavioral theory addressing behavior that looks at how we think and how it changes the manner in which we act.

Themes 1 through 6. Themes expressed by the participants included the initial perception of the social worker, assessment, social worker greeting, manage traumatic situation, avoidance, and humor heals. The responses of the participants in this study were deliberate examples of cognitive behavior, but I have found no past studies that identify with humor incorporated in the pediatric trauma assessment. The participants in this study reported that their perception set the tone for their initial interaction with the social worker. A few of the participants admitted that the feeling changed as the assessment went on. Many shared that the humor used in the assessment did not lighten the mood or affect their coping. Even though some of the participants understood that the social was doing their job, they wished they were more personable and made a connection that could have relieved the initial tension. The compensatory challenge and personal strength elements were apparent throughout the participant's answers in the study. The responses of the participants in this study were specifically thoughtful of their exact personal account with a common factor that if appropriate humor were incorporated in their assessment, their stress would have been minimized, and they would have coped better making the hospital admission bearable. The challenge model of cognitive

behavior considers if you allow negative thoughts to result in negative behaviors, it will expose misfortunes and block opportunities to be receptive.

The compensatory model. The compensatory model explores rational decision making that is systematically assessed (Garmezy, Masten, & Tellegen, 1984). The participants in the study spoke of how they used their coping mechanisms, life experience, and natural capabilities to compensate for traumatic situations. For one of the participants, that meant sticking to things she heard and seen as a police officer coming to this particular hospital, and she did not allow for her experience to be different. As a result, she entered the hospital with a negative attitude toward social worker, instead of having an optimistic view. The humor that was used, would she have been more receptive? In this case, she was adamant that the humor was not influential. The participants in this study shared how they used available supports, interpersonal skills, and resources to compensate for the experiences they encountered, such as interrogating questions.

Initial perception. Consensus was that the social worker's visit with the family was for negative reasons. This thought made it hard to some of the participants to trust the social worker. Many thought they could lose their child based on things they heard and not a personal experience.

Assessment influence. Influence was shared by many that it did not lighten the mood or help with coping. If the assessment was not effective, then nothing the social worker said or did could make for an enjoyable hospital stay.

Social Worker Greetings. Once a greeting begins with a smile that could, in turn,

get a smile and relieve the pressure of the initial perception. They say you only get one chance to make a lasting impression.

Manage Traumatic Situations. Coping may come easy for some when it comes to caring for their child. If your primary focus is your child, then you will not focus on what the social worker may or may not be doing or saying. Understanding that the social worker is doing her job can help one to remain positive.

Avoidance. This is what was felt from the beginning with the initial perception. It also could have blocked the ability to receive any humor if presented. Three of the participants felt there was no need for social work.

Humor Heals. This was the consensus of all the participants. They all agreed that humor changes a hospital experience, and the most common form of humor they all said was a smile.

Findings Implicated by the Unconscious Thought Theory

UTT allows individuals to make decisions without realizing they have and possibly have a positive outcome. In this study participants found themselves smiling or laughing in the midst of the trauma. They also questioned themselves in the interview process saying they do not know why they were laughing. Decisions about complicated matters can be better approached with unconscious thought, as such in a traumatic situation.

Themes 7 through 9. These themes were more related to those ideologies ascribed to in the unconscious thought theory. The next section will examine the findings of the study and their relationship to the unconscious thought theory. Themes shared by

the participants include not being aware of surroundings, humor-verbal/nonverbal, and interpretation of humor in trauma.

Individual Awareness. This allows for participants to be aware of their self. With an unconscious thought, people are not aware of their actions or even why. Many of the participants shared that they were not conscious of their surroundings. Not being aware of surroundings can allow for unconscious decision or actions to be made without realizing it being done. The participants provided examples such as smiling without realizing they were smiling. Many described knowing they were in the hospital but not aware of what was going on and only heard the doctor's voice but had discussions with the social worker.

Humor-Verbal/Nonverbal. Body language can be used in the most horrific experiences without individuals even knowing it was used. Participants reported that the social workers smiled, and they smiled back. Two participants shared that the social worker's body language prompted them to laugh. The issue was that it did not make the hospital stay positive or help with coping with the situation.

Interpretation of Humor in Trauma. Interpretation can be deciphered differently based on the level of trauma, especially with children. The participants said humor was used, and the interviewed allowed them to reminisce on the details of the experience. Some interpreted smiles as humor, but all agreed that no matter what level of trauma, some form of humor used relieves a moment of stress. That moment of relief could set the mindset for future interaction with not only the social worker but all hospital staff.

Limitations of the Study

Due to the phenomenological nature of this research, the following limitations are noted. However, from a qualitative view, each participant has a uniquely valuable experience or perspective, and the findings from this study can provide a more detailed understanding of the unique and multifaceted nature of humor use in assessment with parents whose child suffered a traumatic injury (Creswell & Miller, 2000). The participants were relatively homogeneous limited to parents or guardians, living in the Three-County area (Pennsylvania, New Jersey, and Delaware). The participants had to have been or currently the primary caretaker of their child/children. The participants had to confirm that, their child was not currently in crisis (a) treated and released, (b) residing with someone else, (c) active with social services for abuse or neglect. These parameters around the guidelines for participation may have eliminated candidates based on the nature of the injury and services received.

Many children are injured every year from sports injuries to death. In cases of these injuries, children can be admitted into a certified trauma facility. Some participants who have had children who experienced a traumatic injury and was hospitalized with interaction with a social worker may offer alternatives to changing perceptions and work towards better communication for an amicable hospital stay. Additionally, focusing on existing theories and research on humor may have led the researchers to overlook certain elements of the phenomenon (Fair, 2014). For example, much of the research on humor is focused on the use and effects of overt jokes or puns. However, the forms of humor found in this study were often subtle, and thus required the analysis of contextual and nonverbal elements of expressions of humor (e.g., tone of voice, hand gestures, therapist response).

The results from this study will offer a meaningful supply of data to reinforce those concerned or interested in having discussions or creating training for social workers to change perceptions as well as prepare them for the initial greeting in the face of pediatric trauma. Martin (2007) suggests that humor can serve as a form of social communication that can be heavily changed by cultural variables. Further data regarding social work factors, could have shed more attention on the social aspects of humor in general, as well as within the context of the intake assessment.

Also, being a social worker for over 20 years, I realized the importance of avoiding biases. I employed a peer evaluator, who was a licensed clinician to guarantee impartiality and to authenticate the findings.

Recommendations for Future Research

One recommendation is to expand the research of humor and healing to specific circumstances and assessment completed with families. Researchers can take it one step further than just studying humor used with children, but with parents when their child is injured, and assessment must be completed. Most of the research touches upon humor being used to heal, but I have found none that is specific to this experience which is mandatory if admitted into a Level 1 facility. In response to every other challenge by the parent being faced with this traumatic situation, they all agreed humor could have changed the outcome. Each expressed how they believed some form of genuine humor could have relieved stress during their stay and maybe even how they interacted with the rest of the hospital staff. It would be interesting to find out why social workers initial perception was viewed as negative despite some not knowing why social work was

coming.

Another recommendation is the need for social work to complete a pediatric trauma assessment when patients come through the door. One of the participants questioned even changing the name which was intimidating from the beginning. Also, a study of this nature may provide insight and information regarding social worker's at such a crucial moment that could be helpful in navigating the hospital system. It can also enlighten the medical field of being mindful of their job, position and power to build relationships in this scenario. Having a chance to listen to social workers' personal experiences may help in bringing attention on what can be done to improve the interactions with parents/families to have favorable outcomes.

Finally, it is suggested that this study is duplicated with parents whose child was hospitalized not for trauma specifically but for any reason and a social work consult was needed. As a social worker, I have not heard of any class that teaches social workers what to say when they enter the door of a family, especially one in crisis. Much of the perceptions were based on more negative reports than positive based on how the social worker presented. It would be interesting to assess the commonalities and differences in beliefs, practices, and dispositions of the parents in this study.

Implications for Social Change

While this study supplied a forum to parents to share the cognitive behavior and unconscious thought factors, it also allowed them an opportunity to share their intake assessment experience offering favorable and unfavorable results. Purposeful involvement from social workers/clinicians, development of training around conducting

initial assessments could be areas worth discussing.

Each of the 6 parents participating in this study identified that if humor were used appropriately and at the right time, it would relieve stress and improve their hospital stay. The participants in this study voiced a level of excitement, hope, and thankfulness for having had the chance to share their views when it comes to how they think social workers should set the tone. Most of the participants felt that I should continue research and possibly write a proposal for conducting hospital training once the study was completed. Engaging the parents in this study was not difficult at all. It appeared that the participants were thankful of just being allowed the chance to disclose in a protected environment; dialogue with someone interested in how they were treated; and wants to make a difference. The realization for some of the parents was they never thought about humor until asked if it would have mattered when they were so focused on their child.

It would be ideal for hospitals to research the specific intake assessment process and how families are being swayed. The data from the study also exhibited a high level of apprehension and distrust with social workers. Therefore, some of the tedious work in establishing a survey, which includes getting staff to have confidence in the system that this is for training purposes only, and not used for criticism should be established. The financial burden that comes along with developing a survey would be small. However, I do that that the developer of the survey should have some knowledge of the pediatric intake assessment and its purpose.

This study was established, mainly, regarding the huge gap that exists in the data and current literature which have not examined specifically the use of humor in pediatric

trauma assessments. The researcher examined the humor used in the intake process with families and how this process contributes to mitigating stress. I have found no studies conducted with regards to social workers using humor in intake assessments. As discussed in Chapter 1, research is needed that will allow an exhaustive understanding of the use of humor in pediatric trauma evaluations.

For this study, the theories of the cognitive behavior and unconscious thought were examined. The results concluded from this research reinforce the descriptions of the theories, displaying attention for the need of humor in pediatric trauma assessments in relationship to cognitive behavior and unconscious thought. The trials experienced by the participants in the study, were perpetually reported to be managed by focusing on their child, remaining positive, and understanding the social worker had a job to do.

Summary and Conclusion

Historically, research has been conducted on humor and healing and humor being a helpful coping tool for individuals who have undergone some form of trauma (Ruch, 1998). Past research has provided an abundance of information which explores humor used with children, in particular through work done by Dr. Patch Adams (Clark, 2013). Children who have suffered a traumatic injury and were hospitalized, adds an enormous amount of stress to all involved. This study assessed if humor used in the intake process may relieve stress with families whose child has suffered a traumatic injury. It provided a voice for parents to share their experience in a different forum. There is a need for further discussion and research around social workers use of humor in their approach as well as in their assessment. The participants in this study have deemed that they all were

apprehensive and defensive knowing they had to engage with a social worker. These six parents shared a speech that speaks aggressively to their experience and the desire to hope for change as they feel the assessment is just as important as the medical care. It is the hope of these parents that even though their experience was not as they would have liked it to be, a discussion for change can help the next parents. These parents have discussed the hindrances which impede social workers from being perceived in a negative light. This research is not indicative of all social workers' style, but it is a diverse consensus that at least warrants a discussion. These barriers could pose a hindrance to aspects of future hospital interaction and crucial to the emotional health of a parent trying to care for their injured child. By conducting a qualitative research that relives a traumatic time, the parents were able to share willingly and confidently on elements they believe to be important and of great benefit. The parents in this qualitative study have shared their words challenging the process and previous results of quantitative studies, which did not specifically address pediatric trauma assessment. The parents had an opportunity to share their exact personal account, leading to a source of data that can be applied in various ways for future.

This qualitative phenomenological study examined the use of humor in pediatric trauma assessments of with six parents, as they related to their hospital experience; assessing the capacity of the use of humor on the outcomes of their hospital experience. These parents were able to share their exact personal account concerning their hospital experience. By working with the participants throughout the study, the strength of the parents surfaced as a crucial element that enabled them to survive the

traumatic injury to their child. Some participants did not feel that the use of humor by clinicians during the intake process was helpful but were, however, thankful for the social worker's presence. Their instinctive ability to help and display a confident frame of mind was evident. The results from this study gave acceptance to the capabilities of the parents to use their strength as a provision of being able to work with the social workers in the hospital setting. Sometimes the participants were totally oblivious to their reactions or realization that a small form of humor was used. The pediatric trauma assessment is not something new. Level 1 pediatric trauma facilities have been requiring social work consults for years, as it is a requirement for federal certification. Basic questions have been formatted for social workers to ask during the assessment, but an attitude is everything. Realizing that the trauma assessment along with the initial medical team's response sets the tone for the of the hospital experience. These parents were clear that in the beginning, their impression of the social worker was not positive, and that needs to be changed.

In completing this study, it is the desire that the findings will be helpful in setting a stage for future research and discussion. The findings from this study offer sound literature on humor and healing as a coping mechanism, but I found none specific to this population or area. It is of great importance that pertinent models of study and qualitative methods of research, be employed in the study of the use of humor in pediatric trauma assessments. Research of this nature tends to provide a more positive and universal view of the phenomenon. It is hoped that the findings from this study will advance further dialogue into the elements that may contribute to creating better

communication and relationships with clinicians for a positive outcome. Change agents (clinicians, researchers, educators, etc.) should analyze this research specifically and use it to create training and guidelines addressing the social work interaction in completing the initial assessment.

Another possible path for future research involves the creation of guidelines for social workers regarding humor use in pediatric trauma assessments. More specifically, a manual for social workers could be developed based on current literature (Dozois et al., 2009), including: (a) How to recognize and respond to possible inappropriate forms of humor; (b) How to assist in promoting and maximizing participant use of effective forms of humor; and (c) The risks and benefits of therapeutic humor. This manual could then be evaluated for specific benefits of humor. Training programs could then use this to help social workers to be aware when it is appropriate to invite laughter, fun, and positive emotions into the assessment, and whether and how to facilitate it themselves. In conclusion, this study aimed to heighten general knowledge of the use of humor, an issue that is often regarded as "forbidden." The findings from this study also have implications for training social workers on the risks and benefits of using and responding to humor during intake assessments.

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Appendix A: Criteria Qualifier

**Project Title: A Qualitative Analysis of the Use Of Humor With Families During
Pediatric Trauma Intake**

The information collected will be used solely for completing the dissertation research project identified above as partial fulfillment of requirements for the PhD degree at Walden University.

- Pediatric Trauma Parent – is a parent who assumes responsibility of a child/children, whose child has suffered a traumatic injury and was hospitalized. Would this definition describe you and your past experience? Y ___ N ___

(If no, thank candidate and end screening)

In efforts to ensure the safety and voluntary participation in this research, I will need to ask the following questions:

- Are you 18 years of age or older? Y ___ N ___
- Do you speak, read, and understand English fluently? Y ___ N ___
- Do you currently reside in Philadelphia, Montgomery, or Chester County of Pennsylvania? Y ___ N ___
- Do you have an open case with the Department of Human Services for alleged abuse or neglect? Y ___ N ___
- Do you consider yourself to be an emotionally stable? Y ___ N ___
- Do you have any professional or working relationship to the researcher? Y ___ N ___
- Has your child suffered a traumatic injury? Y ___ N ___
- Was your child residing with you at the time of the injury? Y ___ N ___

- Were you in the hospital emergency room with your child? Y___ N___
- Was any form of humor used by the hospital social worker? Y___ N___
- Was your child admitted into the hospital? Y___ N___
- Did the injury happen less than 2 years ago? Y___ N___
- Is your child currently experiencing a crisis situation or any acute illness at this time?
Y___ N___

If candidate meets the above qualifications, the participant consent form should be completed at this point, before moving on to the next set of questions. You have met the qualifications to participate in this study. At this time, I would like to review with you the informed consent form so you can determine whether you would be in agreement to participate in the study. (Researcher will review participant consent form with candidate. If candidate is in agreement with the terms outlined in the consent form, candidate will sign and will be given a copy for their own records. At this point of the process, the candidate will now be referred to as a participant).

Appendix B: Demographic Questionnaire

Name: _____ Age: _____

Address: _____

City, State & Zip Code _____

Phone #: _____ Email Address: _____

Race/Ethnic Background: _____

Number of Children: _____

(Number of biological: _____ Number of adopted: _____ Number of assumed responsibility
_____)

Age & Gender of Children:

1. Age _____ Sex _____ Highest grade completed _____ 4. Age _____ Sex _____

Highest grade completed

2. Age _____ Sex _____ Highest grade completed _____ 5. Age _____ Sex _____

Highest grade completed

3. Age _____ Sex _____ Highest grade completed _____ 6. Age _____ Sex _____

Highest grade completed

Marital Status: Married _____ Separated _____ Divorced _____ Widowed _____

Single (never married) _____

Highest Level of Education Completed:

_____ 11th grade or under

_____ High School Graduate/GED

_____ College Degree (Assoc./BS/BA) Major: _____

_____ Graduate Degree (MA/MS/MSW) Major: _____

_____ Advanced Grad Degree (Ph.D., etc.) Field: _____

Profession (Current Occupation): _____

Appendix C: Interview Protocol

Interview Guide: **A Qualitative Analysis of the Use of Humor With Families During Pediatric Trauma Intake Assessments**

Introduction: My name is Letitia Batton on (date) with participant (assigned #). I am going to ask you about your experience during the pediatric trauma assessment when your child was hospitalized with regards to what contributed to relieving stress. There is no right or wrong answers; I am basically interested in your honest opinions, thoughts and feelings.

Initials of participant: _____

1. When did your child suffer their injury?
2. How was your child injured?
3. How was your child transported to the emergency room?
4. During the traumatic experience, how did you solicit help or support for your child?
5. When was your child hospitalized? How long?
6. How were you greeted when you reached the emergency room by a social worker?
7. What were your initial perceptions of the social workers? Why do you feel this way?
8. What did the social worker say or do that may have changed your experience?
9. How would you describe their demeanor during the intake assessment?
10. How were you changed by the assessment? How?
11. What forms of humor were used during the assessment (verbal or nonverbal), and how did it affect your experience?

12. How did the social worker do anything that may have lightened the mood?
13. How was the social worker influential in helping to mitigate any stressors? How?
14. How did the social workers influence help you with the care of your child? If yes, what effect did this have on you in helping with caring for your child?
15. What was the most difficult part of the experience? How do you manage?
16. How do you think your child/children handled the experience?
17. Overall, how was your experience?
18. In your opinion how do you think the social worker could have assisted or made experience different?
19. How do you think humor influences healing?

I am going to read to you a list of strength-based factors used most often when faced with adversity or trauma. I am going to read you the list, you can let me know which of these you have used in the past or currently and I will check them off.

- o Relationships - Sociability/ability to maintain positive relationships
- o Perceptiveness – Insightful understanding of people and situations
- o Positive View of Personal Future – Optimism, expects a positive future
- o Flexibility – Can adjust to change; can bend as necessary to positively cope with situations
- o Self-motivation – Internal initiative and positive motivation from within
- o Competence – Is “good at something”/ personal competence
- o Perseverance – Keeps on despite difficulty; doesn’t give up

Appendix D: Participant Feedback Form

A Qualitative Analysis of the Use of Humor With Families During Pediatric Trauma Intake Assessments

Name: _____

Date: _____

REVIEW GUIDELINES

Complete this feedback form, using the following scale: **NA = Not Applicable**

1 = Strongly Disagree

2 = Disagree

3 = Neither Agree or Disagree

4 = Agree

5 = Strongly Agree

	5) = <i>Strongly Agree</i>	4) = <i>Agree</i>	3) = <i>Neither Agree or Disagree</i>	2) = <i>Disagree</i>	1) = <i>Strongly Disagree</i>
Researcher demonstrated respect and listened to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The materials used to conduct the study were easy to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt I could ask questions about things I didn't understand or wanted to further information on.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand the importance of having a study like this one.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I do not feel harmed or threatened by any aspect of the study.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel excited about the possibility of influencing change with regards to the pediatric trauma intake assessment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I feel that training is educational and can assist social workers with making meaningful connections with families that can mitigate stress.

I feel empowered by my participation in the study.

I learned information that will be helpful to me and my family.

I felt that my confidentiality and integrity were respected during the study.

I consented to participate in the study, and gave honest feedback throughout the process.

I am satisfied with the feedback from the researcher regarding the study.

I enjoyed participating in the interviews with the women.

Additional Comments:

Appendix E: Confidentiality Agreement

During the course of my activity in reviewing this research: “A Qualitative Analysis Of the Use of Humor With Families During Pediatric Trauma Intake Assessments.” I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential.

By signing this Confidentiality Agreement I acknowledge and agree that: I will not disclose or discuss any confidential information with others, including friends or family. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant’s names are not used. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information. I agree that my obligations under this agreement will continue after termination of the job that I will perform. I will only access or use systems or devices that I am officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Printed Name: _____

Signature: ____

License Number (if applicable): _____ **Date:** _____

Appendix F: Flyer

INVITATION TO PARTICIPATE

Letitia Batton, a doctoral student at Walden University (Walden University IRB # 06-22-16-0273054) will be conducting a research study that explores the experience of parents whose child has suffered a traumatic injury, was hospitalized and was included in an intake assessment by a social worker. Historically research has pointed to humor as being a healing tool during stressful experiences. Little discussion or attention has been given to the pediatric intake assessment done with parents when their child has been injured and hospitalized, as it relates to relieving stress, and contributing to a positive hospital stay. The purpose of this study is to assess the intake assessment, the connections made with parents during initial contact, the use of humor (verbal/nonverbal), and commonalities that may exist among the participants. This research project will provide an opportunity for parents to tell their story providing a holistic perspective, with the hopes of facilitating the development of training or discussion efforts around the pediatric trauma intake assessment for those affected by this phenomenon.

Pediatric Trauma Parent – is a parent who assumes responsibility of a child/children, whose child has suffered a traumatic injury and was hospitalized.

Please contact letitia.batton@waldenu.edu for additional information and if interested, to schedule an interview.

Study for Parents Who's Child Has Suffered a Traumatic Injury and Was Hospitalized Within the Last 2 Years. @waldenu.edu
Study for Parents Who's Child Has Suffered a Traumatic Injury and Was Hospitalized Within the Last 2 Years. @waldenu.edu
Study for Parents Who's Child Has Suffered a Traumatic Injury and Was Hospitalized Within the Last 2 Years. @waldenu.edu
Study for Parents Who's Child Has Suffered a Traumatic Injury and Was Hospitalized Within the Last 2 Years. @waldenu.edu

Appendix G: Participant Demographics

Participant CODE	Age	Marital Status	Children's Gender/Age	Relation to Children Biological/ Adopted/ Assumed Responsibility	Participant Education Level	Employed (Yes/No)
001	38	Married	Male/6 Female/8	Biological	Masters' Degree	Yes
002	33	Single	Female/7	Biological	GED	Yes
003	38	Married	Male/16 Male/12 Female/4	Biological	Bachelors' Degree	Yes
004	23	Single	Female/2	Biological	Currently Enrolled in College	Yes
005	28	Married	Male/4	Biological	Bachelors' Degree	Yes
006	31	Married	Male/8 Male/10	Biological	Bachelors' Degree	Yes