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Reconciling the good patient persona with problematic and non-problematic humour: A grounded theory

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ABSTRACT

Background: Humour is a complex phenomenon, incorporating cognitive, emotional, behavioural, physiological and social aspects. Research to date has concentrated on reviewing (rehearsed) humour and 'healthy' individuals via correlation studies using personality-trait based measurements, principally on psychology students in laboratory conditions. Nurses are key participants in modern healthcare interactions however, little is known about their (spontaneous) humour use.
Aims: A middle-range theory that accounted for humour use in CNS-patient interactions was the aim of the study. The study reviewed the antecedents of humour exploring the use of humour in relation to (motivational) humour theories.
Participants and setting: Twenty Clinical Nurse Specialist–patient interactions and their respective peer groups in a country of the United Kingdom.
Method: An evolved constructivist grounded theory approach investigated a complex and dynamic phenomenon in situated contexts. Naturally occurring interactions provided the basis of the data corpus with follow-up interviews, focus groups, observation and field notes. A constant comparative approach to data collection and analysis was applied until theoretical sufficiency incorporating an innovative interpretative and illustrative framework. This paper reports the grounded theory and is principally based upon 20 CNS–patient interactions and follow-up data. The negative case analysis and peer group interactions will be reported in separate publications.
Findings: The theory purports that patients' use humour to reconcile a good patient persona. The core category of the good patient persona, two of its constituent elements (compliance, sycophancy), conditions under which it emerges and how this relates to the use of humour are outlined and discussed. In seeking to establish and maintain a meaningful and therapeutic interaction with the CNS, patients enact a good patient persona to varying degrees depending upon the situated context. The good patient persona needs to be maintained within the interaction and is therefore reconciled with potentially problematic or non-problematic humour use. Humour is therefore used to deferentially package concerns (potentially problematic humour) or affiliate (potentially non-problematic humour). This paper reviews the good patient persona (compliance, sycophancy), potentially problematic humour (self-disparaging, gallows) and briefly, non-problematic humour (incongruity).
Conclusions: The middle-range theory differentiates potentially problematic humour from non-problematic humour and notes that how humour is identified and addressed is central to whether patients concerns are resolved or not. The study provides a robust

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review of humour in healthcare interactions with important implications for practice. Further, this study develops and extends humour research and contributes to an evolved application of constructivist grounded theory.

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What is already known about the topic?

- Humour research to date has concentrated on the 'healthy' individual via correlation studies using personality-trait based measurements, principally on psychology students in laboratory conditions.
- The evidence-base for rehearsed humour interventions vis a vis the humour-health hypothesis is ambivalent at best.
- Little is known about spontaneous humour use in dynamic, situated contexts such as healthcare interactions.

What this paper adds

- This paper provides a robust review of humour in real-world healthcare interactions.
- The middle-range theory presented differentiates potentially problematic from non-problematic humour use, noting how humour is identified and addressed is key to whether patients' concerns are addressed or not.
- The use of naturally occurring interactions and an innovative interpretative and illustrative framework contributes to an evolved form of constructivist grounded theory.

1. Introduction

Humour is a complex phenomenon, incorporating cognitive, emotional, behavioural, physiological and social or situational aspects (Martin, 2006). The how, why, when, where and who initiates humour is as complex as its subsequent interpretation. How people perceive or conceptualise humour varies from person to person (Martin, 2001), yet it is often viewed as a somewhat stable expression of personality in humans (Foot and McCreaddie, 2006). Hence, humour research to date has concentrated on the 'healthy' individual via correlation studies utilising personality-trait based measurements, principally on psychology students in laboratory conditions (Martin and Lefcourt, 2004). However, humour is an integral aspect of communication between humans and is also noted to exist (principally via laughter or play) among other species (Martin, 2006). This study reviews the spontaneous phenomenon of humour in the 'real world' specifically the situated contexts of healthcare interactions.

1.1. The literature review in grounded theory

Conducting a literature review pre-entry to the field is a contentious issue in grounded theory (GT) and forms the basis upon which the 'forced' versus 'emerging' debate takes place (Glaser, 1978; Strauss and Corbin, 1990, 1998; Strauss, 1987). The first author initially intended to undertake a randomised control trial on a humour intervention. However, an initial review of the literature identified a preponderance of correlational studies conducted on healthy undergraduates in laboratories. These studies were extremely limited and failed to demonstrate support for a systematic humour intervention. Moreover, they raised questions as to the applicability of much of the research to date particularly in the context of healthcare interactions. Nonetheless, the literature provided insights into humour theories, relevant psychological and social constructs, humour processes and definitions (or interpretations) that would subsequently prove invaluable in better explicating and illustrating emerging data. The reviewed literature also provided a solid justification for obtaining ethical approval. An understanding of the literature across a range of disciplines also allowed the authors to re-visit literature in search of 'secondary' data that may illuminate emerging findings.

A robust and evolving review of the literature (Foot and McCreaddie, 2006; McCreaddie and Wiggins, 2008) pre-, intra- and post-entry to the field, therefore, attempted to offset some of the difficulties noted in previous humour studies, e.g. dependent upon one form of data and purely descriptive as opposed to interpretative (e.g. ignored humour theories). Instead, a robust account of the phenomenon under study with the concomitant potential to inform future research and more importantly have practical application was pursued. Dey's (1999:251) view on undertaking a literature review in grounded theory as being 'open-minded' as opposed to 'empty-headed' was adopted.

2. Literature review

Three key issues emerged from the literature review: (a) humour theories, (b) the humour-health hypothesis and (c) the limitations of research to date.

2.1. Humour theories

A theory of humour should seek to explain or account for the phenomenon, define the conditions under which it may occur, as well as be specific and falsifiable (Popper, 1963). Martin (2006) suggests that psychological theories of humour meet none of these stringent criteria and are often poorly defined. Nonetheless, Martin (2006) contends that they provide a degree of usefulness in shaping concepts from a research perspective.

Currently, there are over 100 humour theories of which 3 predominate (Foot and McCreaddie, 2006). Those theories account for humour types, as in the humour expressed and are based on motivational aspects (see Billig, 2005 for a critique). The three main humour theories are social (superiority), cognitive–perceptual (incongruity) or emotional (release).

The social superiority theory is noted to be the earliest of the humour theories to emerge (Morreall, 1987), may be placed under the umbrella term of the degradation theory of humour and includes self-disparagement (Billig, 2005). Martin (2006:63) describes incongruity humour as being '*a mismatch or clash between our sensory perceptions of something and our abstract knowledge or concepts about that thing*' – or a cognitive perceptual theory of humour. The psychoanalytic release theory of humour incorporates gallows or black humour and is largely credited to Freud (1960[1905]) as humour or laughter that occurs when a joke permits the release of libidinal energy.

The three main theories illuminate how a given stimulus (usually a joke or rehearsed humour intervention) provokes appreciation (or not – e.g. motivation of joke teller) and specific behavioural responses (e.g. laughter). Hence, humour is a complex phenomenon involving social (Apter, 1991), cognitive–perceptual aspects (Koestler, 1964), emotion (Martin, 2006) or behaviour (Provine and Yong, 1991).

2.2. The humour-health hypothesis

Much of the (psychology) humour research to date has concentrated on investigating the humour-health hypothesis. The *direct humour-health hypothesis* suggests that humour can confer positive health benefits and has been explored in several areas for example, the cardiovascular system (Clark et al., 2001), pain (Mahony et al., 2001) and immunity (Kimata, 2004). While there is little significant evidence for a direct causal link, the latter (immunity), is considered more plausible particularly with regards to the impact of emotion (Booth and Pennebaker, 2000). Conversely the *indirect humour-health hypothesis* that humour moderates stress, adverse events or enhances social support or competence, has offered some tangible results. Notably, the humour-health hypothesis is invariably reviewed via *rehearsed* humour interventions and this evidence base, which is incomplete and ambivalent at best, forms the basis of applied humour interventions. Organisations such as the Association of Applied and Therapeutic Humor (AATH) advocate interventions such as laughter therapy, clown doctors and laughter carts to name but a few (www.aath.org/home).

2.3. Limitations of the research to date

There are two points of note about the literature thus far. First, the available research is heavily dominated by the diverse fields of psychology where scale-based studies prevail, seeking to define and measure humour in laboratory conditions with young, 'healthy' undergraduates using *rehearsed* humour interventions (e.g. videos, jokes). It is debatable as to what extent 'humour scales' can properly measure an individual's sense of humour as humour is not a unitary trait. Second, the literature is largely based on the assumption that humour and health positively correlate be it directly or indirectly (McCreaddie and Wiggins, 2008).

Humour use in healthcare however, is largely *spontaneous*. It is complex, dynamic and at the mercy of innumerable mediating factors. Fears and anxieties, environmental factors (clinic or home), previous healthcare experience, physiological symptoms, a desire for privacy and confidentiality and the presence of others can all potentially alter a patient's 'normal' sense of humour. Healthcare professionals, therefore, need to be aware of humour, interpret it and reciprocate appropriately. Protagonists bring many diverse factors to any given interaction thereby making attempts to distil humour measurement into scales developed in sterile conditions on 'healthy' *individuals* appear quite inane and relatively futile. Hence, this study takes an original and alternative approach to researching humour, seeking to review *spontaneous* humour in real world settings with an in-depth interpretative account of a complex and *situated* phenomenon.

3. Methods

This study adopts a constructivist grounded theory approach recognising that researchers and participants co-construct realities which subsequently become, in and of themselves, a co-construction (Charmaz, 2006). This approach attempts to address the difficulties in capturing and making sense of the phenomenon in two ways. First, a relatively open interpretation of humour is adopted in cognisance of the unexplored nature of the topic, particularly in complex, situated healthcare interactions. In this complex and substantive area it is reasonable to suggest that humour may have an *entirely different or unusual presentation*. Second, an *interpretative* framework based upon the *theoretical origins of humour* and its (known) *form or operationalisation* is applied *illustrating* the phenomenon within the *situated context*. What is known (theoretical origins and form) is therefore, balanced with what is unknown (different or unusual presentation) in order to properly capture the phenomenon make it tangible and potentially applicable.

3.1. Sample and setting

Grounded theory is particularly useful in exploring phenomena of which little is known (Morse, 2001). This study used non-researcher provoked healthcare interactions between Clinical Nurse Specialists (CNSs) and patients as the starting point for data collection in recognition of the situated nature of the phenomenon under study. The aims of the study were to review the antecedents of humour, describe humour use and explore the use of humour within the interaction in relation to existing humour theories.

A range of data was collected (Fig. 1). However, the complexities of the phenomenon and the dynamics and contexts under study make it impossible to do the richness of the data collected justice in one condensed journal article. This paper therefore reports the grounded theory and is based on the data highlighted in bold, with the remaining data reported in full elsewhere.

Theoretical sampling identified a cohort of 12 Clinical Nurse Specialists who undertook 20 taped interactions with

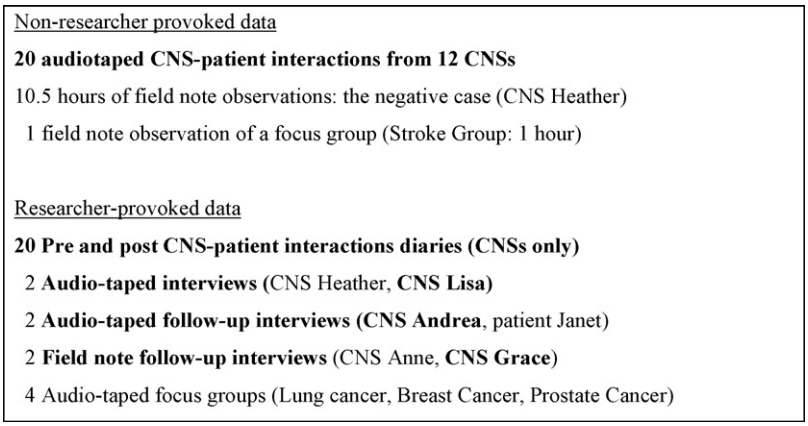

Fig. 1. Data.

patients and others[1] within a large National Health Service [NHS] Trust in a country of the United Kingdom. Theoretical sampling is unique in that it is not pre-determined rather it occurs in conjunction with data collection and analysis and exists to service theory development (Glaser and Strauss, 1967). An experienced CNS was recruited as the first participant as her taped interactions were thought likely to yield considerable data. Subsequent sampling aimed to encapsulate breadth of patients, disease, disease process, nurse characteristics and experience and thereby maximise variation. Theoretical sensitivity (Charmaz, 2006; Glaser and Strauss, 1967) was provided by the first author who had undertaken previous research with the target group (CNSs), the literature review and was an ex stand-up comedienne.

CNSs are nurses who are educated to degree level and above with specific expertise and/or experience in their respective specialities (Roberts-Davis and Read, 2001; Cameron and Masterson, 2003). They are an integral member of the multi-disciplinary healthcare team (Fischer, 2007) working across a range of specialities, e.g. diabetes, stroke, and cancer. CNSs are considered a key player in sustaining the human relations of healthcare (McCreaddie, 2001) and as such offer an ideal opportunity to study interactions with patients, specifically humour use.

3.2. Ethical issues

The principles of research governance were observed (SEHD, 2006) with all data stored securely in accordance with the provisions of the Data Protection Act (1998). All data was stripped of any identifying material and pseudonyms applied. Ethical approval from the local research ethics committee (LREC) was obtained in conjunction with relevant Research and Development permission.

3.3. Data collection and analysis

The CNSs were asked to identify patients who were fairly typical of their case-load, who were willing to consent to being recorded and were available on the days the CNSs had access to the tape-recording equipment. The CNSs were asked to exercise their professional judgement with regards to who would be appropriate to recruit and thus patients who were particularly unwell, in crisis or anxious were excluded.

All CNSs were asked to tape two interactions lasting a minimum of approximately 20 minutes. The first author met with the CNSs, providing information and obtaining written consent: the CNSs then provided written information for the patient participants and obtained written consent from the same. All participants were initially informed the study was broadly about 'communication.' The CNSs undertook a pre- and post-audio-diary by way of responding to questions contained in separate pre- and post-interaction sealed envelopes.[2] The latter envelope, however, specifically asked questions about humour use, thereby making the focus of the study more explicit to the CNS at that juncture.

The constant comparison method of data collection and analysis was applied (Glaser and Strauss, 1967). Data was also collected from two CNSs who were unable to recruit patients[3] and follow-up field notes and interviews with three CNSs. One patient was interviewed 7 months post-interaction.

Theoretical sampling was suspended at CNS 12 and interaction 20 not due to theoretical sufficiency (Dey, 1999) but in recognition of additional and different data being required to service theory development. This necessitated a further ethical submission to extend the

[1] 7 out of the 20 interactions involved 3 or more participants e.g. partners, spouses, daughters, sister in laws.

[2] Pre-interaction diaries requested information on the impending interaction, e.g. details of patient, participants, purpose, patients social network and whether the CNS had met with the patient before. Post-audio-diaries asked questions on the setting of the interaction, environment, layout, participants, etc. plus specific questions on CNS awareness of humour use, including smiling non-use, understanding, interpretation and reciprocation of either CNS or patient.

[3] Two CNSs unable to recruit were interviewed. One CNS worked in an acute palliative care setting while the other CNS worked with drug users in sexual and reproductive health. Unstructured interviews sought data on the CNSs' perceptions of reasons for non-consent as well as their views on humour use in CNS–patient interactions.

Table 1
Interpretive and illustrative framework (open coding).

Mode of analysis	Specific aspects	Explanation/application in this study
Humour theories	Superiority, Hobbes [1588–1679]'Social'	Humour used against self or others in some form, e.g. sarcasm, including SDH
	Incongruity, Kant [1724–1804] 'Cognitive'	Humour where there is a mismatch of content with context that is incongruous, e.g. ridiculous situations/procedures or abstract situations
	Release/Gallows, Freud [1856–1938] 'Psycho-analytical'	Humour that appears to function as a release of sorts without having the obvious focus of either superiority or incongruous humour. This however, also includes black humour, which clearly does have a focus. This humour may mask other motives or desires
Hay (2001) implicatures of humour support: e.g. humour support that is not necessarily laughter based	Recognition of humour, understanding of humour, appreciation of humour, agreement with humour	Examples: Contribute more humour; play along with humour; echo or overlap of speech or humour; offering sympathy/ contradict
Sacks, Schegloff and Jefferson (1974) and Jefferson (1979) – primarily laughter based	Text based transcription which looks for prosodical features of speech, primarily associated with laughter	Specific examples: Outbreaths "h" Inbreaths ".h" [see Fig. 2]

study period and to access other data sources (observation, interview and field notes).

The coding paradigm of Strauss (1987) and Strauss and Corbin (1990, 1998) was broadly invoked thus the data was analysed on three levels, open, axial and selective. Five passes of the transcripts were undertaken at the level of open coding with gerunds (action verbs), in vivo codes and constructs (nursing, psychology, social) being applied. It was clear early in the analysis that humour was integral to the interaction. Thus, an interpretive and illustrative framework, developed from the first author's theoretical sensitivity and the aims of the study in respect of antecedents and humour theories, was applied to the data (Table 1).

The interpretive and illustrative framework was used as a guide and to inform the analysis: to provide a degree of coherence to the analysis of a complex phenomenon. It was not applied or 'forced' upon the data but was a creative and logical approach derived from theoretical sensitivity. The three main humour theories, Hay's (2001) non-laughter based implicatures of humour support and the Jefferson system (Sacks et al., 1974: Fig. 2) of transcription have the potential to interpret or illustrate emerging data.

3.3.1. Humour support

Most humour research tends to focus on laughter as the indicator of 'humour support', e.g. Glenn (2003). Hay's (2001) humour support strategies arise from Conversation Analytic work and subscribe to the notion that language is performative and can be 'objectively' captured within talk (alone). This is at odds with GT and the notion of agency, processes, meanings and actions. No matter the tensions *and limitations* in Hay's (2001) humour support strategies – they remain the only other attempt to broaden the concept of humour support to that other than laughter. Thus, they are used as part of this interpretative and illustrative framework for that reason.

3.3.2. 'Discursive' grounded theory?

The application of a simplified version of the Jefferson (Sacks et al., 1974) system specifically is intended to illustrate relevant datum and provide further context that may or may not support the claim being made. It is therefore, *illustrative* rather than interpretive. Nonetheless, the use of naturally occurring interactions, the Jefferson system, Hay's humour support strategies and the application of other discursive features (e.g. opening, middle, closures, epistemic modalities) saw this approach lean more toward a 'discursive' grounded theory; an evolved form of constructivist grounded theory. This potential methodological development will be reviewed in a separate publication.

Each transcript/field note was reviewed for instances of humour using the above framework. The process, actions and interactions were compared with what the CNS reported as having occurred in the interaction via the CNS post-interaction audio diary.

A second interpretive framework was used in axial coding to assist in the abstraction of data adapted from Martin (2001's) psychological overview of humour. Strauss and Corbin's organising schema (1998) in combination with Clarke's (2005) guidance on integrative diagramming were used to provide a 'frame' and sort, shift, challenge the data as appropriate in axial coding.

Selective coding commences once the core category is selected (Holton, 2007). In this study the core category was 'the good patient', the main challenge being clarifying the role of 'positive coping' in relation to the good patient. *Theoretical sufficiency* (Dey, 1999) occurs when no new patterns emerge in the empirical data in combination with the researcher's theoretical sensitivity. This was considered to have occurred in this study due to (a) decreasing interrogation of data in conjunction with increasing abstraction, (b) sufficient time spent in the field (18 months) incorporating various

(.)	noticeable pause
(2)	timed pauses – in seconds
[	square brackes denote start of overlapping talk.
( )	unclear talk
(something said)	brackets with talk denotes possible text except in chapter seven (field notes) where further information is given regarding what is happening at this juncture.
So she=	equals sign shows that there is no discernible pause
=said	between one speakers turn and another, e.g. latching
>word<	inward arrows denote rushed-through speech
<word>	outward arrows denote slowed-through speech
So::o	colon mid word denotes stretched sound
LOUD	text in capitals denotes loudness in volume
emphasis	underscore of whole or part of word denotes speaker's emphasis
°soft°	degree symbols around text denotes softness in volume
.h	in-breath: full-stop precedes h
h	h without full stop preceding denotes out-breath
ha	denotes laughter particle (out-breath)
.ha	denotes laughter particle (in-breath)
→	analyst drawing reader's attention to significant line
£smile£	sterling signs around words denote smiley voice
1	numbering of transcript lines is done for convenience of author and reader. Silences may also be accorded separate numbering.

Fig. 2. Amended Jefferson transcription notation.

data sources, (c) the literature review being exhausted and (d) a negative case analysis being reviewed. The findings will now be presented in relation to the substantive theory: reconciling the good patient persona with problematic and non-problematic humour. Issues of reflexivity (Finlay and Gough, 2003) such as acknowledging the role of the researcher on the process and the latter being open to scrutiny were explicated via low non-consent/participation rates, triangulation of data sources, member checking and the negative case analysis.

4. Findings

The theory purports that patients' use humour to reconcile a good patient persona and establish and maintain a meaningful and therapeutic interaction with CNSs. The good patient persona is the sum of particular aspects such as compliance, sycophancy and positive coping being enacted to varying degrees within the situated context of the interaction. The good patient persona needs to be maintained within the interaction and is therefore, reconciled with potentially problematic or non-problematic humour. The 'good patient' theme as a core category explains the role of humour within this study and the theory attempts to differentiate between potentially problematic humour and non-problematic humour. The core category is therefore reviewed prior to a comprehensive analysis and discussion of problematic humour and briefly, non-problematic humour (Fig. 3).

4.1. The good patient persona

A number of factors may impact upon the patient's approach to establishing a relationship with the CNS and either augment, dilute or negate their inclination for presenting a 'good patient' persona. Consequently, the good patient theme is axiomatic across all interactions within the data but enacted in different ways according

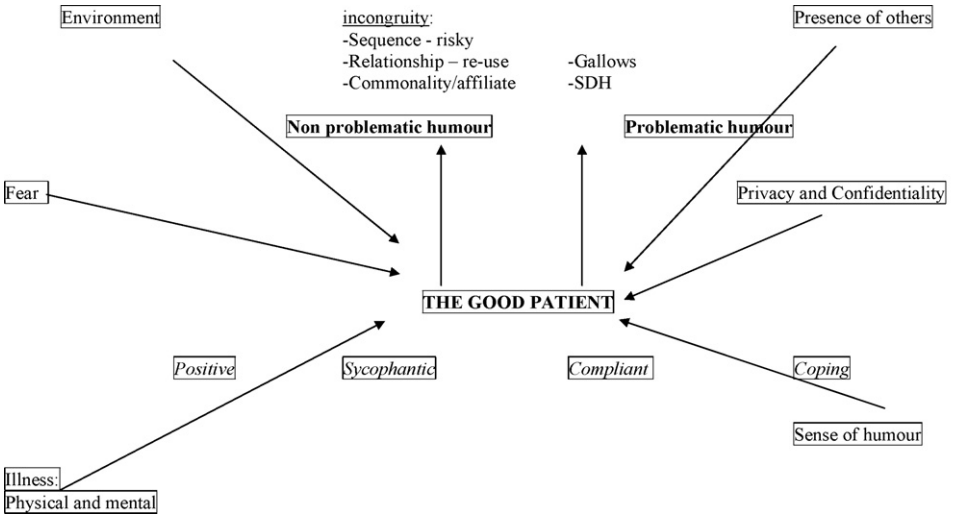

Fig. 3. Good patient and humour.

to the participants and contexts. There are therefore, different aspects to this persona that operate to varying degrees. Some patients may have one aspect, e.g. compliance or several (compliance, sycophancy, positivity, displaced concern). In addition, certain aspects of the persona such as compliance may be presented explicitly or implicitly and to varying degrees. Hence, some patients may present as overtly compliant whilst others may proffer implicit concordance or agreement. Nevertheless, all aspects of the good patient persona remain. Two specific aspects of the good patient persona; compliance and sycophancy will now be reviewed.

4.1.1. Compliance

Compliance is a central tenet of the good patient persona. A 'good' patient does what is expected and/or required of them, preferably without complaint and their compliance can be either implicit or explicit. Patients may indicate implicit compliance by simply attending at the scheduled appointment time. In this study patients indicated *simple compliance* by proffering single utterances of '*yes sister*', '*right*', '*okay*' in response to longer preambles or explanations by the CNS.

Compliance was also indicated in terms of agreement or concordance or in an overstated way through sycophancy. Concordance or agreement tended to offer a more demure, dignified expression of compliance, presenting it in a more palatable, equitable manner, giving the appearance of symmetry within the relationship. Sycophancy however, was also deeply rooted in compliance and was evident to degrees in all but one patient within the study.

4.1.2. Sycophancy

Patients may express sycophancy: a level of gratitude that was, at times, at odds with the level of help proffered. In the following extract Mr Preston is attending the Pain Clinical Nurse Specialist for a follow-up session on the use of a TENS machine.[4] In the preceding dialogue the CNS has indicated that some patients fail to attend scheduled appointments and how it is important to do so:

Extract 1

21:8a[5]

1→	*Mr Preston*[6]	*I know that's why I wouldn't miss it!!. On the whole, since I've met*
2		*you, since you've gave the pain machine and talking about it has*
3→		*been absolutely super*
4	*CNS*	*That's good.*
5	*Mr Preston*	*You've made me feel at ease and your enthusiasm about the pain*
6		*machine as well.*

Mr Preston offers a somewhat overstated response to attending the clinic. This elicits an affirmative response from the CNS [line 4] which is then followed up with more sycophancy and praise with regards to the CNS [lines 5 and 6]. Mr Preston's utterances are (a) explicit or overt (b) have overstated gratitude or sycophancy and (c) are grounded in compliance. Patients indicating compliance via sycophancy uttered superlatives that appeared somewhat

[4] TENS = trans electrical nerve stimulation. A small machine that emits signals that distorts the body's endogenous pain receptor pathway and therefore, reduces the actual pain felt.

[5] First number = participant sequence, second number = number of CNS and corresponding interaction, -/a/b = (a) represents first interaction, therefore focus unknown to both (b) represents second interaction, therefore focus known to CNS only, etc.

[6] Mr Preston was the only patient addressed by his surname within the interaction and across the cohort, hence the reason this has been replicated in the naming of the extract.

incongruous. It is not simple gratitude per se, as in Mr Preston is simply a grateful patient. It is the *overstated gratitude* that denotes sycophancy and the overstated gratitude being at odds with what is being discussed, e.g. a clinic visit (as opposed to a holiday).

The good patient persona invoked compliance, sycophancy and other aspects not discussed here (positive coping, displaced concern) to varying degrees. Arguably, the role of the CNS in terms of how she initiates and treats talk within the interaction, may be a significant factor in the extent to which the persona is enacted. Intentionality cannot be reviewed within a constructivist grounded theory approach only interpreted and illustrated based upon multiple data sources and theoretical sensitivity. However, follow-up data was obtained on three CNSs and one patient. That patient utilised the term 'good patient' unprompted in a follow-up interview to explain her perceptions *7 months after* her initial audio-taped interaction suggesting therefore, that the persona remained a potent and pervasive spur. A separate publication will fully explore that particular case.

It is posited here that an effective 'good patient persona' needs to be presented without contradiction or fear of contradiction. Any challenge or contentious feelings, opinions or beliefs most probably need to be reconciled without the good patient persona being unduly threatened. The following sections detail how humour reconciled the good patient persona.

4.2. Humour use in reconciling the good patient persona

Humour plays a pivotal role in both engaging and maintaining CNS–patient interactions and in managing complaints or feelings. Non-problematic humour is incongruity humour and affiliates, enhances and maintains interactions. Potentially problematic humour use may involve self-disparaging humour (SDH) or Gallows humour. Problematic humour disguises or conveys other meaning, making the 'encoded' humour presentation more palatable and subtle thus requiring the listener to decipher the presentation. Thus, while non-problematic (incongruity) humour facilitates the interaction, problematic (SDH, Gallows) humour deferentially packages complaints or feelings that may otherwise negate the good patient persona. It should be noted that not all SDH or gallows humour is considered problematic. *It is the way in which it arises within the interaction that denotes it as potentially problematic*. First, however, general aspects of humour use such as asymmetry and the identification of distinct humour preferences are briefly discussed.

4.2.1. General humour aspects of interaction: asymmetry

Patients were nearly twice as likely to initiate and reciprocate humour as the CNSs. The CNSs invariably denied that any humour use had occurred according to their first taped post-interaction diary. In the second taped post-interaction diary however, when the CNS was alerted to the focus of the study at hand, they were more likely to recognise humour use. Yet, despite increased humour awareness they remained unlikely to interpret the humour use, or on occasions, appeared to 'misinterpret' the humour use. Thus, humour was either simply dismissed as humour with no particular 'purpose' (e.g. anxiety or nerves) or it was perceived as something positive, e.g. coping, rather than something potentially negative, e.g. maladaptive coping or non-coping.

4.2.2. General humour aspects: distinct humour preferences

Humour use within the interactions was asymmetrical. Patients were either the principal initiators and/or reciprocators. In turn, given the purpose of the humour tended to match the type of humour used (e.g. affiliative = incongruity, encoded = self-disparaging) it is not surprising to note that patients' humour preference differed considerably from CNSs. Patients principally displayed SDH, gallows humour and thereafter, incongruity humour. Superiority humour that was not self-disparaging was rarely evidenced. Conversely, CNSs tended to utilise, in turn, superiority, incongruity, gallows and lastly, SDH.

4.3. Problematic humour use: SDH

SDH use by patients was not necessarily of itself an indication of 'encoding' taking place or potential problems. SDH use is not uncommon in everyday interaction (Hay, 2001). Nevertheless, it generally occurs as a single utterance within the course of an interaction with the preferred responses being contradiction, sympathy or compliment (Hay, 2001; Du Pre and Beck, 1997). What is being suggested from the data here is that *the humour use was potentially problematic*, when SDH:

(a) occurred several times during the course of relatively short timeframes;
(b) was primarily the province of the patient rather than the CNS;
(c) tended to exist in isolation or;
(d) primarily with gallows humour only.

At this juncture it is important to note that how the good patient persona is reconciled with humour is ostensibly a sum of parts. Extracts of the interaction may or may not evidence SDH per se. However, when presented as a sum of parts SDH is evident overall. The context, antecedents, CNS perceptions, patient perceptions, prosodical features of the interaction, laughter and utterances, taken together represent the action, processes and interaction. The following extract illustrates encoding or potentially problematic SDH use within a situated context.

A 55-year-old female patient with chronic back pain is meeting with the CNS who is describing the use of a TENS machine. The CNS is describing the more technical aspects of how the machine works immediately prior to the following utterances:

Extract 2

10; Carol 4b

1	*Carol*	*Well I've actually been ta:ae: a: (-) chi ropractor so I know a lot*
2		*about (-)*
3	*CNS*	*Ex:cellent=*
4	*Carol*	*=the different thi::ngs.h but that didnae help me either?.h*
5		*[he heh]*
6	*CNS*	*[ha I thi-] that*
7	*Carol*	*Two [thousand] pounds ah spent on [chiropractor] treatment=*
8	*CNS*	*[.h] [I]*
9	*CNS*	*°I think° (-) but sometimes you've just got to try*
10	*Carol*	*=OH a:h::d [try a::nything] to get rid of this pain 'cos*
11		*now it's >actually keeping me awake at night again<.*

Crucially, SDH was used unprompted by the patient several times within the context of a relatively short interaction to the exclusion of any other humour types. For example, two other specific instances (not reported here) replicated the SDH: one reported Carol's ineffectual attempts to manage her condition with exercise while another revealed she had lost her job due to her chronic back pain. In all three instances self-disparagement content is juxtaposed with positive prosody and overt humour use, effected by positive loud voice and post-construction stance laughter (Haakana, 2002). Thus, a negative content statement is delivered by Carol in a positive, quick and somewhat incongruous way that is ultimately self-mocking (e.g. self-disparagement if not SDH).

During the interaction Carol incrementally illustrated the extent of her chronic back pain with self-disparagement from failed treatments [lines 4, 7], [insomnia [line 11] to being unable to undertake specific work and latterly losing her job. In this extract the revelation of the insomnia is preceded by her desperate admission that she would try 'anything to get rid of this pain'. Her clear depiction of a serious and apparently deteriorating condition is effectively contrasted with her equally illustrative descriptions of her attempts at self-help and independence: from exercise to a considerable financial outlay on chiropractic treatment.

Carol is evidently keen to inform the CNS of the seriousness of her condition yet she simultaneously appears to emphasise that she is both compliant and responsible: in effect, a good patient. Carol's use of humour however, may arguably serve to diminish her apparent attempts at presenting the gravity of her situation to the CNS (Berger et al., 2004). The CNS after all, responds to the negative, tragic or self-disparagement utterances, not with the norm of an overt rebuttal or disagreement, but instead a reciprocal laugh and a positive affirmation of the patient's endeavours!

The CNS's interpretation of the patient's humour use is evidenced in her response to a post-diary question regarding whether there was much smiling taking place:

Extract 3

8: Elaine – CNS/post-diary 4b

1	*There was a lot of smiling, we got on very well. We were comfortable with each*
2	*other. We had a good visit and I would say that we both enjoyed this meeting*
3	*and I am very positive for the patient and I feel that she is positive about the*
4→	*TENS machine as well, so I would probably say it was very bright smiley sort of*
5	*interview.*

The CNS therefore, has no recognition of the self-disparagement evident in the interview but is instead aware of a positive ambience and warmth locating the corresponding humour use within that frame of reference. In those circumstances it may not be unreasonable for the CNS to respond with reciprocal humour and smiling. There were other examples of patients using SDH use repeatedly where the CNS response was either non-committal or certainly non-affirmative.

In the following extract a stroke CNS is interacting with a 'new' patient. The initial part of the interaction is very didactic with repeated question and answer adjacency pairs regarding medication and medical history. Preceding this dialogue the lady has revealed a considerable history of early deaths in the family from a variety of coronary and vascular disease, a husband who is disabled and a mother who has Alzheimer's Disease. In turn she has admitted forgetting medication and misplacing her purse, suggesting that it might just be 'old age'. All of those statements have been framed in SDH.

Extract 4

25.10b

1	*Rita*	*Well my daughter-in-law said to me last week can I put this stuff in*
2		*the microwave and I said I've not got a microwave. But I have got*
3→		*a microwave but I really thought at that time that I didn't have*
4		*a microwave .hha h.*
5	*CNS*	*Really.*
6→	*Rita*	*They were all laughing at me .ha.*
7	*CNS*	*Yeah?*
8	*Rita*	*But I have got a microwave.*

Here, Rita elevates her apparently 'encoded' concerns of her memory problems to a slightly higher level than perhaps simple forgetfulness. The patient's initial repetitive encoding of her concerns through SDH in the interaction, subsequently gives way to overt, direct questions of the CNS regarding whether she may or may not have Alzheimer's Disease.

There are clear similarities between extracts 2 and 3. First, how the SDH emerges within the course of the interaction and how it appears repeatedly over a relatively short period of time is similar. Second, each provides an account of the patient's world to the CNS, patients concerns are therefore, exhibited in the midst of volunteering narrative (Beach et al., 2005).

Third, both patients are compliant and sycophantic to a degree and appear to be both positive and 'coping'. The latter image is acutely conveyed, somewhat paradoxically, through negative content presented in positive tones. Finally, the humour initiated by the patients is exclusively self-disparaging. Where the two interactions differ is in the respective CNSs' response to the repeated use of SDH use: one of whom positively affirms the self-disparagement whilst the other offers a relatively neutral response.

Juni and Katz (2001) cite SDH as being as self-effacing in relation to oppressed groups (e.g. Jews) while Zajdman (1995) suggests that an admission of defect conversely exhibits strength. However, Sala et al. (2002) identified doctor-initiated SDH in high satisfaction visits with patient-initiated SDH predominating in low satisfaction visits, suggesting that SDH may be affiliative in the former but problematic in the latter.

In the above extracts SDH appears to have been used to (a) alert the CNS to new symptoms, (b) convey the seriousness of existing symptoms or (c) the worsening of symptoms. SDH may allow the patient to present these issues to the CNS whilst still being viewed as a good patient. Nonetheless, the CNS may lack awareness, fail to 'decode' the humour use, or possibly (mis)interpret the humour use as 'humour use as positive coping'. Thus, how SDH is treated in interaction is crucial to whether patient's concerns are resolved or not.

4.4. Problematic humour: gallows

Gallows humour was also evident as patients sought to 'encode' fear and anxieties amongst other possible interpretations. Unsurprisingly gallows humour was most in evidence in patients dealing with terminal conditions such as cancer. In several instances gallows humour tended to co-exist with SDH to the exclusion of other types of humour in respect of patient initiation. At other times however, it existed in isolation although not in the repetitive way in which problematic SDH presented. Clearly, gallows humour is a sensitive issue and who initiates this humour may partly determine its appropriateness. If a patient is dying, knows they are dying and chooses to use gallows humour then it may be, in effect, a kind of permission for others to recognise and verbalise that fact (e.g. awareness contexts, Glaser and Strauss, 1965). However, like most humour presented thus far, the following extracts demonstrate that humour is highly contextual and situational.

In the next extract the CNS is describing a patient with whom she had a taped interaction and subsequent follow-up. Two aspects are worth noting with regards to these taped interactions. Both were undertaken in the patient's own home and were the longest of all of the taped interactions in the cohort.

Jeff is a relatively fit 70-year-old man with advanced lung cancer who lives with his wife. The CNS has known Jeff and his wife since his diagnosis over 18 months ago and describes him in both her pre-interaction diary and follow-up interview as '*an intensely private man*' who has a relatively limited social network. In addition, she suggests that *'other health care professionals can find them quite difficult particularly when his illness isn't going too well*'.

Andrea (the CNS) was interviewed following an initial pass of the transcripts and was therefore able to give an update on Jeff's situation. She reported that Jeff had been seen at the clinic several weeks after the initial taped interaction. Following a scan he was informed by medical staff that his prognosis had worsened considerably. He then specifically asked to see Andrea whereupon he greeted her with;

Is that me in my box then .hha?

Andrea was asked for her interpretation of his use of gallows humour at that juncture and how she responded to it:

Extract 5

4:1a f/up

1	*He was scared*
2	*He was trying to get reassurances from me that he wasn't*
3	*going to die imminently. 'Am I in my box?' Do I look like a*
4	*corpse sitting in my box?' No you don't Jeff, but we need to*
5	*stay focused here. I need to go and speak to your wife.*

Further discussion with Andrea elicited that she believed Jeff was ostensibly looking for her to deny the

undeniable by reciprocating his humour. Andrea was someone who did both initiate and reciprocate humour however, on this occasion *chose* not to. This is in stark contrast to the following extract where the same CNS chooses to initiate gallows humour which was, as noted previously, extremely rare within the CNSs in this cohort.

Rena is a 66-year-old woman with advanced lung cancer with cerebral metasteses. Andrea has known Rena since her diagnosis over 2 years ago. Rena is, unlike Jeff, someone who is overtly compliant and has an extremely well developed social network. She is however, an extremely private individual and according to Andrea did not tell her family or friends of her illness until all the investigations were completed. When consenting to the study she specifically asked whether names would be used in reporting the results of the study, as did Jeff. Despite her well-developed social network she attends the clinic on her own.

This taped interaction had a considerable amount of humour and laughter that was reasonably diverse, in that it was symmetrical, used different types and was initiated and reciprocated in turn. Andrea admitted in the follow-up interview that she had a concern that Rena had '*her disease all compartmentalised*' and had not fully come to terms about her illness and her impending death. The following extract therefore, is notable because Rena has been discussing in some detail and with some humour, the arrangements for her funeral including her pre-ordered biodegradable cardboard coffin and invited guests:

Extract 6

3.1b

1	*Rena*	*There is one person who might come and I'll tell you something, if she*
2		*thinks that's she's there so that I'll forgive her I'll tell you, I'll sit up and tell*
3		*her 'you bugger' no I've not forgive you and I'll never will. [laughter]*
4	*CNS*	*She might not come then?*
5	*Rena*	*Well I'v said to her sisters not to come, the bitch, I said I don't want the*
6		*bitch near me.*
7	*CNS*	*She might not appear then.*
8	*Rena*	*I don't think so, I don't think she has the cheek.*
9→	*CNS*	*She'll be frightened you'd come back and haunt her.*
10→	*Rena*	*.h Oh fuck and I will. Ha ha I know myself, in plain words, she*
11		*would be 'shit scared. So it would suit if I came back and haunted*
12		*her.*

The possible presence of the unnamed woman at her funeral is clearly causing Rena some concern. In this context however, Andrea has known Rena for over 2 years, has seen her numerous times, is aware of her highly developed sense of humour and the preceding dialogue had featured numerous humorous references centring on black or gallows type humour. In some respects the situation is such that Andrea's initiation of gallows humour is simply a continuance of a previously negotiated and accepted parameter of discussion. The antecedents therefore, may be considerable explanatory precursors to Andrea's initiation of gallows humour. Rena also appears to provide humour support in lines 10–12 thereby apparently fully endorsing the humorous concept.

While the contexts including the antecedents are key to how humour is initiated and reciprocated in this instance, the actual use of humour may determine how or what is discussed. Slightly later in the taped interaction Rena tentatively raises new issues such as pain control at the end of life and the 'afterlife' with Andrea. These discussions see Rena breaking down, reportedly for the first time and suggest that, for Rena, Andrea's willingness to invest time, effort and crucially humour, may partly have 'allowed' her to do so.

Gallows humour has been reviewed elsewhere as subversive in relation to AIDS patients (e.g. De Moor, 2005) or prisoners of war (Henman, 2001). Chapple and Ziebland (2004) and Moynihan (1987) have commented on how humour (not necessarily gallows humour) may dissimulate motives and feelings particularly from next of kin. Feinberg (1995:87) notes that black humour 'simultaneously appeals and appals.' In some instances therefore, it may be affirmative or even triumphant (e.g. extract 6) while in others it may be potentially problematic (Jeff, extract 5). The latter promulgating the unspeakable for affirmation, denial or re-assurance. Either way, *it is the way in which it arises within the interaction that denotes it as potentially problematic or non-problematic*.

4.5. Non-problematic humour: incongruity

Incongruity humour was perceived as being unproblematic in CNS–patient interactions because it was easily recognisable as humour and was generally based upon a shared commonality (e.g. hospital associated). It therefore, tended to be more explicit as it more closely resembled a traditional 'joke' (e.g. word play). It was therefore, not 'encoded' or packaged. It was more identifiable, understandable (to both parties) and consequently it was more likely to be reciprocated.

There appeared to be three levels of incongruity humour (a) affiliative incongruity based upon shared commonalities, (b) relationship-building re-use of previous incongruity humour and (c) incongruity initiating a sequence of more risky humour use. Incongruity humour was important in maintaining, enhancing or humanising the interaction (Dean and Major, 2008) and was therefore, *more recreational than revealing*.

4.6. Limitations

This study presents a robust and explicit review of the phenomenon in situated contexts. Nonetheless, as with all theoretical frameworks and corresponding research methods, there are limitations (Burns and Grove, 2001). First, the study would have benefited from more follow-up of

patients' perspectives on the interaction and the phenomenon. Second, this study was carried out in a particular geographical area of the United Kingdom. The results therefore, may be culture-specific (Davies, 2002). Third, the interpretative and illustrative framework may have limited and forced data. However, the absence of such a framework would have rendered this humour study, like many others, irrelevant, lacking robust meaning and therefore, non-applicable. Finally, the data presented here is diverse, complex, highly situational and open to numerous interpretations.

5. Conclusion

There are two key aspects highlighted within the theory presented: the good patient persona and the role of humour in reconciling this persona.

Current political rhetoric, specifically in the UK (Department of Health, 2001) and elsewhere (e.g. International Association of Patients' Organisations) supports 'patient involvement' and is reviewed in various forms within the literature, e.g. participation (Collins et al., 2007), decision-making (Entwistle et al., 2004), compliance, and concordance (Pollock, 2005). Patients however, may want something that is more than 'just' a healthcare interaction; something that goes beyond political rhetoric and is enacted in situated nurse-patient interactions.

We suggest that this patient cohort is not necessarily conscious of, nor deliberate in creating a good patient persona presentation. The philosophical underpinnings of a constructivist grounded theory approach make any claim to knowing the participants' internal cognitive state untenable, in any case. Equally, from a 'discursive' perspective, whether the patients' present an unconscious or conscious presentation is less important than how it is perceived and addressed within the interaction. We would argue that the good patient persona and the reconciling role of humour is a complicated presentation arising out of the vicissitudes of social processes as they are locally situated and produced.

The middle-range theory presented differentiates potentially problematic humour from non-problematic humour and notes that how humour is identified and addressed is central to whether patients concerns are resolved or not. CNSs and other healthcare professionals therefore, need to be aware of humour use, its interpretation and appropriate response in order to effect a meaningful and therapeutic interaction. Finally, this study develops and extends humour research and contributes to an evolved application of constructivist grounded theory.

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None declared.

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