

Hope, Laughter, and Humor in Residents and Staff at an Assisted Living Facility

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Possessing hope and utilizing laughter and humor to cope with life's stressors and losses are especially important to elderly people as they experience a decline in their independence. In this study, hope levels and laughter and humor experiences of 24 elderly residents (ages 69 to 96 years) and 21 staff at an assisted living facility were assessed and compared. Hope was defined as a two-factor cognitive construct that involves (a) Pathways, an individual's ability to set goals and devise multiple plans to reach them, and (b) Agency, an individual's inner determination to implement these plans and overcome obstacles to the goals. Both residents and staff had high total Hope and Pathways scores, but residents' Agency scores were significantly higher than staff's. Residents and staff reported numerous benefits from humor and laughing, but differences arose between the two groups about the sources and frequency of humor and laughter. Differences were found between more-hopeful and less-hopeful respondents in regards to sources of laughter, benefits of laughing and playing more, and the last time they laughed. Implications for mental health counselors are discussed.

Substantial numbers of older adults experience a decline in independence and an increased reliance on caregivers. Of those aged 80 or older, 1 in 4 will be institutionalized because of needing assistance with day-to-day activities (Human Capital Initiative, 1993). This loss of independent living may negatively impact a person's mental health, thus reducing his or her ability to cope (Rybash, Roodin, & Hoyer, 1995). Evidence suggests that those who are hopeful cope most successfully with life's adversities (Farran, Herth, & Popovich, 1995; Menninger, 1959; Nowotny, 1991; Snyder, Harris, et al., 1991). Various scholars have written about the salutary effects of hope on physical and mental health (Averill, Catlin, & Chon, 1990; Cousins, 1989; Farran et al.,

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This study was supported by a research fellowship from Rider University. The author is grateful to the following students enrolled in the master's degree program in Counseling Services, Rider University: research assistant Joseph DiFrancesco and interviewers Patricia Brower, Kerith Glass, Melissa Johnson, Jenifer Kucsan, Daniel Martin, Schinita Melvin, Jennifer Peck, and Stephanie Schneier. Thank you also to Susan Thomas for help with statistical analysis and editing; to Holly Nemiroff for data analysis; and to the residents and staff of the participating assisted living facility.

1995; Schreier & Carver, 1985; Snyder, 1994; Snyder, Irving, & Anderson, 1991). The consensus among these writers has been that hope is related to goal-directed actions, but the research has provided little detail about the means of pursuing these goals. Snyder, Harris, et al. (1991) expanded this scholarly view of hope to include another aspect: inner determination. This model of hope is a two-factor cognitive construct consisting of a pathways component and an agency component. The pathways component involves a person's belief that he or she can set goals and devise multiple ways to reach them. Both short-term and long-term goals should be of value and be challenging but attainable. Once goals are set, a person's thoughts are focused on his or her ability to plan ways to reach these goals. When a route to a goal becomes blocked, those who are more hopeful devise alternate ways to pursue them. If a goal is permanently blocked, higher-hope people set a substitute goal that is satisfying. The agency component involves the person's conviction that he or she has the inner determination to implement these plans, even when faced with obstacles. Successful steps on the pathway towards a goal fuel a person's inner determination that, in turn, propels further progression towards the goal. To have a high hope level, a person must activate both components.

This cognitive model of hope (Snyder, Harris, et al., 1991) provides a positive psychological framework to study people's strengths that buffer them from life's stressors as well as enhance their overall well-being (Seligman, 2002). Over 40 hope studies based on this model of hope have been conducted over the past 12 years (Snyder, Rand, & Sigmon, 2002). Findings suggest that people who are more hopeful, when compared to their less-hopeful peers, recuperate more quickly from physical injury and adjust better to chronic disease or illness (Elliott, Witty, Herrick, & Hoffman, 1991; Tennen & Affleck, 1999); experience less pain (Snyder, Brown, Hackman, & Odle, 1999); feel less depressed (Elliott et al.; Irving, Crenshaw, Snyder, Francis, & Gentry, 1990) and less anxious (Snyder, Harris, et al.); cope better through increased problem solving (Snyder, Harris, et al.); experience less burnout at work (Sherwin et al., 1992); have excellent social support networks (see Snyder, 2000); rely on inner determination to cope with life's stressors (Westburg, 1999a); and use humor to cope with life's stressors (Snyder, 1994). Although research concerning hope among elderly people is scant, studies have shown that significant others and healthcare providers may influence older adults' hopefulness (Resnick, 1996; Westburg, 1999a, 2001). In assisted living environments, maintaining hope-enhancing relationships among elderly women and their caregivers was particularly important (Westburg).

It is important, therefore, to promote overall well-being and to enhance hopefulness through preventive, pro-active strategies (Seligman, 2002). Two such strategies are laughter and humor (Lefcourt & Martin, 1986; Seligman;

Vailliant, 1977). Research suggests that laughter and humor strengthen relationships, reduce tension (Seltzer, 1986), elevate depressed mood (Cann, Holt, & Calhoun, 1999), improve physical well-being (Fry, 1994), and help people to relax (Herth, 1993). More specifically, cancer patients reported health-enhancing effects from participating in a humor support group (Cousins, 1989). Furthermore, those working in healthcare facilities use laughter and humor to cope with on-job stress and prevent burnout (Hutchinson, 1987; Lemma, 2000; Lipson & Koehler, 1986; Peterson, 1992; Warner, 1991).

As clinical experience and research accumulates on the health-related benefits of laughter and humor (Anderson & Arnoult, 1989; Carroll, 1990; Cousins, 1979; Fry, 1994; Lemma, 2000; McClelland & Cheriff, 1997; Saper, 1988), more healthcare facilities are incorporating laughter and humor interventions into their service-delivery programs (Cousins, 1989; Erdman, 1993; Lemma). For example, one researcher developed the Funny Bone History, a short questionnaire that assesses patients' laughter and humor experiences, so clinicians can write laughter and humor prescriptions for their patients and clients (Cousins, 1989; K. A. Herth, personal communication, September 8, 1998). Throughout the United States and Canada, pain centers, outpatient adult and adolescent centers, cardiac surgical units, departments of psychiatry, cancer support groups, chronic obstructive pulmonary disease support groups, and family cancer camps have used the Funny Bone History. According to Herth (K. A. Herth, personal communication, February 27, 2002), "I have received many reports from investigators using the Funny Bone History about its effectiveness and usefulness," but no studies have been reported in the literature.

Even though laughter and humor provide beneficial effects, research is lacking on how these interventions benefit institutionalized elderly people and their professional caregivers. Also lacking are studies that have investigated whether there are differences in laughter and humor experiences between more-hopeful and less-hopeful individuals. The current study was an investigation of hope levels and laughter and humor experiences of residents and staff at an assisted living facility. The following questions were examined: (a) How hopeful are the residents and staff of the assisted living facility? (b) Are there differences in hope levels between residents and staff? and (c) Are there differences in frequency, sources, and perceived benefits of laughter and humor between residents and staff and between more-hopeful and less-hopeful people?

METHOD

Participants

Research participants consisted of 24 residents (18 females and 6 males) who live at a Catholic, assisted living facility and 21 staff (20 females and 1 male) who worked at the facility. All participants were volunteers. The age range of residents was 69 to 96 years, with a mean age of 85.6 ($SD = 6.7$). Twenty-three were Caucasian and 1 gave no answer. Twenty-one were Catholic, 1 was Protestant, 1 was of another religion, and 1 gave no answer. The range of years that residents lived at the facility is 0.5 to 24.5 years, with the mean years of 3.9 ($SD = 5.2$).

The age range of the staff was 25 to 71 years, with a mean age of 46.7 ($SD = 12.8$). Sixteen were Caucasian, 3 were Black, 1 was Hispanic, and 1 gave no answer. Twelve were Catholic, 6 were Protestant, 2 were of another religion, and 1 had no religious affiliation. Their occupations include 5 nurses, 6 nurse's aides or assistants, 3 administrators, 5 administrative assistants, 1 director of activities, and 1 counselor. The range of years that the staff had worked at the facility was 1 to 21 years, with a mean of 8.0 years ($SD = 7.0$).

Measures

The Hope Scale. Snyder, Harris, et al.'s (1991) two-factor hope construct was measured by the Hope Scale, an individual differences, self-report measure consisting of 12 items. The Agency subscale and the Pathways subscale each include four items, and four items are fillers. Each item is rated on a 4-point Likert-type scale (1 = definitely false, 2 = mostly false, 3 = mostly true, 4 = definitely true). Scores for total hope are obtained by adding up the points for Agency items (e.g., "I energetically pursue my goals") and Pathways items (e.g., "There are lots of ways around any problem"). The filler items (e.g., "I am easily downed in an argument") are not added to the total score. The range of possible scores for total Hope is 8 through 32 and the range for Agency or Pathways is 4 through 16.

In six validation studies (Snyder, Harris, et al., 1991), the ranges of means were as follows: 25.08 to 25.64 for total level of Hope; 12.55 to 12.83 for Agency; and 12.53 to 12.81 for Pathways. In this study, Cronbach's alphas were .74 to .84 (item-remainder coefficients of .23 to .63) for total Hope Scale, .71 to .76 (item-remainder coefficients of .40 to .72) for the Agency subscale, and .63 to .80 (item-remainder coefficients of .36 to .63) for the Pathways subscale. The temporal stability of Hope Scale scores, as estimated by test-retest procedures, was .85, $p < .001$, over a 3-week interval; .73, $p < .001$, over an 8-week interval; and .76 and .82, respectively, $p < .001$, over 10-week intervals on two samples. Principal-components exploratory factor analyses with oblique rotations were performed on the eight Hope Scale items. The Agency

subscale generally showed high loadings on Factor 1 but not on Factor 2, whereas the Pathways subscale generally showed high loadings on Factor 2 but not Factor 1. The two factors account for 52% to 63% of the variance across the samples. Even though factor analyses seem to reflect two separable components of the Hope Scale, the Agency and Pathways scores were shown to correlate positively in eight studies. Correlations ranged from $r = .38, p < .57$ to $r = .57, p < .001$. Correlating scores on the Hope Scale with existing scales that measure similar constructs provide evidence of convergent validity. Dispositional optimism, as measured by the Life Orientation Test (Scheier & Carver, 1985), correlated with the Hope Scale $.60, p < .005$ and $.50, p < .005$. The Generalized Expectancy for Success Scale (Fibell & Hale, 1978), which assesses cross-situational expectancies for attainment of goals, correlated $.55, p < .005$ and $.54, p < .005$ with the Hope Scale. The Burger-Cooper Life Experiences Survey (Burger & Cooper, 1979), which measures desirability of control, had a correlation of $.54, p < .005$ with the Hope Scale. Correlating scores on the Hope Scale with existing scales that measure an opposite construct provides evidence of divergent validity. The Hope Scale correlated $-.51, p < .005$ with the Hopelessness Scale developed by Beck, Weissman, Lester, & Trexler (1974). Studies corroborated that goal-predicted behaviors provided additional evidence of construct validity for the Hope Scale. Higher-hope subjects reported more agency (the sense of inner determination or successful goal-related energy) than lower-hope subjects, with the main effect of hope level being significant. When faced with obstacles to goals, higher-hope subjects exhibited more pathways (a sense of successful goal-directed planning) than lower-hope subjects, with the interaction of hope level and treatment being significant. Studies conducted to validate the Hope Scale found no sex differences in level of reported hope (Snyder, Harris, et al., 1991).

The Funny Bone History. In 1984, Herth (K. A. Herth, personal communication, September 8, 1998) developed this 11-item open-ended questionnaire, which has been used in hospitals and medical facilities throughout the United States and Canada to assess patients' and clients' experience of laughter and humor (Cousins, 1989; K. A. Herth). Herth (personal communication, February 27, 2002) reports that there are no hard psychometric data for the questionnaire. Sample questions are "When was the last time you had a good laugh?" and "What role did humor play in your family while growing up?"

Procedure

An administrator of the Catholic, assisted living facility provided a list of residents. Nine trained interviewers in a master's degree counseling program individually interviewed the residents. Each interviewer was given a list of residents to contact. Of the 48 residents contacted, 30 participated in the

study, for a 62.5% participation rate. Demographic information was collected from each participant by completing the Demographic Data Sheet. The research assistants recorded the residents' answers on the Hope Scale and the Funny Bone History. The completed forms were returned to the researcher; 24 were valid and 6 were invalid because participants did not respond to all the Hope Scale items.

The staff was sent a packet of information that included a letter, a form, the Hope Scale, The Funny Bone History, the Demographic Data Sheet, and a reply envelope. Of the 108 employees who were sent the packets, 15 responded to the first mailing and 6 responded to the second mailing, with a 19.5% response rate.

RESULTS AND DISCUSSION

Residents' and Staff's Hope Levels

The first research question was how hopeful are the residents and staff of the assisted living facility? For residents' Hope Scale scores, the means were: total Hope 26.17 ($SD = 3.04$), Pathways 12.04 ($SD = 2.35$), and Agency 14.13 ($SD = 1.68$). The staff's score means were: total Hope 25.90 ($SD = 2.76$), Pathways 12.86 ($SD = 1.77$), and Agency 13.04 ($SD = 1.50$). Based on Snyder's (1994) report that total Hope scores of above 24 indicated high hope levels and below 24 indicated low hope levels, 18 residents and 13 staff were considered higher-hope people, and 6 residents and 8 staff were considered lower-hope. The residents' scores on the Hope Scale indicated high hope levels, with high levels of goal-directed pathways cognitions and extremely high levels of inner determination (agency). Although previous researchers found no gender differences in Hope Scale scores (Snyder, Harris, et al., 1991), four of the six male residents in this study had low hope levels, with three of the men obtaining the three lowest hope scores in the sample. This finding may be due to the small sample size or may indicate that these institutionalized elderly men had lost some of their hopefulness when they lost living independently.

Comparison of Residents' and Staff's Hope Levels

To examine the second question if there were differences in hope levels between residents and staff, three two-sample t tests were conducted. These analyses indicated a significant difference, with a large effect size, between the residents' and staff's Agency scores ($t = 2.26$, $df = 43$, $p < .05$, $d = .68$). However, there were no significant differences between the residents' and staff's total Hope scores ($t = 0.30$, $df = 43$, $p > .05$, $d = .09$) and Pathways scores ($t = -1.30$, $df = 43$, $p > .05$, $d = .39$). These findings indicate that the residents had a higher degree of inner determination than did the employees. Even

more remarkably, the residents' Agency scores were higher than those of eight validation samples (Snyder, Harris, et al., 1991) and all the samples in six studies conducted by this current researcher (Westburg, 1999a, 1999b, 2001; Westburg & Boyer, 1999; Westburg & Guindon, 2001; Westburg & Martin, in press). According to a spokesperson at the facility, most of the residents chose this assisted living facility because it offers daily Catholic mass at the in-house chapel. Thus, a plausible explanation of the exceptionally high Agency scores may be that the religious services and environment enhanced residents' inner determination or hope energy. This suggestion is consistent with research indicating that prayer was positively related to increased hope energy (see Snyder, 1994).

Summary of Funny Bone History

Comparison of Responses Among Higher- and Lower-Hope Staff and Higher- and Lower-Hope Residents

Responses	Staff		Residents	
	HH (n = 13)	LH (n = 8)	HH (n = 18)	LH (n = 6)
Benefits of laughter*:				
Beneficial	12	8	16	6
No response	1	0	2	0
Benefits of laughing and playing more:				
Beneficial	8	5	136	
No change	4	1	4	0
No response	1	2	1	0
Sources of laughter*:				
Everyday happenings	7	2	10	0
People				
Family	2	3	2	0
Friends	2	1	1	0
Others	2	2	1	2
Entertainment	4	4	3	3
Pets	0	2	0	0
Don't laugh	0	0	1	0
No response	0	0	1	1
Sources of laughter today*:				
People				
Family	3	5	1	0
Friends	0	1	1	0
Others	3	1	1	0
Activities	1	1	4	1
Entertainment	1	2	1	0
This study	2	0	4	0
Other	2	1	3	1
Nothing	0	0	1	1
No response	2	0	3	3

Frequency of laughter:				
Daily	6	5	7	1
Often	5	3	4	1
Seldom	0	0	6	2
Vague	0	0	1	1
No response	2	0	0	1
Last time you laughed:				
Today	5	4	7	0
Yesterday	3	2	1	2
Recently	1	2	2	2
Long ago	0	0	2	1
Other	1	0	3	0
No response	3	0	3	1
Last time you played:				
Today	4	3	2	1
Yesterday	3	3	2	1
Recently	3	2	3	1
Long ago	1	0	4	3
Other	0	0	4	0
No response	2	1	3	0
Value and frequency of humor in family:				
High	9	4	12	5
Moderate	1	3	0	0
Little	0	0	6	1
No response	3	1	0	0

Note. HH = higher-hope; LH = lower-hope.

* Respondents may give more than one answer.

Comparisons of Laughter and Humor Experiences

In order to examine the third research question (are there differences in frequency, sources, and perceived benefits of laughter and humor between residents and staff and between more-hopeful and less-hopeful people), content analysis, an inductive analysis procedure (Patton, 1990), was used to identify categories from the answers to the Funny Bone History questionnaire. The primary researcher derived categories by sorting the data and placing similar answers together (see Table). A professional counselor (experienced in qualitative analysis) examined the inquiry process and reviewed the data to confirm the credibility and trustworthiness of the categories (Lincoln & Guba, 1985). Differences arose on the coding of 7 of the 406 responses and were resolved by re-analyzing the data until consensus was reached. The questions and categories along with relevant differences between residents and staff or between higher- and lower-hope people were as follows:

1. Benefits of laughter. When asked how they felt when they laughed, the respondents reported beneficial effects such as feeling relaxed, good,

happy, healthy, relieved, superb, wonderful, light-hearted, and energized. There was overwhelming agreement between residents and staff, regardless of hope level, that they benefited from laughing. Thus there were no differences in perceived benefits of laughter based on hope levels. The literature also provides support for the health-enhancing effects of humor and laughter.

2. Benefits of laughing and playing more. Regarding how they would feel if they laughed and played more, the respondents reported: (a) the benefits of feeling healthier, younger, happier, better, great, more energetic, more positive, more relaxed, less stressed, and less anxious; and (b) no change. Almost three fourths of the respondents said they would feel better if they laughed and played more. Even so, eight higher-hope respondents said they would feel no different. However, their responses ("I do a good deal of laughing and playing," "A lot of things make me laugh now," "There is too much ... already.") indicated they already felt great because they laughed much of the time. Thus higher-hope people when compared to lower-hope people already were experiencing the benefits from frequently laughing and playing.
3. Sources of laughter. Regarding what they found humorous and what made them laugh, participants' responses were categorized as follows: (a) everyday happenings, which included funny situations, most things, spontaneous things, anything, real-life situations that are amusing; (b) people; (c) entertainment, which included movies, jokes, comedians, television, funny stories, and one male resident said sports; (d) pets; and (e) don't laugh. Even though the most frequently named source of laughter was finding humor in everyday happenings, there were differences between higher- and lower-hope respondents. More specifically, the majority of the higher-hope residents and staff said "most things" or "real-life" situations made them laugh, whereas none of the lower-hope residents responded this way. It seems, therefore, that humor was generated by an internal stimulus rather than external stimuli such as entertainment and other people. The ability to find humor in everyday situations as a source of humor seems to be an inner strength that helps these people to feel positive when faced with the stressors of institutional living. This finding is consistent with other research that showed higher-hope elderly women relied on inner determination (the agency component of hope) to get them through difficult times (Westburg, 1999a). In addition, the second most popular source of humor and laughter was interacting with family members and other people. Staff indicated they enjoyed having fun with family and friends outside of work. Likewise, residents said they too enjoyed visits with their family members, which is consistent with an earlier study with elderly nursing home residents who cited family as a source of support (Westburg, 1999a). Finally, the third most pop-

ular source of humor, equally preferred by higher- and lower-hope individuals, was entertainment. It is important to note that humor preferences are different for each individual and may become even more diverse as people age (Thorson, Powell, Sarmany-Schuller, & Hampes, 1997).

4. Sources of laughter today. Regarding what would make them laugh today, participants' responses fell into the following categories: (a) people, which included family, friends, and others; (b) activities, which included playing the piano, playing cards, and going on a trip; (c) entertainment, which included listening to music, watching television or a movie, and listening to the radio; (d) this study, which included completing the Funny Bone History, "Nothing, until you came in to do this study," and "I laughed during your visit"; (e) other, which included anything, "If I got a raise—just kidding," and "If I could get up from here and walk"; and (f) nothing. Although the most popular answer to this question for the staff was being with family and friends, only three higher-hope residents named family and friends. One explanation for this difference may be that the residents are less mobile than the staff. Residents who enjoy visiting with their family and friends may have to wait for visitors to come to them and did not expect any on the day they completed the questionnaire. Alternatively, the most popular response by residents about what would make them laugh today was participation in activities, which included playing cards, taking a trip or outing, and playing the piano. It seems that activities are important to residents whose opportunities to be with family and friends are limited. Nevertheless, three fourths of the male residents (one with higher hope and three with lower hope) and a small fraction of female residents (three with higher hope and one with lower hope) did not respond or could not name anything that would make them laugh today. Perhaps these residents, especially the men, could not think of any sources of laughter because the activities scheduled that day did not match their interests or skill level. According to Nahemow (1986), older people have growth potential and need stimulating activities. Thus, what at first was interesting may over time become static and dull, which results in some residents becoming morose, withdrawn, and unable to find amusement in their environment. Rather, environments need to grow with the residents so they can look forward to enriching and humor-enhancing experiences. What was surprising was the number of respondents who found participating in this study as a source of humor. Perhaps the Funny Bone History questionnaire had a positive iatrogenic effect on the respondents.
5. Frequency of laughter. Regarding the question of how often they laughed, participants' responses fell into the following categories: (a) daily; (b) often, which included a few times a week, as often as possible, very often, once a week, and three times a week; (c) seldom, which included not often,

not recently, and "It doesn't happen too often because I don't see people to converse"; and (d) vague, which included "it depends" and "Whenever I hear something funny." Staff and residents differed in regard to the frequency of their laughter. Although all of the staff and over half of the residents indicated they laughed "daily" or "often," approximately 33% of the residents, both higher- and lower-hope respondents, said they seldom laughed. One explanation is that administration was in transition. This situation may have caused anxiety among the staff that negatively affected their interactions with the residents. The staff, however, found opportunities to laugh when they left the facility, but the residents lived there and did not have similar opportunities for daily outside diversions.

6. Last time you laughed. Participants' responses were assigned the following categories: (a) today; (b) yesterday; (c) recently, which included a few days ago, a week ago, and a couple of weeks ago; (d) long ago, which included 6 months ago, now and then, and a long time ago; and (e) other, which included "before my boyfriend and I broke up," "I had a good laugh with friends," and "a visit from my grandchildren and great-grandchildren." Even though most staff and residents indicated the last time they had laughed was "today" or "recently," no lower-hope residents said they had laughed "today." This finding is consistent with other research that found higher-hope people when compared to lower-hope people use humor more frequently as a coping strategy (Snyder, 1994).
7. Last time you played. Participants' responses fell into the following categories: (a) today; (b) yesterday; (c) recently, which included the other night, last week, last weekend, and monthly; (d) long ago, which included years ago (e.g., "I haven't golfed in years"; "When I played sports 20 years ago"); and (e) other, which included "I play cards," "It's fun to watch yourself get out of bed," "I play the trumpet for people." Although differences did not arise between higher- and lower-hope respondents, differences did emerge between residents and staff in regards to the last time they had played. More staff than residents said the last time they played was "today" or "yesterday." However, one third of the residents said it was more than a month ago, and in some cases years ago, when they last played. Three of the six male residents said they had not played in a long time, with two mentioning they missed playing sports. A reason for these differences may be that staff had more opportunities for play than residents.
8. Value and frequency of humor in family (while growing up). Participants' responses fell into the following categories: (a) high, which included played a large role, important, always there, laughed a lot, fun growing up, happy family, "helped us over the rough times," and "helped us to stay healthy and loving"; (b) moderate, which includes some, "not enough—but had some," and "there was a time and place for humor, but not at the dinner table"; (c)

little, which included not much, sparse, "people didn't joke years ago," and "very strict, humor was a waste of time." A majority of residents and staff indicated that their family of origin highly valued humor and laughter. Conversely, six higher-hope residents and one lower-hope resident said humor had little or no value in their family, which may have affected their current appreciation of humor but not their hopefulness.

LIMITATIONS AND FUTURE RESEARCH

This study has several limitations that preclude broad generalizations. First, the response rate of the staff was low. An explanation may be that a change in administration during the time of the study had a negative effect on staff participation. Second, a convenience sample was used in this study. However, most studies on hope conducted in clinical settings use convenience samples, because obtaining and retaining a random sample in the field is extremely difficult (Farran et al., 1995). Third, although the Funny Bone History has demonstrated clinical utility (Cousins, 1989; K. A. Herth, personal communication, September 8, 1998), there are no data on the psychometric properties of the instrument.

Some suggestions for future research are as follows: (a) increase the participation rate of staff by ensuring the work environment is conducive to their involvement; (b) compare the effectiveness of individualized humor activities that are matched to the individual's humor preferences to generic humor activities that are geared to the group; (c) compare hope levels in a larger number of elderly men living in assisted living facilities to hope levels of older women to learn if there are gender differences in hope levels as older people lose their independence; (d) compare hope levels among those of different religious affiliations along with the strength of religious beliefs; (e) monitor health-enhancing effects of laughter and humor by assessing health levels before and after implementing a humor-enhancing activity schedule; (f) investigate the validity and reliability of the Funny Bone History; and (g) include participants from more diverse religious affiliations, cultural backgrounds, and socioeconomic levels.

IMPLICATIONS FOR MENTAL HEALTH COUNSELORS

Because hope and humor research on institutionalized elderly people and their caregivers is sparse, mental health counselors may consider the implications of this study, keeping in mind its limitations. First, the residents and staff identified many health-enhancing benefits from laughter and humor. Thus, it is important to have numerous opportunities to laugh each day, which is particularly vital for lower-hope people who may need more external stimuli to laugh than higher-hope people. One way to foster humor is through positive

social interaction. Mental health counselors could establish and facilitate humor support groups where participants would share funny stories. For residents who are depressed and/or hopeless, mental health counselors also should offer individual or group counseling, because counseling can elevate hope levels (Westburg & Boyer, 1999). Hope, as an internal coping mechanism, may become an increasingly important resource as elderly people's support systems shrink.

Second, mental health counselors could involve assisted-living residents in planning special events. For example, those who report benefiting from entertainment could identify types of entertainment they would enjoy. They could invite volunteer comics, clowns, and entertainers to perform at the facility. It is important to ensure the older audience will appreciate the content of the comic material. The group could also produce a list of in-house entertainers who would like to perform individually or as part of a variety show. This is an ideal way to acknowledge and highlight older people's talents and skills, which are often overlooked. Moreover, the participants could be active in incorporating humor in day-to-day activities. Some suggestions are to include jokes in newsletters, tell jokes at mealtime and before bedtime, show home movies, provide humor carts to distribute funny books and videos of favorite comedians, plan "laugh activities" or "fun days," and encourage more mirthful interaction and laughter between staff and residents.

Third, residents indicated that participating in activities and interacting with younger people were sources of humor. Thus mental health counselors need to educate administrators and staff about the benefits of offering a wide variety of mind-stimulating activities and people-interacting opportunities. For example, not only is it necessary to provide a wide array of activities, it is also important to have instruction for these activities at different levels, from beginner to advanced. Providing a variety of activities at various skill levels would keep residents stimulated, instead of their stagnating over repetitive activities at the same level week after week, and, in turn, would improve their mental health. Another example is to provide more family- or community-oriented events. To encourage visits from children and grandchildren, offer special activities geared towards youngsters. Other events such as a country fair could be scheduled to attract community residents and children. These community events would provide a way to recruit volunteers for an intergenerational mentoring network.

Fourth, for those who are unable to name what would make them laugh, mental health counselors need to provide individual counseling to assess the barriers to humor appreciation. Are they depressed and thus unable to enjoy anything? Have they grown up in a family that did not value humor, which may still be affecting them? Are there no activities scheduled that they enjoy? In any event, these older people may need individual counseling to help them

find ways to improve their enjoyment of life.

Fifth, because a small number of residents living in assisted living facilities are men, little is known about their hopefulness and laughter and humor experiences. Hence, mental health counselors need to pay special attention to male residents so they do not fall through the cracks. First, assess their hope levels, and if low, provide mental health services that would elevate their hopefulness. Next, identify men's sources of laughter, preferred activities, and skill levels to provide corresponding opportunities. For example, two male residents commented they enjoyed participating in sports when they were younger. Some residents might be able to participate in sports activities modified to accommodate their current physical abilities. Others might enjoy watching more sports on television or attending a sporting event.

Last, even though the staff seems to have after-work opportunities for fun and laughter, their needs at work cannot be neglected. The morale of the staff was brought into question in this study, due to their low response rate at a time when there was a change in the administration. It would be beneficial for mental health counselors to assess the staff morale and, if low, investigate how to reduce the work stressors that are negatively affecting them as well as increase the use of humor to help them cope with the stressors that cannot be eliminated (Moran & Massam, 1999). Moreover, mental health counselors could work with administrators to improve the work environment by incorporating laughter into the facility's philosophy. A mirthful environment may improve the residents' well-being, thereby reducing the demands made on the staff (Cousins, 1989).

In conclusion, despite the limitations, these findings add valuable information to the literature on hope, laughter, and humor. Results indicated that residents and staff were very hopeful, but the residents reported a higher level of inner determination than did staff. Both lower- and higher-hope residents and staff at the assisted living facility agreed on the numerous benefits of humor and said they felt better when they laugh. Most respondents reported they frequently laughed, but a number of residents said they seldom laughed. Accordingly, it is vital for mental health counselors to increase opportunities for humor and laughter and, when necessary, provide hope counseling, which will, in turn, enhance institutionalized elderly people's' mental health and well-being as they live out the last years of their lives.

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