Cultural Differences in Therapeutic Humor in Nursing Education

Lenny Chiang-Hanisko • Kathleen Adamie* • Ling-Chun Chiang**

ABSTRACT: Humor has been recognized by nurse researchers and practitioners as a constructive therapeutic intervention and has shown positive psychological and physiological outcomes for patient care. Because cross-cultural research on humor is sparse, this preliminary study investigates how nursing faculty members approach teaching therapeutic humor in the classroom and clinical education in different countries. Through an investigation of classroom (didactic) education and clinical practicum with direct patient care, the study may elucidate the linkage between theory and practice as well as how nursing faculty members view therapeutic humor in general. Researching nursing faculty teaching practices and viewpoints of therapeutic humor may help reveal cultural differences in the use of humor in healthcare settings. This cross-cultural study included 40 nursing faculty at three nursing programs: two in the United States and one in Taiwan. A qualitative approach was used to perform content analysis on responses to the open-ended questionnaires. Research findings revealed cultural differences between faculties from the two countries. Taiwanese faculty members indicated that they teach more theory and concepts related to therapeutic humor in the classroom than do nursing faculty members from the United States. However, nursing faculty members in Taiwan reported that they observe and practice less therapeutic humor in clinical settings out of respect for the cultural value of “reverence of illness” operating within Taiwanese society. Therapeutic humor was family centered and interdependent on relationships, roles, duties, and responsibilities of family members. In contrast, the U.S. faculty members stated that they teach less theory and concepts related to therapeutic humor in the classroom but observe and practice humor more in clinical settings. United States faculty approached teaching therapeutic humor in the classroom on an informal basis because the subject was not part of the required nursing curricula. In clinical settings, therapeutic humor was patient centered and spontaneous in nature.

Key Words: culture, therapeutic humor, nursing education.

Humor is a universal social phenomenon that has been recognized by nurse researchers and health practitioners as a constructive therapeutic intervention (Christie & Moore, 2005; Du Pre, 1998). Each culture, however, has its own set of values, beliefs, and norms that may affect the use of therapeutic humor in nursing care. Apte (1985) suggested that culture is the foundation of most humor and can be used to gain insights into the individual and collective perceptions of a particular culture. In today’s healthcare environment, nurses will be faced with many different situations and may be ill prepared to identify appropriate versus inappropriate uses of humor and aversive reactions to it, especially with patients from different cultures. Overlooking the cultural implications of therapeutic humor can result in negative outcomes for patient care by impeding recovery and creating a sense of patient-to-nurse distrust. Attention to cultural influences can result in beneficial psychological and physiological outcomes for patient care.

There is, however, a noticeable lack of studies on how healthcare professionals learn to use therapeutic humor appropriately. A review of nursing literature (Adamle RN, PhD, Assistant Professor, College of Nursing, Kent State University; *RN, PhD, AOCN, Assistant Professor; **RN, MSN, Lecturer, Department of Nursing, Hung Kuang University, Taiwan, ROC.

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Cultural Differences in Therapeutic Humor

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Ludwick, 2005; Du Pre, 1998; Robinson, 1991; Wooten, 2005) shows that humor in the context of culture to reach positive therapeutic outcomes in delivering care and avoid its misuse has received limited attention. This research study builds on the phenomenon of humor from a cultural perspective by examining nursing faculty teaching practices and viewpoints of therapeutic humor in two different countries, the United States and Taiwan.

In recent years, a significant number of humor studies have been published, cutting across many disciplines such as sociology, biology, anthropology, psychology, literature, and health sciences (Roeckelein, 2002). Humor investigation has resulted in a myriad of theories attempting to establish a framework for the structure and components of humor phenomena. Although much progress has been made, there is little consensus on theoretical models or an exact definition of humor. The focus of this article is neither to examine the various theories of humor now numbering more than 100 (Foot & McCreaddie, 2006) nor to attempt to put forth a working definition. The study is also not an empirical analysis of humor itself. This preliminary study was designed to investigate how nursing faculty members approach teaching therapeutic humor in classroom and clinical education in their respective countries. Through an investigation of classroom (didactic) education and clinical practicum with direct patient care, the study may elucidate the linkage between theory and practice as well as how nursing faculty members view therapeutic humor in general, for example, appropriate and inappropriate uses, proper circumstances and settings, and as a therapeutic communication tool. Researching nursing faculty teaching practices and viewpoints of therapeutic humor may help reveal cultural differences in the use of humor in healthcare settings.

Literature Review

One early and long-standing view is that humor is an expression of one’s superiority over another (Bergson, 1911). Superiority theory continues to be one of the three dominant theoretical perspectives on humor behavior, along with Freud’s (1928) release (relief to decrease stress) and incongruity (absurdity in situations) theories (Koestler, 1964). Humor can also be viewed as a hostile and destructive force that is used for purposes of aggression (Obrdlik, 1942). To reach positive therapeutic outcomes in patient care settings, humor must be used in a complementary way (Du Pre, 1998; Ferguson & Campinha-Bacote, 1989; Robinson, 1991; Rosenberg, 1989).

Nurse researchers and practitioners have acknowledged humor as a beneficial therapeutic intervention for patient care (Christie & Moore, 2005; Du Pre, 1998; Robinson, 1991; Wooten, 2005). As a complementary therapy and intervention technique, therapeutic humor has been used in numerous areas, including end of life (Adamle & Ludwick, 2005), oncology (Christie & Moore, 2005), critical care (Leiber, 1986), women’s health (Ragan, 1990), psychological settings (Richman, 1996), and the emergency room (van Wormer & Boes, 1997). The use of humor as a coping mechanism is well supported in the literature (Nezlek & Derks, 2001). Yura-Petro (1991) identified humor as an important basic human need that should be considered when nurses plan and evaluate patient care.

From an Eastern perspective, humor is deeply rooted in Chinese art, literature, poetry, and drama. Wells (1971) described the Chinese people as “undeniably possessing a deep-seated humor,” and noted that, “their religious and philosophical visions of life have been distinctly favorable to humor” (p. vii). Although Buddhist scholastics may debate the role and appropriateness of humor in religion, evidence of monastic humor as an expression of enlightenment and liberation is strongly represented in the art, literature, and religious practices of Zen Buddhism (Hyers, 1989). One of the leading authorities on Zen Buddhism, D. T. Suzuki (1971) suggested that humor is given a prominent position in Zen tradition, perhaps one of the few religions to do so. Casquin (2001) suggested that incongruity theory, as opposed to superiority theory, is consistent with the Buddhist point of view since humor helps transcend the “absurdity of the human condition” and life’s incongruities by bringing us “down to earth” (p. 113).

Apte (1985) emphasized that humor is the result of individual and collective cultural perceptions. He suggested that an individual who is not a member of a particular culture, and therefore has not internalized its value systems and patterns of behavior, may not experience humor in the same manner as its members. For example, expressions of humor in Western culture that value individuality, independence, and competitiveness may be different from Eastern culture that emphasizes harmony, interdependence, and seniority. When cultural values differ, understanding attitudes toward humor and appropriate and inappropriate uses of humor in various
social interactions may be difficult. Understanding how nursing faculty members from different parts of the world conceptualize humor as a communication tool and incorporate their views into teaching practice may be an important step toward developing culture-based therapeutic humor approaches appropriate for racially and ethnically diverse patient populations.

The purpose of this study, therefore, was to discover whether cultural differences exist in the use of therapeutic humor through the investigation of formal teaching practices of the subject among nursing faculty members in the United States and Taiwan. The research questions were as follows:

1. What are the differences in teaching therapeutic humor in the classroom and clinical settings in the United States and Taiwan?
2. What are the differences in using therapeutic humor in clinical settings in the United States and Taiwan?
3. What are the cultural factors that help explain these differences?

A descriptive cross-sectional survey design was used for the parent study to examine nursing faculty members' responses about teaching therapeutic humor concepts in the classroom and clinical sites. The current study used a qualitative approach to identify cultural factors and differences in the use of therapeutic humor in clinical settings based upon nursing faculty clinical and classroom teaching experiences. This study involved nursing faculty teaching both graduate and undergraduate levels of nursing education. The rationale for researching nursing faculty members' teaching practices and viewpoints of therapeutic humor is that they are in a unique position to directly observe the use of this phenomenon in clinical practice and combine real-world experience with a theoretical framework in the classroom. Three nursing programs were evaluated, two in the United States and one in Taiwan. The sampling sites for this study in the United States included a large state university and a small private university, both located in a midsize metropolitan area of the Midwest. The nursing program in Taiwan was from a large private university located in a major metropolitan city in the middle of the country. These three participating universities were chosen based upon past collaborative research activities, student and faculty exchanges, and shared interest in the subject matter.

The research team designed a two-part survey questionnaire to elicit participants' use of humor content in the curriculum, classroom, and clinical settings. Part 1 included open-ended self-descriptive questions designed to uncover instances of teaching therapeutic humor in the classroom setting and observing therapeutic humor in clinical settings with patients. Sample open-ended questions included, "describe to what degree have you witnessed therapeutic humor use in your clinical area of teaching," and, "describe to what degree have you discussed therapeutic humor in clinical conference with your students." Participants were encouraged to describe information in detail and provide examples/stories to the open-ended questions. Part 2 included both open-ended and forced-choice demographic questions. The English version of the questionnaire was used, and no translation was deemed necessary for the international site. The spelling of the word *humor* was changed to *humour* for the surveys used in Taiwan. After piloting, minor changes were made to improve readability and reduce the time needed to complete the survey.

Each school designated a faculty member to be the project assistant for the survey. The project assistant ensured that each faculty member received a research packet, in person, at a faculty meeting or in his or her mailbox. The self-administered survey was completed on the participants' own time, sealed in an envelope provided by the research assistant, and returned to a secure site. All completed packets were collected by the project assistant and returned to the research team by mail or in person.

**Ethical Considerations**

The university's institutional review board at each nursing program site approved the study. Participants were informed in writing of their right to refuse or terminate participation without penalty. They were also informed that participation was voluntary, that responses would be anonymous, and that they should not identify themselves or their place of employment in the survey. Each research site was color coded, and each completed survey was assigned a code number.

**Data Analysis**

An inductive qualitative approach was used to perform content analysis on responses to the open-ended questions text data in the questionnaire. Qualitative
content analysis focuses on characteristics of language as communication, with attention to the content or contextual meaning of the text (Budd, Thorp, & Donohew, 1967). The research team, including five doctorally prepared and two master's prepared nursing faculty, conducted the coding process with independently coded descriptions, line-by-line reading of all the descriptions, comparison of empirical indicators, and stories and incidents for similarities and differences to develop potential categories. Four criteria for ongoing systematic evaluation in this study included credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). These elements were used as accurate measures of trustworthiness for the naturalistic paradigm in qualitative research rather than the terms reliability and validity employed as indicators of rigor by qualitative research. Demographic information was entered into SPSS for Windows Version 14.0 to provide descriptive statistics.

Participants

Data from 40 faculty members who provided rich descriptions to the open-ended survey questions were used for this study. Of the participants, 95% were women, 75% were married, and 38% (n = 15) were from Taiwan. Participants ranged in age from 28 to 67 years, with a mean age of 44.73 years. The mean age for the Taiwanese faculty was 37.93 years, and that for the U.S. faculty was 48.80 years. Of all participants, 20% had a doctoral degree. Taiwanese faculty members had fewer years of teaching experience (M = 8.47) than did U.S. faculty members (M = 12.16).

Results and Discussion

Results indicated that important cultural differences exist in how nursing faculty members from the United States and Taiwan view the use of therapeutic humor in clinical settings. In addition, teaching practices about the concept of therapeutic humor in nursing education were different between the United States and Taiwan. Taiwanese faculty members indicated that they teach more theory and concepts related to therapeutic humor in the classroom than do nursing faculty members in the United States. More humor-related concepts are included in course materials in Taiwan than in course materials in the United States. Curriculum design and holism may help account for these outcomes. However, nursing faculty members in Taiwan reported observing and practicing less therapeutic humor in clinical settings out of respect for the cultural value of “reverence of illness” prevalent in Taiwanese society. Therapeutic humor was family centered and interdependent on relationships, roles, duties, and responsibilities of family members. In contrast, U.S. faculty members stated that they teach less theory and concepts related to therapeutic humor in the classroom but observe and practice humor more in clinical settings. U.S. faculty members approached teaching therapeutic humor in the classroom on an informal basis because the subject was not part of the required nursing curricula. In clinical settings, therapeutic humor was patient centered and spontaneous in nature. Cultural differences in using therapeutic humor in classroom and clinical settings between the U.S. and Taiwan sites are summarized in Table 1.

Humor Taught More in Classroom in Taiwan Than in the United States

It is not surprising that alternative therapies have found a place in health sciences and education in modern Taiwan considering the rich history and tradition of holism in Chinese medicine. Taiwanese nursing faculty members indicated that they were more likely to teach therapeutic humor in the classroom setting because alternative therapy topics are commonly taught in a standalone course or embedded in required nursing courses.

Curriculum design embraces holism

Historically, a large part of the education and training of nursing faculty in Taiwan has been based on Western biomedical models. During the past two decades, nursing education has embraced alternative healing approaches, which today include cultural health beliefs and practices based on traditional Chinese concepts of health and illness. Content on alternative treatments has been added to the core requirements of nursing curricula, including acupuncture, music therapy, therapeutic touch, guided imagery, meditation, aromatherapy, Tai Chi, and therapeutic humor. The use of humor in healthcare as an alternative therapy is harmonious with Taiwanese holistic ideals of health and illness. One Taiwanese faculty member stated,

**Therapeutic humor is part of alternative therapy which is included in our nursing program. I teach students why therapeutic humor needs to be appropriately incorporated into nursing care (T4).**
Table 1.
Differences in Therapeutic Humor in Classroom and Clinical Settings

<table>
<thead>
<tr>
<th>Country</th>
<th>Teach therapeutic humor in classroom</th>
<th>Use and observe therapeutic humor in clinical settings</th>
<th>Cultural norms</th>
</tr>
</thead>
</table>
| United States | Alternative therapy not required in nursing curricula  
Decision left to individual faculty member  
Informal approach | As stress relief for patients  
As stress relief for students  
As coping mechanism for patients  
As coping mechanism for students  
To build patient rapport  
To facilitate communication | Spontaneous nature  
Nonkinship based  
Patient centered  
Use for loss bereavement in end-of-life situation |
| Taiwan      | Alternative therapy topics commonly taught in nursing curriculum and may include therapeutic humor  
To link theory with practice  
Use for role play simulation | As caring process  
Use for impolite and difficult patients  
Use in embarrassing situation  
To facilitate patient education | Reverence of illness  
Kinship based  
Family centered  
Family as gatekeeper  
Family decision making  
Consider filial piety  
Not used in end of life |

Another Taiwanese faculty stated,

*I would teach therapeutic humor and use therapeutic humor examples to demonstrate the link between theory and practice. I find students can understand the linkage better by using therapeutic humor in role playing for specific clinical scenarios and then evaluating possible outcomes (T3).*

Nursing faculty members at the study site in Taiwan were younger, had fewer years of teaching experience, and had lower levels of education than did faculty members at the U.S. sites. The “younger” Taiwanese nursing faculty members completed their formal training when holism and alternative therapies were added to complement nursing curricula. It is likely that direct exposure to holism and alternative health and healing practices in undergraduate and graduate education facilitated the inclusion of therapeutic humor concepts in classroom teaching. Although this study was conducted at only one large Taiwanese university, we expect holism and alternative therapy content to be included in most nursing curricula as a requirement due to uniformity in national standards.

Reverence of illness

Issues of health and illness are grave and serious matters in Chinese tradition and must be viewed from a solemn and reverent perspective. According to Confucianism, illness may be seen as a failure to meet the obligations of filial piety. As early as the second century BCE, as stated in Hsiao Ching (The Classic of Filial Piety, second century BCE),

*Our bodies—to every hair and bit of skin—are received by us from our parents, and we must not presume to injure or wound them. This is the beginning of filial piety (Hsiao Ching, 1899).*

Chu Hsi, a Chinese philosopher from the Sung Dynasty (960–1279 AD) added,

*When a parent is ill, the son should look upset; he should neither amuse himself nor go to parties. Disregarding all other affairs, he devotes himself solely to getting the best doctor, filling the prescription, and preparing the medicine. Only after his parent had recovered may he resume his normal way of life (Ebrey, 1991, p. 28).*

Confucian principles of filial piety and family obligation profoundly influence modern health beliefs, attitudes, and actions toward family members who are ill in Taiwanese society. Nurses and caregivers are

Humor Observed Less in Clinical Setting in Taiwan Than in the United States

Participants from Taiwan indicated that they observed and used therapeutic humor less in clinical settings due to cultural values and the kinship system.
expected to view hospital and clinical settings as places to uphold the cultural value of reverence of illness. Regard for this outlook must be considered before attempting to use therapeutic humor. One Taiwanese participant stated,

_Generally, you don’t use humor in critical and serious situations, especially in end-of-life situations (T16)._ 

**Family as gatekeeper**

Within the context of nursing and healthcare in Taiwan, humor is viewed from a more conventional perspective. Perhaps the key to understanding the use of therapeutic humor in the clinical setting lies within traditional patterns of care in Taiwanese culture.

_The family is a unit of a clan, as well as the foundation of society. Social life is based on human relations within the family (Chiang-Hanisko, 2002, p. 420)._ 

Family-centered relationships based upon a kinship system, inherent in Confucian ideology, form the nucleus of care patterns in contemporary Taiwanese society. Confucian scholars wrote about the responsibility of a patient’s family in times of illness during the Sung Dynasty (960–1279 AD):

_Only those who understand the art of medicine can be called children who fulfill their duties toward their parents._

Other scholars added,

_Whoever leaves the care of diseases to common physicians neither possesses compassion, nor does he fulfill his duties toward his parents. The knowledge of medicine is indispensable in the assistance of one’s relatives (Unschuld, 1979, p. 57)._ 

The tradition of family members taking responsibility for care decisions for an ailing relative is still practiced in Taiwanese society. Family members are called upon to be gatekeepers in filtering information between healthcare professionals and their sick relative. They are involved in the continuum of care including assessment, diagnosis, treatment decisions, and ongoing evaluations. One Taiwanese nursing faculty member stated,

_When a nurse deals with the patient, the nurse must deal with the family first (T14)._ 

Patient and family are viewed as one entity. The use of therapeutic humor becomes more difficult in this environment. The nurse must consider both patient’s and family members’ attitudes toward illness and acceptance of therapeutic humor.

**Around-the-clock presence**

Nurses in Taiwan must deal with the reality that communication with patients may be affected by the constant presence of family members. Patient rooms have been designed to accommodate family members who expect to be with their sick family member throughout the day and night. Several nursing faculty members reinforced the following observation:

_Nurses often may not communicate with the patient directly: a family member is always around the bedside (T15)._ 

The family obligation of continual presence was expressly stated by Chinese philosopher Chu Hsi:

_When their parents are indisposed, sons and daughters-in-law do not leave their side without good reason (Ebrey, 1991, p. 28)._ 

Humor in Taiwanese society is not an independent phenomenon to be practiced at will; it is structurally tied into a kinship system. Kin-based humor, especially in the healthcare setting, is bounded by a person’s obligations, responsibilities, duties, and privileges, as determined by the kinship network.

Nursing faculty in Taiwan used and observed fewer examples of therapeutic humor in the clinical setting. Participants indicated that, although therapeutic humor was an important part of the caring process, it had to be used more selectively and with caution with patients. One participant stated,

_Humor is a way to show that you care for a patient but I use it very carefully—such as to ease an embarrassing situation with a patient (T12)._
Humor Taught Less in Classroom in the United States Than in Taiwan

Nursing practice is a delicate balance between the science of nursing and the art of nursing care. Although the focus remains on the individual patient, the concern here is the congruity between what is taught in the preparation of nurses and what is seen in practice. In this study, faculty members from the United States reported that the focus of classroom and clinical teaching is on the complexity and skill of delivering patient care, that is, in-depth knowledge of pathophysiology combined with clinical experience. Alternative therapy courses were not included in the undergraduate or graduate nursing curricula. One participant stated, 

I inject humor concepts in my teaching but it is not formally incorporated into the nursing program. It is up to the individual faculty to decide whether to include therapeutic humor concepts into a course. This subject is not a requirement in our nursing program (US2).

Nursing faculty members from U.S. sites had higher age and education levels than those of Taiwanese faculty members, as well as more years of teaching experience. Several U.S. nursing faculty members suggested that they completed their formal nursing education before alternative therapy courses were widely offered. One possible explanation for fewer humor concepts taught in classroom settings is that, without formal training and knowledge of alternative therapies, the likelihood of including therapeutic humor in the classroom setting may be reduced.

Humor Observed More in Clinical Setting in the United States Than in Taiwan

Spontaneous nature of humor

In contrast to Chinese society, humor in the United States is generally not tied to a kinship system and is not linked to obligations and responsibilities of social structure. Freedman (1977) described kin-based and nonkin-based societies as places in which humor and joking occur “in a social setting where social relations are well determined,” compared with a “social setting where relations are not highly determined, and where familiar and humorous exchanges are a means for interacting persons to alter, create and structure social relations” (p. 155). Humor behavior in nonkin-based societies such as the United States occurs within a social structure of individualism where humor relationships may be more spontaneous and overt. Apte (1985, pp. 32–33) described this kind of connection as person oriented, rather than kinship oriented—that is, it is established with a specific person where exchanges may be more varied and dependent on a person’s creative abilities. This form of communication may be more spontaneous and relaxed between two parties, such as nurse and patient, and can help release tension, avoid conflict, reduce hostility, and foster verbal dialogue. One participant stated,

I try to introduce the concept of therapeutic humor at any given opportunity, use humor in class, in clinical setting, try and show humor as a release mechanism and the importance of laughter (US1).

Individual-oriented environment

Comments made by U.S. nursing faculty members were patient centered and did not reference the necessity to consider environmental or social structure requirements when using therapeutic humor with patients. The use of therapeutic humor in most if not all clinical settings, including end-of-life/hospice care, was frequently mentioned by the U.S. nursing faculty. In this setting, humor was primarily used for stress release and as a coping mechanism for both patients and nurses. One participant stated,

I use clinical situations to highlight (to students) the use of humor usually initiated by a patient near the end of life (US6).

Another participant indicated,

Hospice is a little harder to use humor appropriately, but there are some times when it is successful (US9).

The other participant stated,

Humor is often used to deal with difficult situations in critical care settings....Humor was used to relieve tension and express feelings to co-workers (US10).
In contrast, Taiwanese nursing faculty members indicated that end-of-life/hospice and critical care settings were not appropriate situations for using therapeutic humor.

Conclusion

Nurses need to understand the complexities involved with therapeutic humor to provide culturally appropriate interventions to patients from different ethnic and racial backgrounds. It is important to close the gap between the clinical application of nursing knowledge and curriculum content used to teach nursing students. Nursing education needs to include more culture-specific factors about therapeutic humor such as details of contextual variables and culture-specific elements from a variety of ethnic and racial viewpoints. Hessig, Arcand, and Frost (2004) described this well:

Nurses value complementary therapies, but lack the knowledge regarding their application (p. 71).

Humor is a form of communication. Understanding how to use therapeutic humor appropriately during communication shows that nurses are aware of patient needs and their caregiver preferences. Recognizing therapeutic humor in healthcare situations facilitates building trust in the patient–nurse relationship and validates the communication process from the patient's perspective and with the family when necessary.

A limitation of this study was the small number of participants and only two cultural groups, thus, the findings may not be generalizable. Replication of this study with different and larger cultural groups would enhance the correlation of the findings. The use of nursing faculty as participants is questionable when attempting to generalize results to an extended population that includes nursing students, staff, and other healthcare providers. It is also possible that faculty members may have faced curriculum design constraints that limited their ability to include therapeutic humor concepts in courses.

The present work continues preliminary investigation into humor phenomenon in nursing education and cultural differences for patient care. More research is needed to determine other factors that contribute to nurses' knowledge about therapeutic humor. Future research needs to focus on the best way to incorporate humor content and knowledge into nursing as well as cultural differences in the use of therapeutic humor.

References


治療性幽默在護理教育中之文化差異

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摘要：幽默已被護理人員及護理研究者發現，在臨床照護中對個案身心方面具正向療效。然而以幽默為主題之相關研究卻甚為有限，因此，本研究旨在探討不同文化的護理教師如何將治療性幽默融入課室及臨床教學。藉由此研究，期能說明護理教師對治療性幽默於理論與臨床上之連結性，及對不同文化之治療性幽默概觀。本跨文化研究以開放性問題問卷，收集美國及台灣三個護理學系共40位護理教師（15位來自台灣）提供之資料，以質性研究之內容分析法進行分析。研究結果發現，台灣護理教師指出在課室中教導治療性幽默之理論及概念，較少觀察到治療性幽默被實際運用到臨床照護中。其原因可能為台灣社會對疾病的文化價值觀有別於美國。在台灣，生病是被嚴肅以待的事，治療性幽默在臨床上的運用需以個案及其家屬之互動模式、輩份角色、及責任關係為前提來考量。相反的，治療性幽默雖並未被放入美國的護理教育課程中；但臨床上，治療性幽默則在與個案互動中自然而然的運用出來。

關鍵詞：文化、治療性幽默、護理教育。

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