The Value of Humour Therapy in dealing with Anxiety in HIV-Positive HIV/AIDS Lay Counsellors

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Declaration

I declare that THE VALUE OF HUMOUR THERAPY IN DEALING WITH ANXIETY IN HIV-POSITIVE HIV/AIDS LAY COUNSELLORS is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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Abstract

A convenience sample of 10 HIV-positive lay counsellors from Africa International Research Centre, Mtubatuba, Zululand, participated in the study of humour therapy evaluation. Humour therapy was used as an intervention strategy, which took place in a group format. Three humour therapy sessions were conducted per week over a period of two weeks. Beck's Anxiety Inventory was the chosen standardized instrument used to pre- and post-test anxiety levels of the participants. Individual interviews were also used to evaluate participants' perceptions of humour therapy (pre- and post-intervention). Ninety percent of the participants found humour therapy to be effective, with the exception of one participant who on pre- and post-assessment had equal measurements, indicating no improvement or negative effects. A self-help tool was given to participants to utilize for a period of three months following the humour therapy intervention. Three of the ten participants chose not to use the self-help tool. Out of the seven participants who did make use of the tool, five found it helpful (maintained decreased anxiety levels), while two did not find it useful.

Table of contents

Abbreviations

AIDS – Acquired Immune Deficiency Syndrome

HIV – Human Immunodeficiency Virus

ARVs – Antiretroviral Drugs

STD – Sexually Transmitted Disease

WHO – World Health Organisation

UNAIDS – United Nations Programme of HIV/AIDS

KZN – KwaZulu Natal

NGO – Non-governmental Organization

CHAPTER ONE: INTRODUCTION

1.1 Introduction

The HIV/AIDS pandemic remains a global disaster. The joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimated the number of people living with HIV to be approximately 33.4 million worldwide according to their AIDS epidemic update (UNAIDS and WHO AIDS epidemic update 2009).

An estimated 22.4 million people are living with HIV in the region of sub-Saharan Africa. This constitutes more than two-thirds of the global total. In 2008, 1.4 million people died from AIDS and 1.9 million new cases were reported. In South Africa between 15-20% of the population are known to be affected by HIV (AVERT, 2009a).

Levels of heterosexually transmitted HIV infections are high amongst South African youth, with one recent survey reporting levels of 18.9% amongst 17-20 year olds and 43.1% amongst 21-25 year olds (MacPhail, Williams & Campbell, 2001).

In response to the pandemic, South Africa developed the HIV/AIDS/STD Strategic Plan for South Africa in 1999. The latest National HIV/AIDS/STD Strategic Plan (2007 – 2011) was launched on the 12 March 2007 in order to guide South Africa's response to HIV/AIDS/STDS in the following five years from 2007. This plan stated that all interventions should be subjected to monitoring and evaluation; and HIV/AIDS counsellor intervention was one important form of intervention (HIV and AIDS and STI Strategic Plan 2007-2011).

1.2 HIV/AIDS Counsellors

There is a shortage of trained professional counsellors in South Africa and therefore a great need for HIV/AIDS counsellors. This shortage is due to professional psychologists, counsellors as well as psychiatrists being unable to cope with the

demand for psychological assistance amongst people with HIV/AIDS (van Dyk, 2005). Despite these challenges, counsellors need to find a way to be relatively free from stress/anxiety, in order to counsel effectively.

1.3 Stressors on the Job

HIV/AIDS counsellors experience a wide array of stressors. Some of these stressors may include: feeling unequipped to adequately perform their work duties; feeling uncomfortable talking to clients about their sexual activities; an inability to remain emotionally detached from clients; a lack of social support; female oppression; the effects of poverty; Westernised expectations; single motherhood; a low self-esteem; anxiety and major depression; to name but a few.

HIV-positive HIV/AIDS counsellors have most of these stressors to contend with, as well as the added stressors which come with being HIV-positive. The added stressors may include contending with the following symptoms which may be present in people with HIV: anorexia, anxiety, coughing, delirium, dementia-type symptoms, depression, diarrhoea, dizziness, fatigue, fever, forgetfulness, body fat changes, nausea, neuropathy, night sweats, oral symptoms, pain, sexual dysfunction, shortness of breath, skin conditions, sleep disturbances, vomiting, and weight loss (Nicholas, 2005).

1.4 Why Humour Therapy?

Physicians have known for a very long time that stress/anxiety (a common psychological symptom of HIV/AIDS) weakens the immune system, leaving one more vulnerable to illness. With the possibility of countless threatening illnesses when one is HIV-positive (e.g. tuberculosis of all forms, pneumonia, chronic gastroenteritis, and meningitis, to name a few) there is a need to do as much as possible to avoid/overcome stress/anxiety.

According to Wooten (1996) humour and laughter can be effective self-care tools to cope with stress and possibly even cure stress. She mentioned several studies across the United States supporting the hypothesis that laughter lowers neurotransmitter stress response by weakening neuroendocrine hormones and increasing immune cell activity.

There are two types of stress: distress (negative) and eustress (positive). Distress has been shown to increase stress hormones, but laughter, a form of eustress, decreased these hormones. Laughter is therefore able to combat the negative aspects of stress and strengthen the immune system to help fight against various immune mediated diseases, such as HIV/AIDS (Hasan & Hasan, 2009).

The old saying "laughter is the best medicine" may have quite a bit of weight to it. In this study, Sultanoff's (1995, p.2) definition of humour will be used: "humor is comprised of three components - wit, mirth, and laughter.

- Wit is the cognitive experience,
- mirth the emotional experience, and
- laughter, the physiological experience."

1.5 Statement of the problem

The occurrence of anxiety symptoms in HIV-positive people is at a significantly higher rate than that of HIV-negative people. These symptoms of anxiety weaken the already compromised immune system, which causes HIV-positive persons to be extremely susceptible to illness. It is thus imperative that the anxiety symptoms be minimized. Humour minimizes or even eliminates the effects of stress/anxiety on the immune system. Perhaps HIV-positive persons may not want to laugh, but they *need* to laugh (more).

1.6 Motivation of the Study

The great prevalence of HIV-infected persons, and the many associated problems (with a focus on anxiety in this study), continues to warrant urgent attention. Despite the great amount of research done on HIV with regard to treatment and prevention, little has been done to indicate whether humour could be of value in the context of some of the main psychological problems HIV-positive persons face, namely anxiety as defined in this study.

There is no literature to date on the benefits of humour therapy in HIV-positive lay counsellors dealing with anxiety. This study thus explores an area which is evidently untouched by research, and hopes to contribute to this area through the use of an intervention: humour therapy. With the many diseases threatening the HIV-positive person, it is of utmost importance to keep anxiety levels at a minimum.

One's sense of humour provides a powerful antidote to immunosuppressive effects of stress in two ways. Firstly, through indirect effects resulting from humour's ability to help one cope on the tough days (minimizing or eliminating the negative impact of stress on the immune system), and secondly, through direct positive effects upon the immune system (McGhee, 1999).

1.7 Aims of this research

The aim of this study is to evaluate the effectiveness of a humour therapy intervention on the anxiety levels of HIV-positive HIV/AIDS counsellors. This project also aims to provide a self-help type of tool which has the potential to assist HIV/AIDS counsellors to lower levels of anxiety, without costing money.

1.8 Clarification of Terms

1.8.1 HIV/AIDS

HIV is an acronym for the Human Immunodeficiency Virus. It is a member of the retrovirus family. HIV was the first known retrovirus to infect the human species. There are two types of HIV which have been identified: HIV 1, which is the most aggressive and predominant type in the world; and HIV 2, which is less easily transmitted and is mostly found in Western Africa. Both viruses, however, cause HIV, which ultimately leads to AIDS (Lachman, 1997; Van Dyk, 2001).

AIDS is an acronym for the Acquired Immune Deficiency Virus which is a condition in humans in which the immune system begins to fail, defined by a set of signs and symptoms attributed to infection by the Human Immunodeficiency Virus (Van Dyk, 2001). When a person has full-blown AIDS, the immune system becomes increasingly compromised and as such the body gets to a point of being unable to fight off the infections that a normal and an intact immune system could suppress. This leads to life threatening opportunistic infections (AVERT, 2009b).

1.8.2 Anxiety

Anxiety is a psychological and physiological response to a real or perceived threat (Greene, 1997). Anxiety manifests itself in every aspect of a person's being and produces cognitive (confusion or poor concentration), physiological (insomnia, shortness of breath, or fatigue) and affective (fearfulness or apprehension) manifestations (Rauch & Rosenbaum, 1995).

1.8.3 Humour Therapy

It is also known as therapeutic humour. Humour therapy is the use of humour for the relief of physical or emotional pain and stress. It uses humorous materials such as books, shows, movies, or stories to encourage spontaneous discussion of the clients

own humorous experiences. It is used mainly as a complementary method to promote health and cope with illness (American Cancer Society, 2010). For the purposes of this study, humour therapy will consist of the use of humorous films, and the sharing of jokes.

1.8.4 HIV/AIDS Lay Counsellor

Ideally, these are people who have been trained and are capable to conduct pre-test HIV counselling and post-test HIV counselling. These lay counsellors are trained over a period of weeks compared to the years of training that professional counsellors have received, and therefore cannot be considered to be professionals.

1.8.5 ARVs

ARVs is an acronym for antiretroviral drugs. These are medications for the treatment of infection by retroviruses. It is recommended that antiretroviral treatment is offered to all patients:

- With CD4 counts less than 200 or with severe HIV disease irrespective of CD4
- Co-infected with TB (tuberculosis) and HIV
- Pregnant (The South African Antiretroviral Treatment Guidelines, 2010).

There are different classes of antiretroviral drugs that act at different stages of the HIV life-cycle.

1.9 Conclusion

This chapter propositions the need to study the effect of humour therapy on anxiety in HIV-positive lay counsellors. The current state of the HIV/AIDS epidemic in South Africa has been briefly examined. This vast topic has been narrowed in this study to focus on a small population of HIV-positive persons: HIV-positive lay counsellors

experiencing symptoms of anxiety. The context of the research was illustrated in terms of the research problem, motivation for the study, aims of the study, and clarification of terms.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter begins by outlining the effects of HIV/AIDS infection. Anxiety, as one aspect experienced by people living with HIV/AIDS, is investigated and the physiological and psychological effects of anxiety are briefly described. Some different methods for reducing levels of anxiety will be mentioned and briefly explained.

The role of HIV/AIDS counsellors will then be explored, as well as the different stressors which they commonly encounter, and the added psychological and physiological stressors which commonly co-occur with being HIV-positive.

The concept of humour therapy and the purposes thereof are then explored. Different ways of using humour/laughter are examined, and the different contexts in which humour therapy has proven to be helpful. The physical and psychological benefits of humour therapy are examined, as well as some possible limitations of humour therapy.

2.2 HIV/AIDS

According to the World Health Organisation classification (2006), there are four stages through which the disease progresses. Stage 1 is asymptomatic. Those in stage 2 may experience symptoms such as unexplained moderate weight loss, recurrent respiratory tract infections, or fungal nail infections. Stage 3 of the disease may present with severe weight loss, unexplained chronic diarrhoea, severe bacterial infections or unexplained persistent fever, to name but a few symptoms. Those in stage 4 (when HIV becomes AIDS) have full-blown AIDS which may be reflected by illnesses such as pneumonia, chronic herpes simplex infection, tuberculosis (TB), or meningitis.

2.2.1 Common Symptoms of HIV/AIDS

Much of early research on HIV-infected persons focused on self-reported physical and psychological symptoms. These included:

a) Physical symptoms – fatigue, anorexia, wasting, coughing, pain, night sweats and fever.

b) Psychological symptoms – anxiety, worrying, fear, depression, forgetfulness, dementia and sadness (Ciccolo, Jowers, & Bartholomew, 2004; Casteele, 1999).

2.2.2 Treatment of HIV/AIDS

The use of highly active antiretroviral therapy (HAART) has helped to significantly reduce the mortality and opportunistic infections of HIV-infected persons. This has resulted in HIV infection now being treated as a chronic illness, despite the fact that it is still a life-threatening disease. However, this treatment is associated with a host of adverse effects. Common physical adverse effects include headaches, fatigue, nausea, diarrhoea, rash and lipodystrophy. Some adverse psychological effects may include agitation, confusion, nightmares, hallucinations, mania, depression and anxiety (Ciccolo et al., 2004). Adjunct therapies are thus needed to maintain their quality of life while undergoing treatment. Individuals often seek alternatives to pharmacologic care to relieve symptoms associated with HIV/AIDS and its treatment (Rao, Nainis, Williams et al., 2009). The researcher proposes that humour therapy, as described further on, be an adjunct therapy for people on ARVs.

2.3 HIV/AIDS Lay Counsellors

2.3.1 The role of HIV/AIDS Lay Counsellors

Lay counsellors have come a long way since the first training of lay counsellors in the late 1990s. Collaboration between the Department of Health, NGOs and lay counsellors has resulted in an effective and sustainable response to HIV and AIDS with regard to counselling and support. In just over 10 years, lay counsellors have

come to play an important role working at the frontline on HIV/AIDS responses in the primary health setting (Houten, 2010).

Lay counsellors, when provided with approved and appropriate training, can play a key role in HIV counselling services. As mentioned previously, a major reason for the use of lay counsellors is the potential they have for relieving already over-burdened health care workers. Since lay counsellors are specifically trained in counselling and testing, this degree of specialization allows them to focus exclusively on service provision of consistent quality, while allowing other health care workers to concentrate on other aspects of clinical care (Sanjana, Torpey, Schwarzwalder et al., 2009).

2.3.2 Roots of occupational stress/anxiety in the HIV/AIDS field

Caring for people who are HIV-positive may provoke stress in healthcare workers that exceeds the stress involved when caring for people of other diseases (Ungvarski & Flaskerud, 1999). Some factors involved in the increased levels of anxiety in lay counsellors/health care workers include:

2.3.2.1 The overwhelming nature of HIV/AIDS

The severity and intensity of the HIV/AIDS pandemic, and the fact that AIDS is not a disease of individuals, but involves whole families and communities, is a great source of stress/anxiety.

Some Zimbabwean counsellors expressed feelings of helplessness and stated: “We know our patients will die no matter what counselling we provide” (Mazodze, Richards & Pennymon, 2004, p.1). In a South African study, nurses working in hospitals in the Gauteng province expressed feelings of helplessness due to patients coming to the hospital sick, and still being sick when discharged from the hospital (Smit, 2005). The relatively young age of AIDS patients is also a source of overwhelming stress amongst those working with them.

2.3.2.2 Confidentiality and Stigma Associated with HIV/AIDS Care

In the study done by Smit (2005), in Gauteng, nurses indicated that because of their work with HIV-positive people, the community views them as contaminated. Maintaining confidentiality concerning HIV/AIDS at all costs is regarded as problematic. It is frustrating for health workers to know that many people are dying, but their deaths are not acknowledged as caused by the primary diagnosis of AIDS but attributed to other secondary illnesses such as tuberculosis or pneumonia (Low, 2009).

This stigma and secrecy attached to HIV/AIDS make it difficult for counsellors to convey the message that this is just another disease and not a shameful thing which needs to be hidden (Grinstead & Van Der Straten, 2000).The confidentiality requirement may prevent health workers from utilising the coping mechanism of seeking emotional support from family and friends.

2.3.2.3 Over-involvement

Some health workers experience symptoms of anxiety and depression because they feel they are unable to remain close by at all times that their clients/patients need them. For many health workers in South Africa, personal identification with the suffering of their patients with AIDS is inevitable because they themselves, or their loved ones, may also be infected with HIV (Shisana, Hall, Maluleke, Chauveau, & Schwabe, 2004).

It is particularly difficult for counsellors to deal with those clients who, faced with the prospect of the stigma of living with HIV and the suffering caused by AIDS, consider suicide as an option. The counsellor may feel responsible for having been unable to assist the client to accept the losses resulting from HIV/AIDS. The counsellor may feel obliged to help the client work through the suicidal thoughts, and realise that any

mistake can prove to be lethal, which is both terrifying and stressful for counsellors (Brady, Healy, Norcross, & Guy, 1995).

2.3.2.4 Financial struggles

Significant feelings of helplessness are experienced by people working with HIV-infected persons, especially having to promote the importance of nutrition in severely impoverished areas, where people struggle to even have one meal a day (Lehmann & Zulu, 2005).

2.3.2.5 Bereavement overload

The constant exposure to death and not having opportunity or time to grieve may result in bereavement overload (van Dyk, 2007).

2.3.2.6 Occupational discomfort

Some health workers often experience frustration, anger and helplessness due to organisational factors, such as lack of emotional and practical support, lack of supervision and mentoring, inadequate training and heavy patient/client load (van Dyk, 2007).

2.3.3 HIV-positive HIV/AIDS Lay Counsellors

According to the literature above, HIV-positive HIV/AIDS lay counsellors have to contend with the stressors of being HIV-positive, as well as the stressors which occur when working with HIV-infected persons. Their anxiety levels may therefore be even higher than those of an HIV-positive person who does not work in the HIV/AIDS

field. This small population of people thus are at a greater risk of further compromising their immune systems due to potentially higher anxiety levels.

2.4 Anxiety

Anxiety is a psychological and physiological state characterized by several components which combine to create an unpleasant feeling that is typically associated with uneasiness, apprehension, fear or worry (Phillips & Morrow, 1998). Anxiety is the result of threats that are perceived to be uncontrollable or unavoidable, such as when HIV-positive, as discussed below.

2.4.1 Anxiety and HIV/AIDS

Despite the recent progress in the treatment of HIV/AIDS, anxiety is still a pervasive aspect of living with HIV/AIDS. Besides having an impact on the quality of life, HIV-related anxiety can also play an important role in determining health outcomes (Kemppainen, Eller, Bunch et al., 2006). Anxiety is one of the most significant predictors of non-adherence to antiretroviral treatment (Campos, Bonolo & Guimaraes, 2006).

Numerous studies have evaluated anxiety symptoms in HIV/AIDS. One such example is Cohen et al. (2002), who found that 70.3 % of 101 HIV/AIDS patients receiving care through an urban HIV primary care setting had high levels of anxiety as measured by the Hospital Anxiety and Depression Scale.

In a study on depressive and anxiety disorders in women with HIV in Florida, USA, it was found that HIV-positive women exhibited a significantly higher rate of major depressive disorder and more symptoms of depression and anxiety than did a group of HIV-seronegative women with similar demographic characteristics (Morrison, Petitto, Ten Hav et al., 2002).

Anxiety is a universal problem for people with HIV/AIDS because the disease creates uncertainty and disruption in every aspect of their lives. AIDS causes anxiety of varying types and degrees for affected individuals. The anxiety may be related to the disease process itself, the uncertainty and unpredictability of the course of the disease, as well as many losses experienced by those infected (Phillips & Morrow, 1998).

One factor that may influence the anxiety experienced by people living with HIV/AIDS is the stage of the disease. Flaskerud (1995) identified seven crisis points for greater psychological distress: 1) Learning one's seropositive status, 2) receiving the diagnosis of AIDS, 3) beginning a new treatment, 4) discontinuing treatment, 5) the appearance of new symptoms, 6) recurrence and relapse, and 7) terminal illness.

2.4.2 Methods of Reducing Anxiety Levels

2.4.2.1 Psychological Interventions

Some psychological interventions may include the following:
a) Individual therapy – boundary development and maintenance and promotion of safety and trust are of utmost importance. When dealing with anxious clients, it is important to assess and focus on their strengths and positive aspects, which can be used to heal their more problematic areas (Phillips & Morrow, 1998).

b) Family therapy – the family of people living with HIV/AIDS face unique and challenging situations. It is through family therapy that some of these unique issues can be addressed. Issues especially important to the HIV-infected person's family members include stigma, grief, loss of social support, anticipatory loss and fear of contagion. If the therapist can help family members deal with their own anxieties about the HIV infection and the issues that surround this illness, a less anxiety-producing environment can be produced for the HIV-positive client (Phillips & Morrow, 1998).

c) Group therapy – brings people together who under normal situations may not have met. With a homogenous group, members relax relatively easier than in normal

society (with most people being HIV-negative). Issues that create anxiety are addressed through reflection/feedback from group members (Phillips & Morrow, 1998).

2.4.2.2 Alternative Modalities

These may include:

a) Progressive Muscle Relaxation – the client is taught to tense and relax large muscle groups. The assumption is that anxiety cannot exist if the muscles are truly relaxed (Corey, 2005).

b) Exercise – a program of regular aerobic exercise is recommended for the HIV-positive person as a health-promoting activity because of its positive effects such as increases in strength, balance, flexibility, endurance, lung capacity, and energy (Ciccolo et al., 2004; Galantino, Shepard, Krafft et al., 2005).

c) Massage – massage increases blood circulation to an area by dilating the blood vessels. An increase of blood flow brings oxygen and nutrients to the area, producing a feeling of relaxation, thereby decreasing one's overall anxiety (Phillips & Morrow, 1998).

d) Aromatherapy – is the inhaling of essential oils, which stimulate the limbic system, resulting in improved feelings of well-being and contentment. Calming oils such as jasmine and lavender improve feelings of relaxation and well-being, thus combating anxiety (Phillips & Morrow, 1998).

e) Music Therapy – has been used since ancient times to soothe and to heal. Sound stimulates the right hemisphere of the brain. In most people the left hemisphere is dominant. The left hemisphere inhibits the right hemisphere. Music therapy thus helps to restore balance and communication between the two hemispheres, resulting in reduced anxiety (Phillips & Morrow, 1998).

f) Spirituality – a diagnosis such as HIV/AIDS evokes strong emotions, where a sense of spiritual well-being and hope may relieve some of the symptoms of anxiety and fear that the person experiences (Phillips & Morrow, 1998).

2.4.2.3 Psychopharmacologic Interventions

Pharmacologic management of anxiety may become necessary when other strategies fail to reduce symptoms of anxiety. Cognitive behavioural strategies are usually continued for the duration of pharmacological treatment. Some pharmacological interventions include:

a) Benzodiazepines – approximately 25% of individuals who are HIV positive take one or more of these medications for relief from anxiety or insomnia.

b) Antidepressants – a person experiencing restlessness, insomnia and agitation may benefit from a sedative agent such as a tricyclic antidepressant. A serotonin selective reuptake inhibitor (SSRI) may be beneficial to an HIV-positive person experiencing moderate levels of anxiety that although distressing, do not compromise their ability to function normally (Phillips & Morrow, 1998).

2.4.2.4 Self-care Behaviours

Absence of a cure, and treatments with limited effectiveness, have resulted in increased use of complementary and alternative self-care behaviours among those who are HIV positive (Phillips & Morrow, 1998).

A study completed by Kemppainen et al. (2006) evaluated the frequency and effectiveness of self-care practices used to manage HIV-related anxiety amongst a large international sample of persons with HIV/AIDS. Countries which participated in this study included: Norway, Taiwan and the US (United States of America). The five most frequently used strategies in Norway included watching TV, reading, talking with family and friends, cooking and walking. The five most frequently used

strategies in Taiwan included watching TV, talking with friends and family, using denial, talking myself through it, and staying alone. The five most frequently used strategies among the US participants included watching TV, talking with friends and family, walking, talking with a health care provider, and praying. Watching TV received the highest frequency rates, despite the country. This anxiety management strategy however, received only moderate ratings of effectiveness on a scale of 1 to 10.

A limitation of this study is that the majority of the participants were from the US, so it may not be very reflective of a people living with HIV/AIDS in South Africa. However, the need for more effective self-care strategies to help manage HIV/AIDS-related anxiety is a reality.

2.5 Humour Therapy

2.5.1 Background

Perhaps the earliest citation of the benefits of humour/laughter can be traced back to a biblical reference, Proverbs 17:22, “A joyful heart is good medicine, but a broken spirit dries up the bones.”

Freud was said to have enjoyed jokes and possessed a sense of humour, in addition to studying and writing on the subject. During the time he was writing his "Three Essays on Sexuality," he was also writing "Jokes and their Relation to the Unconscious."

The benefits of humour were however undermined, until Cousins (1976), who had a painful rheumatoid inflammatory disease, used candid camera classics and Marx Brothers films to stimulate about 10 minutes of laughter, which he claimed produced 2 hours of pain-free restful sleep. This led to a renewed interest in the benefits of laughter.

Although laughing and crying are two basic inborn emotional relations, psychoanalysts and psychotherapists have been much more interested in the

phenomenon of crying rather than laughing (Jacobs, 2007). However, variety of studies have emphasized the benefits of humour and proven that humour strengthens the immune system and often speeds recovery from illness (Jacobs, 2009).

2.5.2 Humour Defined

The Association for Applied and Therapeutic Humour (2005) describes humour as an intervention that promotes health and wellness by stimulating a playful discovery, expression, or appreciation of the absurdity or incongruity of life's situation.

In The Oxford English Dictionary, humour is defined as "that quality of action, speech, or writing which excites amusement; oddity; jocularity; facetiousness; comicality; and/or fun". Humour involves cognitive, emotional, behavioural, psycho-physiological, and social aspects. Humour can refer to a stimulus such as a comedy film, a mental process such as perception, or a response such as laughter and exhilaration. Laughter is the most common behavioural expression of a humorous experience. Humour and laughter are typically associated with a pleasant emotional feeling.

Essential elements of the humour process are the stimulus (humour), the emotional response (mirth), and the resulting behaviour such as grinning, laughing, smiling, or giggling (Walter, Hanni, Haug, et al., 2007).

2.5.3 Expressions of Humour

2.5.3.1 The Joke

A joke can be defined as something told to create the desire for laughter, or a funny way of saying something that elicits laughter (Jacobs, 2007). The occasion on which a joke is told, the identity of the teller, and the audience, constitute other dimensions of the joke. When one misuses language purposefully it can be used to make others laugh, however when the misuse of language is seen as bad or harmful, it is no longer

considered humorous (Jacobs, 2007). When one first hears a joke, it is funny, and the reaction is to laugh. Thereafter one experiences pleasure from sharing it with others.

2.5.3.2 Laughing and Smiling

Humour has something to do with laughing, or at least a smile. People react towards the same comical situation in several ways, which indicates different interpretations of the situation. The most effective way people communicate that the situation is comical is by laughing. Laughing can therefore almost be considered as the language of humour (Jacobs, 2007).

2.5.4 Benefits of Humour

Dr P. McGhee was a pioneer in humour research, and laid the groundwork for the current interest in the health benefits of humour. Dr L. Berk later studied the effects of laughter on the immune system. The discoveries, with regard to the benefits of humour, of these two men, are described below.

2.5.4.1 Reduction of stress hormones

Laughter reduces at least four neuroendocrine hormones associated with stress response. These include epinephrine, cortisol, dopac, and growth hormone (Smith, Kemp & Segal, 2010).

2.5.4.2 Immune system enhancement

Clinical studies have shown that humour strengthens the immune system.
After exposure to humour, there is a general increase in activity within the immune system, including:

- An increase in the number and activity level of natural killer cells that attack viral infected cells, and some types of cancer and tumour cells.
- An increase in activated T cells (T lymphocytes). There are many T cells that await activation. Laughter seems to tell the immune system to be more alert.
- An increase in the antibody IgA (immunoglobin A), which fights upper respiratory tract infections
- An increase in gamma interferon, which activates various components of the immune system.
- An increase in IgB, the immunoglobin produced in the greatest quantity in the body, as well as an increase in Complement 3, which helps antibodies to pierce dysfunctional or infected cells. The increase in both these substances was not only present while subjects watched a humour video. There was also a lingering effect that continued to show increased levels the next day (Berk, 1996).

2.5.4.3 Muscle relaxation

A belly laugh results in muscle relaxation. While you laugh, the muscles that do not participate in the belly laugh, relax. After you finish laughing those muscles involved in the laughter start to relax. So, the action takes place in two stages (McGhee, 1999).

2.5.4.4 Pain reduction

Humour allows a person to “forget” about pains such as arthritis. The use of humour consistently results in improvements in pain thresholds. Humour also leads to the release of endorphins in the brain, which help to control pain (Tse, Lo, Cheng, Chan, Chan, & Chung; 2010).

2.5.4.5 Cardiac exercise

A belly laugh is equivalent to "an internal jogging". Laughter can provide good cardiac conditioning especially for those who are unable to perform physical exercises. Humour has been shown to increase lung capacity and strengthen abdominal muscles (McGhee, 1999).

2.5.4.6 Respiration

Frequent belly laughter empties your lungs of more air than it takes in, resulting in a cleansing effect – similar to deep breathing. Laughter is aerobic, providing a workout for the diaphragm and increasing the body's ability to use oxygen (McGhee, 1999).

Laughter therapy can be used as a supplementary treatment to patients who are already on medication for their illnesses. It should not be used as a substitute for medication (Suraj-Narayan, 2008).

2.5.5 Group setting for humour therapy

Both laughter and smiling have long been known to be socially mediated, at least partly so. We laugh when we hear others doing so and smile when we see others doing so, particularly friends. We smile more if we think that we and our friends are watching the same humorous material rather than different material. Simply hearing others laugh leads us to laugh as well (Platow, Haslam, Both et al., 2004). Thus the group setting for humour therapy seems to be ideal.

2.5.6 Warnings when using humour

Although humour and laughter can help reduce stress and anxiety in the early and recovery stages of a crisis, it may be considered offensive or distracting at a peak

crisis period. Clinicians using therapeutic humour and laughter must be sensitive to laugh with, not at, clients (Gibson, 2002). Particular care must be used with clients who are acutely paranoid, critically ill, or terminally ill to ensure humour and laughter are not misinterpreted. In using humour in conjunction with laughter, each individual's perception of what is humorous must be considered (Macdonald, 2004).
It should be emphasized that some forms of humour are unacceptable, and you have to be careful about which you encourage. Humour that belittles or mocks or is prejudicial is ultimately harmful. It can evoke laughter and perhaps momentarily improve an individual's self-esteem, but there is no greater or lasting good, and the potential for harm is real. Also, the timing of humour and its balance with seriousness must be considered. The inappropriate use of humour can be counter-productive, so judgement is necessary to keep this powerful force in check and therapeutic (Cameron, 1990).

2.5.7 International Research: Humour today

Laughter (a part/result of humour) has now been identified as an important component of holistic health care throughout the world.
Several variations of laughter programs exist, including:

• Humour therapy, can be done by individuals or in a group setting, and individuals in the group are encouraged to identify humorous things in their lives to share with each other. A challenge may arise when trying to find material that is humorous to all group members.
Humour therapy has been used in palliative care, where patients have a far-advanced disease in which the prognosis is limited, and thus the focus of care is on the quality of life. Humour therapy is one example of the wide range of complementary therapies used in Canada to provide comfort care and to better the quality of life in palliative care (Hartmann, 2008).
A study completed by Walter et al. (2007) in Switzerland, found that patients with late life depression showed a higher quality of life after undergoing group humour therapy. Patients with Alzheimer's disease however, showed no improvement.

A study conducted in Hong Kong examined the effectiveness of an 8 week humour therapy program in relieving chronic pain, enhancing happiness and life satisfaction and reducing loneliness among elderly people with chronic pain. Once the humour therapy program was completed, there were significant decreases in pain and perception of loneliness, and increases in happiness and life satisfaction for the participants in the humour therapy program (Tse et al., 2010).

• Laughter therapy is another form of a laughter program, and can be used by anyone. Clients are required to identify their laughter triggers. It teaches clients some exercises which can be done on their own, and stresses the importance of relationships and social support. Clinicians must however be aware of what their client perceives as humorous, which may require an initial workshop (Macdonald, 2004).

• Laughter clubs/yoga. This is an intervention performed in groups/clubs which does not require humorous materials, but incorporates breathing and yoga techniques, and includes several laughter exercises. Laughter is not spontaneous, and thus may be awkward for some clients (Kataria & Kataria, 1995).

There are active laugher clubs conducted in India, United Kingdom, United States, Canada, Australia and many more countries, including South Africa (Macdonald, 2004).

2.5.8 South African Research

The field of humour research in South Africa is still in its infancy stage. To date, the researcher was unable to find literature on humour therapy in South Africa. There was however, some research done on laughter yoga.

The first laughter club project in South Africa was started on the 24 October 2007 at Rosendal Home, a place of safety for abused children and children with drug dependency, in the Western Cape (Laughter for Africa, 2010). To date, there are

reports of laughter sessions being held in Cape Town, Durban, Pretoria and Johannesburg (Kataria & Kataria, 2010).

Suraj-Narayan (2008) conducted laughter yoga on stroke patients between the ages of 40 and 90 years, in the Verulum Frail Care Community, Durban, KwaZulu Natal, South Africa. Some of the stroke patients initially viewed laughter therapy with scepticism but following the intervention showed:

- A reduction in post-stroke depression
- A reduction in anxiety
- A reduction in stroke-related pain
- Enhanced mobility
- Improved communication and relations between patients and significant others.

In another study, Dr Suraj-Narayan (2008) conducted laughter yoga with patients suffering from stress, diabetes, asthma, depression and high blood pressure. She combined this with cognitive restructuring.
After being exposed to yoga therapy over a four month period, she found a reduction in stress levels, depression, diabetes and high blood pressure among some of the participants.

2.5.9 Critique of Existing Literature

- The field of humour therapy and anxiety reduction is relatively new, especially in the South African context. This is something which ought to be remedied, particularly when the benefits of humour in dealing with anxiety are taken into consideration. These include reduction of stress hormones and muscle relaxation (Berk, 1996).
- Most of the research on humour in South Africa has incorporated another treatment as part of the intervention, such as cognitive restructuring. This indicates a need for research solely on the benefits of humour therapy.
- There are a number of laughter clubs globally, yet one needs to take into consideration that laughter is not spontaneous, and therefore may be awkward

for some clients. There is therefore a need for more humour therapy programs.

- There is no literature on the value of humour therapy in dealing with anxiety in HIV/AIDS.
- On reviewing the literature, it is clear that much of the research has focused on the elderly population with little focus on youth/young adults.

2.6 Conclusion

Both international as well as local studies supported the notion that humour decreases levels of anxiety. Although the body of existing knowledge on the benefits of humour on anxiety is still in its early stages of development, it is clear that humour can be used to help lower levels of anxiety, as well as assist with a range of other psychological and physiological problems. Studies have shown that humour therapy has assisted with a variety of populations, such as those with cancer, depression, or pain. People who are HIV positive currently have no hope for a cure, but rather try to extend and manage their lives optimally, and perhaps as in palliative care, may benefit from humour therapy.

The following chapter will describe methodological considerations including research design, sample, instruments and data analysis techniques.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter is concerned with the context in which the project was conducted. It explores the rationale and the purpose of the project and how this informed the methodology. It examines the type of measuring instruments employed, and the reasoning behind using these particular tools. Finally, the manner in which the data analysis was handled is explained.

3.2 Rationale for the Empirical Investigation

The literature review revealed that:

- The HIV/AIDS virus compromises the immune system.
- A common psychological symptom of an HIV/AIDS diagnosis is anxiety.
- The work of an HIV/AIDS lay counsellor has many stressors.
- Anxiety further negatively affects the immune system.
- Various researchers agree that humour may be used to strengthen the immune system.

In order to explore the relationship between humour and levels of anxiety amongst HIV-positive lay counsellors, it was necessary to launch an empirical investigation.

3.3 Research Design

This study was executed as an empirical research project where the researcher was involved with numeric (Beck Anxiety Inventory scores) as well as textual data (interviews). The key research question has an exploratory nature.

According to Babbie (1998), in the simplest experimental design, subjects are measured in terms of a dependent variable (pre-tested), exposed to a stimulus representing an independent variable (intervention), and then re-measured in terms of the dependent variable (post-tested). Differences noted between the first and last

measurements on the dependent variable are then attributed to the independent variable. In the current study the independent variable is the humour therapy program offered to HIV-positive HIV/AIDS lay counsellors; and the dependent variables are the anxiety levels and perceptions of humour of the lay counsellors, which were measured prior to the humour therapy program and a week after the intervention.

According to Terre Blanche and Durrheim (1999) exploratory studies are used to make preliminary investigations into relatively unknown areas of research while employing an open flexible approach to research. In this study the researcher investigated the main research question through the qualitative inquiry: *Can humour therapy lower levels of anxiety in HIV-positive HIV/AIDS lay counsellors?*

Figure 1

Research Design

PRE-TEST PHASE		
Participants • 10 participants • Background	**Data Collection** • Pre- Interviews • Beck's Anxiety Inventory	**Data Analysis** • Analysis of interviews • Analysis of anxiety scores

INTERVENTION (6 Sessions Humour Therapy over 2 weeks)		
Participants • Same 10 participants	**Observation** • Participants' reactions	**Humour Therapy Tools** • Mr Bean • Sharing of jokes • Laugh 3 times a day (self-help tool)

POST-TEST PHASE

Participants	Data Collection	Data Analysis
• Same 10 participants are retested with the Beck Anxiety Inventory	• Observation • Post-intervention Interview	• Thematic Content Analysis • Comparison of anxiety levels pre- and post-intervention

FOLLOW UP (3 months later)		
Participants	**Data Collection**	**Data Analysis**
• Same 10 participants	• Whether or not the self-help tool was used • Beck Anxiety Inventory completed	• Comparison of anxiety levels with that of pre-intervention and post-intervention

- **RESULTS FROM THE STUDY**
- **PRESENTATION AND INTERPRETATION OF RESULTS**

3.3.1 Explanation of Research Design/Procedure

3.3.1.1 Sample

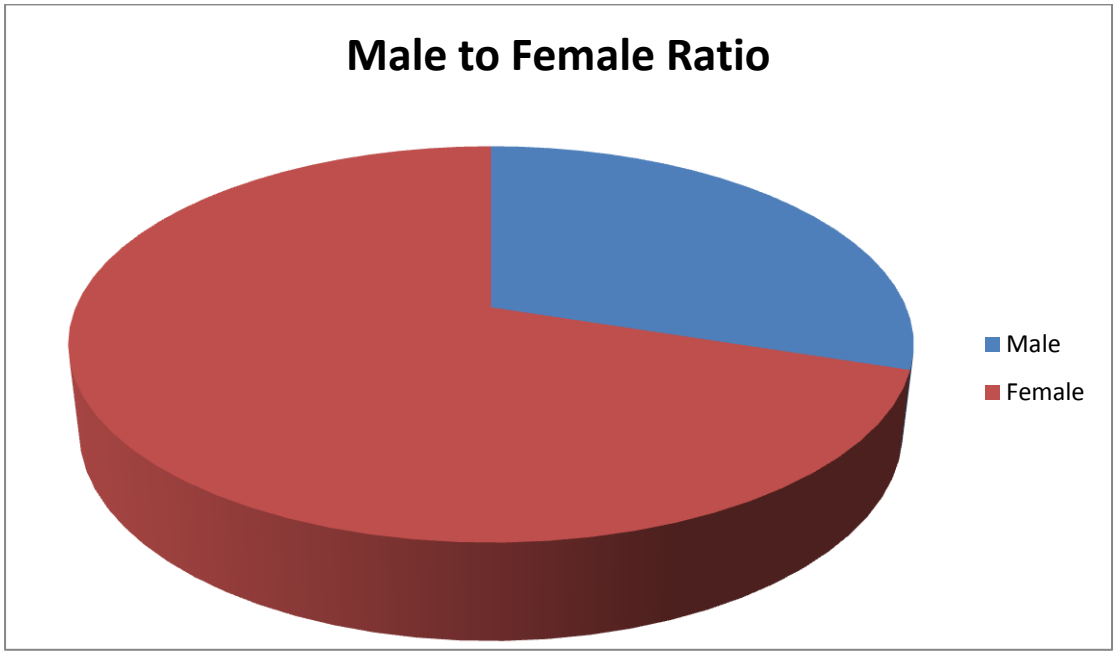
The participants in this study were selected from a group of HIV/AIDS lay counsellors who had tested positive for HIV, from Africa Centre for Health and Population Studies, an NGO, based in Mtubatuba, Zululand, South Africa. The NGO

was chosen for easy accessibility. Ten HIV-positive HIV/AIDS lay counsellors were selected. All participants were on ARVs.

A purposive and convenience sampling method was used. In purposive sampling, participants are chosen with a purpose in mind, when one needs to reach a target sample quickly (Trochim, 2006). Participants were chosen based on their ability to provide needed information, their availability, and their willingness to participate in the study.

With the help of the anxiety inventory, those with moderate or mild symptoms of anxiety were selected. Those with severe anxiety disorders were referred to the psychologist at the NGO (but those who refused to see the psychologist were included in the study).Those with minimal or no symptoms of anxiety were not used in this study owing to the need for change in anxiety levels to be noted.

Table 1



The sample in this research project consisted of six females and four males. They ranged in age from 29 years old to 36 years old. Two participants were married, while the remaining 8 were single.

3.3.1.2 Informed Consent

Before the project began, the participants were all requested to sign a consent form which included relevant details of the research project (Appendix A). This form was explained to all the participants before they were asked to sign it. The contract was translated into IsiZulu, by one of the participants, to ensure that all the participants understood clearly what they were signing. The researcher is fairly competent in IsiZulu, therefore could make sure that everything was correctly interpreted. The form explained the research process, and the possible risks and benefits of participating. The form further stated that the identities of the participants would be protected, and that they would be provided with feedback upon completion of the research project.

3.3.1.3 Pre-Test Phase (Data Collection)

Biographical information was gathered through the use of an unstructured interview in order for the participants to be as representative as possible of HIV-positive HIV/AIDS lay counsellors.

Humour is a subjective phenomenon, and thus an explorative method of inquiry, namely the interview (Appendix B), was used as a tool to collect data regarding the client's perceptions of humour therapy (administered individually to the members in the focus group).

Pre-testing made use of the Beck's Anxiety Inventory (Appendix C), to provide an indication of levels of anxiety. All the items on the Beck's Anxiety Inventory were first translated by the same group member (who translated the consent form) to the entire group, until they completely understood the inventory. An opportunity was provided for any questions to be asked. The inventory was then administered individually.

3.3.1.4 Intervention

The intervention made use of humour therapy in a group setting, with three sessions weekly, for two weeks.

The group form of treatment has been chosen owing to the support the participants can obtain from each other, and to the ease (and power) of laughing with others in comparison to laughing alone.

Humour therapy in this study made use of Mr. Bean's films, a popular comic figure. These particular films were chosen due to them being predominantly non-verbal, thus language would not pose a problem (e.g. For second language English speakers). Approximately 20 minutes of Mr. Bean's films were played for each session.

Group members were encouraged to laugh while watching the films. The films chosen were recorded with a live studio audience. The 'audience' laughing in the actual show provided cues for the participants to laugh.

Participants were then encouraged to share jokes, or funny stories. They first defined what a 'joke' is to help ensure that no one in the group would be offended. Their definition was as follows:

- "It's not a joke when it's something sad
- It's not a joke if it is about death
- It is a joke when something someone says has something wrong in it
- It's a story which can make you laugh, not necessarily a reality
- It should not be about features on/of people which they can't change (making fun of others)"

This section thereafter lasted for approximately 10 minutes per session.

Finally, at the end of each session, participants were encouraged to laugh at least three times a day (a self-help tool). Sessions 2 to 5 then began with the researcher recording which participants had managed to laugh at least three times a day since the previous session.

Each session was carefully planned in advance, taking into consideration the stage of the group –whether they were at the beginning, in the middle, or near the end of the group intervention (Jacobs, Masson & Harvill, 2002).

3.3.1.5 Post-Test Phase

Post-testing made use of the Beck's Anxiety Inventory, which was administered individually. Participants were allowed to ask questions if they could not recall what an item on the inventory meant.

Individual interviews (Appendix D) were then conducted in order to establish whether there had been any change in the group members' perceptions of humour/ humour therapy.

3.3.1.6 Follow-up

A follow-up occurred three months later. The same ten group members indicated whether they had been using the self-help tool (laugh at least 3 times a day), and the frequency thereof. The Beck Anxiety Inventory was administered to measure whether the self-help tool influenced levels of anxiety (when compared with pre- and post-intervention anxiety levels).

3.4 Measuring Instrument

The measuring instrument was presented in English by the researcher and in IsiZulu by the fully bilingual group member.

3.4.1 Beck's Anxiety Inventory

The Beck Anxiety Inventory was created by Dr. Aaron T. Beck. It is a twenty-one question, multiple choice, self-report inventory, that is used for measuring the severity of a person's anxiety. It is about how the subject has been feeling in the last week, expressed as common symptoms of anxiety (such as numbness, hot and cold sweats, or feelings of dread). Each question is rated on a four point scale namely:

- NOT AT ALL
- MILDLY: It did not bother me much.
- MODERATELY: It was very unpleasant, but I could stand it.
- SEVERELY: I could barely stand it.

The items of the Beck Anxiety Inventory are summed to obtain a total score that can range between 0 and 63:

- 0-7: minimal level of anxiety
- 8-15: mild anxiety
- 16-25: moderate anxiety
- 26-63: severe anxiety

The BAI was appropriate for use in this study due to its simplicity and ease of use, and its' high validity for the treatment of adult mental health patients (Ellis-Christensen, 2010).

3.5 Data Analysis

After all the data had been collected, it was checked by two researchers.
Data obtained from the interviews was transcribed and analysed by means of thematic content analysis. This is a method used to organize and make sense of data. This qualitative data was analysed, and certain themes such as being 'less anxious', 'laughing more', and 'feeling happy' arose. These themes were then unified to gain a better picture of the effectiveness of humour therapy, from the participants'

viewpoint. This enabled a more complete picture to be obtained, as statistics cannot communicate the more subjective side of human experience.

The raw pre-test and post-test scores on the anxiety and depression scales were compared and analysed through the use of graphical presentations, and this was used to reinforce the results obtained from the qualitative data.

3.6 Ethical Considerations

3.6.1. Permission

The researcher needed to obtain permission to conduct the research from the Committee of Human Ethics at the University of Zululand. The researcher then obtained permission from the relevant authorities at the NGO to conduct this research. The researcher recruited participants as per recommendation by the authorities at the NGO, and by giving potential participants information sheets to read and contact details in order to contact her if they were interested in participating in the study.
Informed consent was obtained from the participants.

3.6.2. Informed Consent

The participants were given a detailed information sheet, as part of the consent form, explaining the purpose of the study (which was also to be verbally explained to them in a language they understood). The consent forms were signed by the participants.

There can be a disadvantage to humour therapy in a group format, as it can be difficult to provide materials that all participants find humorous. The researcher was aware of the fact that jokes in the context of laughter therapy should not offend any participant.

Should the researcher have come across any patient whom she found with an anxiety disorder, the patient would have been referred to the psychology department at the NGO for the appropriate treatment or intervention.

3.7 Conclusion

The more technical aspects of the research project were discussed in this chapter. This included looking at the reasoning behind using a qualitative method, but with some statistical backup. The statistics came from the Beck Anxiety Inventory scores. The manner in which the data was analyzed was explained in brief detail. The results of this study are presented in the next chapter.

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 Introduction

This study was qualitative in nature, with some numerical data (from Beck's Anxiety Inventory) to back up the qualitative findings. This will be illustrated by separate tables for each participant at first, and a discussion of each participant. The researcher will then take a look at the total findings.

4.2 Individual Results

Participant 1

This participant was a married female who presented with a mild level of anxiety. She reported a number of stressors, and stated that her coping mechanism was exercise. She at first perceived humour as moderately useful, though after the intervention she perceived humour as very important. During the intervention she was very involved (by sharing jokes and laughing freely), and completed her homework prior to every session. Her anxiety level after the intervention was minimal.

Participant 2

This participant was a single male who presented with a mild level of anxiety. He first perceived humour as moderately necessary and following the intervention perceived humour as important. He reported that he copes with his stressors by talking to friends. His participation during the intervention phase was partly reserved, as he did not laugh much. He completed his homework three times out of five. His anxiety level after the intervention had slightly decreased, but he still presented with mild symptoms of anxiety.

Figure 2

Participant 1	
Demographics	• Female • 31 years old • Married • Zulu (first language), Eng (second Language)
Beck Anxiety Rating	• Pre-Test score – 13 • Post-Test score – 1
Interview	**Pre-Test Interview Themes** • Laughter causes headache • Humour is moderately necessary • Stressors: Work, Weight, Family • Coping mechanism: exercise **Post-Test Interview Themes** • Experienced humour therapy as exciting • Laughs at self lately • Humour is very important
Self Help Tool	• **Session 2 –** yes • **Session 3 –** yes • **Session 4 –** yes • **Session 5 –** yes • **Session 6 –** yes
Observations	• Told jokes • Laughed freely

Participant 2	
Demographics	• Male • 32 years old • Single • Zulu (first language), Eng (second Language)
Beck Anxiety Rating	• Pre-Test score – 14 • Post-Test score – 11
Interview	**Pre-Test Interview Themes** • Laughter is good • Humour is moderately needed • Stressor: Family member ill • Coping mechanism: talk with friends **Post-Test Interview Themes** • Humour therapy is interesting • Less stressed about ill family member • Humour is important
Self Help Tool	• **Session 2 – yes** • **Session 3 – no** • **Session 4 – yes** • **Session 5 – no** • **Session 6 – yes**
Observations	• Told jokes • A bit reserved with laughing

Participant 3	
Demographics	• Male • 36 years old • Single • Zulu (first language), Eng (second Language)
Beck Anxiety Rating	• Pre-Test score – 36 • Post-Test score – 8
Interview	**Pre-Test Interview Themes** • Laughter is like exercise • Humour is very important • Stressor: need a wife • Coping mechanism: drinks alcohol **Post-Test Interview Themes** • Humour therapy makes me happy • Group helps release stress • Humour is very important
Self Help Tool	• **Session 2 –** yes • **Session 3 –** yes • **Session 4 –** no • **Session 5 –** yes • **Session 6 –** yes
Observations	• Told jokes • Laughed freely

Participant 4	
Demographics	• Female • 29 years old • Single • Zulu (first language), Eng (second Language)\
Beck Anxiety Rating	• Pre-Test score – 34 • Post-Test score – 7
Interview	**Pre-Test Interview Themes** • Laughter releases stress • Humour is important • Stressor: I want to be married • Coping mechanisms: I cry, prayer **Post-Test Interview Themes** • Humour therapy released my stress • Good way to make friends • Humour is very important
Self Help Tool	• **Session 2 –** yes • **Session 3 –** yes • **Session 4 –** yes • **Session 5 –** yes • **Session 6 –** yes
Observations	• Told 1 joke • Laughed freely

Participant 5	
Demographics	• Female • 36 years old • Single • Zulu (first language), Eng (second Language)
Beck Anxiety Rating	• Pre-Test score – 21 • Post-Test score – 12
Interview	**Pre-Test Interview Themes** • Laughter makes me feel better • Humour is important • Stressor: finance • Coping mechanism: laugh at work **Post-Test Interview Themes** • Humour therapy was fun • I value laughter even more now • Humour is very important
Self Help Tool	• **Session 2 –** yes • **Session 3 –** yes • **Session 4 –** yes • **Session 5 –** yes • **Session 6 –** yes
Observations	• Did not tell jokes • Laughed freely

Participant 6	
Demographics	• Female • 35 years old • Married • Zulu (first language), Eng (second Language)
Beck Anxiety Rating	• Pre-Test score – 23 • Post-Test score – 6
Interview	**<u>Pre-Test Interview Themes</u>** • Laughter releases stress • Humour is important • Stressor: husband has extramarital affairs • Coping mechanism: acceptance **<u>Post-Test Interview Themes</u>** • Humour therapy was helpful • Stress levels are lower • Humour is very important
Self Help Tool	• **Session 2 –** yes • **Session 3 –** yes • **Session 4 –** yes • **Session 5 –** yes • **Session 6 –** yes
Observations	• Did not tell any jokes • Was reserved with laughter

Participant 7	
Demographics	• Male • 34 years old • Single • Zulu (first language), Eng (second Language)
Beck Anxiety Rating	• Pre-Test score – 8 • Post-Test score – 5
Interview	**Pre-Test Interview Themes** • Humour/laughter makes me happy • Humour is very important • Stressor: cruel girlfriend • Coping mechanism: comedy movies **Post-Test Interview Themes** • Humour therapy was lots of fun • Think less about stressor • Humour is very important
Self Help Tool	• **Session 2 –** no • **Session 3 –** yes • **Session 4 –** yes • **Session 5 –** yes • **Session 6 –** yes
Observations	• Told 1 joke • Laughed freely

Participant 8	
Demographics	• Female • 29 years old • Single • Zulu (first language), Eng (second Language)
Beck Anxiety Rating	• Pre-Test score – 21 • Post-Test score – 11
Interview	**Pre-Test Interview Themes** • Laughter releases stress • Humour is important • Stressor: unfaithful boyfriend • Coping mechanism: talks to him **Post-Test Interview Themes** • Humour therapy helps to forget stress • Did not notice any personal changes • Humour is very important
Self Help Tool	• **Session 2 –** yes • **Session 3 –** yes • **Session 4 –** yes • **Session 5 –** yes • **Session 6 –** yes
Observations	• Did not tell any jokes • Laughed freely

Participant 9	
Demographics	• Male • 35 years old • Single • Zulu (first language), Eng (second Language)
Beck Anxiety Rating	• Pre-Test score – 10 • Post-Test score – 3
Interview	**Pre-Test Interview Themes** • Laughter is temporary medicine • Humour is useful occasionally • Stressors: finance, family • Coping mechanisms: pretend stressors don't exist **Post-Test Interview Themes** • Humour therapy is therapeutic • Laugh more often • Humour is important
Self Help Tool	• **Session 2 –** no • **Session 3 –** no • **Session 4 –** no • **Session 5 –** yes • **Session 6 –** yes
Observations	• Told jokes • Reserved with laughter

Participant 10	
Demographics	• Female • 33 years old • Single • Zulu (first language), Eng (second Language)
Beck Anxiety Rating	• Pre-Test score – 16 • Post-Test score – 5
Interview	**Pre-Test Interview Themes** • Laughter releases stress • Humour is important • Stressor: 3 month old baby • Coping mechanism: talks to someone **Post-Test Interview Themes** • Humour therapy was helpful • Fewer symptoms of anxiety • Humour is very important
Self Help Tool	• **Session 2 –** yes • **Session 3 –** yes • **Session 4 –** yes • **Session 5 –** yes • **Session 6 –** yes
Observations	• Told jokes • Laughed freely

Participant 3

This participant was a single male who presented with a severe level of anxiety. He was therefore referred to the psychologist at the NGO, but refused to see the psychologist as he was uncomfortable with the idea. The researcher therefore decided to include him in the research project. This participant perceived humour as very important before and after the intervention, and reported that he drinks alcohol as a coping mechanism. During the intervention, he was very involved with sharing jokes and laughing freely. He completed his homework prior to most sessions, with the exception of once. His anxiety level after the intervention was mild.

Participant 4

This was a single female participant who presented with a severe level of anxiety. The option of a referral to a psychologist was also presented to her, which she turned down. She was therefore included in this research project as a means of possible assistance. This participant perceived humour as important prior to the intervention, and as very important after the intervention. Prayer and crying are what she reported as her coping mechanisms when anxious. During the intervention she was actively involved by telling one joke and laughing freely. She completed her homework on all occasions. Her anxiety level after the intervention was minimal.

Participant 5

This participant was a single female who presented with a moderate level of anxiety. She perceived laughter as important before the intervention and as very important following the intervention. She reported that her coping mechanism for dealing with anxiety was to laugh at work. During the intervention phase she participated by laughing freely, although she did not tell any jokes. She completed her homework on all occasions. After the intervention, her level of anxiety was mild.

Participant 6

This participant was a married female who presented with a moderate level of anxiety. She perceived humour as important prior to the intervention and as very important following the intervention. She reported coping with her stressors by simply accepting them. During the intervention phase she was quite reserved, as she did not laugh freely nor did she tell any jokes. She did however, complete her homework on all occasions. After the intervention she presented with a minimal level of anxiety.

Participant 7

This participant was a single male who presented with a mild level of anxiety. He perceived humour as very important prior to and after the intervention, and reported that he copes with anxiety by watching comedy movies. During the intervention he was actively involved by laughing freely and telling one joke. He completed his homework with the exception of one occasion. His anxiety level after the intervention was minimal.

Participant 8

This participant was a single female who presented with a moderate level of anxiety. She perceived laughter as important before the intervention, and as very important following the intervention. She reported coping with stressors by facing them head on. During the intervention phase she participated by laughing freely, although she did not tell any jokes. She completed her homework on every occasion. Her anxiety level following the intervention was mild.

Participant 9

This participant was a single male who presented with a mild level of anxiety. He perceived laughter as only occasionally useful prior to the intervention, and as important following the intervention. He reported that he copes with stressors by ignoring them (denial). During the intervention he participated by telling a number of

jokes, although he was reserved with laughter. He only completed his homework twice out of the required five times. His anxiety level following the intervention was minimal.

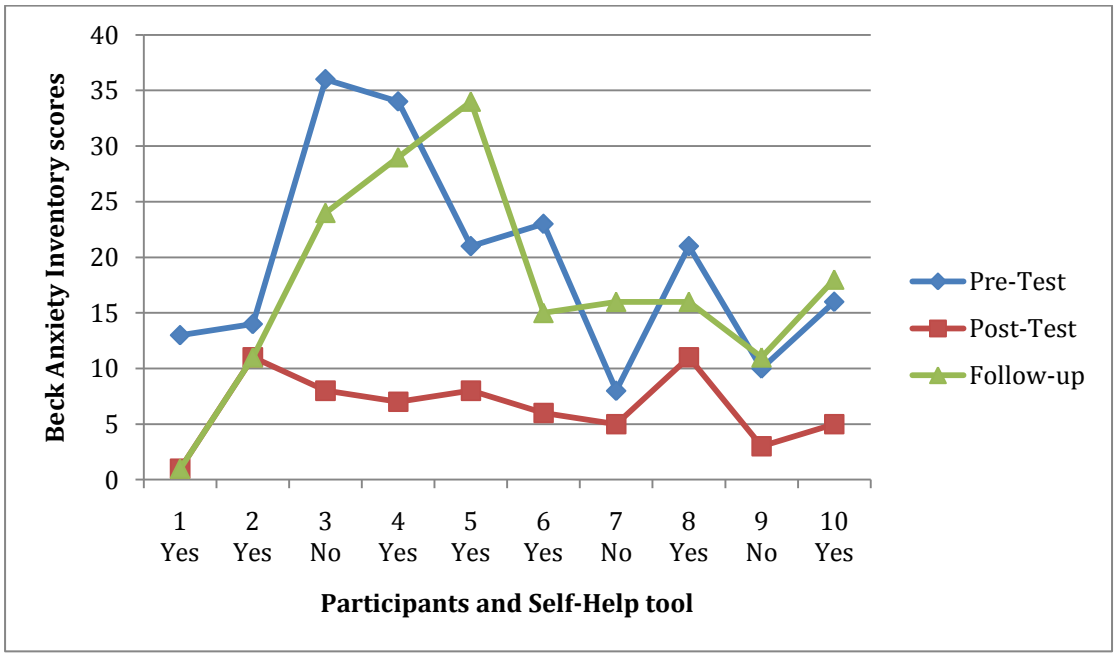
Participant 10

This was a single female participant who presented with a moderate level of anxiety. She perceived humour as important prior to the intervention and as very important following the intervention. She reported that she copes with anxiety by talking to someone. During the intervention phase, she was actively involved by telling jokes and laughing freely. She completed her homework on all occasions. Her anxiety level after the intervention was minimal.

4.3 The bigger picture

4.3.1 Beck's Anxiety Inventory Results

Table 2



4.3.1.1 Assessment of Anxiety: Pre-Test

Anxiety levels pre-test ranged from mild through to severe. Four participants presented with mild symptoms of anxiety. Four participants presented with moderate symptoms of anxiety. Two participants presented with severe symptoms of anxiety.

4.3.1.2 Assessment of Anxiety: Post-Test

Anxiety levels post-test ranged from minimal through to mild. Six participants presented with minimal symptoms of anxiety. Four participants presented with mild symptoms of anxiety. This represents a dramatic decrease in levels of anxiety, with every participant having experienced a decrease in their anxiety levels. The two participants who pre-test presented with severe symptoms of anxiety, presented with mild and minimal levels of anxiety respectively, post-test; and thus experienced the largest decrease in anxiety levels.

4.3.1.3 Assessment of Anxiety: 3 month Follow-up

Anxiety levels three months after the intervention varied greatly. Two participants had similar anxiety levels to when measured post-test, and lower than their pre-test anxiety levels. Four participants had anxiety levels which were less than those they had pre-test, but higher than those received post-test. This indicates that the self-help tool helped to keep their anxiety levels lower than that of when they measured them prior to the intervention. Three participants had anxiety levels which exceeded those that they received pre- and post-test. One participant had an anxiety level which matched that obtained pre-test.

Three participants had not followed up with the self-help tool. Two of the three had anxiety levels higher or equal to those obtained on the pre-test score. Seven of the participants used the self-help tool on a regular basis. Two out of this seven received anxiety scores higher than received when pre-tested. The remaining five participants

who followed up with the self-help tool received lower anxiety scores when compared with the scores received pre-test.
What could have very likely affected the follow-up anxiety scores is the fact that the participants had received news two or three days prior to the follow-up that there was a possibility that they may lose their jobs, due to a lack of funds.

Despite the bad news, the self-help tool seemed to have assisted six out of the ten participants to keep their anxiety levels reduced when compared with the anxiety levels obtained pre-test.

4.3.2 Qualitative Results: Perceptions of humour

The results of the content analysis performed on the ten interviews conducted pre-test and the ten interviews conducted post-test are presented here.

4.3.2.1 Perceptions of Humour Pre-Test

Participants described humour as a temporary solution, as "good", as a method of reducing stress, as a way to feel better, and as a method to become happy. Their responses concerning the importance of humour ranged from humour being moderately needed to it being important.

4.3.2.2 Perceptions of Humour Post-Test

Participants described humour following the intervention as exciting, interesting, very nice, a stress reliever, helpful, good, fun, and therapeutic. Their responses concerning the importance of humour ranged from humour being important to it being very important. There was therefore a clear shift in the participants' description and value of humour. They used more positive terms to describe the phenomenon of humour (such as "fun" and "therapeutic"). Furthermore, they described humour as even more important as when they described itwhen pre-tested.

4.4 Conclusion

Table 2 is a comparison of anxiety levels prior to the intervention (pre-test), after the intervention (post-test), and three months following the intervention. The anxiety levels post-test dropped dramatically from those of pre-test for every participant. One may then assume that the intervention, the independent variable (humour therapy), helped lower these anxiety levels.

The anxiety levels three months following the intervention were generally lower than the pre-test anxiety levels. This indicates that the self-help tool provided (laugh three times a day), assisted in keeping anxiety levels lower than that of pre-test. These anxiety levels might have been even lower had the participants not received the news of possible job loss. Under this circumstance, the fact that the anxiety levels at this stage were relatively lower than those of the pre-test, is quite extraordinary. This suggests that the strength and effectiveness of this self-help tool is worth further investigation.

There was also a significant shift in participants' perceptions of humour from positive to extremely positive. Participants had generally perceived humour as moderately needed prior to the intervention. Following the intervention, their perceptions of humour ranged from important to very important. They experienced greater freedom from symptoms of anxiety, and greater happiness.

The results in this research support earlier studies emphasizing the value of humour (Hartmann, 2008; Walter et al., 2007; Tse et al., 2009). Findings were in the expected direction in that participants had and experienced lower levels of anxiety.

CHAPTER FIVE: CONCLUSION

5.1 Introduction

In this chapter, the main findings of the project will be discussed in relation to the aims of the study, followed by the implications of these findings. The limitations of this study will also be explored. This will be followed with some recommendations for possible future research.

5.2 Main Findings

Research has shown that being an HIV/AIDS lay counsellor is a stressful job (Ungvarski & Flaskerud, 1999; Smit, 2005). Being HIV-positive and an HIV/AIDS counsellor can be extremely stressful. Higher levels of anxiety in this population group, when compared to the general population, is expected. The decision to attempt a humour therapy intervention program with HIV-positive HIV/AIDS lay counsellors was based on research which suggested the benefits of humour therapy on a variety of populations (Tse et al., 2009; Hartmann, 2008).

The qualitative feedback suggested that the participants had experienced many benefits from this intervention. Among the main findings were reports of increased happiness and fewer symptoms of anxiety.

The aims of this study were to:
Evaluate the effectiveness of a humour therapy intervention on the anxiety levels of HIV-positive HIV/AIDS counsellors. This project also aims to provide a self-help type of tool which has the potential to assist HIV/AIDS counsellors to lower levels of anxiety, without costing money.

The aims of this study were fulfilled as humour therapy proved to be an effective intervention, which lowered anxiety levels of HIV-positive HIV/AIDS counsellors, which has been described through qualitative data as well as some numerical data. The self-help tool was proven to be extremely beneficial as it kept levels of anxiety at

a lower level than the anxiety measured pre-test, even through a terribly stressful situation (possible job loss).

5.3 Limitations

The sensitivity of the topic (HIV-positive persons) posed a huge challenge, as most people are not willing to openly admit to being infected with HIV. The researcher's intention was to gather a sample of approximately 50 HIV-positive persons, and randomly choose 25 for a focus group and 25 for a control group. It would therefore have been a quasi-experimental pre- and post-test group research design, with greater validity and reliability.

The researcher was unable to locate such a huge sample due to the sensitivity of the sample. A setting where ones HIV status was known amongst peers, was found among the HIV/AIDS lay counsellors, at Africa Centre, an NGO. The sample was thus purposive and one of convenience. The researcher could not find enough participants in order to create a control group, therefore the design was a simple experimental one.

Another limitation was the language barrier which existed between the potential humour therapy material and the participants. There are a variety of comedy films which one can generally choose from and use during humour therapy. Most of these films are in English, and the participants' home language was IsiZulu. It is important during humour therapy that participants understand what is funny. Mr Bean, a comedy which does not use verbal language, was therefore chosen. Had the humour therapy continued for a longer duration, the researcher may have had a problem in obtaining suitable humorous films.

5.4 Recommendations

The results suggested that the participants benefitted from humour therapy. In South Africa, there exists a large number of HIV-infected persons, so much so that it is

considered to be a pandemic (UNAIDS and WHO AIDS epidemic update 2009). Most of these people experience anxiety as one of the psychological symptoms of HIV-positive people. Here exists a huge potential for the benefits of humour therapy to be experienced.

Government has invested a great sum of money on medical services with regard to HIV-infected patients, and on ARVs. Holistic care of the HIV-positive patient however, includes biological, psychological and sociological aspects. The government is currently investing a great deal in the biological aspect. Humour therapy may be one way in which better psychological care can be provided to the HIV-positive patient.

The researcher recommends that further research on humour therapy is conducted in South Africa, with the HIV-infected population. This research should be done on a larger scale in order to be able to be better generalized. The more that research is done in this area, the greater the chance of government investing in this psychological intervention.

Humour therapy is used successfully in palliative care, in Canada, where the focus of care is on the quality of life (Hartmann, 2008). Perhaps similar programs can be implemented in South Africa, in places such as hospices, where patients may have a far-advanced disease with a limited prognosis. Some examples of such diseases include cancer, stroke, heart attack and AIDS.

5.5 Conclusion

This chapter looked at the main findings obtained during the course of this project in relation to the aims of the study. It also explored the limitations experienced by the researcher and the implications which these limitations may have had on the data. It has further explored the possibilities for future research in this field, and how certain people may benefit from an intervention such as described in this study.

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Appendix A: Consent Form

Informed Consent Form

University of Zululand
Department of Psychology

Informed Consent for Participants

Security code:	Principle Investigator:	Faculty Supervisor:
_____	_____	_____

SIGN BELOW ONLY IF YOU UNDERSTAND THIS DOCUMENT AND AGREE TO PARTICIPATE, AND FULLY UNDERSTAND YOUR RIGHTS. YOUR SIGNATURE IS REQUIRED FOR PARTICIPATION. YOU MUST BE 18 YEARS OF AGE TO GIVE YOUR CONSENT TO PARTICIPATE IN THIS PROJECT. IF YOU DESIRE A COPY OF THIS CONSENT FORM, YOU MAY REQUEST ONE, AND IT WILL BE PROVIDED TO YOU.

All research participation is voluntary, and you have a right to withdraw at any time, without prejudice, should you object to the nature of the research. You are entitled to ask questions and to receive an explanation after your participation.

Description of the Study: This is a 6 session study in which the value of humour therapy on anxiety will be evaluated. This will be done by measuring each participant's anxiety level, with the use of a psychological test, before and after the intervention. The intervention will mainly consist of humorous material shown via a TV screen. Each session will last for about 45 minutes.

Nature of Participation: You will participate in 6 sessions. Each session will incorporate humorous TV material, following which participants will be provided an opportunity to share jokes.

Purpose of the Study: To evaluate humour therapy with regards to anxiety in HIV positive persons. This means the researcher wants to find out if humour has the ability to lower levels of anxiety in HIV positive persons. The researcher is only interested in the evaluation of these variables and how they relate to each other, and not in any specific individual.

Possible Risks: a) When participating in the intervention, you may come across material that you find unpleasant, upsetting, or objectionable. b) You may feel you have performed poorly on the anxiety rating scale. Please be advised that there are no right or wrong answers. You are encouraged to discuss any fears with the test administrator during the debriefing period, once all procedures have finished.

Possible Benefits: a) You may find that humour is a valuable tool for reducing symptoms of anxiety. b) You will have an opportunity to contribute to psychological science by participating in this research.

Confidentiality: You will be assigned a code number which will protect your identity. All data will be kept in secured files. All identifying information will be removed from questionnaires as soon as your participation is complete.

Opportunities to be Informed of Results: In all likelihood, the results of the study will be fully available by the end of 2010.

I have read the statements above, understand them, and voluntarily sign this form. I further acknowledge that I have received an offer of a copy of this consent form.

Dated: Day_____ Month _____ Year_____

_____ **_____**

Signature of Participant **Signature of Researcher**

Appendix B: Interview Guide (Pre-Test and Post-Test)

Interview 1 (Pre-Test)

1. What are your perceptions of humour or laughter? (What do you think about humour/laughter?)
2. How important do you think humour/laughter is in everyday life?
3. What are the stressors in your life?
4. How do you cope with these stressors?

Interview 2 (Post-Test)

1. What did you think of the humour therapy sessions?
2. Did you notice any changes in yourself over the past few weeks?
3. How important do you think humour/laughter is in everyday life?

Appendix C: Interview Transcriptions

Interview 1 (Pre-Test)

A. Perceptions of humour/laughter?

1. "I don't like laughter because I don't want to show my teeth, because they are crooked. And it gives me a headache, but it does temporarily improve how you feel."
2. "Each and every muscle in my body moves when I laugh. It is good."
3. "It makes your cheeks shine. It makes me sweat."
4. "It releases stress and makes you forget your problems, like drinking alcohol."
5. "It releases hormones and makes me feel better."
6. "It releases stress and makes me forget about my problems. "
7. "It makes me happy and forget about worries."
8. "It releases stress"
9. "It is medicine for people who are down, but temporary medicine because after you are back at square one."
10. "It releases stress"
11. "It releases stress and makes me happy."

B. How Important do you think humour/laughter is in everyday life?

Scale of the importance of humour/laughter in Daily life:

1	2	3	4	5
Unnecessary	Now & Again	Moderately Needed	Important	Very Important

Participant	**Rating**
1.	3
2.	3
3.	5
4.	4
5.	4
6.	4

7. 5
8. 4
9. 2
10. 4
11. 4

C. What are the Stressors in your life?

1. "My work life. I don't feel challenged anymore. It's boring. There is not much support from senior supervision. Also, having a daughter far away. And my weight, I'm struggling to keep it under control."
2. "My father was admitted to hospital recently."
3. "I need a wife. I need finance for lobola."
4. "My mother died in Oct 2006. I want to be married. My two children have different fathers."
5. "Finance."
6. "My husband has many girlfriends."
7. "My girlfriend whom I'm living with is cruel and rude."
8. "My boyfriend is cheating."
9. "Finance, family crises, and my relationship."
10. "For the first few months of this year I had stress, and went to see a psychologist, and the psychologist told me what to do, so now I don't have stress."
11. "Last month (June) I lost a cellphone, which I had bought in May this year. I have a 3 month old baby, and lost a bag full of my babies' clothes and my baby's birth certificate."

D. How do you cope with these stressors?

1. "I have an aerobic DVD by which I exercise. I have decided that it is time to bring my daughter to live with me, she will be here in one month."
2. "I talk to other guys... my friends."
3. "I drink beer, and keep my girlfriend happy."
4. "I cry. There are many clowns at work, where I laugh. Through prayer."
5. "I laugh at work"

6. “I just accept the situation.”
7. “I watch comedy movies at home.”
8. “I try to talk to my boyfriend, but it’s too hard.”
9. “I pretend they don’t exist. I just cope.”
10. “By crying, and exercising, and I have a motivational chart in my house.”
11. “I try to tell someone, I look for advice. I was told that these things happen to everyone, and what I lost was just material things. I can get them back.

Interview 2 (Post-test)

A. What did you think of the humour therapy sessions?

1. “Exciting, relieving and it brought me close again to the team members.”
2. “It was very interesting, seeing people laughing. I learned about others too, like who the clowns are.”
3. “Very nice. It must continue. It releases stress and makes me happy.”
4. “It done well for me. It released my stress because I laughed so much.”
5. “It was fun. I enjoy laughing.”
6. “It was helpful and good.”
7. “They did a lot to me, because when I’m here I feel free and have a lot of fun.”
8. “When we gather, I don’t think about hard times.”
9. “At first, I thought it was a waste of time. Along the way I realized that it’s sometimes therapeutic to laugh... even if it’s once a day.”
10. “They were nice. They make people release stress and go on with life.”
11. “They were helpful, because I gained a lot. For now, I’m stress free. “

Have you noticed any changes in yourself over the last 2 weeks?

1. “Definitely. I’m laughing at myself nowadays. I can’t relate anymore with most things on the Anxiety scale, except for indigestion. I am more chatty and less reserved.”
2. “Yes. It has helped me a lot with the stress over my father.”
3. “Yes. I noticed that being with a group helps to release my stress.”
4. “I now know laughter is important and a good way to make friends.”
5. “I value laughter even more now.”

6. “I have no stress because of the sessions.”
7. “Yes. At home I did not think too much about the stress.”
8. “I didn’t notice anything.”
9. “Yes. I’ve been denying myself time to laugh thinking that something worse will happen if I laugh. Not so now.”
10. “Yes. I did not like to sit with others, and laugh. But now I like to sit with them.”
11. “Before, I was not laughing and did not even want to eat. Now, life goes on. It helped me.”

C. How important do you think humour/laughter is in everyday life?

Scale of the importance of humour/laughter in Daily life:

1 2 3 4 5

Unnecessary Now & Again Moderately Needed Important Very Important

Participant	**Rating**
1.	5
2.	4
3.	5
4.	5
5.	5
6.	5
7.	5
8.	5
9.	4
10.	5
11.	5